

FSP

Executive Summary

Sudan has experienced serious economic and social challenges affecting the public health sector and its efforts to improve the general health situation. Sudan's large territory is a major issue and the 20 year old internal conflict has diverted resources away from improving social sectors and health outcomes. In 2002, Sudan ranked at 139 out of 173 countries.

The major governmental revenue is from oil exports and although half of the population works in the agriculture sector their contribution to the overall economy is low. Despite these imbalances, GDP per capita is on the increase and has grown from US\$ 360 in 2000 to US\$ 578 for in 2004¹: for 2005, it is expected to reach US\$ 589.

Despite increases in funding levels, total public health expenditures are not a substantial share of total expenditures, representing only 2.3%, 1.7% and 1.6% of total public expenditures. As a percentage of GDP, public health expenditure was only 0.28% in 2001, 0.23% in 2002 and 0.26% in 2003.

However, Government allocations towards health has been increasing and public health expenditures per capita has both been increasing from US\$ 1.3 in 2001 to US\$ 3.3 in 2004. This has been largely due to increased in central tax revenues generated by the oil exploration industry. The signing of the Comprehensive Peace Agreement (CPA) in early 2005 augurs more increase in health spending from national resources in the coming years.

Since its start in 1976, the Expanded Programme on Immunization (EPI) has expanded and currently offers six traditional antigens in its routine programme to reduce vaccine preventable diseases. In 2005, the programme introduced a last antigen, Hep B, at first, as a pilot in 3 States but with plans for a national roll out. The programme offers its services through the public health sector network through fixed, outreach and mobile services. Access to fixed immunization services is estimated at less than 50% of the population in the whole Sudan. When transportation means are available, mobile teams conduct immunization activities in remote areas in an irregular manner.

In addition to its routine programme, the country also has conducted large supplementary immunizations activities for polio, measles, maternal and neonatal tetanus and vitamin A. The country has been polio free up to 2004, when the polio virus was re-introduced in the country, necessitating large mop- up activities in form of National Immunization Days (NIDs) and sub NIDs. Measles is still an endemic disease, while high risk approach through campaigns is being used for achieving the MNT elimination. Vitamin A capsules are distributed during the polio vaccination days.

¹ Provided by DG/Planning/FMOH, May 10th, 2005.

The EPI strategy is to increase the coverage rates, which was 74% in 2003, and immunization objectives are to increase the proportion of children under 1 year of age to be fully immunized against the 6 traditional VPDs in all Localities to 95% by the end of 2008. In addition, it seeks to eradicate polio by 2005 and measles by 2010. The polio eradication objectives have been delayed because of the re-introduction of the polio virus through neighboring countries. In late 2005, the EPI will design a new MYP for the period 2006-2010. New elements and foci may result from this MYP.

Decentralization was introduced in the mid-1990s, where responsibility for government health system management was devolved to the States and localities. The Federal Ministry of Health (FMOH) is linked to 26 State Ministries of Health (16 of which are in the geographic north of the country). Within each State there are a number of localities (134 in total) managed through Health Area Systems, based essentially on a district health systems approach. This approach was prioritized by the Federal Government and the Federal Ministry of Health within the overall framework of decentralization, has delegated the planning and implementation role to the Localities for a lower and more effective level. Micro planning of EPI activities is among other services and much attention is to be directed towards raising their awareness and prioritization of immunization services. Nevertheless, the Federal EPI programme remains the governing entity supervising, monitoring, supplying and ensuring nation-wide immunization goals are realized. The donor agencies namely WHO, UNICEF and at times the UN Foundation have supported the EPI since it had commenced in 1976 and their input and commitment since then has been substantial. GAVI have joined with the introduction of the Hep B vaccine, as well as immunization services support, injection materials and other funds.

The total cost of the immunization program was (in US\$ million) 24.7, 25.7 and 21.5 in 2001, 2002 and 2003 respectively which include also supplementary immunization activities. Routine activities constituted 72.1%, 71.2% and 93.5 % of the total EPI expenditures during these years. The decreases in the amount of funding from 2001 to 2003 are explained by the fact that supplementary immunization activities, which were conducted in 2001 and 2002 constituted the added amounts in the expenditures.

It is worth noting that the FMOH and States/Localities share of the cost of EPI increased from 57% in 2001 to 69% in 2003 while the rest was funded by external partners. During this period, local resources funded salaries, maintenance and overhead, transportation costs of vaccines and materials, and shared costs of buildings and personnel principally. And external resources funded vaccines, injection materials, campaigns' operational costs, surveillance and monitoring, training and capital costs.

