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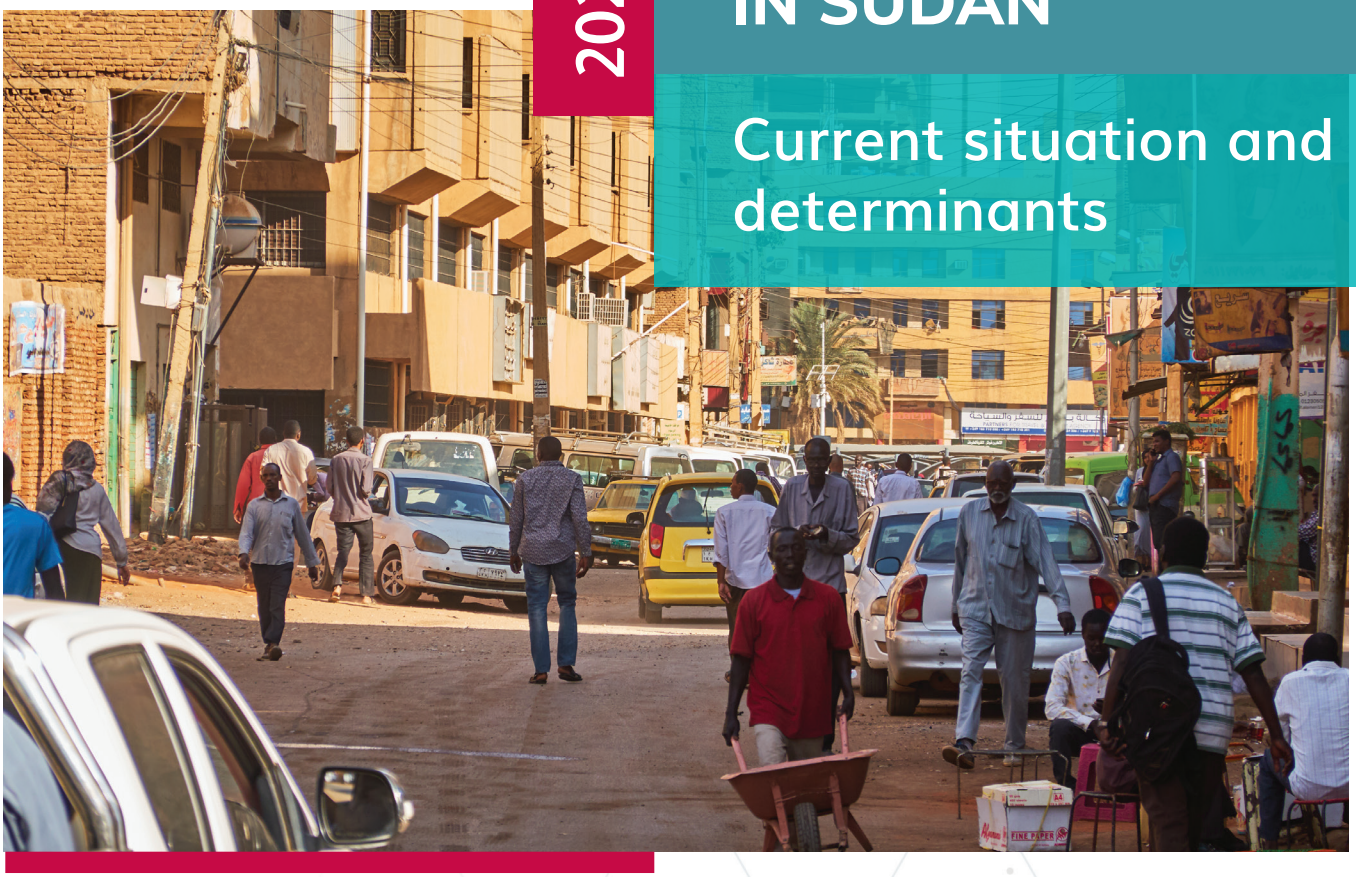
RIGHT TO HEALTH IN SUDAN

Current situation and determinants



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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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RIGHT TO HEALTH IN SUDAN

Current situation and determinants

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CONTENTS

ACKNOWLEDGEMENTS

We sincerely thank the Arab NGO Network for Development (ANND) and the Faculty of Health Sciences at the American University of Beirut (FHS-AUB) for entrusting us with the report on the Right to Health in Sudan as part of the Arab Watch Report 2023. We especially thank Dr. May Hammoud, Dr. Sawsan Abdulrahim, and Ms. Maysa Baroud for their technical support and guidance while preparing the report. We also extend our gratitude to the interviewed colleagues for their precious time and the invaluable documents they provided, which were an excellent aid in preparing the report. We also thank the NIDAA association for coordinating the national consultation and participants.

INTRODUCTION

The Republic of Sudan is an Arab African country with a predominantly Muslim population. It is located in northeast Africa and bordered by seven countries: Egypt, Libya, Chad, Central Africa, South Sudan, Ethiopia, and Eritrea. It covers an area of 1.866 million km2. Before South Sudan's secession in 2013, the Republic of Sudan was the largest country in the Arab World and Africa. Today, it is the third largest.

In 2022, Sudan's population was estimated at 46.87 million, growing at a rate of 2.6% (World Bank 2023). According to the 2014 Sudan multiple indicator cluster survey (MICS), nearly 70% of the population of Sudan lives in the countryside. Almost half of the population is comprised of children, and the number of men is equal to that of women. Around 68% of the population has access to safe drinking water. Although 41% enjoy improved sanitary facilities, the rate fluctuates between 28.2% in rural areas and 69.3% in urban areas. The fertility rate for the three years preceding the MICS was 6.2 per woman. It was higher in rural areas, reaching 225/1000, compared to 167/1000 in urban areas (Republic of Sudan, Council of Ministers & UNICEF 2014).

The survey indicates that six out of 10 young women in Sudan can read and write. However, literacy rates varied by geography, reaching 79.8% in urban and 50% in rural areas. The percentage of women who know how to read and write also varied according to the household's economic status. For example, in the 15-24 age group for women from the wealthiest families, literacy was around 92.2%, compared to 31.1% of women in the poorest households (Republic of Sudan, Council of Ministers & UNICEF 2014).

Furthermore, Sudan hosts many refugees from neighboring countries: Ethiopia, Eritrea, Chad, the Central African Republic, and South Sudan. In recent years, it has also received numerous Syrian refugees and several thousand Yemenis. At the beginning of 2022, Sudan hosted nearly two million refugees. Sudan is a multi-ethnic and multicultural country. It is a federal state with three levels of government, distributed over 18 states and more than 189 districts. According to the Juba Peace Agreement of 2020, a regional level was established below the federal level. The country was divided into eight regions following the Governance and Administration Conference in

2021 (2021-2024 جمهورية السودان، وزارة الصحة الإتحادية).

As a Least Developing Country (LDC), Sudan faces multiple socioeconomic development challenges. According to the Sudan National Health Sector Recovery and Reform Policy 2021-2024, the country's GDP fell to less than US$40.85 billion, and the annual economic growth was merely 2.3%. Thus, about 36.1% of the population lives below the poverty line (2021-2024 جمهورية السودان، وزارة الصحة الإتحادية). Millions of children and households suffer from financial hardship and its health, social, and economic effects, exacerbated by the spread of COVID-19.

Moreover, the country suffers constant risks related to floods, droughts, conflicts, and displacement (Republic of Sudan, Council of Ministers & UNICEF 2014). It is vulnerable to natural and human-made disasters, and an estimated 8.7 million people require emergency assistance due to reduced living standards. In 2020, the worst floods in decades affected nearly 900,000 people, damaging homes, causing deaths, and leading to the loss of livelihoods and agricultural production (2021-2024 جمهورية السودان، وزارة الصحة الإتحادية). High poverty, unemployment, conflict, and insecurity lead many Sudanese citizens to emigrate.

Due to the country's multiple socioeconomic challenges and the long-term state of war, many health indicators are deteriorating. Health services do not cover several geographical areas. Furthermore, health services that exist are inadequate, as human and material resources are not fairly distributed between the various regions (2022-2021 جمهورية السودان، وزارة الصحة الإتحادية).

OBJECTIVES

The report aims to address the following issues and themes:

1. Do all social segments in Sudan enjoy the right to health?
    a. Legal provisions;
    b. Adopting scientific health policies to achieve the right to health;
    c. Planning to attain the right to health for all; and
    d. Fairly providing human and financial resources.
2. The political impact of the right to health.
3. The social impact of citizen awareness and participation in health planning.

