Understanding the private health sector
in Sudan

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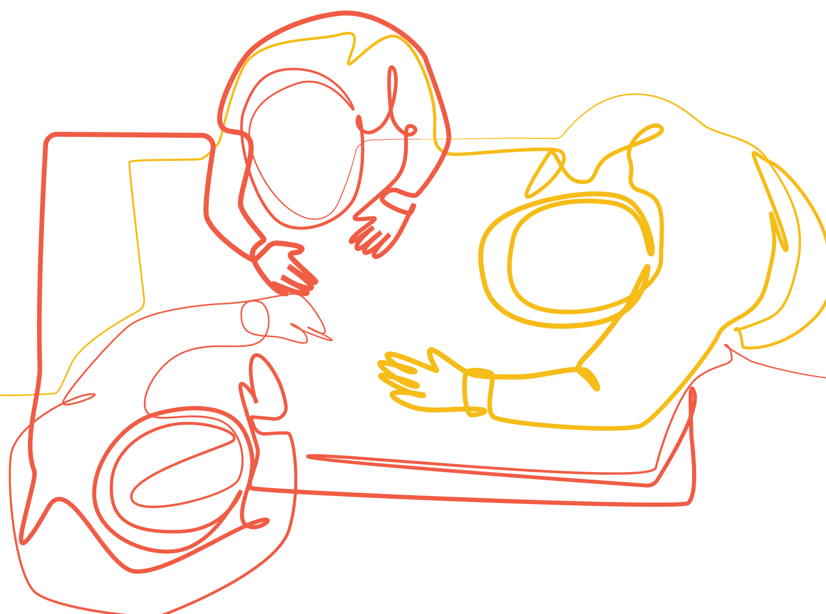

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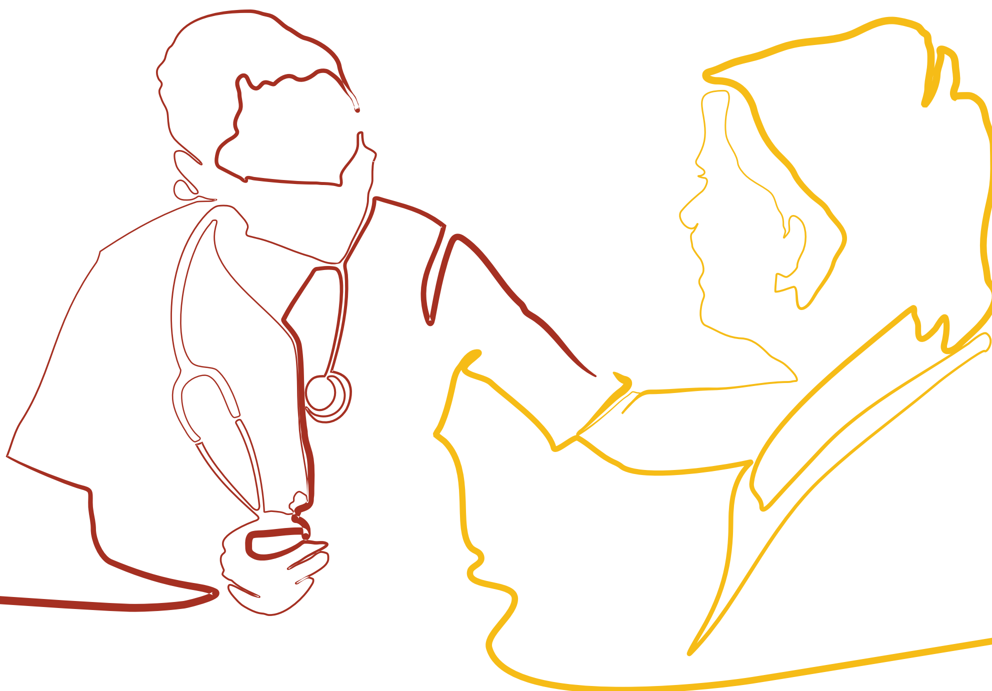


Acronyms and abbreviations

FMOH	Federal Ministry of Health	SMOH	State Ministry of Health
GDP	Gross domestic product	TB	tuberculosis
NHIF	National Health Insurance Fund	UHC	universal health coverage
PPP	public–private partnership		

1

Country context

1.1 Geography and ecology

With a land area of 1.8 million square kilometres, Sudan is traversed by the Nile and its tributaries, and shares its borders with (clockwise from the north) Egypt, Eritrea, Ethiopia, South Sudan, Central African Republic, Chad and Libya. It has access to the Red Sea, with a coastline of 853 kilometres. Its terrain is generally flat, featureless plains, with mountains in the northeast and west and desert dominating the north. The climate is tropical in the south and arid desert to the north, and the rainy season varies by region. The country's geography and ecology contribute to the shaping of health, nutrition and population, while vast distances and poor roads and other transport infrastructure affect access to and the coverage of health services.

1.2 Demography

Sudan had a total population of 41 984 512 in 2018, with the population growing at a rate of 2.8% annually. In all, 88% of the population are settled, including 49% living in urban areas, and 8% are nomadic. Almost 2% of the population are internally displaced, 1.4% reside in institutions and the remaining 0.6% live in cattle camps. Urbanization has been increasing, driven by natural disasters, civil conflicts and poor conditions in rural areas.

Average household size is 5–6 persons, and the fertility rate is 3.9 births per woman. The crude birth rate is 33.3 per 1000, and the crude death rate is 16.7 per 1000 (17.2 for males, 16.3 for females). Those under 15 account for 43.2% of the population, with 15% under the age of 5, 53.4% in the 15–64 age group and 3.4% aged 60 and above *(1).* Life expectancy at birth is 64.1 years (62.4 years for males and 65.9 years for females). About 68 out of every 1000 children do not live to see their fifth birthday *(2).*

1.3 Economy

Economically, Sudan is categorized as a middle-income country (US$ 2899 gross domestic product (GDP) per capita in 2017). Beginning in 2015, the Government of Sudan put in place its Five-Year Programme for Economic Reform, aiming to reduce the inflation rate to less than 10% and raise the growth rate to more than 10% by 2019. The programme also has many interventions to reduce poverty (36.1% of the population were living in poverty in 2014) *(3).* However, in 2018 the country went through an economic and financial crisis that may have changed its macroeconomic status. The inflation rate crossed the 50% threshold, and the overall economic picture is gloomy and unpredictable.

1.4 Social and economic conditions

Sudan is a multicultural society with hundreds of ethnicities, tribes and languages. A large majority of the population is Arabic-speaking Muslim. Sudan ranked 167th on the human development index in 2017 *(4).* Those living below the global poverty line represented 36.1% of the population, and 25.2% were in extreme poverty *(3).* Those hardest hit are rural dwellers, particularly women and internally displaced people. The adult literacy rate (15+) was 61% in 2018, while gross primary and secondary school enrolment were 78% and 48%, respectively *(5).*

2
Health sector overview

2.1 Health status

The main health status indicators for Sudan are shown in Table 1. With an increasingly ageing population, the country faces a double burden of disease, with rising rates of communicable and noncommunicable diseases (NCDs). The Sudan Multiple Indicator Cluster Survey 2014 showed that 29% of children aged 5–59 months had diarrhoea, and 17.8% were sick due to suspected pneumonia in the two weeks prior to the survey. Protein energy malnutrition and micronutrient deficiencies remain a major problem among children under 5, with 12% and 18.2% suffering from severe underweight and stunting, respectively. The most common micronutrient deficiencies are iodine, iron and vitamin A.

Sudan is considered a high-burden and high-risk country for malaria. As a result of malaria control efforts, total confirmed malaria cases decreased by 72% between 2000 and 2014, and mortality decreased by 62%. However, recent reports indicate that malaria cases have increased compared to previous years, with a high frequency of severe malaria. HIV has remained low in prevalence in recent years. However, only 8.2% of people living with HIV are receiving treatment. The tuberculosis (TB) prevalence survey of 2014 revealed a mortality rate of 21 per 100 000 people, a prevalence of 151 per 100 000 people and an incidence rate of 94 per 100 000 people. The main challenges include low detection rates, a rising number of cases of multidrug-resistant TB and poor integration of TB within the health system, particularly with HIV.

Natural and human-caused disasters cause humanitarian emergencies and threaten public health. As an estimate, about 18% of the Sudanese population are affected by floods every year during the rainy season, and around 10% of the population are exposed to drought. Epidemics are another threat to health and well-being, especially meningitis, as Sudan is within the “meningitis belt”, although haemorrhagic fevers such as yellow fever and dengue fever are also present.

Of the 17 globally listed neglected tropical diseases, 10 are a recognized public health problem in the country, including: schistosomiasis, lymphatic filariasis, trachoma, onchocerciasis, mycetoma, soil-transmitted helminths and leprosy. Sudan has recently declared zero cases of the parasitic infection dracunculiasis and is waiting to be certified for eradication of the disease. The country has also succeeded in putting mycetoma on the global list of neglected tropical diseases, which will facilitate mobilization of donors’ funds to control the disease.

