

Sudan Alternative Health Policies Conference

London 6-7 April 2019

Appendices

Appendix 1: Documents

- a) Sudan Health Policy Document (in Arabic).
- b) Health Delivery in Conflict Zones.
- c) Sudan Doctors Union: Sudan 1-year Transition Plan for the Health Sector (1-TPHS)-Draft 18 January 2019. (Arabic version available)
- d) A Basic Health Financing Primer in the Context of Sudan.
- f) Health Reform Initiative: Pharmaceutical sector (Professional Pharmacists Assembly-Sudan)

Appendix 2: Day 1 Presentations

- a) SDU president Opening Speech, Dr Sarah Abdul Galil.
- b) Sudan Alternative Healthcare Policies, Dr Abu Obeida Hamour.
- c) Alternative Pharmaceutical Policies: From Drug Shortage to Efficient Pharmaceutical Practice (Central Committee of Sudan Pharmacists) Rania Elsyegh & Osman Freigoun.
- d) Highlights on Alternative Health Policies (The Unified Committee of Sudanese Dentists), Dr Rianne Gibreel.
- e) Sudan Current Health Status & Alternative Policy Development (Sudanese Public Health Forum) Dr Magda.
- f) From Uprising to Sustainable Development, Prof Allam Ahmed.

Appendix 3: Day 2 Presentations and Press release

- a) Sudan Doctors' Union Speech. Dr Ihsan Fagiri.
- b) Undergraduate medical education in Sudan, Dr Tahra Alsadig.
- c) The role of Junior doctors in development of the healthcare system in Sudan ..(SJDA) Dr Husam Mohsin, Dr Hashim Alsir and Dr Nadir Elamin.
- d) Press release

Appendix 4: Day 2 workshops

- a) Working across agencies and disciplines: Key Challenges Facing the Health Sector + Workshop feedback (1).
- b) Working across agencies and disciplines: Transition Plan for the Health Sector Workshop+ Workshop feedback (2).

نقابة أطباء السودان
الخطة الصحية للفترة
الانتقالية ١٨ يناير ٢٠١٩
(TPHS-١)

1- المقدمة

بدأت مقاومة الشعب السوداني للديكتاتورية العسكرية الحالية في وقت مبكر من حكم النظام الذي استمر 30 عاماً بلغت ذروتها في الاحتجاجات المستمرة والضخمة والتي شملت جميع المدن السودانية منذ ديسمبر عام 2018. ويقود هذا العمل الشعبي المعارض منابر تمثل كافة قطاعات الشعب تهدف إلى إسقاط نظام الإنقاذ من خلال انتفاضة شعبية سلمية. وهذه الخطة تطرح تنفيذ عملية انتقال منتظمة مدتها عام واحد لقطاع الصحة بعد سقوط الإنقاذ. وقد توافقت كل اطراف المعارضة السودانية على أن فترة انتقالية تمتد إلى 4 سنوات لما بعد الإنقاذ تشمل انتحافاً وطنياً عريضاً بقيادة تنفيذية ومشاركة جميع نشطاء المعارضة والأحزاب السياسية والنقابات المهنية والمجتمع المدني والفئات الأخرى. وترتكز خطة الفترة الانتقالية على اهداف تنمية وانسانية لوقف تدهور أوضاع معيشة الناس واقتصاد البلاد وارساء برامج انتعاش سريعة لاستعادة العمل الصحى في جميع قطاعاته. كما تستهدف الخطة، بصفة خاصة، التركيز على أكثر القطاعات المتأثرة بسياسات الإنقاذ: القمع والفساد والممارسات الإدارية المدمرة من خلال وضع الخطط القطاعية واسس الحوكمة لضمان سير عملية انتقال منظم فور ازالة النظام.

الخطة الصحية للفترة الانتقالية (1-TPHS)

تستند الخطة إلى الورقة الأصلية التفصيلية التي اعتمدها اتحاد الأطباء السودانيين (SDU) في عام 2016 كمساهمة لدعوة المعارضة السودانية لوضع سياسات البديلة. هدف الـ1-TPHS هو تقديم رؤية موحدة بين الأطباء السودانيين ، والعاملين الصحيين ، وجموع الشعب السوداني وشركائهم الوطنيين والدوليين حول اولويات القطاع الصحي الأساسية التي يجب معالجتها خلال الأشهر الـ 12 الأولى بعد سقوط نظام الإنقاذ. وبناءً عليه ، فإن الهدف من الـ 1-TPHS هو توجيه قيادات القطاع الصحى لفترة ما بعد الإنقاذ. ومن المتوقع فور سقوط النظام، عقد ورش عمل لتقديم الخطة الصحية وخطط القطاعات الأخرى للفترة الانتقالية والاجماع عليها. وتهدف هذه اللقاءات فتح الحوار والمشاركة لاثرءاء وتوضيح وتعزيز التوافق حول الـ 1-TPHS بمجرد الإزالة الكاملة لنظام الإنقاذ.

مضمون الوثيقة

الورقة السابقة المذكورة أعلاه والتي اعتمدها الـSDU في عام 2016 قدمت تحليل نقدي للتحديات التي تواجه قطاع الصحة السوداني الحالى. وبالنظر إلى الظروف غير الأمانة التي تتم فيها صياغة ومناقشة الخطة الصحية للفترة الانتقالية ، تحتوي الـ 1-TPHS على عرض مختصر للقضايا الصحية (موضح أكثر في الملحق الثاني) بينما يوفر الملحق 1 المؤشرات الأساسية التي تلخص الوضع الحالى. ويشمل الجزء الاخر فى الـ 1-TPHS الاهداف الرئيسية، المبادئ والقيم التي ترشد سبل إنعاش القطاع الصحي، المنهج والإطار التحليلي بالإضافة إلى الإجراءات الإستراتيجية ذات الأولوية المطلوبة خلال العام . وأخيراً ، ستكون النسخة العربية متاحة بمجرد الموافقة على إصدار اللغة الإنجليزية من قبل الـSDU.

2- الاهداف الرئيسية لTPHS-1

- بحلول الشهر ال12 من تنفيذ الخطة وقف تدهور ما لا يقل عن 10 مؤشرات صحية رئيسية تشكل عائقا لحصول جميع السودانيين على الخدمات الصحية الأساسية والتركيز بشكل خاص على ما يقرب من 3 ملايين سوداني يعيشون في المناطق المتضررة من الحروب (أي كل من المقيمين في مناطق الحرب في دارفور والنيل الأزرق وجنوب كردفان وكذلك أولئك النازحين داخليًا والمقيمين حاليًا في أجزاء أخرى من البلاد) وكافة الشعب السوداني

- بحلول الشهر ال12 من تنفيذ الخطة: وضع الأسس اللازمة لتدابير الإصلاح الصحية الوطنية المتوسطة والطويلة الأجل اللاحقة مما يعيد السودان إلى مساره نحو تحقيق الهدف 3 من أهداف التنمية المستدامة (SDG) للقطاع الصحي (بما في ذلك التغطية الصحية الشاملة). ويتم ذلك عن طريق صياغة / تنقيح / تحديث السياسات والاستراتيجيات والخطط القائمة من أجل جعل قطاع الصحة السوداني أكثر استجابة لتطلعات الشعب السوداني وأكثر انساقًا مع المبادئ والالتزامات المقبولة دوليًا و القدرة على الاستثمار بشكل ذكي في الصحة وبالتالي إنتاجية رأس المال البشري اللازم للتنمية.

3- المنهج والاطار التحليلي للخطة

- إدارة الصحة والإشراف (HGS) ؛ على سبيل المثال ، اتخاذ القرار بطريقة شفافة ، والمساءلة ، وما إلى ذلك.
- البنية التحتية الصحية والتقنيات والمستحضرات الصيدلانية (HTP) ؛ مثل المباني والمختبرات والامدادات الطبية
- الموارد البشرية من أجل الصحة (HRH) ؛ على سبيل المثال. الإنتاج والإدارة والتنظيم والشهادات وغيرها
- نظم المعلومات الصحية (HIS) ؛ مثل المراقبة ونظم إدارة المعلومات الصحية وغيرها
- تمويل الرعاية الصحية (HCF) ؛ يشمل التأمين وغيره من المخاطر التجميعية ، والشراكات بين القطاعين العام والخاص ، الخ
- تقديم الخدمات الصحية (HSD) ؛ على سبيل المثال تنظيم المرافق الصحية ، ونوعية الخدمة ، وما إلى ذلك

4- عرض القضايا الصحية

منذ منتصف الثمانينيات ، حقق القطاع الصحي في السودان تقدمًا كبيرًا في الحد من عبء المرض ، وزيادة إمكانية الحصول على خدمات الرعاية الصحية الأساسية وتعزيز النظام الصحي للحفاظ على المكاسب. والجدير بالذكر أن المؤشرات الصحية الرئيسية في السودان اليوم أخذة في الانخفاض وهي ليست عرضية ولكنها جزء لا يتجزأ من سياسة متعمدة لحكومة الانقاذ بسحب الدعم من قطاع الخدمات بأكمله والسماح لقوى السوق المتفشية بتحديد مستوى الخدمات المقدمة للمواطنين قيمة الخدمات المقدمة. إن التحليل الكامل

وتحديد الاسس والمعايير لسياسة القطاع الصحي خارج نطاق هذه الورقة. ومع ذلك ، فإن التحليل الملخص للقضايا والتحديات الرئيسية التي تم تحديدها في كل مكون من مكونات النظام الصحي الستة يتم إرفاقه بالملحق الثاني لهذا الـ TPHS 1.

5- المبادئ المقترحة لتوجيه السياسة القومية للصحة في السودان:

- الصحة حق من حقوق الإنسان ، كما هو منصوص في دستور السودان لعام 2005 ؛
- الصحة استثمار في التنمية البشرية وليس مجرد خدمة اجتماعية أو نفقات رعاية اجتماعية
- منظمة الصحة العالمية تعرف المرض بأنه ليس مجرد هدم وجود المرض
- للدولة دور رئيسي لتنظيم وتوفير الخدمات في القطاع الصحي
- السياسات المرتكزة على الانصاف ودعم الفقراء والمساواة بين الجنسين: شنت الانقاذ منذ العام 1989 حرباً ضارية على حقوق المرأة وعلى توفير الخدمات الصحية. وبالنظر إلى تفاقم مستويات الفقر ، من الأهمية بمكان ليس فقط القضاء على عدم المساواة في الحصول على الرعاية المؤسسات الصحية ، ولكن ، بنفس القدر من الأهمية ، ازالة أوجه عدم الإنصاف الهيكلية في المستوى الأعلى من المحددات الاجتماعية للصحة
- تكامل الأدوار بين قطاع الصحة العام بالشراكة مع المجتمع المدني السوداني ويشمل ذلك تمكين وضمان ملكية الأفراد والمجتمعات في جميع القرارات التي تؤثر على صحتهم ، وذلك في الصحة وغيرها من القطاعات ذات الصلة بالصحة مثل السكن والدخل والتعليم وإمدادات المياه والصرف الصحي. ((بما في ذلك النقابات المهنية للعاملين في المجال الصحي ، والروابط المهنية ، ووسائل الإعلام ، والمجموعات المجتمعية غير الرسمية ، والمنظمات غير الحكومية الوطنية / الرسمية) ، والقطاع الخاص والمؤسسات التعليمية البحثية والقطاع الخاص لدعم السياسات الصحية المشتركة القطاع الخاص والمؤسسات البحثية البحثية والقطاع الخاص لدعم السياسات الصحية المشتركة: لا يتطلب هذا المبدأ مجرد إشراك منظمات المجتمع المدني والقطاع الخاص كمجرد متعاقدين أو قنوات لمنافذ تمويل أو خدمات إضافية. ويجب إشراكهم كأقران في وضع السياسة ، ووضع الاستراتيجيات ، فضلاً عن رصدها وتنفيذها.
- الدور الأساسي (ولكن ليس الوحيد) للحكومة في نظام الرعاية الصحي: من جهة ، توصي هذه الورقة الحكومة (الوطنية والمحلية) أن تأخذ زمام المبادرة في تحديد السياسات والاستراتيجيات والأولويات الصحية ، ووضع القواعد والمعايير للرعاية والخدمات ، وتخصيص الموارد العامة ، وتنظيم تقديم الخدمات من قبل جميع الجهات الفاعلة (عامة ، خاصة ، غير هادفة للربح) ، تطلب / تطبق خطط التأمين الصحي المختلفة (بما في ذلك على سبيل المثال لا الحصر ، مخططات التمويل / التمويل المشترك من الحكومة) لضمان التغطية المالية الكاملة ضد الأحداث الكارثية والمهنية. من ناحية أخرى ، توصي هذه الورقة ، بالإضافة إلى ذلك ، بدور أساسي للحكومة في إنشاء وإدارة مقاييس قياس / تنظيم الأداء بشكل مباشر ، لتسليم السلع العامة مباشرة (مثل التطعيم ، وتدابير مكافحة ناقلات الأمراض ، ومجموعة من الخدمات الأساسية (مثل الحوادث / الطوارئ ، RMNCH ، خدمات الأمراض الرئيسية ، الخ) وتقديم خدمات مباشرة للسكان الذين يعانون من نقص في الخدمات الاجتماعية في السودان.

- الاستناد على الأدلة: على الرغم من عدم حصولها على الوصول اللازم إلى البيانات والمعلومات الكافية لضمان استنادها إلى أدلة كاملة في هذا الوقت ، تعتمد الورقة تعاريف وقواعد ومؤشرات ومعايير عالمية. والأهم من ذلك ، أن الورقة تدعو أيضاً إلى وضع مقاييس صحية تمكّن من توجيه الاتجاهات السياسية وأداء النظام الصحي بشكل جيد وإقامة مساءلة سليمة على جميع مستويات إدارتها.

سياسة الإصلاح ذات الأولوية والإجراءات الإستراتيجية في السودان خلال TPHS-1: بناءً على ما سبق ، فإن السياسات الصحية ذات الأولوية والإجراءات الاستراتيجية الموصى بها هي كما يلي:

1. وقف جميع الحروب مع تحقيق وفورات في الميزانية من مواقع السلطة التنفيذية والتشريعية العليا على مستوى الحكومات الوطنية والولائية والمحلية (بما في ذلك الأجور والمزايا والنفقات المتكررة) وإعادة تخصيص المدخرات من نفقات الانقاذ التنفيذية والعسكرية والأمنية لإعادة الاستثمار لهم في قطاعات الصحة والتعليم والحماية الاجتماعية كأولوية فورية مطلقة.
2. ضمن قطاع الصحة ، إعطاء الأولوية للمساعدات الإنسانية العاجلة وإعادة تأهيل الخدمات الصحية الأساسية لجميع السكان في المناطق التي كانت سابقاً متأثرة بالنزاعات ، وأذلك بين أولئك الذين ما زالوا نازحين من هذه النزاعات في البلاد.
3. زيادة مستوى الإنفاق الحكومي على الصحة والحفاظ عليه على المستوى الوطني ودون الوطني (الولايات والبلديات) بحيث يمثل 15٪ على الأقل من إجمالي الإنفاق الحكومي تمثياً مع إعلان أبوجا للاتحاد الأفريقي (2006)
4. بالتعاون الوثيق مع كيانات قطاع الحماية الاجتماعية ، تطوير وتكلفة وخطة لتجريب تنفيذ حزمة الخدمات الصحية ذات الأولوية (PSP) التي يتم تسليمها لجميع المواطنين السودانيين والمهاجرين المقيمين في السودان من خلال منافذ القطاع العام على جميع المستويات (الاساسية والمتوسطة والعليا).
5. زياده نسبة الموازنة الحكومية التي تنفق على قطاعي الصحة والحماية الاجتماعية بنسبة عالية، بما في ذلك إصلاح التأمين الصحي الوطني الحالي لضمان زيادة تغطيته وتلبية احتياجات الحماية الاجتماعية لأضعف المواطنين السودانيين. وينبغي أن تشمل الفئات المستهدفة على وجه الخصوص ضحايا حروب السودان ، والقطاعات الديمغرافية المحرومة اجتماعياً اقتصادياً ، مثل النساء والشباب والمراهقين والأطفال وكبار السن وذوي الاحتياجات الخاصة والأيتام فضلاً عن العمال الزراعيين والصناعيين والخدميين المحرومين. تطوير خطط يتم بموجبها تقديم نظم تأمين ابداعي بتمويل مشترك بين أرباب العمل في القطاعين الحكومي والخاص وكذلك خطط التأمين المجتمعية للعاملين لحسابهم الخاص والعاملين في القطاع غير الرسمي والعاملين الزراعيين (خاصة في المناطق الريفية مثل كما مستوطنات "الكامبو" في مواقع مختلفة).
6. إنشاء مجلس وطني (NHC) متعدد التخصصات يقوم على المشاركة يرأسه رئيس الوزراء (وليس وزير الصحة). وإشراك جميع الوزارات والمؤسسات الأكاديمية وهيئات البحث والمجتمع المدني وممثلي القطاع الخاص الذين يرتبط عملهم بالمحددات الاجتماعية والبيئية والاقتصادية والديمغرافية

للصحة. وينبغي تمكين NHC بموجب القانون للإشراف على وضع السياسات والإرشاد والتخطيط الإستراتيجي الشامل للقطاع الصحي.

7. بالتعاون الوثيق مع القضاء ، يقوم المدعي العام ، والمراجع العام ، ووزارة المالية ووزارة الداخلية ، بإنشاء منبر لتتبع ومكافحة الفساد (غرفة مقاصة) تديرها مجموعة مناسبة من فئات المجتمع المدني بالتعاون مع السلطة التشريعية (أي مجلس الحكم الانتقالي المؤقت). يتمثل دور المنبر في مراقبة ممارسات الفساد وتوثيقها ونشرها في قطاعي الصحة والقطاعات الأخرى ، تسجيل الاستجابات القانونية والعملية والتدابير المضادة المضطلع بها ، لرسم وتعزيز القدرة على جهود مكافحة الفساد التي يقودها المجتمع المحلي والمجتمع المدني ، وكذلك توفير موارد الخبراء والتواصل والروابط مع المجموعات المماثلة في أفريقيا والعالم. كما يقوم المنبر بإنشاء مقاييس تتبّع الفساد داخل أنظمة إدارة المعلومات الصحية للقطاع الصحي الرسمي عن طريق تكييف الخبرات مثل نظام تتبّع البيانات في أوغندا. ويتضمن المنبر أفضل وسيلة إلكترونية آمنة لتمكين الوصول إلى جميع المواطنين على أوسع نطاق ، على أن يفوض قانونياً و يكون دوره مكملاً لأي لجنة وطنية لمكافحة الفساد تنشئها السلطة التنفيذية.

8. تقنين وتمكين مؤسسات وأنشطة مجموعات المواطنين والمرضى وجماعات المستهلكين على جميع المستويات (مثل الجمعية السودانية لحماية المستهلك ، وغيرها).

9. الالتزام بمعايير فعالية العون الدولية ، وإشراك جميع أصحاب المصلحة (المديرين المستقلين ، والمانحين ، والمنظمات الدولية ، إلخ) لضمان تبسيط جميع المشاريع الصحية الرئيسية (مثل شلل الأطفال ، والملاريا ، وفيروس نقص المناعة البشرية / الإيدز ، والسل ، إلخ) حتى : (أ) تنسجم فيما بينها ، (ب) تتماشى مع أولويات السياسة والاستراتيجية الوطنية السودانية ؛ (ج) تتكامل تدريجياً للعمل من خلال القطاع العام وتقوية الأنظمة الصحية .

10. إنشاء آليات مساءلة محلية شفافة في مواقع تقديم الخدمات ، على مستوى المحليه والولاية وعلى المستوى الوطني تشمل نفايات عمالية منتخبة ، وممثلي مجموعات المرضى / المستهلكين ، وبرلمانيين / واعضاء في المجلس التشريعي ومقدمي الخدمات. على أن يتم تمكين هذه الهيئات بموجب القانون ودعمهم في إنفاذ عملهم لمساءلة مقدمي الخدمات عن جودة ومدى تغطية تقديم الخدمات الصحية ؛

11. استعراض وتطوير أو تعزيز الأطر والقوانين التشريعية الحالية ذات الصلة بالصحة مع إعطاء الأولوية لأولئك الذين ينظمون الإمدادات الغذائية ومعايير استيراد السلع الطبية ، ومعايير التصنيع الدوائي ، والممارسات الطبية ، وصحة البيئة والنظافة العامة ، ومكافحة الأمراض السارية ، وحقوق المرضى ؛

12. تطوير آليات لتنظيم ومراقبة جودة ونظم تقديم الخدمات الصحية في القطاع الصحي الخاص من خلال معايير مساءلة قوية للدولة ، والهيئات المهنية ، والمرضى والمجتمع. ايجاد معايير ومبادئ توجيهية معقولة لتحديد التكاليف والتي تمكن القطاع الخاص من تحقيق الربح مع الحفاظ على القدرة على تحمل تكاليف وصول السكان (مثل تجربة الأردن). تمكين هذه الهيئات بموجب القانون والمساعدة في إنفاذ عملهم لمساءلة مقدمي الخدمات عن جودة ومدى تغطية تقديم الخدمات الصحية.

13. البدء في إنشاء منهج وآلية رسمية لتطوير سياسة الصحة الوطنية في السودان على المدى المتوسط والطويل من أجل تحقيق الهدف الثالث من أهداف التنمية المستدامة ، والتغطية الصحية الشاملة ، بما في ذلك التماس الدعم التقني والمالي من الدول والمانحين والأمم المتحدة.

14. إجراء مراجعة علمية سليمة لوضع الموارد البشرية الصحية في السودان وعمل سياسات واستراتيجيات قصيرة الأجل تعالج النشوات الرئيسية التي تؤثر على هذا العنصر المركزي في القطاع الصحي. ويشمل ذلك تحديد الاحتياجات المتوقعة الحقيقية لإنتاج الموارد البشرية ، وتعزيز

الإقامة الريفية للعاملين الصحيين حيث يصبح أكثر جاذبية ، ومعالجة الاختلافات القائمة في إنتاج وتوزيع وتنمية الموارد البشرية الصحية ، وكذلك معالجة الشهادات ، والتعليم الطبي المستمر ، والترخيص والجوانب التنظيمية للموارد البشرية الصحية في السودان . من المهم أيضا النظر في الإغلاق المحتمل و / أو إعادة توزيع الأصول والموارد لعدد من كليات العلوم الصحية / الطبية القائمة ، وتكثيف الاستثمار في عدد قليل من كليات الطب الأساسية بالإضافة إلى الاستثمار في تعزيز مدارس العلوم الصحية المتحالفة (خاصة القبالة والتمريض ومؤسسات تعليم / تدريب الموارد البشرية المماثلة).

15. زيادة الاستثمارات والمدخلات الفنية لتحسين نوعية (وليس كمية) تدريب وتعليم العلوم الصحية في المؤسسات التعليمية / التدريبية العامة والخاصة على السواء.

16. إعادة تأهيل وتأسيس خدمات الطوارئ والحوادث والإنعاش الأساسية في المرافق الصحية الأولية والثانوية والتخصصية والتي يتم تمويلها من نفقات حكومة الولاية إلى حين بلوغ التغطية المؤسسات التأمينية الوطنية تغطية تكاليفها.

