Strategic Health Sector Priorities for Post-War Recovery & Reform in Sudan

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Presented At

University of Bergen Celebration of 60 Years of Collaboration

between Kingdom of Norway and Republic of Sudan

Bergen, Norway 18th October, 2023

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A. Key Messages

1. **Peace** is the current top priority; followed by **stabilizing policies and actions**

2. **Civilian interim/transitional government priorities** must include stabilizing the peace, ensuring accountability for crimes, resuscitating the economy, restoring people's livelihoods and intensifying social service support (including health services)

3. Particularly if based on evidence, standards and Sudan's previous policy directions, the **recovery for Sudan's health sector presents an opportunity** for basic reforms, while also saving lives and reducing disease burdens

4. Significant, continued **international partnerships**, assistance and political solidarity is needed to achieve the civilian government's priority programs, including between Norway and Sudan.

B. Background Context

(Please refer to the handout accompanying this Power Point for further details)

1. Former dictator Omer Elbashir's Transitional Military Council resists the civilian December 2018 Revolution, enters power-sharing agreement by August 2019 with civilian bodies led by Forces for Freedom & Change (FFC), removes civilian government in military coup by October 2021 and by April 2023 plunges Sudan into the current war inbetween the army led by Burhan and former dictatorship groups against the Janjaweed militia led by Hemedti.

2. FFC continues to be fractured into two sets of factions; one rejecting any negotiation or power-sharing with TMC and another seeing TMC negotiation as a necessary pre-requisite for peace and stability.

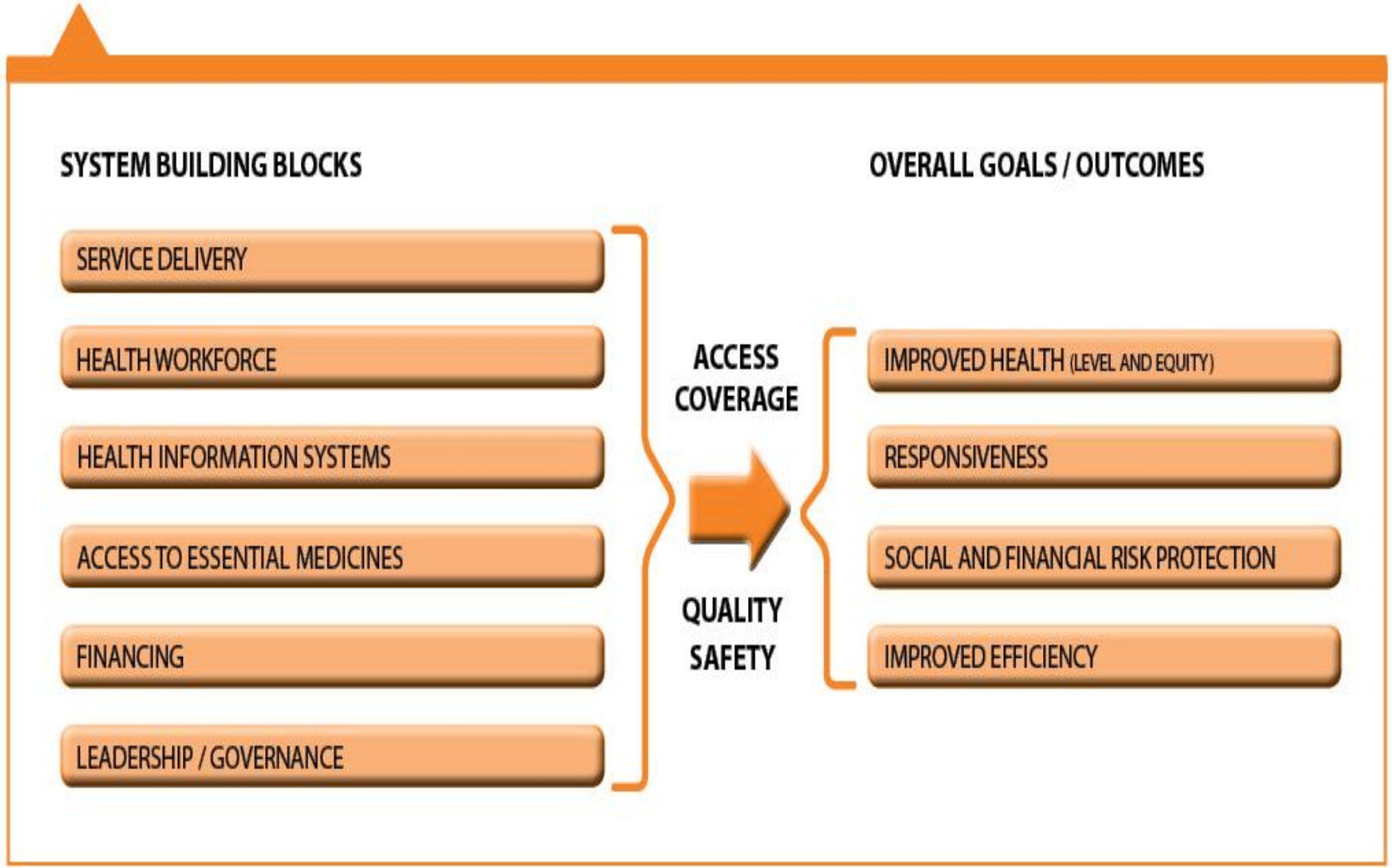
3. Led by US, Saudi Arabia and the African Union, peace talks in Jeddah and Addis Ababa continue to be violated by both TMC factions.