Table 1. Sudan’s main health status indicators in 2018

Indicator	Value
Crude birth rate (per 1000 people)	35.24
Crude death rate (per 1000 people)	7.0
Total fertility rate (births per woman)	4.7
Life expectancy at birth (years)	66.0
Infant mortality rate (per 1000 live births)	41.0
Under-five mortality rate (per 1000 live births)	59.0
Maternal mortality ratio (per 100 000 live births)	293.0

Source: The World Bank, 2018

Of all deaths, cardiovascular diseases account for

11.6%,

cancers

5.2%,

respiratory diseases

2.4%

and diabetes mellitus

1.8%

Noncommunicable diseases cause 33.9% of all deaths in Sudan. Of all deaths, cardiovascular diseases account for 11.6%, cancers 5.2%, respiratory diseases 2.4% and diabetes mellitus 1.8%. Adults aged 30 have a 22.8% probability of dying from one of these four main NCDs by the age of 70. Injuries caused 13.4% of all deaths in 2012, 72.6% of which were unintentional, mostly from road traffic accidents *(6)*.

Mental health services are provided at specialized hospitals and centres and are not integrated within primary health care (PHC) services. A national mental health policy and strategy (2012–2016) was developed, but the strategy was not operationalized, so there was no implementation of mental health activities and no reports are available. There are no mental health promotion programmes targeting priority groups. Occupational health services are very limited, and there is no clear strategy to address risks associated with the working environment.

Looking at all aspects of the health system and health indicators, there are remarkable discrepancies between socioeconomic strata as well as among the states of Sudan. The lack of equity is apparent even within the states, between rural and urban areas, between rich and poor and between different localities. Inequity also manifests in the distribution of health system inputs, including human resources, health facilities and health expenditure.

2.2 Health system organization

In addition to the federal and state ministries of health, health services are also provided by health subsystems such as insurance schemes (social and private), the armed forces and private providers. The public sector health system has a three-tiered structure: 1) the Federal Ministry of Health (FMOH); 2) the State Ministry of Health (SMOH) in each state; and 3) the locality health management authority in each locality. The National Health Insurance Fund (NHIF), in addition to being a financing actor, has its own health facilities. The armed forces and parastatal organizations, such as the seaports, have their own networks of health facilities and insurance schemes. The private sector is growing at a rapid pace, focused on curative care and concentrated in major cities.

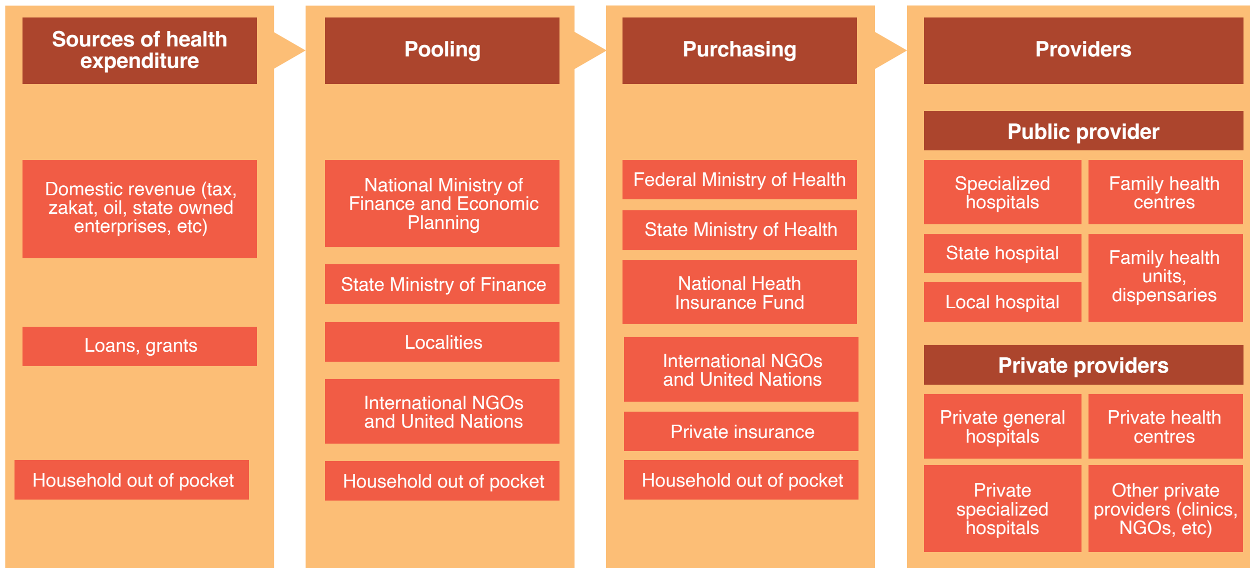
The provision of services in the health system in Sudan is organized at three levels: 1) the PHC level, which includes service providers starting at the community level such as village midwives and established facilities such as family health units, family health centres and rural hospitals; 2) the secondary care level, which includes health institutes such as general hospitals and state hospitals; and 3) the tertiary care level, which mainly consists of specialized hospitals and centres. The private sector in Sudan is represented at every level.

2.3 Health system financing

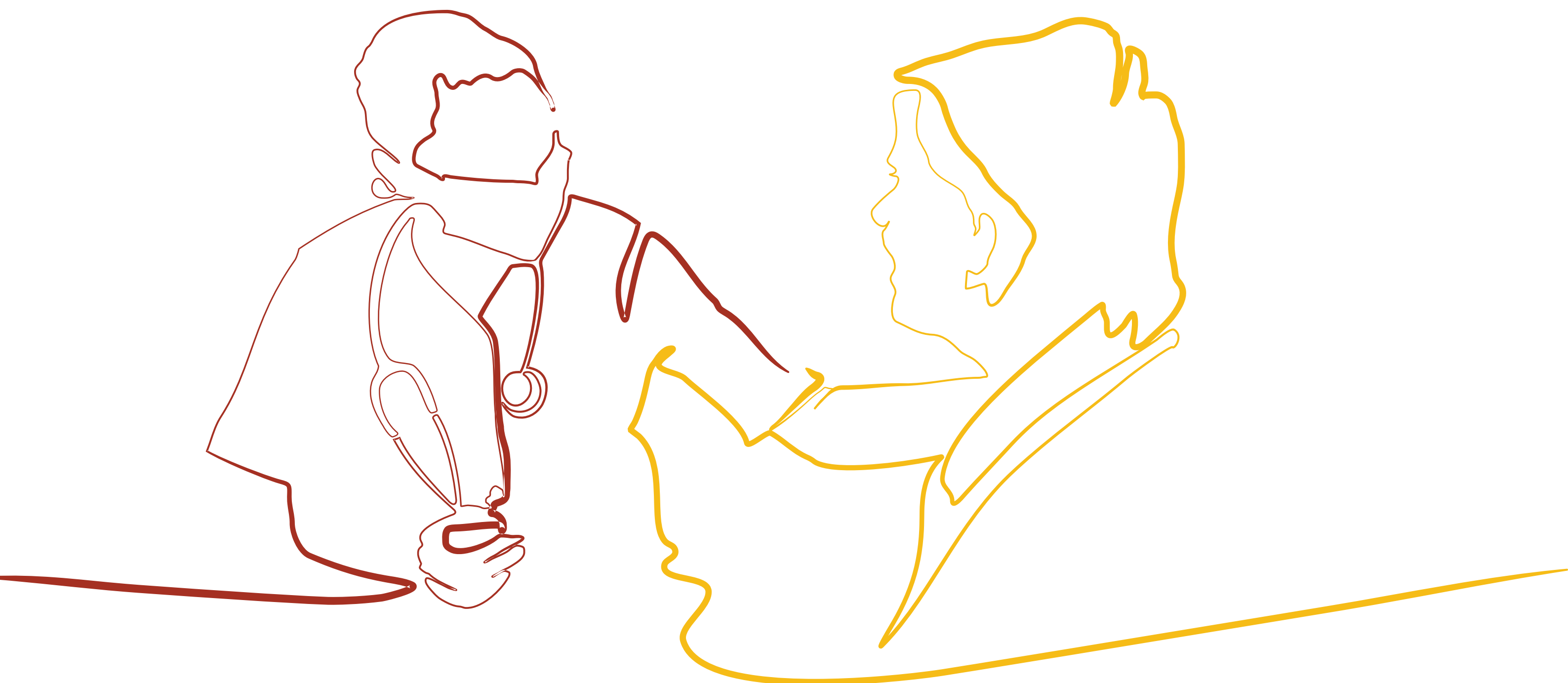
Major health financing schemes include ministries of health, the NHIF, the armed forces' health insurance schemes, out-of-pocket expenditures and international donors' schemes. According to System of Health Accounts 2018, 69.3% of funding is from private sources, of which about 69.23% is out-of-pocket expenditure *(7)*. The contribution from the rest of the world or partners was 6.63% of current health expenditure in 2018, while public sector funding was 24.06%, almost 5% lower than in 2008.

