

# Stuck in Crisis: The Humanitarian Response to Sudan's Health Emergency

ALBERT TRITHART



**Cover Photo:** Medical personnel from the Sudanese NGO Humanitarian Assistance and Development work at a new tent sponsored by the UNAMID humanitarian division with the support of the World Health Organization (WHO) in Zam Zam IDP camp, North Darfur, July 9, 2013. Albert González Farran/UNAMID.

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**Suggested Citation:**

Albert Trithart, "Stuck in Crisis: The Humanitarian Response to Sudan's Health Emergency," International Peace Institute, April 2019.

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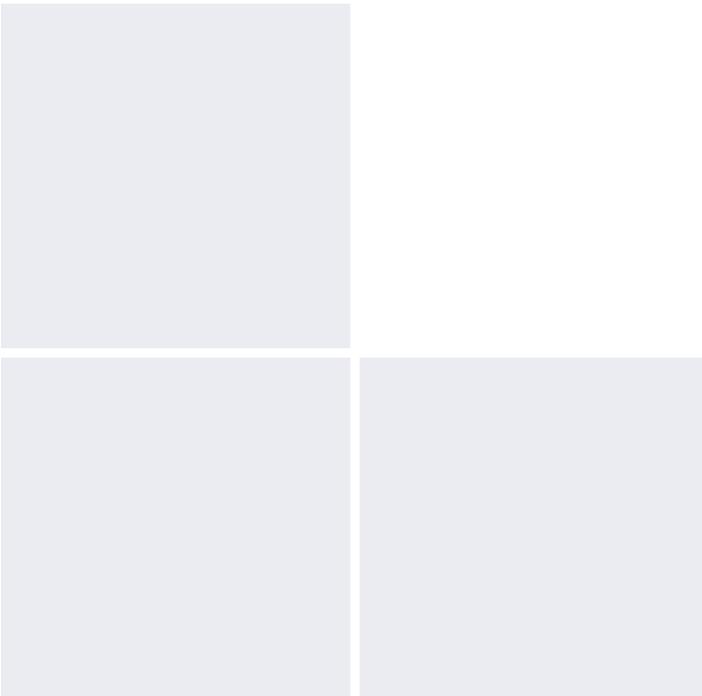
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**ACKNOWLEDGEMENTS**

IPI owes a debt of gratitude to its many donors for their generous support. IPI is particularly grateful to the Bill and Melinda Gates Foundation for making this publication possible. The author would also like to thank stakeholders in Sudan who generously gave their time to contribute to this research, Alice Debarre for her guidance, Thong Nguyen for designing the graphics, and Gretchen Baldwin for editorial support.



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## Abbreviations

AU	African Union
COR	Commission for Refugees
HAC	Humanitarian Aid Commission
IDP	Internally displaced person
NISS	National Intelligence and Security Services
NWOW	New Way of Working
OCHA	UN Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the UN High Commissioner for Human Rights
SLA-AW	Sudan Liberation Army–Abdul Wahid
SPLM-N	Sudan People’s Liberation Movement–North
UNAMID	UN-AU Mission in Darfur
UNDAF	UN development assistance framework
UNHCR	UN Refugee Agency
WASH	Water, sanitation, and hygiene
WHO	World Health Organization



## Executive Summary

Following decades of war, economic decline, and underinvestment, Sudan's healthcare system entered a new phase of crisis as peaceful protests broke out across the country in December 2018. These protests, which led to the ouster of President Omar al-Bashir in April 2019, were fueled by Sudan's economic deterioration, especially the rising price of food. But the country's degraded healthcare system also played a role, driving health workers into the streets as protest leaders. Historically, the government has not invested adequately in healthcare, especially in the peripheral regions of the country. The system is fragmented between governmental, nongovernmental, private sector, and international actors, making coordination and information management difficult. There is also stark geographic inequality in access to functional health facilities, qualified health workers, and lifesaving medicines.

