Sudan's Alternative Health Policy Conference

London 6-7 April 2019

Alternative Health Policies Documents

Pre- Conference Preparation

- الخطة الصحية للفترة الانتقالية 18 يناير 2019 (1-TPHS)

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

- Health Delivery in Conflict zones

- A Basic Health Financing Primer in the Context of Sudan

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 الذى استمر 30 عامًا بلغت ذروتها في الاحتجاجات المستمرة والضخمة والتى شملت جميع المدن السودانية منذ ديسمبر عام 2018. ويقود هذا العمل الشعبى المعارض منابرتمثل كافة قطاعات الشعب تهدف إلى إسقاط نظام الانقاذ من خلال انتفاضة شعبية سلمية. وهذه الخطة تطرح تنفيذ عملية انتقال منتظمة مدتها عام واحد لقطاع الصحة بعد سقوط الانقاذ. وقد توافقت كل اطراف المعارضة السودانية على أن فترة انتقالية تمتد إلى 4 سنوات لما بعد الانقاذ تشمل ائتلافاً وطنياً عريضاً بقيادة تنفيذية ومشاركة جميع نشطاء المعارضة والأحزاب السياسية والنقابات المهنية والمجتمع المدني والفئات الأخرى. وترتكز خطة الفترة الانتقالية على اهداف تنموية 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 الانقاذ: القمع والفساد والممارسات الإدارية المدمرة من خلال وضع الخطط القطاعية واسس الحوكمة لضمان سير عملية انتقال منظم فور ازالة النظام.

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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 الـTPHS-1 هو تقديم رؤية موحدة بين الأطباء السودانيين ، والعاملين الصحيين ، وجموع الشعب السوداني وشركائهم الوطنين والدوليين حول اولويات القطاع الصحي الأساسية التي يجب معالجتها خلال الأشهر الـ 12 الأولى بعد سقوط نظام الانقاذ. وبناءً عليه ، فإن الهدف من ال 1-TPHS هو توجيه قيادات القطاع الصحى لفترة ما بعد الانقاذ. ومن المتوقع فور سقوط النظام، عقد ورش عمل لتقديم الخطة الصحية وخطط القطاعات الاخرى للفترة الانتقالية والاجماع عليها. وتهدف هذه اللقاءات فتح الحوار والمشاركة لاثراء وتوضيح وتعزيز التوافق حول 1-TPHS بمجرد الإزالة الكاملة لنظام الانقاذ.

مضمون الوثيقة

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

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 السودانى

- بحلول الشهر ال12 من تنفيذ الخطة:

وضع الأسس اللازمه 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 اتساقًا مع المبادئ والالتزامات المقبولة دوليًا و القدرة على الاستثمار بشكل ذكي في الصحة وبالتالي إنتاجية رأس المال البشري اللازم للتنمية.

3- المنهج والاطار التحليلى 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 الصحى 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 آخذة في الانخفاض وهى 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 للقضاياوالتحديات 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 فى 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 بانه ليس مجرد هدم وجود المرض
- للدولة دور رئيسي لتنظيم وتوفير الخدمات في القطاع الصحي
- السياسات المرتكزه على الانصاف ودعم الفقراء والمساواه بين الجنسين: شنت الانقاذ منذ العام 1989 حربا 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 ، ووسائط 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 أوخدمات 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 الرأسية الرئيسية ، الخ) وتقديم خدمات مباشرة للسكان الذين يعانون من نقص في الخدمات الاجتماعية في السودان.

- الاستناد على الادلة: 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 ، وآذلك 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 تمشيا 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 اجتماعيا اقتصاديا ، مثل النساء والشباب والمراهقين والأطفال وكبار السن وذوي الاحتياجات الخاصة والأيتام فضلا 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 دورالمنبر 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 تتبع الفساد داخل أنظمة إدارة المعلومات الصحية للقطاع الصحي الرسمي عن طريق تكييف الخبرات مثل نظام تتبع البيانات في أوغندا. ويتضمن المنبر أفضل وسيلة إلكترونية آمنة لتمكين الوصول إلى جميع المواطنين على أوسع نطاق ، على ان يفوَّضً قانونيًا و يكون دوره مكملا 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 تدريجيا 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 نقابات عمالية منتخبة ، وممثلي مجموعات المرضى / المستهلكين ، وبرلمانيين / واعضاء فى المجلس التشريعي ومقدمي الخدمات. على ان 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 الدوائى ،والممارسات الطبية ، وصحة البيئة والنظافه العامة ، ومكافحة الأمراض السارية ، وحقوق المرضى ؛
12. تطوير آليات لتنظيم ومراقبة جودة ونظم تقديم الخدمات الصحية فى القطاع الصحى الخاص من خلال معايير مساءلة قوية للدولة ، والهيئات المهنية ، والمريض 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 إنشاءمنهج 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 التشوهات 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 ايضا 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 الاولية 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 التى يتم التعرض اليها) والتصدى لها ، من خلال تدابير أقوى لمكافحة التبغ ، وخفض استهلاك الملح و بتعزيز 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 فى 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

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

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 القرارعند تقديم الخدمات ، فى القطاعات الحكومية المحلية والعامة ؛ وعلى وجه الخصوص استبعاد الجهات الفاعلة فى المجتمع مثل الروابط المهنية/التجارية والمرضى والمجتمع المدني وشركاء التنمية الآخرين والمجتمع المدني وغيرهم من شركاء التنمية الاخرين
- قلة التمثيل القطاعي في المنابر التى 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 نفاد 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 المجمعة الطوعية للقاحات الطفوله ، 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 فى صنع القرار ؛

4- تمويل الخدمات الصحية (HCF):

- شح التمويل المزمن 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 المزمن 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) وتركيزالخدمات الصحية للمستويات الوسيطة والعليا.
- تناقص إمكانية الحصول على الرعاية الصحية (لا سيما الرعاية الصحية الأولية ، وحتى فى المؤسسات الصحية الاعلى) 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 فى المستويات الاعلي 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 Inqaz[1] regime through a Popular Uprising[2]. 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: This1-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.

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[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 this1-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. I 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, chikingonya, 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 mis-management 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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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 collects $50 million ($2,500 X 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 X $50,000). So each individual covered by the insurance who develops CHD will receive $50,000 (i.e. $50 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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