17. تكثيف الصحة المدرسية ، بما في ذلك التغذية المدرسية ، والنظافة الصحية / الصرف الصحي ، والتطعيم ، والتغذية ، والتخلص من الديدان ، وخدمات العيون والأسنان ، وتناول الغذاء الصحي ، وتحسين نمط الحياة ، وتدخلات الصحة النفسية / العقلية ، والصحة الجنسية والإنجابية ؛

18. الحد من انتشار الأمراض المزمنة غير المعدية من خلال تحديد عوامل الخطر الرئيسية بالسودان (بما في ذلك التعرض للمواد المسببة للسرطان من النفايات الصناعية ، واستخدام المبيدات وغيرها من العوامل البيئية التي يتم التعرض اليها) والتصدي لها ، من خلال تدابير أقوى لمكافحة التبغ ، وخفض استهلاك الملح وبتعزيز أنماط حياة أكثر صحة. بالإضافة إلى ذلك ، تحسين إدارة ودعم الأمراض المزمنة بما في ذلك من خلال أنظمة الرعاية الملطفة للالام (palliative care) والرعاية المنزلية ، والكشف المبكر والوقاية (برامج الوقاية في كافة مستويات تقديم الخدمات) الخاصة بالأمراض المهنية ، والقلب ، والسرطان ، والسكري ، وارتفاع ضغط الدم وغير ذلك من الأمراض غير المعدية ، إلخ .

19. بمساعدة فنية من الأمم المتحدة والشركاء المانحين ، إجراء استعراض مكتبي عاجل لاحتياجات القدرة الاستراتيجية للمعلومات ونظام المعلومات الصحية الأساسية (بما في ذلك تحليل التقارير ، واستخدام البيانات من أجل اتخاذ القرارات ، ودقة البيانات ، والعملة ، والاكتمال ، والموثوقية ، والتردد ، الخ) ، لتصميم قاعده للمؤشرات الصحية الرئيسية في السودان.

20. بالتعاون الوثيق مع الهيئات البحثية الوطنية والدولية مثل منظمة الصحة العالمية ، وضع المقاييس اللازمة للقطاع الصحي الفوري (TPHS-1) وقياس أداء القطاع الصحي على المدى الطويل للتحليل الدقيق للعقبات ، ووضع معايير للنجاح ، وتتبع التقدم ، ورصد وتقييم وخطة إضافية يجب أن تشمل هذه الأدوات أطر منظمة الصحة العالمية ، والمبادئ التوجيهية ، والمنهجيات والأدوات الخاصة بقياس أداء النظام الصحي ، وإدارة الموارد البشرية ، وحوكمة القطاع الصحي ، وأدوات تحليل الوضع ، وطرق تحديد أولويات حزمة الخدمات ، ونماذج التمويل القائمة على الأداء ، والأولويات دراسات الأعباء ، والدراسات الخاصة بالأمراض ، ودراسات استخدام الخدمات والتغطية ، والبحوث التشغيلية وغيرها.

المرفق أ : الإحصاءات الاجتماعية والاقتصادية والديموغرافية والصحية الرئيسية للسودان

متوسط اقليم شرق المتوسط	سنة البيانات	القيمة للسودان (للكور للإناث)	تعريف نوع المؤشر
	2015	40.24 مليون	1 إجمالي عدد السكان
68.8 (67.4/70.4)	2015	64.1 عام (62.4/65.9)	2 توقع الحياة عند الولادة
60.1	2015	عام 55.9	3 متوسط العمر المتوقع الصحي عند الولادة
166	2015	311 لكل 100,000 مولود حي	4 معدل وفيات الامهات
71	2005-2016	78 %	5 الولادات التي يحضرها موظفون صحيون مهرة
52	2015	70.1 لكل 1000 مولود حي	6 معدل وفيات الأطفال دون الخامسة
26.6	2015	29.8 لكل 1000 مولود حي	7 معدل وفيات الولدان
0.13	2015	لا توجد بيانات	8 إصابات جديدة بفيروس نقص المناعة البشرية بين البالغين 15-49 سنة
116	2015	88 لكل 100,000 من السكان	9 معدل الإصابة بالسل
19	2015	للكل 1000 من السكان معرض 36.6 لمخاطر الملاريا	10 معدل الإصابة بالملاريا
80	2015	93 %	11 نسبة الرضع الذين يتلقون 3 جرعات من لقاح التهاب الكبد
86,152,675	2015	26,533,962	12 عدد الأشخاص الذين يحتاجون إلى تدخلات ضد أمراض المناطق المدارية المهملة
21.8	2015	25.7 %	13 احتمال الوفاة من أمراض القلب والأوعية الدموية والسرطان والسكري أو أمراض الجهاز التنفسي المزمنة بين 30 و 70 عاما
3.8	2015	10.2 لكل 100,000 من السكان	14 معدل وفيات الانتحار
0.7	2016	لتر من الكحول 3.3	15 إجمالي استهلاك الكحول للفرد من بين 15 سنة أو أكثر (تقديرات متوقعة)
19.9	2013	24.3 لكل 100,000 من السكان	16 معدل وفيات حوادث الطرق
61.1	2005-2015	30.2 %	17 نسبة النساء المتزوجات أو المرتبطات ممن هن في سن الإنجاب واللائي تمت تلبية احتياجاتهن لتنظيم الأسرة بالأساليب الحديثة
46.1	2005-2014	87 لكل 1000 امرأة ما بين 15-45 عاما من العمر	18 معدل المواليد لدى المراهقات
58.8	2012	64.5 لكل 100,000 من السكان	19 معدل الوفيات المنسوب إلى تلوث الهواء المحيط في المنازل
13.1	2012	34.6 لكل 100,000 من السكان	20 معدل الوفيات الذي يعزى إلى التعرض لخدمات المياه والصرف الصحي والنظافة غير الآمنة
1.4	2015	4.2 لكل 100,000 من السكان	21 معدل الوفيات يعزى إلى التسمم غير المقصود
لا توجد بيانات	2015	لا توجد بيانات	22 مدخني التبغ حسب العمر بين الأشخاص الذين تبلغ أعمارهم 15 سنة أو أكثر
80	2015	93 %	23 نسبة التغطية بالتطعيم ضد الدفتيريا والكزاز والسعال الديكي بين الأطفال الذين بلغوا العام الأول من العمر
1.46	2014	دولار أمريكي (بالدولار 2.47 الأمريكي الثابت 2014)	24 إجمالي المساعدة الإنمائية الرسمية الصافية للبحوث الطبية والصحة الأساسية للفرد
26.3	2005-2015	42.2 لكل 10,000 من السكان	25 كثافة المهنيين المهرة في القطاع الصحي
72	2010-2016	71	26 درجة لتنفيذ 13 قدرة أساسية من اللوائح الصحية الدولية
8.8	2014	11.6 %	27 نفاق الصحي الحكومي كنسبة مئوية من الإنفاق الحكومي العام
25.1	2005-2016	38.2 %	28 انتشار التقرم لدى الأطفال دون سن الخامسة
9.1	2005-2016	16.3 %	29 انتشار الهزال لدى الأطفال دون سن الخامسة
6.7	2005-2016	3 %	30 انتشار الأطفال دون 5 سنوات الذين يعانون من زيادة الوزن
91	2015	لا توجد بيانات	31 نسبة السكان الذين يستخدمون مصادر مياه الشرب المحسنة
78	2015	لا توجد بيانات	32 نسبة السكان الذين يستخدمون مرافق الصرف الصحي المحسنة
71	2014	23 %	33 نسبة السكان الذين يعتمدون بشكل أساسي على الوقود النظيف
0.2	2011-2015	0.1 لكل 100,000 من السكان	34 متوسط معدل الوفيات بسبب الكوارث الطبيعية
6.5	2015	6.5 لكل 100,000 من السكان	35 معدل الوفيات بسبب القتل
19.5	2011-2015	7 لكل 100,000 من السكان	36 معدل الوفيات المباشرة بسبب الصراعات

الملحق الثاني: ملخص تحليل المشكلة: التحديات الرئيسية التي تواجه قطاع الصحة في السودان في عام

2019

1- الحوكمة الصحية والإشراف

- الإهمال الحكومي للمتطلبات الدستورية لدعم الحق في الصحة ؛
- لإهمال الحكومي للمتطلبات الائتمانية للحوكمة الرشيدة في القطاع ؛
- غياب المشكها في اتخاذ القرار عند تقديم الخدمات ، في القطاعات الحكومية المحلية والعامه ؛ وعلى وجه الخصوص استبعاد الجهات الفاعلة في المجتمع مثل الروابط المهنية/التجارية والمرضى والمجتمع المدني وشركاء التنمية الآخرين والمجتمع المدني وغيرهم من شركاء التنمية الآخرين
- قلة التمثيل القطاعي في المنابر التي تدعم وتشجع على المساهمة في الصحة ، بما في ذلك استبعاد التعليم ، والتمويل ، والزراعة ، وإمدادات المياه / الصرف الصحي (WASH) ، والحماية الاجتماعية ، والعدالة والكيانات الأخرى المسؤولة عن المحددات الاجتماعية للصحة (SDHS).
- إرباك / تفويض مسارات المساءلة وتجزئة المسؤولية في مجالات حوكمة القطاع الصحي الرئيسية ، بما في ذلك تطوير البنية التحتية الصحية ، ومعايير الشراء بالمشاركة ، ومعايير تقديم الخدمات الصحية ، والرقابة التنظيمية على الجهات الفاعلة من غير الدول (إيصال القطاع الخاص ، والمنظمات غير الحكومية ، إلخ) (
- الافتقار السائد لآليات المساءلة الحكومية الوطنية والمحلية التي يمكن أن تقوم برصد وتوجيه والتحقق بشكل فعال من تخصيص الموارد المرتبطة بالصحة ، وتخطيط الميزانية ، والإنفاق والتكاليف على جميع مستويات إدارة القطاع الصحي ؛
- غياب معايير أداء خاصة بالنظام الصحي تكون منشأة علمياً ومراقبة بدقة وشفافية للإبلاغ عن قطاع الصحة استناداً إلى نظام إدارة معلومات صحي قوي ؛
- غياب آليات تنسيق فعالة بين مختلف السلطات الصحية المختلفة ؛
- الفساد المستشري وسوء الإدارة في القطاع الصحي وممارسات المرافق الصحية

2- البنية التحتية الصحية والتقنيات والمستحضرات الصيدلانية (HTP):

- زيادة عبء المرض عندما يتم اختلاس سلع ومعدات طبية تم شراؤها علناً وبيعها في سوق خاصة تتسبب في نفاذ المخزون في مرافق القطاع العام.
- زيادة تكاليف الرعاية المباشرة بسبب ممارسات الشراء الفاسدة (مثل الحصول على مصدر واحد للسلع والمعدات الطبية من خلال التخلي عن العطاءات التنافسية ، ونقص الأدوية العامة الأقل سعراً أو التخلي عن فرص خصم الحجم من خلال المشاركة في عمليات الشراء بالجملة مع البلدان الأخرى).
- السلع والمعدات الطبية غير المقررة التي يسمح بها الفساد في نظام الرعاية الصحية مما يؤدي إلى انخفاض كفاءة وجودة التدخلات الصحية مما يؤدي إلى زيادة معدلات الاعتلال والوفاة بسبب الأدوية أو الأجهزة المزيفة أو التي لا تنتهي صلاحيتها أو التي تنتهي صلاحيتها.
- عدم وجود رقابة تنظيمية فعالة على معايير شراء السلع الصحية للقطاع العام ووضع ميزانية ناقصة لمتطلبات مشتريات القطاع العام للأدوية والإمدادات الطبية والتقنيات الصحية والمختبرات والأشعة وغيرها من العلاجات التقليدية ؛
- نظم إدارة وتوزيع إمدادات الخدمات الطبية الخاصة غائبة ، مما يؤدي إلى ضياع الاستثمارات ، والفساد ، والسرقة ، ونفاذ مخزون السلع الأساسية ؛

- إهمال الاستثمارات والسياسات السابقة التي ساعدت على خلق قدرة صناعية محلية صغيرة قوية في السودان وانتاج ادوية اساسية وامدادات طبية ، مما أدى إلى الاعتماد على الاستيراد بتكلفة عالية للحكومة و / أو المريض ؛
- عدم الاستفادة من أو متابعة ترتيبات التجارة الدولية الفعالة مع الدول / الشركات المصنعة الأساسية بالإضافة إلى الدول الإفريقية والجيران الآخرين لتحقيق تخفيضات في الحجم ، وتحديد أولويات استيراد الأدوية بدلاً من الأدوية التجارية ، والانضمام إلى ترتيبات الشراء المجمع الطوعية للقاحات الطفولة ، ومضادات فيروس نقص المناعة البشرية ، والسلع الصحية للأمهات وغيرها من الفرص الضائعة ؛

3- نظم المعلومات الصحية (HIS)

- غياب البيانات المنسقة يحتاج إلى ترتيب الأولويات وجمعها وتحليلها والإبلاغ عنها واستخدامها في صنع القرار، مما يؤدي إلى ضعف الأداء في أنظمة المراقبة الصحية الوطنية والمرضية الخاصة بالأمراض، واتخاذ القرارات بطريقة غير عقلانية وأساس ضعيف للمساءلة على المستوى الوطني والمحلي مستويات المرافق في القطاع ؛
- اتاحت فرص التلاعب بالمعلومات الصحية لخدمة الاحتياجات السياسية ؛
- غياب الشفافية في الإبلاغ عن البيانات الصحية ؛
- ضعف النظم لتحويل البيانات الصحية إلى معلومات قابلة للاستخدام في صنع القرار ؛

4- تمويل الخدمات الصحية (HCF):

- شح التمويل المزمّن مع التغطية الضعيفة لمخططات التأمين بجميع أنواعها ، مما أدى إلى زيادة كارثية في النفقات من الجيب الخاص (out- of- pocket) لتصبح أكثر من 75٪ من إجمالي الإنفاق على الصحة ؛
- زيادة تكلفة الفرصة البديلة (opportunity cost) على النظام الصحي العام بسبب نقص التمويل المزمّن للخدمات الوقائية (ارتفاع عبء المرض على مستوى السكان والأفراد) ، مما يؤدي إلى غياب أو ضعف مراقبة الأمراض المعدية وغير المعدية ، ومراقبة السلامة البيئية ، والصرف الصحي السكني ، وأماكن العمل والسلامة المهنية وسلامة السلسلة الغذائية وإمدادات المياه والمنتجات الصناعية والمنتجات الثانوية وتنظيم النفايات ، إلخ.
- عدم كفاية تنسيق ومواءمة الاستثمارات الخارجية للمساعدة الإنمائية الرسمية في مجال الصحة مع الدعم الحكومي لقطاع الصحة ، حيث لا تنعكس معظم استثمارات برنامج الأمم المتحدة والمانحين في الحسابات الصحية الوطنية ؛ ضعف وضع الميزانيات الواقعية والفعالة والشاملة بالإضافة إلى المساءلة السليمة عن تمويل الخدمات الصحية (HCF) ؛

5- تقديم الخدمات الصحية (HSD):

- عدم تنفيذ الاستراتيجيات الحالية للسياسات الصحية و التراجع عن مبادئ إعلان ألما آتا واهمال خدمات الرعاية الصحية الأولية (PHC) وتركيز الخدمات الصحية للمستويات الوسيطة والعليا.
- تناقص إمكانية الحصول على الرعاية الصحية (لا سيما الرعاية الصحية الأولية ، وحتى في المؤسسات الصحية الأعلى) نتيجة للتفكيك المنظم والرسمي للمرافق الصحية في القطاع

العام ، مما يترك للمرضى خيار اللجوء إلى المرافق الصحية الخاصة التي يملكها المسؤولون الحكوميون.

- تحديد الأولويات غير واقعية في توزيع تقديم الخدمات حيث يوجد تركيز مستمر ومضلل على تطوير المؤسسات الصحية في المستويات الاعلى او التخصصية لدوافع سياسية ، مع إهمال وتفكيك المؤسسات القائمة بالفعل بالإضافة إلى ترك فجوات واسعة في إنشاء أو تحديث البنية التحتية للرعاية الصحية الأولية القائمة ؛

Sudan Doctors' Union

Sudan 1-year Transition Plan for the Health Sector (1-TPHS) - Draft 1 - 18 January 2019

I. Introduction & goal:

Country context: The Sudanese people's resistance to the current military dictatorship had begun early in the regime's 30-year rule, culminating in the ongoing massive street protests ongoing in all Sudanese cities since December 2018. This groundswell of popular opposition action is led by well-coordinated opposition platforms which aim to topple the Inqaz¹ regime through a Popular Uprising². Planning for an orderly transition following the Inqaz's downfall is well-underway and represents the context for this 1-year Transition Plan for the Health Sector (1-TPHS). Almost all major opposition groups in Sudan have agreed that the post-Inqaz Transitional Period of approximately 3-4 years will be led a consensually-appointed broad national coalition Transitional Government that will include technocrats leading its executive with participation of all opposition activists, political parties, trade/professional unions, civil society and other categories. The overriding humanitarian and developmental goals during this Transition Period aim to stop further the deterioration of people's living conditions and the country's economy while also laying the groundwork for a quick recovery towards normalcy in all sectors and dimensions. There will be a special emphasis on targeting those most affected by Inqaz's wars, oppression, corruption and destructive management practices. Having such governance and sectoral plans elaborated now is critical for ensuring an orderly, well-governed transition will follow once the regime is removed.

Document context: This 1-TPHS is **based on the original longer paper adopted by the Sudan Doctors' Union (SDU) in 2016** as its contribution to the Sudanese opposition's call for Alternative Policies. The 1-TPHS's purpose is to present a united view among Sudanese doctors, allied health workers, the Sudanese people and their national and international partners regarding what key health sector priorities must be addressed during the first 12 months following the downfall of the current Inqaz dictatorship regime. Accordingly, this 1-TPHS is meant to guide the post-Inqaz Transition period authorities as they assume leadership of the health sector. It is expected that national consensus workshops around 1-TPHS and other sectoral plans currently being developed will all be held immediately following the downfall of the Inqaz regime. This further debate will aim to further enrich, elaborate, cost and strengthen the consensus around the 1-TPHS once open participation and dialogue are possible following the complete removal of Inqaz regime.

Document structure: In terms of structure, there is already a robust critical analysis of challenges facing the Sudanese health sector available in the above-mentioned earlier paper adopted by SDU in 2016. Hence, and given the insecure circumstances under which this 1-TPHS is being developed and negotiated, the 1-TPHS contains only a brief **Problem Statement (further elaborated in Annex II)** while **Annex I provides the Key Baseline Indicators** summarizing the current situation. The other sections in this 1-TPHS are the **Main Objectives**, the **Principles and Values** guiding the health sector recovery effort, a brief **Methodology and Analytical Framework** as well as the **Priority Strategic Actions** needed over the 1-year timeline. Finally, an Arabic version will be simultaneously available once this English version is approved by SDU.

¹ Inqaz or "salvation" in Arabic; the name which the military dictatorship had assumed when its military coup toppled Sudan's last democratically-elected multi-party government on 30th June 1989).

² This would be Sudan's 3rd Popular Uprising; the previous 2 being the ones that toppled Abboud's dictatorship in October 1964 & Nimeri's dictatorship in April 1985, respectively.

II. Main Objectives of 1-TPHS:

1. By month 12 of its implementation, to **stop the deterioration in at least 10 key health outcome indicators** currently challenging access to basic health services among all Sudanese people, with a particular emphasis upon approximately 3 million Sudanese living in areas affected by Inqaz's wars (ie both those residing in the war zones of Darfur, Blue Nile and South Kordofan as well as those internally displaced and currently residing in other parts of the country) and all Sudanese people.
2. By month 12 of its implementation, to **establish the necessary basis for subsequent medium- and long-term national health reform measures** which can put Sudan back on track to achieving the Sustainable Development Goal (SDG)'s Target 3 for the health sector (including Universal Health Coverage). This is to be done by formulating/revising/updating existing policies, strategies and plans in order to make the Sudanese health sector more responsive to the aspirations of the Sudanese people, more consistent with internationally-accepted principles and commitments as well as better able to invest smartly in the health and, hence, productivity of human capital needed for development.

III. Methodology & Analytical framework:

This 1-TPHS adopts the WHO **definition of the health sector** which consists of all individuals and entities that contribute to preventive, curative, promotive and rehabilitative health services delivered from any platform (e.g. health facility, community/household-based, school, etc), including the private sector, community-based organizations, educational institutions, etc. The 1-TPHS also adopts the 6 WHO Health System Building Blocks as a framework for analyzing the health system in order to establish a common frame of reference for analyzing the problems and recommending reform directions 1-TPHS. The following are the 6 components and their acronyms in this 1-TPHS:

1. Health governance & stewardship (**HGS**); eg transparent decision-making, accountability, etc.
2. Health infrastructure, technologies & pharmaceuticals (**HTP**); eg buildings, labs, medical supplies
3. Human resources for health (**HRH**); eg. production, management, regulation, certification, etc
4. Health information systems (**HIS**); eg surveillance, health management information systems etc
5. Health care finance (**HCF**); includes insurance & other risk-pooling, public-private-partnerships, etc
6. Health service delivery (**HSD**); eg organization of health facilities, service quality, etc

IV. Problem statement:

As of the mid-1980's, Sudan's health sector was achieving considerable progress in reducing the burden of disease, increasing access to basic health care services and strengthening the health system blocks to sustain the gains. The fact that Sudan's key health indicators today are declining is not incidental but is an integral part of a deliberate policy of withdrawing Inqaz government's support from the entire services sector and allowing rampant market forces to determine what services are delivered to citizens, at what cost and with what quality. A full analysis and establishment of baselines and benchmarks for a health sector policy are beyond the scope of this paper. However, the **Summary Problem Analysis** of key challenges identified in each of the 6 health system components is attached as Annex II to this 1-TPHS.

V. Recommended principles to guide Sudan's national health policy direction:

1. Health is **a human right**, as already enshrined in Sudan's 2005 constitution;
2. Health is **an investment in human development**; it is not merely a social service or welfare expenditure;
3. Health is defined as per the **WHO definition**: not the mere absence of disease;
4. The government has a key regulatory obligation and service delivery role in health sector.
5. **Pro-poor, gender-responsive and equity-focused policy**: Since its 1989 coup, Inqaz has waged a destructive war on women's rights and access to health. Given the worsening poverty levels it is critical to eliminate not just the inequities of access to care at the point of health services but, equally importantly, to also remove the structural inequities at the upstream level of the social determinants of health. These include empowering and ensuring ownership by individual and communities in all decisions that affect their health, in the health and other health-related sectors such as housing, income, education, water supply and sanitation.
6. **Complementarity of roles between public health sector in partnership with Sudan's civil society** (including health worker trade unions, professional associations, media, informal community-based groups and national/formal NGOs), **private sector and research educational institutions** and private sector in support of common health policies: This principle requires not just involving CSO and private sector entities as mere contractors or channels for additional funding or service outlets. They must be involved as peers in setting policy, developing strategies as well as monitoring and implementing them.
7. **Primary (but not sole) role of government in stewarding health system**: On the one hand, this paper recommends that the government (national and local) to take the lead in defining health policies, strategies and priorities, establishing norms and standards of care and service, allocating public resources, regulation of service delivery by all actors (public, private, not-for-profit), requiring/enforcing various health insurance schemes (including but not limited to government financed/co-financed schemes) to ensure full financial coverage against catastrophic and occupational events. On the other hand, this paper additionally recommends a primary role for the government to directly establish and manage the metrics for performance measurement/regulation, to directly deliver public goods (e.g vaccination, vector-control measures and a basic package of services (e.g. accident/emergency, RMNCH, key vertical disease services, etc) and to directly provide services to socially-protected underserved populations in Sudan.
8. **Evidence-based**: Despite not having the required access to sufficient data and information in order to ensure that it is fully evidence-based at this point in time, the paper adopts global definitions, norms, indicators and standards. Crucially, the paper also calls for health metrics which enable the policy directions and health system performance to be well-monitored and proper accountabilities to be established at all levels of its management.