METHODOLOGY

The study follows a qualitative analytical approach based on a review of published and online information from relevant parties' official websites and communication platforms. Interviews with key health and social rights figures supplement the data extracted from these documents. The documents include health laws, regulations, plans, and reports.

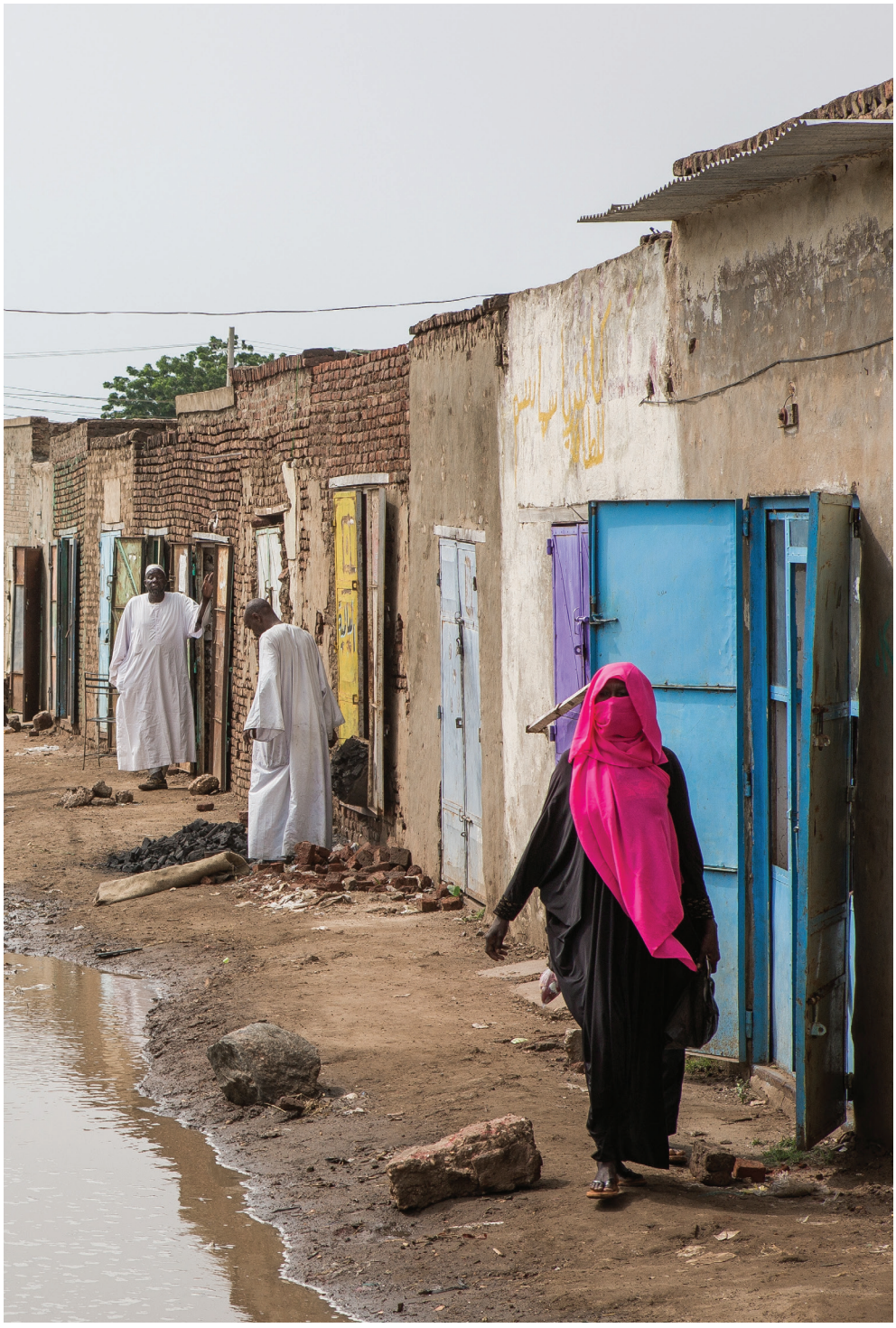
Interviews were conducted with decision-makers in the Federal Ministry of Health and some employees of the Ministries of Justice and Social Development (formerly Welfare and Social Security). Moreover, focus group discussions were held for representatives of the Khartoum Resistance Committees, a representative of the Central Physician's Committee, and representatives of research centers and organizations working on gender, women's rights, and people with disabilities and special needs.

The collected data focuses on economic, social, and health indicators. The study delves into the recognition and knowledge of the right to health and the availability of health services for all groups, including conflict areas, refugees, displaced persons, and other vulnerable groups. Furthermore, the study findings provide insight into health insurance coverage, distribution of human resources, and availability of essential medicines. They also address political instability, peaceful protests, demonstration casualties, and economic decline.

The report addresses health through its social determinants, including clean water, food, housing, education, and the political and social situation. On the other hand, it analyses the six health system structures through governance and leadership, human resources, health services, government spending on health, information and research systems, and drug supplies. The report also addresses international support for health in the transitional period. Finally, it focuses on health challenges, such as the most common diseases and epidemics, including COVID-19, and their direct and indirect impact on securing the right to health in Sudan.

The Federal Ministry of Health Undersecretary approved data collection from the Federal Ministry of Health staff and other institutions.

The study faced several obstacles, particularly difficulties in coordinating with relevant authorities, especially the Ministry of Health, to conduct interviews. Moreover, political instability has negatively affected institutional structures and memory, including data available in the various ministries. Finally, demonstrations and protests made it difficult to move around the capital to collect data.



THE SOCIAL, ECONOMIC, AND ENVIRONMENTAL DETERMINANTS OF HEALTH

The country's environmental determinants of health are linked to growing concerns about the impact of climate change and biodiversity loss on the changing patterns of communicable and non-communicable diseases, disabilities, and injuries. Decisive action is needed to address current and emerging challenges. The 2030 Agenda for Sustainable Development highlights the critical and inextricable links between development, the environment, human health, well-being, and the economy, as central to realizing a wide range of human rights. It includes the right to life, enjoying the highest attainable standard of physical and mental health, an adequate standard of living, safe food, drinking water, sanitation, safety, and clean soil, water, and air, essential for promoting justice and peace. Sound environmental and health policies contribute to an overall increase in life expectancy and well-being, and health gains are among the most desirable social and economic benefits of adequate environmental protection.

Environmental degradation, pollution, climate change, exposure to harmful chemicals, and destabilization of ecosystems threaten the right to health. Moreover, they disproportionately affect disadvantaged and socially vulnerable populations, exacerbating inequalities. However, according to Federal Ministry of Health officials, the Ministry seeks to cooperate with all related actors through its strategic plan to improve justice. Thus, it intends to adopt health issues in all policies and ensure its systematic consideration in all other sectors.

The Federal Ministry of Health of Sudan recognizes the 2030 Agenda for Sustainable Development. Thus, it is committed to coherent multi-sectoral strategies emphasizing system-wide preventive policies and justice to improve environmental health conditions and mitigate their consequences on social health determinants (جمهورية السودان، وزارة الصحة 2021-2024 الإتحادية). Education is a significant indicator of the right to health. However, low educational attainment, especially among women, remains a critical obstacle to spreading knowledge of fundamental human rights.

THE CURRENT POLITICAL SITUATION AND THE RIGHT TO HEALTH

The political situation is crucial to achieving the right to health in Sudan. After a government that lasted thirty years, the Sudanese Revolution erupted in late 2018. It brought about political change leading to a transitional government in April 2019 comprised of civil forces and the military. According to the Constitutional Document, the government was entrusted with ensuring stability and paving the way for national elections after three years. The government appointed according to the Constitutional Document stayed in power until October 25, 2021. On that date, the President of the Transitional Sovereign Council issued what is known as the October 25 Decisions and dubbed the October 25 Coup by some politicians and respondents. The date was a turning point, but the Decisions faced growing international, regional, and local opposition.

Accordingly, the modern history of Sudan can be divided into four stages: before the fall of the Inqaz regime, between the fall of the regime and the decisions/coup of October 25, 2021, after the October decisions, and currently, a new era that began in December 2022 with the adoption of a framework agreement between the military authority and some political forces.

The stage between the regime's fall and the decisions/coup of October 25 was characterized by openness in all fields, including health. A strategic plan was developed that was consistent with the requirements of the transitional period. The health sector witnessed the influx of many international organizations and the resumption of vital projects to strengthen the health system through developing the work environment, training cadres, and supporting the information system. During this period, the transitional government adopted critical issues such as providing medicine and increasing insurance coverage by introducing an additional million families to expand health insurance coverage. This period was accompanied by basic measures to remove empowerment from government institutions and all state agencies. This led to a vacuum in senior administrative positions at the center and state levels. Despite filling all posts and the renewal of faces with new patriotic blood, a defect in the administrative system remained, due to the weak follow-up of the handover processes and the absence of documentation, which weakened institutional memory and

led to problems in the follow-up and implementation of health interventions and projects.

