

Country Cooperation Strategy for WHO and Sudan

2003–2007



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ABBREVIATIONS

AFP	Acute flaccid paralysis
AIDS	Acquired immunodeficiency syndrome
APW	Agreement for performance of work
ARI	Acute respiratory infection
BCG	Bacillus Calmette–Guerin
BDN	Basic development needs
C/TSA	Contractual/technical service agreement
CA(P)	Consolidated appeal (process)
CBI/O	Community-based initiative/operations
CCS	Country cooperation strategy (WHO)
CEM	Country economic memorandum (WB)
CMH	Commission on Macroeconomics and Health
CSA	Contractual service agreement
DHS	Demographic and health survey
DOTS	Directly observed treatment, short-course
DPT	Diphtheria, pertussis and tetanus
EHA	Emergency and humanitarian action (WHO)
EMRO	Regional Office for the Eastern Mediterranean (WHO)
EPI	Expanded programme on immunization
EWARN	Early warning and response network
FAO	Food and Agriculture Organization of the United Nations
FGC/M	Female genital cutting/mutilation
FMoH	Federal Ministry of Health
FT	Fixed-term
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross domestic product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoS	Government of Sudan
HAMT	Health area management team
HATCI	Horn of Africa Tuberculosis Control Initiative
HF	High frequency
HIPC	Highly indebted poor country
HIV	Human immunodeficiency virus
HOAI	Horn of Africa Initiative
HQ	Headquarters (WHO)
ICRC	International Committee of the Red Cross
IDPs	Internally displaced persons
IGAD	Intergovernmental Authority on Development
IMCI	Integrated management of childhood illnesses
IMF	International Monetary Fund
JPM	Joint planning mission
JPRM	Joint programme review and planning mission
LC	Local costs
MDGs	Millennium development goals

MDT	Multidrug therapy
MICS	Multiple indicators cluster survey (UNICEF)
MoH	Ministry of Health
MOSS	Minimum operational security standards
NDA	National Democratic Alliance
NDA	National Democratic Alliance
NGOs	Nongovernmental organizations
NIDs	National immunization days
NTA	National training activities
OCHA	Office for the Coordination of Humanitarian Assistance
OLS	Operation Lifeline Sudan
OPD	Outpatient department
OPV	Oral poliomyelitis vaccine
ORCHC	Office of the United Nations Resident and Humanitarian Coordinator
PHC	Primary health care
RAMS	Regional activity management system
RBM	Roll Back Malaria
SAF	Sudan assistance framework
SPLM/A	Sudanese People's Liberation Movement/Army
SRRA	Sudan Relief and Rehabilitation Association
SSA	Special services agreement
STP/G/C	Short-term professional/general/consultant
TB	Tuberculosis
TLG/P	Term-limited general/professional
ToR	Terms of reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCHR	United Nations Centre for Human Rights
UNDAF	United Nations development assistance framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
WB	The World Bank
WFP	World Food Programme
WHO	World Health Organization
WR(O)	World Health Organization Representative (Office)

1. INTRODUCTION AND EXECUTIVE SUMMARY

The WHO Country Cooperation Strategy (CCS) is a reference framework for decisions influencing a Member country's health sector in the medium-term. In developing the CCS the country's needs and expectations with regional orientations and global priorities for public health are considered. The key principles that govern WHO's search for new strategic agendas at country level are:

- Greater focus on what to support in the country health sector.
- Greater flexibility within precise boundaries for response.
- More emphasis on WHO's role as policy adviser and broker.
- Wider partnerships and greater attention to partners' strategies and activities.
- Maintenance of the visibility and credibility of WHO and differentiation of WHO's work and performance from that of the government.
- Guidance for achieving the health sector related millennium development goals (MDGs).

Within the four global, strategic objectives of reducing excess mortality, morbidity and disability, promoting healthy lifestyles and reducing risk factors, developing health systems, and framing policies that are enabling for the health sector, WHO identifies five distinct functions for its country offices:

- Supporting long-term implementation of routine activities.
- Catalysing adoption and adaptation of strategies; seeding large-scale implementation.
- Supporting research and development; monitoring health sector performance.
- Sharing information and knowledge; providing policy options; standards; advocacy.
- Providing policy advice; serving as broker; influencing policy, action and spending.

The CCS process for Sudan started in late 2002 with a preliminary situation analysis conducted in parallel at country, regional and headquarters levels. Following this, in November 2002, the first working session was organized comprising of the WHO country office staff and staff from the Nairobi sub-office for southern Sudan, the Regional Office for the Eastern Mediterranean (EMRO) and HQ, who consulted and exchanged ideas with national and international counterparts and partners. Between December 2002 and June 2003 these notes were consolidated in a first draft outline. A second working session took place in June 2003, during which the strategic outline was discussed with partners and additional information gathered. In between the two sessions, the process was influenced and enriched by parallel sectoral and intersectoral initiatives (e.g. studies and consultations for health recovery planning, and a major overhaul of the United Nations humanitarian coordination mechanisms in Sudan).

Sudan's civil war spans more than four decades and has resulted in more than 2 million deaths and over 4 million displaced people. Well over 50% of the population lives below the poverty line. The health and nutritional indicators depict an unacceptable reality, and the country and its international partners must be quick in grasping the current opportunities of peace and recovery. It is in this context that WHO wants to reduce unnecessary mortality and morbidity and provide access to an equitable and financially fair health system.

In the CCS process four specific strategic directions have been identified for WHO in Sudan for the period 2004–2007:

- 1) Stewardship. Health deserves a central position in the broader peace and macro-development agenda of the country: WHO will act as an advocate and play a proactive role in policy formulation, priority setting and strategic planning for the health sector.
- 2) Health systems development. Sudan needs health systems that are equitable and fair, i.e. based on a comprehensive view of the determinants of health. WHO will contribute technical leadership, capacity building, integrated delivery of services through primary health care, public-private partnerships, research, health intelligence and monitoring.
- 3) Reducing burden of diseases. Sudan's burden of mortality and morbidity must and can be reduced. WHO will continue long-term support for selected programmes, address priority and emerging issues, promote healthy lifestyles and improve the quality of life with a special focus on the most vulnerable and underserved segments of the population.
- 4) Responsiveness. Sudan's exceptional circumstances and the fast pace of change pose extreme challenges to people's survival and healthy livelihoods. WHO will work at strengthening the knowledge, institutional resources, technical and managerial capacities and mechanisms that are needed for an effective response to all health aspects of emergencies, humanitarian assistance and the peace process.

Until 2003, most of the human, financial, institutional and managerial capacities that WHO provided for public health in Sudan were concentrated in government-controlled¹ areas, although some technical assistance to non-government controlled areas was channelled through Operation Lifeline Sudan (OLS). WHO's unique responsibilities in humanitarian action, the demands of the peace process and the challenges of health sector recovery, require consolidated planning and management for the entire country and a reallocation of resources. WHO country cooperation in Sudan will need to be sufficiently flexible to aid the country's progress and to respond to the emerging requirements of national macro-economic policies and the peace process. In the period 2004–2007, WHO Sudan will have to:

- Shift from mainly programme support to strategic planning and management.
- Decentralize technical presence across the country.
- Build new partnerships and alliances across and around the health sector.
- Upgrade its structure for greater efficiency and operational and administrative flexibility.

This document, which reflects the situation as at the end of September 2003, illustrates the rationale behind these strategic, technical and managerial transformations.

¹ In this document, the terms government and non-government controlled are used to differentiate between areas that are or are not reliant on administration and funding from the central government.

2. GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

2.1 Demography and main health status indicators

Sudan borders the Red Sea and nine other African states. With a total land area of 2.5 million square kilometres, Sudan is the largest country in Africa. Sudan is a multicultural and multi-ethnic society. The country is a federal state, divided administratively into 26 states. The climate is arid in the north and tropical in the south, where the rainy season lasts from April to October.

Sudan's last census took place in 1988 (a new census is planned for 2004). In July 2002, the total population was estimated at 31 million of which 27 million live in the north. Estimates for the population of the south vary between 5 and 8 million. With an annual growth rate of 2.6% and fertility rate of 5.9 (5.1 in urban and 6.5 in rural areas), young people dominate Sudan's demographic structure: 16% of the population is less than 5 years and 45% less than 15 years. The health indicators are poor: life expectancy at birth is 56 years, and the disability-adjusted life expectancy is around 43 years. Overall, the other health status indicators, mirror the north–south differentials (Table 1).

2.2 Governance

Sudan gained independence from Britain in 1956. Since then, the country has experienced severe political instability, of which civil war in the South has been one important, but by far not the only feature. The political dynamics of the 1960s, 1970s and 1980s were strongly influenced by those of the Cold War. This changed significantly in the late 1980s, when Islamic-oriented governments started dominating the political arena. A new constitution drawn up in 1989 was partially suspended in 1999, and the opposition boycotted the presidential and parliamentary elections that were held in December 2000. Relations with neighbouring countries and dialogue with the international community have been altogether difficult, especially in the last ten years, and this applies to the government as well as the Sudanese People's Liberation Movement (SPLM).

Table 1. Main health status indicators, Sudan

	North	South
Infant mortality rate per 1000	68	82
Under 5 mortality rate per 1000	104	132
Maternal mortality rate per 100 000	509	365–865

Source. UNFPA. Safe Motherhood Survey 1999

2.3 A protracted and devastating civil war

Sudan's civil war spans more than four decades and started with a military mutiny in the south in 1959. The first crisis came to a close in 1972, but flared again in 1983. Since its start, the war has led to more than 2 million deaths, over 4 million displaced people, and the emigration of most of the intelligentsia. The conflict has also impacted on neighbouring countries. In general, the long war has limited political debate all over the country and has become the major focus of social and economic processes.

Since 1997, the SPLM has controlled much of the south. Recently, the SPLM and the government started direct negotiations under the auspices of the Inter-Governmental Authority on Development (IGAD). A protocol signed in Machakos in July 2002 was followed by other agreements and negotiations are still ongoing. Informed sources expected "peace in the first six months of 2003."

However, the war, is complicated by second-tier conflicts that reflect subregional and local ethnic grievances and conflicting interests in the war economy, as well as cross-border tensions and active disputes with neighbouring states, including Uganda and Eritrea. The political history of Sudan is marred by repeated coups, and armed conflict also affects the west and the east of the country. In this respect, some political commentators note with concern that civil society bodies and some political parties have had little or no voice in the peace negotiations.

The outcome of the peace process will depend on difficult arrangements, possibly including a re-definition of Sudan's federalism, some sort of power sharing in the south and the redistribution of oil revenues. It is unlikely that the antagonisms that have spawned civil violence for so long will disappear immediately with the cessation of formal hostilities, but security will improve. Previously inaccessible areas have opened up and others will follow soon. Equitable and transparent humanitarian assistance will carry considerable weight in the peace process.

