Community Health

Policy and Implementation Landscape Mapping in the Middle East and North Africa Region 2024

Sudan Country Brief

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1. Community health in Sudan

Existence of a community health policy in place	Recognition of CHWs as part of the national health workforce	Number of CHWs currently deployed	Inclusion of CHWS in emergency preparedness plans	Domestic funding available	Community engagement mechanisms in place	Formal linkages between community health and other sectors available
In progress	Yes	57,423	Yes	Yes	Yes	Yes

1.1 Country context

The Republic of Sudan is a country in Northeast Africa with a total population of 48.1 million.[1] Sudan has experienced conflict and political instability over the past two decades, including two civil wars and a protracted conflict in the western region of Darfur. In 2023, fighting broke out between the Sudanese Armed Forces (SAF) and paramilitary Rapid Support Forces (RSF) in the capital, Khartoum. Since then, the country has been in a state of war with violence occurring across the country, and especially concentrated in Khartoum and Darfur. Over the past year, the war has created significant instability in the country, leading to further crisis, insecurity and internal displacements.[2]

In terms of administrative systems, the health system in Sudan is decentralized. The Federal Ministry of Health (FMoH) is responsible for policymaking and strategic planning as well as health legislation, standards and guidelines, training of different health care personnel and overseeing and monitoring performance of State Ministries of Health (SMoHs) in addition to financial and technical support to the States. It is also responsible for regional and international relations in addition to declaration and control of epidemics. State ministries of health are responsible for planning, implementing of national health policies, standards and guidelines, establishment of PHC facilities, provision of secondary and tertiary health services, overseeing localities' performance and for providing support to the localities. Localities are, in turn, responsible for provision and management of primary health care (PHC) services, health promotion and community participation.[3]

1 WHO (2024). Sudan: Health data overview for the Republic of Sudan. Retrieved from https://data.who.int/countries/729.
2 ACLED (2024). Sudan Situation Update. Retrieved from https://acleddata.com/2024/04/14/sudan-situation-update-april-2024-one-year-of-war-in-sudan/.
3 Federal Ministry of Health (2016). Sudan's National Health Policy 2017-2030, FMoH.

1.2 Overview of community health

In 1976, PHC was endorsed in Sudan as the principal health care approach with an aim to reach rural and underserved populations.[4] Community health is part of this approach and community health workers (CHWs) are formally recognized as health care personnel and are deployed in health care settings. In addition, in 2012, Sudan endorsed the Universal Health Coverage (UHC) approach.

Sudan has a long history of community health service delivery. Services are often delivered through vertical programmes leading to some duplication between states and localities.[5] Several policies and initiatives have been undertaken by the FMoH to reform community health, including through the National Health Recovery and Reform Strategic Plan (NHRR - SP) 2022-2024, and the PHC Expansion Project, among others. The protracted state of conflict and ongoing war in the country negatively impacts efforts to harmonize and monitor existing programmes.

2. Health systems pillars

2.1 Governance and accountability

- While there is currently no overarching community health policy in Sudan, community health remains a priority in the country.
- Community health is often included in vertical programmes and strategies. These include the Reproductive Health (RH), Expanded Programme on Immunization (EPI), and Malaria programmes, among others.
- Integrated community case management (iCCM) and integrated management of childhood illness (IMCI) also both focus on community-based services and serve as a foundation for investing in community health in the country. The iCCM strategy was developed in 2018, but was not endorsed due to instability in the country at that time. Currently, UNDP is providing support to the FMoH to develop a new iCCM strategy through a grant from the Global Fund.
- Sudan has also made a significant effort to strengthen community health through its PHC Expansion Project. This project started in 2012 and aims to increase PHC coverage and move away from a hospital-centric model. Through this project, the scope of services offered has expanded with a significant increase in the total number of formal CHWs and community midwives (CMVs) trained and deployed.
- Of note, Sudan's National Health Policy (2017-2030) includes as one of its priority areas to strengthen the management capacity of decentralized health services through integration of vertical programmes into PHC service delivery.
- To lessen the duplication resulting from vertical programmes and parallel approaches,[6] the FMoH has recently set up a task force for community health to spearhead this issue and to expand existing efforts on community health integration.
- There is no framework for public-private partnership with the health sector in Sudan. There is some private sector regulation at State level, but with limited enforcement due to capacity issues and limited engagement at community level.

