Humanitarian-development-peace nexus for health profile

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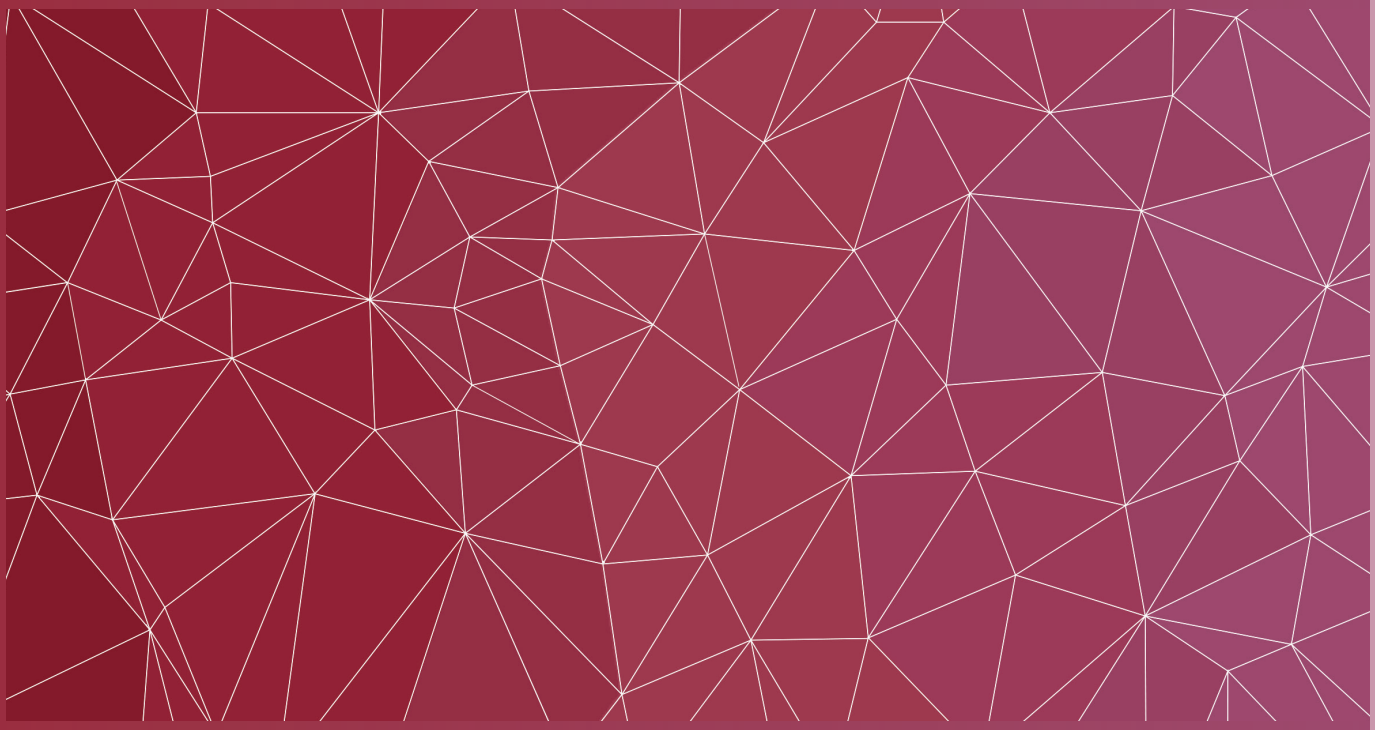

December 2020

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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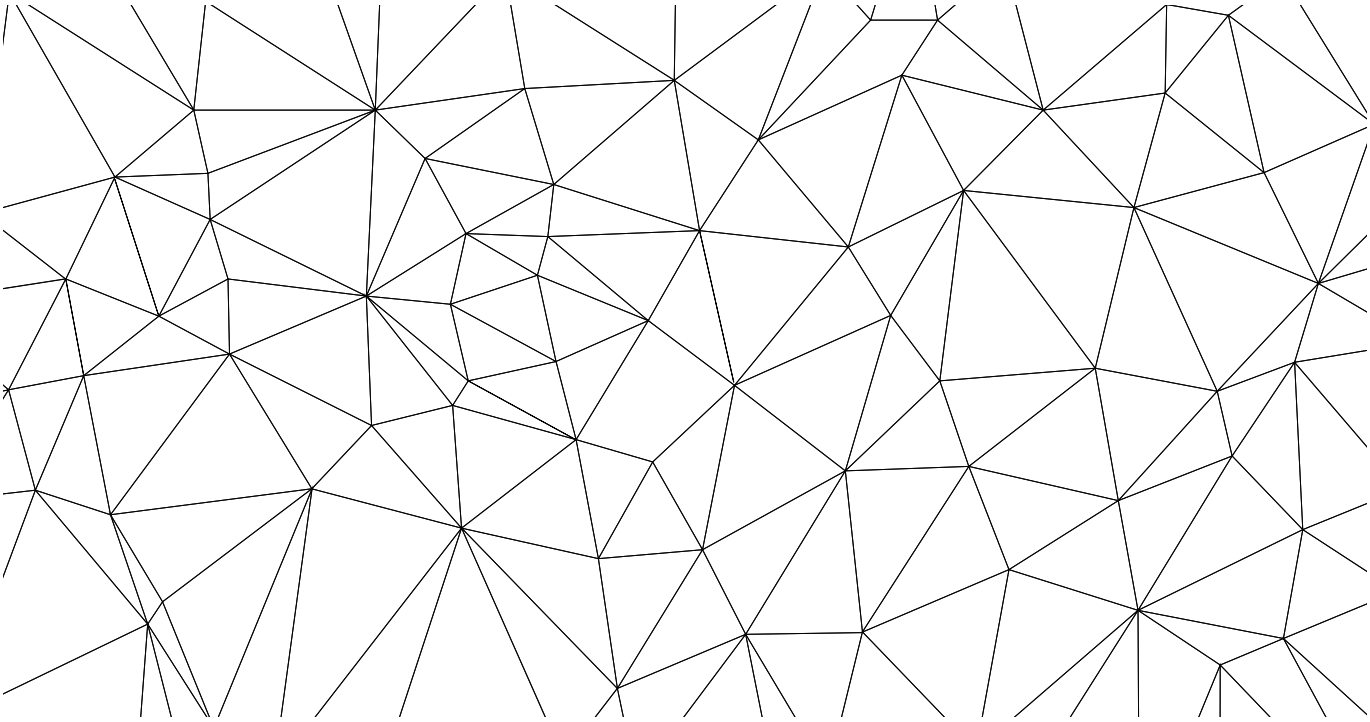