VI. Priority Policy Reform & Strategic Actions in Sudan during 1-TPHS:³

Based on the above, recommended priority health policies and strategic actions are as follows:

1. Stop all wars while achieving budgetary savings from a drastically downsized top executive and legislative branch positions at national, state and local government levels (including emoluments, benefits, recurrent expenditures) and **reallocate the savings from Inqaz's executive, military and**

³ Not listed in any chronological or other order of importance but loosely-grouped within each WHO Health System Building Block.

security expenditures to reinvest them in health, education and social protection sectors as an absolute immediate priority.

2. Within the health sector, prioritize urgent humanitarian aid and rehabilitation of basic health services for all **populations in areas previously-affected by conflict** as well as among those still displaced by such conflicts in the country.
3. Increase and maintain the level of **government expenditure on health** at national and subnational (states, municipalities) so that it represents at least 15% of total governmental expenditure in line with the African Union's Abuja Declaration (2006).
4. In close collaboration with the social protection sector entities, develop, cost and plan to pilot the implementation of a **Priority Health Service Package (PSP)** to be delivered to all Sudanese citizens and migrants living in Sudan through public sector outlets at all levels (primary, secondary, tertiary).
5. Dramatically increase the proportion of governmental budget spent on the health and social protection sectors, including reforming the current **national health insurance** to ensure it increases its coverage and it meets the social protection needs of the most vulnerable Sudanese citizens. The target groups should particularly include the victims of Sudan's wars, socio-economically disadvantaged demographic segments such as women, youth, adolescents, children, elderly, people with special needs, orphans as well as disadvantaged agricultural, industrial and service-sector workers. To cover private sector employees, schemes need to be developed whereby creative co-financed insurance schemes between government and private sector employers as well as community-based insurance schemes for the self-employed, informal sector workers and agricultural workers (particularly in rural areas such as the Combo settlements in various locations).
6. Establishment of a national participatory multi-disciplinarily **National Health council (NHC)** chaired by the Prime Minister (not the Minister of Health) and involving all ministries, academic institutions, research bodies, civil society and private sector representatives whose work relates to the social, environmental, economic and demographic determinants of health; the NHC should be empowered by law to oversee policy setting, overall strategic guidance and planning for health sector.
7. In close collaboration with the judicial branch, public prosecutor, the Auditor General, Ministry of Finance and Ministry of Interior, create an **anti-corruption tracking platform (clearing-house)** to be managed by a conglomerate of suitable Sudanese civil society groups in collaboration with the legislative branch (ie the interim Transitional Governing Council). It's role is to monitor, document and publish corruption practices in the health and other sectors, to record legal and practical responses and counter-measures undertaken, to map and strengthen the capacity for community-based and civil society-led anti-corruption efforts as well as to provide expert resources, networking and linkages with similar groups in Africa and globally. The platform should also create corruption tracking metrics within the formal health sector's health information management systems by adapting experiences such as Uganda's Data Tracking System.⁴ The

⁴ Uganda Data Tracking Mechanism to Monitor Anti-Corruption. Government of Uganda Inspector General and Economic Policy Research Center (EPRC) – Makerere University, Kampala, Uganda. 2011.

platform best involve a secure electronic one to enable broader access to all citizens and its role should be legally-empowered and perform its work in a manner complimentary to any national anti-corruption commission which the executive branch creates.

8. Legalize and empower the institutions and activities of **citizen, patient and consumer-action** groups at all levels (eg the Sudanese Consumer Protection Association, among others).
9. To comply with **international aid effectiveness standards**, engage all stakeholders (autonomous managers, donors, international organizations, etc) to ensure streamlining of all major health projects (eg polio, malaria, HIV/AIDS and TB, etc) so that they are (a) harmonized among one another, (b) aligned with national Sudanese policy and strategy priorities and (c) gradually integrated to operate through the public sector and strengthen exiting health systems.
10. Establish transparent **local accountability mechanisms at service delivery points, municipal, state and at national** level to comprise elected health worker unions, patient/consumer group representatives, parliamentary/formal legislative branch and service providers. Empower such bodies by law and assist in enforcing their work to hold service providers accountable for the quality and extent of health service delivery coverage;
11. Review and develop new or strengthen existing **legislative frameworks and laws** relevant to health while prioritizing those regulating food supply, medical commodity importation and manufacturing standards, medical practice, environmental hygiene & sanitation, communicable disease control and patient rights;
12. Develop mechanisms to effectively and transparently regulate and monitor the quality and standards of delivery in the **private health service delivery** sector, with strong accountability parameters to the state, the professional bodies, the patient and the community. Consider establishing reasonable costing parameters and guidelines which enable the private sector to profit while maintaining the affordability of access by the population (eg the experience of Jordan). Empower such bodies by law and assist in enforcing their work to hold service providers accountable for the quality and extent of health service delivery coverage.
13. Begin establishing a **process and formal mechanism to develop Sudan's medium and long-term National Health Policy towards achieving SDG-3 and UHC**, including seeking technical and financial support from suitable countries, donors and the UN.
14. Conduct **proper scientific review of Sudan's HRH situation** and develop short-term policies and strategies which address the key distortions affected this central element of the health sector. This includes, determining the true projected needs for HRH production, addressing existing discrepancies in HRH production, distribution and deployment as well as addressing the certification, continued medical education, licensing and regulatory aspects for HRH in Sudan. Furthermore, and based on the review, it is important to consider possible closure and/or redistribution of assets and resources from a number of existing health sciences/medical schools, intensifying investment in a few core medical schools as well as investing in strengthening schools for allied health sciences (particularly midwifery, nursing and similar HRH teaching/training institutions).
15. Increase the investments and technical inputs to improve the **quality (not quantity) of health science training and education** in both the public and private educational/training institutions

16. Rehabilitate and establish the **essential emergency, accident and resuscitation services** at key primary, secondary and tertiary facilities to be funded by the state governmental expenditure until national insurance coverage is attained to off-set its costs
17. Intensify **school health**, including school feeding, basic hygiene/sanitation, vaccination, nutrition, deworming, eye health, dental health, healthy dietary intake, lifestyle improvement, psychosocial/mental health interventions, sexual and reproductive health interventions;
18. Reduce the incidence of **chronic non-communicable diseases** by identifying key risk factors relevant to Sudan (including exposure to carcinogens from industrial waste, pesticide use and other exposures) and actively addressing them including through stronger anti-tobacco measures, lowering salt intake and actively promoting healthier lifestyles. Additionally, improve chronic disease management and support including through palliative and home-based care delivery systems, early detection and prevention (primary, secondary & tertiary prevention) programs for occupational, cardiac, cancer, diabetes, hypertension and other non-communicable diseases, etc.
19. With technical assistance from UN and donor partners, conduct an urgent desk-review of key **strategic information and health information system** capacity requirements (including analyzing reporting, data utilization for decision-making, data accuracy, currency, completeness, reliability, frequency, etc), followed by the design of one or more exercises to serve as the baseline for key health indicators in Sudan.
20. In close collaboration with national and international research bodies such as WHO, develop the necessary metrics for the health sector's immediate (ie 1-TPHS) and longer term **health sector performance measurement**. These will be needed as tools to further dissect the problems, establish parameters for success, track progress, monitor and evaluate and further plan. Such tools should include WHO frameworks, guidelines, methodologies and tools for measuring health system performance, human resources management, health sector governance, situation analysis tools, methods to determine, prioritize & cost the Priority Package of Services, performance-based funding models, disease burden studies, disease-specific studies, service utilization and coverage studies, operational research and others.

Annex I: Key Indicators and Baseline for the 1-Year Transitional Health Sector Plan (1-THSP)⁵

	Indicator Definition	Value for Sudan (male/female)	Year	WHO EMR average (*)
1	Total population	40.24 Million	2015	
2	Life expectation at birth	64.1 years (62.4/65.9)	2015	68.8 (67.4/70.4)
3	Healthy life expectancy at birth	55.9 years	2015	60.1
4	Maternal mortality ratio	311 per 100,000 lb (**)	2015	166
5	Births attended by skilled health personnel	78 %	2005-2016	71
6	Mortality rate of children under 5 years of age	70.1 per 1000 lb	2015	52
7	Neonatal mortality rate	29.8 per 1000 lb	2015	26.6
8	New HIV infections among adults 15-49 years	N/A (***)	2015	0.13
9	Incidence of tuberculosis (TB)	88 per 100,000 pop (****)	2015	116
10	Incidence of malaria	36.6 per 1000 pop at risk	2015	19
11	Infants receiving 3 doses of hepatitis B vaccine	93 %	2015	80
12	Reported number of people requiring interventions against neglected tropical diseases	26,533,962	2015	86,152,675
13	Probability of dying from any cardiovascular disease, cancer, diabetes or chronic respiratory disease between age 30 and exact age 70 years	25.7 %	2015	21.8
14	Suicide mortality rate	10.2 per 100,000 pop	2015	3.8
15	Total alcohol consumption per capita among 15 yr-olds or older -projected	3.3 liters of pure alcohol	2016	0.7
16	Road traffic mortality rate	24.3 per 100,000 pop	2013	19.9
17	Proportion of married or in-union women of reproductive age who have their family planning needs satisfied with modern methods	30.2 %	2005-2015	61.1
18	Adolescent birth rate	87 per 1000 women aged 15-49 years	2005-2014	46.1
19	Mortality rate attributed to household ambient air pollution	64.5 per 100,000 pop	2012	58.8
20	Mortality rate attributed to exposure to unsafe water, sanitation and hygiene services	34.6 per 100,000 pop	2012	13.1
21	Mortality rate attributed to unintentional poisoning	4.2 per 100,000 pop	2015	1.4
22	Age-standardized tobacco smoking among persons 15 years or older	N/A	2015	N/A
23	Diphtheria, tetanus & pertussis (DPT3) immunization coverage among 1-yr olds	93 %	2015	80
24	Total net official development assistance (ODA) for medical research and basic health per capita	2.47 US Dollars (at constant 2014 US Dollar)	2014	1.46
25	Skilled health professional density	42.2 per 10,000 pop	2005-2015	26.3
26	Average of 13 International Health Regulations (IHR) Core Capacity scores	71	2010-2016	72
27	General government health expenditure as a % of general government expenditure	11.6 %	2014	8.8
28	Prevalence of stunting in children under 5 years	38.2 %	2005-2016	25.1
29	Prevalence of wasting in children under 5 years	16.3 %	2005-2016	9.1
30	Prevalence of overweight children under 5 years	3 %	2005-2016	6.7
31	% of population using improved drinking water sources	N/A	2015	91
32	% of population using improved sanitation facilities	N/A	2015	78
33	% of population with primary reliance on clean fuels	23 %	2014	71
34	Average death rate due to natural disasters	0.1 per 100,000 pop	2011-2015	0.2
35	Mortality rate due to homicide	6.5 per 100,000 pop	2015	6.5
36	Estimated direct death rate due to major conflicts	7 per 100,000 pop	2011-2015	19.5

⁵ Data source: World Health Statistics Report 2017. World Health Organization, 2017, Geneva. Available at http://www.who.int/gho/publications/world_health_statistics/2017/en/. (*) WHO Eastern Mediterranean Region (EMR) includes Sudan, Somalia, Djibouti, Egypt, Libya, Tunisia, Morocco, Saudi Arabia, Yemen, Oman, United Arab Emirates, Qatar, Bahrain, Iraq, Kuwait, Iran, Afghanistan, Pakistan, Syria, Lebanon, Jordan & Palestine. (**) lb=live births. (***) N/A=Data not available. (****) pop=population. Pink-highlighted indicators denote where Sudan is worse than the WHO EMRO regional average of the 22 countries.

Annex II: Summary Problem Analysis: Key Challenges Facing Sudan's Health Sector in 2019

i. Health governance & stewardship (HGS):

- Governmental neglect of the constitutional requirement for upholding the right to health;
- Governmental neglect of its fiduciary requirement of good governance in the sector;
- Lack of participatory approaches to decision-making at service delivery, local & national government levels; in particular the exclusion of key social and community actors, trade/professional associations, patients, civil society and other development partners;
- Narrow range of sectorial representation in platforms actually enabled and encouraged to contribute to health, including the exclusion of education, finance, agriculture, water supply/sanitation (WASH), social protection, justice and other entities in charge of social determinants of health (SDHs);
- Defective/confused/undermined accountability pathways and fragmentation of the responsibility in key health sector governance areas, including in health infrastructure development, HTP procurement standards, health service delivery standards, regulatory control over non-state actors (private sector delivery, NGOs, etc).
- Pervasive lack of public national and local government accountability mechanisms which can effectively monitor, guide and verify health-related resource allocation, budget planning, disbursement and costs at all levels of health sector management;
- Lack of health system performance benchmarks that are scientifically-established, rigorously-monitored and transparently reported for the health sector based on a robust health information management system;
- Absence of effective coordination mechanisms between various different health authorities;
- Rampant corruption and mismanagement in the health sector and health facility practices;

ii. Health infrastructure, technologies & pharmaceuticals (HTP):

- Increased disease burden when publicly-purchased medical commodities & equipment are embezzled & sold in private market causing stock outs at public sector facilities.
- Increased direct costs of care due to corrupt procurement practices (eg single sourcing of medical commodities and equipment by foregoing competitive bidding, lack of lower-priced generic medicines or foregoing opportunities for volume discount through participating in bulk purchases with other countries).
- Substandard medical commodities and equipment being allowed by corruption into health care system causing decreased efficacy and quality of health interventions leading to increased morbidity & mortality due to fake, substandard, expired or otherwise dangerous medication or equipment.
- Absence of effective regulatory control over health commodity procurement standards for the public sector and deficient budgeting for public sector procurement requirements for medicines, medical supplies, health technologies, laboratory, radiology and other HTP;
- Ad-hoc or absent medical commodity supply management and distribution systems, resulting in wasted investments, spoilage, theft and commodity stock outs;
- Neglect of previous investments and policies which helped create Sudan's previous small but robust local manufacturing capacity for key drugs and medical supplies, with resultant reliance on importation at high cost to the government and/or the patient;

- Failure to take advantage of or to pursue actively enough international trade arrangements with key supplying countries/manufacturers as well as African and other neighbours to achieve volume discounts, prioritize importation of generics instead of commercial brand name medicines, join voluntary pooled procurement arrangements for childhood vaccines, HIV ARVs, maternal health commodities and other missed opportunities;

iii. Human resources for health (HRH):

- An inadequate health work force density that is inequitably distributed between urban and rural areas (below the WHO minimum of 2.5 health workers per 1000 people);
- The imbalance in the production of health cadre that favors training doctors and ignores the training of the allied health cadre.
- Lack of an HRH management policy framework, resulting in uncontrolled production of weakly-trained HRH;
- Insufficient investment by the State in proper training, mentoring and supervision of the health workers;
- Reduced quality of preventive and curative services caused by replacing competent health workers with those who are loyal to government policies, including distortion of health worker training which favors training facilities owned by government officials (by exempting them from training costs)

iv. Health information systems (HIS):

- Absence of coordinated data needs prioritization, collection, analysis, reporting and utilization in decision-making, resulting in weak performance of national and disease-specific health surveillance systems as well as irrational decision-making and poor basis for accountability at national, local and facility levels in the sector;
- Tendency to manipulate health information to serve political needs;
- Inadequate transparency in reporting health data;
- Poor systems for turning health data into usable information for decision-making;

v. Health care finance (HCF):

- Chronic under-funding with inadequate coverage of insurance schemes of all types, with resultant catastrophic increase of the out-of-pocket expenditure portion to become more than 75% of total expenditure on health;
- Increased opportunity cost to the overall health system due to the chronic underfunding of preventive services (higher disease burden at population and individual level), leading to absent or weak communicable and non-communicable disease surveillance, control of environmental safety, residential sanitation, workplace & occupational safety, safety of food chain & water supply, industrial product and by-product and waste regulation, etc.
- Insufficient harmonization and alignment of external ODA investments in health with governmental support to the health sector, whereby most UN and donor program investments are not reflected in the national health accounts; preventing realistic, efficient and holistic budgeting as well as proper accountability for HCF;

vi. Health service delivery (HSD):

- Failure to implement existing health policies strategies particularly through regressing from Alma Ata Declaration principles by focusing less on primary health care (PHC) and more on secondary and tertiary;
- Decreased access to health care (particularly primary, but also secondary and tertiary health care) caused by systematic and official dismantling of public sector health facilities leaving patients with only the option of resorting to private health facilities owned by government officials (eg KTH).
- Inappropriate prioritization in organizing service delivery whereby there is a persistent and misguided focus on developing politically-motivated new tertiary health care institutions, while neglecting and actively dismantling existing ones as well as leaving wide gaps in creation or renovation of existing primary health care infrastructure;

Health Delivery in Conflict zones

Sudan Demographic and Current Health Status

Sudan population is around 42 million with 41% under 15 years of age; and 1 in 5 are below 25 years; hence the majority of the population are children and young adults. Most of the population are in rural areas, with only a third in urban cities, mostly in the capital Khartoum where there are 7 million, including 2 million displaced from conflict areas.

Sudan's health profile is among the lowest worldwide at position 154 out of 160 countries and is among the lowest 16 countries in Human Development Indexes (HDIs) (See Human Development Report, 2010).

Sudan has one of the world's highest infant and maternal mortality rates.

The Sudanese Ministry of Health declared recently that 2.3 million children are malnourished & about 45 per cent of all deaths in children under five are directly related to malnutrition. Eleven out of eighteen Sudanese states have malnutrition prevalence among children of above 15 per cent, which is above the WHO emergency threshold. (Humanitarian Needs Overview, Sudan, Feb 2018, OCHA)

The health challenges are not just in the young;

The government Food Security Technical Secretariat (FSTS) estimates that in 2018, some 4.8 million people are living at crisis or emergency levels of food insecurity. 1 in 10 people in Sudan are estimated to be food insecure.

About 75% of the population (24 million) is at risk of malaria.

TB burden puts Sudan among the worst affected countries in the world.

Perhaps the best indicator of the collapse of medical services in Sudan and its devastating effect on its predominantly rural population is the yearly outbreaks of epidemics, especially in the past three years, increasing in intensity and geographic spread. Outbreaks of cholera (the official name given, acute watery diarrhea), Yellow Fever, chikungunya, dengue fever, and other hemorrhagic fevers occurred in more than three States; Gezira, Eastern State, Nile State, White Nile and some pockets in Khartoum.

On the other hand health staff concentrate in urban centers where more than half of all specialist doctors and technicians in Sudan work in Khartoum with two-thirds of them working in secondary health facilities.

The doctor to patient ratio is well below WHO recommendations with only one doctor per 3,333 populations. (WHO ratio is 2.28 to 1000population)

Current Health Services

This has not been the case for Sudan's health situation in the past as Sudan was one of the first countries that adopted Primary Health Care in 1976 as its principle strategy for health care and throughout its subsequent programs Primary Health Care was emphasized e.g. in the "Nation-Wide 25 year Strategy for the Period 2003- 2027" &

“Sudan’s Health Sector Strategic Plan for 2012-2016” (the second five-year strategy in the current 25-year health plan period).

With the adoption of economic liberalization policies in mid 90ies and introducing the concept of "fee-for-service", the government withdrew any financial support from the entire services' sector, mainly health and education, allowing unrestrained market forces to determine what services are delivered to citizens, at what cost and with what quality. Public expenditure on health has been negligible at less than \$2 per capita per year

The result on the ground;

- Health coverage is low across the country and extremely scant in many areas especially in conflict areas. Inequalities in health and access to healthcare are marked across all divides: urban vs. rural, north vs. south and socioeconomic groups and gender.
- Health delivery is fragmented
- Health facilities outside the capital are barely functional

This is the case in both urban and rural areas and worse in conflict zones.

Conflict Zones

The impact of the conflict in Darfur, Nuba Mountains and Blue Nile is well documented. There has been widespread displacement, with 2-3 million internally displaced people (IDPs).

Darfur remains the focus of large-scale persistent displacement and most IDPs are unable to meet their basic needs independently. Some 1.6 million displaced people are registered in camps. Another half a million displaced live in host communities and settlements in Darfur.

A further half a million are displaced in areas under the control of armed resistance movements in Nuba Mountains and Blue Nile— two-thirds of those are children and pregnant and lactating mothers.

On the other hand, refugees and asylum seekers, especially from South Sudan, continue to arrive in Sudan seeking protection and humanitarian assistance. There have been 450,000 new arrivals from The Republic of South Sudan since 2013.

The scale and long term nature of the conflicts in Darfur (since 2003), and Nuba Mountains & Blue Nile (over a period from 1987 – 2002 and re igniting since 2011) has exposed the populations to immense and protracted hardships losing their way of living as subsistence farmers.

In Summary

The main humanitarian needs in Sudan result from several factors: new and protracted displacement due to conflict, chronic poverty and under-development due to mismanagement of public funds.

Priority Strategic Action

To address the huge health and humanitarian crisis in the country, one of the main policy directives is a bottom up approach emphasizing community empowerment, disease prevention and health promotion. Control of the entire health care system is essential to ensure efficient implementation and equal distribution of services.

The main focus points would be to;

1- Re-allocate the savings from government executive, military and security expenditures to reinvest them in health, education and social protection sectors as an absolute immediate priority. Scale up government expenditure on health and maintain it at national and subnational (states, municipalities) levels so that it represents at least 15% of total government expenditure in line with the African Union's Abuja Declaration (2006).

2- Prioritize urgent humanitarian aid and rehabilitation of basic health services for all populations in areas previously-affected by conflict as well as among those still displaced by such conflicts in the country; aided by collaboration with the social protection sector entities to pilot the implementation of a Priority Health Service Package (PSP).

3- Redistribute health personnel to rural and conflict zones by developing short-term policies and strategies which adjust the distortion of concentration of health personnel in urban areas to improve coverage to conflict and rural areas. Draw the attention of graduating doctors towards rural service (a two year rural residency) for promoting their career rather than salary incentives to become specialists.

4- Increase the proportion of governmental budget spend on the social protection sectors by reforming the current national health insurance scheme to increase its coverage and meet the needs of the most vulnerable Sudanese citizens particularly the victims of Sudan's wars; and socio-economically disadvantaged segments of the population (such as women, youth, adolescents, children, elderly, people with special needs, orphans as well as disadvantaged agricultural, industrial and service-sector workers).

5- Establish transparent local accountability mechanisms at a service delivery level through workers' unions, patient/consumer group representatives, parliamentary/formal legislative branches and service providers.