As a result, Sudan's healthcare system is unable to cope with the acute level of need, particularly in the conflict-affected areas of Darfur, South Kordofan, and Blue Nile as well as among South Sudanese refugees. Dozens of UN agencies and international and national NGOs have stepped in to fill the gap with health-related humanitarian assistance. With so many actors involved, coordination is critical. The main coordination mechanism is the health cluster, which includes sixty-seven UN agencies, NGOs, and governmental bodies. The Sudanese government is deeply involved in this coordination, including by co-chairing the health cluster. However, the government's sensitivity and high turnover among its personnel have made it a difficult partner for humanitarian actors. Partnerships between international and national NGOs are also sometimes strained, partly because the government has required them to work together.

The government's involvement in the response has constrained humanitarian access—one of the biggest challenges facing the UN and international NGOs. Humanitarian actors are required to sign

technical agreements with the government for every project they implement, and international staff need approval to travel to conflict-affected areas. Until recently, aid to South Sudanese in Sudan was also restricted by the government's refusal to recognize them as refugees. Restrictions have eased since the government announced new humanitarian directives in 2016, opening access to some areas that had been cut off from aid for years. However, the directives have been unevenly implemented, and starting new projects can still take several months. Moreover, areas occupied by armed groups in the Jebel Marra region of Darfur and the Nuba Mountains of South Kordofan and Blue Nile remain inaccessible.

Even though many humanitarian needs remain unmet, after more than a decade and a half of an international humanitarian presence, there is a push for longer-term approaches to humanitarian needs in Sudan. The humanitarian country team developed a Multi-Year Humanitarian Strategy for 2017–2019—the first ever multi-year strategy for Sudan—and is working toward “collective outcomes” as part of its effort to implement the “humanitarian-development nexus.” Humanitarian actors have also bolstered efforts to hold themselves accountable to affected populations. For its part, the government has been eager to shift toward recovery and reconstruction, pushing humanitarian actors to work more through the public healthcare system and national NGOs.

However, this shift toward long-term approaches has not come with a commensurate increase in development funding. With no comprehensive peace deal, an uncertain political future, and the country's continued presence on the US list of state sponsors of terrorism, many donors are hesitant to invest. This leaves humanitarian actors struggling to lay the foundation for long-term development work with short-term humanitarian funding. The result is that the humanitarian health response is stuck: most agree on the need to move beyond short-term approaches, but the national capacity and development funding needed to make this transition are missing.

## Introduction

Following decades of war, economic decline, and underinvestment, Sudan's healthcare system entered a new phase of crisis at the end of 2018. In December, peaceful protests broke out across the country. By January, they had reached a level of intensity not seen in more than thirty years, and by April, President Omar al-Bashir had been pushed out of power.

Protesters initially took to the streets over rising food prices, then demanded that Bashir step down and a civilian government replace him. But the country's collapsing healthcare system was also a factor behind the protests, as testified to by the leading role played by medical personnel. Years of poor working conditions and supply shortages had fostered discontent among doctors and other medical professionals, pushing many to leave the country for better opportunities elsewhere. Those remaining went on strike in December, and many took to the streets. The Sudanese Professionals Association—which includes unions representing doctors, pharmacists, medical laboratory technicians, and health officers, as well as professionals in other fields—spearheaded the protests. In response, security forces killed or arrested health workers and fired teargas into hospitals for treating wounded protesters.<sup>1</sup>

This political upheaval comes on top of a decades-long humanitarian disaster. Across the country—and especially in Darfur, South Kordofan, and Blue Nile, which have suffered years of armed conflict—health clinics lie abandoned, malnutrition is rife, and disease outbreaks are frequent. As of March 2019, 3.66 million people had health-related needs, and Sudan had nearly 2 million internally displaced persons (IDPs) and more than 1 million refugees (see Figures 1 and 2).<sup>2</sup> While humanitarian actors have been responding to these needs for decades, ongoing armed conflict, government restrictions, and a lack of cash, fuel, medicines, vaccines, and data hamper their operations. Humanitarian funding falls far short of what is required and has been stagnating, even as

needs remain high.