2.4 Economy

Sudan is rich in terms of natural and human resources, but economic and social developments have been below expectations (CEM). Sudan is a highly indebted poor country and has one of the most complex and heavy debt situations in the world. In 2001, the gross domestic product (GDP) per capita was estimated at US\$ 395, and the stock of the debt amounted to over US\$ 20 billion, most of it in arrears. Military expenditures-more than US\$ 1 million per day, an estimated 27% of total government budget, and other non-development expenditures leave little resources for the social sectors. In Sudan, well over 50% of the population live below the poverty line. Projections for 2002 estimated agriculture contribution to GDP as 38.4%, industry as 17.9% and services as 41.7%. Most of the rural

Socio-cultural profile

The literacy rate is 46.1% (male 57.7% and female 34.6%).

The official language is Arabic. In urban areas English is also spoken.

Legal system is based on English Common Law and Islamic Law.

Islam is practised by 60% of people; animism by 25% and Christianity by 15%.

(UNDAF 2002)

population is subsistence farmers and pastoralists, often nomadic. The economy, at household and community level, suffered in the 1970s. In the early 1990s, Sudan's external debt arrears became unsustainable, and the country could no longer obtain international loans. Since then, there have been improvements. A rise in the industry's share of GDP accompanied investment in oil exploration in the 1990s. Inflation, which exceeded 100% in the mid-1990s, fell to 6% in 2000.

At present, economic growth, driven by the inflow of foreign capital, is strong² the government's structural adjustment programme has the approval of the International Monetary Fund (IMF), and relationships with the international financial community and neighbouring countries have improved. The advent of peace would allow the country to take advantage of its many assets—a rich agricultural/livestock resource base with considerable export potential, sound medium-term prospects for the oil industry, a dynamic private sector, a rich and talented diaspora abroad, and the goodwill of a number of donors to support the peace process. What will be critical at that point is how much, how promptly and how equitably will be the people of Sudan be able to adapt to, and reap benefits from the economic transition.

2.5 Threats and vulnerabilities

The ongoing and protracted civil war, recurrent floods, droughts, storms, and the wide range of endemic, epidemic and epizootic diseases constitute important health and environmental threats, which have intricate impacts on the economic and socio-political processes of the country. Furthermore, at least three of the nine countries bordering Sudan are suffering from active, violent internal conflicts.

Sudan's geographical features, as well as its history, contribute to its baseline vulnerability. In such a vast and sparsely populated country the most evident factors are related to the high cost required to establish and maintain any meaningful infrastructure, a weak economy, poverty and socio-political instability. Sudan has the largest population of internally displaced persons (IDPs) in the world (3 to 4 million according to rough estimates). Of these, an estimated 1.8 million live in the Khartoum area, around 900 000 in other government-controlled areas and 1.5 million in non-government controlled areas. In 2001, Sudan was host to 350 000 refugees from neighbouring countries. In addition, 3.5 million Sudanese are considered to be vulnerable and include people living with HIV/AIDS as well as food insecurity and flood-affected people.

More precisely, the number of people living below the poverty threshold countrywide and those inaccessible in the non-government controlled areas outline a picture that is more composite and wider than the one accepted by conventional wisdom (Figure 1). For instance, the people in need of relief that are living in the increasingly accessible areas of the non-government controlled areas are estimated to be in the range of 500 000–600 000.

² 5% according to the Economist Intelligence Unit, July 2002

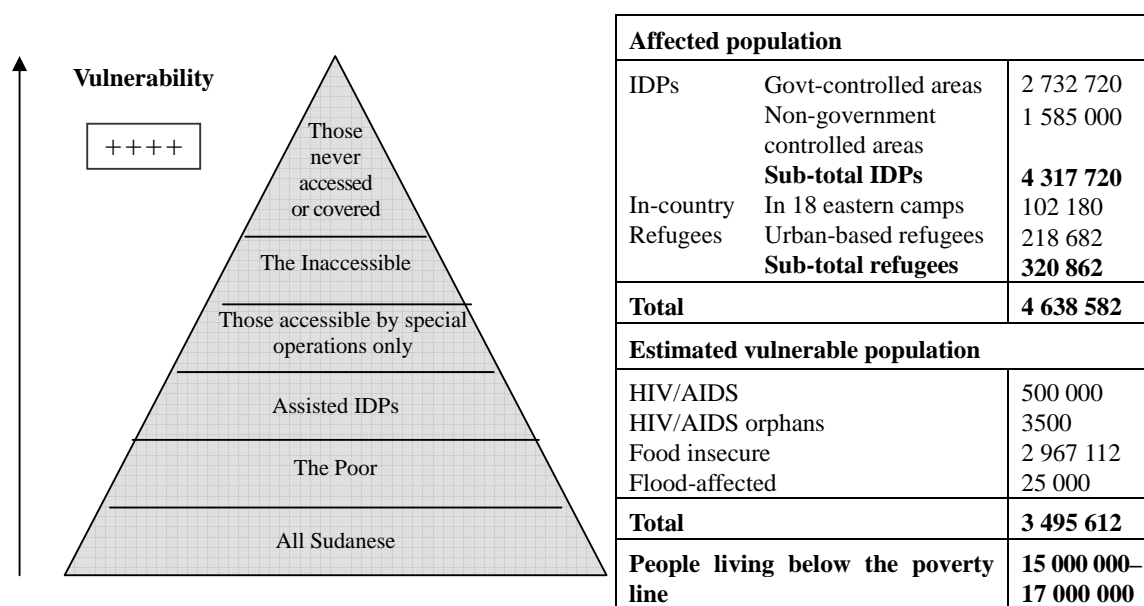


Figure 1. Sudan: different aspects of vulnerability

At present, approximately 1.4 million people are beneficiaries of food aid, but the World Food Programme foresees an increase of 20%–30% in food aid needs due to rainfall shortage and limited land cultivation during the current year. However, forced displacement and seasonal subsistence migration hinders any precise assessment. The variations in indicators from state-to-state and the low coverage attained by relief in non-government controlled areas (Tables 2–6) point to the existence of fairly large non-accessed, and possibly not-yet-recognized groups and areas, whose vulnerability could be extreme. The fact that population estimates for the non-government controlled areas oscillate between 5 and 8 million should be taken as the ultimate indicator of vulnerability.

2.6 Challenges

- The anticipated influx of new donors, and humanitarian organizations as well as additional funds in the first months of peace will require close coordination so as to maximize the benefit.
- Sudan is at the same time vulnerable to external shocks, recurrent natural events, a high burden of tropical diseases, epidemics, including the recent resurgence of yellow fever, and the new pandemic of HIV/AIDS.
- Not all stakeholders have been represented and involved in the peace process.
- Humanitarian action is conducted in the South by UN agencies and nongovernmental organizations (NGOs) under OLS agreement, and in close collaboration with local authorities, but coordination is still in its infancy, just as in Khartoum and Nairobi.
- All the parties in Sudan do not perceive the international community as a neutral broker.

- Poverty is very much associated with the war in Sudan: for the peace dividends to be evident to the Sudanese people, the transition will have to deal with a wide range of needs and expectations (as well as with a macro-economic structural reform).
- The crisis in Sudan and its resolution are intimately connected with the analogous processes taking place in neighbouring countries. The country's transition to peace will need to be envisaged in the subregional context.

Morbidity and mortality

Under-five morbidity: the bulk of outpatient department consultations is constituted of diarrhoea (23%) malaria (16%), respiratory infections (15%) and malnutrition (9%).

Under-five hospital admission: top causes are malaria (30%), respiratory infections (24%), diarrhoea and dehydration (7% each) and malnutrition.

Main causes of hospital admissions: malaria (26%), obstetric/gynaecologic-related emergencies (19%) and respiratory infections (9%).

Main causes of hospital death: malaria (16%), respiratory infections (7%) post-procedural causes (5%); malnutrition, malignancies, anaemia and septicaemia (about 5% each) are other common causes.

Under-five hospital deaths: 17% attributed to malaria, 14% to respiratory infections, 13% to malnutrition, the rest to septicaemia (9%), dehydration (9%) and diarrhoea (7%).

(FMoH 2001)

- Humanitarian action looks at the manifestations of the crisis (mortality, malnutrition, numbers of affected, vulnerable groups, types of needs). However, during the transition, the focus of action must move from vulnerable groups to the systems that determine their vulnerability. Experience shows that pressure for recovery planning can start while the humanitarian crisis is still ongoing, and while the capacity of absorption of national actors, both in the North and in the South, will be still very limited.

2.7 Health status

Life expectancy at birth is 56 years, and the disability-adjusted life expectancy is around 43 years. Overall, the other health status indicators already presented in Table 1 mirror the differentials between government-controlled and non-government controlled areas.

Reproductive health in the government-controlled areas faces many constraints. Only 12% of deliveries occur in a health facility and trained health personnel attend 57% of all deliveries. In the non-government-controlled areas, there are few services for pregnant women and only 6% of births take place in a health facility. Maternal mortality per 100 000 childbirths is 509 in government-controlled areas and 865 in non-government controlled areas. The use of contraception is low, around 7%, and many women suffer from cultural and religious taboos including female genital mutilation.

Communicable diseases dominate the scene. The main causes of morbidity and mortality are infectious and parasitic diseases: tuberculosis, diarrhoea, malaria, measles and acute respiratory infections. South Sudan hosts an estimated 80% of the total guinea-worm cases worldwide. Sleeping sickness and leishmaniasis are endemic and severe epidemics have been reported. The prevalence of HIV/AIDS is low but shows a steadily increasing trend; recent surveys show that general prevalence rate for Sudan is 1.6%, but levels of infection in groups-at-risk are higher and reach 10% in Juba in the South. The vulnerability to outbreaks is high, as shown by the meningococcal meningitis epidemic that affected 18 out of the 26 states

in 1998–1999 and resulted in more than 33 000 cases and 2300 deaths. The outbreak of yellow fever, which started in the South, is now threatening other districts in Sudan and neighbouring countries.

EPI coverage has remained low for many years and there are serious imbalances between different areas (UNDAF, 2002) (Table 2). However, poliomyelitis (polio) coverage has increased significantly and no wild polio case has been reported since April 2001.

Nutrition is an area of major concern throughout Sudan despite relief assistance and food aid, which alone, totals 73% of all assistance provided. Although agricultural resources represent 28% of the GDP in Sudan, food insecurity is widespread and several anthropometric surveys show a very poor nutritional status. Chronic malnutrition in children under five is estimated at 36% and acute malnutrition at 16% but this deteriorates further in places of high insecurity, such as in the southern states and in Darfur state, where humanitarian access is a problem. Micronutrient deficiencies including iodine and vitamin A are common.