Funds flow to states and facilities (public and private) in a complex manner (Fig. 1). User fees are charged at all health facilities, paid either out of pocket or as co-payments through insurance if covered or exempted.

Fig. 1. Flow of funds in the health system



Source: System of Health Accounts 2018 *(7)*.



3

Private health sector analysis and stakeholder perspectives

The assessment team undertook a systematic and comprehensive analysis of the operational environment of the private health sector, using WHO's assessment tool. The assessment tool was developed in 2018 following the endorsement of regional resolution EM/RC65/R.3 Private sector engagement for advancing universal health coverage. This resolution requested the WHO Regional Office to "support assessments to identify challenges and opportunities related to the engagement of private care providers in service delivery in order to develop strategic action plans for effective partnership towards achieving universal health coverage".

The tool is divided into two parts. Part one, involves conducting desk review that aims to provide descriptive information and numerical data on the national context. While part two, requires conducting key informant interviews to gather qualitative insights from key stakeholders. For each part, the tool includes a detailed list of information areas that are to be compiled in the form of factual and analytical information, numerical data and subjective insights.

The purpose of this analysis was to provide policy-makers with evidence to make better and more informed decisions on the private health sector in Sudan, with the goal of improving overall health system performance and achieving universal health coverage (UHC).

This section presents the salient findings of the exercise. First, private health sector growth and its determinants are described, followed by an overview of private sector resources; financing, payments and mode of access to services; standards, quality and responsiveness; the regulatory framework and governance; public–private partnerships (PPPs) and collaboration. The findings conclude with recommendations and policy implications.

3.1 Private sector growth and its determinants

Both private for-profit and private not-for-profit entities exist in Sudan, and they play a major role in the provision of health care services. The private health sector has expanded rapidly during the last three decades. The private not-for-profit entities, including NGOs and faith-based organizations, are mainly concentrated in the Darfur states and the South Kordofan and Blue Nile states, which have been beset by conflict and instability for decades.

Historically, private practice in the health sector has developed over many years. Before the late 1940s, and during British colonization, the Sudanese health system was a fully public system. Later, physicians from the public system were permitted to have their own practice in a private clinic after official office hours. If they left public service, they were able to gain a licence to open a full-time private clinic. Unlike their colleagues in FMOH, staff members of the Faculty of Medicine of the University of Khartoum were not allowed to practise privately until the late 1960s, when they obtained the right to have a private practice outside official hours.

The first private hospital was established in the late 1950s, but by 1990 there were still only five private hospitals in Sudan. However, the private health sector expanded considerably during the 1990s. Development of the private for-profit sector in recent years, encouraged by the Government, both provided a market for and is probably increasingly

There is consensus that the private sector provides specialized services that the public sector lacks the capacity to provide

being driven by a strong production of medical graduates. Private health services are concentrated mainly in urban and better-off rural areas. They are perceived to be of better quality than government services and are mainly accessed by wealthier individuals.

As mentioned, public practitioners are allowed to practise in the private sector in addition to their work in public facilities. The bulk of the private health care facilities are clinics. Private secondary and tertiary care expansion was limited to a few states such as Khartoum and Gezira. The pattern of private sector expansion has been mostly in curative and secondary health care rather than in preventive or PHC areas.

The private health sector in Sudan is making significant contributions across all health sector levels. There is consensus that the private sector provides specialized services that the public sector does not have the capacity to provide. Despite this, the full scope of private health sector activity and contributions to health is typically excluded, or minimally represented, in assessments and evaluations of the health system.

When one looks at the full scope of private sector activities beyond service delivery – including medical training, commodity supply and health financing – a more realistic image emerges of a Sudanese private health sector that is diverse, widespread and complex. Over one third of the general health services available in the country could be accessed through private sector health facilities, faith-based organizations and other private not-for-profit facilities; these have recently been critical to extending into rural and hard-to-reach areas. Moreover, a wide range of private facilities provide key supportive diagnostic and pharmaceutical dispensing services.

Despite these contributions, a large portion of the private health sector has not been effectively engaged or included in national health planning processes. In particular, it was not effectively considered or involved in the creation of the National Health Policy (2017–2030) or National Health Strategy (2017–2020). Recently, the private sector has sought more presence and more of a role in the Sudanese health system, revealing the significant opportunities that exist to further leverage private health sector capacity in strengthening accessibility and the delivery of essential health services.

This assessment focuses on the private for-profit health sector, which has developed in the context of a national economy that encourages free markets and prohibits monopolies. The country promulgated the Investment Encouragement Act (with subsequent amendments in 1990) with the aim of attracting more investment, streamlining the investment procedures and facilitating privatization programmes. Accordingly, wide-ranging incentives, facilities and guarantees were offered to the private sector. These included complete exemption of customs fees on major projects; freedom of capital transfer; simplification of procedures; and tax breaks for 5–10 years on projects. One of the consequences of these policies is that the private for-profit health sector has flourished.

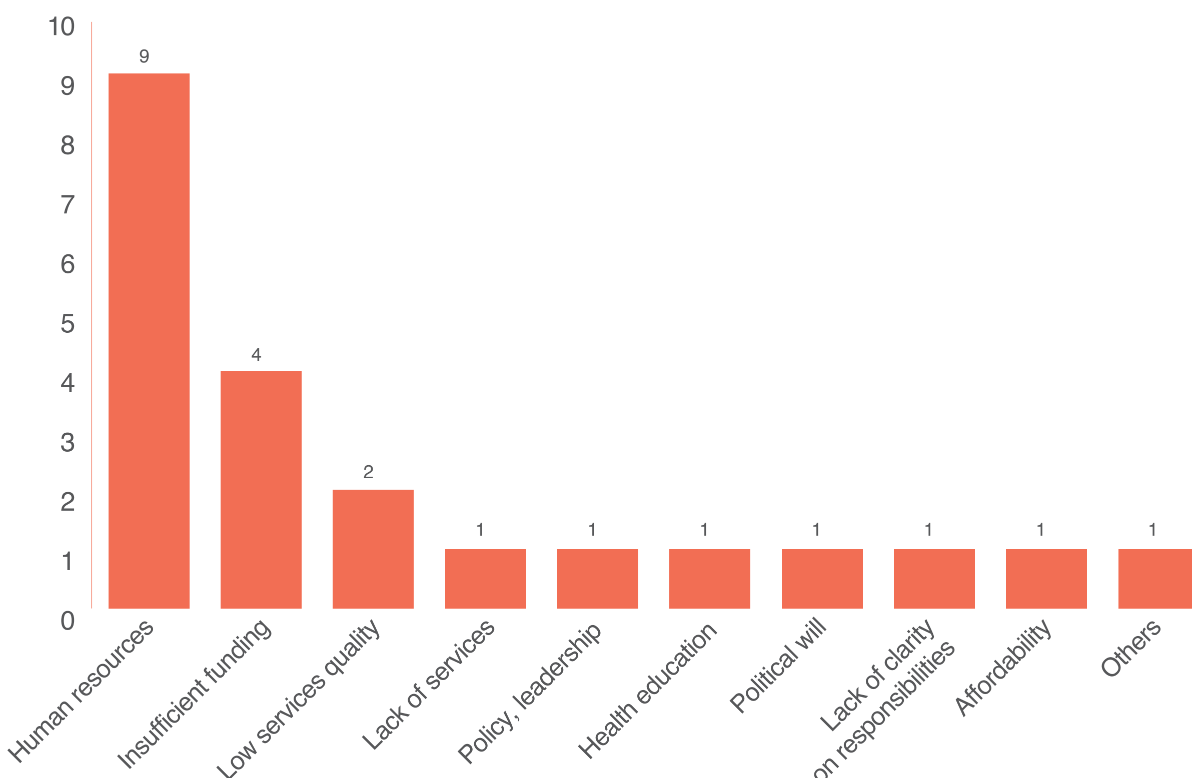
The private health sector has grown dramatically in the last two decades. A factor in that growth, besides the encouraging policy environment, was the deterioration in the quality of public health services, despite the introduction of user fees in public facilities from 1992. To represent and advocate its interests and issues in a formal body, the private health

sector affiliated and elected a Private Sector Providers Chamber under the Sudanese Businessmen and Employers Federation and the Union of Chambers of Commerce. The Chamber participated in several activities with the FMOH to develop clinical guidelines and develop proposals for small grants to support its members.

Private sector services in Sudan are organized at the primary, secondary and tertiary levels. Primary care at the community level is mainly provided by village midwives and traditional healers. In fact, those providers were the main actors in health care in Sudan before the introduction of a modern health care system by the Turkish–Egyptian regime in the 19th century, and they continue to play a considerable role in the provision of health services. At the facility level, PHC centres (for-profit and not-for-profit) provide primary health services. Doctor's clinics, medical laboratories and pharmacies are usually organized in the form of polyclinics and standalone facilities at the secondary level. At the tertiary level, many specialized hospitals and advanced diagnostic centres are established in the capital and other large cities.