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Contents

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Abbreviations

COVID-19	Coronavirus disease 2019
FMoH	Federal Ministry of Health
GDP	Gross domestic product
HCT	Humanitarian Country Team
HDPNx	Humanitarian-development-peace nexus
HRP	Humanitarian response plan
JAR	Joint Annual Review
NGO	Nongovernmental organization
S3M	Simple, Spatial Survey Method
SDGs	Sustainable Development Goals
UHC	Universal health coverage
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
UNITAMS	United Nations Integrated Transition Assistance Mission in Sudan
UN-OCHA	United Nations Office for Coordination of Humanitarian Action
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
3W	Who is doing What, Where

Executive summary

THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX) is a framework for coherent, joint planning and implementation of shared priorities between humanitarian, development and peacebuilding actors. Although the HDPNx approach is not new, the question remains of how to operationalize it. This country profile is intended to provide a foundational understanding of the current progress on HDPNx for health in Sudan, by providing an overview of the crisis, public health status/health system and current HDPNx operationalization.

Sudan has been affected by a long history of conflict in Darfur and other parts of the country, economic deterioration, as well as obstruction to humanitarian aid in South Kordofan and Blue Nile. However, in September 2019, a transitional government was established, with economic reform and peacebuilding as the main agenda. Adding to this, the United Nations (UN) Security Council adopted a new resolution on 3 June 2020, calling for the establishment of a United Nations Integrated Transition Assistance Mission in Sudan (UNITAMS), designed to work with the people of Sudan and the Sudanese Transitional Government towards a peaceful transition.

Sudan has built a solid foundation for HDPNx work in the country. It was among the first countries in the region to develop a long-term vision and policy for attaining universal health coverage. The backbone to this was the creation of comprehensive policies that promoted the implementation of the nexus approach. Coordination mechanisms such as the Sudan Partners Forum, which includes all humanitarian and development actors, have become primary coordination bodies. The Sudan Partners Forum incorporates existing and new technical working groups, along with their corresponding ministries, in thematic areas such as WASH, health, education and macro-economic reform.

Although nexus-style joint analyses and collective outcomes have been defined in Sudan, they are not yet specific to health. From a policy perspective, the HDPNx has been addressed well in Sudan's National Health Policy 2017 – 2030. In terms of implementation, the WHO Country Office, funded by the European Union, is set to begin a two-year HDPNx implementation programme to support governance mechanisms to control the outbreak, and any future outbreaks, to improve surveillance systems and the National Public Health Laboratory, to promote risk communication and provide additional support in order to maintain essential primary health care and emergency care services.

Lastly, peace is central to achieving economic recovery and sustainable development in Sudan. The health sector plays a pivotal role in strengthening local government capacity and better coordinating efforts to achieve Sustainable Development Goal (SDG) 10 (reducing inequalities) and SDG16 (promotion of peaceful and inclusive societies). Sudan's humanitarian coordinator continues to advocate for quicker responses that reach the most vulnerable, thereby further strengthening the neutral and essential position of health actors in the Sudan conflict. The recent establishment of UNITAMS shows the urgent need to support peace agreements and other peacebuilding efforts.

The groundwork has been laid for the HDPNx in Sudan, and different actors have begun to build on this foundation. However, there is recognition that further improvements must be made in order to formally articulate and align HDPNx for health efforts. Potential opportunities for advancing implementation of HDPNx for health in Sudan include:

I. Revitalizing the Health Sector Coordination Forum and developing the health sector nexus strategy;
II. Improving the joint assessment of the health system;
III. Define health sector development objectives and identify the collective outcomes accordingly;
IV. Shift towards multi-year strategic planning;
V. Bolster monitoring and evaluation mechanisms;
VI. Create HDPNx-related resource and financing records;
VII. Mainstream conflict analysis and peacebuilding prioritization using the Health for Peace approach.

