Experience in Collaborative Work in Healthcare

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Background: It is clearly evident to the visitor of Sudan that the economic growth over the past 10 years has improved the lives of many people in the Sudan. Despite the political turmoil and the international pressure a boom in infrastructure, manufacturing, construction, power and some services sectors is quite evident. Healthcare in the Sudan, however, remained lagging behind and is still considered one of the worst in the world. This is a report of our experience in collaboration with health institutions in Sudan with critical assessment of the state of healthcare delivery.

The state of Healthcare in Sudan:
The deterioration of health services is attributed to several factors:

1. Absence of preventive health programs: Despite the availability of funding and manpower, the simple fundamental disease prevention principles of awareness, disease surveillance and treatment, and hygiene are largely ignored.
2. Lack of vision for healthcare planning: In the absence of accurate health statistics, it is impossible to accurately assess the magnitude of health problems, and prioritize allocation of resources.
3. Lack of advanced healthcare facilities: Currently healthcare facilities are either run by the Ministry of Health (This comprises the major public hospital and clinics in Khartoum and throughout the country, and probably account for 80% of healthcare facilities in the country), the armed forces hospital, the police force hospital, University of Khartoum (SUH). The remaining facilities are privately run hospitals and clinics that range from few beds to 50 bed hospitals. In a recent unofficial survey none of those facilities met minimum international standards.
4. Lack of proper training of healthcare personnel (Physicians, nurses, and allied health professionals). Most physicians have either received partial training in Europe or received substandard training in Sudan. Nursing and allied health professional are similarly under-trained.
5. Compensation for medical doctors and healthcare professionals remained extremely poor, which led physicians to either have private evening offices, or work in private hospitals in off duty hours. Many doctors do not feel obligated to spend time in these hospitals, nor work towards improving their practice.
6. Commercialization of healthcare: With the economic growth, over the past decade, private health clinics and hospitals have proliferated all over Sudan, and particularly in Khartoum. While these facilities proved to be cleaner and somewhat more efficient, the quality of care they delivered is clearly suboptimal. Many foreign and local companies now provide some sort of health insurance to their employees and reimburse these facilities handsomely. The rest of the population has to pay out of pocket to be seen and treated. It is understandable

that it is important for these facilities to cover operating costs and achieve a margin of profit. It is unfortunate, however, that this has led to exploitation of the sick and their families, who often pay large amounts of money anticipating to receive care. In many instances the care they receive is substandard and may have immediate or long term harmful consequence.

7. Lack of regulations and monitoring of health care facilities and professionals: In the absence of regulations set forth and mandated by the ministry of health or the Sudan Medical Council, and in the absence of practice guidelines, it is up to the individual practitioner or facility to set their policies. This lack of oversight, and absence of accountability does very little to ensure the safety of the millions of people who seek medical care.

My experience: My area of expertise is in liver disease, so I was particularly interested in doing some related work in Sudan. In the absence of a dedicated organization, I attempted a modest individual effort to collaborate with healthcare professionals from Sudan to share my knowledge, and transfer my experience in an attempt to improve some of the aspects of liver disease in the Sudan. In October 2004 I invited a professor of Surgery from the faculty of medicine, University of Khartoum, and a former Head of the Department of Surgery to spend a few months at the division of hepatobiliary and liver transplantation at the Lahey clinic in Boston to gain some perspective on the modernization of the practice of medicine in general and in the surgical aspects of liver and pancreatic disorders. His visit albeit short, was extremely successful and was a nucleus of collaboration between the Lahey Clinic and Soba University Hospital.

Over the past 2 years I made 3 trips to the Sudan where I talked to the Academy of Medicine and Technology Annual Conference in the Friendship Hall in January 2005. In June 2006 I talked to the Faculty of Medicine University of Khartoum weekly surgical club and gave a commentary at the monthly Sudanese Gastrointestinal Society at the Khartoum Hilton. In my preparation for these talks I realized that liver disease constitutes a serious health problem in the Sudan that is either ignored or poorly dealt with. Viral hepatitis is endemic in Sudan, with 8-15% of the population infected with hepatitis B, 1-2% with Hepatitis C. Liver cancer is among the top 3 killers of adults in Sudan. The talks ignited some debates and discussions, which I found interesting and useful. It also gave me insights into the priorities of the decision makers in Sudan.

In March of 2007 together with a surgeon from Saudi Arabia we hosted the Hepatobiliary workshop at Soba University Hospital in Khartoum. The aim of the week was:

1. To provide treatment to patients with conditions that require advanced surgical treatment currently unavailable in the Sudan
2. Introduction of new instruments in Surgery
3. To promote awareness of the magnitude of liver problems in Sudan
4. To train surgeons in liver and pancreas surgery
5. Teaching of nursing staff new aspects in patient care

The week included a series of lectures in various aspects of liver and pancreas diseases. We performed several advanced surgical procedures that included pancreatic and liver resection. The procedures were live broadcast to an audience in a lecture hall in the hospital and were attended by several surgeons in various stages in their career (house officers, registrars, junior and senior surgeons). Both senior surgeons and surgeons in training learned the basic concepts and techniques in performing liver surgery. The daily postoperative rounds were an excellent opportunity to interact with the ICU staff and implement simple aspects of critical care. Despite the poor planning the week was a success, and in my opinion achieved, or exceeded, its set goals. Future similar workshops are in the works. We are also working to bring some young surgeons for training courses here in the United States.

Conclusion: Healthcare in Sudan is chaotic and fragmented. Major organized effort is required to make significant change in the philosophy and practice of healthcare. With very little effort, we can make an enormous impact.