The impact of the political situation after the October 25 decisions/coup on the right to health can be summarized in three axes related to donors, support and staff retention, demonstration injuries, and the rise in displaced persons due to increased violence in conflict and border areas. This report will highlight the impact of the political situation on the right to health by focusing on the most critical basic structures of the health system affected by the political situation. In-depth analysis and approaches to the status of the right to health in urban areas were conducted for peaceful demonstrators, displaced persons, and refugees from remote rural areas.

The current problematic political situation is related to the consequences of the decision/coup of October 2021, which were followed by many statements rejecting the decisions, followed by a series of measures to stop cooperation with the existing government. Support for health sector projects funded by the European Union, United Nations organizations, and the Global Fund also stopped. Thus, several health projects and services were suspended, especially in areas dependent on donors. The freezing of support was documented in a report on the effectiveness of development partnerships issued by the General Department of International Health at the Federal Ministry of Health, which dealt with funding challenges in light of the current political situation, especially after the October decisions/coup.

The frozen amounts for health projects are estimated at US$316,700,749, of which US$159 million were from the World Bank and US$40 million from the EU.[1] The report showed that health services and medical supplies bore the brunt of removing subsidies. The influence of the October decisions/coup on the health system in Sudan is documented in an analytical article by Osman and colleagues titled “Saving the Fundamentals: The Impact of the Military Coup on the Sudan Health System” (Osman et al. 2021). The paper addressed the consequences of the October 25 decisions/coup on the health sector, which can be summarized in the administrative vacuum of senior positions, the cessation of health services, the antagonization of health personnel by the security and regular forces, and the impact of stopping donor support on medical services and drug supplies.

The October decisions/coup also led to a change in donor funding and support policies. They began adopting an

[1] Directorate General of Global Health, Federal Ministry of Health, *Effective Development Partnership*.

approach of direct implementation, leading to delays in implementing some projects, especially vaccination campaigns, due to the complex bureaucratic procedures of organizations that require direct financing of activities. The previous measures also weakened the Ministry of Health's governance as the implementing body for health interventions, according to the Director of Evaluation and Follow-up at the General Department of International Health at the Federal Ministry. The decisions created an administrative vacuum for senior positions in the Ministry of Health, disrupting administrative procedures and the workflow on the federal and state levels, negatively affecting health services and interventions.

Furthermore, due to the prominent role played by health cadres in the Sudanese Revolution, which was recognized in international and local forums, medical cadres became known as the White Army. They played a prominent role in opposing the October 25 coup, organizing an open strike with an 80% observance rate, which paralyzed health services, especially in peripheral regions. On the other hand, many violations and repeated attacks on hospitals and medical personnel were registered, increasing the loss of medical personnel and negatively impacting retention policies in government facilities (Osman et al. 2021).

In January 2020, the WHO issued a statement condemning the repeated attacks by regular forces on health facilities, amounting to 15 episodes, 12 confirmed in Khartoum and other cities. The attacks ranged from intimidation to verbal and physical violence. In addition, there were reports of attacks on patients and medical staff and arrests of the wounded. Consequently, some hospitals were forced to suspend emergency services, and patients sometimes had to escape before the treatment was complete. In addition, frequent incidents of interception of ambulances and forced searches of medical staff were recorded (WHO-EMRO 2022).

Representatives of the Ministry of Health, voluntary organizations, and the Central Physicians Committee agreed that attacks by the security services and the police impede access to health services during protests, impacting regular citizens and protesters. The attacks were a prominent reason for stopping service in some hospitals providing emergency services to the injured from the demonstrations, such as Al-Arbaeen Hospital in Omdurman and Royal Care and Fadil Hospitals in Khartoum.

RIGHT OF PROTESTORS TO HEALTH

The impact of the political situation on wounded demonstrators was evident. The numbers rose, and serious injuries increased after the October 2021 decisions/coup. More than 8,000 people were injured during the peaceful demonstrations, according to a statement by the representative of the Central Physicians Committee, with 78 cases requiring intensive care, 116 deaths, and 50 cases of rape, three of which were documented in the courts (*Hadhreen* 2022).

The number of serious injuries reached 1074 (mostly direct injuries to the chest, head, and neck), resulting in permanent disability or death. The Council of Ministers formed a committee to follow up on the issue regarding those injured in the protests and to cover the cost of treatment. Technical committees were also created from the relevant ministries, such as the Ministries of Health and Foreign Affairs. Injury cases and supporting agencies were monitored to legalize their work and improve coordination between the various agencies. However, most organizations refused to deal with state agencies and limited their work to monitoring and covering treatment costs. On the other hand, civil society organizations (CSOs) adopted the issue, most prominently the "*Hadhreen*" organization, which documented those injured in the Revolution and peaceful protests in coordination with the Central Physicians Committee.

Hadhreen organization monitored and followed up the treatment of 5,600 cases, collected donations to cover the treatment of the injured and contributed to treating 855 injuries, of which 19 were enough to be treated outside Sudan. The total cost of treatment by the "You are not alone" coalition is estimated at 517,846,269 Sudanese pounds or 97,308,500 US dollars (Hadhreen 2022).

Notably, the National Supply Fund for Health Insurance contributed to treating the injured to fulfill the social responsibility clause. The Central Physicians Committee established standard protocols and procedures for facilitating access to emergency services. The medical staff in health facilities across Sudan and Khartoum, in particular, contributed to maintaining the continuity of emergency services to those injured in the demonstrations, despite the difficulties, political

pressures, and attacks on some health facilities. Health institutions and facilities, both public and private, supported the provision of treatment services, as 80% of the injured were treated inside Sudan, and this confirms the commitment of doctors to the right of demonstrators to health and also documents the state's commitment to its responsibility towards the demonstrators, according to the statements of the representative of *Hadhreen* organization.

In August 2022, *Hadhreen* announced that it would stop covering treatment expenses due to the growing costs, the accumulation of debts, and the budget deficit. The decision is expected to lead to negative consequences on obtaining health services and the deterioration of the health condition of the 400 patients under treatment.

RIGHT TO HEALTH IN LAWS AND LEGISLATION

Sudan has ratified several international agreements and charters, aligning its laws accordingly. Thus, the State of Sudan is legally bound before the international community to ensure and protect its citizens' right to health. National legislation and laws stipulate that all citizens have good health and fair access to health services. In 2019, the Constitutional Document stipulated the following in Article 4.1 of Chapter One as follows (جمهورية السودان، وزارة العدل 2019):

> The Republic of Sudan is an independent, sovereign, democratic, parliamentary, pluralistic, and decentralized state in which rights and duties are based on citizenship without discrimination on the grounds of race, religion, culture, sex, color, gender, social or economic status, political opinion, disability, or affiliation.

The document also adopts the rights and duties included in ratified international and regional human rights conventions, covenants, and charters ratified. Moreover, it stipulates that the state undertakes to protect and promote the rights included in the document and guarantee them to all without discrimination based on race, color, gender, language or religion, political opinion, social status, or other reasons. Furthermore, the document stipulates that "the state is committed to respecting human dignity and diversity and is based on justice, equality, and the guarantee of human rights and basic freedoms." It adds that every human has an inherent right to a decent life and personal safety, that citizenship is the basis of equal rights, and that men and women enjoy civil rights equally.

In terms of health, the 2019 constitutional document stipulates that the state provides healthcare for motherhood, childhood, and pregnant women and guarantees the elderly respect of their dignity and their benefit from medical care and services. Furthermore, Article 65 stipulates that the state undertakes to provide the minimum level of healthcare, primary healthcare, and emergency services, free of charge for all citizens, to develop public health, and to establish, develop, and rehabilitate primary treatment and diagnostic institutions. Sudan's 2005 transitional constitution stipulated these same rights (جمهورية السودان، وزارة العدل 2005).

The National Public Health Law of 2008 guarantees all citizens the right to obtain healthcare free of charge in state facilities for primary healthcare services and emergencies involving accidents. Free primary healthcare was also guaranteed for children up to the age of 5 and for pregnant women, including standard delivery and C-section (2008 جمهورية السودان، وزارة العدل). The 2008 National Health Insurance Fund Law provides compulsory health insurance for all resident Sudanese, foreigners, and refugees (2016 جمهورية السودان، وزارة العدل).

