



Country Cooperation Strategy for WHO and Sudan 2022–2025



World Health
Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

Country Cooperation Strategy for WHO and Sudan 2022–2025



REGIONAL OFFICE FOR THE

**World Health
Organization**

Eastern Mediterranean

WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean

Title: Country Cooperation Strategy for WHO and Sudan 2022-2025 / World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, 2022

Identifier: ISBN 978-92-9022-969-8 (pbk.) | ISBN 978-92-9022-970-4 (online)

Subjects: Health Systems Plans | Strategic Planning | Program Evaluation | National Health Programs | International Cooperation | World Health Organization | Sudan

Classification: NLM WA 540

© World Health Organization 2022

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation: Country Cooperation Strategy for WHO and Sudan 2022–2025. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

CONTENTS

ACRONYMS AND ABBREVIATIONS.....	iv
EXECUTIVE SUMMARY.....	1
SECTION 1. INTRODUCTION	3
SECTION 2. SUDAN’S CONTEXT.....	4
2.1 Sociopolitical, demographic and economic context.....	4
2.2 Health and equity.....	5
2.3 Using the GPW 13 Impact Framework to guide systematic analysis of Sudan’s health situation	7
2.4 Health system	7
2.5 Universal health coverage	8
2.6 Emergency preparedness and response	9
2.7 Promoting a healthier population	10
2.8 Gender, equity and human rights.....	10
SECTION 3. PARTNERSHIP ENVIRONMENT	11
3.1 Main health and development partners in Sudan	11
3.2 Development partners.....	12
SECTION 4. WHO COLLABORATION WITH SUDAN	13
4.1 Country presence	13
SECTION 5. STRATEGIC PRIORITIES	16
5.1 Prioritization process and alignment with GPW 13, UNSDF and national health policy and plans.....	16
5.2 National health sector framework and priorities, 2021–2024.....	16
5.3 Strategic priorities	18
SECTION 6. IMPLEMENTING THE STRATEGIC PRIORITIES	23
6.1 Key contributions to the four strategic priorities.....	23
6.2 Financing the strategic priorities	33
SECTION 7. MONITORING AND EVALUATION	34
ANNEX 1. SIGNATURE PAGE	35

ACRONYMS AND ABBREVIATIONS

AMR	Antimicrobial resistance
CCS	Country Cooperation Strategy
EP	Emergency preparedness
EU	European Union
EWARS	Early Warning and Response System
GDP	Gross domestic product
GNI	Gross national income
GOARN	Global Outbreak Alert Response Network
GPEI	Global Polio Eradication Initiative
GPW 13	WHO's Thirteenth General Programme of Work
HCI	Human Capital Index
HDI	Human Development Index
HiAP	Health-in-All-Policies
HIS	Health information system
HIV	Human immune deficiency virus
HeRAMS	Health Resource Availability Monitoring System
HRH	Human resources for health
HSS	Health system strengthening
IDPs	Internally displaced persons
IHR	International Health Regulations 2005
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
PHC	Primary health care
PHEOC	Public Health Emergency Operations Centre
SCORE	Survey, Count, Optimize, Review, Enable
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal health coverage
UN	United Nations
UNCT	United Nations Country Team
UNICEF	United Nations Children's Fund
UNSDF	United Nations Sustainable Development Framework
WHO	World Health Organization



WHO's Director-General Dr Tedros Adhanom Ghebreyesus and WHO's Regional Director for the Eastern Mediterranean Dr Ahmed Al-Mandhari visit the National Medical Supply Fund



WHO's Director-General with a child in El Salam Cardiac Centre in Khartoum in 2018

EXECUTIVE SUMMARY

The Country Cooperation Strategy for WHO and Sudan 2022–2025 has been developed at a time that Sudan is passing through a transitional period, facing escalating socioeconomic and political challenges, which have also been aggravated by the COVID-19 pandemic.

The goal of the Country Cooperation Strategy (CCS) is to strengthen and guide cooperation between the Government of Sudan and WHO for the next five years on mutually agreed priorities to improve the health of all people in Sudan. The CCS builds on Sudan's National Health Sector Policy (2021–2024), as well as on the United Nations Sustainable Development Framework (UNSDF) for Sudan. The development of the CCS was undertaken within a wide and inclusive, comprehensive consultative approach that involved a series of structured interviews with the Federal Ministry of Health, state ministries of health, development partners and donors, as well as with other United Nations agencies, civil society and WHO technical staff.

Sudan's progress towards achieving health for all depends on a strong and sustainable health system. Sudan is committed to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs) by 2030 and is exploring mechanisms to improve health service coverage and financial protection that focuses on poor and vulnerable populations.

Demographic and epidemiological transition, increasing rates of determinants of poor health, and rising health care costs have resulted in Sudan's health sector facing increasing needs and vulnerabilities with continued demand for services for the Sudanese population, internally displaced populations (IDPs) and refugees. Determinants of poor health, such as tobacco use, obesity and other unhealthy behaviours, are becoming increasingly prevalent in Sudan and are contributing to the increased incidence of noncommunicable diseases.



WHO Representative Dr Nima Saeed Abid visits a refugee camp in Gadarif State

Sudan's health care system is fragile, hospital-centric and fragmented, in both the public and private sectors. According to the WHO Global Health Expenditure Database for 2018, out-of-pocket expenditures paid by households are approximately 74% of total expenditure on health, while general government health expenditure represents 26%. Approximately 79% of the out-of-pocket expenditures are paid for curative care and 19% on medicines and medical consumables. National health coverage was 65% in 2018 but varies markedly across states. Health indicators are greatly lagging behind SDG targets. Health outcome disparities across states, gender and poverty levels have not yet been fully addressed. Moreover, poverty in Sudan is complex and is experienced in multiple, interrelated dimensions necessitating further efforts to consolidate and improve progress.

The role of WHO in this CCS is to support the Government to overcome these prevailing health challenges and in enacting ongoing health reforms and improvements to ensure a better quality of life for each citizen, especially the vulnerable and the poor. WHO will gradually shift its focus on result-based approaches in selected areas, building a multi-hazards emergency system, developing strategic partnerships with other governmental sectors academia and civil society. This innovative focus should be combined with a stringent monitoring and evaluation system to measure the impact of the interventions and accordingly introduce appropriate modifications. This will result in provision of high-level policy guidance and advocacy. WHO's support to the Government in the next five years will be focused on the following four strategic priorities:

Strategic priority 1: Strengthen the health system to advance towards UHC

Strategic priority 1 focuses on building a resilient health system that adopts a multi-hazard approach starting with implementation of Sudan health sector reforms; aimed at enhancing health sector governance towards achievement of UHC. This will be achieved by expanding access to quality primary health care (PHC) services and providing financial protection, particularly to the most vulnerable population.

Strategic priority 2: Promote health and well-being

Promoting health and well-being covers a wide range of issues that affect health and wellness. It also addresses the social determinants of health (economic stability, access to education and quality, health care services and quality, physical environment and the social and community context through multisectoral implementation of the health for all by all vision. Special attention will be given to address antimicrobial resistance through improving surveillance and reporting, training on infection prevention and control at health care facilities, and on surveillance of antibiotic use.

Strategic priority 3: Build health system resilience and capacity to prepare, and respond to health emergencies

Sudan is exposed to multiple emergencies that are expected to continue for the foreseeable future. Thus, there is great need to invest in and enhance multi-hazard emergency preparedness and response at all levels through a more integrated and coordinated multi-sectoral approach. This encompasses public health surveillance and outbreak detection and response. It also includes strengthening the country's institutional capacity for implementation of the International Health Regulations (IHR 2005).

Strategic priority 4: Strengthen data and innovation capacity

This strategic priority addresses the reinforcement of data capacity at different levels of the health system to effectively use data for decision-making. It will ensure collection and flow

of data from both the public and private sectors, alignment and development of an integrated national health information system (HIS). It will also include development and implementation of global and regional standards. WHO will also support the Federal Ministry of Health to develop a unified digital repository based on the principles and standards outlined in the SCORE for Health Data technical package.

WHO's regional vision 2019–2023 is to support countries to move towards “Health for All by All” based on *WHO's Thirteenth General Programme of Work 2019–2023* (GPW 13) and the 2030 Sustainable Development Agenda. Thus, the above-mentioned four strategic priorities are fundamental as they aim to ensure healthy lives, serve the vulnerable and promote well-being for all. They advocate organizational shifts that, if attained, will change the health map of Sudan. They will also transform partnerships, communications, financing and enhance the active participation of academia, the community and private sector. It would be greatly advantageous if there is focus on selected states and localities or areas to measure the impact of interventions and manage the results.

SECTION 1. INTRODUCTION

The *Country Cooperation Strategy for WHO and Sudan 2022–2025* reflects a five-year vision for WHO's technical cooperation with the Government of Sudan. This Country Cooperation Strategy (CCS) provides a roadmap for WHO support to the Government to improve the health of its population over the next five years. It clarifies the proposed role of WHO and how its core functions are applied in supporting national health and development plans and strategies. It also addresses the global strategic health priorities as set out in GPW 13. GPW 13 is focused on three interconnected strategic priorities so as to ensure healthy lives and promote well-being: achieving universal health coverage (UHC); address health emergencies and promote healthier populations.

The strategic agenda for the Country Cooperation Strategy for WHO and Sudan for 2008–2013 addressed: strengthening governance at all levels; monitoring and securing investment equity; improving the capacity of the health sector; supporting health care delivery based on comprehensive primary health care (PHC); improving human resources; strengthening the health information system (HIS); reducing the high maternal mortality ratio and the under-5 mortality rate; reducing the burden of communicable and noncommunicable diseases; improving mental health and unhealthy lifestyles and supporting early emergency preparedness and humanitarian needs. Although it initially intended to outline support until 2013 it was extended until 2017. A Joint Annual Review Report 2016–2017 was developed, which proposed 49 recommendations for 2018 based on health system strengthening building blocks broken down as follows: governance (12); service delivery (8); HIS (6); human resources for health (5); medicine and medical technology (11) and health financing (7). One important innovation of this CCS is to focus strategically, outlining a clear results chain designed as a country-level impact framework that includes targets related to expected outcomes and the triple billion goals of GPW 13 encompassed also in the SDGs. Thus, priorities identified in the CCS can be addressed.

The development of this CCS has taken place at a critical moment in which the country, the region and the world are facing the COVID-19 pandemic, which poses significant challenges for Sudan, and has created an unprecedented need for national and international solidarity and a strong and resilient coordinated response. Phase 1 of this response covers 2018 and phase 2 2019–2021.

This CCS sets out four broad strategic priorities and directions for WHO support for the next five years, namely:

- Strategic priority 1: Strengthen the health system to advance towards UHC
- Strategic priority 2: Promote health and well-being
- Strategic priority 3: Protect populations against health emergencies
- Strategic priority 4: Strengthen data and innovative capacity.

SECTION 2. SUDAN'S CONTEXT

2.1 Sociopolitical, demographic and economic context

Sudan covers an area of 1.8 million km² that is traversed by the River Nile and its tributaries. It has borders with seven countries: Central African Republic, Chad, Egypt, Eritrea, Ethiopia, Libya and South Sudan. It has a long coastline of 853 km with the Red Sea.

Sudan is led by a transitional government that is a partnership between armed forces and civilians agreed upon after the revolution 2019. The fundamental challenge to Sudan's prosperity is its deep-seated political issues. Sudan has experienced conflict for most of its post-independence era. The Juba Peace Agreement, signed on 3 October 2020, created a window of opportunity for peace throughout Sudan.