4 Ebrahim, E., Gebrehiwot, L., Abdalgfar, T., & Juni, M. (2017). Health Care System in Sudan: Review and Analysis of Strength, Weakness, Opportunity and Threats (SWOT Analysis). *Sudan Journal of Medical Sciences, 12(3)*.
5 World Bank. (2017). Moving toward UHC: Sudan national initiatives, key challenges, and the role of collaborative activities.
6 Mohamed, A. M. (2023). Challenges of Primary Health Care in Sudan and the Role of the Health System Building Blocks as Contributing Factors: Rethinking Primary Health Care in Sudan's Journey to Universal Health Coverage, KIT Royal Tropical Institute.

2.1.1 Community engagement

- As outlined in the NHRR -SP 2022-2024, there is an aim to improve PHC through a family health approach. This includes contributing to community systems strengthening by fostering community engagement through the establishment of community health dialogues and community health committees. The Strategic Plan also outlines establishing community accountability mechanisms such as Period Health Assembly, although no specific accountability mechanism for CHWs is mentioned.
- These aims to increase community engagement have yet to be operationalized, however. Currently, there is limited engagement in the setting, planning and delivery of national health policies and services, also in maintaining oversight and social accountability.

2.2 Health management information systems

- DHIS2 is used for data management in Sudan. A community health information system module is available in the DHIS2, but has yet to be rolled out.
- A community-based HMIS was piloted in two states in 2014-2015 (Sinnar and Red Sea). The pilot included the design and testing of data collection tools, evaluating the data flow pathway and identifying and training CHWs. An additional phase included setting up a supervisory mechanism and analysing the results from the first phases, but this was only partially completed. At the time, the intervention was not scaled up, although there is now a plan to take this forward for full implementation.
- The community-based HIS was developed jointly with different departments in the FMoH such as surveillance, maternal and child health, emergencies, malaria and health promotion; however, it mainly registered vital statistics (births and deaths).
- Most community health data is collected manually via paper-based reports. Data collection is often irregular. There is a lack of training and capacity on data collection, entry and analysis and limited capacity for dissemination.
- At national level, data can be used for decision-making, such as for the allocation of resources. Health programmes often have defined standardized indicators for community health (e.g., RH, non-communicable diseases, nutrition), although there are issues with implementation.

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2.3 Medicines and health commodities

- Procurement and supply management is provided through a unified supply system known as the National Medical Supply Fund (NMSF), which is regulated by the NMPB.[7]
- Supply systems are integrated as part of the PHC package. For example, for CMVs, NMSF is responsible for procurement of midwifery bags and clean delivery kits. These are distributed according to the RH programme distribution plan at state level and in some instances at locality level. However, direct distribution of the kids to the midwives is the responsibility of the programme and the chief midwives of the state and locality.
- For certain programmes, a standard national list of CHW supplies to be provided to community health providers is often outlined in the respective policies and strategies. This is the case, for example, in the iCCM policy and the RH policy.
- In line with the PHC Expansion Project, formal CHWs and CMVs receive supplies, which are "topped up" during supportive supervision or when needed (and the request is made to the locality). Supplies are also renewed completely every three years in conjunction with recertification processes. The role of the NMSF is to procure these kits and distribute to the state or locality level as per the agreement in each state.
- For medicines and consumables, the NMSF distributes commodities in accordance with the given programme's distribution plan and places supplies as per agreement with that programme.