2.8 Health sector

2.8.3 Overview

Due to the differences in health structures, services and providers between government-controlled and non-government controlled areas, these have been described separately in this document. However, both sections of the country share a common characteristic: health information is scarce and there is a strong demand for it from within and outside the health sector. In respect of the North, the Federal Ministry of Health (FMoH) publishes an *Annual statistical report*, but the information is too aggregated and its processing too slow and unwieldy for management purposes. Data on outputs and coverage are especially scarce. As for the non-government controlled areas, the information reflects the high fragmentation, the low coverage and the many NGOs, who in most instances operate in an institutional vacuum.³

Table 2. Immunization coverage in Sudan, 2000

Areas/regions	DPT3	OPV3	Measles	BCG
Government-controlled areas	64%	64%	62%	68%
Non-government controlled areas	25%	30%	35%	28%

Source: FMoH. *Annual statistical report 2002*

³ UNICEF is analysing health programmes in the South, NGOs, financial resources, etc; this exercise should soon provide a more comprehensive and updated information base

2.8.2 Government-controlled areas

Health policy

The Ministry of Health (MoH) document *Country strategy notes*, covering 1992–2002, represents the framework for the national health policy. This policy is based on the primary health care (PHC) approach. A new strategic plan, with a 25-year timeframe, is in the final stages of development.

Health network

The delivery of care is organized in three tiers. The first level consists of PHC units (providing “essential PHC services”), dressing stations (delivering curative care for common diseases), dispensaries (managing more serious cases) and health centres (which include laboratory and X-ray units, but no inpatient wards). The second level (first referral) is represented by rural hospitals. Specialized and teaching hospitals in the state capitals, offering more developed services, represent the tertiary (second referral) level.

Primary level health facilities represent 95% of the total network, while the two higher levels contribute only 5% (Table 3). From the mid-1990s, there has been a small increase in the number of hospitals and a decrease in the number of beds (Table 4). This trend reflects a decrease in first level facilities and an increase in referral units. This could be a response to a number of factors: population movements from rural to urban areas, concentration of cadres in the capitals, difficulties in ensuring regular supplies and management at the periphery. However, when population growth is taken into account, it can be seen that while the number of hospitals has remained stable, their functional capacity has decreased.

Table 3. Distribution of health units by level between 1994 and 2000

Level	Type of health facility/year	1994	1997	2000
1	PHC unit	3070	2729	2558
	Dressing station	1412	1442	1236
	Dispenser	1400	1468	1475
	Health centre	531	693	915
	Sub-total	6413	6332	6184
2	General/rural hospital	162	186	200
3	Provincial/specialized/teaching hospital	78	88	109

Source: FMOH. *Annual statistical report 2001*

Table 4. Number and capacity of hospitals between 1994 and 2000

	1994	1997	2000
Hospitals per 100 000 people	0.9	0.9	1.0
Hospital beds per 100 000 people	85	79	74

Source: FMOH. *Annual statistical report 2001*

Management

The Federal Government Act of 1993 establishes three levels of management.

- The Federal Ministry of Health is responsible for formulating national sector policies, supervision, evaluation, development and management of human resources, international relations and allocation of central funds to the states.
- The State Ministry of Health is in charge of planning, administration and financing within the framework of national policies.
- The Health Area Management Team (HAMT) is responsible for planning and implementing health programmes at the locality level.

The management system is complex and at present the government is reviewing it. PHC units, dressing stations and dispensaries are administratively under the responsibility of the local administrative councils, and technically under the state MoH. Health centres and rural hospitals are under the exclusive responsibility of the state MoH.

Human resources

The total workforce consists of 45 000 staff, of which 5000 are doctors, 6200 medical assistants, 17 500 nurses and 9300 midwives. With respect to regional imbalances, Table 5 shows the extreme ratios of the main categories per population. Not surprisingly, the pattern is consistent with the differences highlighted for the network.

Financing

The financing policy reflects the extreme economic difficulties, which the country is facing. Central government and state expenditure on health is extremely low compared with nearby comparator countries. For instance in 1998 and 1999 the average expenditure on health was 0.7% of GDP compared to about 1.8% and 1.3% in Egypt and Ethiopia respectively.

Table 5. Distribution of categories of health workers by state

State with best/worse ratio	Doctors per 100 000 population	Medical assistants per 100 000 population	Nurses per 100 000 population
Khartoum	35		
Northern state		62.8	125.7
South Darfur	1.0	5.2	16.2

Data on health expenditure are missing and therefore public expenditure is underestimated. Recent estimates give a total per capita health expenditure of US\$ 17.5. This corresponds to 4.5% of the GDP, with household out-of-pocket expenditure contributing more than half of the total. International organizations would contribute only 2.4% of total spending, a share that seems grossly underestimated.

Although funding levels are still higher than those of several sub-Saharan countries, most informants agree that federal and state funds are insufficient to cover recurrent costs. Salaries are low, which explains the high attrition of qualified staff.

Public expenditure for drugs is about US\$ 2 per capita, i.e. at the lowest levels of the range that the World Bank (WB) deems the minimum for providing basic care. Since 1999, only UN agencies and bilateral donors have sustained the purchase of vaccines.

The funding system further complicates the already complex management. First level facilities (up to health centres) depend on community funds that are administered by the Executive Director of the Administrative Council. Some higher-level facilities are either funded by the state or by the federal government.

Since public expenditure is insufficient to sustain the delivery of health care, three additional strategies were developed to mobilize resources:

- Community involvement in health financing (through cost-recovery)
- Expansion of the private sector to reduce pressures on public services
- Introduction of a compulsory national health insurance since 1995, complemented by military and police health insurance and other schemes employed by large companies.

Coverage and outputs

Data on coverage and outputs are scarce. Available indicators (Table 6) show that the productivity of health services is low.

Table 6. Coverage and output indicators

Indicator	Value	Year	Source
Access to:	% of total population		
Health services	40–60	2002	MICS
Fixed immunization services	50	2001	EPI
Essential drugs	15 (0–49)		UNDP
Immunization coverage:	%		
Measles among infants	62	2002	FMoH
Tetanus among pregnant woman	35	2002	FMoH
Hospital bed occupancy rate	40% of beds occupied	2000	FMoH
Deliveries attended by skilled staff	57% of total deliveries	1999	Safe Motherhood survey
Outpatient consultations per capita	0.8 per capita per year	2000	FMoH

2.8.2 *Non-government controlled areas*

Health policy

In 1998, SPLM released the document *Health policy of the new Sudan*, which was followed in 1999 by the *Guidelines for the implementation*. Four levels of services are envisaged, i.e. community, county, national and regional. For each level, the policy defines the package of services provided, the human resource requirements and the management structure. Communities are called to play an important role in the sector: financing, ownership, administration, control of first level facilities, monitoring and even selection of candidates for training. Community financing is expected to cover up to 30% of total costs; other sources of funds include licensing and certifying fees for private practice and external assistance. The aim for the health budget is an expenditure of US\$ 10 per capita per year.

Health networks

The SPLM's highest health authority is the Health Commissioner, who reports to the Commission of Social Services, under the National Executive Council. At the county (district) level, health authorities are in place: reportedly they have very limited capacities, and policy implementation has been largely unsuccessful. Health care (mostly curative care and/or disease control) is mainly provided by NGOs and religious institutions through a network of basic units. The referral system is limited to the large International Committee of the Red Cross (ICRC) hospital in Lokichoggio and eight other smaller facilities supported by NGOs and religious congregations.

Human resources

Training of local staff suffers due to the lack of sufficiently educated candidates and the fact that there are no standardized curricula. The Health Personnel Council registers health staff and works at standardizing job descriptions and criteria for accreditation.

Financing

The overall health expenditure through international agencies is estimated at US\$ 60 million per year. Transport and logistics absorb approximately 50% of the agencies' budget.

Coverage and outputs

The PHC coverage is low and ranges between 10% and 30%. With respect to health outputs, the UNICEF MICS survey for South Sudan (2000) confirms the extremely low coverage levels: 34% for measles, 30% for routine poliomyelitis, 25% for DPT. UNICEF is planning a demographic and health survey (DHS) to obtain baseline data for both programming and evaluation purposes.

Intercountry and interregional collaboration for health

Sudan participates in various intercountry and interregional collaborative frameworks in the area of public health, such as the cooperation with Maghreb countries, the Horn of Africa Initiative (HOAI), the Horn of Africa Tuberculosis Control Initiative (HATCI) and the Horn of Africa Polio Eradication Programme. Moreover, it has bilateral agreements with most of its neighbours, addressing HIV/AIDS, malaria and other diseases for eradication. WHO is instrumental in assisting Sudan's participation in these initiatives

Intercountry collaboration for public health in the border areas of Sudan and neighbouring countries is very relevant, as health services tend to be particularly weak in these areas and the people are generally poorer and more vulnerable. Prompt intercountry exchange of surveillance data is critical for effective outbreak control; and collaboration on disease control, laboratory networking and staff development is essential in a context where infectious agents and vectors are abundant and where armed conflicts and natural disasters often cause mass population movements from one country to another.

Humanitarian coordination for health

Health activities in the South are coordinated through several mechanisms. A Health Advisory Body includes Sudan Relief and Rehabilitation Association (SRRA), OLS and non-OLS agencies and meets every three months in Nairobi. Monthly health and nutrition meetings are held in Lokichoggio. UNICEF leads the Emergency Preparedness and Response Team, which coordinate need assessments and relief interventions. WHO coordinates an Early Warning and Response Network (EWARN) for outbreak investigation and response.

2.9 Main health challenges

- Given Sudan's epidemiological profile, the delivery of health care will always be difficult and expensive, but the current health and nutritional indicators depict an unacceptable reality. The needs of the population are huge, and the capacity of the sector to meet them is inadequate. The people suffer from low quality of, and unequal access to health services. This may be applied, in different degrees, to the entire country.
- In Sudan, there is a discrepancy between health funding, on one side, and outputs at the local level:
 - The government's health system is reasonable in absolute numbers; however, all the available indicators on outputs show low productivity;
 - Due to the limited investment in non-government controlled areas, services are limited to PHC and coverage is low. Moreover, health expenditure indicates that the system is inefficient.
- The high prevalence of infectious and parasitic diseases makes the choice for strong vertical control programmes an easy option. However, given Sudan's natural environment, it is also an expensive option and hard to sustain in terms of community participation and/or partnerships between private and public sectors. It carries the risk of being a technocratic choice, difficult to reconcile with administrative and political

decentralization, and it is traditionally quite poor in terms of synergies with the other sectors of social and economic development.