And empower such bodies by law and assist them in enforcing accountability for the quality and reach of health service delivery coverage

6- Begin establishing a process and formal mechanism to develop Sudan's medium and long-term National Health Policy towards achieving SDG3 - Universal Health Coverage: Including financial risk coverage;

Access to quality essential health care services &
Access to safe effective quality and affordable essential medicines and vaccines for all
as well as.
Seeking donor commitment for technical and financial support.

The recommendations mentioned above are part of the document "Sudan 1-year Transition Plan for the Health Sector", developed by Sudanese Doctors in Sudan and the Diaspora who are members of the Sudan Doctors' Syndicate & SDU/UK & Ireland, and are being discussed to be finalized ready for implementation.

In conclusion,

We are aware of the extent of damage to the whole health set up but we health care professionals in Sudan and the Diaspora are determined to rectify the situation and address the calamity through, commitment, collaboration and volunteerism in the spirit of the current revolution. We will fulfill what our youth and young Sudanese are calling for, fighting for and losing their lives for a better Sudan for all.....

TASGUT BAS

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- 9- Sudan National Health Sector Strategic Plan II (2012-16)

18th January 2019

A Basic Health Financing Primer in the Context of Sudan

Modes of health financing

Largely related to historical factors, international comparisons show that countries use different ways of paying for health services. There are three broad approaches to health system financing, each of which can be found in Sudan:

- **Out-of-pocket (OOP) payments.** These are payments made directly to a health care provider by patients.
- **Tax-based funding.** This is where health care is funded through general taxation; funds from those paying taxes are used to finance the provision of health services to the general population.
- **Health insurance.** This is a device by which individuals can protect themselves against the uncertainty of financial losses from illness.

Sudan

Sudan is a developing country with a population of 39.5 million (2016) and a gross national income in 2013 of US\$2370 per capita (adjusted for purchasing power parity). As can be seen on the table below, current health expenditure in Sudan during 2015 as a percentage of gross domestic product (GDP) was 6.3%. Expressed in per capita terms, current health expenditure in US\$ in 2015 was \$151.8 (int. \$277 per capita, when adjusted for purchasing power parity). This expenditure was lower than the current health expenditure per capita in the Eastern Mediterranean Region, which was US\$556.8 in 2015. Moreover, general government health expenditure is dominated by private health expenditure. In other words, approximately two-thirds of health care expenditure (66.9% in 2015) is accounted for by private health expenditure. Also, out-of-pocket expenditure accounts for 63.2% of current health expenditure. A combination of the introduction of user fees at government facilities as well as the growing importance of the fee-for-service in the private sector has contributed to the increase in out-of-pocket payments in Sudan.

Health expenditure ratios							
Year	Current health expenditure as percentage of gross domestic product (GDP)	Domestic general government health expenditure as percentage of current health expenditure	Domestic private health expenditure as percentage of current health expenditure	Out-of-pocket expenditure as percentage of current health expenditure	Domestic general government health expenditure as percentage of gross domestic product (GDP)	Current health expenditure per capita in US\$	Current per capita expenditure on health (PPP int. \$)
2015	6.3	31.1	66.9	63.2	2.0	151.8	277.0

Data source: *Global Health Observatory Data Repository*.

Overview of out-of-pocket payments for health care

Depending on the country, OOP or direct payments are levied by government, nongovernmental organizations, faith-based and private health facilities. OOP payments range from private consultations with doctors and the purchase of medications to copayments and user fees. The latter, user fees, usually refers to direct payment for publicly provided health care at the time of use (this will be in addition to contributions made through taxation). User fees are charges made directly to service users, usually on the basis of a specified fee-for-service. User fees will typically only cover part of the cost of the service (can be complete cost recovery or partial). In addition, cost-sharing under health insurance can also be seen as a form of user fee (as with deductibles and coinsurance). User fees for public health services were introduced in Sudan during the early 1990s (there are exemptions for vulnerable groups and for emergency services). Prior to this, health care services were free of charge and

financed through general taxation. During the 1990s, the private health care sector in Sudan witnessed a significant increase, particularly after the implementation of major macroeconomic reforms. As a consequence, out-of pocket expenditure has increased consistently and significantly.

One of the problems of making people pay for health care at the point of delivery is that it may discourage them from using services (particularly for health promotion and prevention), and it is likely to encourage them to postpone health checks. More generally, OOP health payments can be catastrophic for households. This is where the payments exceed 40% of a household's non-subsistence spending (household subsistence spending is the minimum requirement to maintain basic life. In other words, this is when people have to pay fees or co-payments for health care where the amount in relation to income results in financial catastrophe. The expenditure on OOPs can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education. In general, the higher the share of OOP in total health expenditure and the greater is the risk of catastrophic expenditure and impoverishment. Finally, direct payments are the least equitable form of health funding. They are regressive, allowing the rich to pay the same amount as the poor for any particular health care service.

Overview of taxation as a mode of financing for health care

Historically, the public health system in Sudan was the main provider of health services, and the major source of funding was through taxation. The advantages of using taxation as a mode of financing include that taxes can be cheap and easy to collect, and that they can be equitable. In other words, tax-based financing of health care has the advantage that the rich may pay a higher proportion of their income in tax than the poor (i.e. tax-based financing of health care can be progressive). For example, in high-income countries income tax (a direct tax) is typically progressive and constitutes a major source of total tax revenue. However, in low-income countries, because the formal sector is generally small, the revenue from direct taxes like income tax will account for a smaller share of total tax revenue relative to indirect forms of taxation (e.g. taxes levied on goods and services). In the short-term, low-income countries with large informal economies will tend to focus on taxes that are relatively easy to collect, such as those on formal-sector employees and corporations, import or export duties of various types and value added tax (VAT). The progressivity of an indirect tax like VAT or general sales tax will vary from place to place. And in many countries such taxes can be regressive (in that the poor will pay proportionately more of their income on tax than the rich). Hence, it is not always the case that tax-based funding of health care will be equitable.

Sources of tax include:

- Personal income tax (direct)
- Corporate income tax (direct)
- Import duties (indirect)
- Excises (indirect)
- General sales tax (indirect)
- Carbon tax (indirect)

In addition to the above, a tax on a harmful product (sometimes referred to as a sin tax) like tobacco, has the advantage of improving health at the same time as providing a source of government revenue.

The overall burden of taxation in Sudan is progressive. Specifically, a higher share of taxation is taken from the rich as opposed to the poor. Therefore, tax-based funding of health care can be redistributive by both health status (from well to unwell) and income (from rich to poor).

Typically, taxes are raised for general unspecified purposes. By contrast, the hypothecation of a tax (also known as the ring-fencing or earmarking of a tax) is the dedication of the revenue

from a specific tax for a particular expenditure purpose. Hypothecated taxes have the advantage of linking tax and spending directly, which makes it transparent where tax moneys are being spent. A disadvantage of hypothecated taxes is that they reduce the ability to be flexible; as with investing more resources where needed in an emergency. However, apart from the Wounded Tax, which was an earmarked tax for health care introduced in the late 1990s (primarily to be used for the Military Medical Services), moneys raised through taxation in Sudan are not earmarked - so may be used for an alternative purpose other than health care services.

Overview of health insurance

Health insurance schemes can be voluntary, involuntary, for profit, and not-for-profit. Individuals choose to buy health insurance because they are risk averse. Insurance can be supplied because risk pooling enables insurers to predict the number of individuals who will become ill and require health care. Essentially, an insurer collects a small amount from everyone but pays a large amount to only a few individuals.

As an illustration consider the following. If we assume that the probability of a 50 year old male with hypertension who smokes developing CHD is 5%, with 100 such males randomly chosen we would expect that on average 5 would develop CHD. By taking a larger sample insurance companies can predict the incidence of ill-health more accurately (the law of large numbers) and be relatively certain of the required health care. If we further assume that CHD treatment cost \$50,000 an appropriate annual premium of \$2,500 could be estimated. Therefore if twenty thousand 50 year old males with hypertension and who smoke take out insurance premiums at \$2,500 each the insurer would collect \$50 million ($\$2,500 \times 20,000$) in premiums. Of the twenty thousand insured, 1,000 will develop CHD and this will cost the insurance company \$50 million ($1,000 \times \$50,000$). So each individual covered by the insurance who develops CHD will receive \$50,000 (i.e. $\$50 \text{ million}/1000$). Clearly, the larger the pool (i.e. the greater the number insured) and the less likely unexpected costs per case will occur.

This is the basis of insurance. However, for health insurance against particular claims, as with the above (covering CHD), there are specific aspects of health care, as with maternal health, where a system of risk pooling like insurance may be problematic (given that for many a claim would be inevitable). Even so, the uncertain aspects of maternal care could be covered and/or a qualifying period could be applied to reduce the selection problem of women joining the scheme when they expect to become pregnant. Beyond this, the occurrence of the insured event should not be under the direct control of the individual (i.e. people should not be able to influence their risk). Also, insured risks need to be independent (the risk of falling ill is not a single event that could affect all the insured, as with an epidemic). More generally, the probability of the insured event must be less than 1 (so will exclude pre-existing conditions that will inevitably produce illness). To be comprehensive (covering all health needs), the health insurance would need to have a premium that reflects the likelihood and costs of all health events.

Health insurance in Sudan

A national health insurance scheme was introduced in Sudan during the 1990s. The scheme covers around 8% of the population. The majority of those covered by the scheme (75%) are government employees but some poor families and students are also covered. The premium comprises 10% of salary; 60% of which is paid for by the employer (the government) and 40% by the employee. The premiums for the poor and others are covered by various government programmes and charities including Zakat Chamber. The system has large administrative costs, which are estimated at 25 per cent of expenditure. In addition, the scheme is hampered by difficulties in the collection of premiums and the existing information system.

Under the national health insurance scheme, the insured are registered at a health centre, which acts as a gatekeeper for referrals. The scheme's benefit package includes all medical consultations, admissions, diagnostic procedures and therapeutics including surgical operations. Dental services are included with the exception of denture and plastic surgery. The highest cost diseases, namely cardiac surgery, renal failure and cancers, are excluded. The scheme also provides for 75% of the cost of medicines on its approved list of essential medicines. The beneficiaries pay the remaining 25% of their prescription and pay the full cost of medicines prescribed that are not on the list. Each level of health professional has a defined list of drugs that they are allowed to prescribe (with different lists for medical doctor and specialists) and only generic medicines are allowed.

In health care systems characterised by dominant out-of-pocket financing of health care (as with Sudan), there has been a growing interest in voluntary forms of health insurance like community health insurance. Typically, these are schemes that target the informal sector in countries where user fees are charged. Often encountered forms of community financing include:

- *Community involvement in user fee collection* - resource mobilization relies mainly on OOP payments at the point of contact with providers. However, the community is actively involved in the design of these fees and in managing the collection, pooling, and allocation of the funds that are raised in this way.
- *Community prepayment scheme or mutual health organisations* - the community collects payments in advance of treatment (prepayment) and then manages these resources to pay for providers.
- *Provider-based community health insurance* - providers that serve a particular community collect the prepayments themselves.
- *Community-driven prepayment scheme attached to social insurance or government-run system* - the community acts as "agents" in reaching rural and excluded populations on behalf of the formal government or social health insurance system via contracts or agreements.

However, community financing schemes are vulnerable to a number of shortcomings:

- Schemes that share risk only among the poor will deprive their members of much needed cross-subsidies from higher-income groups.
- Schemes that remain isolated and small deprive their members of the benefits of spreading risks across a broader population.
- Schemes that are disconnected from the broader referral system and health networks deprive members of the more comprehensive range of care available through the formal health care system.

Conclusion

Sudan health financing policy should move away from the current mode where it is very heavily reliant on Out Of Pocket (OOP) payments; and to move back to its pre 1990 original mode of tax-based funding, supplementing it with a strengthened and more equitable health insurance element. This is essential if the country is to achieve Universal Health Coverage (UHC) the health goal committed to globally, and at country-level, including by Sudan, as a critical component in realising Sustainable Development Goals.

Good health is essential to sustained economic and social development and poverty reduction. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care.

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

UHC enables everyone to access the services that address the most significant causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them.

Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. Countries that progress towards UHC will make progress towards the other health-related targets, and towards the other goals. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

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Alternative pharmaceutical Policies

(Efficient drug procurement
and pharmacy services)

Central Committee of Sudan Pharmacists (CCSP)

Rania Elsayegh
Osman Freigoun

Central Committee of Sudan Pharmacists



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- Drug Shortage Crisis.
- Sudan Medicine market profile.
- Major reasons behind medicine shortages in Sudan.
- Why these alternative strategies are needed?

- Alternative Pharmaceutical strategies (Aims/ short and long term strategies).
- Our ambition (product/pharmaceutical service).
- Learning points/ Experience elsewhere.
- References .

Drug Crisis (shortage & pricing)



Problem statement

The economic crisis started in 2010, but the government started a monetary policy in 2013 which is the allocation of 10% of export earnings of hard currency in Central Bank of Sudan to go to drug import . Which kept the US\$ price below 19 SDG for the importers.

The government stopped that policy in 2016 and left the importers to the currency fluctuation and Black market prices and this led to a sever drop in medicines availability/affordability.

Central Committee of Sudan Pharmacists Action started 2016

launched a campaign in order to rise people awareness
of the true reason behind the crisis

#أعيدوا_الدعم_للأدوية

CCSP also organized and still organizing community
pharmacists strikes and protests against those wrong
policies

For One Goal

Safe, Affordable, Effective Medicine For all

CCPS joined S.P.A and the uprising in Sudan



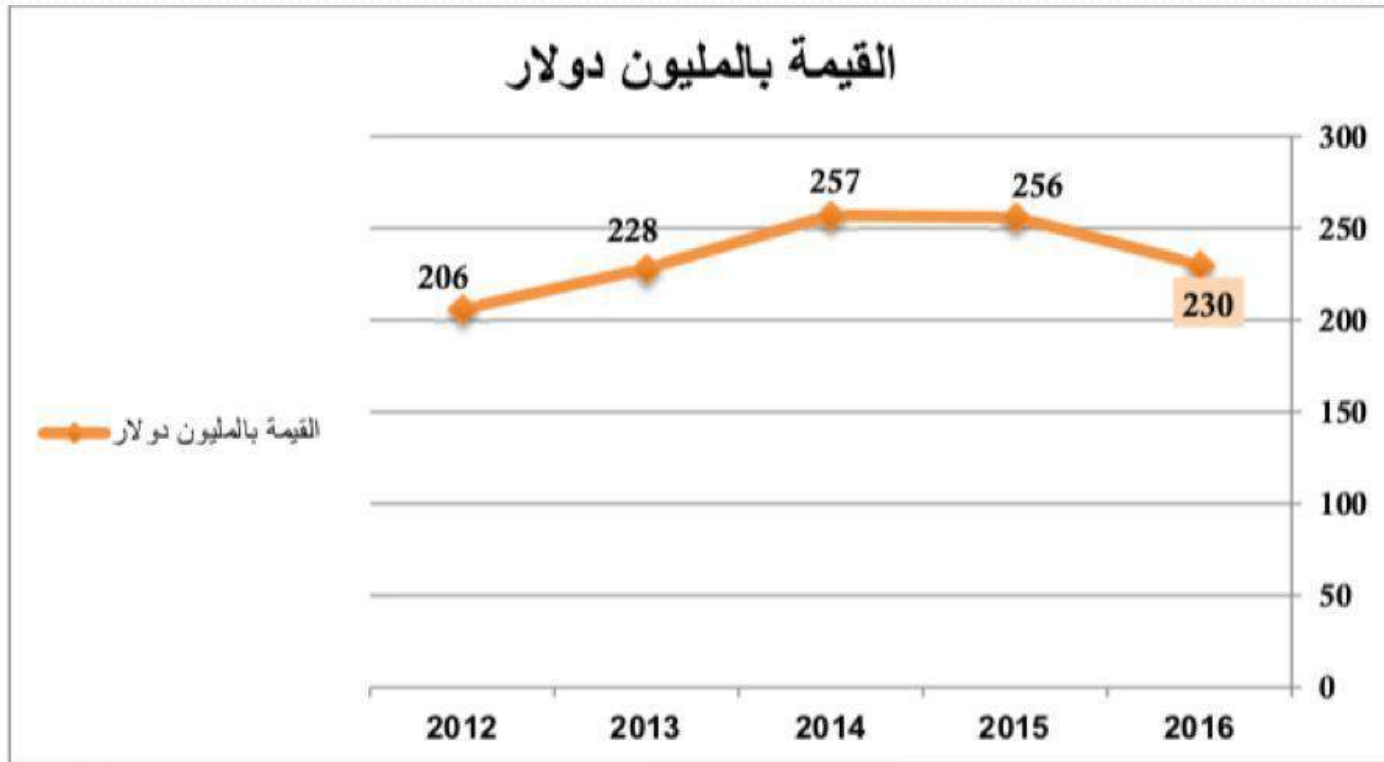
Because we believe that

The first step of the solution is to remove Sudan
regime

Estimated Pharmaceutical Market profile in Sudan 2016

Pharmaceutical Market size (in million US\$)	450 Million US\$
Import	350 Million US\$
Local industry	100 Milliom\$

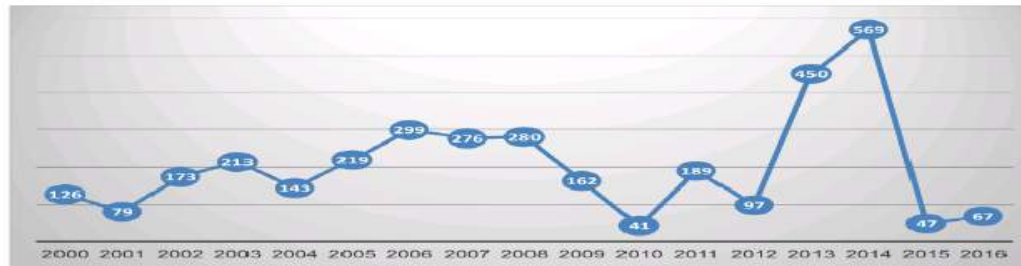
Private Sector share in Pharmaceutical Market



المصدر: قاعدة بيانات الأمانة العامة 2016 م ، برنامج Excel 2017 م.

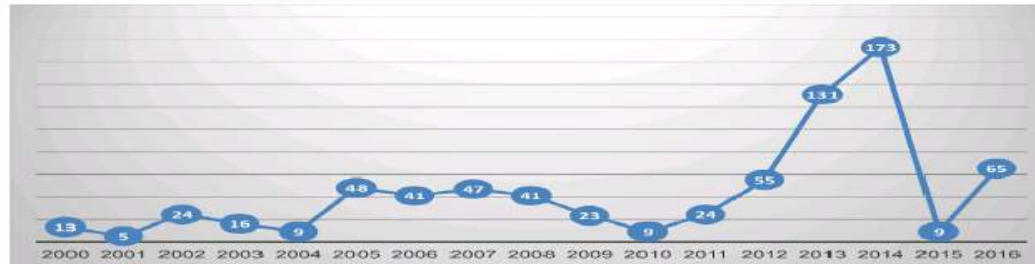
Medicines registered in the period 2000-2016

الشكل (11)
عدد الأدوية البشرية المسجلة 2000-2016م



المصدر: إدارة التسجيل - قسم تسجيل الأدوية البشرية، برنامج Excel، 2017م.

الشكل (12)
تسجيل الأدوية البشرية الصناعية الوطنية 2000-2016م



المصدر: إدارة التسجيل - قسم تسجيل الأدوية البشرية، برنامج Excel، 2017م.

Estimated comprehensive figure of Pharmaceutical Market Size

2014	2016	2019
US\$= 9 SDG	US\$= 16 SDG	US\$= 70 SDG
528 Million \$	450 Million \$	232 Million \$

Causes

- Insufficient/ Irregular government funding (health is not a priority)
- The absence of transparent/effective medicines management system
- Sudan's currency devaluation.
- Weak/ineffective Pharmacy regulatory bodies
- Poor governance/accountability and corruption.
- Irresponsible policies/decisions.
- Lack of clear implantation plan/monitoring and evaluation of pharmaceutical policies.
- The Exit of multinational pharmaceutical companies (GSK/Sandoz/Sun Pharma/ Jamjoom).
- Sudan is not a member of WTO(international deals)

Shocking Reality

Sudan government is barely expending 6.2% of it's whole budget on health 9% of which on pharmaceutical sector.

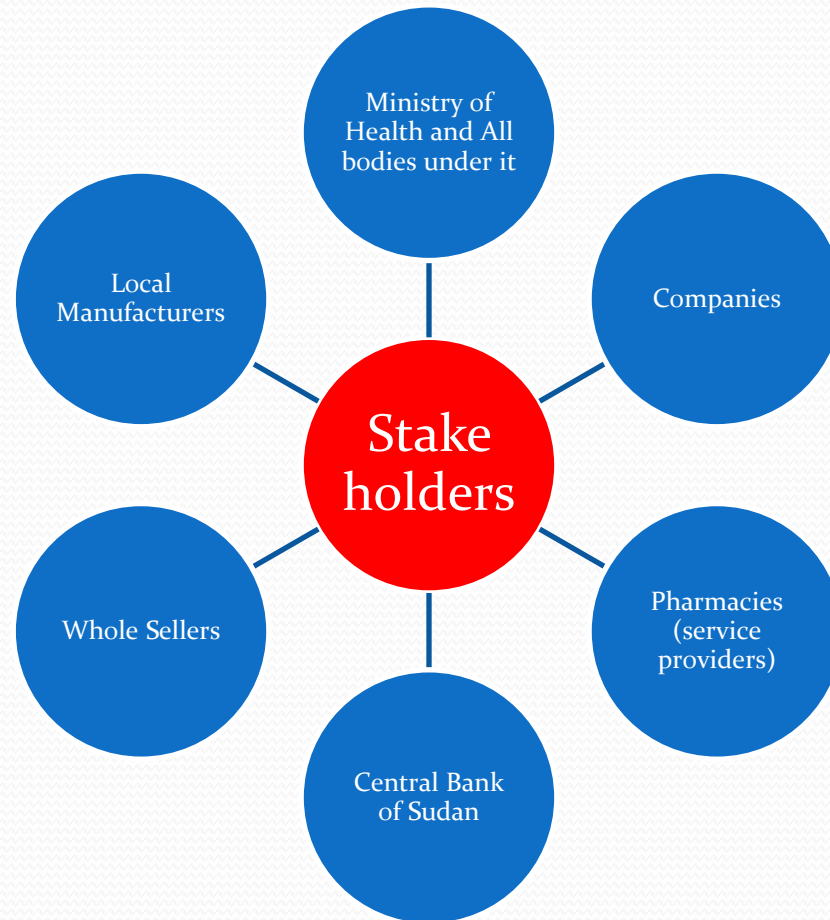
Total Expenditure on health in Sudan was 11 US\$/Capita in 2017.

Health Sector is **NOT** one of the Government priorities.