There is an immediate humanitarian task of dealing with internally displaced persons (IDPs), orphans and those affected by conflict. There is also the task of rehabilitation and reconstruction of substantial parts of the country's urban areas.

The total population was approximately 44 million in 2021, growing at a rate of 2.8% annually. Children under 5 represent 15.4% of the population and those under 15 represent 41.4%. The 15–24 year age group represent 20% and those aged 25–64 years approximately 33.4%. Those aged 60 years and above represent 5.6% of the total population. Life expectancy at birth is 64.1 years. Approximately 88% of the population are “settled”, including 49% in urban areas, while 8% are nomadic. The average household size is 5–6 persons, while the fertility rate is 3.9; crude birth rate is 33; and crude death rate is 16.7 per 1000 (17.2 males, 16.3 females).

Two thirds of Sudanese are living below the national poverty line, with the highest observed poverty rates in conflict-affected states. The overall basic school enrolment rate is 74%. Access to water is 63%, while access to sanitation is much lower. Although there are multiple sources for water in Sudan, it did not meet the Millennium Development Goal (MDG) targets for water supply and sanitation and still has a long way to go to meet UHC by 2030.

Sudan is a lower middle-income country. Since independence, Sudan's economic performance has been below expectations. Poverty is widespread, human development indicators are very low, and the gross national income (GNI) per capita of US\$ 590 masks wide regional disparities in economic and social development. The World Bank Human Capital Index (HCI) ranks Sudan 139 out of 157 countries, and it has a HCI of 0.38. Also, Sudan ranks at 170 out of 189 countries in the 2019 Human Development Index (HDI) (Table 1).

Table 1. Cross-cutting themes in the Sudan context

Themes	Elements
Socioeconomic	<p>Gross domestic product (GDP) fell from \$66.4 billion in 2011 to \$33.6 billion by 2019</p> <p>The social protection system has limited coverage, irregular transfers and under-developed implementation systems</p> <p>Public infrastructure, such as roads and bridges, which are essential for service delivery, are lacking in many parts of the country, particularly during rainy seasons</p> <p>Rural and urban poverty rates are 54.1 and 39.9%, respectively, and 6.2 million people suffer from extreme poverty</p> <p>The number of people requiring humanitarian assistance increased from 5.2 million in 2015 to 9.3 million in 2020</p>
Political	<p>The political system is decentralized with three levels of governance: federal, state and locality</p> <p>Public participation and community engagement in governance are increasing</p> <p>The economy is suffering from structural trade and fiscal deficits, mass poverty, high inflation, high levels of inequality, limited public expenditures on basic services and low fiscal effort that rely on regressive indirect taxes</p> <p>The lifting of economic sanctions and debt relief provide an opportunity for the re-integration of Sudan with the international community</p>
Climate and environment	<p>States continue to remain at different levels of risk for certain outbreaks and public health emergencies, including waterborne diseases, as a result of limited access to safe water and lack of sanitation</p> <p>Protracted conflicts, political instability, the COVID-19 pandemic and other concurrent emergencies, in addition to the risks of floods, compound the humanitarian situation</p>
Humanitarian-development-peace nexus	<p>The initiation of the humanitarian-development-peace nexus in Sudan began in 2015 through the development of relevant policies and in-country national assessments</p> <p>The Sudan Partners Forum was formed comprising all humanitarian and development actors and became the main coordination body</p> <p>Collective outcomes were developed by the United Nations Country Team to provide a broad framework for improved engagement between the international community and the Government</p>

2.2 Health and equity

Sudan health indicators are lagging behind MDG/SDG targets. Sudan continues to have high rates of child and maternal mortality. The under-5 mortality rate of 68 deaths per 1000 live births is far above the 2015 MDG target of 41 per 1000 live births and the 2030 SDG target of 25 per 1000 live births. The maternal mortality ratio was 295 per 100 000 live births in 2017 (Fig. 1), while the 2015 MDG target is 134 and the 2030 SDG target is 70. Sudan's infant mortality rate of 33 deaths per 1000 live births is high compared to the SDG target of 12 in 2030 (Fig. 2).

Health outcome disparities across states, gender and poverty levels have not yet been fully addressed. The under-5 mortality rate is highest in East Darfur State (112 per 1000 live births) and lowest in the Northern State (30 per 1000 live births) (Fig. 3). Children living in the poorest households are twice more likely of dying before their fifth birthday (under-5 mortality rate of 84), compared to children from the wealthiest household (under-5 mortality rate of 39).

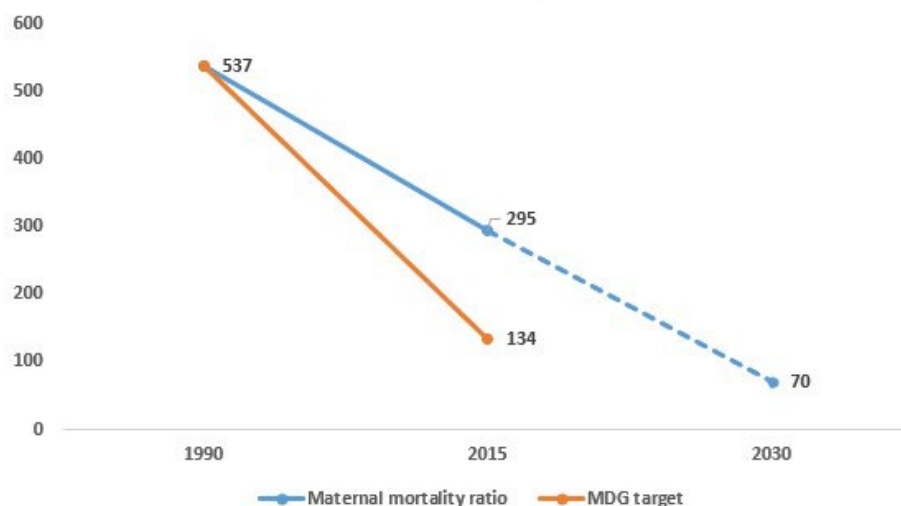


Fig. 1. Maternal mortality ratio, 1990–2030

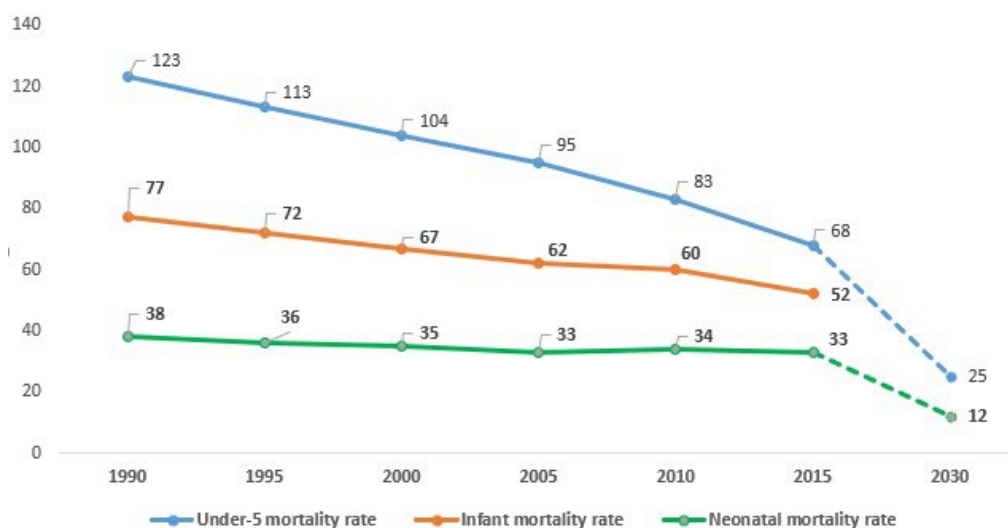


Fig. 2. Under-5, infant and neonatal mortality, 1990-2030

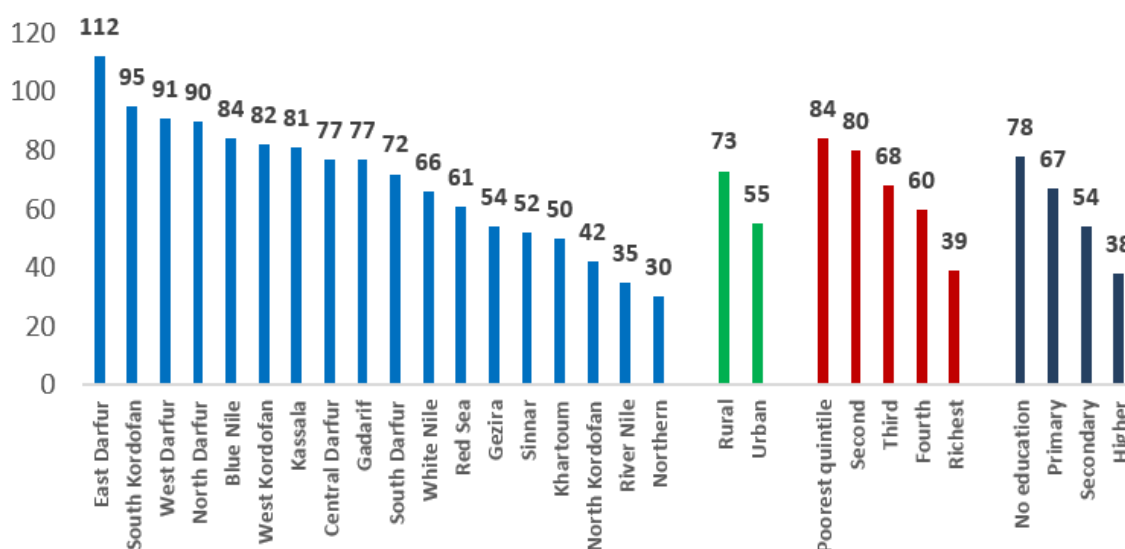


Fig. 3. Under-5 mortality rate per 1000 live births by states, rural-urban, income, quintiles and education level

2.3 Using the GPW 13 Impact Framework to guide systematic analysis of Sudan's health situation

The GPW 13 goal is to reach the triple billion target by 2023. The CCS, as a joint WHO-Member State instrument, is intended to facilitate the implementation of GPW 13: its triple billion target stands in alignment with priorities based on the country's needs and which can be measured by the defined outcome indicators and milestones set out in the CCS.

The CCS defines, for each outcome, the country's strategic priorities and indicators (SDG and others) to measure progress and impact. Sudan in coordination with the WHO country office, decides which specific targets and indicators will be chosen to track and evaluate a milestone (target). Tracking methods are set out below and are linked to the WHO Impact Framework outlined in Fig. 4, as measured by Healthy Life Expectancy (HALE), the triple billion targets and programme outcomes.

Presenting quantitative results alongside qualitative stories about implementation of the CCS will allow the WHO country office to report on GPW 13 and SDG outcomes and present a holistic view of WHO's impact in Sudan.