Meanwhile, the respondents agreed that there are still many obstacles that hinder the private sector in its role for UHC in Sudan. A lack of well-trained health staff, insufficient funding and the relatively low quality of services are the main barriers (Fig. 2). More coordination between the public and private sectors is needed to facilitate the complementary role of the private sector for UHC. Establishing UHC committees under the Health Services Coordination Council could be challenging but also promising. A special committee under the Council's umbrella to regulate the role of the private sector in Sudan could strengthen its role and create enabling contexts and opportunities for better PPPs.

Fig. 2. Main barriers preventing the private health sector in Sudan from fulfilling its role



Source: Federal Ministry of Health. Sudan's National Health Policy 2017–2030 *(6)*

Proponents of the National Health Policy (2017–2030) argue that one of the many challenges facing the health system is the regulation, coordination and involvement of the private sector. The private sector is weakly regulated, with a lack of coordination among the different partners. Accountability is another challenge: while some private sector regulatory structures exist at the national level, most have no branches at state level and lack sufficient financial or human resources. The policy states that for better coverage and access to health services, the country should ensure good governance, effective coordination and accountability mechanisms to improve, oversee and regulate health care provision by different stakeholders including the private sector *(6).*

However, there are still many other political and contextual factors that hinder the expansion of private sector networks and wider engagement. These include the continuous conflicts in some areas of the country and population displacement. The underdevelopment of vast areas of some states has hampered the establishment of private health facilities and proper provision of services. Consequently, coverage of large populations with private sector services has not been possible, especially in rural and remote areas.

In addition, the recent economic context (high inflation and low growth) since the split of the southern part of the country to form the new nation of South Sudan means the establishment of planned or new health investments has slowed down, as have international funding and investment.

3.2 Private health sector resources

The private health sector is making significant contributions to health service provision in Sudan. As indicated in Table 2 below, of the total 10 645 estimated health facilities operating in Sudan, almost 5293 are run by public providers, and 5312 by private for-profit or private not-for-profit organizations – meaning that just over half of the health facilities in the country are privately operated.

However, the volume of services provided by the private sector within those facilities is far lower than that of the public sector (Table 3). Only 23.6% of the total services were provided by the private sector. This can be explained by the inequitable geographical distribution of the private facilities and the relatively high cost of private health services compared to public services, which create financial barriers to those services.

On the other hand, provision of services at private sector facilities can enhance the quality of health services and outcomes. Most of the patients interviewed at those facilities believe that the quality of services in the private sector is better than in the public sector. More utilization of private health services could improve diagnosis and treatment prognosis and hence reduce the number of visits per disease episode and could also reduce patient loads at public facilities.

In some areas, especially in conflict areas, the private sector (mainly private not-for-profit) is a principal supplier of health services. For example, out of 149 working health centres in South Darfur state, 51 are operated by NGOs and most of them are in displaced persons camps or hard-to-reach areas. The private health sector – through the

provision of human resources, specialized diagnostics and consultative services – can be critical in extending the reach of health services even into those areas.

Table 2. Public and private health sector resources

Type	Governmental	Quasi-governmental	Private (for-profit)	Private (not-for-profit)	Total
Individual clinics/ outpatient posts	2141		1748	321	**4210**
Clinics/dispensaries	2562		0	0	**2562**
Small hospitals (<50 beds)	279		230	0	**509**
Large hospitals (general)	73	40	7	3	**123**
Speciality hospitals	74		5	0	**79**
Diagnostic centres	0		147	0	**147**
Laboratories	0		885	0	**885**
Blood banks	164		0	0	**164**
Pharmacy stores	0		1966	0	**1966**
Total health facilities	5293	40	4988	324	**10 645**
Medical colleges	72	2	38		**112**
Training institutions	12		NA		
Hospital beds	30 212		3451		**33 663**

Source: Institute for Health Metrics and Evaluation. Sudan Annual Health Statistical Report 2017

Table 3. Volume of services delivered

Services	Governmental	Quasi-governmental	Private (for-profit)	Private (not-for-profit)	Total
Primary care/outpatient department	33 606 839	2 445 031	10 781 610	829 799	**47 663 240**
Disease control communicable diseases	1 258 313	91 574	403 687	31 069	**1 784 617**
NCD screening/treatment	1 654 622	120 380	530 829	40 855	**2 347 687**
Diagnostics/laboratories	253 567		758 059		**1 011 635**
Hospitalization/surgical	485 813	35 345	155 857	11 595	**689 010**
Dental care	1 143 090	83 164	357 075	28 224	**1 611 553**
Injuries/accidents	17 003	1 237	5 455	420	**24 115**
Mental health	63 441	4 616	20 353	1 566	**89 977**
Total	38 482 688	124 362	13 012 925	41 805	**55 221 834**

Source: FMOH. Sudan Household Health Utilization and Expenditure Survey 2012 *(8)*

Most of the private sector facilities, especially those working at PHC level, confirmed that their facilities provide most of the health services package with varying levels of “comprehensiveness”. Some facilities offer the complete package (curative, preventive and promotive packages), whereas others provide only curative services (mainly private facilities at the secondary and tertiary levels). Besides curative services

at the primary care level, private facilities usually provide nutrition, immunization and maternal health services. Standalone facilities such as medical laboratories, diagnostic centres and pharmacies provide only these specialist services.

Although the private sector network is not distributed equitably across the country, many people prefer to get their health services at private facilities (mainly charity health centres) because of their closer proximity. The cost of services may be higher than the public sector, but their reputation means people tend to prefer private facilities (Table 4). As noted above, there is a widely held view that private sector service quality is better.

However, weak coordination between private sector providers and the absence of a referral system are shared concerns of the respondents. These issues were attributed mainly to lack of basic services at the primary care or gatekeeping level, which has consequently led to a weak referral system between health facilities, including private sector facilities. Findings indicate that when primary care level facilities lack qualified staff or basic items such as laboratory services (e.g. analysers or haemoglobin machines) and/or patients are geographically close to higher-level facilities, patients often by-pass primary care facilities and select a private provider at a higher level instead. There were no clear regulations determining how patients should be referred from private sector facilities to public facilities or vice versa. Private pharmacies, laboratories, specialist clinics and hospitals accept patients for all kinds of services, including primary care services. People are permitted to access most of the secondary and tertiary private facilities for most of the services directly, which affects the efficiency of the health system.

The NHIF has a well-established referral system including both public and private facilities. Patients are not received and treated without being allocated to a specific facility at the primary care level (health centre). Referral to higher levels is subject to specific guidelines and criteria to which facilities and service providers have to adhere. Meanwhile, coordination between SMOHs and the NHIF remains weak.

Table 4. Main reason for selecting a private health facility

Type of facility	Distance (%)	Reasonable cost (%)	Good reputation (%)	Previous experience (%)	Referred to the facility (%)	Health insurance (%)	Staff can help me (%)	Other (%)
Private hospital	22.60	6.20	47.90	6.70	1.10	6.20	2.80	6.60
Charity health centre	76.50	12.70	6.00	0.00	1.70	0.00	0.30	2.80
Private clinic	21.10	4.10	56.40	7.00	2.80	1.10	2.80	4.60
Private diagnostic centre	44.30	6.60	25.60	7.80	5.30	1.50	5.20	3.70
Physiotherapy clinic	22.60	20.20	51.30	0.00	4.20	0.00	0.00	1.60

Source: FMOH. Sudan Household Health Utilization and Expenditure Survey 2012 *(8)*

3.3 Human resources in the private health sector

Although there is wide agreement that private sector health professionals fill an important gap in the health system in Sudan, there are no accurate statistics about how many people work in the private health sector: specifically, the exact composition of the health cadre in this sector and how those facilities are equipped. Most of the facility surveys conducted in the country focus on the public sector.

The little statistical data available show that the distribution of private health workers is uneven. Despite the fact that over 50% of the population resides in rural areas, 70% of health workers are in the urban areas, with 38% in the capital, Khartoum, alone. Moreover, 67% of the staff work in secondary and tertiary care. The great majority work in the public and private sector at the same time – dual practice is common among public sector employees. Only 9.3% of the health workforce work exclusively in the private sector. Some figures for the health workforce of both sectors combined are found in Table 5.

There is no clear system in place to attract private sector providers to rural or remote areas, as the distribution is mainly market driven. The rural areas are usually poor areas. In some states the incentives provided are relatively small to convince health workers to willingly move to those states or rural areas, but there is also a lack of specific policy. Most health workers are concentrated in Khartoum state and the capitals of a few other states. For instance, in 2017, almost 64% of specialists were working in Khartoum state or Gezira state.