1. Introduction

THE HDPNX, AS PART OF THE NEW WAY OF WORKING, is a framework for coherent, joined-up planning and implementation of shared priorities among humanitarian, development and peacebuilding actors in emergency settings. Due to the dynamic and non-linear nature of emergencies, in any crisis-affected setting different stages of the nexus process may be ongoing, which may lead to varying presence and levels of activity of humanitariatn and/or development actors. The HDPNx approach should therefore be initiated from the earliest phases of the emergency and should remain in operation until a humanitarian response is no longer needed.

Advancing the HDPNx in a given country requires a shared, foundational understanding of current progress. Finding such a resource can be challenging, however, perpetuating poor understanding, planning and operationalization. The HDPNx for health profiles aim to address this need through a health lens, by providing an overview of health-related nexus efforts as well as of opportunities for the advancement of humanitarian and development collaboration and peace initiatives in countries affected by protracted emergencies in the Eastern Mediterranean Region of the World Health Organization (WHO).

Although the HDPNx approach is not new, the question of how to operationalize it remains . As HDPNx operationalization is at a nascent stage, many cross-cutting humanitarian, development and peacebuilding activities have not been formally labeled or conceptualized as "HDPNx," although the collaborations between the three groups of actors exist. Therefore, conceptual criteria were needed for evaluating whether or not an activity should be considered "HDPNx" work. In this profile, HDNPx (or nexus-style) activities are defined as:

> "Any health-related activity where at least two of the three groups of actors (humanitarian, development and peace), work together with the aim of fulfilling the following: providing immediate lifesaving and life-supporting assistance; strengthening or rebuilding national systems, institutions and capacities; strengthening emergency management capacities; and/or addressing the drivers of emergencies."

The development of the *Health-development-peace nexus for health profile: Sudan* is a joint initiative by the WHO Country Office in Sudan and the Health Systems in Emergencies Lab of the Department of Universal Health Coverage/Health Systems, in collaboration with the Department of Health Emergencies and the Department of Healthier Populations, at WHO Regional Office for the Eastern Mediterranean, as well as relevant programmes in WHO headquarters.

Initiation of the HDPNx in Sudan began in 2015 through the development of relevant policies to coordinate humanitarian, development and peacebuilding actions. (*1*) Its implementation required significant commitment and intricate political engagement with the Government of Sudan, as well as technical expertise in order to shift resources from humanitarian to development activities. Thanks to the enhancement of health policies in recent years, the Government has been less reliant on external assistance and has begun to regulate and provide health services with less dependence on foreign aid.

However, in 2019, the country faced economic decline, followed by changes in the political environment. (*2*) As a result of this civil movement, Sudan is currently in a transitional period of three years (2019–2022). As these changes in the economic and political landscape have been recent, it is expected that it will take some time for the nexus to be revitalized.

2. Overview of crisis

Darfur context

In order to fully comprehend the situation in Sudan, it is essential to know the history of the conflict in the Darfur region. Since the 1960s, attempts to bridge the gap between the political elites of Khartoum and Darfur tribes have failed. (*3*) The priorities and concerns of Darfur were not adequately reflected in national policies. (*4*) During the 1980s and 1990s, changes in land ownership, desertification and droughts led to famine and conflict. (*5*)

More recently, in 2003, the fighting in the region escalated dramatically, leading to increased diplomatic pressure on the Government of Sudan and the Darfur movements. In 2006, the Darfur Peace Agreement was signed, resulting in the formation of the Transitional Darfur Regional Authority. Based on a comprehensive needs assessment, the Darfur Peace Agreement compelled the Government and donors to commit to development funding amounting to US$ 300 million in initial capital and US$ 200 million per year for three years. (*6*) These steps would later lead to the adoption of a national agenda for the HDPNx.

In addition to Darfur, South Kordofan and Blue Nile have also experienced years of protracted conflict, obstruction to humanitarian aid, and limited to no investment in basic services.

Recent national, political and economic changes

From 2018, Sudan witnessed months of increasing inflation combined with a negative gross domestic product (GDP). In December of the same year, civil protests started in response to the austerity measures adopted and the increased price of goods such as bread and fuel. In April 2019, Omar Al-Bashir was ousted after more than 29 years in power, and the Transitional Military Council was established. However, peaceful protests continued to demand a civilian government.