Core reason of the crisis is:

Shadows of economic and political Failure had strongly darkened Public health Sector particularly Pharmaceutical sector and drug availability .

stakeholders



Actions: Medicines shortage list (1)

No	Generic name
1	Sodium Valporate (Syrup & Taplet)
2	Warfarin 5mg/1mg tab
3	Salbutamol sulphate(inhalor)
4	Nifedipine (5mg &10 mg)
5	Anti rabies vaccine
6	Tetanus toxoid vaccine
7	Captopril (5 & 10 mg)
8	Human albumin
9	paracetamol infusion
10	Salbutamol solution

No	
11	Diazepam inj.
12	Hydrocortisone inj.
13	Immunoglobulin 5mg inj.
14	Dexamethazone
15	Noradrinaline
16	Adrenaline
17	Dopamine
18	Dextrose 5%&10%
19	Phenytoin
20	Acetylcystene

The need for alternative Pharmaceutical strategies

- Public and private sectors are deprived from essential medications, Sudan is NOW a vulnerable country for medicine shortage.
- patient access to quality pharmaceutical service is a big challenge.
- We expect practice violations such as counterfeit medicine due to complete negligence of the current control system in Sudan
- Healthcare system is generally sabotaged and many patients find themselves helpless to access medical services in Sudan. Patients desperately in need NOW for medications, including lifesaving medicines. Many patients can not afford to buy these medicines if they are made available at all.

Overall corrupted, inefficient health system and poor implementation of theoretical strategies and plans

- Closing this gap in the short and long-term should be reflected positively on the country's public health position which is already undergoing a huge deterioration.

CCSP Project

Based on the discussion around the causes and contributing factors to current situation of pharmaceutical services in Sudan, alternative solutions and best practices are **URGENTLY** required to improve pharmaceutical services therefore prevent or mitigate major healthcare impairment.

Alternative Pharmaceutical Strategies



Aims(Government commitments)

- Ensure the availability/affordability of essential medicines to all the citizens
- Ensure safety, efficacy and quality of medicines and pharmacy services
- Ensure good prescribing/dispensing practices and regular auditing
- Promote rational use of medicines through provision of training, education and evidence-based information

Aims(Government commitments)

- Identify pharmaceutical manufacturing as a priority sector for the economy growth strategy to grow exports and substitute imports (Sudan is a potential pharmaceutical export hub for Africa)
- Strengthen the national medicine regulatory system
- efficient and transparent medicine management system
- Provide stable and encouraging environment for strong profitable pharmaceutical market (annual market growth of 10%)

Alternative pharmaceutical strategies- short term

- Political commitment /accountability/Funding
- National drug policy (implementation plan/ monitoring and evaluation

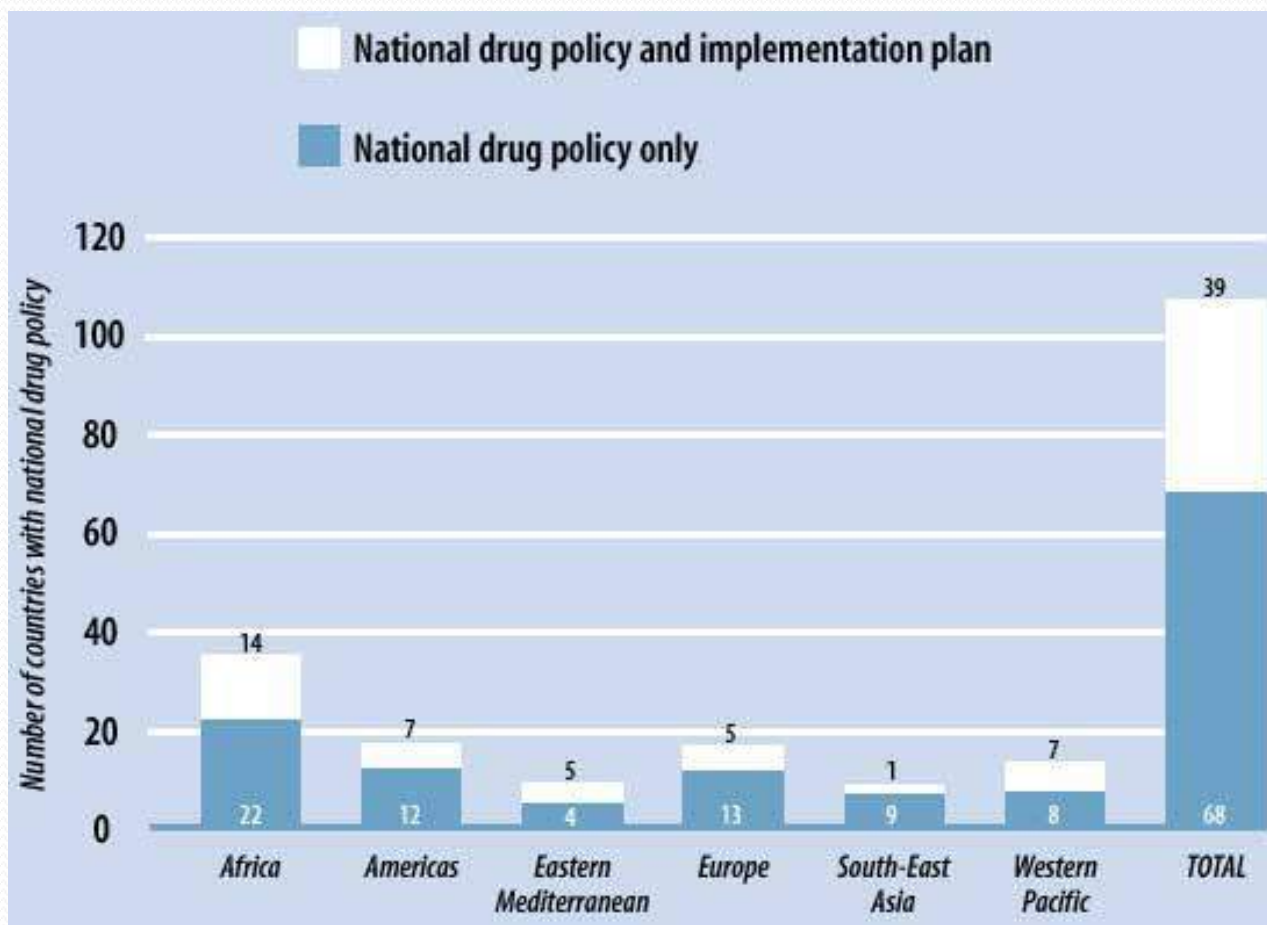
Standard treatment guidelines/ formulary system (cost-effectiveness)

Essential Medicines list(locally tailored and regularly reviewed)

drug procurement strategy(public/private)

- Exempt medicines from government fees (eliminate tariffs).
- International Pharmaceutical community/ donors
- Active national medicines price monitoring system for retail prices
- Drug availability and prices to be accessible to public/HCPs
- Enforcing the pharmaceutical law and regulations

Learning point



Alternative pharmaceutical strategies- short term

- Addressing corruption/ conflict of interest issues.
- Procurement of high quality generics and promotion of generic prescribing.
- **stage 1** of supporting the national drugs manufacturing (APIs/Excipients/ policies to produced patented medicines locally /GMP roadmap).
- Wholesaling Distribution system (government investment partnership).
- World Trade Organization (WTO) membership (international pharmaceutical deals)

Our ambition



Alternative pharmaceutical strategies- Long term

- Service-oriented Pharmacy practice
- Pharmacy Education (Law and ethics/Therapeutics/Pharmaco-economics)
- Pharmacists (training/Registration/ development support)
- Support pharmaceutical research (5% market size)
- Set/ monitor standards for pharmacy professionals and pharmacies to enter /remain in the register.

Alternative pharmaceutical strategies- Long term

- Digitalization of Pharmacy (PMR/ Ordering and management software)
- **stage 2** of supporting the national drugs manufacturing Supportive industries (APIs and excipients production)/ fast track registration/tax exemptions)
- Limiting direct-to-consumer advertising of medicines and control the excessive medical promotion
- Bulk tendering of medicines with neighbors countries (Ethiopia/ Rwanda)
- Cooperation between the stakeholders (government/ pharmacist/suppliers)

Alternative pharmaceutical strategies- Long term

- Establish a good Pharmacovigilance system (yellow Card scheme / combatting Substandard and Falsified Medicine/ medicine Smuggling/ drug recalls and safety data updates)
- WHO Model Framework of Good Governance for Medicines
- Patient Safety and pharmaceutical care (clinical governance/Sops/ Dispensing errors)
- Re-structure of the Pharmacy bodies/defined roles/Accountability

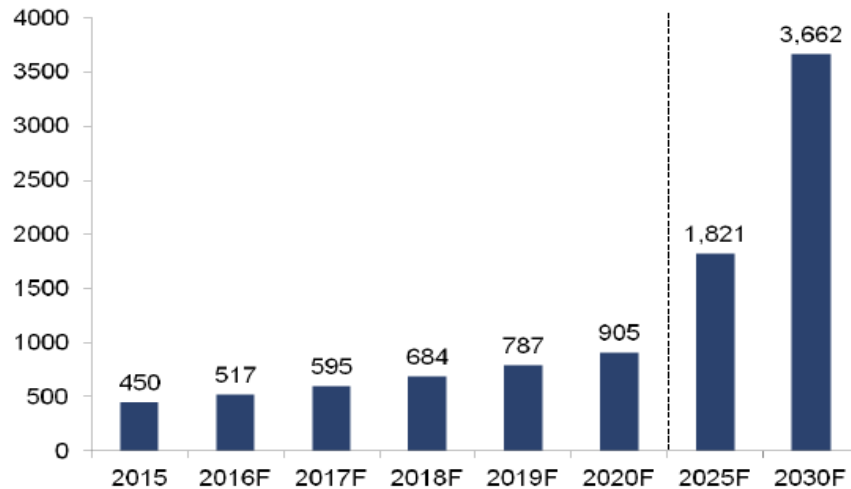
Examples:

Sudan General Pharmaceutical Council
Pharmacy and therapeutics Committee
Fitness to Practice Committee

Experience elsewhere

The **Ethiopian pharmaceutical market** is expected to grow at **15% per year** to reach nearly **\$1 billion** by 2020

Pharmaceutical market in Ethiopia
(2015-30F), US\$ million



- In 2015, the Ethiopian pharmaceutical market was estimated to be valued at **\$450M**
- It is expected to **grow at a CAGR of 15%** to reach an estimated value of **USD 0.9 billion** by 2020

Experience elsewhere

Cost of medicines are under control

Under the PPRS - which covers 85% of new medicines - NHS spend has been flat for 5 years. Any overspend is paid back: industry has given £3 billion over this period.

Potential spend without the scheme

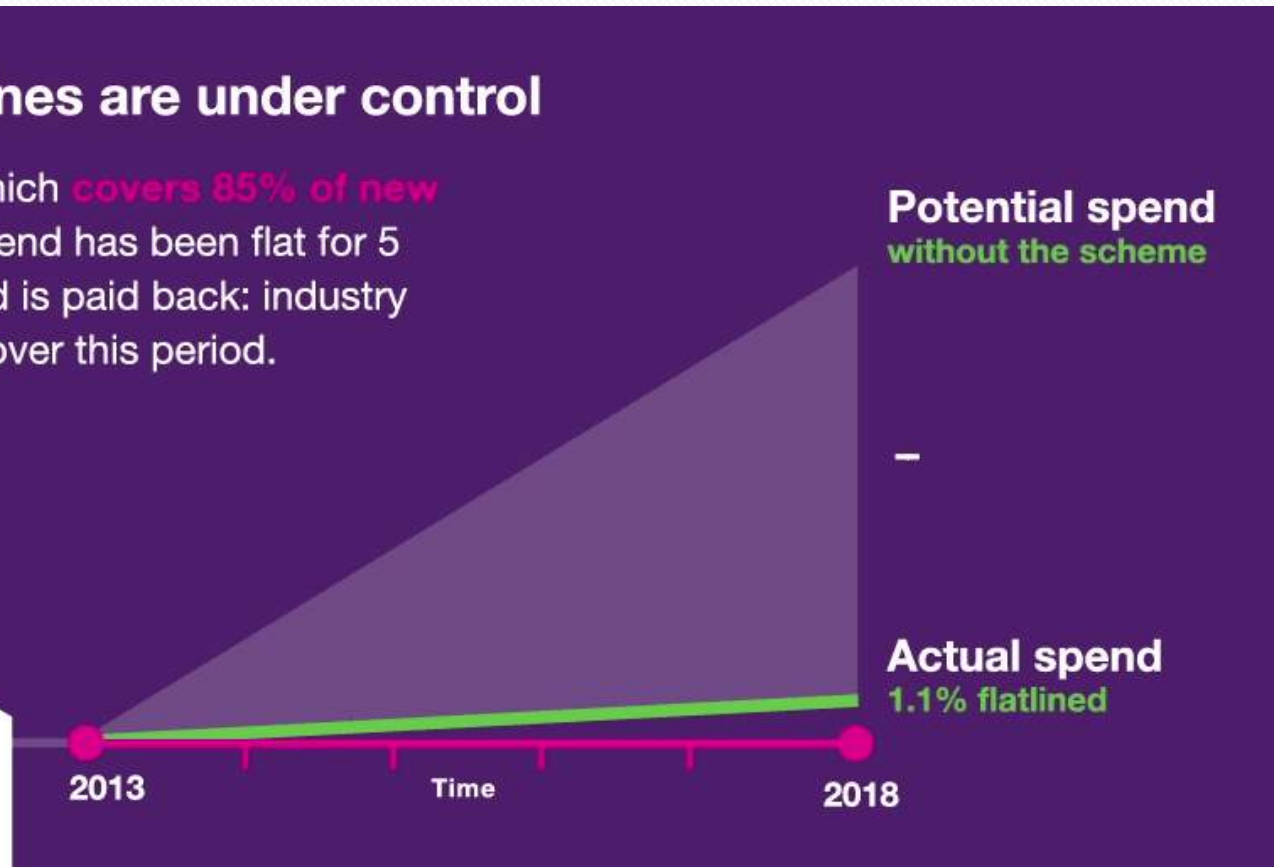
Actual spend
1.1% flatlined



2013

Time

2018



References

- Sudan pharmaceutical profile 2010
- Sudan Pharmaceuticals and Healthcare Report 2016
- Policy options for pharmaceutical pricing and purchasing: issues for low- and middle-income countries 2015
- National drug supply Sudan 2015
- Good Governance of medicines-Model framework 2014
- An integrated national pharmaceutical policy for The United Kingdom 2017
- General Pharmaceutical Council/Royal Pharmaceutical Society (UK 2019)
- WHO guidelines on Drug Policy/ Essential Medicines.

Communication team

- Rania Elsayegh

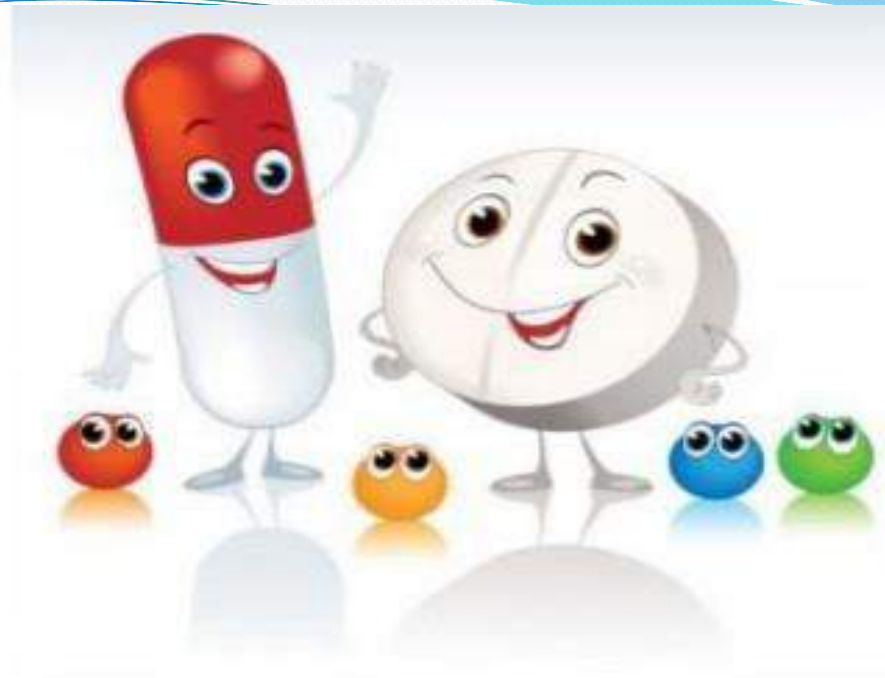
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Thank You

كلمة الافتتاح د. سارة عبد الجليل

الي كل الدماء التي سالت في ارض السودان لتصنع جسرا ممتدا لنا لنعبر الي الحرية و السلام الي كل ام و اب غسلوا بدموعهم الغالية جسد ابناءهم و بناتهم المضرج بالدماء ال كل الاطفال اليتامي و هم يدثرون بذكريات من فقدوهم من اجل الوطن اليهم جميعا نكرر و نجدد التزامنا الكامل بان نسدد هذا الدين و انا لا نحيد من الطريق فلا سبيل لنا سوي التغيير نحو الحرية و السلام و العدالة هذه الدعوة للحضور الكريم لوقفه دقيقة حداد علي ارواح الشهداء و تضامنا مع اسرهم

التحية للشعب السوداني و هو يخط بكل بسالة و وعي و حضارة مخطوطة ثورية لمقاوته السلمية لتحقيق مطالبنا المشروعة التحية لقوي الحرية و التغيير التي توحدت من اجل إنجاح الحراك الثوري لضمان مستقبل جديد في السودان التحية لجميع قطاعات المهنيين و العمال و الحرفيين لتقدمهم الصفوف لدفع عجلة التغيير نحو نهضة و تنمية مستدامة في وطن ديمقراطي حر

التحية للكوادر العاملة في الحقل الصحي التي جابهت الانتهاكات المتعددة من قبل هذا النظام التحية لهم و لموقفهم المشرف و هي تندد بسوء الخدمات الصحية و بيئة العمل و ضعف مخصصات الصحة في ميزانية الدولة الذي انعكس جليا بانهيار هذا القطاع المهني المهم

التحية لحضورنا الكريم و للمشاركة في هذا الملتيقي الدولي بمدينة لندن في مؤتمر تباحثي يعكس التزامنا الحراك الثوري الموحد في السودان التغيير السلمي المرتقب بقيادة شعبية مهنية مدنية و حزبية و الإعداد للبناء و التاهيل لمرحلة انتقالية مستقرة ضمن بنود اعلان الحرية و التغيير بتاريخ الاول من يناير هذا العام لقد وجه تجمع المهنيين جميع الكيانات المهنية المنضوية تحت مظلته بعقد المؤتمرات المهنية لمختلف القطاعات لوضع خطط بديلة عند سقوط النظام ولهذا بادرنا بتنظيم هذا الملتيقي لنضع خطة بديلة للخدمات الصحية حتي نكون علي أهبة الاستعداد للمرحلة القادمة.

ان العمل المقدم من خلال هذا المؤتمر هو نتاج مجهودات متواصله لعدد من السنوات تفاني فيها العديد من الكفاءات و المتخصصين و العلماء ايمانا منهم بدورهم القيادي في اعادة بناء البيئات التحتية استنادا علي الخبرات العالمية و البحث العلمي و المعايير الدولية المتفق عليها

و سيتواصل هذا الجهد في مختلف قطاعات الصحة في السودان و في المهجر أملين في ان نعقد مؤتمرنا الختامي في السودان قريبا ان شاء الله

لا يخفي عليكم جميعا حضورنا الكريم و المتابعين لهذا المؤتمر عبر وسائل التواصل المتعددة ما الت اليه الخدمات الصحية في السودان الذي انعكس بدلالات بينه في تقرير منظمة الصحة العالمية في عام ٢٠١٨ و كان ذلك نتاج مباشر و جلي لعدم التزام النظام الحاكم بالخدمات الصحية و عجز و فشل اداره السياسات القومية و إهمال الرقابة و غياب الحكومة و انتشار الفساد و إنعدام الشفافية و اتباع مفهوم التمكين في الإختيار للعمل القيادي دون الالتزام بالكفاءة و القدرات المؤهلة مما ادي الي هجرة هي الأكبر من نوعها في الثلاث عقود المنصرمة

لكننا اليوم نقف علي مشارف التغيير نحو وطن معافي و نحن اليوم نعلن التزامنا الكامل بالعمل و البناء في سودان الغد التزامنا بأخلاقيات المهنة و التزامنا بمسئوليتنا الوطنية التزامنا من جميع الكفاءات و القدرات المؤهلة بان نعمل عل التعمير لاستعادة خدمات صحية تتميز بعدالة التوزيع متاحة للجميع شامله للخدمات الوقائية و العلاجية و الدوائية التي تتناسب مع حوجة المجتمع السوداني جغرافيا اجتماعيا اقتصاديا و التي تسلتهم من تاريخنا السوداني ان الخدمات الصحية في السودان كانت تتميز بالجودة و تضمن سلامة الممارسة الصحية المقيمة و تعزز البحث العلمي و تنمي التاهيل و التدريب و التطوير الطبي المستمر فنحن أمه تمتلك القدرات و الكفاءات دون ادني شك و كل ما تفتقده امتنا الان هو نظام حكم اداري وطني

هذا العمل المقدم من خلال هذا المؤتمر هو ملك للشعب السوداني و ما نحن الا منفذي لهذه الخدمات لتحقيق بنودها و التأكد علي إنجازها و مراقبة و تقييم ما ينتج عن هذا التنفيذ

اليوم في ذكرى انتفاضة ابريل لآبد ان نستلهم من هذه الانتفاضة رمزية وحدة الصف و الالتفاف حول الهدف الموحد - نحي التجمع النقابي آنذاك الذي كان احد صناعات التغيير

و اليوم نحي تجمع المهتمين احد قوي للحرية و التغيير

يوم غد الأحد السابع من ابريل هو اليوم العالمي للصحة الداعم لمفهوم الصحة للجميع و الذي ينص علي

ان هذا المفهوم هو حق للجميع و كذلك يؤكد ان الإخلال بتنفيذ هذا المبدأ الأساسي و هو التغطية الشاملة للصحة هو انتهاك لحقوق الانسان و عدم الالتزام بالمواثيق الدولية و عليه فان واقع الحال في السودان و سوء الخدمات الصحية في يعتبر انتهاك واضحا لحقوق المواطن السودان

مجددا

احي جمعكم الكريم و جميع المتحدثين و المشاركين حضورا او بالإعداد للأوراق و المواد الأكاديمية
نقابه اطباء السودان الشرعية
اللجنة المركزية لأطباء السودان
الاستشاريين و الاختصاصيين السودانيين
قطاع التمريض السوداني
مجموعة الصحة العامة السودانيه
قطاع التعليم الطبي و التطوير المهني المستمر
نقابه اطباء السودان بأيرلندا
نقابيه اطباء السودان بكندا
تجمع اطباء السودان بامريكا
لجنة الصيادلة المركزية
تجمع الصيادلة المهنيين
رابطه شباب الاطباء السودانيين بالمملكة المتحدة
اللجنة الموحدة لأطباء الأسنان السودانيين
الاطباء السودانيين بالمناطق المحررة

واذكركم بصدور العدد 49 من مجلة الحكمة وهو مخصص عن ثورة ديسمبر تحت إشراف د حسام المجرم نائب نقيب
الاطباء بالمملكة المتحدة

و اتقدم بالشكر للسكرتارية الأكاديمية بقيادة د سارة عمر بليل و د تدي كمال الحاج علي المجهودات المقدره للعداد لهذا
المؤتمر

كما احب ان أشير الي انعقاد مؤتمر صحفي يوم غد لإعلان اجازة الخطة الاسعافية للصحة بعد اكتمال مداولات المؤتمر و
ذلك في تمام الساعة الرابعه مساء

حننبيهو البنحلم بيه يوماتي و طن خير ديمقراطي و طن شامخ و طن عاتي
وطن البيفهو نتساوي نحلم نقرا نتداوي
وطن حدادي مدادي و ما بنبيهو فرادي

التحية لقتنا الموحدة لصنع التغيير
حرية سلام و عدالة و الثورة خيار الشعب



Sudan Alternative Health Care Policies



الهيئة النقابية للأطباء السودانيين بكندا

Sudan Doctors' Union

Canada branch

Dr Abu Obeida Hamour
Sudan Doctors Union
Canada Branch

April 6, 2019



Outline

- Human development indicators in Sudan
- Environmental health
- Communicable diseases
- Access to health care
- The poor state of our public hospitals & people
- Redefining priorities
- The quality gap
- The solution

Human Development Indicators in Sudan

- Life expectancy at birth: 64.7
- Infant mortality: 44.8 (per 1000 live births)
- Infants lacking MMR: 10%
- Malaria incidence: 35.3 (per 1000 at risk)
- TB incidence 82.0 (per 100,000 people)
- HIV prevalence (ages 15-49): 0.2 %



UNDP Report 2017



UNDP Human Development Index (HDI) for Sudan

- HDI in 2017 was 0.502
- Average low HDI 0.504
- Sudan rank 167 out of 189
- Djibouti rank 172
- Yemen 178



Environmental Health

- Air
- Water
- Food
- Roads
- Waste



Communicable Diseases

- Diarrhoeal diseases
- Malaria
- TB
- HIV
- Dengue
- Chikungunya
- Measles



Unaffordable Health Care



ساغادر وزارة الصحة بعد شهرين
مامون حميدة - 4 أكتوبر 2016م

Underfunded and Neglected Hospitals



عشان عيون أطفالنا
ما تضوق الهزيمة

أضراب أطباء السودان



Neglected People!