- Besides these economic, political and environmental considerations, Sudan's dimensions and the dispersion of the population suggest that a horizontal, PHC approach retains its value: for nomadic communities, health care must be sited or brought as close as possible to the people's needs and appreciation.
- The national health authorities need to show strategic vision and have (i.e. gain or maintain) explicit leadership: health goals must be consistent with those of the other sectors and synergies need to be ensured with the other line ministries, the private sector and the communities. To be effective and sustainable, the health sector requires technical, economic, managerial, cultural and political partnerships.
- At the moment, both poverty and the civil war continue to suppress the people's demand for services. Both the government and SPLM agree on the principle of a health system and on its objectives at large, but health is not yet a major heading in the agenda of peace negotiations. With peace, health services will need to immediately scale-up their quality and coverage. At the same time, construction and reconstruction will have to be planned, financed and implemented, while a close relationship with possible beneficiaries is maintained in order to make it clear that they have a stake in stability and peace.
- Local planning will need a good information basis, but both government and SPLM national health authorities seem to have scarce technical capacity and/or institutional opportunities to produce information and influence strategic decisions. On the other hand, relief NGOs (and/or religious institutions) do not seem to perceive this area of work as a priority.
- Finally, the steady increase of HIV/AIDS prevalence suggests that the window for interventions aimed at reducing the transmission could close soon; on the other hand, there is the very real risk that HIV/AIDS becomes a factor of exclusion, e.g. it is exploited to limit the circulation of people in spite of peace agreements.

3. DEVELOPMENT AND HUMANITARIAN ASSISTANCE

3.1 Introduction

In the last 30 years Sudan has had a noticeable diversion of financial and human resources from development into humanitarian relief. National investment was reduced and bilateral and multilateral funding for development from the international community became rare. Official development assistance figures over the past 15 years show a marked downward trend. The further one moves away from the centre of Sudan, the clearer it becomes that years of missed investment have impacted on the social and economic infrastructure.

3.2 Development: a guarded optimism

In 2000–2001, the UN moved to increase their focus on improving development aspects with the preparation of the United Nations Development Assistance Framework (UNDAF). With UN assistance, the Government of Sudan has also started to prepare a Poverty Reduction Strategy Paper (PRSP) in 2002–2003, which will be completed by early 2004. Altogether, in the last 12 months, the prospect of peace has brought an obvious change in the attitude of the international community. Major donors are reopening their embassies and in the last six months there has been a reengagement of the World Bank. Positive political and security developments on the ground provide donors with the opportunity to engage in a more concerted and robust manner. Three meetings of the Donor Working Group on the Sudan were held in quick succession, in Geneva, Oslo and the Hague, in order to facilitate preparations and mobilize international support for a peace agreement.

In February 2002, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) secured funds for a two-year malaria control programme covering both the government-controlled (US\$ 14.2 million) and the non-government controlled areas (US\$ 12.8 million), and for another two-year programme for the control of tuberculosis in the non-government controlled areas only. The Global Alliance for Vaccination and Immunization (GAVI) supports the strengthening of the Expanded Programme on Immunization (EPI) infrastructure with a grant of US\$ 3 million for five years, of which US\$ 1.5 million was recently released. Sudan also received support for safe injections through GAVI. In the development of these national plans and fund requests WHO played a key role in providing the technical assistance required for the preparation and operational planning for implementation.

3.3 Humanitarian aid flow

In October and November 2002, the Government of Sudan and the SPLM committed themselves to a cessation of hostilities and to unimpeded humanitarian access to all areas within Sudan. The indications were that humanitarian assistance could soon be expanded and implemented in tandem with transitional activities. Thus, in 2003, with the Machakos Peace Talks continuing, the Consolidated Appeal Process (CAP) was marked by great optimism, with an explicit “humanitarian-plus” orientation aimed at saving lives and sustaining livelihoods as a base for full-scale recovery where opportunities prevailed.

Four key objectives were identified:

- Saving lives and reducing human suffering
- Provision of essential basic social services
- Building capacity and resilience
- Strengthening protection and grassroots peace-building mechanisms.

The original requirements listed in the 2003 Consolidated Appeal (CAP) totalled US\$ 255 million. Expanded humanitarian access and new assessments led to the identification of additional requirements and the CAP was revised to include these, thereby totalling US\$ 263 million, a 3% increase. Of the total revised CAP 2003, only US\$ 89 million (34%)

had been received by September 2003 (Table 7). However, despite this general optimism, peace is still to come and donors' response, although improved in relation to 2002, remains low, with a response rate of 29% of the requirements.

Additionally, approximately US\$ 20 million were allocated outside the CAP programmes in the Nuba Mountains and to respond to floods in eastern and central Sudan in July–August 2003. As a result, the pledge both within and outside the CAP by September 2003 was approximately US\$ 109 million.

In both 2002 and 2003 there were sizeable disparities between the levels of funding received by different agencies, sectors, target groups and geographical regions (Table 8). As in the past five years, donors show a clear preference for the food sector, which by mid-2003 had received 53% of the funding, while all other sectors had averaged 4%–5%.

Table 7. Total humanitarian assistance for Sudan, as at August 2003 (contributions to the CAP and additional contributions)

Donor	Value US\$	% of funding
United States of America	28 144 106	30.88%
United Kingdom	18 934 074	20.77%
Japan	10056 121	11.03%
Private/NGO	6 718 261	7.37%
Norway	6 544 897	7.18%
Netherlands	5 977 617	6.56%
Canada	2 586 497	2.84%
Switzerland	2 104 838	2.31%
Sweden	1 782 664	1.96%
European Commission	1 650 734	1.81%
Italy	1 323 828	1.45%
France	1 155 987	1.27%
Finland	861 143	0.94%
Germany	300 115	0.33%
Cyprus	5000	0.01%
Total	91 145 882	100%

Source: www.reliefweb.int.

Table 8. Funding by sector through the CAP, as at end September 2003

Sector	Total revised requirements US\$	Total received US\$	Percentage received (August 2003)
Agriculture	19 551 202	4 900 000	25%
Coordination and support services	12 807 348	4 200 000	29%
Economic recovery and infrastructure	2 789 760	0	0
Education	8 644 000	3 800 000	43%
Family shelter and non-food items	2 210 000	400 000	20%
Food	136 300 000	53 400 000	37%
Health	21 345 744	4 700 000	22%
Mine action	3 536 340	3 400 000	51%
Multi-sector	32 876 263	6 700 000	20%
Protection/human rights/rule of law	9 512 400	2 000 000	20%
Security	4 733 600	2 900 000	62%
Water and sanitation	6 735 200	3 200 000	47%
Total	262 967 857	89 600 000	34%

Source: www.reliefweb.int

3.4 Partnerships and coordination

In the last few months the UN system in Sudan has refocused its work, and adopted a new guiding framework, the Sudan assistance framework (SAF). The purpose of UN assistance is to “promote a peaceful environment that enables the fulfilment of the rights of Sudanese people to survival and protection, to be able to exercise informed choices, and to enjoy equal dignity and development.”

The new framework is structured around the Millennium Development Goals (MDGs), as elements of a binding consensus among all countries of the world to reduce poverty and promote sustainable development. Sectoral strategy-level coordination is carried out in Goal Groups convened by nominated UN agencies in partnership with other agencies (including interested NGOs, bilateral agencies) active in the delivery of particular MDGs (Table 9). The process prioritizes Sudanese ownership and leadership. The intention is that as institutional arrangements become clear, Sudanese counterparts will take on the responsibilities of coordination. A joint planning mechanism (JPM) was established in May between the government and SPLM. The purpose of the JPM is to enable the two parties to jointly assess needs, develop priorities, and draw up action plans for implementation during the pre-interim period. This Secretariat is facilitated by the Office of the UN Resident and Humanitarian Coordinator (ORCHC) and is intended to be jointly staffed by technical experts from both the GoS and SPLM.

Table 9. UN millennium development goals

Thematic MDG groups	Convenor
<i>Goal 1: Eradicate extreme poverty and hunger</i>	FAO
<i>Goal 2: Achieve universal primary education</i>	UNICEF
<i>Goal 3: Promote gender equality and empower women</i>	WFP
<i>Goal 4: Reduce child mortality</i>	UNICEF
<i>Goal 5: Improve maternal health</i>	UNFPA
<i>Goal 6: Combat HIV/AIDS, malaria and other diseases</i>	WHO
<i>Goal 7: Ensure environmental sustainability</i>	UNDP
<i>Goal 8: Develop a global partnership for development</i>	UNIDO

Through the Office of the UN Resident and Humanitarian Coordinator (ORCHC), more services have become available in 2003 with the establishment of the following groups:

- Area Coordination Service for improved coordination.
- Joint Planning and Review Service for joint planning.
- Information and Public Communication Service and Resource Tracking Service for dissemination of information, resource mobilization and assistance in improving allocation of resources to neglected sectors.
- Partnerships Development Service for services needed by the various elements of the UN presence in the Sudan.
- Sudan Transitional Assistance Financing Facility to work on a trust fund facility.

The cooperation with UN agencies and international NGOs expanded progressively to include more support to health programmes. WHO provides the main health, technical and financial support to FMoH and covers all the national areas of concern through its joint country programme. UNICEF assists in the field of child health with reference to EPI and Polio Eradication. UNFPA gives considerable support in the area of reproductive health. Moreover, WHO has recently strengthened its relationship with UNDP and OCHA in the field of humanitarian actions and emergency response.

In the government-controlled areas, humanitarian programmes are implemented by 150 NGOs and eight UN agencies focusing on lifesaving programmes through the delivery of PHC programmes. In the South, the majority of UN agencies, international and national NGOs work through OLS. For the health sector there are approximately 64 agencies, of which 45 are international and 19 national. Some agencies deliver single programmes while others deliver a multitude of programmes throughout the area. The programmes implemented mainly address primary health care with a limited referral system.

In non-government-controlled areas, approximately 66 agencies are involved in the provision of health services in the southern sector of Sudan including four counterpart organizations and four UN agencies. Although the number seems high, not all agencies are involved in health programme activities to the same extent; some implement a single activity at a single location while others implement multi-sectoral programmes in many regions. Some

agencies implement only primary health care activities, others specialize in hospital programmes, still others run vertical disease control programmes or a combination of health activities. Of the 66 agencies and organization operating in the southern sector of Sudan, 33 belong to OLS, 45 are international, 19 are Sudanese NGOs, 27 are faith-based. In some regions many agencies are present on the ground while in other regions there are only a few agencies. Agencies may have a dual role, acting as implementers and also as donors (i.e. the Carter Center helps to implement the Sudan Guinea Worm Eradication Program and trachoma programme, but it also funds other agencies to carry out the field-based activities).