In September 2019, a transitional government was established, with economic reforms and peacebuilding as the main agenda. On 3 June 2020, the UN Security Council adopted a new resolution, "mandating the establishment of the United Nations Integrated Transition Assistance Mission in Sudan (UNITAMS), for an initial period of twelve months." (*7*) UNITAMS aims to complement the existing work of UN agencies, funds and programmes, while working closely with the Sudanese Transitional Government and people of Sudan to support the peaceful transition. (*7*)

Despite these challenges, Sudan has made great strides in developmental indicators. (*8*) Nevertheless, the recent economic decline has made it impossible for the Government to support its programmes in a sustainable way. In addition, until very recently Sudan featured on the United States of America's list of "state sponsors of terrorism," which presented a major barrier to debt relief and financing. All of these challenges have left 6.2 million people currently in need of food assistance, in addition to a high level of malnutrition in the country. Investment in the service sector has been negatively impacted by the struggling economy, putting the health sector, among others, at risk (8.6 million people in need of life saving health activities). (*9*)

Impact of the COVID-19 pandemic

Sudan's first case of coronavirus disease (COVID-19) was confirmed on 13 March 2020. (*10*) As of 26 December 2020, the number of confirmed cases has risen to 23 316 with 1468 associated deaths. (*11*) The impact of COVID-19 has exacerbated the pre-existing humanitarian needs that stem from the ongoing economic crisis, years of conflict, climate-related emergencies and disease outbreaks. (*10*) Furthermore, the restrictions put in place due to COVID-19, such as nightly curfews, banning of gatherings and closure of schools, markets and universities, continue to worsen the economic situation. (*12*)

3. Public health status and health system

Primary health care was adopted as the main strategy for health care provision in Sudan in 1976. Primary health care was then re-emphasized in the National Comprehensive Strategy for Health in 1992, as well as the 25-Year Strategic Health Plan 2003–2027. However, the inefficiency of the health system in Sudan must be addressed. This inefficiency is apparent when comparing health outcomes with health expenditure between Sudan and other similar countries. This is caused mainly by fragmentation within the health system, inefficient financing systems, irrational use of medicines and technology, mismanagement of human resources and lack of quality indicators. (*13, 14*) The economic crisis in Sudan has also negatively impacted the national health system, particularly in hard-to-access, conflict-affected areas such as Darfur, South Kordofan and the Blue Nile.

The COVID-19 pandemic has further highlighted the inadequacies of Sudan's health system.There is currently a countrywide shortage of trained medical staff to meet the increased demand due to COVID-19. There is a lack of the isolation units, intensive care units, infection control materials, medicines and supplies needed to control the outbreaks. The surveillance system does not have the capacity to cover the whole country. Health actors have been experiencing further challenges in clearing and obtaining necessary medical supplies due to factors such as limited government staffing, fuel shortage and COVID-19-related movement restrictions. (*10*) Furthermore, isolation procedures can mean that COVID-19 cases in health facilities may force them to close to other patients, suspending essential health services such as maternal care or immunizations.

As COVID-19 continues to spread, Sudan remains susceptible to other outbreaks, such as cholera, chikungunya, dengue, malaria, measles and Rift Valley fever. (*14*) Currently, the overall health response to the pandemic is guided by the Humanitarian Country Team (HCT) /UN Country Team (UNCT) and the COVID-19 Country Preparedness and Response Plan, which aim to support the Government of Sudan's COVID-19 response. Sudan's COVID-19 Country Preparedness and Response Plan covers the nine pillars of response detailed in WHO's COVID-19 Strategic Preparedness and Response Plan. (*15*)

Service delivery

Sudan has a basic health care package, which includes maternal and reproductive health care services, nutrition services, immunization, infectious diseases and free medicines. The health service providers are the Ministry of Health, in addition to the National Health Insurance Fund, military, police, nongovernmental organizations (NGOs), universities and the private sector. (*14*) Currently, one third of health facilities offer the complete basic health care package. (*16*)

Between 2018 and 2019, the percentage of women who received the minimum of four antenatal care visits during their pregnancy was 51%, with the main gap occurring in conflict areas such as Darfur. (*17*) Approximately 81% of the population does not have access to a functional health centre within two hours of their home. (*10*) This situation continues to worsen during COVID-19 as many health centres are closing due to isolation procedures.

The Expanded Programme on Immunization has achieved approximately 93% coverage of the diphtheria-pertussis-tetanus vaccine, but this drops down to 60% in specific areas. (*18, 16*) The gap in immunization coverage has led to the reappearance of vaccine-preventable illnesses, such as measles and diphtheria in 2019. The lowest vaccination coverage was recorded in Darfur state and West Kordofan. (*16*) The vector-borne disease burden remains high, with new disease outbreaks, particularly of malaria, chikungunya, dengue and Rift Valley fever, emerging in association with changes in rainfall patterns. (*19*)

Review of the health system and health indicators reveals noticeable variation between states. Inequalities exist between states, between rural and urban areas and between localities. Inequity also manifests in the allocation of resources, including human resources, health facilities and health expenditure. Inequity in private health care

Fig. 1: Roles and responsibilities of different levels of the decentralized health system

Federal	Policy, planning, legislation, coordination, external relations, capacity building, tertiary referral centres
States	Operational planning, human resources for health, capacity building, secondary and rural hospitals
Localities	Primary health care services, midwifery and maternal and child health, environmental health, vector control,human resources for health

Source: WHO Sudan

utilization is clear: the utilization of services by the richest 20% was nearly four times greater than utilization by the poorest 20%. (*13, 14*) Most of the public prefers private health care facilities to public facilities.