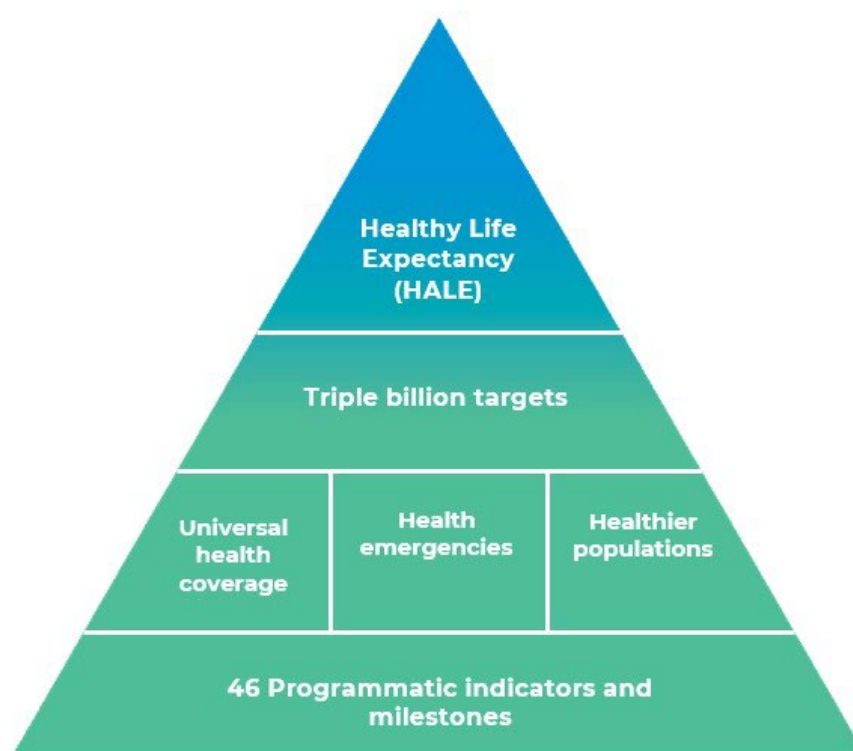


Fig. 4. WHO Impact Framework

2.4 Health system

The allocation of public expenditure to the health sector, as a share of total public spending fluctuated between 7 and 8% during the last decade but is expected to rise as indicated in the transitional government's plan. Health expenditure predominantly takes place at the state level amounting to 87%.

Although the Government is committed to providing free medical care in emergency situations, free medicines for children under 5 and free medical care for certain diseases, people pay a considerable amount as out-of-pocket health expenditure. The WHO Global

Health Expenditure Database for 2018 reported that the share of out-of-pocket health expenditure paid by households is about 74% of total expenditure on health, while general government health expenditure represents only 26%. Total expenditure on health was 4.5% in 2018 as a percentage of gross domestic product (GDP). There is marked variation among the states in all social development indicators.

Sudan is facing several challenges in relation to its human resources for health. There is disparity in the distribution of health care personnel between the public and private sectors and between urban and rural areas. Moreover, the high turnover and migration of health professionals continue to threaten the capacity of the Federal Ministry of Health to respond to the increased demand for health services. There is a low nurse-to-doctor ratio, which affects the running and quality of care. There are 33.5 nurses and midwifery personnel and 2.8 physicians per 10 000 population according to 2021 data.¹

The National Health Strategic Plan was drafted in 2021. The major challenges facing Sudan's health care system include:

- lack of clarity on the roles and responsibilities at all levels of the health system and an overall fragile system of governance;
- low public expenditure on health aggravated by high out-of-pocket expenditure;
- insufficient provision of quality essential services, including essential medicines at different levels;
- unfair and inequitable distribution of health care workers at state and locality level;
- a fragmented and non-aggregated HIS leading to uninformed evidence-based decision-making;
- poorly structured community and academic involvement at all levels of the health sector;
- weak coordination among all related sectors, including the private and public sectors;
- weak capacity to prepare, prevent, timely detect, and respond to emergencies.

2.5 Universal health coverage

Responsive health systems are required at both state and federal levels. The Joint Annual Review of 2017 noted that some states do not use national policies and guidelines of PHC units. The review also reported inequality of access and uptake of services among and within states and fragmented training of health promoters at the community levels. In general, there was underutilization of PHC services, especially noted in public centres, and the justification according to reviewers was due to a gap in having comparable health service standards/quality between government health providers on one hand and the private and nongovernmental facilities on the other. Sudan's UHC Service Coverage Index data was reported at 44.3% in 2017.

Without a strong PHC system, it is difficult to address the challenges posed by both communicable and noncommunicable disease or progress towards universal health coverage. Unless there are well-motivated and skilled health professionals at PHC level, it will be difficult to sustain high levels of immunization coverage, as well as deliver cost-effective interventions for tuberculosis (TB), HIV/AIDS, antimicrobial resistance and diarrhoeal diseases, among others. Also, additional efforts are needed to strengthen the HIS to generate disaggregated data.

¹ Data are from the UHC Global monitoring report (2019), World Bank Sudan Database (2018), World Bank 2021 data on physicians per 1000 people, and WHO Global Health Observatory 2021 data on nursing and midwifery personnel per 10 000 population.

The following four confounding factors present challenges that need to be addressed: 1) presence of several actors working without adequate and efficient coordination mechanisms that generate unnecessary duplication of actions and resources; 2) sub-optimal PHC system with limited human and financial resources; 3) a fragmented and weak HIS that does not allow generation of evidence for timely decision-making; baseline data for only 14 indicators from the 21 proposed by WHO's GPW 13 framework (Table 2) are present for UHC; and 4) high out-of-pocket expenditure that is fuelling the levels of poverty, particularly among the most vulnerable populations.

2.6 Emergency preparedness and response

The protracted conflicts in different parts of the country have resulted in approximately 5.4 million people in need of humanitarian support. More than 3.1 million people directly affected by conflicts have been displaced, and 1.1 million people have been affected by severe food insecurity and emergency levels of acute malnutrition. The protracted crises continue to undermine the gains or progress of development efforts. The coverage of routine vaccination remains low, and access to safe drinking-water and improved sanitation has not been achieved for the entire population, combined with the hardships of displacement, creates a significant risk for outbreaks of vaccine-preventable and water- and vector-borne diseases. As a result, within the past few years, Sudan has experienced several outbreaks, including cholera, chikungunya, Rift Valley fever, malaria, dengue, diphtheria, circulating vaccine derived poliovirus type 2 and hepatitis E, sometimes even occurring simultaneously.

The first case of COVID-19 was diagnosed on 12 March 2020, and the first case due to community transmission occurred on 28 March 2020. Khartoum state has a population of 8 million people (19%) and since the beginning of the epidemic it has hosted 74% of COVID-19 cases.

The fragile surveillance system has low coverage in all states and is unable to cope and absorb the needs for enhanced surveillance in a situation of countrywide community transmission. No



WHO technical teams test water quality in a village in Darfur. Credit: WHO

The fragile surveillance system has low coverage in all states and is unable to cope and absorb the needs for enhanced surveillance in a situation of countrywide community transmission. No effective tracing system has been implemented during the pandemic. Tracing has been based on voluntary data provided by patients and/or contacts using telephone calls. The ineffective tracing slowed early identification and isolation of infected individuals and contributed to the occurrence of the second wave during the period of November 2020 to January 2021. To date (29 August 2021) the total number of cases is 37 709 and the number of deaths at 2835 amounting to a case–fatality rate of 7.5%, as the health system struggled to scale up isolation centres and necessary health facilities promptly due to multiple factors, including a lack of funding, equipment, personal protective equipment and essential medicines and medical supplies accompanied by a shortage of qualified human resources and high staff turnover.

2.7 Promoting a healthier population

According to the Annual Health Statistical Report 2019, the total number of visits to outpatient departments and governmental health centres was approximately 22 million. The 10 leading causes accounted for 12 million (55%), comprised of six communicable diseases and four noncommunicable diseases. The number of hospital admissions was approximately 1.4 million, with malaria topping the list (13.1%). Among the 10 major causes of death, pneumonia was first (7.4%); followed by malaria (6.8%); and then malignant neoplasms (4.6%). Although the report provided valuable information, there are significant challenges due to the multiple non-aligned, un-linked, uncoordinated data systems in use. There is a lack of data sharing, disaggregated data and weak data analysis, reporting capacity and use of data collected in decision-making processes. Information relies heavily on population studies rather than routine data.

Infectious diseases and parasitic diseases are still among the top causes of morbidity and mortality in Sudan; malaria is one of the major health problems in the country. The entire population of Sudan is at risk of malaria. In 2018, the disease led to an estimated 2 million cases and 5000 deaths. From 2016 to 2018, confirmed malaria cases increased from 14.2 per 1000 to 38.4 per 1000. TB incidence is 63 per 100 000, which results in 28 000 cases per year. Mortality from TB is estimated to be 4100 per year. Sixteen (16) of 20 neglected tropical diseases are endemic in Sudan. Recent evidence classifies Sudan among countries with a high hepatitis B virus infection (prevalence $\geq 8\%$ according to WHO 2016 data). Although the HIV epidemic in Sudan has been classified as a low epidemic for the last 10 years, enrolment and retention on treatment are low.

A countrywide risk assessment for 2019 has shown that states are at different levels of risk for certain outbreaks and public health emergencies. Risk assessment took into consideration the type of diseases/events, the effectiveness of security and emergency services and the susceptibility of states to natural disasters.

2.8 Gender, equity and human rights

By looking at all aspects of the health system and health indicators, there are remarkable discrepancies between socioeconomic strata in states. The lack of equity is apparent even within states, between rural and urban areas, between high-income and low-income and between different localities. Inequity also manifests in distribution of inputs of the health system, including human resources, health facilities and health expenditure.

Coverage of reproductive, maternal, neonatal and child health services remains consistently lower in rural areas.

The use of modern family planning methods varies significantly across regions with 20% in urban areas compared to 9% in rural settings.

Access to health services tends to disproportionately benefit those with greater economic means or higher levels of education. Despite government efforts to address financial barriers, large variations in health outcomes by educational status and wealth quintiles can be observed.

Key challenges in addressing gender disparities in health are limited enforcement of existing laws and policies on the rights of women and girls, inadequate capacities of the health system in designing and implementing gender-responsive health services, and limited capacity for the provision of comprehensive and multisectoral services for survivors of gender-based violence.

Gender inequalities resulting from harmful cultural practices and structural and social discrimination contribute to poor health, nutrition, education and livelihood opportunities for women and girls.

Sudan has developed a roadmap for implementation of a Health-in-All-Policies (HiAP) approach to address inequities in health through addressing the social determinants of health.

SECTION 3. PARTNERSHIP ENVIRONMENT

3.1 Main health and development partners in Sudan

The main health and development partners are listed according to the groupings below.

Government

Ministry of Finance, Ministry of Irrigation, Federal Governance Chamber, Ministry of Social development, Ministry of Agriculture and Animal Resources, Ministry of Higher Education, Ministry of Youth and Sport and Ministry of Education.

Bilateral donors

Japan, Italy, Canada, United States of America, United Kingdom, France, South Korea, Germany Sweden, Norway, Qatar, Saudi Arabia, Kuwait and Finland.

South-south cooperation

South Sudan, Chad, Egypt, Libya, Ethiopia and Eritrea.

Multilaterals

WHO, European Union (EU), World Bank/International Development Association, Food and Agriculture Organizations of the United Nations (FAO), International Labour Organization (ILO), International Organization for Migration (IOM), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Integrated Transition Assistance Mission in Sudan (UNITAMS), United Nations - African Union Hybrid Operation in Darfur (UNMID), United Nations Interim Security Force for Abyei (UNISFA), and United Nations Industrial Development Organization (UNIDO).