A framework for donor coordination existed for a long time within the FMoH. However, it functioned mainly as a forum for exchanging ideas, while donors assisted in different elements of relief and health programmes, often using varying approaches and covering separate parts of the country. At the end of 2002, the government and major donors were still expressing concerns about the fragmentation, lack of consistency, gaps and overlaps in donor support.

Since the beginning of 2003, the FMoH, with WHO assistance, has become more active in humanitarian action by conducting workshops and leading the sixth MDG thematic groups to combat HIV/AIDS, malaria and other diseases. In the FMoH, Department of International Health, there are now two staff working as counterparts to the Emergency and Humanitarian Action (EHA) programme of WHO, one preparing MoH's participation in the joint government/SPLA planning mechanism and the other working as a focal point for international NGOs. Currently all international humanitarian actors are being mapped in Sudan by main programme and geographical areas.

The GFATM partners operating in the two sectors of Sudan work through two separate coordinating mechanisms merging into an All Sudan Coordination Mechanism. At the national level, donors and UN agencies are assisting coordination under the global funding initiatives for Roll Back Malaria (RBM), STOP Tuberculosis, control of HIV/AIDS and EPI. Under the All Sudan Coordination Mechanism, an operational plan of action was developed which includes all agencies' activities for these diseases. This has resulted in a successful allocation of US\$ 27 million for RBM, US\$ 5.8 million for tuberculosis and US\$3 million for EPI.

3.5 Challenges

- With more coherent coordination of all actors in the health sector, interventions can be more focused and gaps and duplications minimized. However, donors need to participate in designing a common action plan, delineating responsibilities and prioritizing funding, milestones and benchmarks. Mechanisms are needed for sharing information on donors' priorities so as to optimize the comparative advantages for each of them.
- There is a growing awareness of the need to integrate humanitarian, recovery and developmental aid. However, if the peace process is not consolidated the momentum may be lost. National health strategies are needed for the donors to align themselves and

ensure common approaches to health sector recovery and development. Only a better balance between humanitarian and transitional funding can ensure strategic synergies between life-saving, life-sustaining and peace-building activities.

4. THE WHO COUNTRY PROGRAMME IN SUDAN

4.1 WHO country office

WHO considers itself to be in partnership with the government for actions that promote the health status and well being of the population. The emphasis of the collaboration is to assist the national efforts to achieve better health outcomes through support to key areas of work.

Sudan became a member of WHO in 1956, and the relationship is regulated by an agreement between the Ministry of Foreign Affairs and the Organization. The WHO Representative Office (WRO) in Sudan is one of the largest offices in the Eastern Mediterranean Region. Presently it has three offices – the Representative’s office in Khartoum, responsible for the entire Sudan, one sub-office in Juba covering government-controlled areas of the south and a sub-office in Nairobi/Lokichoggio (Kenya) covering the non-government controlled areas. Generally, the physical and support facilities are adequate in the Khartoum office but are deficient in many aspects in the other two offices.

In Khartoum, the office has undergone three expansion phases in order to increase available space. Despite the increase in size, space is still limited and there is no place to accommodate additional staff.

4.2 Key areas of work

4.2.1 WHO activities in government-controlled areas

WHO support to the country is provided through biennial assistance. The collaborative plans are prepared by the joint programme review and planning mission (JPRM), a team of staff from the government and WHO, after careful consideration of the national and WHO priorities and review of the progress of implementation in the previous biennium.

The WHO’s regular budget supported 35 programmes in 2000–2001. These were reduced to 32 programmes in 2002–2003 and were grouped into six major areas of work (below). They are covered by seven technical staff/programme officers. For polio, EHA and RBM there are dedicated technical staff, whereas the other staff cover several areas of work:

- Health policy and management. In this area, WHO supports the MoH in developing its capacity in policy formulation and strategic planning. By 2003, the MoH had established four planning units at state and federal levels. Technical and limited financial support was made available to MoH to strengthen its staff management capacity through in-country training and external fellowships.

- Health services development. WHO also supports comprehensive and accessible health systems including development of human resources for all levels and capacities for essential drug policy and management. In order to achieve better health outcomes through sustainable development and poverty reduction the basic development needs (BDN) approach is promoted in the country. This approach assists communities in assuming greater responsibility in defining their needs and attaining self-sufficiency.
- Health promotion. In this area, WHO supports the management of community water supply and sanitation and the promotion of healthy lifestyles. Health of special groups of the population, namely the elderly, women and children, receive the attention of WHO through different approaches and strategies such as the integrated management of childhood diseases. Environmental protection gained the growing attention of the WRO and the national authorities.
- Integrated control of communicable diseases. Most of WHO's support is directed towards this area of work. Eradication and disease control programmes receive major attention from WHO as well as other partners. RBM, control of tuberculosis, HIV/AIDS, and parasitic and zoonotic diseases is the main components of this area, and as malaria is a major health problem in Sudan, it receives particular attention.
- Poliomyelitis eradication. The biennium 2000–2001 witnessed WHO leadership in this area, together with UNICEF, Rotary International/Sudan Club, other UN agencies and NGOs. WHO contributed more than US\$ 4 million annually to cover operations, management, technical assistance and human resources. External support is expected to start phasing out at the beginning of 2004.
- Emergency and humanitarian action. Emergency preparedness and humanitarian action is one area where WHO has increased its involvement. Priority areas of work in the transitional context included interventions that support national authorities in making the health sector more effective, the new transitional health services' needs assessment in the areas of return of IDPs and refugees, monitoring of the emergency situation, contingency planning, development of reconstruction plans, provision of technical assistance in the formulation of projects and appeals, and resource mobilization.

The joint programme review and planning mission for the 2004–2005 biennium prioritized the following 12 areas of work:

- Policy formulation planning and management
- Human resources for health
- PHC system development including sustainable community-based initiatives (CBI) and integrated management of childhood illnesses (IMCI)
- Secondary and tertiary care support and quality control including blood safety
- National drug policy, essential drugs and traditional medicine
- Laboratory technology
- Health promotion
- Reproductive health and family planning

- Vaccine preventable diseases including polio eradication
- Integrated control of communicable diseases
- Emergency and humanitarian action
- Supportive environment for health.

4.2.2 *WHO activities in non-government-controlled areas*

In spite of the civil war, WHO has been increasing its presence in SPLM areas by creating new partnerships and adopting new modes of work. Through Nairobi and Lokichoggio, WHO contributes to the public health aspects of OLS. However, the peace process and the transition period brings forward the need and opportunities to extend the coordination to other determinants of ill health in a more integrated manner and long-term approach for sustainable community based development and high-incidence diseases.

- **Malaria.** The WHO programme for malaria focuses on health education and technical coordination for rapid diagnosis and treatment. Use of bednets, both insecticide-treated and not, effective case management and vector control remain the most important measures.
- **Tuberculosis.** The entire programme of tuberculosis control employing the directly observed treatment, short-course (DOTS) strategy is coordinated by WHO, and is now implemented by eight NGOs running 12 health facilities with 115 international and national staff, covering 1.3 million people (16% of the total population).
- **Leprosy.** In 2002, WHO launched a leprosy control programme, introducing rapid and simple diagnostic tools and delivering free short courses of multidrug therapy (MDT).
- **Poliomyelitis eradication.** This initiative is a major endeavour and the performance indicators are good even though some pockets are still to be reached. The last wild polio case in Sudan was identified in April 2001. It is expected that the goal of certification as polio-free by 2005 can be attained, as easier access should allow for accelerated national immunization days (NIDs) and sub-national immunization days (SNIDs), in-depth acute flaccid paralysis (AFP) surveillance and training activities through the entire region.
- **Early Warning and Response Network (EWARN).** Since its establishment in 2000, EWARN has shown considerable success. Within 48–72 hours of an alert, EWARN can respond by assessing, confirming or ruling out rumours of an epidemic, thus contributing to the saving of precious resources, as well as limiting avoidable mortality and morbidity. In addition, the programme fulfils an important capacity building function by training local health workers.

4.3 **Financial allocation to programmes**

In the 2000–2001, 45% of funds were utilized for the purchase of supplies and equipment, with the next greatest amounts going to travel authorizations and national training activities. The distribution of resources according to the activities undertaken in the programmes during the 2000–2001 biennium is given in Figure 2.

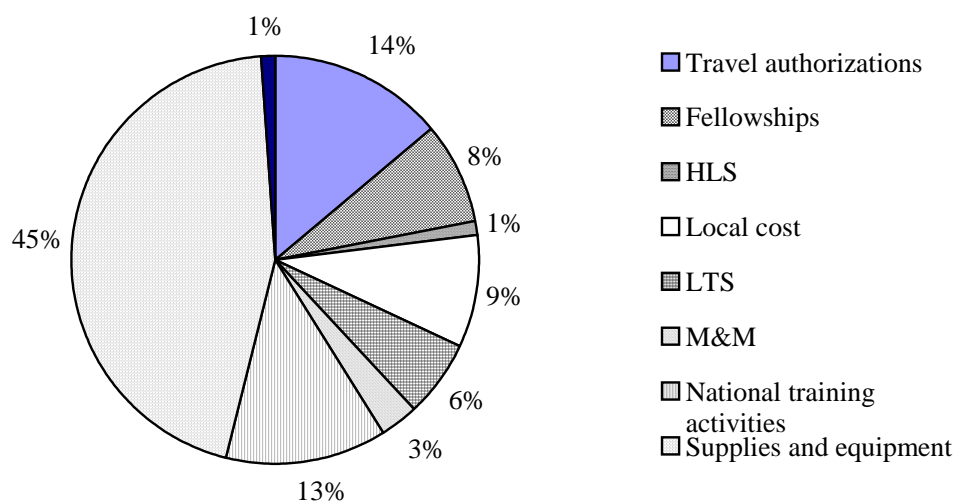


Figure 2. Distribution of resources by activities, 2000–2001 biennium

In the 2002–2003 biennium, WHO has provided approximately US\$ 4.4 million in regular budget funds and about US\$ 11 million in extrabudgetary funds. The latter were primarily for polio eradication and RBM in government-controlled areas. For non-government controlled areas, there was no allocation from the regular budget although extrabudgetary support was available for certain programmes. The financial allocation according to the main areas of work from the regular and extra budgetary resources for the biennium 2002–2003 is given in Table 10.