This lack of funding stems in part from donor fatigue after so many years of humanitarian crisis. Many people displaced by the outbreak of war in Darfur more than sixteen years ago still cannot return home. While dire humanitarian needs remain, the Sudanese government and many humanitarian and global health actors are eager to make the response more sustainable. The UN's humanitarian country team in Sudan now has a Multi-Year Humanitarian Strategy and is prioritizing implementation of the “humanitarian-development nexus.” This places Sudan at the center of broader debates on how to make humanitarian action more coordinated, sustainable, and accountable.

In reality, however, the focus is still on the humanitarian response: even as the flow of humanitarian funding slows, development funding is still only trickling in. This reflects not only the continued urgent humanitarian needs but also Sudan's historically thorny foreign relations. Bashir's administration had a record of human rights violations and of expelling and restricting international organizations and their staff, making many donors and NGOs reluctant to engage with the government. While the US lifted most economic sanctions on Sudan in 2017, the country's economy has only gotten worse since then. It remains unclear what effect the political transition will have on the economy, foreign relations, peace negotiations, or governance of healthcare.

Despite these challenges, humanitarian and global health actors continue striving to deliver healthcare more effectively and to strengthen Sudan's healthcare system. This paper focuses on their response in Darfur, South Kordofan, and Blue Nile. It is based on twenty interviews with representatives of UN agencies, international and Sudanese NGOs, and donors.<sup>3</sup> After providing an overview of the roots of the current crisis and the state of Sudan's healthcare system, it explores the main challenges facing humanitarian and global health actors in the country. It concludes by looking ahead at what needs to happen for interna-

1 Joseph Goldstein, “The Revolutionary Force behind Sudan's Protest Movement? Doctors,” *New York Times*, April 20, 2019.

2 UN Office for the Coordination of Humanitarian Affairs (OCHA), “Sudan Humanitarian Snapshot,” March 1, 2019.

3 Due to travel difficulties, most interviews were conducted by Skype or phone. It was not possible to speak with representatives of the Sudanese government. Research was conducted prior to the overthrow of President Bashir in April 2019 so reflects government policy before this political transition.

tional and Sudanese actors to lift healthcare out of its current state of crisis in Sudan's conflict-affected areas.