Public-private partnership organizations

The Global Fund to Fight AIDS, TB and Malaria, GAVI – the Vaccine Alliance, Roll Back Malaria, Rotary International, nongovernmental organizations, members of the Health Cluster,

civil society organizations, religious institutions, voluntary organizations, recreational and sport clubs, trade unions, professional associations, employees' associations and cultural institutions.

3.2 Development partners

Partnerships remain key in creating a healthier Sudan. Over the years, WHO has been working with donors and partners to reduce mortality, morbidity and disability, and to improve population health, especially of vulnerable populations. This goal has been achieved through building national capacities, strengthening the health system, implementing public health interventions and providing humanitarian assistance during emergencies.

Sudan's programme of activities are funded through both WHO's regular budget and voluntary contributions from the following donors: Bill & Melinda Gates Foundation; Carter Center; Centers for Disease Control and Prevention; EU and ECHO; GAVI Alliance; Global Environment Facility; Global Fund to fight AIDS, TB and Malaria; Global Health Workforce Alliance; Governments of Finland, Germany, Netherlands, Norway, Saudi Arabia and Sudan; International Health Partnership; Italian Development Cooperation; Kuwait Fund; Measles Initiative Partnership; Multi-Donor Trust Funds; Rotary International; UK's Department for International Development United Nation's Central Emergency Response Fund; United States Agency for International Development (USAID).

Partnership, both developmental and humanitarian, is crucial to the ongoing transformation process in Sudan. The humanitarian aspect is playing a role in strengthening the health system and in provision of health care that increases the complexity. In 2009, the Sudan Health Cluster was established to coordinate humanitarian activities. It has approximately 62 partners, comprising 24 national nongovernmental organizations, 23 international nongovernmental organizations, 8 United Nations agencies, 5 donors and the Federal Ministry of Health and state ministries of health. This plethora of actors adds to the existing fragmentation and coordination issues and presents many challenges that need to be addressed. The objective is to reduce duplication of efforts, complement resources and maximize the efficient use of funding to improve outcomes.

Another main challenge is the lack of assessment at locality and state levels. Also, as the humanitarian activities are dealing with refugees and IDPs it is of paramount importance to establish an early warning system and create a Health Resource Availability Monitoring System (HeRAMS).

The WHO country office in Sudan has been fully engaged and leading most health-related matters, in close collaboration with other United Nations sister agencies (UNICEF, UNFPA, UNAIDS, UNDP, WFP, OCHA, UNHCR, IOM, ILO, UNIDO and others) with tireless efforts to complement each one's work to ensure a common approach and rationalization of the limited resources available. The most recent example is the leading role that WHO has played in addressing the COVID-19 epidemic in Sudan.

As the lead United Nations agency for health, WHO works closely with many partners to support Sudan in reaching its development goals to ensure that their efforts are coordinated, harmonized, and well-aligned with each other and the Government considering each agency's mandate, comparative advantage to maximize the efficiency and effectiveness in supporting the Government and delivering on United Nations Sustainable Development Framework (UNSDF) commitments.

In this context, the WHO country office has actively contributed to the development of the Common Country Analysis (CCA), by addressing the health component. WHO will also contribute in the development of the upcoming UNSDF as a strategic planning framework for increased collaboration, coherence and effectiveness of United Nations initiatives in Sudan.

The leadership role and convening power of WHO in Sudan has been well recognized. Currently, WHO is co-chairing both humanitarian and development coordination platforms, which is a good recognition of its leadership role and its capacity in strengthening partnerships to implement and scale up interventions that can contribute towards positive health and well-being outcomes. In the context of the pandemic, WHO also took the driving seat in the coordination of the COVID-19 response. All of these serve as a platform for partners to share information, best practices and lessons learnt from ongoing or implemented activities, hold discussions on critical issues, and to coordinate technical and financial support to the Government and other local partners.

With the launch of the *Global Action Plan for Healthy Lives and Well-being for All* at the United Nations General Assembly in September 2019, 12 multilateral health, development and humanitarian agencies have committed to better supporting countries to accelerate progress on the health-related SDGs and to deliver on other major commitments to health (including UHC and PHC). In Sudan, the CCS will take the global action plan forward to coordinate implementation with United Nations agencies and partners.

WHO collaborating centres are a highly valued mechanism of cooperation in which selected institutions are accredited by WHO to assist the Organization with implementing its mandated work. This is accomplished by supporting the achievement of planned strategic objectives at the regional and global levels, enhancing the scientific validity of its global health work, and developing and strengthening institutional capacity in countries and regions. Sudan used to host a number of collaborating centres, but currently it has only two: the University of Khartoum, WHO collaborating centre for mycetoma and the University of Gezira, WHO collaborating centre for health professional education. Institutions of good standing should apply to become WHO collaborating centres in their areas of excellence.

SECTION 4. WHO COLLABORATION WITH SUDAN

4.1 Country presence

Table 2 provides information on WHO support to Sudan in various areas of technical focus and lists achievements.

Table 2. WHO collaboration with Sudan and country achievements

Technical focus	Country contribution	Achievements
HIV/AIDS prevention and control	WHO is committed to working with the Federal Ministry of Health and partners to ensure zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination to ensure that people living with HIV are able to live long and healthy lives.	WHO has provided support in the areas of HIV prevention, testing and treatment, and health system HIV service delivery.
Malaria control and elimination	WHO provides technical support to the Federal Ministry of Health through malaria-related directorates and working with other partners in planning to eliminate malaria as a public health	WHO has provided support to the Federal Ministry of Health in conducting a malaria indicators survey (2016), malaria risk map (2016), malaria programme review (2018), in developing national malaria strategic plans, vector control strategic plans, a malaria programme review and in conducting vector control needs assessments. WHO has provided support in: <ul style="list-style-type: none"> • monitoring of therapeutic efficacy of antimalarial medicines;

Country Cooperation Strategy for WHO and Sudan 2022–2025

Technical focus	Country contribution	Achievements
	problem and an obstacle to socioeconomic development.	<ul style="list-style-type: none"> • conducting the HRP2 gene deletion survey in two states; • conducting external competency assessments for malaria macroscopies; • developing a surveillance database for early detection of epidemics; • responding to malaria and other vector-borne disease outbreaks.
Viral hepatitis prevention and control	WHO is supporting the Federal Ministry of Health to establish a national programme for the prevention and control of viral hepatitis and supports strengthening of the national response to control viral hepatitis in the country	Establishment of hepatitis programme and development of hepatitis national strategic plan (2019–2025), national treatment guidelines, and introduction of routine vaccination for infants (2021).
Tuberculosis	WHO supports the country in aligning its TB response with the Global End TB strategy and with support from the Global Fund is implementing a project to increase access to directly observed therapy in Sudan, focusing on hard-to-reach populations	<p>WHO has provided support in:</p> <ul style="list-style-type: none"> • updating the TB programme strategic and guidelines; • expanding TB rapid diagnostic tests and laboratory services to guide the country towards accreditation; • expansion of drug-resistant TB services through an annual review mission by the WHO Green Light Committee and conducted training in drug-resistant-TB sites in 11 states; • expanding services in under-served areas; • monitoring and evaluating TB programme monitor activities, including leading TB-HIV testing coverage and latent TB management coverage and drug-resistant TB; • conducting operational research on stigma and extra pulmonary TB.
Polio eradication	<p>The Global Polio Eradication Initiative (GPEI) is funding the country programme for, supplementary immunization, acute flaccid paralysis (AFP) surveillance, capacity-building, microplanning, cross-border coordination and operational support.</p> <p>The country programme has been developing an annual plan for polio eradication, in consultation with the Federal Ministry of Health</p>	<p>The last endogenous wild poliovirus case was reported in 2001. One case of wild poliovirus was imported in 2007 and two cases in 2008. Five cases imported in March 2009 resulted in an outbreak and since then the country has been polio free.</p> <p>The WHO country office in Sudan implemented joint measles-oral polio vaccine and vitamin A supplementary immunization activities targeting 13.3 million children between 0 to 10 years, and two rounds of polio supplementary immunization days.</p> <p>The GPEI has built infrastructure for disease surveillance, social mobilization, vaccine delivery and learned valuable lessons about reaching the most vulnerable populations.</p> <p>The GPEI achieved 99.9% of its goal. During this period the GPEI has built infrastructure for disease surveillance, including laboratory, microplanning, pool of public health professionals, social mobilization, vaccine delivery and learned valuable lessons about reaching the most vulnerable populations. following these achievements of eradication, the GPEI will wind down three decades of operations in polio-free and selected countries for polio transition.</p> <p>Certain activities and functions of the GPEI should continue. These include:</p> <ul style="list-style-type: none"> • The Government and GPEI partners must plan for some essential functions and activities to be incorporated into existing public health programmes. The process will include: analysing the infrastructure, and functions of the polio programme to manage scaling down or transferring to other health programmes. • During polio transition, some of this key knowledge, infrastructure and functions of the GPEI will be transitioned to the national health system. National governments and GPEI partners must plan for these essential functions and activities to be incorporated into existing public health programmes in order to keep the world polio free. • Areas for polio transition in Sudan could be strengthening the integrated disease surveillance system, routine immunization programme, sustaining

Country Cooperation Strategy for WHO and Sudan 2022–2025

Technical focus	Country contribution	Achievements
		the 4 polio-free status of the country, and strengthening the integrated public health team.
Neglected tropical diseases	WHO has developed a brief neglected tropical disease profile to control, eliminate, and eradicate neglected tropical diseases with clear targets aligned globally with the 2030 global roadmap	<p>WHO has provided Sudan with medicines to conduct several cycles of mass drug administration campaigns for five neglected tropical diseases and to treat leprosy through its medicine-donation programme for many years, which contributed to interruption of trachoma transmission in conflict-affected Darfur.</p> <p>WHO supported new ways of working to control visceral leishmaniasis in hyper-endemic areas along with securing medicines through donation from AmBisome, which resulted in significant reduction of visceral leishmaniasis mortality.</p>
Health emergencies	WHO plays a leading role in supporting the Federal Ministry of Health in the preparedness and response to multiple public health hazards that occur regularly in Sudan and comprise outbreaks of waterborne, vector-borne and vaccine-preventable diseases, natural disasters, population displacement and conflict	<p>WHO has supported the development and regular update of specific response plans for cholera, viral haemorrhagic fevers and COVID-19.</p> <p>WHO collaborated with the Federal Ministry of Health to update the technical guidelines and input in strategic case management and surveillance.</p> <p>WHO provided operational and technical guidance at national and subnational levels in vector surveillance and integrated vector control.</p> <p>WHO supported the scale up of the “One Health” approach in Sudan and a disease prioritization exercise.</p> <p>WHO supports the National Public Health Laboratory in strengthening its role in public health surveillance and the identification and confirmation of public health risks due to infectious agents.</p> <p>WHO supported the establishment of health resources availability mapping (HeRAMS).</p>
Health system strengthening	WHO has been a key partner in providing technical guidance to the Federal Ministry of Health and other stakeholders to strengthen and build a resilient health system to attain UHC	<p>Drafting and revision of Sudan’s national health policy</p> <p>Develop the key policies and strategies such as Health Financing Policy options and strategy, Family Medicine, Hospital Sector, Laboratories, etc.</p> <p>WHO is supporting the Federal Ministry of Health and partners in:</p> <ul style="list-style-type: none"> • designing and implementing the UHC Essential Benefit Package and provider payment mechanisms; • institutionalizing the joint annual review process; • adopting the “One Plan” approach; • promoting linkages between the humanitarian and emergency response with the development of the humanitarian-development-peace nexus; • implementing Sudan’s human resources for health initiative; • developing and implementing a roadmap to improve emergency health care; • developing and implementing a roadmap for HiAP; • supporting improvements to health information and data management systems.
Mental health	WHO, the EU and Federal Ministry of Health are collaborating to achieve the global WHO mental health action plan’s objectives	A national mental health policy and strategy has been developed.
Noncommunicable diseases	WHO provides technical and financial support to NCD control activities and work closely with the Ministry’s programme to reach the SDG target and medium-term targets for NCDs	<p>Noncommunicable disease services have been integrated in the PHC system.</p> <p>Standard management protocols developed.</p> <p>Family doctors trained.</p> <p>Cancer services assessed.</p> <p>Implementation of tobacco-free initiatives scaled up.</p>

SECTION 5. STRATEGIC PRIORITIES

5.1 Prioritization process and alignment with GPW 13, UNSDF and national health policy and plans

The strategic prioritization process has taken into consideration the type of support needed in Sudan based on factors such as capacity and health system stability. These priorities were identified in a series of discussions with the Ministry of Health and stakeholders and are based on a critical analysis of country needs and WHO's comparative advantage in addressing these priorities. It spells out WHO's jointly agreed priorities and their alignment with the national context and needs, specifically the health and development agenda, as well as opportunities for collaboration and interaction between various partners and stakeholders.