Table 10. Financial allocation for WHO programmes 2002–2003

Main areas of work	Allocation				Total
	Regular budget		Other sources		
	Government-controlled areas	Non-government – controlled areas	Government-controlled areas	Non-government –controlled areas	
Health policy and management	952 000	0	0	0	952 000
Health services development	1 140 000	0	200 000	0	1 340 000
Health promotion	693 000	0	200 000	0	893 000
Integrated control of communicable diseases	1 374 000	0	1 700 000	780 000	3 854 000
Poliomyelitis eradication	219 000	0	7 912 000	2 700 000	10 831 000
EHA	0	0	847 000	110 000	957 000
Total	4 378 000	0	10 859 000	3 590 000	18 827 000

4.4 Office and resource management

4.4.1 Human resources

As at September 2003, the WHO country office in Sudan (Khartoum) consisted of 104 staff members including the following.

- WHO Representative
- Two international medical officers (polio)
- One international technical officer (EHA)
- One international short-term professional (RBM)
- Five national programme officers
- One international Administrative Finance Officer (polio).

WRO staff, except those working for EHA, RBM and polio eradication, are funded from the regular budget. Six staff members, of whom three are technical staff, work out of the sub-office in Juba. All staff in Juba are on special service agreement (SSA) contracts. Details of staff distribution are listed in Table 11. In WRO Sudan, a majority of staff is on SSAs and their salaries not commensurate with UN system. Very few fixed term posts have been established and this poses a problem for staff on term-limited posts. Staff has a heavy workload and some of them are not adequately trained and continually updated on WHO procedures.

For the non-government controlled area, WHO has established a sub-office in Nairobi. This office has an international Health Coordinator and a Polio Programme Coordinator who are assisted by 259 staff members comprising of 34 technical staff, 188 general services staff and 39 support staff in over 100 different locations (Table 12).

Table 11. Distribution of WHO staff by contract and location in government-controlled areas

Contract type	Khartoum WRO	Juba sub-office	17 other locations	Total	Remarks
FT	9	0	1	10	WR, 2 polio Medical Officers, 2 secretaries, 3 admin personnel, 2 drivers
STP/TLP	3	0	0	3	Admin Finance Officer (polio), Medical Officer (RBM), Technical Officer (EHA)
STG/TLG	7	0	0	7	4 drivers, 3 secretaries working in WRO
STC	0	0	6	6	Polio consultants working with MoH
SSA	24	6	42	72	52% of SSAs are polio staff
Temporary	6	0	0	6	Cleaners, drivers and Information Officer
Total	49	6	49	104	

Table 12. Distribution of WHO staff by contract and location in non-government controlled areas

Contract type	Nairobi, Kenya	Lokichoggio, Kenya	143 other locations	Total	Remarks
FT	5	0	0	5	1 Public Health Coordinator, Head of Office, 1 Regional Polio Coordinator, 1 Polio Technical Officer
STP	2	2	4	8	MO, Polio International Focal Points
STG	1	0	0	1	3 MO, 1 Operations Officer, 2 Admin/Finance and Logistic Staff
STC	0	0	1	1	Polio secretary
SSA	4	8	234	246	3 EWARN MO, 32 county supervisors, 5 national polio MO, 199 support staff
Temporary	0	0	0	0	Senior Secretary for South Sudan WHO Office
Total	12	10	239	261	

4.4.2 Administration and finance

- Accounting. The WRO currently uses an accounting system provided by WHO. This system is outdated and does not have the facility to adequately track or manage activities, allotments, sticker numbers and funds; staff do not have sufficient expertise to develop independent systems to perform these activities. In addition, re-inputting of data at EMRO is timely and introduces the possibility of transcription errors.
- Monitoring at regional and country level. The regional activity monitoring system (RAMS) is maintained by EMRO. It provides programme and financial information of limited use as it is not current (sometimes 4–6 weeks out of date), planned funds are sometimes only shown at product and not activity level, and it is impossible to track information at the lower levels. Information on RAMS cannot be manipulated so as to provide useful reports.
- Internal monitoring. In 2003, an Access-based database and monitoring system was developed by the WRO in order to track activities, i.e. national training activities (NTAs), local costs (LCs), visiting missions within the office. Although the system has proved useful, it does not show minor details on the status of requests.

4.4.3 Connectivity and technology

- LAN and office connectivity. In WRO Sudan there is a network that connects 27 workstations through a LAN to a Hewlett Packard Net8000 Server. There is no back-up server and security is limited, as data and communications go through the same server. Back-ups, when done, are stored only on hard disk and are not secure.

- Internet. Sudanet is the ISP (internet service provider) providing the WRO with internet service by contract. It is technically unreliable and government-controlled. The system does not permit the WRO to create advanced communications and connection is slow and sometimes impossible for several days.
- Landline communications. The landlines in the WRO run through an Electronic Modular Digital Switching System, (capacity for 12 external lines and 40 extensions). WRO has 12 external lines (four are dedicated lines and do not go through the switching system), four international lines and two fax machines (one dedicated for polio use). All international calls are made through the WR assistant's phone, and there is often a backlog and queue for international calls. If the WRO fax machine has a heavy load, fax communications are difficult.
- Other communications. A government subsidiary, Mobitel, owns the only mobile network in Sudan. The WRO Sudan has 11 satellite phones that rely on a network managed by a government subsidiary, Sudatel. These phones are for use by staff on duty travel. Both the mobile and satellite networks are unreliable and information transfers are not confidential.
- Printers. In the WRO, five printers are in good working condition (including 1 heavy duty printer). However, printer distribution is problematic and seven users access one printer, which is therefore overloaded.
- Security and service. Two UPS systems support all the WRO computers, and the server room has a dedicated UPS system. The present electronic system is insecure, as all files/documents are stored in the Q drive, which is located on the server.

4.4.4 Documentation, filing and information dissemination

- Documentation centre. Recently the library in the WRO was upgraded to serve as a documentation centre, with a comprehensive, indexed electronic filing system, 2068 documents and reports, and a workstation with a database for data entry and searching. The database on the workstation in the library is not secure and the workstation does not have internet access. At times, the person who manages the documentation is unavailable to do a search on the computer, as she also manages supplies and equipment and has a considerable workload. There is no process for the translation of documents from Arabic to English and vice versa.
- Information dissemination. The WRO receives annual reports, newsletters and press releases and information on CD, which are distributed to donors, NGOs, universities, manually or by courier.
- Electronic and hard copy filing. Each secretary is responsible for one of the main WHO activities (STCs, NTAs, LCs, CSAs, TSAs, etc) as well as work from a programme officer. They are required to maintain documentation and correspondence in lever arch files (hard copies) and electronically. At present each secretary uses her own filing

system. There is a need for a standardized system applied across all programmes, with soft copies saved on the secretary's hard drive and not in the electronic filing system located on the LAN (server), which is still basic.

- Website. The WHO Sudan website is managed by the Regional Office and contains information on the collaborative programmes, the WRO, FMOH, partners and photographs. However, it is outdated and lacks recent information on the work of WHO in Sudan.

4.4.5 Logistics

At present WHO Sudan is responsible for the insurance and maintenance of 32 vehicles and one motorcycle. Of these vehicles, 23 carry "red" diplomatic plates and the remainder, "blue" project plates. The WRO has access to 12 vehicles and polio consultants and medical officers in the field use the remaining 20. Nineteen vehicles are equipped with HF radios and the office is in the process of installing mine-blankets in vehicles travelling to areas where these are deemed necessary. Although the number of vehicles should be adequate to address the needs of the office drivers are not sufficient to cover the needs.

4.4.6 Security

Considerable work has been done to meet the UN Minimum Operating Security Standards (MOSS) in WHO Sudan and in October 2003 a review mission will visit Sudan to assess compliancy. In response to a request from WHO, the UN Field Security Office conducted a security assessment of the Khartoum office. Some progress has been made in response to their recommendations, including the recruitment of additional guards in order to shorten shifts and have two guards on duty during the day. However, considering recent events in the Region, access control is still inadequate and needs to be reviewed and amended. The parking of cars in the street outside WHO also poses a security risk, especially at night.

4.4.7 Technical support to WHO Sudan

In the period 1 January 2002 to 31 August 2003, WHO Sudan received 160 technical support missions (Table 13). Approximately a third of the missions were for polio. The Khartoum office received 25 missions and most of these were for financial and technical (IT/communications/mapping) support as well as for the upgrading of the documentation centre. Of concern is the fact that, by end September, technical reports with recommendations had not been received for all missions. Moreover, follow-up of the recommendations made by the consultants is done in approximately 15% of cases.

Table 13. Technical missions to WHO Sudan, 2002 to end August 2003

Programme	HQ	EMRO	Other	Total	Percent	Report submitted, if required (%)
Polio	18	10	6	34	21.3	94.1
Tropical diseases	22	3	0	25	15.6	52.0
Malaria	7	9	11	27	16.9	83.3
WRO	6	12	7	25	15.6	65.0
Disease surveillance	7	2	0	9	5.6	65.0
AIDS and STD	1	6	0	7	4.4	100.0
Tuberculosis	1	5	0	6	3.8	83.8
EHA	4	0	0	4	2.5	100.0
Pharmaceutical	1	3	0	4	2.5	50.0
Reproductive health	3	0	0	3	1.9	66.7
Health policy and economics	0	3	0	3	1.9	100.0
Other	3	10	0	13	8.1	69.2
Total	73	63	24	160	100.0	

4.5 Challenges

- The peculiar political and social situation in Sudan requires efficient and timely responses from WHO. At present, most of WHO's collaboration and financial resources from the regular budget are focused on the government-controlled areas, while support to non-government controlled areas is primarily from other sources and OLS. The leadership role of WHO in the health sector for humanitarian assistance and the demands of the peace process require consolidated planning and management for the entire country, including resource allocation from the regular budget in the coming biennia.
- At present, the country office is mainly involved in long-term support to the country programmes. This includes recruiting short-term consultants, disbursing funds for local trainings and capacity building, facilitating purchases from abroad and other activities of similar nature. The analysis of the country programme costs for 2000–2001 shows that about 70% of the regular budget was in support of non-technical activities, of which 45% was for supplies and equipment. Technical assistance and training received only 14% and 21%, respectively. However, despite the provision of a large number of national training activities and short-term consultants, the lack of capacity for assessing needs, preparing and following up potentially reduces the impact of WHO cooperation in many cases. The support for policy advice receives a relatively small proportion of the regular budget in spite of its crucial importance. Similarly, although the burden of non-infectious diseases such as diabetes, cardiovascular diseases and cancer is increasing, they are receiving moderate support. There is a need for a gradual but definite shift from supporting a wide range of activities to a more focused, integrated and strategic collaboration in the country.