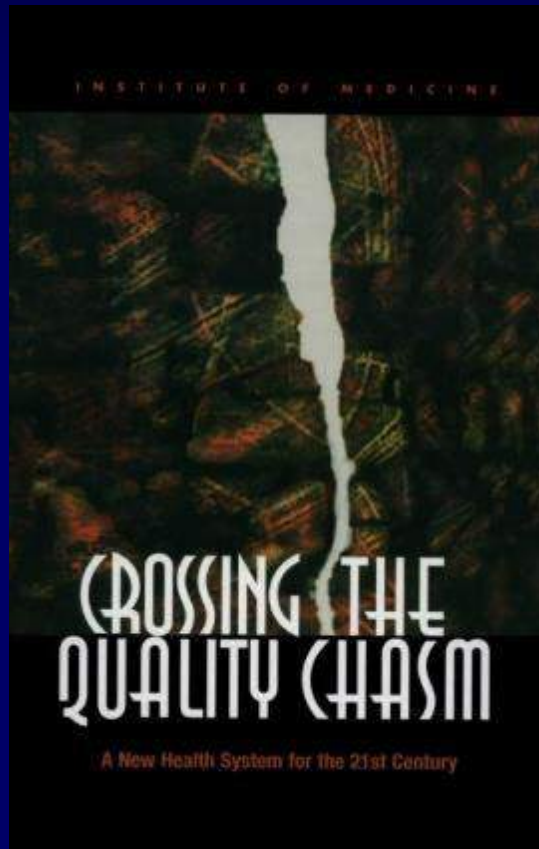


Redefining Priorities

- Healthcare is a basic human right
- Patient centered approach
- Publicly funded health care system
- Public health and preventive medicine
- Primary health care and rural health
- Human resources development
- Research, EBM and QI
- Technology utilization



Strategy for Reinventing the System



“Between the health care that we now have and the health care that we could have lies not just a gap, but a chasm.”

Institute of Medicine

A New Health System for the 21st Century

The Dimensions of Quality

- Accessible
- Safe
- Patient-centered
- Timely & appropriate
- Effective
- Efficient
- Equitable



Revolution is the Solution



Thank You



Tasgot Bas!



Highlights on Alternative Oral Health Policies

**Sudan's Alternative Health Policy
Conference**



Oral health systems

The oral health care system is not clearly defined, and considered low priority compared to other aspects of health.

Availability and accessibility.

“87.7% of adult population in Khartoum had untreated teeth”.(Nadia,2012).

Financing

- The oral health sector currently receives negligible amount of the monetary allocation to the FMoH.
- The main method of financing the services remains out-of-pocket payments.
- Dental services are largely produced by private dentists.

Education, training and workforce

- The number of training facilities is inadequate to meet the oral health needs of the population and their geographical distribution.
- Develop Community-based oral health curriculum.

Legislation and regulations

- Sudan General Dental Council.
- Regulate oral health training institutions and personnel.

Oral Health Information center

- National oral health information system.
- More research on oral health-related issues in the country.



Dental care quality office

The aim is to regulate and monitor the quality and standards of dental equipment, material and medications.

Oral health promotion

- National oral health awareness programs supported by World Federation of Dentists (FDI).
- Integration of oral health provision to general health system.
- School oral health.

Plans

- Strengthen the stewardship role of the Division of Dentistry in the FMoH.
- Decentralization of oral health service.
- National oral health awareness programs.
- Proper implementation of policies supported by WHO, FDI.
- Primary dental health care provision in every local government area.

- More quality training facilities.
- Training of more allied dental professionals.
- Provision of oral health services on the National Health Insurance Scheme.

Challenges

- Lack of fund allocations to oral health provision.
- No clear guidelines and strategies to address oral health issues nationally.
- Lack of coordination between the oral health sector and other sectors.
- Poor knowledge of and attitudes towards oral health.
- Migration of oral health care workers to other countries.

Reference

Nadia Khalifa et. 2012, A survey of oral health in a Sudanese population.

Etersen PE. The World Oral Health Report 2003: continuous improvement of oral health in the 21st century – the approach of the WHO Global Oral Health Programme. Community Dent Oral Epidemiol 2003



Thank you

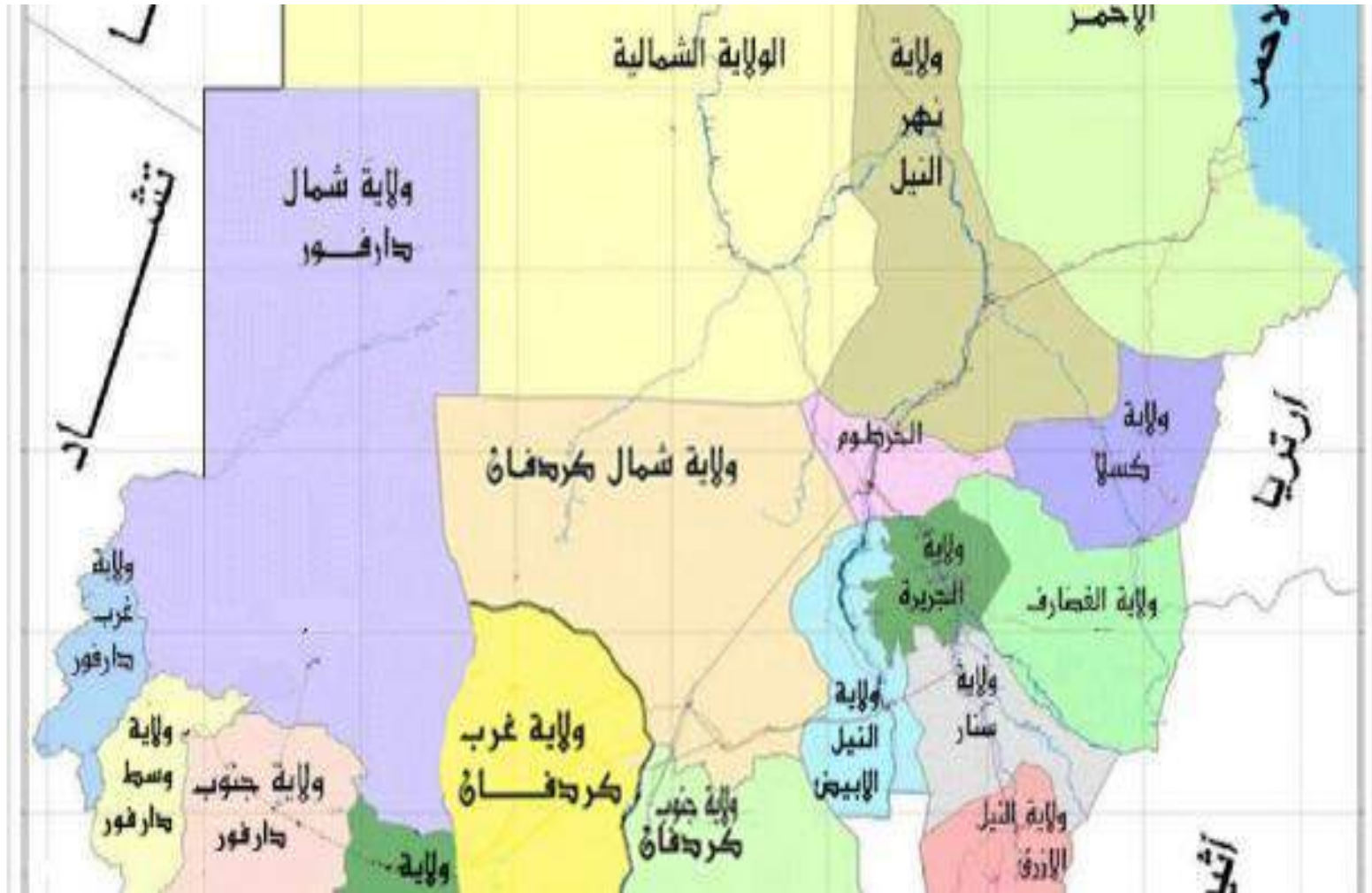
Sudan Current Health Status & Alternative Policy Development

Dr Magda Ali

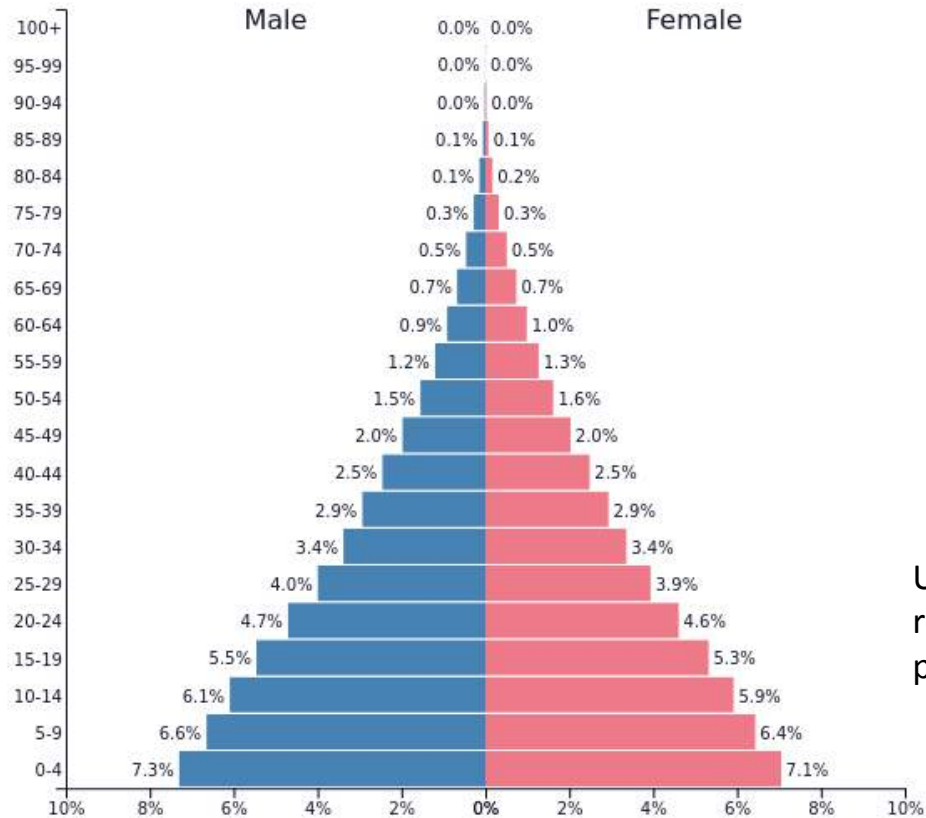
Sudanese Public Health Forum

6 April 2019

MAP OF SUDAN 18 STATES



SUDAN POPULATION PYRAMID 2018



Under age of 25 years represent 63% of the population

PopulationPyramid.net

Sudan - 2018
Population: **43,196,092**

0-14 years: 43.07% (male 9,434,634 /female 9,136,951)

15-24 years: 20.22% (male 4,459,335 /female 4,259,341)

25-54 years: 29.8% (male 6,236,954 /female 6,612,593)

55-64 years: 3.93% (male 876,614 /female 819,048)

65 years and over: 2.98% (male 688,391 /female 596,982) (2018 est.)

SUDAN RURAL POPULATION % OF TOTAL POPULATION BY YEAR



WORLD BANK | TRADINGECONOMICS.COM

Rural population (% of total population) in Sudan was reported at 65.99 % in 2016, according to the World Bank collection of development indicators, compiled from officially recognized sources.

Ref

<https://tradingeconomics.com/sudan/rural-population-percent-of-total-population-wb-data.html>

FOOD SECURITY STATUS 2018

2.3 million children are malnourished

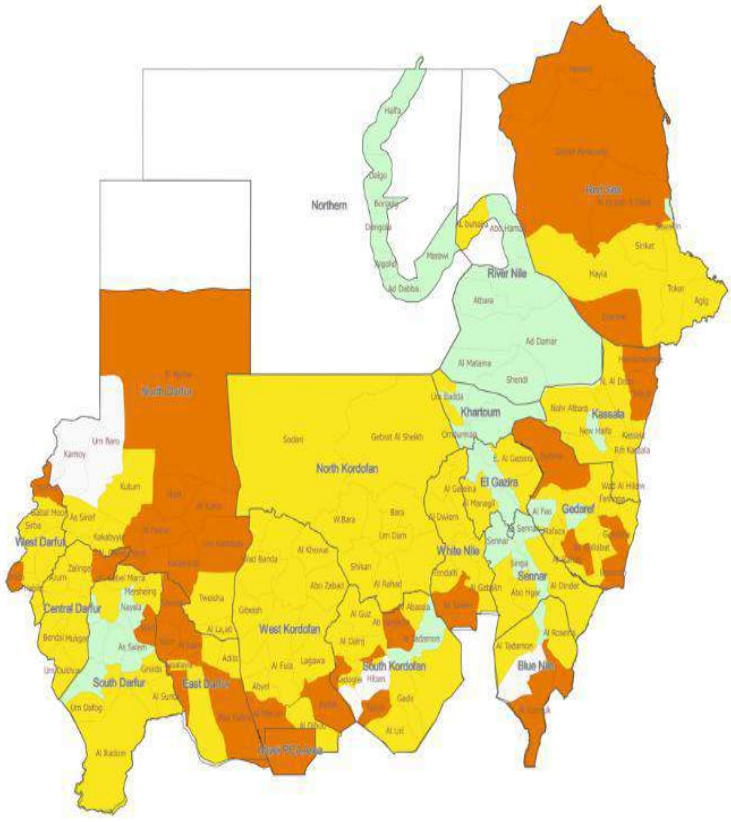
about 45 per cent of all deaths in children under five are directly related to malnutrition.

Eleven out of eighteen Sudanese states have malnutrition prevalence among children of above 15 per cent,

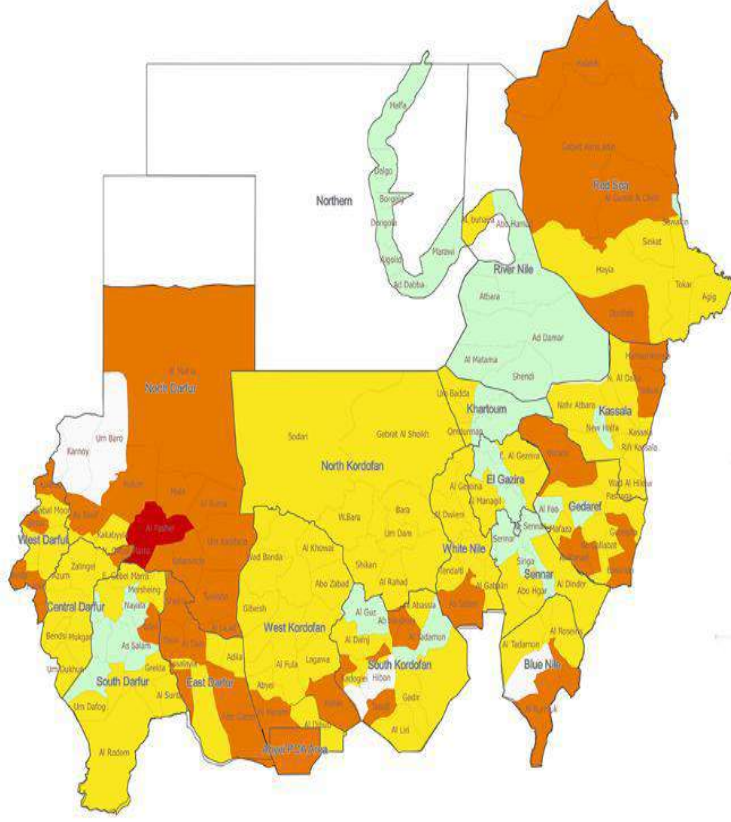
4.8 million people are living at crisis or emergency levels of food insecurity.

1 in 10 people in Sudan are estimated to be food insecure.

SUDAN ACUTE FOOD SECURITY SITUATION OVERVIEW



April 2018



May – July 2018

May to July 2018 5.5m are food insecure i.e. 1 in 10 people are food insecure

مفتاح الخريطة
Acute Food Insecurity Phase
 مراحل التدهور الغذائي الحاد

- Phase 1 المرحلة الأولى
- Phase 2 المرحلة الثانية
- Phase 3 المرحلة الثالثة
- Phase 4 المرحلة الرابعة
- Phase 5 المرحلة الخامسة
- Areas with Inadequate Evidence
- لم يتم تحليلها
- IDPs Camp
- Urban/ Settlement حضرية

! Area would likely be at least 1 Phase worse without the effects of humanitarian assistance
 سيتدهور الوضع في المنطقة لمرحلة واحدة على الأقل إذا توقفت المساعدات الإنسانية

مفتاح الرموز
 * Acceptable مقبولة
 ** Medium وسط
 *** High عالي

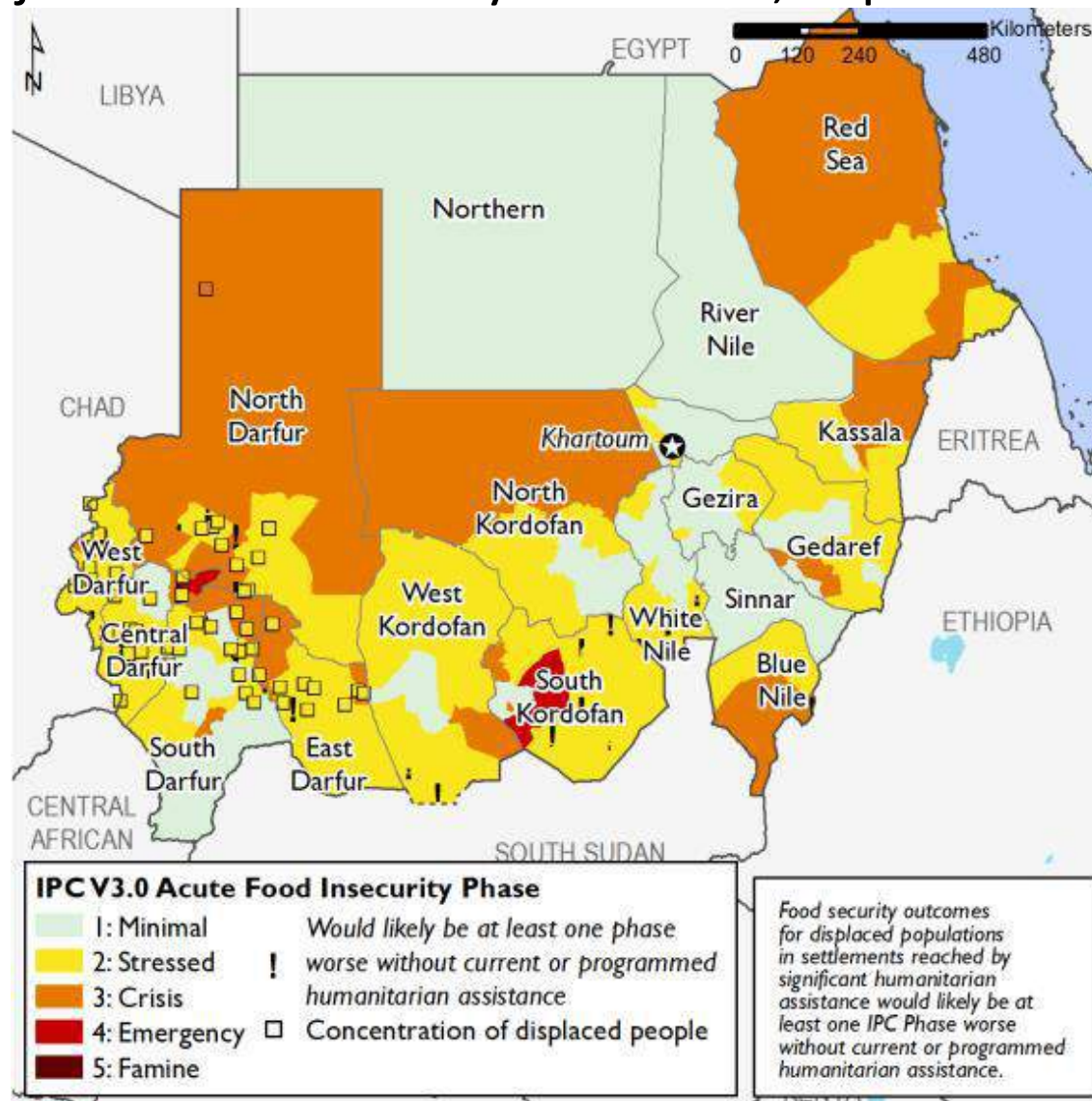
Confidence of Analysis
 درجة الثقة في التحليل

Area has reached Phase 3, 4, or 5 for more than 3 consecutive years
 المنطقة في المرحلة 3, 4 أو 5 لأكثر من ثلاث سنوات على التوالي

1 Low منخفض
 2 Moderate وسط
 3 High عالي
 4 Very High عالي جداً

Chronic Food Insecurity Level (if available)
 مستوى التدهور المزمن الغذائي (إذا كان متاحاً)

Projected food security outcomes, September 2019



Projection for January to March 2019, 5.8 m & by September 2019, 6 m.
food insecure

Main Health Issues

- The Maternal mortality ratio per 100 000 live births estimated at 730 [380–1400] deaths per 100 000 live births in 2010.
- About 75% of the population (24 million) is at risk of malaria . Malaria led to the death of 23 persons in every 100 000 population
- TB burden puts Sudan among the worst affected countries in the world. The annual incidence of new TB cases for 2010 is 119 per 100 000
- HIV-AIDS, the epidemic is classified as low among the general population estimated prevalence rate of 0.24%

POSTER "CHOLERA IN SUDAN"



MAKESHIFT EMERGENCY FACILITY KASSALA HOSPITAL
UNDECLARED EPIDEMICS 2018



HOSPITAL GROUNDS DURING EPIDEMIC KASSALA STATE 2018



Sudan Current Health Status & Alternative Policy Development

Alternative policy is a measure where the gap between the desired solution and the existing solution is closed...it is a combination of measures which solves a defined problem sufficiently through which a national health policy is created ensuring good health for the entire population with plans and actions that are undertaken to achieve health care goals. It outlines the role of the government in properly funding the health sector through government health insurance and through provision of publicly employed doctors and public hospitals, fair distribution of medical care services and goods to ensure upgrading of the health status of the population

However, to be able to agree on an appropriate solution we need to briefly scan the current health situation in Sudan and foresee what lies ahead and how we can address health issues that have been deteriorating during the past decades.