2.4 Health workforce

- CHWs are recognized as part of the national health workforce in Sudan. There are three primary cadres in operation, including formal CHWs (service providers), midwives and health volunteers, including nutrition guides and health promoters. These cadres include both volunteer and formal CHWs. Formal CHWs and CMVs are employed at state level with employment rates varying by state and resources available.
- The health cadres in Sudan are regulated by the Sudanese Council for Health Professions, which is responsible for licensing, accountability, and ethical standards. The Ministry of Labour and the Civil Service Bureau/Chamber play a critical role in the recruitment of health workers.
- The roles and responsibilities of CHWs vary by cadre. Formal CHWs and CMVs have clearly defined roles and responsibilities outlined in their training programmes. For health volunteers, clarity of roles is dependent on the programme. Health volunteers are also deployed by programmes as needs arise.
- The Evaluation of CHW Programme (2022) estimated that there are over 57,000 CHWs currently deployed in Sudan. However, this number has most likely been impacted by the ongoing conflict since April 2023.
- Although there CHWs are available in the country, training, supervision and accountability systems need revitalization, investment and improvement to ensure quality service provision.
- A training curriculum for formal CHWs was developed by the FMoH and the University of Health Sciences in 2012. Formal CHWs are required to complete pre-service training using this curriculum. The programme lasts 9 months and accreditation is received upon completion. The curriculum is in need of updating to include more programme-related content. An updated version was created but has yet to be fully endorsed and adopted due to the political instability in the country.

7 Federal Ministry of Health. (2022). Evaluation of Community Health Workers' Programme in Sudan.

- CMVs are trained in midwifery schools through a 15-month curriculum. However, the quality of education varies. While there is commitment to the criteria outlined by the International Confederation of Midwives (ICM), there is not always full alignment due to the realities of the local context. For example, due to low literacy in some states, literacy is not a pre-requisite for becoming a CMV (although basic literacy courses are provided in a pre-induction course).
- Health volunteers attend short-term training courses ranging from a few days to weeks that are programme specific. These courses are conducted through the PHC programme with support from NGOs.
- Programme-specific training is also offered as in-service training for CMVs and formal CHWs. The training is carried out by doctors, midwives and nurses who underwent training of trainers (TOT) programmes and is supported by the government or NGOs depending on the programme.
- Supportive supervision is carried out to CHWs as programmatic components, although this is sometimes irregular and piecemeal. Supervision is provided through PHC programmes by associated facilitators or by monitoring and evaluation officers of specific programmes.

2.5 Service delivery

- Community health services are primarily characterized by vertical programmes (e.g., Non-Communicable Disease [NCD] programme, Child Health programme, RH programme, Nutrition programme) delivered as an extension of PHC services.
- Efforts for integration have also been established through the PHC expansion project with coordination of both CHW and CMV activities as part of primary health initiatives.
- According to the Evaluation of the CHW programme (2022), there are 24 different community health programmes. While administrative personnel dedicate their time to specific programmes, CHWs fulfil responsibilities under multiple programmes.
- Although gender considerations are not routinely integrated across all programmes, GBV has been an important component in the RH programme in the context of the ongoing conflict.
- CHWs play an important role in emergency response. Community health surveillance is integrated into emergency response, this includes for disease outbreaks and armed conflict. There is no additional training currently provided on security measures in the context of armed conflict for all health cadres.
- While refugees and IDPs have some involvement in community health, their integration has not been documented.
- Referral pathways were further coordinated in line with the PHC expansion project and are available to higher level care facilities. However, these sometimes have suboptimal implementation due to a lack of resources.
- Guidelines for improvement of quality of care at the community level are sometimes outlined for specific programmes as is the case for iCCM.

2.6 Partnerships and financing

- Expenditure on health as a percentage of GDP is 3 per cent, while the proportion of government budget allocated to health is 8 per cent as of 2022.[1]
- For programmes funded by the Government, most programmes are centralized and, depending on state capacity, funds are redirected to each respective state.
- States are responsible for distribution and management of funds as well as payment of CHWs.
- External partners play an important role in supporting community health, including through funding specific programmes, such as EPI and ICCM.
- As of 2023, 6 per cent of health expenditure is sourced from external funders. However, this remains fragmented and vertical and dependent on donor's varying mandates and scope of work.[8]
- Support provided by external partners includes both technical and material support.
- The main external partners supporting community health efforts include UNICEF, WHO, Global Fund, UNFPA, JICA, UNHCR, IRC, MSF, and Save the Children.