The process has been inclusive involving the Ministry of Health and other key partners and stakeholders. Several consultation meetings were held with different stakeholders, including Ministry senior management, director generals of state ministries of health, key United Nations agencies, representatives of donors, the Health Cluster, representatives of youth, women's groups and activists and WHO technical staff.

The CCS development process has been informed by the recommendations of a WHO high-level mission conducted in April 2021. WHO has identified 46 core health indicators distributed in nine domains: 1) demographic and socioeconomic determinants; 2) risk factors; 3) mortality; 4) morbidity; 5) health expenditure; 6) health workforce; 7) health system capacity; 8) service delivery; and 9) service coverage. The GPW13 monitoring framework will be used to monitor and evaluate implementation of this CCS.

5.2 National health sector framework and priorities, 2021–2024

The national health sector framework identifies the priorities as the following.

Improve access to a quality equitably distributed Health Services Basic Benefit Package

- Improve access to integrated PHC services based on the family health approach at community, family health units and centres.
- Improve health services in emergency care units.
- Improve health services at secondary and tertiary level.
- Enhance core capacities to prepare, timely detect and respond to outbreaks and health emergencies.

Address key health system bottlenecks and challenges focusing on:

- strengthening leadership, management and coordination capacities;
- strengthening the local/decentralized health system;
- improving equitable distribution of health workforce with appropriate mix of skills;
- implementing fair retention packages;
- ensuring availability and affordability of essential medicines at all levels;
- improving access to appropriate health technology;
- developing an integrated health information system and improving evidence-based policies and decision-making
- increasing government health expenditure to 15% of the annual budget;
- increasing effective coverage by health insurance focusing on poor and vulnerable populations;
- implementing appropriate public purchasing mechanisms;
- strengthening public financial management systems;

- scaling up implementation of the HiAP approach to address the social determinants of health;
- strengthening community systems and enhancing community participation.

Table 3. Priorities and key alignments

	Strengthening the health system to advance towards UHC	Promoting health and well-being	Protecting populations against emergencies	Strengthening data/innovative capacities
GPW13 strategic priorities	1 billion more people benefiting from Universal Health Coverage	1 billion people enjoying better health and well-being	1 billion more people better protected from health emergencies Addressing health emergencies	Strengthened country capacity in data and innovation
National health sector strategic plan 2021–2024	Improving access to quality equitably distributed health services (Basic Benefit Package)	Addressing communicable and noncommunicable diseases and related risk factors and Scaling up implementation of HiAP to address the social determinants of health	Enhancing core capacities to prepare, timely detect and respond to outbreaks and health emergencies	Developing an integrated HIS to inform evidence-based policies and decision-making
UNSDF 2018–2022	Output 3.1: Targeted population have improved access to and use of quality preventive and curative health and nutrition services	Output 3.4: National and subnational government partners have strengthened institutional capacities to develop and deliver child- and women-sensitive social protection, particularly to children and families in the most vulnerable	Output 3.2: Targeted population have improved access to/and use of safe and adequate WASH services	–

WHO through this CCS encourages an intensively focused approach to support Sudan's progress towards attaining UHC and health security. The four strategic priorities will collectively support the following strategic directions for the coming years:

- improving access to quality equitably distributed health services focusing on PHC and emergency health care
- enhancing core capacities to prepare, timely detect and respond to outbreaks and health emergencies, including the COVID-19 pandemic
- addressing key health system bottlenecks and challenges focusing on:
 - strengthening leadership, management and coordination capacities
 - strengthening the local/decentralized health system
 - improving equitable distribution of the health workforce with appropriate skills mix
 - ensuring availability and affordability of essential medicines at all levels
 - improving access to appropriate health technology
 - developing an integrated HIS and improving evidence-based policies and decision-making
 - supporting improvement of health financing and increasing effective coverage by health insurance focusing on poor and vulnerable populations
 - scaling up implementation of HiAP to address the social determinants of health
 - strengthening community-based systems and enhancing community participation.

5.3 Strategic priorities

5.3.1 Strategic priority 1: strengthening the health system to advance and accelerate progress towards UHC

Governance

Sudan's health system is hospital-centric and characterized by fragmentation within both public and private sectors. The proliferation of providers and stakeholders has resulted in considerable inefficiencies. Thus, the following evidence-based measurements should be implemented:

- Strengthening health system coordination and interrelation between and among stakeholders with emphasis on the importance of joint planning and implementation of activities.
- Strengthening the capacities of the Federal Ministry of Health to lead and coordinate the process in revising and updating national, state and local health system structures, roles, standards and interrelation among actors vertically and horizontally to ensure synchronization. It shall also lead and coordinate the process of revising and updating all laws that govern health management and practices.
- Strengthening of research governance and coordination.
- Supporting national multisectoral research projects addressing priority health problems and health determinants within the framework of the SDGs.
- Encouraging use of information and other types of evidence on improvement of decision-making and planning according to priorities, needs and context findings.
- Implementing systematic advocacy activities to highlight health priorities and issues for communities, among policy-makers and community leaders.

WHO has been supporting the Ministry of Health and other stakeholders on different dimensions in governance, including governance assessment, training and policy dialogue. WHO is also committed to continue working with the Ministry and other health stakeholders to provide technical support to improve governance as a key function to advance towards UHC.

Primary health care

The Government is committed to improving health services and providing financial protection for its population through progress towards UHC. The current COVID-19 pandemic has shown the importance of strengthening PHC, which requires a strong, efficient subnational health system to timely address the threats of the interruption of essential health and social services. Although the country is committed to strengthening PHC additional efforts must be exerted to address prevailing challenges. WHO will continue to provide support for PHC as an entry point to strengthen the health system as essential in fulfilling the 2030 Agenda for Sustainable Development.

Health financing

The Government is committed to improving the coverage of health services and financial protection for its population through progress towards UHC by 2030. The development of a health financing strategy needs to focus on revenue, effective organization and pooling of resources, prepayment mechanisms, and strategic purchasing. Working on these functions will ensure equitable and sustainable health financing and protection against catastrophic payments for the entire population.

The national health sector strategic plan outlines the following steps to improve health system responsiveness with high financial risk protection:

- Revising and restructuring the national health financing projects package, its implementation process monitoring and evaluation system and feedback.
- Updating the UHC benefit packages and services covered by national health insurance to ensure complementarity and better services and effective population coverage.
- Enhancing the role of the private health sector in health services' provision and financing.
- Developing/updating the multisectoral health financing policy according to expected health financing agents and schemes' role and share in health financing to ensure adequate public health financing allocation at all levels of the health system.
- Formulating a coordinated plan for mobilization of resources from national and international entities to support research activities.

WHO has partnered with national and international partners to support the health financing functions and will continue to do so.

5.3.2 Strategic priority 2: promoting health and well-being for all

“Health for all” means that health is to be brought within the reach of everyone and by “health” we mean a personal state of well-being, not just the availability of health services; a state of health that enables a person to lead a socially and economically productive life.

Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighbourhood, physical environment, employment, and social support networks, as well as access to health care.

Communicable diseases

Sudan has a high burden of communicable diseases. Therefore, in its four year collaborative plan, WHO will prioritize the control of communicable diseases, particularly malaria. WHO support will focus on strengthening the malaria surveillance system and the quality of information to improve the decision-making process and ensure a timely response, in addition to addressing malaria in pregnancy and reducing mortality from malaria.

Furthermore, WHO will strengthen TB services, focusing on decentralizing services into conflict-affected and under-served areas and enhancing the TB response through a multisectoral accountability framework.

The hepatitis response is currently fragmented; however, with support from WHO, the country has developed a five-year strategic plan. WHO will support the Ministry of Health in leading an integrated, coordinated viral hepatitis control response, in collaboration with partners.

WHO works in neglected tropical diseases to support the country to control, eliminate and eradicate these diseases as public health threats in Sudan by 2030. This support includes the provision of technical support and resource mobilization to implement the national strategic plan for neglected tropical diseases.

WHO technical support areas for HIV will continue to focus on strategic information strengthening, providing guidance and support for scaling up HIV prevention and treatment.

Noncommunicable diseases

Noncommunicable diseases are a leading cause of morbidity and mortality in Sudan, the rates of which could be reduced through a change of policies and actively engaging all sectors through a whole-of-government and whole-of-society approach. Based on the 2016 STEPs findings and recommendations, WHO will continue supporting the Government to enhance its institutional capacity and impact of multisectoral interventions, not only in translating recommendations into policy actions in line with WHO guidance, but also in monitoring disease trends and the level of implementation of strategies and approved plans of action.

Mental health

Although mental health is projected to be the major cause of morbidity in 2025, mental health programmes in Sudan continue to be allocated insufficient resources. Substantial efforts have been dedicated by the Federal Ministry of Health and WHO to strengthen and reform the national mental health system. These efforts have been aimed at supporting the integration of mental health into PHC and the reorientation of secondary and tertiary care systems to improve the availability and accessibility of effective services. To this end, WHO will continue working with national counterparts on identified priorities, including restructuring of mental health programmes to promote mental health advocacy, and scaling up quality interventions and services, particularly at PHC level.

Health and climate change

Climate change has traditionally been a neglected area of work in Sudan. It threatens the essential ingredients of good health, clean air, safe drinking-water, nutritious food supply and safe shelter, and it has the potential to undermine decades of progress in achieving health gains. There is an urgent need to establish a task force on climate action, spearheaded by WHO, that could bring together United Nations agencies that have active programming in climate change, including different ministries concerned with climate change. Therefore, using its comparative advantage, WHO will provide technical support to reduce the health impacts of environmental emergencies, advocate for healthier cities, as well as healthy transport solutions among other areas of intervention, as defined in national policies and strategies addressing health and climate change in Sudan.

WHO is committed to continue supporting the Government to build capacity to promote, implement and evaluate “health for all” and encourage engagement and collaboration across sectors to address the social determinants of health. The ongoing COVID-19 pandemic has urged all partners and stakeholders to holistically address public health challenges in a holistic manner, by implementing a “Health for All” approach with a strong coordination and accountability mechanism. The following evidence-based measurements should be implemented.