3.4 Regulatory framework and governance of the private health sector

The FMOH recently developed a Private Health Facilities Law in coordination with the Ministry of Justice. However, the law has not yet been endorsed by Parliament. It defines private health facilities and stipulates who should own the private facility, the qualifications of facility managers, the licensing process and the characteristics of each type of private health facility. Each SMOH would be responsible for implementation of the law in its state.

Table 5. Sudan's health sector human resources (public and private combined), 2017

Type of health workers	Total
Doctors (houseman, general and registrars)	5763
Specialists	2098
Dentists	553
Pharmacists	1229
Nurses	13 664
Medical assistants	6233
Medical technicians	12 710
Certified midwives	16 698

Source: Institute for Health Metrics and Evaluation. Sudan Annual Health Statistical Report, 2017

The Sudan Medical Council is an independent government body affiliated to the Council of Ministers and is responsible for receiving medical complaints or claims of malpractice

At the state level, Khartoum state has issued its own Private Health Facilities Law, which has been approved by the state legislative council. The Department of Private Curative Facilities at the SMOH is responsible for implementing the law. The Department is well staffed and reports directly to the State Minister of Health. Besides issuing and renewing licences, the Department is to conduct regular visits to private facilities to check their compliance with service standards. If a private facility is found not to be fulfilling the standard criteria for services, they can close the facility and stop the services. However, not all states have such a department in their organizational structure, and the responsibilities of supervising private facilities are distributed among various departments such as human resources, PHC and curative care.

The Sudan Medical Council is an independent government body affiliated to the Council of Ministers and is responsible for receiving medical complaints or claims of malpractice in private or public facilities and deciding on them according to the Sudan Medical Council Act. The Council has the right to cancel the registration of any medical practitioner and to prevent the practitioner from providing any further medical services at any facility if malpractice is proven.

In 2010, the Health Care Institutions Inspection Committee was established with the objective of ensuring that good medical practice and professional conduct are well established in health institutions. The Committee ensures adherence to the National Service Delivery Standards set by the FMOH, and it also issues recommendations to meet the standards to improve service delivery at health care institutions (both public and private). The Committee includes representatives of the FMOH, armed forces, police, medical services and professional organizations.

At the level of civil society, the Sudanese Consumers Protection Society handles consumer complaints, including medical complaints, and has been a leading voice in educating the community on consumer protection issues in Sudan since 1998. The Society is active in educating key stakeholders in Sudan about the importance of consumer rights.

3.5 Regulatory mechanisms for private health facilities

Licensing is obligatory for all facilities owned by private entities, whether individuals, companies or NGOs, and for some governmental entities (such as the NHIF). Licences are issued by a specific department in the SMOH, the Private Health Facilities Directorate. To acquire the licence, the entity should agree to provide the basic health services package as part of their services. The licence is issued in two stages: initial licensing to establish the business (at the registration phase) and the final licence after fulfilling all requirements to start providing the services to the population. Respondents criticized the licensing process in some states as it focuses on the collection of fees at the registration phase but not on assuring fulfilment of standards.

A facility licence is usually to be renewed annually, although in some states licensing can be for up to three years. Renewal is compulsory, and cases of noncompliance incur penalties to be paid on top of renewal fees. Professional staff licensing is not required annually except for midwives.

Another example of regulatory mechanisms is the accreditation programmes conducted by specific committees using specific forms (started as a pilot in some states) to license health facilities. Health facility accreditation targets all facilities, both private and public, and helps them apply quality standards. Accreditation includes continuous medical training, but training is not covering the gap. It tends to be only for specific funded service packages, rather than for all curative services.

3.6 Quality, accreditation and oversight of services in the private health sector

One of the main arguments of those who prefer to use private health services is the better quality of services they receive compared to public facilities. Some of the standalone for-profit facilities have state-of-the art equipment along with highly trained staff. But this not the case for all for-profit facilities, nor for many of the not-for-profit facilities. The qualifications and training of the staff can be questionable, as can be the availability of all necessary equipment. The assessment of both professional services providers (by the Medical Council and training institutions) and facilities (by SMOH authorities) is critical to make sure that they have the relevant qualifications and training and the minimum setup requirements to provide services according to FMOH standards.

The national health information system is primarily based on health facility reporting and supplemented by surveys. The main challenges to the health information system include fragmentation and low reporting rates, especially at PHC facilities (the reporting rate is 85% from hospitals and 30% from PHC facilities). Data quality assurance is limited. Systems for data management and analysis are largely manual and focus on the public sector, whereas data from the private sector are rarely reflected.

Private sector data completeness is often lacking. Most of the respondents agreed that much work was needed to improve the generation, completeness and use of the data. There is a need to hold regular meetings at the state and locality levels. In addition, state teams should organize regular supervisory visits to private facilities.

Most of the vertical health projects or programmes collect their data from private facilities separately, then compile them with other reports into one integrated report. Sometimes they include the data in the public health information system, but usually the data are not well integrated into or reported to that system. The compiled reports are referred to as PHC, then shared with the health information system, where they are included in the main country report.

Although Ministry of Health instructions to the private sector are to submit integrated reports that include the indicators from all programmes, information is still collected through separate programme reports. These reports are integrated into monthly and annual notifiable disease reports and in the annual FMOH statistical report. Private facilities claim that they submit regular reports but that they receive no feedback from the Ministry.

Currently, the NHIF receives regular and detailed data from the private sector via the financial claims process. However, these reports are not usually integrated or shared with the FMOH. Respondents agree that the health sector has been through a process of services integration and planning. NHIF-owned facilities and centres are classified as quasi-public facilities, reporting to the FMOH on items such as cases treated.

However, indicators generated from those reports are not usually used as evidence for planning for the private sector's role in Sudan's health system. Worse, the lower levels (the facility and locality levels) receive no feedback from upper levels. Some vertical programmes use their own data collected from the private sector to plan for their future activities. The situation is better at the state and federal levels, where information generated from annual reports is used as evidence for planning and solving problems, and initiatives are typically based on assumptions generated from reports.

The NHIF has in place a very effective monitoring and evaluation system that monitors all services provided for its clients, including private facilities, but the NHIF does not share the resultant data with the Ministry. The system helps the NHIF identify and track utilization rates at private facilities. However, the respondents reported that there were some delays in those reports as they are paper based.

Some private providers at the primary care level confirmed that the NHIF makes routine supervisory visits to their facilities to assess their operations. NHIF staff examine outpatient department books, diagnoses, the laboratory and the dispensary, and, at times, they examine waiting times and prescription practices.

3.7 Financing and mode of access to services

There was consensus among all interviewed policy-makers on the importance of private sector engagement to achieve UHC in Sudan through filling gaps in service availability, increasing coverage and accessibility, and improving service quality. Typically, the private sector (mainly for-profit) is considered a provider at the secondary and tertiary levels as a response to market demand, but it is actually found to be a provider of different packages of services, including even the basic components of the health system (immunization, growth monitoring, management of communicable and noncommunicable diseases and health emergencies), with a comprehensive range of service packages (both curative and preventive) directed towards all populations in all age groups *(7)*.

As seen in Table 6, the main source of health system funding in Sudan is directly out of pocket, which reached 69.23% of total health expenditure in 2018 *(7)*. Most of these expenditures were for curative care at the secondary and tertiary levels, at both private and public facilities (user fees became obligatory in public facilities in 1992). The System of Health Accounts 2015 estimated the private sector for-profit market at SDG 4.95 billion (US$ 812 million), which represented almost 16% of the total health market in the country. This was a conservative estimate because it included only private hospitals, health centres and clinics. Private not-for-profit facilities, pharmacies and private medical schools were not included.

Table 6. Health financing indicators in 2018

Health financing indicator	Value
Total health expenditure (THE) (US$, billions)	2.4
THE per capita (US$)	58.8
THE as percentage of nominal GDP	4.78%
Private (household) out-of-pocket expenditure as percentage of THE	69.23%
Public health expenditure as percentage of THE	24.06%
External aid/donors	6.63%
Medical technicians	12 710
Certified midwives	16 698

Source: System of Health Accounts 2018 *(8)*

Donors' funds for the private sector are directed to cover primary care interventions and humanitarian responses (mainly private not-for-profit). Usually, donors' private sector funding focuses on preventive care, although it can include curative services, especially in emergencies and conflict areas. Respondents reported that the private sector had received increasing funds in recent years to include some public health programmes such as malaria, TB and HIV. The private sector, especially civil society networks, has good community access as a result of providing services to communities.

The private sector can be contracted by the NHIF through state branches, as stated in the Act of National Health Insurance Fund, 2016 *(9)*. Through its branches in states, the NHIF negotiates the prices of services and claims reimbursement mechanisms. Private insurance companies usually contract private sector providers, and each company has created its own network of private providers.

There are no clear mechanisms for the public sector to finance the private sector. The respondents did not report any cases where the FMOH financed or purchased services from the private sector. Some of the welfare funds such as the Zakat Fund provide financing for medical services that are not available in public facilities nor affordable to poor people.