SLIDE 1

Sudan population is around 42 million distributed within 18 states of Sudan covering a total area of 1.9 million sq.km.

SLIDE 2

The majority of the population is below 25 years of age where 0-14years constitute 43% of the population and those between 15-24 years represent 20% of the population (one in every 5citizens).

SLIDE 3

Most of the populations are in rural areas, with only a third in urban cities. Khartoum is the most populated city where there are 7 million, including 2 million displaced from conflict areas. However, there is a trend of urbanization which is rapidly growing mainly due to displacement as a result of the long conflicts. Nearly all of the urban large cities host rural populations who have been forced to leave their areas for several reasons;

- Pursuing safety and shelter or due to poverty and lack of basic services that destroyed rural livelihood

- better opportunities as wealth and economic growth and service provision is concentrated in urban cities
- seeking jobs as most of the traditional farming areas were turned to mechanized agricultural schemes

SLIDE 4

Sudan has one of the world's highest infant and maternal mortality rates.

The Sudanese Ministry of Health declared recently that 2.3 million children are malnourished & about 45 per cent of all deaths in children below five are directly related to malnutrition. Eleven out of eighteen Sudanese states have malnutrition prevalence among children of above 15 per cent, which is above the WHO emergency threshold. (Humanitarian Needs Overview, Sudan, Feb 2018, OCHA)

Malnutrition is chronic in many parts of Sudan, with high levels of malnutrition remaining unchanged for decades. This is particularly significant in eastern Sudan, and often results in periodic acute humanitarian needs. The main contributing factors to these high levels of malnutrition are food insecurity, diseases, lack of access to primary healthcare, lack of clean drinking water, inadequate sanitation facilities, and poor infant nutrition.

SLIDE 5

According to the latest Food Security Periodic Classification (IPC)*, as shown in the map about 5.8 million people in Sudan are projected to be food insecure between January-March 2019, including a considerable number of newly food insecure people in urban and peri-urban areas. The map shows clearly that 11 of the 18 states suffer from food shortage at crisis level of emergency, just one or two levels away from a state of famine.

*IPC is a set of tools and procedures to classify the severity and characteristics of acute food and nutrition crises as well as chronic/persistent food insecurity based on international standards

- 1 in 10 people in Sudan estimated to be food insecure.

Sudan with low expenditure on health and weak infrastructure resulted in poor access to health care. The conflict for the past 25 years, in combination with the weak infrastructure, cause an increased risk of infection, greater morbidity and

mortality from major communicable disease especially amongst the poor, displaced and refugee populations and the spread of epidemics.

This is reflected in Sudan's health profile which is among the lowest worldwide at position 154 out of 160 countries and it is among the lowest 16 countries in Human Development Indexes (HDIs) (see Human Development Report, 2010).

SLIDE 6

Sudan has a history of frequent and devastating malaria epidemics in the low and unstable seasonal transmission areas in the Northern, River Nile, Khartoum, White Nile, Geziera, Kassala, Gedarif, Red Sea and North Kordofan, especially in urban areas. About 75% of the population (24 million) is at risk of malaria. However it is difficult to conclude the exact magnitude of the reduction particularly at subnational level from the available data, mainly from Health Management Information System (HMIS), due to its incompleteness and inaccuracy (Sudan Malaria Program Performance Review Aide Memoire, Federal Ministry of Health National Malaria Control Program, December 2013)

TB burden puts Sudan among the worst affected countries in the world
Sudan carries 15% of the TB burden in the Eastern Mediterranean Region.

SLIDES 7,

Outbreak of Epidemics

For the past years, the country encountered yearly epidemics increasing in intensity and geographic spread reflecting breakdown of emergency preparedness mechanisms and weakness of medical services.

Since 1993 outbreaks of epidemics were a common factor with outbursts of visceral leishmaniasis, cholera, meningococcal meningitis, rift valley fever, ebola, dengue and lately chikungonia and some form of hemorrhagic fever in October 2018 spreading to more than three States, Gezira, Eastern State, Nile State and some pockets in Khartoum.

Distribution of health personnel

One of the major factors that is affecting health delivery is the misdistribution of health staff who concentrate in urban centers. More than half of all specialist doctors and technicians in Sudan work in Khartoum with two thirds of them working in secondary health facilities.

The doctor to patient ratio is well below WHO recommendations with only one doctor per 3,333 populations where the recommended WHO ratio is 2.28 to 1000 populations.

SLIDE 8 & 9

Health Service Delivery

Sudan was one of the first countries that adopted Primary Health Care in 1976 as its principle strategy for health care and throughout its subsequent programs Primary Health Care was emphasized. However during the subsequent years, the health scene has been completely fragmented with curative services replacing primary health care and preventive approach; and hospitals becoming the available alternative for all levels of medical care.

The adoption of economic liberalization policies in mid 90ies and introducing the concept of "fee-for-service", led the government to withdraw almost all financial support from the entire services' sector, mainly health and education, allowing unrestrained market forces to determine what services are delivered to citizens, at what cost and with what quality. Public expenditure on health has been negligible at less than \$2 per capita per year.

Out-of- pocket expenditure represents 70% of the total health expenditure which is amongst the highest in the world. Sudan follows the out-of- pocket model and minimal national health insurance with some benefits to the better off, leaving the vast majority of Sudanese with no financial cover to any health service needed.

Public health care has markedly deteriorated and is nearly non-existent. Health coverage is low across the country and extremely scant in many areas especially in conflict areas. Marked inequalities in health and access to health are manifest across divides; urban vs. rural, north vs. south and socioeconomic groups and gender. Moreover, health delivery is fragmented and health facilities outside the capital are barely functional. This is the case in both urban and rural areas and worse in conflict zones.

The scale and long term nature of the conflicts in Darfur (since 2003), and Nuba Mountains & Blue Nile (over a period from 1987 – 2002 and re igniting since 2011) has exposed the populations to immense and protracted hardships losing their way of life as subsistence farmers. Darfur remains the focus of large-scale persistent displacement and most IDPs are unable to meet their basic needs independently.

Some 1.6 million displaced people are registered in camps. Another half a million displaced live in host communities and settlements in Darfur.

A further half a million are displaced in areas under the control of armed resistance movements in Nuba Mountains and Blue Nile— two-thirds of those are children and pregnant and lactating mothers. On the other hand, refugees and asylum seekers, especially from South Sudan, continue to arrive in Sudan seeking protection and humanitarian assistance. There have been 450,000 new arrivals from The Republic of South Sudan since 2013.

The burden of rampant communicable disease and the yearly out-break of epidemics is combined with the millions of Sudanese who are refugees, displaced and malnourished. Millions more are facing food crisis in 11 of the 18 states. One in 10 people in Sudan are estimated to be food insecure.

This clearly urges us as health professionals to address this calamity, develop a health plan expressing the needs of the majority of the population. Rectifying the collapsing health system is a huge load, but the passion, commitment, bravery & heroism of the new generation of Sudanese doctors, engineers, teachers, and techniciansleading the change, in Sudan or Diaspora confirms that we will bring back our Sudan.

From uprising to sustainable development in Sudan: ideas for the future

KEYNOTE BY

Professor Allam Ahmed

Many consider Sudan as one of the most important countries in the 21st century but Sudan score very low on **Human Development Index (HDI)** world ranking, with **Growth Domestic Product (GDP), productivity and investment** rates well below the global average. Despite abundant **human capital**, Sudan still lack adequate scientific and technological infrastructure to achieve sustainable development (SD). Sudan is facing a daunting challenge in diversifying its economy.

Sudan could be – with its massive untapped land and water potential – the bread basket of the world. Sudan has always been seen as the “**largest farm in the world**” in the Gezira irrigated Cotton scheme (Mohamed, et al, 2008; Yousif, 1997) and was until recently the **biggest producer of Gum Arabic** in the world. Sudan was optimistically referred to as an “**awakening giant**” by the hype merchants of the 1970s, and its vast plains were seen by development experts as a potential “**bread-basket**” – **either for Africa or for the Arab World across the Red Sea** (O’Brian, 1981). In 1974 at the World Food Conference held in Rome, Sudan declared that Sudan alone would be able to produce 40% of the world’s food requirements and therefore Sudan will be one of the largest agricultural power in the world. The Food and Agriculture Organisation (FAO) of the United Nations considered Sudan (with Canada and Australia) as the future bread basket of the world (The Economist, May 23, 2009). Sudan also have good access to the sea from many neighbouring countries and therefore, Sudan is also being considered as an investment destination for agricultural investment, particularly from oil-rich Arab countries. However, more than 40 years on, the potential of Sudan to be the bread basket of the world has always been overshadowed by the high level of poverty, food insecurity, food imports and Sudan is faced with many developmental problems. It is therefore not surprising that for many people it is becoming very hard to be optimistic about Sudan’s agricultural potential to feed its own people. A diverse economy for Sudan would mean huge benefits for the country in terms of economic growth, global market reach and less dependence on a single commodity sector.

The [World Commission on Environment and Development famous report “Our Common Future”](#) published in 1987 defined SD as the development that meets the needs of the present without comprising the ability of future generations to meet their own needs. However, since the Rio summit in 1992 SD is increasingly becoming a concern for both developed and developing countries (DCs). Yet, translating the principles of SD into effective economic and environmental policies seems to be a major challenge for all countries. Further initiatives and projects by the United Nations such as the [Millennium Development Goals \(MDGs\)](#) and the [17 Sustainable Development Goal \(SDGs\)](#) have also attempted to expand the concept of SD further to ensure countries across the world understand it better and able to implement its goals and objectives.

Moreover, the entire concept of SD is about the future and the future is all about the children and youth! For Sudan to succeed in the future, Sudanese youth must be equipped with all necessary skills and capabilities to manage and adapt to future challenges. Youth population is growing rapidly in Sudan and we are very keen to understand the youth perspectives and expectations for their future to help them be ready to grasp the various opportunities generated in the digital economy. We strongly believe our children and youth should be the cornerstone of any strategy by all governments and policy makers. We must listen to our children and youth and more importantly how we can help our youth with their future employment plans and aspirations.

The talk is therefore timely from the country's need to ***examine the current status quo of Sudan uprising, a necessary step for realisation of new prospects and adoption and application of future policies and programs in the changing global paradigms*** to meet the [2030 Agenda for SD](#) and [17 SDGs](#) in the new Sudan after the uprising by providing a clear roadmap for shaping and ensuring a prosperous future for Sudan and all its people.

The core of the discussion that Sudanese people will be having in the next period among themselves and with some of the world's leading thinkers and practitioners on the challenge of SD is no small and is critical for the future of Sudan. Indeed, while the topic of SD is neglected in our current politics inside Sudan, it's probably the central challenge Sudan face if we aim to stay secure, stay alive, and bequeath a safe and prosperous country to the next generation. During its 30 years in power, we have never heard the Sudanese government talk about SD, so the key question in the mind of many Sudanese Diaspora to be addressed is what SD really means and how can Sudan achieve the United Nations [2030 Agenda for SD](#) and its [17 SDGs](#). The talk will therefore aim at ***showing the difficulty in attaining SD for Sudan with a weak technological and knowledge base***. It deals first with the issue of **knowledge-based economy** and its links with sustainability from a conceptual and practical point of view. It highlights the specific situation of Sudan stressing the difficulties it meets in this respect and shows how technological capabilities are highly correlated with levels of sustainability using knowledge and sustainability indexes.

Knowledge is a prerequisite for achieving SD, chief currency and the essence of modern age. Knowledge is also considered as a strategic resource and a lifeline for all countries' SD. Managing knowledge and improving people's capability to learn together and create processes to increase **human and social capital**, are the success factors that seem to become the most crucial in competition between nations. The World Bank's recommendation in 1998 for all countries particularly those economies heavily dependent on oil to embark on the diversification of their economic resources such as approaching development from a **Knowledge Management** perspective by adapting policies to increase know how and knowledge attributes that can improve people's lives in myriad ways. ***How can knowledge contribute and enhance SD?*** This is one of the main issues we will address in this talk. Based on the assumption that knowledge must be widely disseminated and freely accessible to have an impact, knowledge systems and knowledge economy seem to open up new and varied avenues to be explored in the direction of sustainability.

The talk also aims to ***assess Sudan's position with regard to implementation of the Knowledge Economy (KE) pillars and to evaluate the country's performance in terms of transition to a KE and global competitiveness.*** The talk will focus on the question ***what do policy makers actually need to know about the knowledge-based economy and the underlying boundlessness of the concept of knowledge-based economy*** and whether ***"science, technology and innovation (STI)"*** *has anything to offer policy makers.* Also, what policy makers need to do in order to raise awareness about economic diversification with particular focus on the fundamental concepts of a KE across the private and the public sectors aiming of turning the economy into a KE. In doing so, the talk will ***adopt a holistic approach to critically examine these issues through an interactive discussion and debate.***

It is hoped that the talk will be a good opportunity for all participants to reflect on their understanding of SD and the use and management of knowledge within their organisations. New perspectives on how these can be improved to better serve their goals will be developed. The discussion addresses leadership, innovation and technology transfer as key elements of knowledge, while the conclusion explores some of the opportunities to achieve SD.

دكتورة احسان فقيرى مسئولة مكتب العلاقات الخارجية، النقابة الام

من غيرنا يعطي لهذا الشعب معني ان يعيش وينتصر
من غيرنا ليقرر التاريخ والقيم الجديدة والسير
من غيرنا لصياغة الدنيا وتركيب الحياة القادمة
جيل العطاء المستجيش ضراوة ومصادمة
المستमित علي المبادئ مؤمنا
المشرئب الي النجوم لينتقي صدر السماء لشعبنا
جيلي انا

السيد نقيب الهيئة النقابية للطباء السودانين المملكة المتحدة د. سارة عبدالجليل
السيد نقيب نقابة الاطباء السودانين بجمهورية أيرلندا د. وائل عبده
السيدات والسادة الحضور الكريم

ها هي الاجيال جميعها من شبيها لشبابها تنتفض تخرج الي الشوارع فاتحة صدورها للرصاص وهي تعلم علم
اليفين وحشية النظام وحبه لسفك الدماء وقد قتل اكثر من 250 شابا في اربعة ايام فقط في سبتمبر في عام 2013 .
لقادر علي ممارسة نفس الشي ولكنهم صمدو وواجهو الرصاص والغاز المسيل للدموع والقنابل الصوتية غير مبالين
ولا هيايين بل كان جل همهم تحرير الوطن من الطغاة -

فلنقف دقيقة حدادا علي شهداء الوطن بدءا من علي فضل ومرورا بشهداء رمضان - العيلفون - كجبار -
امري - المناصير وبورتسودان وصولا الي شهداء دارفور والنيل الازرق وجبال النوبة، وايضا شهداء الحركة
الطلابية في كافة انحاء البلاد

وايضا نترحم علي زملائنا في المكتب التنفيذي الذين رفعو راية النقابة شامخة وتوفوا الي رحمة الله دكتور محمد
عبدالرازق - دكتور الفاتح علي حسن - دكتورة فتحية عبدالمحمود .

نرسل تحاينا العطرة عبركم لتلك الجموع الهادرة في الشوارع - والشوارع لا تخون . فغدا تشرق شمس الحرية
والحرية لكل المعتقلين من أبناء وبنات الوطن وعلي رأسهم نقيب نقابة أطباء السودان دكتور أحمد الشيخ ونائبه
دكتور نجيب نجم الدين ودكتور عايد عبد الحفيظ عضو النقابة وبقية الأطباء الشرفاء .
والتحية لاطباء السودان كافة لتلك الوقفة الشجاعة واضرابهم المستمر ولاكثر من 100 يوم
ويقف اليوم نواب الاخصائين وقفة جسورة برفضهم التوزيع في المستشفيات حتي لا يكسرو الاضراب
والتحية لاطباء مرة اخري وهم يبذلون الجهد مع الكوادر الصحية الاخري في معالجة الجرحي والمصابين
والشكر والتحية لكافة السودانين بالخارج للدعم اللوجستي والمعنوي للثورة في الداخل

السادة الحضور:

يشرفني نيابة عن زملائي اعضاء المكتب التنفيذي لنقابة اطباء السودان حضور مؤتمركم العظيم واحي كل الزملاء
الذين بذلوا الجهد وساهموا في الاعداد والتجهيز وتقديم الاوراق ونأمل ان تكلل هذه الخطوات بالنجاح في اصلاح
النظام الصحي والذي عملت الانقاذ علي تدميره
تعرفون تماما التخريب الممنهج المنظم الذي مارسته حكومة الانقاذ في كافة مناحي الحياة املا منها في صياغة
الانسان السوداني الذي صبر وصابر خلال ثلاثين عاما ولكن حانت الان ساعة المحاسبة

- هذا التخريب الذي طال السياسة الاقتصادية منذ بداية التمكين مرورا بتشريد العاملين نتيجة للخصخصة ثم
اتباع سياسة السوق الحر مما ادي الي هجرة الكوادر للخارج خاصة الاطباء حيث عمدت الانقاذ منذ انقلابها
الي التنكيل بالاطباء والكوادر الصحية وقتلهم وتشريدهم وتهجيرهم قسرا الي المنافي مما ادي الي
- تدهور الخدمة المدنية بل عمدت الي بيع واقفار المشاريع الحيوية في البلاد كمشروع الجزيرة - صناعة
النسيج - وكل المشاريع التي يعناش منها المواطن كالنقل النهري - الواورات والسكة حديد -- ليس هذا
فحسب بل التفتت الحكومة للنسيج الاجتماعي فدمرته عن طريق خلق صراعات دامية في دارفور وجنوب
كردوفان والنيل الازرق لاضعاف النسيج الاجتماعي مما ادي الي النزوح القسري واقامة معسكرات
النازحين التي تفتقر الي العناية الصحية بل ابسط مقومات الحياة . ويمارس فيها كافة انواع العنف ضد النساء
والاطفال الذين اصبحو بلا تعليم واذدادت وفيات الامهات والاطفال . وكان مشروع الانقاذ الاصلي والذي
استهدفت به النساء ومحاوله اسكات صوتهن بل ارجاعهن الي حوش الحريم وذلك بفرض قوانين وعلي
مدي ثلاثين عاما تستهدف النساء مما كان له بالغ الاثر في اوضاعهن الصحية البدنية والنفسية وعلي سبيل

المثال ففي قانون الاسرة فان سن التمييز هي عشرة سنوات بما يسمح بزواج الطفلات ونحن نعلم اثر ذلك علي الطفلة التي اصبحت فاقدًا تربويًا وحرمت من ممارسة الطفولة الي التأثيرات علي صحتها الانجابية – كما ان اسقاط المادة 13 من قانون الطفل تعني تقنين الخفاض وعدم توقيع عقوبة علي الفاعل- وكذلك المادة اللعينة 152 أ من القانون الجنائي اللبس الفاضح والعمل الفاضح مما يشكل وصمة اجتماعية طالت الاسر واثرت نفسيًا علي النساء بل طالت هذه المادة نساء كادحات بائعات الاطعمة والشاي في رزقهن بعد ان فقدن المعين اما بالقتل او او التشريد من العمل. كل هذه السياسات ذات اثر بالغ علي صحة المجتمع خاصة ونحن ننظر الي الصحة كحالة ديناميكية كاملة من الرفاه الجسدي والنفسي والروحي والاجتماعي بل هي التنمية الاجتماعية وعدالة توزيع الموارد لانه يؤثر علي مجمل حياة وصحة الانسان البدنية والعقلية والنفسية والروحية والاجتماعية وليس فقط انتقاء المرض او الموت والعجز. لذا طال التخريب قطاع الصحة وهو القطاع المتصل بحياة الانسان ورفاهيته والصحة هي حق من حقوق الانسان كما ورد في اصدارات هيئة الصحة العالمية ولكن لاسف اتبعت الحكومة سياسة التكيف الهيكلي وروشتة صندوق النقد الدولي في القطاع الصحي فرفعت يدها عن الخدمات بل عمدت ان يكون الصرف علي الصحة اقل من 2% مما ادي الي تدهور مريع في صحة الانسان و تدهورت صحة البيئة وانتشرت الاوبئة وارتفعت تكلفه العلاج التي تتوأمت مع ارتفاع معدلات الفقر. لذا فقد تصدت الهيئة القومية لدرء الوبائيات التي كونتها نقابة اطباء السودان مع منظمات مجتمعية أخرى واشركت فيها المجتمع لدرء وباء الكوليرا والشغغونيا عندما اجتاحت البلاد وانكرتهما الدولة بلا حياء او واعز ضمير.