- The limited management capacity and resources in the country office coupled with the sheer number and diversity of activities further constrains the critical mass of inputs necessary to make a difference. The existing managerial processes and the level of authority to the WR need to be made more flexible for an effective response to the emerging requirements. Special skills and capacity for advocacy, expanding partnerships and resource mobilization need strengthening.
- The technical capacity of WHO is limited within the regular budget as most of the available human resources are associated with the polio eradication programme. This restricts the ability to pursue a technical leadership role at the health development scene. Also, due to time-consuming office procedures, technical staff are spending a considerable part of their time on administrative work and follow up with Regional Office. The capacities of the secretarial staff can be strengthened through specialized training and career development to provide more substantive assistance to the technical staff. Revision of the existing contractual arrangements and a programme of continuous professional development for the technical staff can also provide the motivation and incentive for excellence.

5. MAIN DIRECTIONS FOR 2004 ONWARDS

The health and nutritional indicators of Sudan depict an unacceptable reality, and the country and its international partners must be quick in grasping the current opportunities of peace and recovery. It is in this context that WHO wants to see avoidable mortality and morbidity reduced. Access to an equitable and financially fair health system will be the Organization's major technical contribution to the fulfilment of the basic right of the Sudanese people to healthy and sustainable livelihoods.

In addition to the WHO global priorities, the WHO Eastern Mediterranean Region has adopted a list of regional priorities aimed at improving the social and economic determinants of health with particular focus on a healthy environment and sustainable development through community-based initiatives like BDN. The commitment to emergency preparedness and response was reiterated by the Regional Committee for the Eastern Mediterranean in 2002 and has self-evident relevance for Sudan. Human resources development is high on the regional priority agenda, building on existing regional and national training institutions. Control of diseases with special focus on noncommunicable diseases and emerging priorities, strengthening surveillance and promotion of healthy lifestyles are among priorities in most countries of the Region. Regional priorities also focus on the need to enhance access to affordable quality medicines, to promote rational use of pharmaceuticals and to improve blood safety and laboratory services, as well as to improve access to quality childcare.

During the development of the CCS for Sudan, the country's needs, the national health strategy and expectations with regional orientations and global priorities for public health as well as the Millennium Development Goals were considered. Four specific strategic directions for the action of WHO in Sudan have been identified for the period 2004–2007.

- Stewardship. Health deserves a central position in the broader peace and macro-development agenda of the country: WHO will act as an advocate and play a proactive role in policy formulation, priority setting and strategic planning for the health sector.
- Health systems development. Sudan needs health systems that are equitable and fair, i.e. those are based on a comprehensive view of the determinants of health. WHO will contribute technical leadership, capacity building, integrated delivery of services through primary health care, public–private partnerships, research, health intelligence and monitoring;
- Reducing burden of diseases. Sudan’s burden of mortality and morbidity must and can be reduced. WHO will continue long-term support for selected programmes, address priority and emerging issues, promote healthy lifestyles and improve the quality of life with a special focus on the most vulnerable and underserved segments of the population.
- Responsiveness. Sudan’s exceptional circumstances and the fast pace of change pose extreme challenges to people’s survival and healthy livelihoods. WHO will work at strengthening the knowledge, institutional resources, technical and managerial capacities and mechanisms that are needed for an effective response to all health aspects of emergencies, humanitarian assistance and the peace process.

Within the four strategic directions, WHO identifies five functions for the country offices.

- Supporting long-term implementation of routine activities.
- Catalysing adoption and adaptation of strategies; seeding large-scale implementation.
- Supporting research and development; monitoring health sector performance.
- Sharing information and knowledge; providing policy options; standards; advocacy.
- Providing policy advice; serving as broker; influencing policy, action and spending.

6. STRATEGIC AGENDA FOR SUDAN

6.1 Current challenges

The WHO strategic agenda is based on the main challenges Sudan is facing at present. These are:

- High vulnerability. Civil unrest, vulnerability to external influences, recurrent natural disasters, high burden of infectious diseases including tropical endemic diseases, the recent resurgence of yellow fever in the South, and the new HIV/AIDS pandemic all have a profound negative effect on the health status in Sudan. Therefore, in order to stay relevant to the needs of the country, WHO’s cooperation must include strategies for adequate and timely responses.
- Lack of information. Much of the information that Sudan’s health sector should produce, and that is vital for the future of the country, is currently not available or

inaccurate. WHO can enable the Ministry of Health to provide reliable and updated figures.

- Health as a bridge to peace. During conflict, health issues can provide a bridge to peace, highlighting common needs as a platform for dialogue between conflicting parties. Through health partners, WHO can help focus dialogue on common human and humanitarian needs, and work at demystifying unjustified fears.
- Health central in all agendas. Although peace is on the horizon, the initial peace period will still constitute an emergency and the transition will entail important changes for the entire country; the health authorities should lead and promote health in the working agenda of the entire society throughout these changes. WHO can help the Ministry of Health to develop and show a strategic vision and maintain, or gain this leadership.
- Wider supportive approach. The crisis in Sudan and its resolution are intimately connected with the analogous processes taking place in neighbouring countries. The Horn of Africa Initiative will have to be synergized with similar processes taking place in the sub-region, so as to assist the WHO country office in the transition period, especially along border areas.

6.2 Country policy framework

WHO country cooperation in Sudan will be sufficiently flexible to adapt and progress in spite of the civil unrest localized conflicts, the HIV/AIDS threat and frequent humanitarian emergencies. The capacities, and the expectations of the partners at the local, state, and federal levels constitute further variables which WHO must coordinate, respond to and monitor, in order to optimize progress towards the millennium development goals and to consolidate its comparative advantage.

The planning horizon of the WHO CCS in Sudan will be influenced by the emerging requirements of national macro-economic policies and peace process in the South of the country. WHO country office will work to strengthen both its partners' and its own capacities for management and implementation and, in particular, its ability to respond with prompt assessments and quality interventions to any important development arising during the period set for CCS. Special attention will be given to ensuring timely mobilization of technical support and other resources from headquarters and the Regional Office.

The explanation of the critical nexus between health and sustainable development and poverty reduction is self-explanatory, but requires embarking on the crucial steps to move from analysis to policy and from policy to action. Three of the eight MDGs directly address health issues: Goal 4 (reduce child mortality), Goal 5 (improve maternal health) and Goal 6 (combat HIV/AIDS, malaria and other diseases). These goals can only be achieved by establishing a balance between macro-level policies and micro-level initiatives. The MoH alone cannot play an effective role to curtail the ill effects of poverty on the health of the population unless a wide base partnership is available. In order to ensure that broad frameworks such as GFTAM, GAVI and CAP benefit Sudan's health sector as much as

possible, WHO will provide strategic inputs and raise non-core resources to fund field implementation of relevant development and relief health initiatives, while supporting more robust inter-agency coordination. In this spirit, WHO will also support and participate in any joint inter-agency programming and initiatives to address with greater efficiency and effectiveness the many crosscutting challenges ahead.

6.3 Strategic profile

WHO aims to contribute towards the reduction of avoidable mortality and morbidity in Sudan in the face of the daily challenges of health development as well as extreme events such as wars and natural disasters. This will be the Organization's technical contribution to the creation of a peaceful, enabling environment conducive to the fulfilment of the basic right of the Sudanese people to survival, sustainable livelihood, access to equitable and financially fair health system and attainment of the millennium development goals.

WHO is already providing programmatic support to the health sector of Sudan according to the biennial country collaborative plans. This support includes technical assistance and guidelines, training and different capacity building activities, equipment and supplies and financial support to operations. Looking at the situation analysis and on the basis of a preliminary consultation with various stakeholders, it is concluded that WHO needs to compliment and optimize this programmatic support under the following principles:

- The leadership function of FMoH requires capacities for advocacy and negotiations, policy, planning and management in a manner that suits the developmental and humanitarian needs of the country. This implies a precise pro-poor strategic choice for vulnerability reduction and effective mechanisms for the management of human resources, infrastructures and financing, as well as for administration, strategic coordination and decision-making.
- The health systems must be based on the principles of equity, efficiency, effectiveness and community empowerment by working across all the relevant levels of institutions and communities. The decentralization must be horizontal as well as vertical, fostering partnerships across all sectors and with all actors that are relevant to public health in Sudan. The contribution of private sector and NGOs in promoting and protecting health is essential but needs a clear understanding of responsibilities and regulatory mechanisms.
- FMoH and WHO must be proactively involved in the health aspects of humanitarian assistance and reconstruction in South Sudan, in terms of setting overarching priorities, principles and strategies to ensure that universally accepted public health policies, norms, standards and actions that are fully integrated in all the phases of the peace process and transition.

The four specific strategic directions of CCS for entire Sudan for the next four years will be as follows.

1) *Stewardship*

WHO will act as an advocate and play a proactive role in policy formulation, priority setting and strategic planning for the health sector for securing a central position for health in the broader national macro-development agenda with a coordinated approach with civil society including public and private sectors, NGOs, academic institutions, communities, UN organizations and donor agencies. Specifically, WHO will support:

- Capacity strengthening of the Health Planning Directorate (HPD) in FMoH and in the states.
- Development and refinement of national policies, plans and management systems on best available evidence i.e. human resource policy, drug, private sector, health insurance, maternal and neonatal health, IMCI and nutrition policies etc.
- Development of a pro-poor national strategy for sustainable development based on CBI approach and in line with the recommendations of the Commission on Macroeconomic and Health (CMH).
- Implementation of a comprehensive health information system including community level information.
- Strengthening of the national health research system.

2) *Health systems development*

WHO will contribute towards the development of equitable and financially fair health systems based on a comprehensive view of the determinants of health through technical leadership, capacity building at all levels, integrated delivery of services through the primary health care approach, public-private partnerships, health system research and an in-built culture of health intelligence and monitoring. Specifically, WHO will support:

- Capacity strengthening of training institutes.
- Strengthening of continuous professional development.
- Strengthening and better equity in distribution of the decentralized PHC system and secondary and tertiary care systems at all levels.
- Increasing of accessibility to essential integrated PHC packages of service and improvement in the quality and safety of services at all levels.
- Strengthening organization, management and functions in secondary and tertiary care levels.
- Improving critical and emergency care services at the secondary and tertiary care levels.

- Expansion of the comprehensive of the BDN approach and implementation of the healthy city project (HCP) in a systematic manner for health, environment, and social protection and promotion in urban settings.
- Development of national and local management capacities, increasing and scaling up of IMCI and nutrition.
- Improving quality of medicines and pharmaceutical services and increasing accessibility to essential drugs.