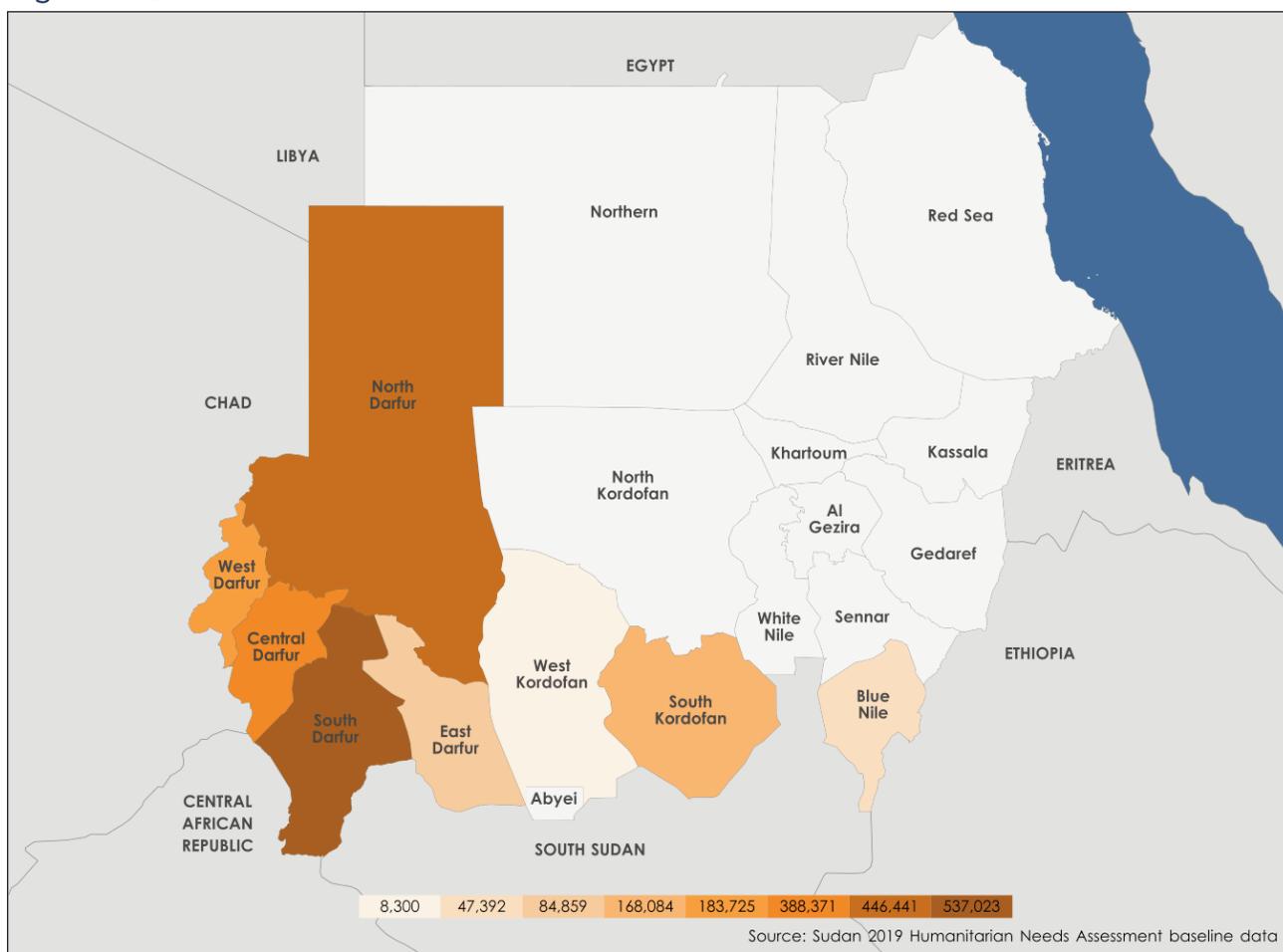
## A Healthcare System in Collapse

More than thirty-five years of armed conflict in Sudan's peripheral regions have devastated the country's healthcare system. Together with economic, governance, and environmental crises, these conflicts have left nearly 2 million Sudanese internally displaced, 3.7 million with health-related humanitarian needs, and 5.8 million food insecure (see Figure 1).<sup>4</sup>