4. Resistance Committees (RCs) & Emergency Committees (ECs) along with Sudanese health professional bodies inside and outside Sudan are providing essential services with whatever resources they can bring.

C. Conditions, Risks & Assumptions

1. Successful Jedda/Addis negotiations to **stop the war**.
2. **Civilian Peace & Recovery (CPR) interim or transitional government** assumes full control
3. Well-planned & organized gradual **return of IDPs and refugees** to places of origin
4. Sufficient **CPR government political will, cohesion and capacity** to implement priority reforms, including in the health sector
5. Significantly **increased volume of international recovery funds** delivered by donors and partners, including considerable “Budget Support” for the civilian government’s capacity to implement all peace and recovery priorities
6. Effectively-mitigated risks from **external political shocks** (eg. Negative geopolitical and economic impacts of conflicts in occupied Palestinian territories, Ukraine, Libya, Ethiopia, South Sudan and Sahel countries, etc) and **economic shocks** (eg. Inflation, recession, etc).

Figure 1. The WHO Health Systems Framework



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D(i). Diagnostic Analysis (by WHO Health System Building Block):

1. Health Governance
2. Health Finance
3. Human Resources for Health
4. Health Service Delivery
5. Health Infrastructure/Technology/Pharmaceuticals
6. Health Information Systems

1. Health Governance, Stewardship & Leadership

- GoS neglect of obligation to protect right to health, good governance
- Political de-commitment from responsibility for health sector;
- No mechanisms to monitor budget allocation, spending & costs
- Disastrously deteriorating health system performance,
- Arbitrary policy, planning, management decision-making;
- Defective accountability at all levels (legislatures, patients, etc)
- Corruption, mismanagement & fragmentation of accountability
- No statutory multi-stakeholder public health governing body
- Perceiving health as welfare; not an investment in human capital;
- No social protection policy framework to restore inequity
- No GoS role to provide public goods contributing to health
- No multi-stakeholder platform to monitor progress & accountability.

2. Health Care Financing

- Declining GoS expenditure on health as % of total GoS expenditure
- Chronic under-funding; inadequate coverage of insurance schemes
- High out-of-pocket expenditure (75%) within total health expenditure
- High-cost of services (e.g. emergency/accident); GoS & private sector
- Corruption, mismanagement, improper management of external aid
- Inequitable investment among regions, care levels, diseases
- Inadequate private sector service regulation; with GoS collusion
- Negligible leverage of key Sudanese private sector strengths (risk-pooling, co-investment, innovation, management, logistics, IT, outreach depth/breadth)
- No performance-based management, return-on-investment, etc
- Increasing financial investment costs due to poor system performance
- Political/tribal/religious/ethnic/geographic bias in allocating GoS resources

3. Health service delivery

- Poor quality curative & preventive services;
- Weak impact, coverage, access & utilization of services
- Inverted focus on tertiary/secondary care, neglect primary
- Fragmented, poorly-performing service delivery organization,
- Decentralized responsibility; but no authority nor resources
- Increasing disease burden and worsening basic health indicators (e.g. MMR, IMR, U-5 Mortality, manlnutrition, etc)
- No standardized training and service norms for patient care pathways by clinical condition and level of care
- Almost complete divestiture from basic high-impact, low-cost prevention, including immunization, nutrition, water suply, sanitation hygience, school health, food safety, primary/secondary prevention/control of communicable and non-communicable diseases, environmental health protection, occupational health

4. Health infrastructure, technologies & pharmaceuticals

- Destroyed health infrastructure, equipment at facility level.
- Inappropriate prioritization when developing new facilities, including misguided focus on developing politically-motivated new tertiary health care institutions, while actively dismantling existing ones;
- 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;
- Weak medical supply management & distribution systems;
- Neglect of previous investments and policies which helped create Sudan's previously-robust national drug manufacturing capacity, with resultant reliance on high-cost importation;
- Failure to envision/pursue regional/international trade arrangements to increase local capacity, bargaining power, reduce costs and regain control over medical supply market (eg. volume discounts, importing generics, voluntary pooled procurement arrangements, compulsory licensing & other missed opportunities;

