The Present Context

In January 2005, the Government of Sudan and the Sudan People’s Liberation Movement (SPLM) signed a Comprehensive Peace Agreement (CPA), putting an end to a 20 years war that left some 1.5 to 2 million dead. The conflict also had a devastating impact in terms of displacement and destruction of infrastructure and social fabric. In Darfur, not included in the agreement, low intensity conflict continued throughout 2005 with several serious escalations, despite ongoing peace talks. Protracted insecurity, violations of human rights and drought led to an increase in the conflict-affected population from 2.5 million in May to 3.4 million people in August. Floods and droughts are recurrent events.

Based on the findings of a UN/WB/GoS/GoSS Needs Assessment presented at the April 2005 donor conference in Oslo, the 2006 Work Plan for the Sudan has both a humanitarian component and a recovery and development component. It focuses on supporting the implementation of the CPA, efforts for a peaceful resolution of other conflicts in the country and the provision of humanitarian, recovery and development assistance to complement the GoNU and GoSS initiatives. The Work Plan outlines programmes and projects covering all of Sudan and focusing on seven areas: Southern Sudan, Darfur, Abyei, Blue Nile, Southern Kordofan, Eastern Sudan and Khartoum and Other Northern States.

Main Public Health Issues and Concerns

Health Status

- In the South, infant and maternal mortality rates are 150 per 1,000 and 1,700 per 100,000 live births respectively. In Eastern Sudan, under-five mortality rates range from 117 per 1,000 live births in Gedaref State, to 165 in Red Sea State, and reaches 172 in Blue Nile State.
- In 2006, at least 2.5 million people in Darfur and nearly three million people in the south, east and transitional areas will be requiring food assistance. In both the South and Darfur, the proportion of children suffering from global acute malnutrition is estimated at 22%.
- In the South, less than 40% of the population have access to safe drinking water or sanitation. The incidence of diarrhoea in children may be as high as 45%. Further, the prevalence of tropical diseases, largely controlled elsewhere, is very high.
- Some 600,000 people are believed to be living with HIV/AIDS, with higher rates of infection in specific geographical areas. Lack of information on HIV and increased mobility between the various states and with neighbouring countries renders the population increasingly vulnerable. Sudan is on the list of countries for ART treatment scale-up of the 3 by 5 Initiative.

Disclaimer

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• Malaria is the leading cause of morbidity and mortality in the country. It accounts for 20 to 40% of outpatient consultations and about 30% of hospital admissions, amounting to three million reported cases in 2003. The entire population is at risk and P. falciparum is by far the predominant parasite. In 2004, the national drug policy was updated to artemisinin combination treatment (ACT) for first line treatment.

• Although Sudan has been polio-free since April 2001, the virus has gradually reappeared; in 2005, 27 cases of wild poliovirus have been reported. The outbreak appears to have been curbed.

Health System

• In the North, the infrastructure network and the workforce are quite developed in absolute numbers. However, up to a third of health facilities are reported not to be fully functional.

• The low sectoral performance is due to a combination of causes: limited utilization of health services (at aggregate level, 40-60%) also due to financial barriers, large regional and economic access inequalities; facilities and equipment deterioration resulting from lack of maintenance. Services and coverage are worst in the South where there is absence of infrastructure, poor transport, and low technical and managerial capacity at local level.

• Public health financing is low and skewed towards hospital services and urban areas; decentralization has not been supported by transfer of resources nor capacity. There is a progressive deregulation of the sector; low levels of external assistance – particularly bilateral – and no access to grants/loans from international financial institutions.

• The level, direction and implementation of international emergency assistance are insufficient and local institutions have only limited capacity to absorb additional financial and technical support.

• In the South, overall coverage is estimated at only 25% of the population. Infrastructure is inadequate, geographically concentrated and in poor conditions. Most health services are supported by international NGOs under humanitarian programmes.

Main Sector Priorities

Nationwide, the main common priorities include:

• Expanding and consolidating the provision of a comprehensive package of basic health and disease control services, particularly to the conflict-affected population;

• Strengthening emergency preparedness, response and mitigation;

• Strengthening the communicable disease surveillance system;

• Building, strengthening and sustaining the institutional and human resources capacities of the Federal, State and local health actors including health authorities and health science institutes.

Additionally a number of area-specific priorities deserve highlighting:

• In Southern Sudan, expanding the disease surveillance and outbreak early warning system in the ten states of Southern Sudan and establishing an integrated disease surveillance and response system by building the capacity of the Federal MoH in these areas.

• In Darfur, scaling up humanitarian interventions to ensure health protection among conflict-affected populations.

• Ensuring health assistance to IDPs, refugees and host communities in Abyei, Southern Kordofan, Eastern Sudan and Khartoum and other Northern States.

• Ensuring treatment of severe acute malnutrition among under-five children and nutrition surveillance in Southern Kordofan, Eastern Sudan and Khartoum and other Northern States.

More information can be obtained from the CE-DAT, a database on the human impact of complex emergencies part of the SMART initiative launched in June 2002 by a consortium of UN agencies, NGOs and academic institutions.