- Accelerating action on preventing noncommunicable diseases and promoting mental health.
- Accelerating elimination and eradication of highly prevalent communicable diseases.
- Supporting implementation and monitoring of a comprehensive nutrition programme to address malnutrition in Sudan.
- Supporting development and implementation of effective policies and strategies to reduce maternal and child mortality and promoting child development.
- Supporting national capacities to improve universal access to sexual and reproductive health care services and address gender, equity and human rights-related barriers.
- Enhancing national capacities to tackle antimicrobial resistance.
- Providing support to address the health effects of climate change.
- Scaling up implementation of the HiAP approach to address the social determinants of health.

5.3.3 Strategic priority 3: Protecting populations against health emergencies

Sudan is repeatedly prone to disasters, whether natural or manmade. The local response capacity at states and localities are weak and cannot withstand the various types of disasters. About 8.7 million people are estimated to require emergency assistance. The highest needs include health, water and sanitation, and food security. Particularly vulnerable groups include 2.5 million IDPs and 1.05 million refugees.

To strengthen public health emergencies preparedness system, WHO will support implementation of the following measures in line with national health priorities:

- Improving and operationalizing emergency operation centres (EOCs) at the federal, state, locality and community levels, adopting an incidence management system approach to ensure an effective emergency response.
- Developing/updating governing documents, laws, policies, strategies, standard operating procedures, guidelines and protocols for public health emergencies.
- Supporting managing, maintaining and upgrading the disaster information system, as well as the emergency forecasting risk assessment.
- Improving preparedness and response capacity so as to be able to predict, detect and respond to public health emergencies effectively.
- Strengthening communications and coordination between health-related sectors and partners during public health emergencies to maintain functionality of essential services.
- Building capacity (staff and infrastructure) focusing on mitigation, early preparedness and effective response for risks or outbreaks in line with IHR 2005 core capacities.
- Strengthening implementation of safety hospital initiatives for hospital emergency preparedness and response for mass causality incidents.
- Supporting the strengthening of control system at points of entry to be prepared for public health emergencies envisioned under the IHR 2005.
- Supporting development and upgrading of laboratory network services for all hazards according to the public health priority list and as required by IHR 2005.
- Developing guidelines and systems for community partnership starting from risk analyses.

Another three areas that require attention and focus during this period are:

One Health approach

The One Health approach in Sudan calls for the establishment of multisectoral partnerships to address the threats of zoonotic infection at the animal-human interface. In August 2021, a workshop was conducted by the Federal Ministry of Health, in collaboration with WHO, in which they used the United States Centers for Disease Control and Prevention (CDC) process for One Health disease prioritization that brings together representatives from the human, animal and environmental health sectors, as well as other relevant partners, to prioritize zoonotic diseases of greatest concern for multisectoral One Health collaboration, the workshop identified eight priority diseases for a One Health approach and all three sectors agreed on a plan and the way forward to address these disease priorities.

The COVID-19 pandemic has generated further momentum for investments in this area of work. In the next five years, WHO will keep providing strategic and technical support to the implementation of priority components of the One Health Framework for Action. WHO will focus its interventions on the strengthening of multisectoral approaches to enable effective One Health collaboration and coordination across sectors, the Federal Ministry of Health, Ministry of Agriculture, Ministry of Animal Resources and veterinary faculties in different universities. Thus, Sudan's capacity to prevent, detect and rapidly respond to high impact, emerging, re-emerging diseases at the animal, human and eco-system interface will be

enhanced. Surveillance and information-sharing will be supported. Also, WHO will keep advocating for increased domestic investments in the One Health approach, while contributing to the mobilization of external resources.

IHR core capacities

The impact of the COVID-19 pandemic on the health system and on socioeconomic output calls for reinvigorated efforts to strengthen national IHR capacities. In this context, WHO will significantly increase its collaboration with national counterparts to expedite enhancing the strengthening of IHR capacities.

Emergency operations centres and disease surveillance

WHO has been working closely with the Federal Ministry of Health to enhance the capacity to detect and respond to public health emergencies in recent years. Such capacity is even more critical during the COVID-19 pandemic, which led to diminished reporting of several communicable and noncommunicable diseases. While support is provided to strengthen indicator-based surveillance through timely and accurate identification of vaccine-preventable diseases and other illnesses of international concern, WHO is supporting the establishment and implementation of event-based surveillance at the level of emergency operations centres, which would enable complementary capacity in early detection of events and response to future threats.

5.3.4 Strategic priority 4: Strengthen data and innovation capacity

The HIS in Sudan is fragmented. Vertical programmes have independent HISs and there is limited sharing of data with the central HIS directorate. HIS laws are not activated. A system of an integrated health facility report for hospitals and PHC has been developed but poor quality of data in terms of completeness and timeliness and low reporting represent big challenges. Work on inclusion of vertical programmes in the integrated health facility report is under way to eventually reduce verticality and streamline data flow to the HIS. Birth registration, although better than death registration, still needs improvement. The death notification form is also deficient in providing needed information. A comprehensive review of the birth registration system is currently under way, in a collaboration between UNICEF and the Federal Ministry of Health. Approximately 80–90% of deaths occur outside health facilities and are thus not registered or captured by the health system and the civil registration office. Recording of cause of death also remains one of the key challenges to improving the HIS.

SCORE Health Data Technical Package

SCORE is the acronym for: Survey (population and health risks); Count (births, deaths and cause of death); Optimize (health service data); Review (progress and performance); Enable (data use for policy and action). The SCORE Health Data Technical Package was developed by WHO and other development partners as a single harmonized package and consists of all elements that are critical to optimize HIS performance. The tools and standards in the SCORE technical package are the most effective in strengthening country health data as the foundation for evidence-based policies to improve health. The COVID-19 pandemic has shown that timely sharing of information and data, and people-centred communication contributes to early detection of, and response to, the risks associated with a pandemic.

Availability of disaggregated health data remains a main challenge that limits the country's capacity to adequately plan and implement evidence-based interventions towards reducing prevailing health inequities at all levels of care in line with SDG global, regional and national strategies. Therefore, WHO will continue focusing its interventions in the next four years in

building capacity in data analysis to ensure that data collected are timely and appropriately used for local decision-making processes.

A paper-based annual statistics report is published by the Federal Ministry of Health. There is currently no mechanism through which health systems-related, disease-specific case-wise and group data are collected, collated and housed centrally at the Ministry on a regular/monthly basis. In the next four years, WHO will support the Ministry to develop a unified digital repository in which all reports and information on indicators can be accessed with ease and in a timely manner. These efforts will be undertaken and be consistent with the recommendations from a comprehensive assessment of national health information that was conducted in 2020.

The following evidence-based measurements should be implemented:

- Enhancing the governance of health information system through supporting legislation that address the collection and dissemination of transparent and reliable information and support implementation of evidence-based policies that will consider innovative and more advanced technologies.
- Supporting building national capacities to conduct, analyse and disseminate quality population-based surveys through initiating an efficient network of partners among governmental and nongovernmental organizations.
- Strengthening the civil registration and vital statistics system with support to data governance, human resources and infrastructure, using electronic-based platforms and software that will accelerate reporting times and improve quality and dissemination of data at federal and states levels.
- Promoting and supporting the use of DHIS2 system at all levels by improving the health management information system infrastructure, printing/supplies and human resources, while observing, promoting and implementing one report for all vertical programmes.
- Adopting a community-based health information system as an additional method to strengthen the routine HIS system, especially in remote areas to increase coverage capacity.
- Promoting and supporting capacity-building of the HIS system to generate reliable and practical evidence through updated guidelines, building capacity for research and improvement of ethical skills to support strengthening of evidence-based policies.

Update of existing national targets and indicators: The SDGs have 17 goals of which the overarching health goal – SDG 3 – is associated with 13 health targets and 27 indicators that countries need to consider and monitor in national health strategies and policies. In addition, there are 32 additional health-related SDGs that are related to GPW13 indicators. Health is closely linked to other SDGs that have a direct or indirect impact on health-related targets and indicators. Therefore, non-health sector data sources, such as civil registration and vital statistics systems, satellite data, air quality monitors for air pollution, and road traffic mortality, etc. serves as significant secondary data sources that will contribute to reviewing progress made towards achieving SDG targets in Sudan. In the next four years, WHO will provide technical support to jointly assess the SDGs indicators and targets in general, with a focus on SDG 3.

SECTION 6. IMPLEMENTING THE STRATEGIC PRIORITIES

6.1 Key contributions to the four strategic priorities

WHO has played an important role in Sudan in strengthening the health system by influencing and shaping health policies, strengthening capacity for planning, implementing and monitoring health policies and programmes and providing continual, hands-on support during health emergencies. WHO will engage directly with Federal and state ministries of health, other line ministries and government entities, in addition to communities, academia, nongovernmental

organizations, civil society organizations, women's and youth groups and other implementing partners to support implementation of Sudan's CCS. Throughout the CCS cycle, WHO will support the Government to identify opportunities and work with other sectors to develop and implement relevant health policies, regulations and interventions. Furthermore, WHO will enhance its capacities at its main office in Khartoum and sub-offices to ensure effective and efficient implementation of this CCS. An outline of the envisaged role of the WHO country office during the process of implementation of the four main strategic priorities is shown below.

Strategic priority 1: Strengthen the health system to advance and accelerate progress towards UHC:

- Support the health sector reform by enhancing health systems governance and improve equitable access to quality essential health services with an emphasis on PHC, aimed at advancing UHC and reducing gender and health equity gaps.
- Support health financing reform to reduce the number of people suffering financial hardship, particularly among the most vulnerable and poor populations.

How success will be measured:

- Equitable access to quality essential health services and to people-centred health care improved.
- Vulnerable groups, including refugees and IDPs, suffering financial hardship reduced.
- UHC coverage index improved.

Key implementation partners will include the Federal Ministry of Health, state ministries of health and localities, the community and academia at different levels, nongovernmental organizations, civil society organizations, the private sector, key line ministries and government entities, such as the Ministries of Finance, Social Welfare and Labour, United Nations agencies, development partners and donors.

Strategic priority 2: Promoting health and well-being for all

The role envisaged for the WHO country office includes:

- supporting the institutionalization of evidence-based and cost-effective health promotion policies at PHC level to address underlying communicable, endemic and noncommunicable diseases and their risk factors;
- supporting multisectoral responses in addressing the social determinants of health to tackle inequalities, through the implementation of the "Health for All by All" approach;
- strengthening the deinstitutionalization of the mental health programme by scaling up services at PHC level and through human resources capacity-building;
- supporting the implementation of national policies and strategies addressing health and climate change;
- enhancing multisectoral response and strengthen surveillance (including antimicrobial resistance) and institutional capacity.

How success will be measured:

- Social determinants of health increasingly addressed.
- Noncommunicable disease risk factors assessed, quantified, monitored and policy responses developed and implemented.
- Nutrition indicators improved.
- Provision of mental health services at PHC level.

Antimicrobial resistance surveillance system implemented and data available for decision-making.

Key implementation partners include: the Federal Ministry of Health, state ministries of Health for developing and leading a multisectoral response to NCDs; other ministries and national counterparts for partnering in the designing of people-centred NCD responses, such as the Ministries of Education, Youth and Sports, Ministry of Information; United Nations agencies for partnering in equitable noncommunicable responses; communities and academia in all states; the private sector, nongovernmental organizations and civil society.