- ومثال اخر لهذا التخريب ايلولة المستشفيات ثم تجفيف المستشفيات بدعاوي نقل الخدمة الي الاطراف مما جعل المواطن يلهث بين المستشفيات الخاصة عالية التكلفة وانتفت نهائيا مجانية العلاج وتظل – ازمة الدواء الخائفة نسبة لتذبذب سعر الدولار ودخول الطفيليين كمستثمرين في الادوية وكذلك ايضا ظلت مراكز الرعاية الصحية الاولية – خاوية علي عروشها ينقع فيها اليوم وتم نهب أموال المنظمات الدولية بدلا من صرفها على الرعاية الصحية الاولية
- اما تدريب الاطباء فقد ظل التجاذب واضحا بين وزارة الصحة ومجلس التخصصات فكان لا بد لنا ونحن في نقابة اطباء السودان الشرعية ومنذ قيامها عام 2012م وقد رفعت النقابة صوتها احتجاجا لهذه السياسات سواء كان بالوقفات او البيانات والمذكرات مما ادي الي المطاردات الامنية والاستدعاءات والاعتقالات وما زال نقيب الاطباء دكتور احمد الشيخ ونائبه د. نجيب نجم الدين ودكتور عايد عبد الحفيظ قيد الاعتقال في ظروف سيئة للغاية لذا كان لزاما علينا العمل بجدية لكي نخرج برنامجا متكاملا كبديل لما خربته الانقاذ لذا كان لا بد ان تتكون لجان لرسم خريطة صحية وخطة اسعافية بديلا لما حدث من تخريب في القطاع الصحي فكان هذا مجهود زملائنا في الصحة العامة وهو مجهود مقدر ولكن اول الغيث قطرة فهناك كثير من الصعوبات والمشاكل التي يجب علينا مواجهتها كاسترداد المستشفيات التي تم تجفيفها وتاهيل المراكز الصحية وعمل خريطة صحية حسب توجيهات ال WHO يكون فيها عدد المستشفيات حسب عدد السكان كما لا بد ان نلتفت الي مناطق الحروب والصراعات وما خلفته الحرب من مشاكل خاصة الالغام وتدمير المستشفيات بل ايضا يجب علينا النظر الي البنية التحتية للمكان لكي يسترد المواطن امنه العذائي اولا لذا ومن واقع تجاربنا ندعو ان تشمل السياسات البديلة استنهاضا لدور المجتمع وقيمه في بناء النظام الصحي وتطويره بالكفاءات مع البرامج الصحية القومية الاخرى كما نتطلع الي توصيات قوية تساعد في بناء النظام الصحي
- وختامنا اننا كنقابة اطباء السودان الشرعية ندعو كافة المهنيين لكي يحذو حذو النقابة الشرعية لوضع سياسات بديلة
- ختامنا اشكر نقابة اطباء السودان ببريطانيا وايرلندا لتبنيهم هذا المؤتمر لاصلاح الصحة في السودان وليكن برنامجنا في الفترة الانتقالية عاشت نقابة اطباء السودان الشرعية عاشت وحدة الاطباء والمجد لشعبنا ودمتم

Role of Junior Doctors in Development of Healthcare in Sudan

“One day, we will build it!”

Why Juniors?

- Junior doctors are in frontlines facing all kind of challenges
- Current movement is led by youth

SJDA as an example

- Open Platform
- Project-based management
- Helping junior doctors to integrate in NHS

Our Response to Exciting changes in Sudan

- Sense of individual/organistical responsibility
- Brainstorming
- Networking & seeking experts' advise
- Paradigm shift
- Scientific approach

Summary

- We are taking the question of development seriously
- We are organised, We have the Energy, We are well connected and we have good potential
- We need your help, wisdom, expertise

“One day, we will build it!”



SJDA-UK SPRING EVENT 2019



SALAMAT



Sudanese Junior Doctors Scientific Conference - UK المؤتمر العلمي لأطباء الشباب السودانيين بالمملكة المتحدة بالتعاون مع منظمة سلامات الخيرية

Role of Junior Doctors in building future health system in Sudan

Panel discussions

- Opportunities for junior doctors in the UK to develop into future healthcare leaders in Sudan
- Potential role for Organisations such as SJDA in supporting health system in Sudan

Workshops

- Health Systems: Basics for understanding types of health systems, overview of NHS structure and Sudan health system
- Audits & QIP: Beyond the basics
- Preparing for a consultant post
- Personal effectiveness and resilience

Oral posters and presentations

Social Dinner

Beach trip & BBQ

**20 April
2019**

**Discount Vouchers
for SJDA member**

**One day,
we will build it!**



Novotel hotel Newcastle Airport,
Newcastle Upon Tyne, NE3 3HZ

**Bank Holiday Weekend
20-21 April 2019, Newcastle UK**



Register at

www.sjda.uk

SJDA UK

- Created for junior doctors and led by junior doctors, SJDA UK is the first independent body of its kind, filling the gap between medical students' organisations and doctors' organisations led by consultants.
- Vision & Commitment aims towards providing quality training to the Sudanese junior doctors and medical students.



Working across agencies and disciplines Key challenges facing the health sector

,

Workshop will be guided by the WHO Health System Building Blocks
as a framework for analysing the health system

7th April 2019

WHO Health System Building Blocks

A misty forest scene with tall, thin trees and dense undergrowth, serving as a background for the title. The text is centered in the upper half of the image.

1. Health governance & stewardship (**HGS**); eg transparent decision-making, accountability, etc.
2. Health infrastructure, technologies & pharmaceuticals (**HTP**); eg buildings, labs, medical supplies
3. Human resources for health (**HRH**); eg. production, management, regulation, certification, etc
4. Health information systems (**HIS**); eg surveillance, health management information systems etc
5. Health care finance (**HCF**); includes insurance & other risk-pooling, public-private-partnerships, etc
6. Health service delivery (**HSD**); eg organization of health facilities, service quality, etc

World Café



Based on text from the café to go reference guide. Authored by the World Café community.

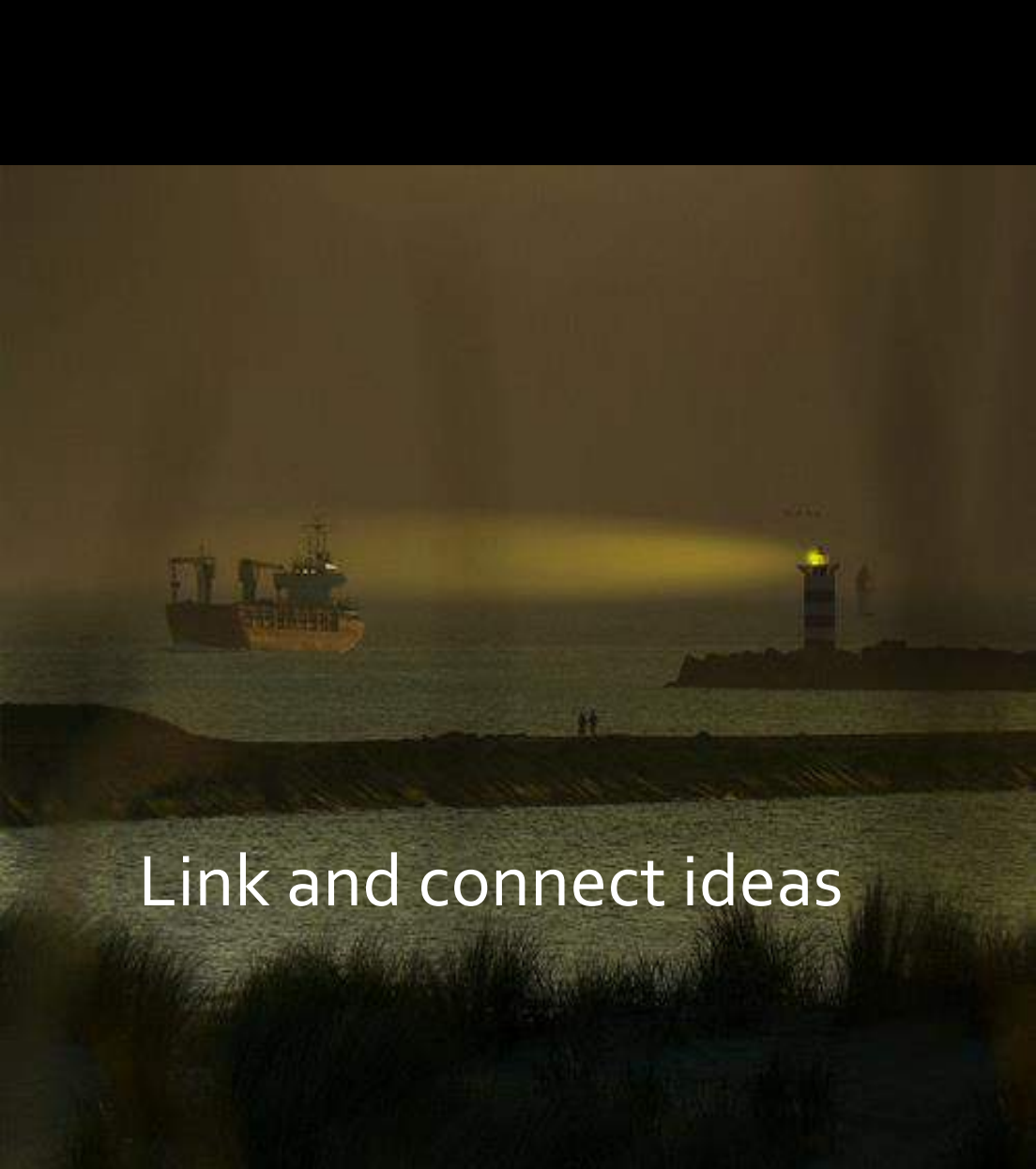
World Café at a Glance...

- **Three progressive rounds** of conversation with each round (and lasting 20 minutes)
- At the **end of each round**, participants are invited to **move to a different table**
- **New question discussed** while linking and connecting ideas with previous conversation rounds
- **Flipcharts and post-its** provided to create a **visual memory** of the conversation
- World Café **principles** include the following....


Contribute
your thinking

Speak your
mind and heart



A night scene of a lighthouse on a rocky island. The lighthouse is illuminated, and a ship is visible in the distance. The foreground shows dark grass and a body of water.

Link and connect ideas

A brown rabbit sitting on a wooden floor. The rabbit is looking towards the camera. The background is a wooden wall.

Listen together
for insights and
deeper questions

One more thing...

Each group's **table hosts** will remain at the table during the 3 conversation rounds to:

- **welcome** newcomers
- share the **main ideas, themes and questions**
- encourage guests to **link and connect ideas** (USING THE FLIPCHARTS & POST IT NOTES)



World Cafe

- **Tables 1:** Health governance & stewardship challenges.
- **Tables 2:** Health infrastructure, technologies & pharmaceutical challenges.
- **Tables 3:** Health workforce, health information systems & health care finance challenges.

Debrief

Break





Working across agencies and disciplines

Transition Plan for the Health Sector Workshop

Year 1

Priority recommendations for reform & strategic actions in Sudan

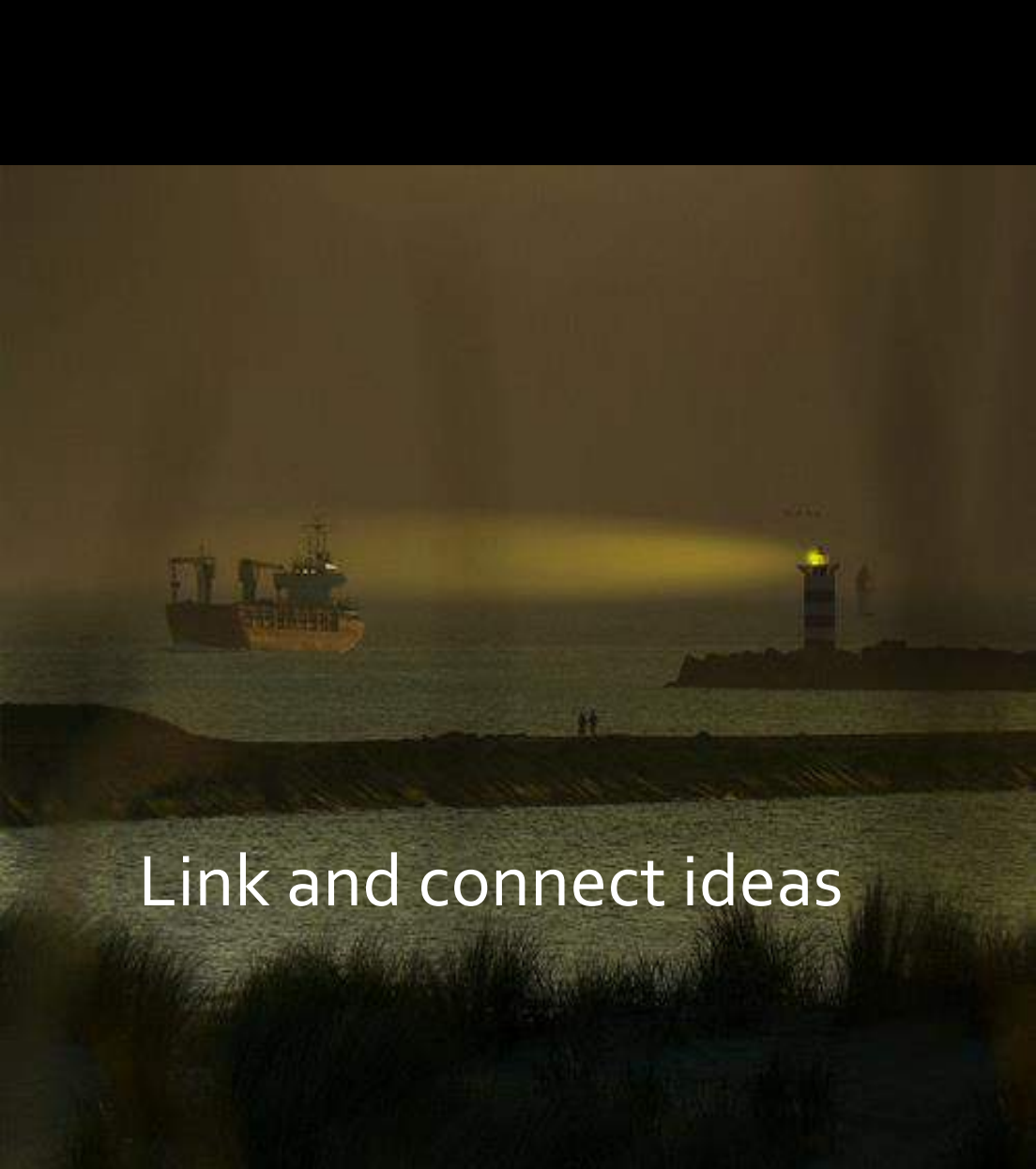
Principles to guide Sudan's national health policy direction

- Health is a human right
- Health is an investment in human development
- Health is not the mere absence of disease (WHO)
- Government has a key regulatory obligation and service delivery role
- Pro-poor, gender-responsive and equity focused
- Complementarity of roles between public health sector in partnership with Sudan's civil society
- Government role in stewarding the health system
- Evidence- based.


Contribute
your thinking

Speak your
mind and heart



A night scene of a lighthouse on a rocky island. The lighthouse is illuminated, and a ship is visible in the distance. The foreground shows a grassy field.

Link and connect ideas

A brown rabbit sitting on a wooden floor. The rabbit is looking towards the camera. The background is a wooden wall.

Listen together
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World Cafe

- **Tables 1:** Priority issues 1 to 7.
- **Tables 2:** Priority issues 8 to 14.
- **Tables 3:** Priority issues 15 to 20.

Debrief

Break



Group 1 discussion:

Governance and Stewardship

Chair: Marwa Gibril

Facilitator: Huda Hassan

Scriber: Hashim Elsir

Health is a human right:

1. This should be reflected in reality
2. A patient charter is needed.
3. Inclusion of lay person and frontline health workers in decision making
4. Empowerment of citizens

Governance Finance:

1. Political will and commitment is essential
2. Health should be free at point of delivery
3. There should transparency about healthcare funding

Accountability:

1. Governmental level and professional /regulatory body
2. Social and community accountability is very important

Collaboration and coordination:

1. Inclusiveness of all parties.
 2. Tailored approaches e.g conflict zones
 3. Coordination in a professional and ethical manner
 4. Power of decision making should be shared among all sectors
 5. Integration with social care as a holistic patient centred approach
-

Group 2:

Chair: Dr Nadir Elgadi

Scriber: Hussam Muhsin

Health infrastructure:

1. Establishing emergency services including ambulances , training of paramedics and emergency departments.
2. Establishing a system for the disposal of clinical wastes
3. Focus on retrieval of governmental hospitals in the transitional periods
4. Corporating bodies between private and public sectors
5. Decentralisation and distribution of healthcare services

Health technologies:

1. Establishing a central database to be used for research and guidance of health policies. (e.g Patient medication records)

2. Making use of the rapid development of health technology to upgrade the health care system in Sudan
3. Quality assurance from medical laboratories and pharmaceutical manufactures

Pharmaceuticals:

1. Classify the medication into three groups with different government commitments:
 - a. Life saving (fully funded)
 - b. Essential medicine (commonly prescribed) (partial fund)
 - c. Patent/ branded medicine (indirect funding)
 2. Strengthening the central body to procure medicine for all the public institutions (bulk tendering)
 3. Exempt the drugs with marketing authorisation in Europe and America from the standard registration procedures
 4. Empowering the existing regulations applications, monitoring, and evaluation
 5. Exempt medications from government taxes.
-

Group 3:

Chair: Suhair Elshowaya

Facilitator: Suhair Elshowaya

Scriber: Nadir Elamin, Mohammed Elhassan

Health information system:

All points agreed. Added points:

1. The body collects the data is independent from the government to ensure a reliable system In collecting and **data sharing**.
2. **This body should have a direct authority to publish this data**
3. The biggest challenge is the formation and the structure of this body
4. The base of data , transparency is the most crucial thing (e.g issues with transparency of the Cholera outbreak in Sudan)
5. Confidentiality, however, is an important factor.
6. Health personnel lacks mentality of data collection.
7. Training and development of the workforce is required to promote the data collection, sharing and transfer the data
8. To implement penalties to healthcare systems failing to notify public health of a notifiable disease.

Health Care finance:

1. Health budget Must be increased to a level where it can match the needs by healthcare in Sudan along with the national recommendations.
2. Review of health insurance scheme to meet the requirements. **The ultimate goal is free healthcare in Sudan.**
3. The rest of the points agreed. All accordance to the WHO recommendation.

Health service delivery:

1. Health **Must** be accessible to everybody.
2. Regulation of private sectors including ambulance services
3. The rest of Points written agreed

ENDORSEMENT

① Pharmaceuticals and
pharmaceuticals tender bulking

② PROMISORSHIP (SOU)

③ FINANCIAL
⇒ ⇒ Emergency plan

- Distribution of services
- Using technology develop
- Database (pt medic
- link between hospital
- Quality assurance in

~~He~~

④ Collaboration & Coordination

- Inclusiveness
- Tailored approach
- Coordinated in a
- Power of Decision making shared among
- ~~Go~~ Integration with ^{patient care} as a holistic approach

Health Governance & Stewardship

Health is a human right

A - A latent charter

- Inclusion of lay person & frontline health workers

- Empowerment.

③ Participatory approaches in

- The problem of (is)
- Importance of Transparency
- Importance of Inclusion
- All health sectors
- Involvement of lay

④ Accountability

- Change of mentality
- Has to be by law
- lack of system of

Transitional plan Po

Group 1

Chair: Abdelmohmoud No

Facilitator: Hayfaa

Scribe: Hashim

① Stop war

Will generate
Allow rebuilding

② Prioritize conflict zones

Involve conflict zone ci

Survey local an
R e h e b

③

Transitional Plan Part

Group 2

Chair
Facilitator
Scribe

⑧ Legalize + empower institute of citizen, pt & consumer

- Support groups

- Advocate

- Group to represent

⑨ Compliance to international

- "Existing" vs. exiting

- All in agreement

⑩ Accountability mechanism

- lack of clear com pathways.

- Needs to be a cult

Group 2

Key Challenges

Health IS, Technology

Sources of Meds. → 100

Uncon

- Central body for drug pro
the public sector [Bul
Pur

- Fast track Registration f

European/American market Aut

- Grouping of Medicines (lid

HLS

- * Defining challenges
- = Identifying type of system
- To collect data which is re-transparent about it.
- = Sharing the data is lack
- Deciding which ~~is~~ body collecting & sharing the data
- (lack of awareness to the int)

⑫ Private health service de
- Similar to point # 10

⑬ Establish process & formal
medium & long-term
towards achieving SDG-3
- ↑ Compensation
Workers

⑭ Conduct proper scientific review
situation.

- ↑ fear,
Independent reg
akin to GMC

Chair : Marwa

facilitator : Huda

1- Right to health

- Current documents do not

- Constitution & documents

- Health as a right should

- Patient Charter

Health Finance:

- Chronic underfunding
- Health only have 1.25%
→ there we should increase it
by 2020.
- FMOI should ensure health
everyone
- Review of health insurance set
- Investing in improving the environment
- Focusing on building a primary
health care that is accessible
- Setting the results for the

/ ACCOUNTING / EDUCATION - PR

/ EDUCATIONAL SYSTEM

② Neglect of fiduciary/financial of good governance.

- Distribution of resource to

 - Currently poor distribution

- Shift focus to primary health

- Allied Health Professionals,

- Need for Political commitment

- Need to improve social ca

⑤ National Health

- open to everyone
- Insurance to be involved in delivery
- Regulation of Pr
- Need to Reform System,

⑥ National Health C

is it duplication of
Empowered to

ENDORSEMENT

① Pharmaceuticals as

about tender bulking

② PREMISESHIP (SOUT)

③ FINANCIAL — Other
⇒ Emergency plan

⑦

Anti corrup

1993

Reallocate investments - to

- 2 - Essential - AAE -> in
 - Paramedic + ambul
 - 004 resuscitation
 - Trauma centre

es. preventive health, SD (focus)
 3a -> horiz approach
 5 -> maternal health
 5 -> child health

School health

Focus on maternal, p health -> ↓ IMR/...

- Vaccination
- School curriculum
- Hygiene
- Sanitation
- Alcohol

انعقد في مدينة لندن مؤتمر السياسات الصحية البديلة والخطه الاسعافية لما بعد سقوط النظام بمبادرة من نقابة اطباء السودان بالمملكة المتحدة انعقد في مدينة لندن مؤتمر السياسات الصحية البديلة والخطه الاسعافية لما بعد سقوط النظام بمبادرة من نقابة اطباء السودان بالمملكة المتحدة ومشاركة وإعداد من نقابة الاطباء الشرعية، لجنة الاطباء المركزية، الاستشاريين والاختصاصيين نقابة اطباء السودانين بكندا، تجمع الاطباء السودانين بامريكا، نقابة الاطباء السودانين بايرلندا، رابطة شباب الاطباء السودانين بالمملكة المتحدة، لجنة الصيادلة المركزية، تجمع الصيادلة المهنيين

التمريض السوداني، تجمع اطباء الأسنان السودانيون، التعليم الجامعي والتدريب والتأهيل هذا المؤتمر هو نتويع لجهود متواصلة في خلال الثلاثة عقود المنصرمة. صادف هذا المؤتمر ذكرى ابريل المجيدة وأيضاً صادف ثورتنا السودانية العظيمة والمتواصلة والمنتصرة بأذن الله. لقد أعلن الإضراب العام الان في السودان والاعتصام أمام القيادة العامة لقوات الشعب المسلحة ما زال متواصلًا منذ الامس. وقد تمت مخاطبة الوطنين في القوات النظامية حتي ينخرطوا لارادة الشعب السوداني. في خلال الـ ٤٨ ساعة الماضية في مؤتمر دولي وحضور متعدد وشامل لقطاعات الكوادر الصحية تمت اجازة الخطة الاسعافية في مجال الخدمات الصحية للعام الاول وتم الاتفاق علي استمرار الجهود الجمعية الشاملة المتمثلة في مبادرة تجمع الاطباء السودانين بامريكا في خلال المرحلة الانتقالية. قيام مؤتمر السياسات الصحية في السودان بعد سقوط النظام والذي سيشمل الخدمات الوقائية، العلاجية، الدوائية، التركيز علي مناطق النزاعات والمعسكرات، التدريب والتأهيل الطبي.

حرية سلام وعدالة والثورة خيار الشعب