Health workforce

Human resources for health are primarily governed by the Federal Ministry of Health, under the Directorate General of Human Resources for Health Development. In 2017, Sudan had 1.9 physicians, 7.9 nurses and midwives, 0.1 dentists and 0.3 pharmacists per 10 000 persons. Physicians and nurses make up only 15% and 18% of the overall health workforce respectively. Maldistribution of health workers between urban and rural areas is conspicuous, with an estimated 70% of health professionals working in urban areas – 38% in Khartoum alone. (*19*) Although the majority of these health professionals work in the public sector, only 9.3% work exclusively in the private sector, making dual practice very common.

The migration of health professionals for economic reasons is one of the major health workforce issues in Sudan; It has been estimated that 60% of physicians and 25% of pharmacists practise abroad. Additionally, lack of medical staff and high turnover are challenges that the health system continues to face. (*10*)

Health information systems

Sudan has well-developed policies, legislation and vision for the Digital Health System. This is supported by good governance and coordination structures that have only been revived post-2019. In addition, the presence of a widespread network of primary health care facilities within national standards is a strong component of good health information coverage. The existence of the disease surveillance system and District Health Information Software 2 with good infrastructure is a precursor for further expansion and improvement. (*18*) The Ministry of Health is currently working on refining the quality of data collected in order to improve information reliability. (*18*)

Essential medicines

Imports of medicines and medical supplies have dropped by approximately 35% in 2019 compared to the same period in 2018. This has contributed to cost increases, reducing the overall availability of essential medicines in the public sector from 60% in 2018 to 43% in 2019. As a result, medicine availability was only 43% in the national medical supply fund, 49% in the national health insurance fund, and 59% in the private sector. (*16*)

Health financing

To fully understand the state of the health system in Sudan, it is important to analyse health system financing. Sudan spends 4.95% of its GDP on health. Most of the expenditure on health is out of pocket, accounting for 69.3% of the total health expenditure. (*20*) Private insurance schemes finance about 7% of total health expenditure, with coverage being 37.3%. In addition, 4.1% of households face catastrophic expenditures and 2.2% become impoverished due to health expenses. (*14*) The national health insurance scheme plays a significant role in health spending, covering about 76.6% (US$ 31.5 million). (*21*) The responsibility of basic health service provision has been decentralized to

state and local levels, with funding modalities varying from national to local levels. (*22*) This is mainly due to the fragmentation of financing sources, as the National Health Insurance Fund and the Ministry have different policies and funding streams. (*14*)

Leadership and governance

The introduction of federalism in Sudan in 1991 fostered a three-layered health system structure. These are the Federal Ministry of Health (FMoH), State Ministries of Health and local health systems (localities). The FMoH has general directorates for policymaking, strategic planning, coordination, regulation, international relatio ns and is a central source of technical support and guidance to states. The state ministries are responsible for planning and providing secondary and tertiary health care services, in addition to overseeing financial and technical support to the localities.

4. HDPNx operationalization

Sudan was among the first countries in the Region to develop a long-term vision and policy for attaining universal health coverage (UHC). The backbone for this was the creation of comprehensive policies that promoted implementation of the HDPNx. (*23*) Work can be traced back to 2015, when in-country national assessments and the Darfur Stocktake took place, organized by the United Kingdom's Department for International Development and UN-OCHA. (*1*)

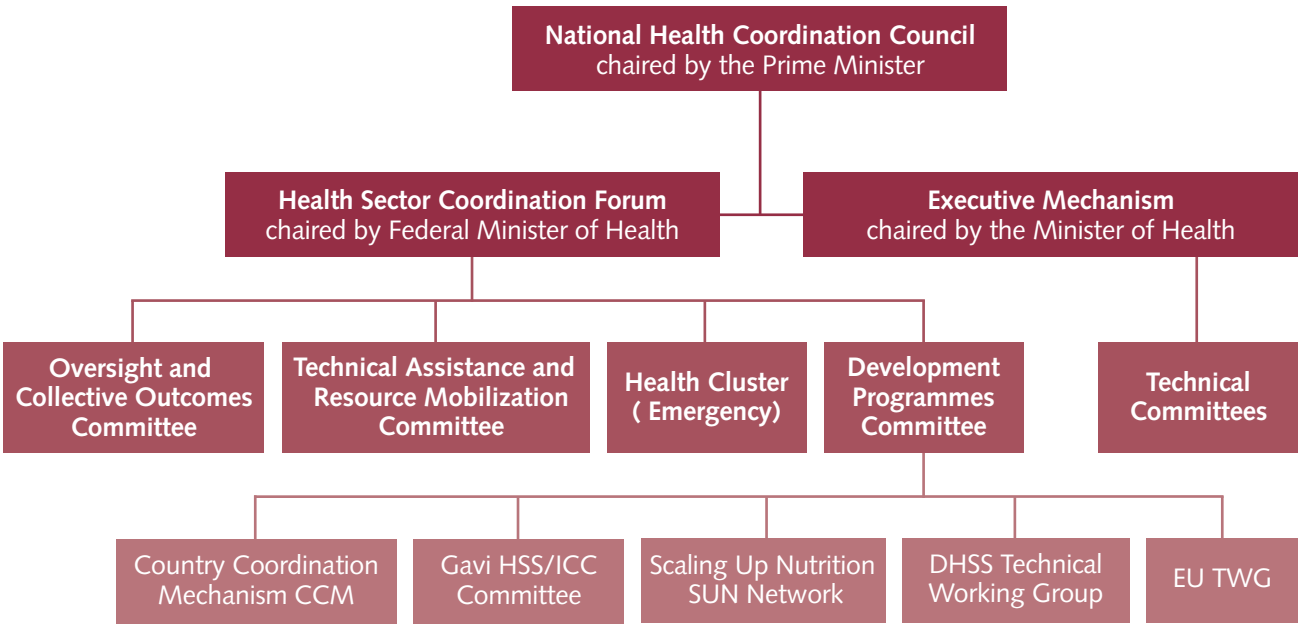
More recently, the National Health Policy 2017–2030 focuses on addressing social determinants of health through adopting a multi-sectoral approach towards achieving SDGs and investing in health system resilience. WHO supported the evidence generation, as well as the drafting and revision of the policy. Moreover, the Deputy Director-General participated in the endorsement in 2018 of the National Health Policy to promote and mobilize political commitment for implementation of the transformational shifts needed to attain UHC in Sudan. WHO, in collaboration with the World Bank, provided technical assistance to FMoH and the Ministry of Social Welfare for the development of the options and strategy for the Health Financing Policy. Other policies and strategies developed in recent years include the Family Health Policy, the Quality Policy and the Global Health Strategy.