In terms of mechanisms, the National Mechanism for Human Rights and International Law was formed in 1994 and tasked with following up the implementation of international covenants and agreements, monitoring human rights, and harmonizing national legislation with international covenants. The National Mechanism is affiliated with the General Department of Human Rights and International and Humanitarian Law at the Ministry of Justice. It comprises 21 members representing relevant ministries, including the Ministry of Health, commissions (humanitarian aid and refugee affairs), universities, civil society organizations, and a UN observer.

The Mechanism submits periodic reports on indicators related to international recommendations and monitors their implementation by the Ministries. Sudan's third report was submitted and approved before the UN UPR mechanism in its third session (2022 Sudan News Agency/وكالة السودان للأنباء (سونا)). Recently, in a notable development, Sudan legislated the criminalization of Female Genital Mutilation (FGM) after 40 years of demands. Accordingly, the crime was added to Article 141 of the Criminal Code.

However, although Sudanese laws and legislation guarantee the right to health, the reality on the ground is different. Interviews with decision-makers indicated a unanimous agreement on the discrepancy between legislation and implementation. For example, a decision-maker at the National Health Insurance Fund (NHIF) confirmed the following:

> The state believes that citizens have the right to health, reflected through laws, plans, and programs that set high aspirations, such as broadening health insurance and allocating budgets. However, in reality, health does not represent a top priority for the state. Spending the allocated budget depends on the availability of money. When budgets are short, health budgets are dropped, and the existing funds are spent on other priorities that the state values, such as security, salaries, and peace agreements entitlements.

RIGHT TO HEALTH IN POLICIES AND PLANS

The General Department of Health Policies and Planning at the Federal Ministry of Health is tasked with developing health policies, strategies, and annual plans and following up on their implementation. The Federal Ministry of Health is keen to cooperate with government partners to ensure the effective development and realization of policies and plans in partnership with health-related sectors and through community participation. In particular, these partners include the NHIF, development agencies, including the UN, donors, development banks, national and international NGOs, and local community organizations. It also cooperates with other health service providers, including the private health sector, the army, the police, and voluntary organizations that provide health services (جمهورية السودان، وزارة الصحة الإتحادية 2021-2024; جمهورية السودان، وزارة الصحة الإتحادية 2007). Moreover, officials from health-related entities, such as the water, environmental, and educational sectors, are also involved. The Ministry of Finance plays a pivotal role in the process, the WHO usually provides technical and financial support, and UNICEF and UNDP also participate in policy development and planning.

During his presentation of the Strategic Plan for Health Sector Recovery and Reform, 2022-2024, the Minister of Health stated that he looks forward to working with various health sector stakeholders to achieve the desired results of the strategic plan, especially in its implementation. He considered strengthening the health system at the state and local levels a prerequisite for implementing the strategic plan and achieving its goal of reaching universal health coverage for the population. He also pointed out the importance of community participation and that of all government agencies related to health, especially the NHIF, and partners in the humanitarian and development fields, including UN organizations, donors, development banks, local and international volunteer organizations, and CSOs (جمهورية السودان، وزارة الصحة الإتحادية 2021-2024; جمهورية السودان، وزارة الصحة الإتحادية 2007).

The National Quarter-Century Strategy 2002-2027 was developed to follow a ten-year strategic plan. The health document was approved in all policies in 2018. Several other policies were prepared, such as the Sudanese child health

policy, the policy towards voluntary organizations, the health research policy, and the nutrition policy. In their entirety, these policies refer to the right of all residents to obtain adequate health services. Several policies and plans were drafted after the April-December 2019 Revolution. They include the Sudanese National Health Sector Recovery and Reform Policy 2021-2024, the National Health Sector Recovery and Reform Policy 2022-2024 and the National Health Sector Recovery and Reform Strategic Plan 2022-2024.

The quarter-century strategic plan envisions a health system capable of improving health and fulfilling citizen aspirations based on justice, efficiency, modernity, and the harmonization of technologies and the environment. Moreover, it must focus on quality, innovation, and health promotion and actively involve the community. The 25-year strategic plan also envisions that the system helps improve citizens' health and quality of life so that they can enjoy the highest attainable level of health, enabling them to lead an economically productive social life. Most significantly, the strategy is committed to providing health for all as a fundamental right of citizens. It also adopts primary healthcare in its broad sense to achieve health for all, which includes fairly covering the entire population with healthcare according to need and paying attention to poor and vulnerable groups. In addition, it calls for justice in the provision and financial contribution through social solidarity, where the poor groups contribute much less than wealthier segments through direct or indirect payment methods. The strategy's priority programs involve expanding health coverage, ensuring fair distribution, removing geographical and physical barriers that impede access to services, and building and strengthening the health system's capacities (جمهورية السودان، وزارة الصحة الإتحادية 2007).

The National Policy for the Recovery and Reform of the Sudanese Health Sector 2021-2024 and the National Strategic Plan for the Recovery and Reform of the Sudanese Health System 2022-2024 adopted the same approach to ensure that "all people in Sudan enjoy high-quality and equitable access to basic health services and are protected from emergencies towards a healthier, fairer, and safer future." In addition, they adopted a mission to "organize and strengthen the health system to provide quality, equitable, and affordable health services, aiming to achieve universal health coverage and the relevant, sustainable development goals and objectives, overcome health challenges, and cooperate with all actors by

incorporating health in all policies to ensure an optimal status for all and contribute to comprehensive social, environmental, and economic development and peacekeeping" (2021-2024 جمهورية السودان، وزارة الصحة الإتحادية; 2007 جمهورية السودان، وزارة الصحة الإتحادية). The guiding principles of the above policy included the right to health, equality, quality, accountability, transparency, and community participation. The above policy's guiding principles encompassed the right to health, equality, quality, accountability, transparency, and community participation.

The 25-year Pharmaceutical Strategy 2005-2029 focused on access to medication and providing essential medicines to the population reasonably and affordably (وزارة الصحة، الإدارة العامة للصيدلة 2005).

The above health policies and plans are appropriate and fully cover the right to health for all. However, persistent problems still face their implementation in a manner that allows the right's full realization. The challenges were stressed by most respondents, who pointed to several examples:

1. Officials and health workers are not familiar with legislation, policies, and plans, particularly on the level of implementation in states and localities. The Director of the General Department of Planning and Policies stated that the Ministry informs health officials at the state level of plans and policies. Still, the implementers of these plans are usually not informed. Knowledge of the plans is also lost due to the continuous replacement of trained health officials.
2. The scarcity of financial resources is a critical obstacle preventing implementation.
3. Weak infrastructure.
4. Weak governance, mismanagement of available financial resources, and unfair distribution of resources between hospitals and primary healthcare facilities that provide services to more than 75% of citizens and are managed and financed by localities suffering from considerable scarcity of financial resources.
5. The instability of policies and their impact on political change.
6. Weak information systems and lack of national surveys.

PERCEPTIONS OF THE RIGHT TO HEALTH

Respondents almost unanimously agreed that citizens' knowledge of the right to health varies according to several economic, social, and geographical determinants, primarily educational levels, geographical location in terms of rural and urban areas, and age. The Director General of the NHIF stated that educated people consider health and health insurance their right because it guarantees them treatment without financial barriers. On the other hand, he believed ordinary citizens, especially in rural areas, appreciate health insurance cards as a state service. Moreover, health partners and experts see health as a right for citizens, which the state must provide adequately through the six essential components identified by the WHO: service provision, human resources, health information systems, access to essential medicines, financing, leadership, and governance. They discuss the importance of health system reforms. For example, the former Minister of Social Development believes that health is a right, should be accessed without discrimination, and must be provided through government facilities, even to foreigners. The approach distinguishes Sudan from most countries, even rich ones, which only provide services to foreigners who pay the fees. Sudan's system does not deprive anyone of its services. On the other hand, the Director of Health Policy and Planning stated that there are attempts to inform citizens of their right to health. Work is underway to develop strategic plans for community engagement and risk communication.

RIGHT TO HEALTH SITUATION IN SUDAN

HEALTH SERVICES

Sudan's primary healthcare program was established in 1976, even before the Alma Ata Declaration (OCHA – Sudan 2020). Thus, the country provides health services on three levels: primary, secondary, and tertiary healthcare. The state offers Primary healthcare through local governments (the third level in the country's governance hierarchy) in collaboration with some private entities and voluntary organizations. Primary health service facilities are classified into three categories: family health units that provide the basic primary healthcare package. Family healthcare centers offer a larger package and a higher level of primary health services to which medical doctors are assigned, and rural hospitals.