2.7 Cross-cutting issues

2.7.1 Gender

- Gender considerations are not routinely integrated across community health programmes. That stated, GBV response and referral have been important components in the RH programme in the context of the ongoing war.

2.7.2 Emergency preparedness

- CHWs play an important role in emergency response. Community health surveillance is integrated into emergency response, this includes for disease outbreaks and armed conflict.
- There is no additional training currently provided on security measures in the context of armed conflict for all health cadres.

2.7.3 Refugees and IDPs

- While refugees and IDPs have some involvement in community health, their integration has not been documented.

8 Bashir, F & Allen, L. (2023). Health financing in Sudan: key informant interviews in the wake of the 2023 conflict. https://doi.org/10.1101/2023.12.20.23300333

Insights: The role of community midwives in the ongoing crisis

- CMVs have played a critical role in the ongoing war, particularly in Khartoum. In Khartoum State, over 60 per cent of deliveries occur in health facilities, which is the highest in the country. With the outbreak of war in 2023, all of the maternity hospitals were forced to close, leaving a severe deficit and maternal health crisis in its wake.
- Using social media platforms, the MoH was able to mobilize CMVs in the area. With support from their supervisors, CMVs formed groups to respond to the crisis and safely conduct deliveries across localities in Khartoum. Deliveries are conducted at home or in makeshift labour rooms set up in PHC centres across the localities.
- Additional training was provided to the CMVs at the outset of the war to better meet the emergent needs. This included a refresher training on maternal and neonatal warning signs. It also included an orientation on recognition and referral of cases of gender-based violence. As frontline responders, CMVs took on the responsibility to ensure early referral to local health centres for appropriate case management.
- The availability of the CMVs and the strength of their response to the war highlight the potential of the community health workforce to be mobilized and rapidly deployed, especially if further integrated into emergency mechanisms in response to conflict.

3. Conclusions

3.1 Challenges

- There is an availability of fragmented policies addressing community health, but no overarching community health policy. Vertical programmes in community health lead to duplication of efforts and indicate a need for integration.
- There is a gap in training and capacity for data entry for some programmes, which can lead to poor quality data and reporting.
- Some CHWs receive regular payments from the government, while others rely on irregular and sporadic incentives from projects.
- Training curricula for formal CHWs are not fully up-to-date with current programmes.

3.2 Enablers

- There is an ongoing strategy development process focused on strengthening community health. This effort aims to enhance the integration, coordination and overall effectiveness of community health initiatives, ensuring that resources are utilized efficiently and health outcomes are improved across various programmes.
- Initiatives, such as the PHC expansion project and the iCCM strategy, have laid important groundwork for strengthening community health.
- The community health workforce is available in the country and actively engaged in programmes.
- Structures are in place, such as training institutions for both formal CHWs and for CMVs through the University of Health Sciences, including in-service, refresher and follow up training, with opportunities for investment and improvement.

3.3 Priority policy directions

- Establish policies and strategies to organize the work around community health:
  - With the existing community health task force, create an overarching community health policy with full integration and harmonization of vertical programmes.
  - Harmonize policies and standards with regards to formal CHWs and CMVs with clear definitions and opportunities for career progression. Ensure gender sensitivity is incorporated throughout.
  - Invest and update formal CHW and CMV training courses to include programme-specific content and work to align educate with global standards (e.g., ICM). In addition to the accreditation process, the training courses should be linked with periodical recertification of CHWs with target continuing professional development (CPD) hours from the Civil Service Chamber.
  - Invest in and strengthen the regulatory system responsible for regulating the CHW cadres, including the Sudanese Council for Health Professions as well as the role of the Ministry of Labour, and the Civil Service Bureau. Strengthen systems related to the issuing of licenses, enforcing accountability and ensuring up-to-date codes of ethics and conduct.
- Establish strong monitoring mechanisms, including:
  - A harmonized community-based information system, integrating vertical programmes and streamlining data flow, building off previous pilots.
  - Incorporation of C-HMIS into the DHIS2.

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