## ONGOING CONFLICT AMID A NATIONWIDE CRISIS

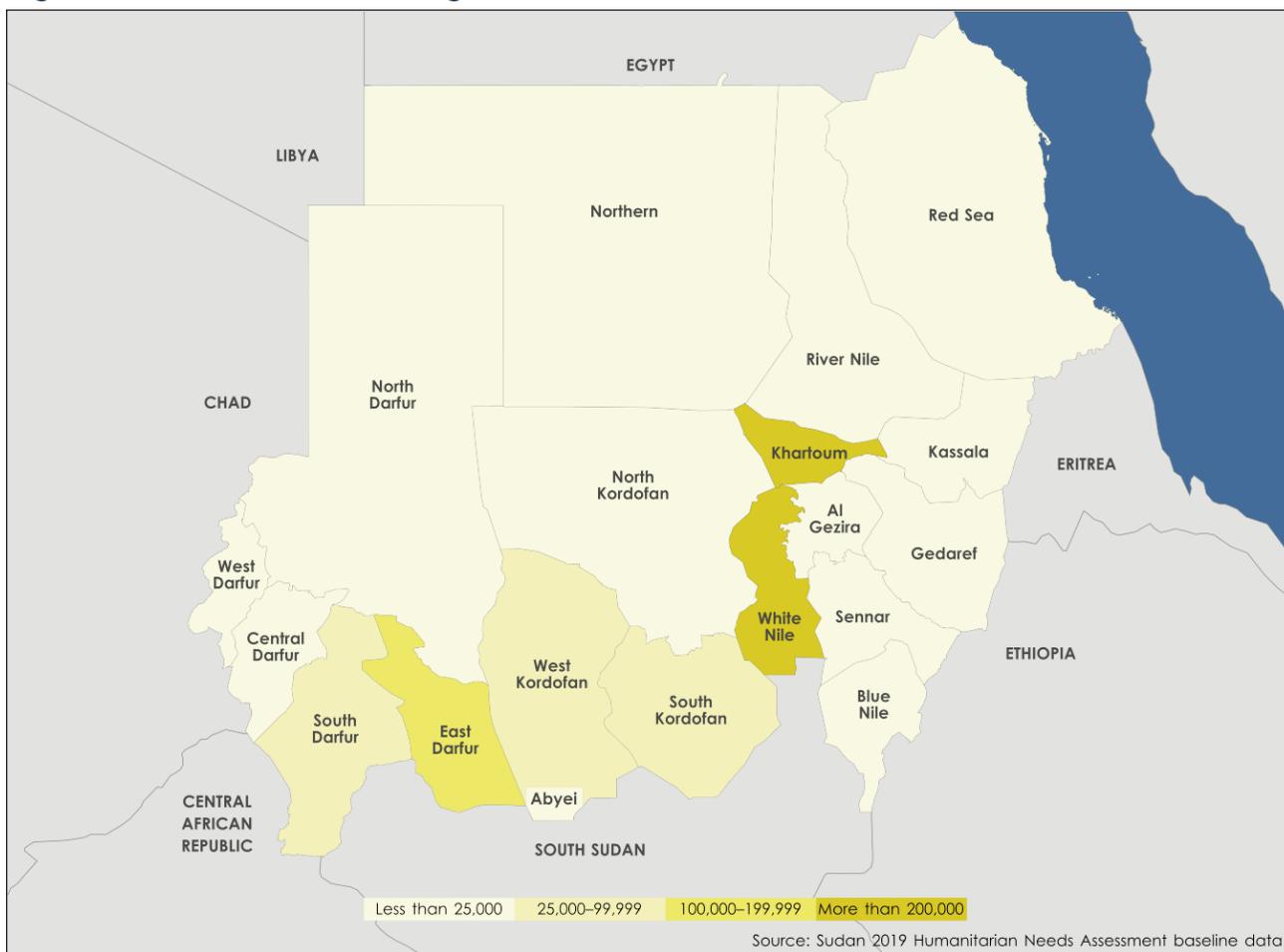
Armed conflict in Darfur broke out in 2003, pitting armed opposition groups against pro-government militias and paramilitary forces. Over the ensuing years, hundreds of thousands of civilians were killed, and millions fled their homes, many across the border into Chad. In response to these mass atrocities, the US imposed a series of economic sanctions, and in 2007, the UN and African Union (AU) deployed a joint peacekeeping mission, the UN-AU Hybrid Operation in Darfur (UNAMID). In 2009 and 2010, the International Criminal Court issued arrest warrants for President Bashir and several others implicated in the atrocities.

Figure 1. IDPs in Sudan



<sup>4</sup> UN Office for the Coordination of Humanitarian Affairs (OCHA), "Sudan Humanitarian Snapshot," March 1, 2019.