Between 2011 and 2018, the proportion of health facilities offering a minimum complete primary healthcare package increased from 24% to 95%. The improvement is attributed to the Primary Healthcare Expansion Project, which began in 2012. However, although the plan aimed to distribute one healthcare facility per 5000 people, the rate remains at 1/6816. Moreover, only 83% of facilities were in operation in 2019 due to a shortage of health personnel, poor infrastructure, and security issues.

On the other hand, a remarkable disparity in the number and quality of primary healthcare facilities appears between and within states (جمهورية السودان، وزارة الصحة الإتحادية2021-2024). Around a quarter of the population cannot access health facilities due to distance, poverty, or conflict. Access to facilities varies between regions. In addition, financial, social, and economic barriers limit access to health services. Patients from high-income segments use healthcare services almost ten times more than those from lower-income segments (جمهورية السودان، وزارة الصحة الإتحادية2021-2022). Conversely, target villages covered by midwives rose from 36% in 2011 to 85% in 2019, and the training of midwives, paramedics, and community health workers expanded.

In parallel to the primary healthcare level, the second level encompasses general hospitals, and the third level covers

specialized hospitals and centers. There is a significant disparity in the geographical distribution of hospitals. For example, the rate in the Northern State is 3.2, compared to 1.1 in Central Darfur. Similarly, the Northern State has 178.1 beds per 100,000 inhabitants, compared to 58.9 in Central Darfur (2022-2021جمهورية السودان، وزارة الصحة الإتحادية). Nevertheless, despite adopting relevant national guidelines, the referral system between the different levels is inoperative.

Public Health Insurance is consequential in ensuring the right to health. It allows access to health services to all categories and covers 81.7% of the population (Elfadul & Elfadul 2022), with broader coverage for poorer segments. By actively providing health services in areas where they do not exist, it ensures access for all citizens, even those who can afford them.

The private sector is also a leading contributor to access to health services. The strategic health plan acknowledges the issue. In addition, the Director of Health Policies and Planning at the Federal Ministry of Health believes the private sector has a significant role, especially in dealing with COVID-19. However, coordination could be improved, as he explained.

Furthermore, voluntary organizations participate in providing health services. For example, the Director of the Voluntary Organizations Department said there is coordination with the Federal Ministry of Health, represented by the Department of Emergency and Epidemic Control. Thus, the organizations work according to the health strategy and in line with the Federal Ministry of Health policies and protocols. Similarly, the Director of the General Department of Therapeutic Medicine at the Federal Ministry of Health indicated that there is a health map according to which curative, preventive, and promotional health services are fairly distributed. However, lacking human resources in some areas diminishes the ability to provide services fairly.

The Ministry of Social Development is another ministry closely influencing the right to health through its several arms. They include the Zakat Bureau, which, according to the Minister, helps the poor access the right to health and protects the middle class from falling into poverty due to disease. She also mentioned that the Zakat Bureau pays the health insurance contributions of a set number of poor and pensioners, contributes to treating children under five, and tackles malnutrition, tuberculosis, and other diseases that lead to poverty, such as kidney failure and cardiovascular diseases. Health treatment is one of the Bureau's main expenditures.

According to its Unified Treatment Department, it also supports treatment abroad for those who need it. In addition, its Humanitarian Aid Commission intervenes during health emergencies, epidemics, military clashes, and natural disasters and focuses on the displaced. The Ministry also reports to the Public Authority for Prosthetics, which provides them for people with disabilities.

The health system in Sudan suffers from multiple problems caused by scarcity of resources, high workforce turnover, poor infrastructure, and poor service delivery, all of which lead to unsatisfactory health outcomes (جمهورية السودان، وزارة الصحة2022 الإتحادية).

The COVID-19 pandemic affected the health system. It disrupted health service provision directly, especially at the onset, due to the preventive measures (complete and partial closures) that limited access to health services. In early 2020, a study by the Occupational Safety and Health Administration (OSHA) estimated that only 38% of primary healthcare institutions were operational (Elfadul & Elfadul 2021). Another study on the impact of lockdowns on health services recorded that 80% of Khartoum patients faced access difficulties due to the lack of health personnel and targeted health services, including emergency and pharmaceutical. Furthermore, another study confirmed the impact of the pandemic on maternal and child services. It showed that access to prenatal services was as low as 40%. Postpartum services recorded the lowest access rate at 15%. The study also documented the indirect impact of COVID-19 (WHO 2022), particularly fear of infection and transportation difficulties (Mohamed et al. 2021).

Sudan faced many challenges related to COVID-19 due to the health system's fragility and structural deficiencies, including in medical personnel, health information systems, and financing essential medicines. Challenges related to governance also weakened oversight and accountability. In addition, it led to shortcomings in preserving the right to health and health services.

Based on the above and the statements by the Director of Health Policy and Planning, there is another problem in the unfair distribution of services. For example, specialists are only available in major cities, and some states lack mental health doctors and neurologists. Indicators also show that infant mortality differs between rural and urban areas and various states.

HEALTH INDICATORS

Table 1 shows the significant disparities in child mortality rates between rural and urban areas. The rate is significantly higher in urban areas, especially for children under five. Among states, the ratio in four states is greater than 90 per 1,000 live births, compared to 29.9 per 1000 live births in the Northern State. The four states that top the child mortality list are the regions suffering from instability and witnessing frequent internal and tribal conflicts.

Table 1. Geographical and Urban Distribution of Child Mortality Rates

Indicator	Under- five mortality rate	Infant mortality rate	Newborn mortality rate
Geographical area			
Urban	56.5	45.1	30.3
Rural	72.8	54.5	33.4
State			
Northern	29.9	30.0	23.0
Nile River	35.1	28.1	25.8
Red Sea	61.3	44.2	18.6
Kassala	80.5	62.1	47.2
Al-Qadrif	76.7	53.4	32.6
Khartoum	49.8	45.1	30.5
Gezira	53.5	41.4	26.2
White Nile	65.8	46.8	30.3
Sennar	51.6	34.1	18.0
Blue Nile	83.9	46.8	26.0
North Kordofan	41.9	35.6	23.0
South Kordofan	95.4	70.2	32.5
West Kordofan	82.1	68.2	43.4
North Darfur	90.3	68.5	43.9
West Darfur	91.4	71.2	39.2
South Darfur	71.9	52.6	35.2
Central Darfur	77.4	44.5	24.7
East Darfur	111.7	88.5	51.8
Sudan	68.4	52.0	32.6

Source: Data from the 2014 MICS, Republic of Sudan, Council of Ministers & UNICEF

HEALTH ISSUES

The country suffers from the double burden of communicable and non-communicable diseases, malaria being the country's number one challenge in all states. In 2021, the frequency of malaria patients reached 17% of the total number of visitors to health institutions; it was the primary cause of hospital deaths in 2021 at 8.4%. However, the rates vary by state and are highest in the Blue Nile, Sennar, and Gezira (2022-2021جمهورية السودان، وزارة الصحة الإتحادية). Other endemic diseases include schistosomiasis, tuberculosis, and leishmaniasis. However, there was a decrease in TB incidence and prevalence, and the death rate associated with the disease is estimated at 25 per 100,000 people (2021-2024جمهورية السودان، وزارة الصحة الإتحادية). Furthermore, malaria, diarrhea, and pneumonia are the leading diseases affecting children. As for non-communicable diseases, 21.1% of the population suffers from diabetes, and cancer cases are increasing dramatically (2022-2021جمهورية السودان، وزارة الصحة الإتحادية).

According to a WHO report on March 12, 2022, the COVID-19 pandemic led to an estimated 631,275 cases, including 419,61 deaths (WHO 2022). Khartoum State ranked first in the number of cases, followed by Gezira State. The first case was announced in March 2020. Accordingly, many health precautions were issued to limit the spread of the disease in communities and neighboring countries following international health requirements published by the World Health Organization. Regarding vaccines, Sudan was one of the first African countries to complete arrangements to introduce the vaccine through the joint COVAX mechanism. Twenty percent of the population was set as a target for vaccination coverage. As a result, the total coverage rate for Sudan reached 82% of the target. The states of Darfur (Central and West Darfur), South Kordofan, and Blue Nile state topped the list in achieving the coverage target, while the Red Sea state recorded the lowest coverage at 40% (Federal Ministry of Health 2022).