Most respondents interviewed at private facilities such as private hospitals, pharmacies, laboratories and specialist clinics indicated a need for greater working capital to improve facility infrastructure and install advanced and sophisticated technologies. The majority of private health practices in Sudan are established with personal funding (either savings and/or loans from relatives or friends). In a few cases, private providers were able to secure institutional or bank loans to initiate a private practice because they had the requisite collateral. Many private providers stated that they were unable to expand to meet health needs with some services because of limited revenue to invest in facility and/or equipment upgrades.

In general, while Sudanese commercial banks and financial institutions are interested in expanding health sector access to finance (e.g. Bank of Khartoum and Sudanese Arabic Bank), few financial institutions possess the know-how and tools for effective health sector lending.

Most private health service providers are paid in the form of a fee-for-service in which individual patients are charged before they access the service

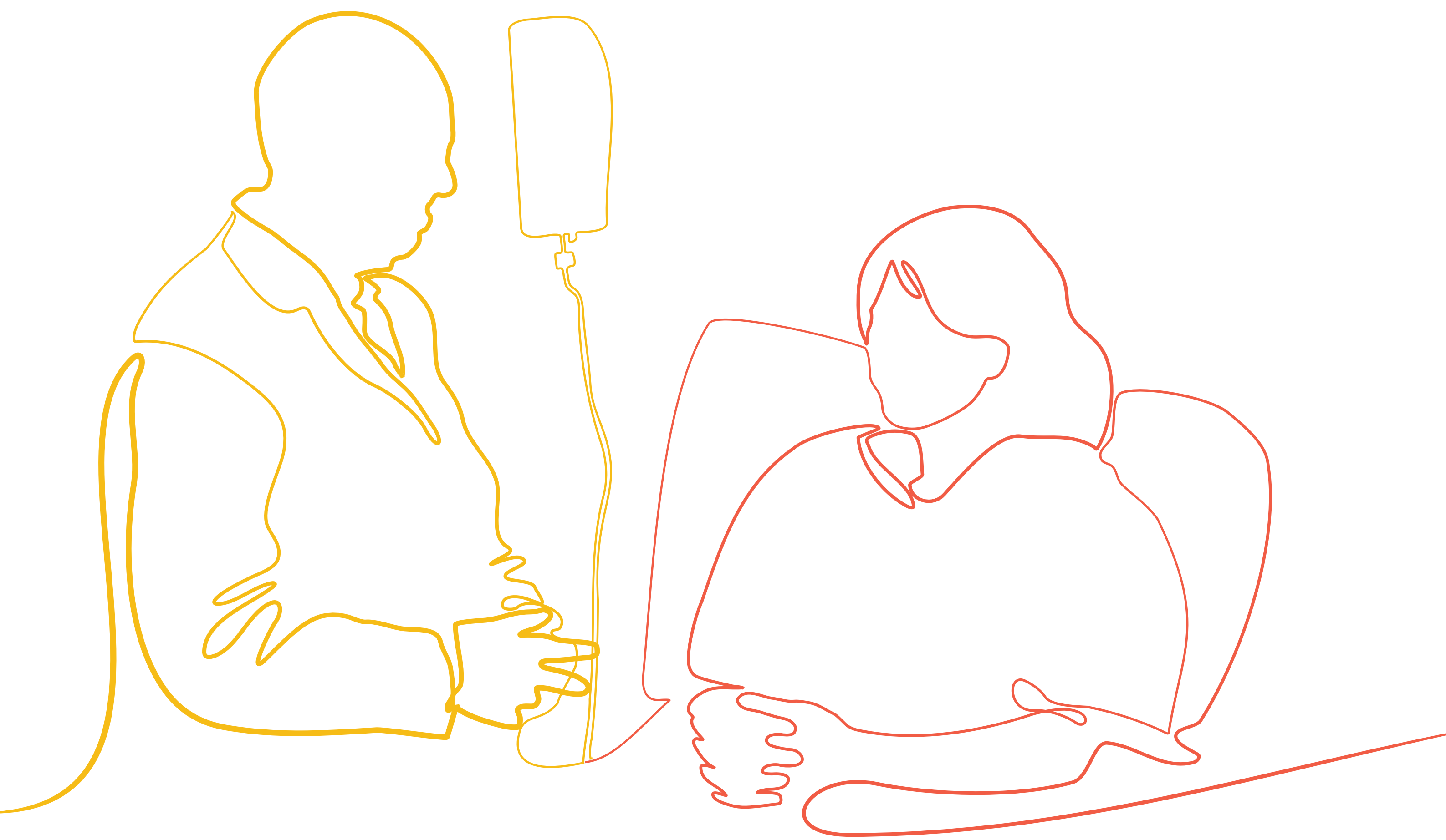
Bank and microfinance institutions' lending initiatives for the private health sector have been unsustainable and limited. When loans were provided, they were usually in the form of short- and medium-term loans of no more than 5 to 10 years' duration. The inability of banks and microfinance institutions to adequately assess and analyse their levels of lending to the private health sector poses a problem for future access to finance for these institutions.

Large private facilities such as hospitals and diagnostic centres usually succeed in obtaining funding through bank loans, although the success rate in obtaining loans varied by size of health facility, type of operation and the existence of personal relationships. Hospitals required financing of US$ 5–20 million, and smaller private facilities (e.g. health centres and health units) indicated financing needs of approximately US$ 100 000–150 000 in working capital for investments in equipment and infrastructure.

The costing of services – and consequently the prices of services – in the private sector is not scientifically developed. Prices are usually decided by comparing with other providers. Budgets are typically estimated according to the cost of the previous budget. Most of the respondents agreed that funds were insufficient to cover all required upgrades to private sector services components. Available funds were used mainly to cover staff salaries or incentives and running costs.

Various mechanisms of payments to health service providers have been reported in Sudan, especially for public providers. However, most private health service providers are paid in the form of a fee-for-service in which individual patients are charged before they access the service, according to specific prices for each service. The owner of the private facility decides on the fees. There are no government regulations on the private sector regarding the price of services. On the other hand, when health insurance companies or large private firms contract private providers, they negotiate the list of service prices and tend to secure discounts.

Some respondents stated that if the NHIF were to expand the package of medical services that could be purchased from private providers at a reasonable price, it would significantly raise private service providers' contribution to filling the gap in service provision, helping to improve the population's health status and meet UHC objectives. To date, private providers have not added preventive services to their service line. Private providers explain that their operations are largely based on recovering their costs and generating profits to pay the salaries of workers, purchase medical supplies, and provide and maintain infrastructure. They report that there is currently no incentive for them to provide preventive services. The neglect of the private sector as a partner in prevention may be hampering health promotion in Sudan.



4

Public-private partnerships in health service delivery

There are no well-established models where a private sector provider has been financed by the public sector or uses existing public facilities to provide a complete package of services

The National Policy for the Private Health Sector (2009) discussed the issue of PPPs and defined the roles and responsibilities of the states vis-à-vis the private health sector in the overall context of the health system. The policy stated that the private sector may be contracted, at the expense of the public sector, to provide services such as the laundry and central sterilization room, kitchen and catering, gardening and cleaning. This a common trend in many public hospitals in Sudan, and usually SMOHs outsource these kinds of services to private providers.