Coordination architecture

The previous coordination structures separated the humanitarian actors (HCT and the humanitarian response plan) from the development actors (UNCT and the UN Darfur Assistance Framework). This arrangement did not serve to foster a nexus approach. Therefore, a Coordination Review Task Team was formed to create a coordination structure that would better advance the HDPNx approach (Fig. 2).

The Sudan Partners Forum was also formed, comprising all humanitarian and development actors, becoming the main coordination body. The coordination structure incorporates new and existing technical working groups, co-led by WHO and the United Nations Children's Fund (UNICEF), and membership

Fig. 2: Coordination structure between humanitarian and development sectors



of other organizations and humanitarian and development actors and their corresponding ministries in thematic areas such as WASH, health, education and macro-economic reform.

With COVID-19, a COVID-19 Strategic Coordination Group has been created, chaired by the Resident / Humanitarian Coordinator . It is comprised of WHO, UNICEF, UN-OCHA, the World Food Programme, UN Developmemt Programme, UN High Commissionerfor Refugees and the UN Population Fund and aims to alignment of the UN and humanitarian actors in supporting the GoS's preparedness and response efforts. It interfaces with the higher-level COVID-19 Committee and is supported by the COVID-19 Working Group. At the state-level, existing coordination mechanisms have been leveraged when possible, where national pillar focal points work closely with the state COVID-19 focal points. (*15*)

Joint analysis

In November 2015, a workshop was conducted with relevant government and UN representatives to formally launch the United Nations Development Assistance Framework (UNDAF). (*24*) The development of the UNDAF was informed by the Common Country Analysis, which was centered on four broad areas: i) Economic development and poverty reduction; ii) Social services and social protection; iii) Environment, climate change, and disaster risk management; and iv) Governance and institutional capacity development.

In the absence of a comprehensive, nationwide needs assessment, several multi-sectoral and sectoral assessments conducted in 2018 and 2019 fed into the analysis of the HNO 2020. (16) The Simple, Spatial Survey Method (S3M II) of 2018, funded by the European Commission, is an internationally recognized special survey that formed the bulk of the HNO 2020, informing six sectors including health, nutrition, WASH, child protection, education and food security. (*16*)

In the context of COVID-19, the UNCT has finalized the COVID-19 Socio-Economic Response Plan with a 12-18 month horizon, based upon its assessment of the socio-economic impact of COVID-19.

Collective outcomes

Through the coordination platforms mentioned above and after consulting relevant stakeholders, the following collective outcomes were developed for Sudan:

1. **Economic development and sustainable livelihoods.** By 2022, communities and households benefit from increased production and productivity that lead to sustainable livelihoods, sustainable access to food systems and improved nutrition status, with emphasis on the agriculture sector as a driver.
2. **Basic social services.** By 2022, people in Sudan, including refugees, have more equitable and sustainable access to social services.
3. **Governance.** By 2022, people in Sudan benefit from more efficient, accountable and participatory governance, enhanced rule of law and access to justice, and greater protection of human rights.
4. **Energy, environment, climate and DRR.** By 2022, the population has increased access to energy and the risk for disasters is reduced, through more effective management of natural resources and environmental and climate change by national institutions and communities.

Although the health sector in Sudan falls under Collective Outcome 2, the remaining collective outcomes also contribute to health through addressing social determinants of health.

The collective outcomes establish a broad framework for improved engagement between the international community and the Government. Moreover, it provides a mechanism that facilitates the gradual reallocation of resources from humanitarian to development assistance. The Multi-Year Humanitarian Strategy for 2017–2019 adopted the collective outcomes as an integral part of the Humanitarian Response Plan (HRP) and as a transition to development.