Strategic priority 3: protecting populations against health emergencies

The role envisaged by the WHO country office includes:

- strengthening health emergency preparedness and operational readiness to prevent, detect and rapidly respond to emerging and re-emerging diseases, building on the lessons learnt by the COVID-19 pandemic;
- scaling up implementation of event-based surveillance for early detection of public health events by enhancing the PHEOC at the Federal Ministry of Health, in line with Sudan's national health sector policy, 2021–2024;
- supporting the strengthening of IHR capacities at national and subnational level and improving IHR coordination mechanism under the One Health approach.

How success will be measured:

- Developing a multi-hazard national public health emergency preparedness and response plan.
- Strengthening the PHEOC to be operational, action-oriented working in optimum coordination with all sectors and stakeholders.
- Strengthening rapid response teams at federal, state and locality levels.
- Increasing national and state capacities for case management of IHR-related hazards, so that emergencies can be effectively responded to and the delivery of quality essential health services is maintained.

Key implementation partners will include: the Federal Ministry of Health, for coordination of emergency operations at national and state levels through the PHEOC; a national centre for crisis management comprising the PHEOC, Ministries of Agriculture and Animal Resources; and academia and civil defence to coordinate all hazard emergency preparedness and response and strengthen the One Health approach; and United Nations agencies, international and local nongovernmental organizations, civil society and the private sector for collaboration in responding to emergencies.

Strategic priority 4: strengthening data and innovation capacity

The role envisaged by the WHO country office includes:

- enhancing the country's institutional capacity on health data analysis using disaggregate data for decision-making processes;
- improving access to health indicators by reinforcing the unified digital repository with a reporting/output's illustrative platform;
- strengthening the Federal Ministry of Health and state ministries of health capacities to measure and monitor national indicators and trends related to SDGs targets and goals in the context of the GPW 13 Impact Framework.

How success will be measured:

- HIS strengthened, harmonized, and integrated.
- Institutional capacity to utilize data for policy-making enhanced.
- Institutional capacity to monitor national indicators and trends, including SDG-related targets.

Key implementation partners will include: Federal Ministry of Health for implementation of the HIS strategy, 2020–2024; all health partners who should facilitate process of data collection, its processing, analysis, storage, retrieval and sharing; and Department of Statistics and Central Bureau of Statistics to support generation of evidence and dissemination to national and international health partners.

Table 4. The CCS results framework

A results chain: measuring GPW 13 aligned outputs and impact targets for the four SCS strategic priorities				
Strategic priorities 2022–2025	Focus areas	Enabling policy and strategic environment	Proposed targets (in line with national health policy)	Proposed indicators (in line with the SDG Indicator Framework and GWP 13)
Strengthening the health system to advance and accelerate progress towards UHC	Enhancing health system governance and improving equitable access to quality essential health services with emphasis on PHC Health financing reform	Government commitment, effective partnerships at all levels, sustainable health financing	Equitable access to quality essential health services Vulnerable people, including refugees and IDPs, experiencing reduced financial hardship UHC coverage index improved	Mortality rates Coverage of essential health services and treatments Health worker density and distribution. Vaccination coverage Out-of-pocket expenditure
Promoting health and well-being for all	Enhancing and institutionalizing evidence-based and cost-effective health promotion policies at PHC Applying multisectoral responses to address the social determinants of health Provision of mental health services at PHC Strengthening surveillance and HIS	HiAP, effective partnership, including the community, academia and private sector	Social determinants of health increasingly addressed NCD risk factors assessed, quantified, monitored and policy responses developed and implemented Mental health services provided at all levels Public health surveillance system implemented and data available for decision-making	Nutrition indicators Environmental and pollution indicators
Protecting populations against health emergencies	Health emergency preparedness and operational readiness strengthened Scaling up the implementation of event-based surveillance for	Establishment of national centre for crisis management Coordination of emergencies at national and	Development of a multi-hazard national public health emergency preparedness and response plan Strengthening of the PHEOC	IHR core capacities

A results chain: measuring GPW 13 aligned outputs and impact targets for the four SCS strategic priorities

Strategic priorities 2022–2025	Focus areas	Enabling policy and strategic environment	Proposed targets (in line with national health policy)	Proposed indicators (in line with the SDG Indicator Framework and GWP 13)
	early detection of public health events Strengthening of IHR capacities at national and subnational level	subnational levels through the PHEOC	Rapid response teams strengthened at federal, state and locality levels Increased national and state capacities for case management of IHR-related hazards	
Strengthening data and innovation capacity	Increased national and state capacities for case management of IHR-related hazards Improved access to health indicators Federal Ministry of Health and state ministries' capacity to measure and monitor national health indicators strengthened	–	HIS strengthened, harmonized, and integrated Institutional capacity to utilize data for policy-making enhanced Institutional capacity to monitor national indicators and trends Functional digital repository with a reporting/output illustrative platform	–

The means of implementation will include:

- providing technical and policy advice;
- enhancing integration and promote addressing inter-programmatic inefficiencies;
- adopting a Humanitarian-Development-Peace-Nexus approach;
- strengthening data management and use;
- adopting a gender, equity and rights-based approach;
- strengthening partnerships and multisectoral collaboration, including adoption of the HiAP approach;
- strengthening strategic communications;
- mitigating risks.

Table 5. Implementation support for CCS priorities

WHO's key contributions		
Country office	Regional Office	Headquarters
Strengthening national capacity to prepare, timely detect and respond to health emergencies, noncommunicable diseases and risk factors within the national health system; emphasis on PHC in order to achieve UHC and reduce gender and health equity gaps	Boosting country office capacity to prepare, timely detect, diagnose, treat and manage health emergencies, noncommunicable diseases and risk factors Assist in adapting and strengthening health information systems to collect disaggregated data in order to track	Developing guidance and support for improving equitable access to basic technologies and essential medicines, including generics for noncommunicable diseases Generating international best practices and developing guidance to support Sudan in

WHO's key contributions		
Country office	Regional Office	Headquarters
Enhancing national capacities to advance progress towards attaining UHC focusing on supporting implementation of the UHC Essential Benefit Package and social protection	disease-related mortality, morbidity, risk factors and health inequities and guide future policy-making Adapting global tools to the regional context in order to improve health	scaling up of multisectoral policy dialogue and capacity-building for effective development and implementation of intersectoral actions and HiAP for UHC

How success will be measured:

- The health information system has been upgraded to collect high quality disaggregated data for health inequality monitoring;
- A comprehensive national health strategy and implementation plan is in place to support universal health coverage; and
- A sustainable health financing model based on social health insurance has been established to ensure financial risk protection.

Table 6. GPW 13 impact framework indicators: one billion more people benefiting from universal health coverage

Indicator	2023 milestone GPW 13	Country baseline	Global target/ /GPW13/SDG/WHO	Regional average
1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	20% relative reduction in premature mortality (age 30–70 years) from NCDs (cardiovascular disease, cancer, diabetes or chronic respiratory disease) through prevention and treatment	22.8% (2019)	18.24% 1.1/3.4.1	24.5%
2. Suicide mortality rate	Reduce suicide mortality rate by 15%	8.2/100 000	6.5/100 000 1.1/3.4.2	5.9
3. Increase the proportion of women of reproductive (aged 15–49 years) whose family planning needs have been met with modern methods	Increase the proportion of women of reproductive (aged 15–49 years) whose family planning needs have been met with modern methods to 66%	32.4	66% 1.1/3.7.1	Data unavailable
4. Tuberculosis incidence per 100 000 population	Reduce by 27% the number of new tuberculosis cases per 100 000 population	46	33.6 1.1/3.3.2	114
5. Maternal mortality ratio	Reduce the global maternal mortality ratio by 30%	295	206 1.1/3.1.1	164
6. Hepatitis B incidence per 100 000 population	Reduce hepatitis B incidence to 0.5% for children aged under-5 years (estimated HBsAg prevalence (95% confidence interval))	2.9 (2014)	206 1.1/3.3.4	1.6
7. Number of new HIV per 1000 uninfected population, by sex, age and key populations	Reduce number of new HIV infections per 1000 uninfected population by sex, age and key populations by 73%	0.08/1000	0.02 1.1/3.3.4	0.1

Country Cooperation Strategy for WHO and Sudan 2022–2025

Indicator	2023 milestone GPW 13	Country baseline	Global target/ /GPW13/SDG/WHO	Regional average
8. Age-standardized prevalence of raised blood pressure among persons aged over 18 years (defined as systolic blood pressure >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	20% relative reduction in prevalence of raised blood pressure	22.8%	18.2% 1.1/WHO66.1	26.3%
9. Coverage of treatment interventions (pharmacological, interventions psychosocial and rehabilitation and substance use disorders aftercare services)	Increase service coverage of treatment (pharmacological, rehabilitation and psychosocial and after care services) for substance use disorders	Data unavailable	1.1/3.5.1	Data unavailable
10. Health worker density and distribution	Increase health workforce density, with improved distribution	2.8 physicians per 10 000 and 33.5 nurses per 10 000 persons	5.5 physicians and 50 midwives/nurses per 10000 1.1/3.c.1	Data unavailable
11. Coverage of essential health services (defined essential health services as the average coverage based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access among the general and the most disadvantaged populations)	Increase coverage of essential health services (UHC Service Coverage Index ²)	44.3% (2017)	60 1.1/3.8.1	Data unavailable
12. Proportion of births attended by skilled health personnel	Reduce the global maternal mortality ratio by 30% (proportion of births attended by skilled health personnel (%))	78%	90% 1.1/3.1.2	Data unavailable
13. Under-5 mortality rate	Reduce the preventable deaths of newborns (neonatal mortality rate) and children under-5 years (under-5 mortality rate) by 17% and 30%, respectively	27/58 per 1000 live births (2019)	22/41 per 1000 live births 1.1/3.2.1	25/46

² The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. More details at SDG3.8.1 metadata source: <https://unstats.un.org/sdgs/metadata/>.