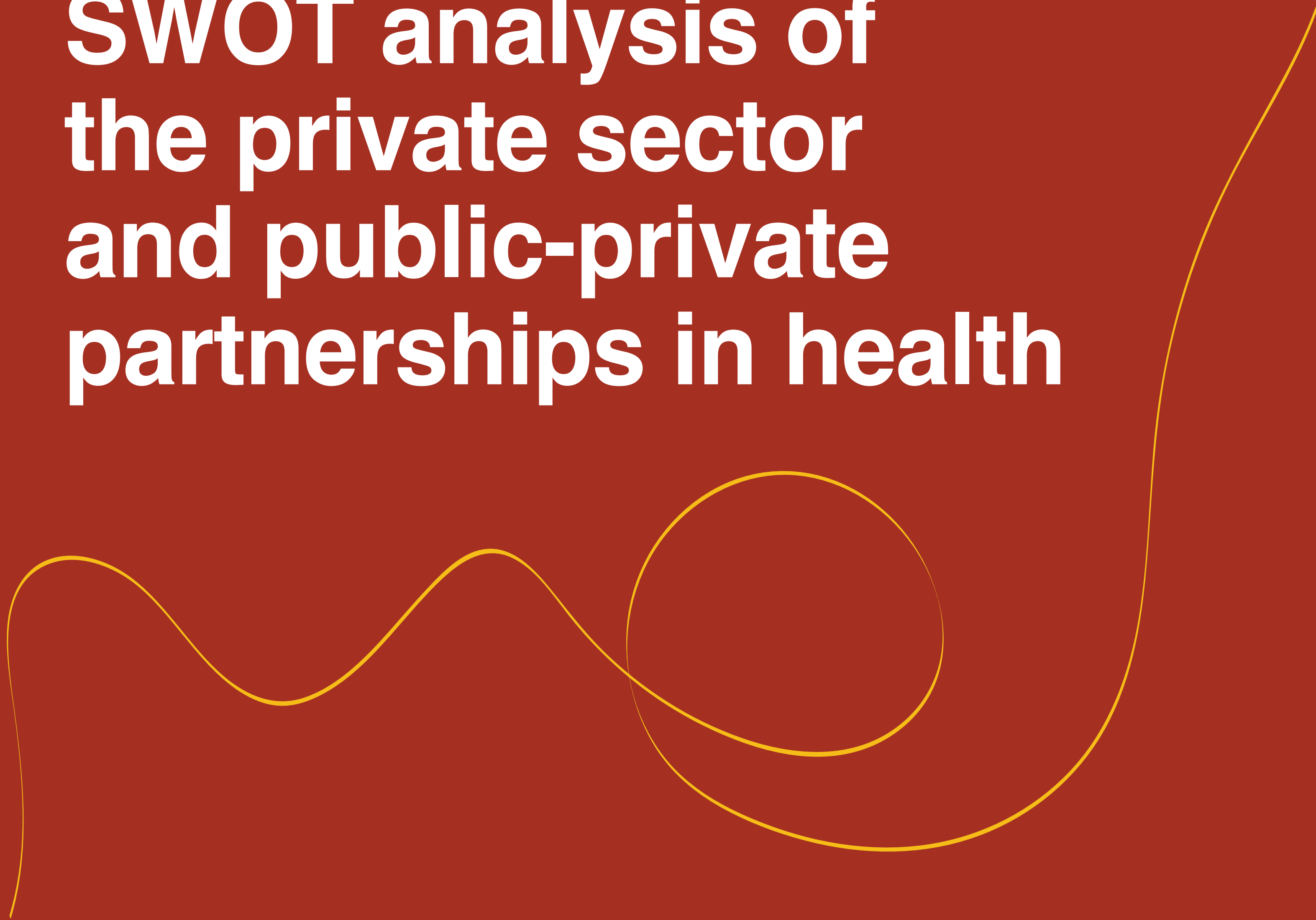
However, the policy also stated that the contracts may be made with private providers to organize and manage health services using public sector infrastructure. The contracting-out arrangement is a sort of PPP, which the policy supports. The Government could develop a detailed mechanism for instituting arrangements to contract out support services. The private sector could also be contracted to provide a defined health services package.

However, this model of PPPs' role in the country is actually very limited, and there are no well-established models where a private sector provider has been financed by the public sector or uses existing public facilities to provide a complete package of services. Only one model has been reported here where the FMOH has co-financed a private not-for-profit facility with an Italian NGO (El Salam Cardiovascular Hospital).

The NHIF has much experience with PPP. Under the Health Insurance Law (2015), the NHIF can make a direct contract with private providers to fill any gaps in the package of services committed to the insured population. The NHIF has developed a detailed reimbursement policy to regulate the relationship between it and contracted private providers. However, concerns were raised on the range of services that could be covered and reimbursed. The provider reimbursed only for provision of a package of curative primary care services and some secondary services. Respondents noted that this policy discourages private providers from delivering high-cost tertiary and secondary services to NHIF customers. For instance, the NHIF does not fully cover joint replacement operations, which makes providers reluctant to conduct them. This explains the high out-of-pocket expenditure by the insured population, especially for chronic diseases.

5

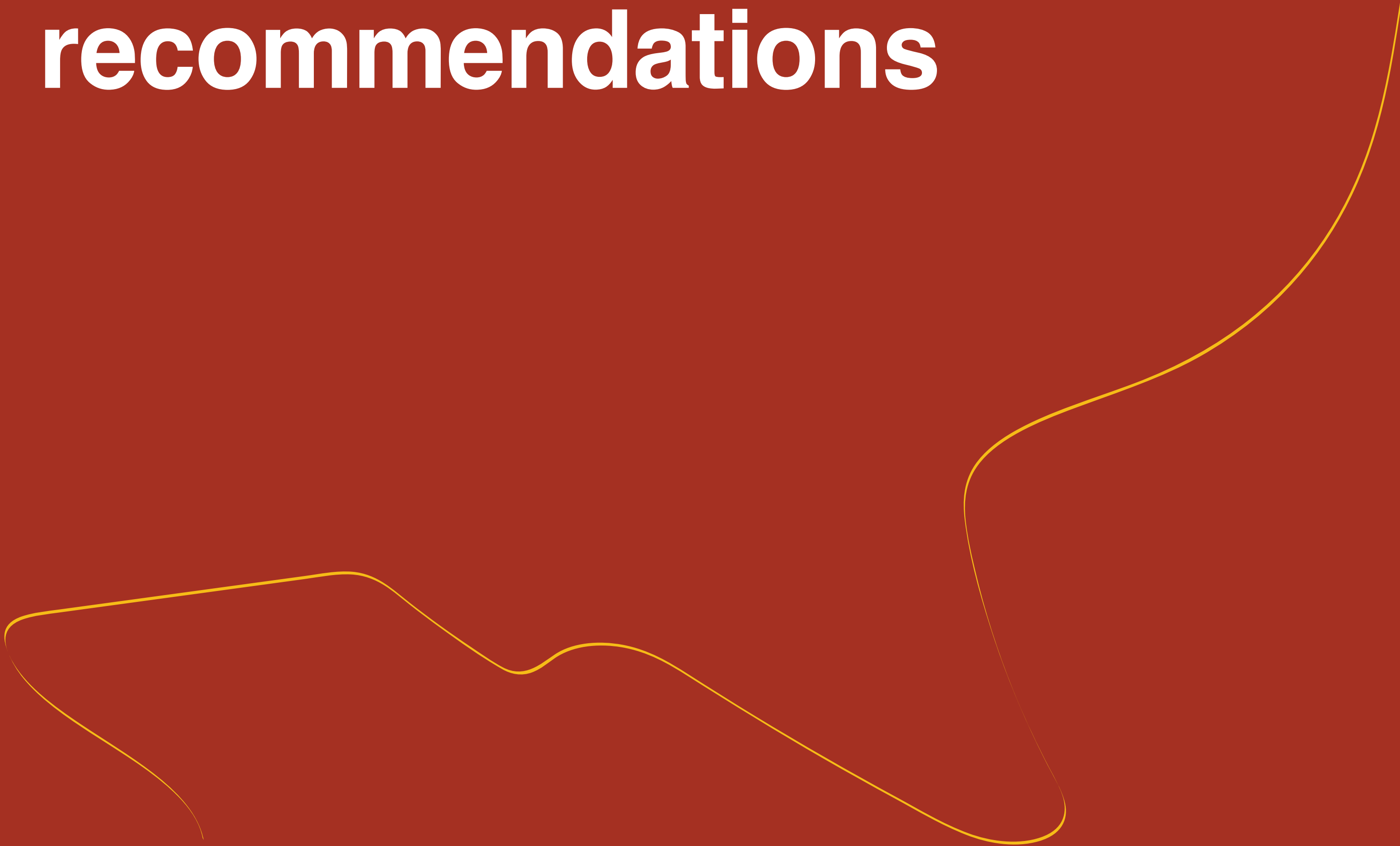
SWOT analysis of the private sector and public-private partnerships in health



As noted, PPP practices in the country are not well studied. However, the following SWOT analysis was prepared using the information obtained from the desk reviews and from stakeholder interviews (Fig. 3). The results of the SWOT analysis were then used to identify challenges facing the engagement of the private health sector through PPP contracts.

Fig. 3. SWOT analysis for PPP

6
Policy options and recommendations



In analysing the results of the study, the team found that there are many gaps that hinder the achievement of UHC in the current engagement and practices of the private sector in Sudan. These include political, structural and organizational issues. Most of these issues fall under the responsibility of both the public and private sectors, regulation of the roles of each sector and complementary partnership.

The FMOH and NHIF (representing the public sector) are making ongoing efforts to achieve UHC in Sudan; however, serious challenges will continue if the private sector's involvement in the UHC reforms is not addressed and properly defined.