Moreover, several modern models and methods deliver services in remote regions. However, difficulties were observed in obtaining vaccine services in some states of Darfur. In 2002, a study by al-Anoud and others found many obstacles in the fragile health system in some Darfur States that limit access to the required COVID vaccine coverage. Shortcomings were reported regarding quality and cold-chain storage. In addition, the unstable electricity supply impeded vaccine preservation

and added to difficulties in transportation and delivery to remote areas and the precarious security situation in areas of tribal conflicts (Mohamed et al. 2021). Furthermore, respondents from the Federal Ministry of Health also reported that the worsening security situation in West Darfur in the Jebel Moon region poses a threat to vaccine interventions and primary healthcare services and that they are an obstacle to access to health services, especially among vulnerable groups such as children under five and pregnant women.

Although the vaccination rates in some states surpassed 100%, some researchers and representatives of international organizations had severe reservations about the target. Based on WHO guidelines, they believed it was very far from the minimum level to reach herd immunity (80% of the population).

MATERNAL, CHILD, AND ADOLESCENT HEALTH

Maternal and child health is one of the main priorities in development plans and government grants due to its crucial impact on improving the entire community's health, economic, and living conditions. These commitments are reflected in many supporting projects and strategies, such as the free medication policy for children under five, the free C-section policy, the introduction of new vaccines, and national commitment and international support for the Integrated Management of Childhood Illnesses (Emergency Obstetric and Neonatal) strategy and Newborn Care, for example.

Despite some improvement, health officials confirm that maternal and child mortality rates are still high compared to other countries of similar social standing. In addition, a significant difference is evident between rural and urban areas and the different states, as shown in **Table 1**.

In 2021, a UNICEF report uncovered impediments to children's access to health services. For example, the rate of access to health centers for children sick with diarrhea was around 25% (Mohamed et al. 2021) The report also indicated an apparent decline in health indicators among children from the vulnerable segments who live in crisis and conflict areas. For example, one in seven children does not have enough food to prevent malnutrition and stunting, and survival rates for children under five are declining (one in eighteen children will die before their fifth birthday) (UNICEF 2021).

Most adolescent deaths could be avoided through access to quality health services, education, and social support, which are currently unable to cover needs. Furthermore, the National Adolescent Health Strategy is still in preparation, albeit providing a package of services expected to meet the health needs of Sudanese youth. Youth and adolescent drug abuse issues have recently come to the surface. In January 2023, the head of the Sovereignty Council inaugurated a campaign aimed at combating this phenomenon (UNICEF 2021).

VACCINATION

The Director of the immunization program at the Ministry of Health said his program provides vaccines in fixed centers that serve the population within 5 square kilometers and is called the holding area. Areas between 5-10 square kilometers are served in sub-centers. Those of more than 10 square kilometers around the region are served through mobile teams. He said it was because health is a right for citizens and must be provided wherever they are, regardless of their geographical location or numbers. He added that vaccine services are fairly distributed. The program is based on the location of the targeted population, covered through fixed and mobile teams. He also spoke about community participation in planning and implementation. The coverage rate for children under one was around 82% or about 1,313,458 who took the third dose of the DTP3 vaccine. In addition, 11,281,745 children (82%) received the first dose of the measles vaccine, compared to 64% for the second dose (UNICEF 2021).

MENTAL HEALTH

The Sudanese mental health policy was prepared in 2008 and indicated the importance of integrating mental health within primary healthcare services, increasing human resources, involving patients and their families, strengthening advocacy, protecting patients' human rights, fairness, facilitating access to mental health services for all groups, improving quality, financing, follow-up, and evaluation. Furthermore, although the mental health law was passed in 2009 (2021-2024جمهورية السودان، وزارة الصحة الإتحادية), mental and neurological health services are not provided through primary healthcare facilities. Only 12 states out of 18 have government hospitals fully equipped and staffed to provide mental health services. As a result, the rate of mental health personnel is around 1.6 per 100,000 people, compared to the global target of 6 per 100,000 to reach universal coverage (Osman et al. 2020).

The concentration of services in large cities has limited access in remote regions, according to the Director of Health Policy and Planning and the Director of Human Resources Development at the Ministry of Health. He reiterated the results of the health statistical report, which shows 23 specialists in Khartoum State, while 11 states lack specialists (جمهورية السودان، وزارة الصحة الإتحادية2021). Thus, neuropsychiatric services are unequally distributed, and the vast majority of citizens do not access them unless the disease worsens and the patient's family is forced to seek services in these hospitals or go to municipal therapists, elders, or, in a few cases, general physicians. Nevertheless, around 6.5% of the population suffers from neuropsychiatric disorders, reaching 12% in Khartoum State. Studies in the country registered the highest rate of disorders among IDPs, which reached 35% (Osman et al. 2020).

HUMAN RESOURCES FOR HEALTH

Sudan faces challenges in health human resources regarding their numbers, expertise, and distribution, in addition to their poor salaries and lack of work incentives. The situation was exacerbated by the country's general political and economic crises and the challenges posed by COVID-19. In addition, the country suffers from a constant drain of health personnel due to their migration outside the country (حاتم 2021).

Therefore, according to the 2017 Annual Health Report, the ratio of the total health workforce per 1,000 population is 1.9 compared to the global average of 2.35 (جمهورية السودان، وزارة الصحة الإتحادية2021-2024). In addition, the distribution of health workers is not commensurate with population needs. For example, 38% work in Khartoum (34.2 doctors per 100,000 people), and 70% are in urban areas. Moreover, although 70% of the population resides in rural areas, more than half of the doctors' work in Khartoum, while six states only have 1% of doctors each, compared to a national average of 21.3/100,000. Khartoum also has around 1000 specialists, compared to four states with one to ten specialists (جمهورية السودان، وزارة الصحة الإتحادية2021). Furthermore, two-thirds of the doctors are in the secondary and tertiary systems rather than the primary healthcare level (جمهورية السودان، وزارة الصحة الإتحادية2021-2024).

The contradiction in heath capacities and resources between and within states and localities has created a significant discrepancy in the health workforce's absorption, provision, and distribution. Consequently, their ability to provide primary

health services was reduced, weakening the possibility of securing the right to health.

The discrepancy in human resources distribution could be attributed to limited employment opportunities, weak budgets, shortages, unfavorable working conditions, unattractive living conditions (mainly in rural and remote areas), security concerns in conflict-affected areas, and lack of career development opportunities. All of these reasons contributed, directly and indirectly, to the unfair distribution and the migration of health workers to other countries for better employment opportunities and a promising future.

MEDICAL SUPPLIES

Although the pharmaceutical sector in Sudan aims to ensure sufficient quantities of safe, affordable, and high-quality essential medicines, the country is facing a drug availability crisis. In January 2020, drug availability was less than 50% of the target. As a result, imports of human medicines decreased significantly from US$256 million in 2015 to US$159 million and US$161 million in 2018 and 2019, respectively. In 2015, the local pharmaceutical industry accounted for 36% of the total value of medicines in the country, estimated at US$227 million. However, the share decreased to US$80 million in 2017 (جمهورية السودان، وزارة الصحة الإتحادية2021). Furthermore, the cost of medicines is increasing dramatically due to economic inflation.

The free treatment program, approved in 2008, provides medicines for cancer and kidney diseases, heart and eye surgery, children under five, and transfusion and hemophilia services. In 2020, its total budget was US$29,100 million. However, the project faces significant challenges due to the unavailability of medicines, distribution issues, transportation, weak supervision, poor reporting, and a high staff turnover rate.

Each state has been assigned a specialized pharmacist and a program committee to improve performance (جمهورية السودان، وزارة الصحة الإتحادية2021). Vertical programs provide medicines for tuberculosis, AIDS, and malaria free of charge. However, out-of-pocket spending on drugs remains high despite the interventions.

Sudan's National Health Sector Recovery and Reform Policy aims to improve access to essential medicines, health products, and health technologies in a safe and effective manner, of good quality, and at reasonable prices (جمهورية السودان، وزارة الصحة2022

الإتحادية). According to the latest data on personal spending on medicines in 2008, the proportion of out-of-pocket expenditure was 26% (جمهورية السودان، وزارة الصحة الإتحادية2021-2024).

Consequently, the supply of medicines in Sudan is a cause of concern due to increased out-of-pocket spending, rising prices, and the general deterioration of the health sector's performance.

HEALTH FINANCING

The federal, state, and local governments finance the health sector. The federal government supports governmental health facilities using 69.3% of its budget (الصندوق القومي للإمدادات الطبية 2015). The budget director at the Ministry of Finance confirmed that spending on health is carried out according to the approved plan and from the three levels of government (federal, state, and local). In 2018, total health spending amounted to US$2.554 billion, or 4.9% of GDP. The Federal government spends 3.45% of its budget on health. As a result, federal expenditure on health amounted to 23.3% of total spending, compared to 6.7% from external financing (جمهورية السودان، وزارة الصحة الإتحادية2021).