5. Human resources for health (HRH)

- Inadequate health work force density; inequitably distributed (urban vs rural areas; public vs private sectors, primary/secondary/tertiary care, health cadre types, health/medical disciplines & between geographic states
- No vision, policies nor strategies to ensure high retention & decent working conditions among health workers in underserved areas; irresponsible reactions to legitimate health worker protests
- No HRH management policy framework, causing uncontrolled production of weakly-trained HRH whose numbers, training & competencies are non-responsive to the reality of clinical & other health sector needs;
- Very poor quality & weak systems for certification, licensing, regulation & monitoring health sciences education performance
- Non-existent standards to guide health worker skill mixes needed for specific disease/service pathways, facilities, etc
- No HRH vision; e.g. regaining Sudan's competitive advantages by attracting fee-paying students from various countries (neighbors, small islands, emerging/fragile/resource-poor countries, etc)

6. Health information systems (HIS)

- No coordinated systems to determine 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
- Policy and management decisions are not based upon data, evidence generated by health information systems
- No transparency in reporting health data;
- Poor use of advances in IT technology supporting public health at service, local, national levels
- Disinvestment of financial and human resources away from HIS, including M&E staff, systems, processes

E. Goal & Strategic Objectives

Goal:

Contribute to Sudan's post-war Civilian Peace and Recovery (CPR) effort by saving lives, restoring services and reducing morbidity and mortality.

Strategic Objectives:

1. To increase preventative, curative, rehabilitative and promotive health service coverage within 12 months after the start of the CPR government

2. To improve the health sector performance in the domains of governance, health care finance, health information systems and human resources for health within 12 months after the start of the CPR government

F(i). Priority Health Sector Strategic Directions

1. Stop the war & stabilize the peace
2. Mobilize to rebuild destroyed health systems
3. Strengthen participation, engagement, transparency and accountability by establishing FMOH and SMOH Advisory Council's with multisectoral stakeholders and by involving health professional unions, Resistance Committees, patient/consumer representatives and civil society in FMOH, SMOH health service and facility governance
4. Review and respond to health information system improvement needs
5. Review & improve health regulatory frameworks
6. Develop the National Health Policy & Strategic Plan
7. Harmonize international health interventions and align with national strategic plan
8. Increase CPR government expenditure on health
9. Overhaul National Health Insurance to improve governance, efficiency and coverage
10. Strengthen service capacity, coverage & quality in communicable disease control, school health, nutrition, mental health, SRMNCAH (sexual, reproductive, maternal, neonatal, child & adolescent health; including GBV), traumatology/accident/emergency and rehabilitative services.

F(ii). Priority Health Sector Strategic Directions

12. Develop, place Primary Health Care (PHC) at center of health sector & strengthen secondary/tertiary care, within a health catchment area model for each locality/county.
13. Strengthen quality, coverage, production capacity, regulatory control by CPR government in health science training and education in both the public and private educational/training institutions.
14. Review the health workforce (HRH) situation in Sudan, including creation of HRH stable career paths, increased absorption of key HRH categories as regular federal government employees, creating a system of incentives and retention strategies to enable equitable and attractive redistribution of work-force across levels of care (eg. Primary, secondary, tertiary), in underserved locations (eg rural, war-affected), disciplines (eg. Traumatology, Psychiatry, Pathology, etc).
15. Develop public-private-partnerships (PPP) and mechanisms to invest in capacity, quality, standards of delivery and costs of private sector local pharmaceutical production of generic medicines and medical supplies, health science education, rehabilitation of destroyed public and private sector infrastructure, digitization of health information systems,

F(iii). Priority Health Sector Strategic Directions

16. Improve non-communicable and chronic disease case management, including through PHC, palliative/home-based care, early detection and prevention programs.
17. Create a multi-stakeholder annual platform/mechanism for Joint Health Sector Review
18. Develop and implement programs with Sudanese diaspora country institutions and associations to incorporate circular migration pathways to enable well-organized Return of HRH Talent and external HRH career development rotations as part of HRH career pathways.
19. Drastically reduce unnecessary CPR government expenditure on health and increase FMOH's control over the health sector, including by temporarily centralizing (**not** decentralizing) health sector management during at least Year 1 of the CPR government tenure, legislating full FMOH control over the sector (except the National Health Insurance Fund and Sudan Medical Council which should remain independent of FMOH).
20. Ensure full transparency by efficiently publishing monthly health situation summaries and health sector performance data for the general public and internationally.

G. References

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