Joint planning and implementation

Sudan was the first country in the Eastern Mediterranean Region to organize a high-level conference on UHC in January 2014. This conference followed the

first UHC meeting organized by the WHO Regional Office for the Eastern Mediterranean in December 2013. After the conference, Sudan developed several policies and strategies to guide the way towards UHC, including the National Health Policy 2017-2030 (*14*) and 'Sudan's Declaration on UHC'. Both documents reflect Sudan's commitment to advancing UHC, with the National Health Policy 2017-2030 directly addressing the HDPNx in statement 2.3.a, "ensure humanitarian and emergency responses are linked with development through building system resilience, adopting durable solutions and implementing new ways of working." (*14*) Furthermore, Sudan is currently selecting a Policy Adviser to support WHO and the FMoH in paving the future of the health system and the path towards UHC.

Sudan has also made strides in HDPNx implementation. The WHO country office, funded by the European Union, is going to start a two-year HDPNx programme for "Strengthening preparedness and response of the health system addressing the COVID-19 pandemic in Sudan." The programme aims to support health governance, surveillance systems, case management capacity, risk communication and WASH activities. (*25*) While Sudan has succeeded in developing HDPNx-style policies and strategies; there have been obstacles to effective implementation of these policies. One main challenge is the capacity discrepancy between the central/ministerial level and state/institution levels.

Joint monitoring and evaluation

Joint Annual Review (JAR) is a tool developed by the International Health Partnership that is used to review health sector evolution and detect areas for potential upgrading. It is a viable tool in coordinating health system strengthening efforts. Sudan organized its first JAR in 2018, with the participation of all stakeholders and partners at the national and state levels. (*26*) It was proposed that this process be repeated annually to provide an independent view of the progress made, including what works and what does not, in the implementation of the annual plan. However, no JAR was conducted in 2019, mainly due to the changes in Sudan on the political and economic fronts. There is a need for stronger commitment from the transitional government to maintain and improve the previously implemented JAR.

Since the onset of COVID-19, the monitoring and reporting outlined in the Country Preparedness and Response Plan is to be led by the COVID-19 Working Group, in conjunction with the Information Management Working Group. (*15*) With the support of partners, the COVID-19 Working Group has created a 3W (Who is doing What, Where) to collect information about implementation of activities stated in the Country Preparedness and Response Plan. The objective is for information gathered through this monitoring process to be made available on the Humanitarian Response website, allowing decision-makers at all levels to more easily view progress against the activities outlined in the Country Preparedness and Response Plan. The data is also shared in the Humanitarian Data Exchange in order to promote transparency and to allow partners to conduct independent analyses. (*15*)

Harmonized resources and financing

WHO, in collaboration with the World Bank, has provided technical assistance to the FMoH and the Ministry of Social Welfare to develop the strategy and options for the Health Financing Policy. The Government has gradually increased health sector funding in the last years and it now stands at 7.2% of the country's GDP. Total reported international funding to Sudan has dropped from US$ 1.4 billion in 2009 to US$ 600 million in 2019. Although the needs of the health sector in 2019 were US$ 1.1 billion, only 51% of the requested amount was met by international donors, compared to 70% in 2009.

Conflict prevention, peacemaking, and peacebuilding

In fragile and conflict-affected countries, "peace building strategies are necessary to ensuring lasting health gains." (*27*) Conversely, "the health sector can play a significant role in promoting peace by using its competencies, credibility and networks." (*27*) The neutrality of the health sector and health workers can be leveraged to mediate and promote dialogue. The Health and Peace Initiative is an established

framework that supports the health workforce in operating in conflict settings while contributing to peacebuilding. It calls for increased partnerships among Member States, UN and non-UN partners and academia to conduct diplomacy, build capacity on the ground and design and implement strategic initiatives linking health interventions with peacebuilding. (*28, 29*) The multilateral consultation meeting on Health as a Bridge for Peace, held on 1 November 2019 and co-sponsored by Oman and the Government of Switzerland, in collaboration with WHO Regional Office for the Eastern Mediterranean and participation of WHO headquarters, gave the opportunity to share lessons learned from the field with the international community.

In Sudan, the health sector plays a pivotal role in strengthening local government capacity and better coordinating efforts to achieve SDG 10 (reducing inequalities) and SDG 16 (promotion of peaceful and inclusive societies). The Sudan Humanitarian Coordinator continues to advocate for quicker responses that reach the most vulnerable, thereby further strengthening the neutral and essential position of health actors in the Sudan conflict. The recent establishment of UNITAMS shows the urgent need to "support implementation of peace agreements in conflict affected areas, as required; assist in national-led peacebuilding efforts, strengthening of human rights and rule of law institutions, and a scale-up of support to recover and development to build resilience and mitigate protection risks." (*7*) Peace is central to achieving economic recovery and sustainable development in Sudan.

5. Way forward and recommendations

In Sudan, the foundations for the HDPNx have already been laid, but the ongoing economic decline in the country has impeded the expected progress. Although donors, such as the European Union, continue to fund HDPNx programmes in Sudan, there is consensus that additional advances are needed in order to sustain the progress that has been made in the past five years. The following are proposed recommendations for advancing the HDPNx for health in Sudan:

I. **Revitalize the health sector coordination forum.** The first step forward is to reinforce the previously-adopted structure for collaboration and coordination between the humanitarian and development partners. As Sudan already has existing policies and regulations for HDPNx coordination, the focus should be on advocacy and capacity building among FMoH, other government entities, development and humanitarian partners and stakeholders at different levels in order to further the operationalization of the HDPNx approach. It is important to note that health is part of a broader system, and the success of HDPNx for health therefore depends on the realization of wider HDPNx coordination. The National Health Policy should be leveraged as it presents a strong foundation for enhancing collaboration among humanitarian and development health stakeholders to advance health system goals and targets.