According to the Budget Director at the Ministry of Finance, most national spending on health goes to salaries, operations, maintenance, and projects. Additionally, the NHIF provides 27.6% of expenditures (جمهورية السودان، وزارة الصحة الإتحادية2021). The budget Director added that 2021 public spending on health amounted to about 6% of general government spending. It did not include spending from states, localities, or foreign grants. However, according to the Director General of Health Insurance, the targeted goal for health spending had been set at 15% by the 2015 Abuja Agreement.

Financing the health system is primarily through out-of-pocket expenditures (69.2%) (جمهورية السودان، وزارة الصحة الإتحادية2021). The high rate explains why citizens face financial obstacles in accessing health services. Consequently, the risk of increased impoverishment and catastrophic health spending is rising. For some groups, financial costs are a barrier to access to health services (no less than 60% of citizens). Illnesses may even lead to the impoverishment of those who could pay for the services, often through selling property, especially for incurable and chronic diseases. However, Health insurance guarantees them access to these services without financial obstacles, as stated by the Director General of the NHIF.

According to the Director of Voluntary Organizations, national voluntary organizations also contribute to health spending through various interventions, especially in peripheral areas and areas of conflict. For example, they assist in providing health services, medicines, tents, and saturated mosquito nets. However, it is difficult to obtain information about the amount such organizations spend due to a lack of data.

Although critical steps were taken to strengthen the health financing system in recent years, significant challenges remain. Funding shortages, weak governance, and inefficiency are among the main challenges facing health financing in the country. In addition, the severe economic crisis in the country has led to high rates of inflation, depreciation of the local currency, and scarcity of cash. It resulted from South Sudan's secession in 2011, leading to a significant drop in oil revenues and the ongoing conflicts and wars in South Sudan, then in Darfur, South Kordofan, and other regions. An additional factor is the US sanctions that began in 1997 by freezing Sudanese financial assets and banning economic activities in all their forms. The scope of sanctions was later expanded in 2006 and 2007.

Consequently, investments amounting to US$745,300,000 million were suspended, and the value of seized assets amounted to US$48,200,000 million. In addition, the US imposed fines amounting to US$1,530,000 million on countries violating the American Economic Emergency Act. Thus, Sudan lost the international cover for investment by losing any opportunities for international financing from global or regional financial institutions after the commitment of most countries to the US decision, especially EU countries (نون بوست/Noon Post 2014).

One of Sudan's National Health Sector Recovery and Reform Policy's main elements involved financing public health to improve health system efficiency and provide strong protection from financial risks (جمهورية السودان، وزارة الصحة الإتحادية2022).

The Budget Director stated that preserving the right to health requires developing the country's resources, improving national income, committing the Federal Ministry of Health to set an accurate and precise national budget, activating the institutional follow-up and evaluation mechanisms, and ensuring the clarity and accuracy of the Federal Ministry of Health Budget by specifying expenditure channels.

NEOLIBERAL POLICIES

Neoliberal policies were adopted in Sudan in the 1970s, as the country went through severe economic crises that led it to submit to IMF policies to obtain World Bank and IMF loans. As a result, the government adhered to the recommendations of what is known as the "Sudanese Economy Structural Reform Program," according to which the regime was able to obtain some loans and technical assistance in return for adhering to the IMF prescriptions, which included devaluing the currency, withdrawing subsidies on essential commodities, increasing taxes, and liberalizing foreign trade, among other conditions (عبد الحميد 2019).

Accordingly, health policies guaranteeing citizens' enjoyment of free health services were halted. Indeed, the country did not benefit much from these loans but rather fell into more debt. The negative social impact of IMF policies on poor classes continued, and health, social, and educational services deteriorated, leading to less social justice. Following the lifting of US sanctions in December 2017, the IMF initiated a recommendation paper for Sudan. It instructed the regime to pursue structural reforms to "exploit the opportunity of the US lifting its sanctions in the best possible way." The IMF recommendations included floating the Sudanese pound, a "vital factor for Sudan's economic stability," and unifying currency exchange rates in the Sudanese market. The fund also recommended the abolition of government subsidies on wheat and energy resources and expanding the tax base to collect more money for the state treasury (عبد الحميد 2019). All of this exacerbated the problems, especially for the poor, despite the state's attempts to carry out some remedies, which included direct cash support for the poorest groups, support for bringing the poor under the umbrella of health insurance, and others.

The former Minister of Social Development indicated that the state usually looks at international policies and prepares its national policy based on local knowledge. For example, the World Bank recommended cash support for the poor, while the state's approach was to integrate development and livelihood projects (humanitarian aid based on development) and limit cash support to those who cannot work. She also referred to the concept of solidarity that characterizes the country and its solid social system, where citizens assist their poor relatives, acquaintances, and neighbors, for example. She added that social solidarity had a significant impact on people's resilience.

Finally, she referred to her Ministry's policies promoting social solidarity as a moral issue.

On the other hand, the Director of Financial and Administrative Affairs at the Federal Ministry of Health believes that the World Bank's demand to lift subsidies should be accompanied by mitigating policies. For example, although free treatment had been a highly successful policy, the lack of resources caused by the World Bank's demands reduced its impact.

HEALTH INSURANCE

Health insurance is provided through several institutions, the largest of which is the National Health Insurance Fund (NHIF) (جمهورية السودان، الصندوق القومي للتأمين الصحي2023). Other insurance schemes include regular forces (army, police, and national security), for example, and other institutions. In addition, some individuals receive health services through local and international private insurance companies.

The NHIF is under the Ministry of Social Development and supervises the health insurance departments in various states. It is a solidarity-based institution providing distinguished medical care services fairly, sustainably, and conveniently for beneficiaries. The NHIF aims to cover all citizens. The former Minister of Social Development believes that health is a citizen's right and that her Ministry continues to fulfill this right by providing health insurance to citizens.

In 2020, the number of subscribers to the NHIF reached more than 33.6 million people, or 81.7% of the population (Elfadul & Elfadul 2022). The NHIF provides medical services to all subscribers without discrimination between different sectors. It is particularly interested in poor families and seeks to cover them through several donors. Coverage of poor families began in 2007, and by 2020, 5,787,122 families were covered, representing 71% of the total insured families (جمهورية السودان، وزارة الصحة الإتحادية 2021-2024). The Federal Ministry of Finance covers the cost of most of these families in active cooperation with the Zakat Bureau. In addition, the Federal Ministry of Finance and some organizations, companies, and individuals participate through the White Hands Initiative. As for refugees who put pressure on health services, an agreement has been reached with the United Nations and the UNHCR to include them under the health insurance umbrella, as stated by the finance minister.

The NHIF offers a wide range of medical services compared to many countries in the Eastern Mediterranean region, according to the Minister's statement, which was certified by the WHO. Services even include dental treatment, which is unavailable in most countries' insurance systems. Beneficiaries contribute to 25% of the price of medicines available in the country. The Zakat Bureau covers the amount for those who cannot pay it, according to the Minister whose Ministry the Zakat Bureau reports to. She also noted several complaints from citizens about the unavailability of medicines through the insurance card. However, she believes the problem is not with availability but the diversity of companies providing medication.

It is worth noting that hospital expenditures comprise 80% of the total budget for medical services, reducing funds for primary healthcare facilities, which provide services to more than 75% of the population (جمهورية السودان، وزارة الصحة2021-2024 الإتحادية).

Although the proposition of the insured population is high, the availability of services in rural areas remains a challenge due to the unfair distribution of services and their concentration in urban areas. Consequently, many have to travel long distances to access services.

However, as the Minister said, a lack of understanding of how to benefit from the insurance card is also an obstacle. She also believes that health insurance is the most adequate health intervention. It allows providing services to the poor, contributes to the operation of many health facilities that the Ministry of Health cannot operate, establishes new health facilities in agreement with the Ministry of Health, and offers a wide range of costly medical devices.

Despite the great efforts to increase insurance coverage, there are persistent obstacles to covering the informal sector. The informal sector absorbs poorest and low-income classes amid rising poverty rates, economic crises, and displacement. However, the lack of information and current surveys makes it difficult to accurately project the number of people working informally and targeted by health coverage schemes.

Another data challenge is that coverage indicators are calculated by considering the number of insured issued with a medical insurance card. However, planning experts believe the indicator falls short of expressing the actual coverage rate based on the total number of insured who used the card

to receive health services in a specific sector. Therefore, high coverage rates do not mean the actual use of the card, as reflected in practice. The paradox in health financing appears clearly between high insurance coverage and out-of-pocket spending that exceeds 67%. It shows that most of the population spends on treatment from its own money, despite access to health insurance.