For the projection periods, the first year of projection was considered 2004 in the spreadsheet tool and the last year of the projections is 2010, three years after the end of the GAVI fund. The projections reflect the EPI objectives of increasing coverage to 90% in 2007 and 95% by 2009, matched with necessary increased of resources. Also up to 2008, the program will continue fairly large supplemental immunization activities, especially for polio eradication to match the synchronized campaigns with neighboring countries. On the short term and up to 2010, the EPI will need to increase staffing and training at the Localities level, continue the replacement of the cold chain and the transportation fleet, and continue strengthening the immunization surveillance

system. These objectives need to be carefully planned and complemented by committed financial resources.

Based on these planned activities, the EPI programme costs increase to US\$ 36 million in 2004, increase to a very high US\$ 53.1 million in 2005, level around US\$ 40 million in 2006 – 2008 and drop to pre projection levels of mid US\$ 20 millions in 2009 and 2010. There is also a shift in the programme funding during the projection years compared to the pre projection period. During the projections, national resources decrease as a percentage of the total funding to lower levels, between 30 to 40 percent of total funding with the rest being funded by external resources. This is principally due to the enormous requirements that are anticipated for the supplemental immunization activities which will be funded by donors. However, despite this shift, the projections also show increased local resources funding for items that have been traditionally supported by donors: traditional vaccines and injection supplies are two key items that the Federal EPI program will advocate for more support from both the Federal Government and the States/Localities governments. A multi year staged approach for the local resources funding is proposed whereas the local resources would start funding injection equipment and vaccines in annual increments as early as 2006 and 2007 respectively. In addition, the Federal EPI programme will advocate States/Localities to begin shouldering the full costs of training, IEC/Social mobilization and outreach/mobile activities. For the latter, although the projections reflect increasing costs for the fixed sites strategy, outreach and mobile activities will still be needed to ensure the programme is reaching population in need.

The total future cost of the programme for the entire projection period (2004 to 2010) amount to US \$ 265.5 million. Of this amount a total of US \$ 221.2 million can be considered secure funding, resulting in a gap of US\$ 44.3 million. When considering probable funding, the gap is reduced to US\$ 15.7 million. Further analysis shows that the funding gap starts as early as 2005 (as of the writing of the FSP) with a funding shortfall of US\$ 2.2 million for capital items. The gap continues in other years and principally affects capital items. Other items left unfunded are in small amounts and discussions with international donors should be able to secure funding for them.

In a close overlook to the EPI plan, evidence suggests that the overall situation would be sustainable, given that the share of the gap from the total cost is due to the lack of knowledge about who can fund capital items specifically. Discussion with either donors or with the Federal government could ensure the funding of capital costs and ensure the sustainability of the proposed EPI plan for the period 2004-2010 but more specifically 2005-2010. Nevertheless, a couple of underlying risks may arise which are mostly beyond the control of the health system. Examples of such risks are; epidemics or disasters and most importantly the overall growth of economy and its alignment with the population growth as well as the dependency of the economic growth on oil production and exports. On the other hand, a couple of opportunities are foreseen in the future which would have positive implications on the EPI plan. The interest of new donors such as the World Bank, the UN and a consortium of new donor, and the fact that immunization activities are major interventions to reduce child and women mortality and morbidity increase the chance that the Sudanese EPI programme will receive the necessary required funds. It is likely that several components of the EPI plan could be included in forthcoming donor programme and projects.

The EPI programme would like to use the following strategies to increase the financial sustainability of the program:

1) Mobilizing additional resources

- FSP advocacy to Federal Government for additional resources and an “immunization line item” during budget discussion
- Stretching, re-aligning and increasing the period and amount of GAVI support to the end of the projection period
- Ensuring and maintaining the current support
- Creating new financial support

2) Improving the program efficiency

- Reducing vaccine wastage of the Hep B vaccine,
- Training Localities personnel in vaccine management
- Investing and continue the refurbishment of the cold chain and vehicles replacement
- Restarting an IEC/social mobilization to attract population.

3) Increasing the reliability of the available resources

- Conducting to local authorities
- Increasing the profile of ICC members from the Federal government.

This Financial Sustainability Plan will be used as an advocacy tool and will be vital in mobilizing resources. With the strong government commitment and the partnership of the external partners and using this detailed financial plan for mobilizing more resources, there is a high degree of expectation that the financial gap of either US\$ 44 million or US\$ 15 million can be closed.