Country Cooperation Strategy for WHO and Sudan 2022–2025

Indicator	2023 milestone GPW 13	Country baseline	Global target/ /GPW13/SDG/WHO	Regional average
14. Neonatal mortality preventable rate	Reduce the preventable deaths of newborns (neonatal mortality rate) by 17%	27/1000 live births	22 1.1/3.2.2	25
15. Proportion of the target population covered by all vaccines to 85% in their national programme	Increase coverage of second dose of measles vaccine to 85%	DTP 93% Measles 90%	95% 1.1/3.b.1	82%
16. Number of people requiring interventions against neglected tropical diseases	Reduce by 400 million the number of people requiring interventions	14 342 843	10 000 000 1.1/3.1.5	Data unavailable
17. Malaria incidence per 1000 population	Reduce malaria case incidence by 50%	40.9/1000	20.5/1000 1.1/3.3.3	Data unavailable
18. Proportion of population with large household expenditure hardship (defined as on health as a share of out-of-pocket spending of total household expenditure or income)	Stop the rise in percent of people suffering financial hardship (defined as out-of-pocket spending exceeding ability to pay) in accessing health services	Catastrophic expenditure at 25% of household income 7.8% (2016)	5% 1.2/3.8.2	Data unavailable
19. Proportion of total government spending on essential services health (education, health and social protection)	Increase the share of government spending on essential services health by 10%	10.7%	15% 1.2/3.a.2	Data unavailable
20. Proportion of health facilities that have a core set of relevant essential medicines, available and affordable on a sustainable basis	Increase the availability facilities of essential medicines for primary health care, including those free of charge, to 80%	40% 2020	1.1/3.b.3	Data unavailable
21. Patterns of antibiotic consumption at ≥60% overall level consumption	ACCESS group national account for antibiotics	Data unavailable	1.3/WHO68.7	Data unavailable

Table 7. GPW 13 impact framework indicators: one billion more people enjoying better health and well-being

Indicator	2023 milestone GPW 13/CCS	Country baseline	Global target/ GPW13/SDG/WHO	Regional average
1. Mortality rate attributed to household and ambient air pollution	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination (age-standardized mortality rate attributed to ambient air pollution (deaths per 100 000 population))	105/100 000 (2016)	80/100 000 3.1/3.9.1	125
2. Prevalence of malnutrition (weight-for-height ≥ 2 or ≤ 2 standard deviations from the median value of the WHO Child Growth Standards) among children aged under 5 years (overweight)	Halt and begin to reverse the rise in childhood overweight (0–4 years)	2.3% (2018)	2.0 3.1/2.2.2	7.7%
3. Proportion of children aged under 5 years who are developmentally on track in health, learning and psychosocial well-being, by sex	Increase the proportion of children aged under 5 years who are developmentally on track in health, learning and psychosocial well-being to 80%	Data unavailable	Data unavailable 3.1/4.2.1	Data unavailable
4. Proportion of children aged 1–17 years who have experienced any physical punishment and/or psychological aggression by caregivers in the past month	Decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by caregivers in the past month, by 20%	Data unavailable	Data unavailable 3.1/16.2.1	Data unavailable
5. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Decrease the proportion of ever-partnered women and girls aged 15–49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%	Data unavailable	Data unavailable	Data unavailable
6. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	Increase the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care to 68%	Data unavailable	3.1/6.5.1	Data unavailable
7. Death rate due to road traffic injuries (per 100 000 population)	Reduce the number of global deaths and injuries from road traffic accidents by 20%	25.7/100 000 (2016)	20.6 3.1/3.9.2	17.8
8. Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe water, sanitation and hygiene for all (WASH) services) (deaths per 100 000 population)	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	17/100 000 (2016)	13 3.1/3.9.2	10.6
9. Mortality rate attributed to unintentional poisoning (deaths per 100 000 population)	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	1.7/100 000 (2019)	1.2 3.1/3.9.3	1.1

Country Cooperation Strategy for WHO and Sudan 2022–2025

Indicator	2023 milestone GPW 13/CCS	Country baseline	Global target/ GPW13/SDG/WHA	Regional average
10. Proportion of population with primary reliance on clean fuels and technology	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	Data unavailable	3.1/7.1.2	72.1
11. Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (weighted population) (micrograms perm ³)	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	All areas: data unavailable and urban data unavailable	3.1/11.6.2	Data unavailable
12. Proportion of population using safely managed drinking-water services	Provide access to safely managed drinking-water services for 1 billion more people	60% (2017)	80% 3.1/6.1.1	Data unavailable
13. Proportion of population using: 1) safely managed sanitation services; and 2) hand-washing facilities with soap and water	Provide access to safely managed sanitation services for 800 million more people	37% (2017)	55% 3.1/6.2.1	Data unavailable
14. Prevalence of stunting (height-for-age ≤ 2 standard deviations from the median value of the WHO child growth standards) among children aged under 5 years	Reduce the number of stunted children aged under 5 years by 30%	36.6%	25% 3.1/2.2.1	26.2%
15. Prevalence of malnutrition (weight- for-height ≥ 2 or ≤ 2 standard deviations from the median value of the WHO child growth standards) among children aged under 5 years (wasting)	Reduce the prevalence of wasting among children aged under 5 years to less than 5%	14.2%	7.0% 3.1/2.2.2	Data unavailable
16. Age-standardized prevalence of current tobacco use among persons aged 15 years and older	25% relative reduction in prevalence of current tobacco use in persons aged 15 years and older	9.6% (2015)	7.2% 3.2/3.a.1	Data unavailable
17. Harmful use of alcohol, defined according to the national context as per capita consumption (aged 15 years and older) for a calendar year in litres of pure alcohol	7% relative reduction in the harmful use of alcohol as appropriate, within the national context	0.5 l/per year per 1000 (2018)	0.45 3.2/3.5.2	Data unavailable
18. Percentage of people protected by effective regulation on trans fats	Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)	Data unavailable	3.2/WHA66.10	Data unavailable
19. Prevalence of obesity	Halt and begin to reverse the rise in obesity	28.9% overweight and 8.6% obesity	20%overweight and 6% obesity 3.2/WHA66	Data unavailable
20. Percentage of bloodstream infections due to antimicrobial resistant organisms	Reduce the percentage of bloodstream infections due to selected antimicrobial resistant organisms by 10%	Data unavailable	3.2/WHA67.2	Data unavailable

Table 8. GPW 13 impact framework indicators: one billion more people better protected from health emergencies

Indicator	2023 milestone	Country baseline	Global target /GPW13/SDG/WHA	Regional average
1. International Health Regulations (IHR 2005) capacity and health emergency preparedness (percentage of attributes of 13 core capacities that have been attained at a specific point in time)	Increase in the IHR capacities of Member States	65 IHR annual reporting (2018)	80 2.1/3.d.1	66
2. Vaccine coverage of at-risk groups for epidemic- or pandemic-prone diseases	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza	Data unavailable	2.2/WHE	Data unavailable
3. Number of cases of poliomyelitis caused by wild poliovirus	Eradicate poliomyelitis to zero cases caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus	0	0 2.2/WHA68.3	Data unavailable
4. Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population	Reduce the number of deaths, missing persons and persons affected by disasters per 100 000 population	Data unavailable	2.3/1.5.1	Data unavailable
5. Proportion of vulnerable people in fragile settings provided with essential health services	Increase the number of vulnerable people in fragile settings provided with essential health services to at least 80%	Data unavailable	2.3/WHE	Data unavailable

6.2 Financing the strategic priorities

Table 9. Five-year budget estimate, 2019–2023

Strategic priority	Estimated budget required (A)1 (US\$)	Anticipated funding (B)2 (US\$)	Anticipated funding gap (C)3 (US\$)
Strengthen the health system to advance towards UHC	74 360 000	36 504 000	37 856 000
Promote health and well-being	37 180 000	18 252 000	18 928 000
Build health system resilience and capacity to prepare, and respond to health emergencies	55 770 000	27 378 000	28 392 000
Strengthen data and innovation capacity	7 809 813	9 126 000	9 464 000
Total	185 900 000	91 260 000	94 640 000

SECTION 7. MONITORING AND EVALUATION

The CCS will be monitored during implementation and reviewed at mid-term and towards the end of the CCS cycle. The lessons learnt and recommendations from the final review will be shared within WHO and with the Government of Sudan, national stakeholders and development partners.

The primary aim of monitoring and evaluating the CCS is to determine the extent to which joint actions, initiatives and programmes described under each of the four strategic priorities are being implemented. It will also provide an opportunity to refocus biennial work plans and collaboration with national counterparts in the future.

The regular monitoring of CCS implementation, as well as the mid-term and final evaluations will be led by the WHO and carried out in full collaboration with the Federal Ministry of Health, state ministries of health and other relevant partners, including United Nations agencies. The monitoring and evaluation process will be harmonized wherever feasible, with other monitoring and evaluation processes. The WHO country office will also solicit inputs from the WHO Regional Office and headquarters for the evaluation of health programmes and outcomes for the mid-term and final CCS evaluations.

The lessons learnt and recommendations from the final review will be shared within WHO and with the Government, Federal Ministry of Health, state ministries of health, national stakeholders and development partners, among others who have been involved in the development and implementation of the CCS.

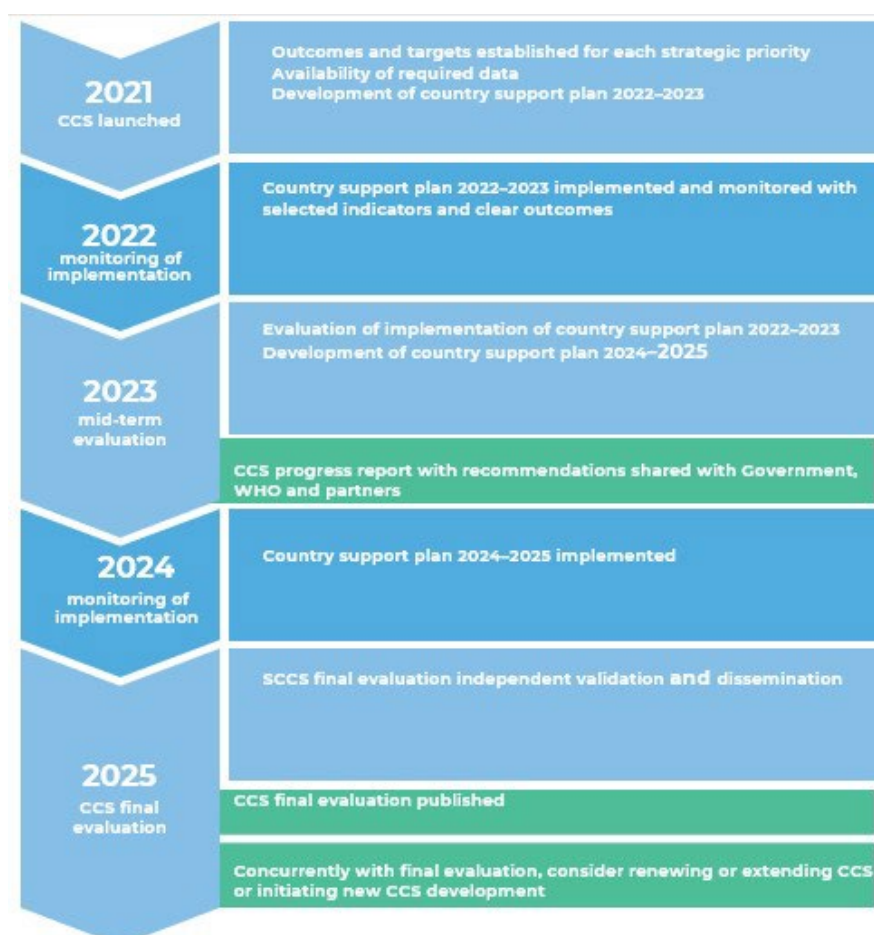


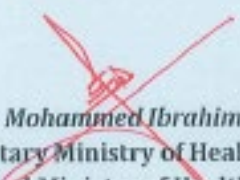
Fig. 5. Key milestones, approach and activities

ANNEX 1. SIGNATURE PAGE

The signing of the Sudan's Country Cooperation Strategy 2022–2025 reaffirms the strength of the relationship between WHO as part of the wider UN system and Sudan.

It advances WHO's long history of collaboration with the Sudan and underscores their mutual commitment to work together towards agreed priorities of greater importance and relevance to the people of Sudan as envisioned in the Sudan National Health Sector Strategic Plan (2021–2024) and the Sustainable Development Goals (SDGs).

In line with the strategic priorities of WHO's 13th General Programme of Work (2019–23), the strategy emphasizes the need for coherence and coordination at all levels of the organization when working with Sudan in order to help it achieve its SDG priorities to their full extent.


Dr Heitham Mohammed Ibrahim Awadalla
Undersecretary Ministry of Health a.i
Sudan Federal Ministry of Health




Dr Ni'ma Saeed Abid
WHO Representative
Sudan Country Office