HEALTH INFORMATION SYSTEM

The Ministry of Health has several health information systems. Data is collected from various health facilities, namely primary healthcare units, primary healthcare centers, and all types of hospitals. Reports from rural departments, centers, and hospitals are sent to the centers of the localities. In contrast, the reports of the specialized hospitals and specialized centers are sent to the ministries of health in the states. The information system is a standard paper and electronic system. The data is collected on paper monthly in particular forms and appears on the locality and Ministry's websites. In addition, the data on the Ministry's website can be accessed on the Internet from anywhere. Following the collection, the Department of Health Information, Follow-up, and Evaluation at the Federal Ministry of Health collects and analyzes overall reports and issues the Annual National Health statistical report.

However, the information system is a negative factor influencing the right to health in Sudan. Its shortcomings in completeness, periodicity, and quality of published data on right-to-health indicators are evident. As mentioned previously, there is no data on the health situation in Sudan during the past two years. Most of the information on health interventions targeting vulnerable segments such as IDPs, immigrants, and women is unavailable on the official websites of the concerned departments. It must be obtained, with difficulty, from voluntary and international organizations specialized in health interventions. Furthermore, the health information system does not link the private and public sectors, an obstacle to monitoring health indicators between the two sectors. Furthermore, there is no obligation to share data except in cases during disasters and epidemics.

According to researchers and experts, the health information system's failures came to the fore in the collection and integrity of information on COVID vaccines. The shortcomings are attributed to conflicting information between government

agencies and on-the-ground observations. The conflict also appears in coverage rates between other vaccines and COVID. States that suffer from eternal problems in vaccination coverage, such as Central Darfur and South Kordofan, recorded high rates. While not enough studies have been published on the Ministry of Health data, recent studies dealt with coverage in the states of the Darfur region.

All of the above has meant the lack of indicators reflecting the reality of health for citizens and vulnerable segments. It has led to weakening strategic planning to preserve the right to health and affected decision-making related to health, in general, and the right to health, in particular.

ACCOUNTABILITY AND REFORM MECHANISMS

The mechanisms for accountability and reform in the health system are multiple. They start with the legislative body, which presents annual reports to the Minister of Health and asks him to respond to any questions received from deputies. Next, the Minister directly presents the periodic reports to the Services Committee of the Council of Ministers and the annual report to the Council of Ministers.

The Supreme Council for Health Coordination, chaired by the Head of State, reviews the performance of the health system and health-related ministries and the extent of their coordination with the Ministry of Health. The Medical Council and the Health Professions Council investigate medical errors by medical personnel and issue appropriate penalties that could amount to withdrawing work permits. The General Audit Bureau reviews financial and administrative performance and presents an annual report to the legislature.

According to the 2021 World Bank report on governance indicators, namely the Voice and Accountability Index, Sudan's progress since 1996 was scored -1.47, indicating failings in accountability and citizens' ability to claim rights. The highest reached by Sudan was in 2020 after the December 2019 Revolution, accompanied by an immense interest in reforming state systems and legislation to preserve human rights and implement monitoring and evaluation tools to achieve the Revolution's slogan, "Freedom, Peace, and Justice." Nevertheless, several obstacles to accountability were mentioned by interviewed officials and in discussion groups in the national consultative workshop. They are summarized in the following points:

- A weak culture of accountability and claiming rights at the competent authorities and relevant institutions.
- Lack of awareness among citizens of the fundamental rights guaranteed by the state and the relevant authorities entrusted with preserving and monitoring human rights.
- There is no publication and exchange of information on the recommendations of the last meeting of the International Review Mechanism at the level of senior management

and directors of public departments in the Ministry of Health. However, a representative of the Ministry of Health was present in the national mechanism. In addition, no plan exists to follow up on the implementation of the recommendations approved by the national mechanism regarding health. Nevertheless, the Secretariat of the National Mechanism at the Ministry of Justice provided the health representative with all the information related to health recommendations discussed in the international review mechanism to share with the relevant departments and follow up on their implementation in the next four years.

- CSOs play a limited role in accountability, especially in raising awareness about rights and building the capacities of society and vulnerable segments. For example, the representative of persons with disabilities stated that "the role of civil society organizations is almost minimal, and there are no initiatives to adopt issues of the right to health systematically. Rather, there are individual efforts of organizations or persons to advocate for specific issues, such as sexual violence or ethnic discrimination.

On the other hand, political instability and the consequences of the October 25 decisions slowed the implementation of interventions and plans for institutional reform in the relevant Ministries. Thus, according to the representative of the Secretariat of the National Mechanism at the Federal Ministry of Justice, they cast a shadow over monitoring, follow-up, and the promotion of all rights, including the right to health.

CONCLUSIONS AND RECOMMENDATIONS

The following conclusions were formulated based on the above information and a framework consisting of three themes: respect, guarantee, and performance, by which human rights are measured.

In terms of respect, the extent of the state's diligence in concluding covenants, harmonizing national legislation, and passing laws to preserve rights when necessary is evident. It could be said that Sudan has made an appreciable effort in concluding international covenants, working to harmonize national legislation, and establishing mechanisms to follow up on human rights, including the right to health.

Several laws and legislations were adopted to guarantee access to the right to health at all times (peace, war, and epidemic) and for all groups without discrimination or exception. Sudan included health and education among the priorities of the transitional period. National strategies and plans have been developed in line with the SDGs and take a health perspective in all policies as a framework to ensure the complementarity of roles between the relevant authorities and ministries in preserving the right to health.

Moreover, the right to health was guaranteed through interventions to ensure and secure access to health services by providing health insurance and continuing Zakat support. The health system also offers free emergency treatment and treatment for children under five, patients with kidney failure, heart catheterization, and other procedures. At the planning level, Sudan has worked to strengthen the health system in fragile, less developed, and conflict areas through particular interventions, including policies to retain staff and expand the contribution of national and international organizations to health services during conflicts.

In terms of performance, health indicators point to the poor health of Sudanese citizens. The burden of diseases is concentrated among vulnerable segments and in rural and less developed areas. This reality appears in the discrepancies in access to essential health services between Khartoum, the capital, and major cities, on the one hand and other towns

and villages, on the other. In addition, the health system shows weaknesses in its six components, primarily financial and human resources and drug supply. These weaknesses have led to the unavailability of health services for the most common ailments and childhood diseases. The COVID-19 pandemic exhausted health services. However, health subsidies, including health aids and training, increased hospital readiness for emergency services and expanded infection control.

The political situation remains one of the most influential determinants of health performance. Political instability has obstructed the implementation of the transitional period's priorities in the health sector. Political transformations created confusion in public administrations at the central and state levels, blocking operational plans. On the other hand, the transitional period saw many strikes by health workers, adding to the deterioration of health services in the public sector. In addition, citizens became reluctant to use government health facilities due to the unstable receiving. Thus, they started using the private sector and incurred exorbitant expenses.

In war and conflict regions, the importance of political stability is evident in securing peace and ensuring the continuity of sustainable development, closely linked to other fundamental rights related to health, namely the right to life, food, peace, environment, and development. The complex political situation faced by the current Sudanese government, lack of recognition by the international community, and international pressure also profoundly impact Sudan's performance in the right to health. For example, removing health subsidies impeded services, drug and medical supplies, and staff training. Indirectly, it led to freezing plans and activities on other human rights related to health, such as food, peace, development, and the environment.

The following recommendations are based on the interviews and reviewed literature:

- Achieve political stability with national consensus and provide security and stability for conflict areas.
- End the economic decline, develop the country's resources, and raise the national income.
- Spread a culture of knowledge of health laws, legislation, plans, policies, and accountability of implementation agencies.

- Control governance and build the capabilities of states and localities in leadership, management, and resource mobilization.
- Develop an accurate and precise national health budget, define spending channels, activate monitoring and evaluation mechanisms, provide the necessary financial support to implement plans, and commit to implementing government health financing of at least 15% of the national income.
- Increase citizens' awareness of their rights and duties, and promote active community participation in planning and supervision.
- Expand social security mechanisms and networks, such as Zakat and NHIF.
- With regard to the health sector's human resources, coordinate with health-related authorities such as the Ministries of Higher Education, Finance, and Labor to ensure the production, employment, motivation, and retention of health personnel and find incentive packages to retain positions with the highest need and the least developed areas. In addition, put in place the necessary remedies to reduce the migration of health personnel, improve the health system's capacity to absorb staff, and create jobs for midwives, health assistants, and medical assistants, among others.

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