3) *Reducing burden of disease*

WHO will continue long-term support for selected programmes and will address priority and emerging issues, in line with WHO global and regional priorities and consistent with national strategies to reduce the burdens of mortality and morbidity in Sudan, promote healthy lifestyles and improve the quality of life with a special focus on the most vulnerable and underserved segments of population by influencing all determinants of health. Specifically, WHO will support:

- Implementation of activities related to the prevention and control of the six major causes of mortality: malaria, diarrhoea, malnutrition, ARI, tuberculosis and vaccine preventable diseases.
- Reinforcement of HIV/AIDS prevention through increased awareness and promotion of safe sexual behaviour, volunteer testing and counselling, and blood safety.
- Prevention and control of endemic tropical diseases (trypanosomiasis, leishmaniasis, leprosy, schistosomiasis, lymphatic filariasis, onchocerciasis and Buruli ulcer, dracunculiasis and nodding disease) in the southern part of Sudan and other specific areas.
- Prevention of and response to disease outbreaks (i.e. cholera, meningitis, yellow fever, Rift Valley fever).
- Extension of an integrated system of communicable diseases surveillance.

4) *Responsiveness*

WHO will create an institutional environment, technical and managerial capacities and mechanisms for an effective response and assistance on emergencies, humanitarian assistance and the peace process. Specifically, WHO will support:

- Core human, financial and functional capacities in the country office and sub-offices that are needed to meet its responsibilities in any emergency: in terms of staff security, rapid assessment of the situation and operational planning, resource mobilization, sectoral coordination and technical guidance.

- Establishment of functioning disasters and health emergencies management structures at federal and state levels.
- Improvement the capacity of health related sector, other stakeholders and the community in disasters management.
- Monitoring of response to emergencies.

6.4 Strategic shift

The matrix in Tables 15 and 16 will guide the functional emphasis and financial resource allocation from regular budget and other sources, for WHO's future work in Sudan. The proposed strategic shift for Sudan, which is need-based, represents a significant departure from WHO's current emphasis. There is a major refocusing from support of implementation of routine activities towards an upstream policy emphasis (Table 16). This shift is consistent with ongoing reforms within WHO which aim at taking an active leadership role in world health and strengthening contributions at the country level. However, it is recognized that the technical and financial shift can only be effected gradually. The first milestone for this transformation will be the WHO country collaborative programme for 2004–2005.

Table 15. Strategic profile and functional emphasis during the next four years

Strategic directions	Function 1: Long term implementation	Function 2: Piloting, seeding	Function 3: Research and monitoring"	Function 4: Information and knowledge	Function 5: Policy advice
1: Stewardship	+	+	++	+++	++++
2: Health systems	+++	+	+++	++++	++++
3: Burden of disease	+++	+	++	++++	++++
4: Responsiveness	++	+	+	++	++

Table 16. WHO strategic profile shift relevant to functions (compared to current situation)

Strategic direction	Function 1: Long term implementation	Function 2: Piloting, seeding	Function 3: Research and monitoring	Function 4: Information and knowledge	Function 5: Policy advice
1: Stewardship	↓↓	↓	↑	↑	↑↑
2: Health systems	↓	↓	↑	↑↑	↑↑
3: Burden of disease	↓	↓	↑	↑↑	↑↑
4: Responsiveness	↑	↑	↑	↑	↑
Total	↓	↓	↑	↑↑	↑↑

6.5 Prerequisites

- Full mutual understanding with and continuing trust from the national authorities are critical. They can be maintained and strengthened by investing in consistent technical assistance to FMoH in the central functions of policy formulation and strategic planning, while at the same time ensuring that these and the other functions of the

Ministry benefit from the other components of WHO country cooperation in terms of inputs (health intelligence, guidelines, external resources) and outputs (opportunities for delivery of services).

- Gaining the trust of other partners can only be a work-in-progress. Success will be measured against the outputs of establishing and maintaining relevant systems and partnerships between national and international health actors. All new strategic proposals within the parameters set by this CCS should be developed in consultation with the FMoH and other partners. The biennial joint programme reviews should ensure that coordination and monitoring are effective and timely, and that the health sector's needs meet with appropriate responses.
- National execution, flexibility and transparent management should be the means for enhancing ownership and self-reliance. Making a difference will require predictable presence close to the point of service-delivery, along the model of the polio programme, and meaningful contribution in inter-agency planning and operational coordination, as well as easy communication with the Regional Office and HQ. It will have to be based on consistent processes of knowledge management, integrating epidemiological surveillance, programme monitoring and research in health intelligence, learning, documentation and dissemination.
- WHO's credibility can come from translating public health expertise in concrete life-saving actions. Given the natural environment of Sudan, its vulnerability profile and the current and foreseen transitions, the country office needs to be capable to provide emergency public health responses as, when and where they are needed. A first level of readiness and surge capacity can be established by building competencies in health emergency management in the country team, and by setting sufficiently flexible procedures for exceptional circumstances. Additionally, given the current and immediate-term scenarios, procedures will have to be in place for the WR to mobilize promptly regional and global solidarity and expertise to address the demands of the peace process.

7. IMPLICATIONS FOR WHO

7.1 Country presence

7.1.1 Overview

The shift from a role of programme implementation to one of an effective advocate and catalyst for strategic development of the health sector has immediate implications for the WRO in Sudan. Changes should be adopted as soon as possible and facilitated by all levels of the Organization to strengthen the capacities of the country office and fulfil its functions in the areas of technical knowledge, management, sectoral advocacy, representation and partnerships.

7.1.2 Technical knowledge

Technical knowledge will need significant enhancement to assume the more proactive technical leadership role among health stakeholders as foreseen in the strategy as opposed to the current emphasis on administrative processing of requests. This will depend largely on the ability to draw on WHO's leading expertise for the full range of specific topics and disciplines required, as well as staying abreast with the latest international developments through access to databases and the world wide web. Specific requirements include:

- Establishment of clear procedures through which the WR will be in the position to mobilize technical support at short notice from the Regional Office or HQ.
- Recruitment of at least two international public health "all-rounders": one assigned to support policy, planning and management of FMoH and northern Sudan one to be assigned to the development of health system for South Sudan.
- Need-based local recruitment of public health professionals to be posted in the country office and at the sub-office levels.
- Redefinition of terms of reference (TOR) of the existing WHO country staff to incorporate the new strategic directions.
- Revision of contractual conditions, both international and national, so as to be competitive with prevailing rates in Sudan and other WHO regions.
- Training for the WHO country staff to consolidate their technical and managerial competencies. Specific provisions for this will have to be made in terms of budget and working plans.

7.1.3 Management

WHO country office will have to work in a complex context. It will be scrutinized vis-à-vis the performance of other agencies, and will have to set a model for national counterparts. It will have to be resilient and authoritative, too, as it will have to face sudden increases in workload, both in terms of resource flows and administrative challenges. The success of the WHO country cooperation relies on judgments made by the WR and goes far beyond the current, largely administrative and political functions. Therefore, management will have to be, effective, transparent and efficient in order to respond to changing situations in the country and to the national counterparts and other agencies. Specific requirements include:

- Review of the biennial plan of work 2004–2005, to "anchor" the planning of the country programme on the CCS orientations.
- Implementation of the new expanded delegation of authority to the WR from the Regional Office, commensurate with his responsibilities including flexibility to allocate, re-allocate, and spend resources within the strategic framework.

- Urgent identification of ways and means to maintain the polio network (human resources, infrastructures and logistics) after phasing out of the programme.
- Establishment at zonal level, of new technical units covering a specified number of states, and utilizing the existing polio network in an integrated manner.
- Financial allocation provided from the regular budget for sustainable presence and systematic programme contribution for the non-government controlled areas of South Sudan.
- Similar arrangements in place for the office and logistic support in harmony with other international partners.
- Upgrading and standardization of the financial and accounting system to make them more responsive to management and monitoring needs.
- Upgrading of logistics and general equipment to respond to the new orientation and role of the office.
- Recruitment of an international Arabic-speaking administrative and finance officer to facilitate the country office management;
- Preparation of contingency plans to deliver emergency assistance to the specified number of people through active intercountry and cross-border cooperation through joint inter-agency programming initiatives and strategic coordination among implementing partners.
- Skill-based training for all members of the WHO country team.

7.1.4 Advocacy and representation

These are a prerequisite to the Organization's technical credibility. WHO will have to be more visible, coordinated with and acknowledged by national and international partners. Timely flow of information between country office, Regional Office and HQ, dissemination of epidemiological evidence and guidelines, and facilitating access to scientific resources will constitute a major piece of WHO work in knowledge management and system development. It is therefore essential that the communications facilities of the country office become state of the art.

This would require substantial communication and information technology investment as well as support for its operation and maintenance. Specific actions will be the following.

- The Minimum Operational Security Standards (MOSS) utilized as a guideline to ensure good connectivity between the WHO office in Khartoum and sub-offices.
- Recruitment of an information/communication officer.

- Publication of a quarterly bulletin.
- Connection to internet at sub-offices level in line with the facilities established in the country office.
- Attitudes and skill training across all WHO country team, including security training.

7.1.5. Partnerships

Building partnerships and alliances with all segments of the civil society bring synergies, resources and unified actions between all stakeholders. CCS should lead to an expansion of partnerships with the government at state and federal levels, other national stakeholders like the media, NGOs, professional associations, communities, CBOs, state councils and international organizations including the WB, NGOs, bilateral agencies and UN agencies. While moving into the critical phase of peace consolidation, the WHO country office should work more closely with other health partners and strengthen its efforts towards more robust inter-agency strategies to build capacity of local actors. Coordination mechanisms will have to be factored into the workload of WHO Sudan. This requires secretarial capacities including staff time, office and operational resources, delegation of authority, circulation and dissemination of information.

7.2 Regional Office and headquarters

The new Country Cooperation Strategy for Sudan would require the country office to assume the lead role in decision-making and programme planning and implementation. The performance of this changed function and the minimal requirements stated above will depend to a large extent on the transformation from decisive to supportive management at the Regional Office and HQ.

The staff at these levels of the organization has to be willingly to accept this change for a proactive response to the needs and requests of the country offices. It will involve new ways of thinking, operating and mobilizing resources to fill gaps in health programmes of Sudan.

The Regional Office and HQ must work closely in identifying and tracking technical resources in a more coordinated manner to support the country office activities by sharing global and regional experiences, developing standards, guidelines and protocols and providing documents and publications. The traditional and modern communication and information technology should be utilized for the dissemination of the technical resources between different levels of WHO. More specifically, the Regional Office should:

- Help with the redaction of terms of reference.
- Mobilize and allocate additional resources to the country office.
- Build capacity of programme officers, by inviting them to participate in regional focal points meetings.

At headquarters level, some catalytic funding has already been provided to implement priority activities (recruitment of an Administrative Officer and installation of a VSAT). However, more funds will be necessary in the near future. In addition, headquarters level should help with the creation of new positions, and increase and coordinate resource mobilization at the global level in line with the country focus.