II. **Improve the joint health system assessment.** Although many assessments have been conducted from a humanitarian perspective, with consideration of development needs, a comprehensive health system assessment to advance HDPNx for health in Sudan is lacking. The Simple, Spatial, Survey Method (S3M II), in addition to disease surveillance and health services data from WHO, UNICEF, UNFPA and FMoH, can serve as a valuable basis for joint humanitarian and development analysis. A shared outline for data collection and analysis will ensure consistent prioritization, design, and monitoring of the HDPNx for health.

III. **Define health sector development objectives and identify HDPNx for health collective outcomes.** Health-specific collective outcomes need to be jointly identified, in order to drive planning and programming while bridging the spectrum between immediate assistance and long-term development. The collective outcomes should be based on the results of the joint assessment. Key entry points for health, such as the National Action Plan for Health Security, should be leveraged. It is important to consider the implementation of other SDGs, as progress towards achieving other targets will have an impact on overall health outcomes.

IV. **Shift towards multi-year strategic planning.** The current HRP is based on a one-year interval and the Multi-Year Humanitarian Strategy is based on a two-year strategy. These do not allocate enough time for work at the nexus of humanitarian and development efforts. Longer, multi-year strategic planning is therefore needed to ensure both urgent and long-term development needs are addressed. This involves formulating, articulating, and establishing the plan for achieving collective outcomes, including making decisions on how to mobilize and allocate resources accordingly. The strategic planning should be reflected in the operational plan, leveraging potential entry points (e.g. building on health information systems, advancing district health management, developing a health security plan, etc.) as a means to advance the HDPNx in Sudan. All partners, including donors, UN agencies, national and international NGOs, and health system representatives, should be included in this process to ensure cohesive and collaborative joint planning. Cross-cutting issues such as gender equality and human rights should be integrated in HDPNx programme planning, implementation, and monitoring and evaluation.

In the midst of the COVID-19 pandemic, it may be challenging for HDPNx actors to come together to develop a shared, multi-year strategy, in light of the ever-changing nature and unknowns of the pandemic. However, as the effects of COVID-19 will continue to impact vulnerable populations into the future, it is vital to have a sustainable strategy for response, recovery, and resilience-building. There is consensus as to the need to build back a better, post-pandemic future that is resilient not only to COVID-19, but also to future outbreaks. (*28*) The momentum, solidarity and achievements that COVID-19 has led to, in bringing together humanitarian, development, and non-traditional health actors, should be sustained.

V. **Bolster monitoring and evaluation mechanisms.** Regular monitoring of progress should be undertaken in order to assess the impact of HDPNx for health activities against the collective outcomes. There is currently some coordination of monitoring and evaluation, such as the JAR, but more robust monitoring and evaluation mechanisms are needed. Simultaneously, HDPNx for health focal points should be assigned for each health-related actor to facilitate communication and knowledge management. Systematic collection and archiving of HDPNx-related documents should be conducted. Additionally, due to the dynamic nature of the emergency, the HDPNx for health profile should be updated every 6 to 12 months.

VI. **Create HDPNx-related resource and financing records.** At this time, there are no agreed upon HDPNx funding mechanisms, and discussions surrounding an interagency framework are ongoing. More precise breakdown of finances is needed in order to understand the current level of resources allocated to HDPNx for health activities and in turn, to gauge the appropriate short, medium and long-term financing/resources required to further HDPNx efforts.

VII. **Mainstream conflict analysis and peacebuilding prioritization using the Health for Peace approach.** Closer coordination among humanitarian, development and peacebuilding actors can be achieved by ensuring health-related activities are more inclusive of and informed by peacebuilding activities in the country. The Health and Peace Initiative framework is a prime example of an initiative that can be used for defining interventions to advance the HDPNx agenda. (*29*) One potential starting point is thorough conflict analysis. (*27*) Secondly, the development of a risk management strategy is needed to not only identify and assess risks, but also develop mitigating measures to address these risks. Once completed, the conflict analysis and risk management strategies can inform HDPNx programme design. (*27*)

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THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX), as part of the New Way of Working, offers a framework for coherent, joined-up planning and implementation of shared priorities between humanitarian, development and peacebuilding actors in emergency settings. Advancing the HDPNx in a given country requires a shared, foundational understanding of current progress. However, it can be challenging to find such a resource, perpetuating poor understanding, planning and operationalization. *The Humanitarian-development-peace nexus for health profile: Sudan* is one of a series of profiles that aim to address this need by providing an overview of health-related nexus efforts in a country, territory or area. The development of this profile is a joint initiative by WHO Sudan Country Office and the WHO Regional Office for the Eastern Mediterranean, as well as relevant programmes at WHO headquarters. This profile should be updated regularly to reflect the changing landscape in Sudan.