The assessment team prepared the following set of recommendations, largely directed to both the FMOH and NHIF, as well as the private sector itself:

- **Based on the recently developed National Health Policy and National Health Financing Policy, the ministries of health and NHIF should work together to create a national private sector policy that elaborates clear definitions of the private sector's roles towards achieving UHC. The policy should detail the private sector inputs to complement and strengthen the health sector in Sudan. The role of the collective private health sector should be strengthened at the national and state policy levels and through advocacy groups and specialized associations.**

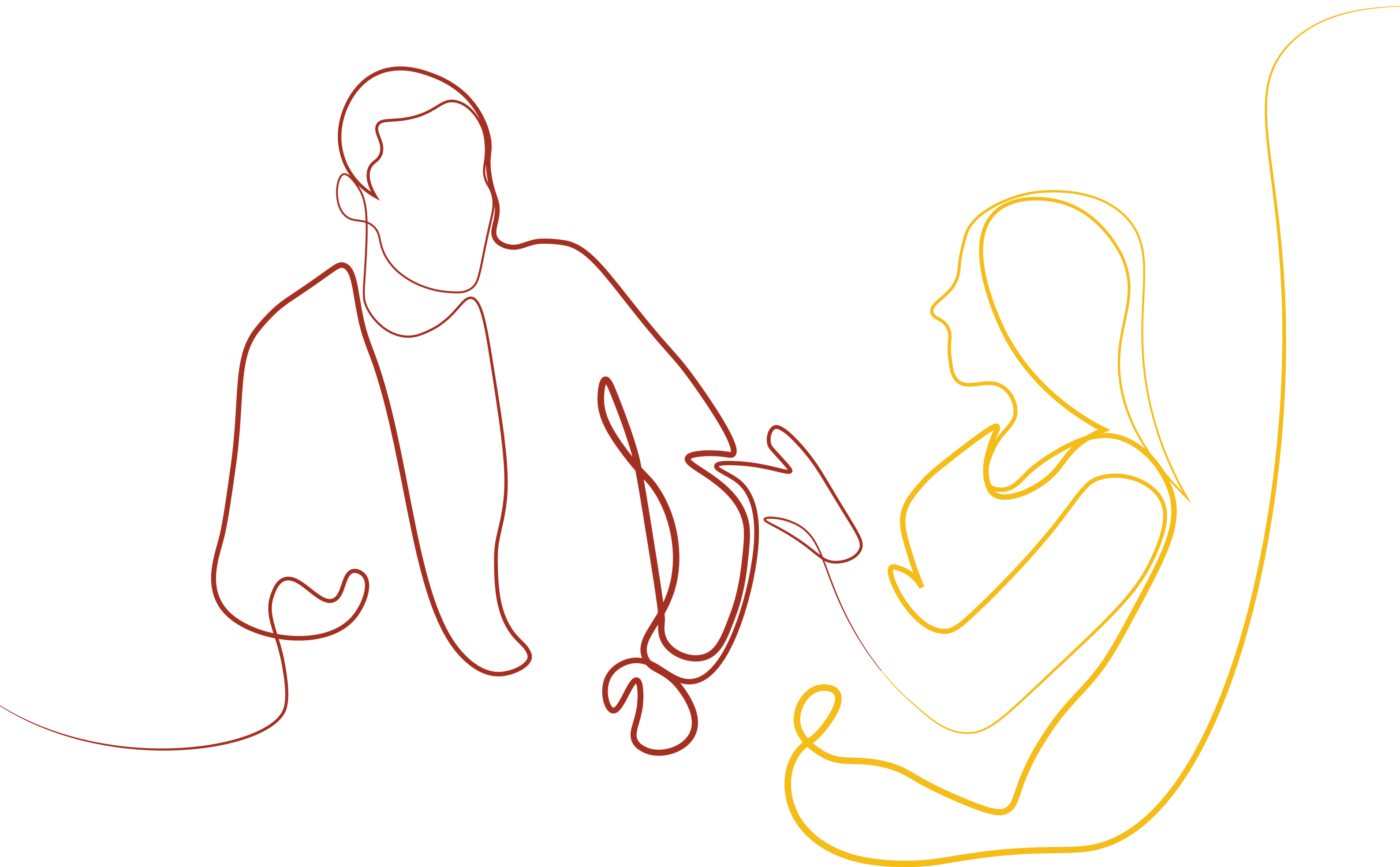
- **Maintaining a rigorous research agenda to advance knowledge about the private sector's contribution to health system outcomes in Sudan can help alleviate misconceptions and contribute to integration and evidence-based policy dialogue: one of the greatest barriers to fully integrating and leveraging the private health sector in Sudan is the dearth of valid, accurate and consistent data about the private health sector concerning its quality, the utilization of its services and its size.**

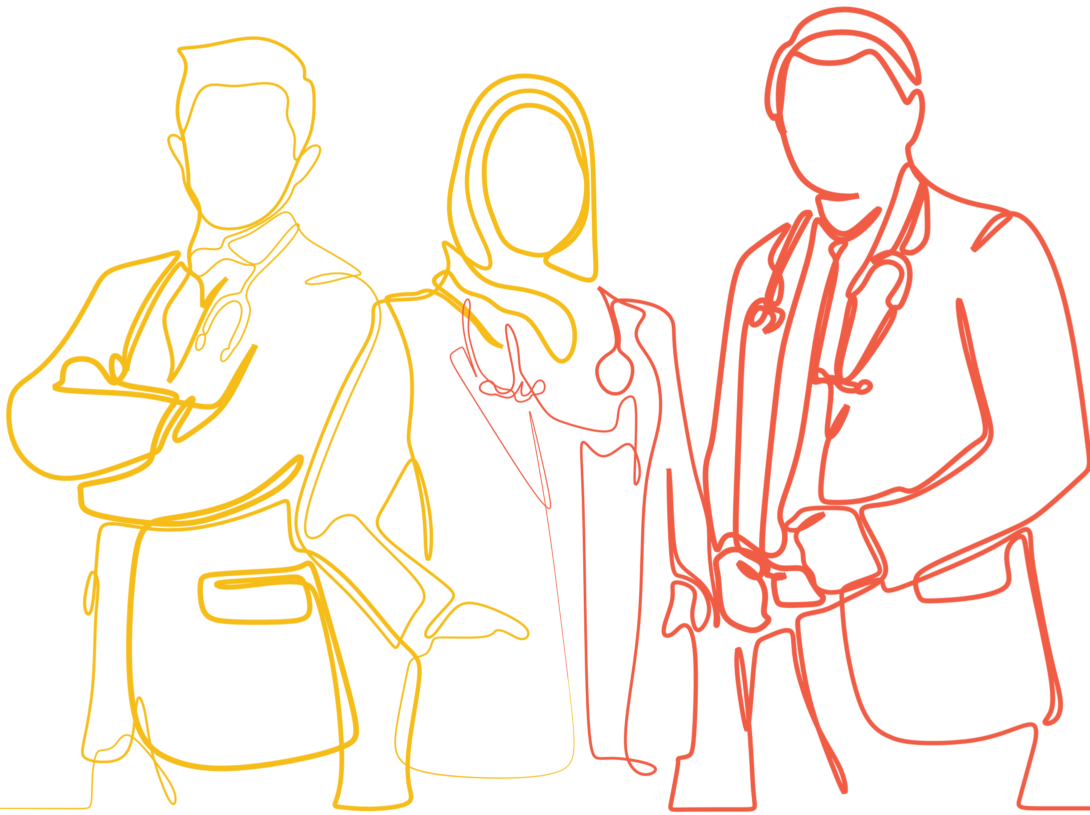
- **A comprehensive research agenda that includes mapping of private sector health facilities can help determine new areas for expansion based on the density and utilization of clinic-based private facilities. Similarly, impact evaluations can help us to understand the effectiveness of ongoing interventions, such as the relationship between improved access to credit for private providers and improved provider quality of health services, as well as improved client outcomes. Baseline measures of quality at multiple levels of service provision in the private health sector are also important for prioritizing the interventions that will work best to improve the quality of private health services.**

- **Improve opportunities for easy access to finance and to increase the business capacity of private providers. Design agreed-upon models for private health investors to access finance programmes with banks and microfinance institutions to strategically provide incentives for business formalization and sustainability.**

- **Stimulate a more desirable mix of health providers (private and public) all over the country that could fill the gaps in health care services and packages by carefully channelling targeted and supervised loans and incentives to private providers that would advance health outcomes in less-developed geographies, underserved urban areas and remote areas of the country.**

- **The quality of services should be standardized among all private for-profit and private not-for-profit providers. The SMOHs' capacity to assure good quality and standards should be strengthened. With the support of the FMOH and professional bodies (such as the Medical Council), efforts should be made to sustain a good level of quality at those facilities, including: i) reviewing existing clinical standards to determine if they meet international best practices; ii) establishing universal quality standards that apply to both public and private medical providers; and iii) investing in systems and staff to monitor quality standards across all sectors – public, private not-for-profit and private for-profit alike.**





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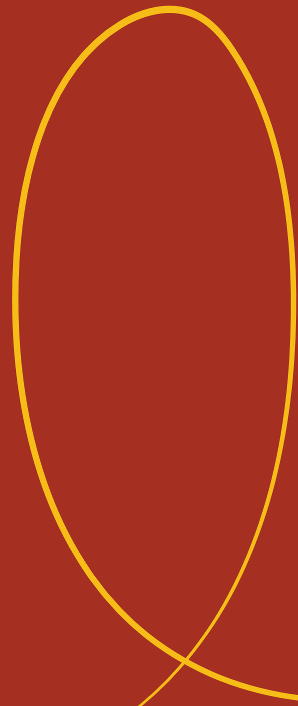

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