Figure 2. South Sudanese refugees in Sudan



In the ensuing years, Darfur's armed groups splintered into a dizzying array of factions. Some of these signed a peace agreement with the government in Doha in 2011, but implementation has been slow and underfunded. Recently, the security situation has improved. Unilateral cease-fires have been in place across most of the region since 2017, and the government has claimed the conflict is over. Citing improved security, in 2017, the Security Council decided to begin drawing down UNAMID.<sup>5</sup> But Darfur is still not at peace. The cease-fires fall short of a comprehensive peace agreement, parts of the mountainous Jebel Marra region remain under the control of a faction of the Sudan Liberation Army led by Abdul Wahid (SLA-AW), and sporadic fighting continues. Darfur also suffers from periodic outbursts of intercommunal

violence over land and resources.

Nonetheless, with security improving, some IDPs and refugees have begun returning home. In May 2017, the UN Refugee Agency (UNHCR) and the governments of Sudan and Chad decided to begin repatriating Sudanese refugees from Chad to Darfur, a process that began in earnest in April 2018. The government has also started closing IDP camps, giving inhabitants the option to remain where they are and integrate into a new permanent settlement, return to their original home, or relocate to a new location. But despite the government's promise of protection and basic services, many who return find both lacking: some returnees are attacked or harassed by new settlers who occupy their land—disputes that mirror the original conflict lines—and health services and

<sup>5</sup> Some believe this decision was based more on financial than security considerations. According to one analyst, "the only reason" for UNAMID closing "is that donors have no more appetite for it." Jérôme Tubiana, "The Dangerous Fiction of Darfur's Peace," IRIN, August 2, 2017.

water supplies are often inadequate.<sup>6</sup> Some IDPs have criticized the government's policy as an attempt to "erase the impact of the displacement," as one camp leader put it.<sup>7</sup>

In addition to Darfur in the west, there is also ongoing armed conflict along Sudan's southern border, which broke out after Southern Sudan voted for independence in a 2011 referendum. Fighting first broke out in Abyei, a small region disputed between Sudan and South Sudan. Soon after, the Sudan People's Liberation Movement–North (SPLM-N) took up arms against the national government in the states of South Kordofan and Blue Nile (the "Two Areas"). Hundreds of thousands were displaced in the ensuing conflict. AU-led peace negotiations between the government and SPLM-N have been on-and-off. While the government declared a unilateral cease-fire in 2016, it has repeatedly been broken. The SPLM-N remains in control of parts of the Nuba Mountains, though a split in the organization in 2017 led to inter-factional fighting and further displacement. These rebel-held areas are completely cut off from the rest of the country, and the humanitarian situation is dire. As in Darfur, the government has reported that people are returning, but returnees have complained of government restrictions and insecurity.<sup>8</sup>

These humanitarian crises are exacerbated by nationwide economic and governance crises. The secession of South Sudan in 2011 cost Sudan more than half of its revenue and 95 percent of its exports, leading to rising inflation and government austerity measures.<sup>9</sup> US economic sanctions and the US listing of Sudan as a state sponsor of terrorism have also taken a toll.<sup>10</sup> While the sanctions were partially lifted in 2017, the US suspended negotiations to fully normalize relations following the ouster of Bashir. While Sudanese mostly welcomed the lifting of sanctions, the effect has been imperceptible: "Say what you want, the

sanctions are still there," said one trader in Khartoum—a widely shared view.<sup>11</sup> In fact, the economy has spiraled downward since the lifting of sanctions, contributing to the protests that brought down Bashir.

Alongside these economic and governance crises, environmental disasters have exacerbated humanitarian needs in Sudan. Pockets of drought in several states have resulted in crop failure, and heavy rains and flash floods affected hundreds of thousands of Sudanese in 2018.

### A FRAGMENTED, UNDERFUNDED, UNEQUAL HEALTHCARE SYSTEM

This confluence of armed conflict, economic collapse, bad governance, and natural disaster has devastated Sudan's healthcare system. On paper, Sudan has a decentralized system that operates at three levels: national, state, and local. At the national level, the Federal Ministry of Health has launched a National Health Policy 2017–2030 (aligned with the 2030 Agenda for Sustainable Development), a National Health Sector Strategic Plan 2017–2020, and a raft of other policies—all prioritizing the achievement of universal healthcare.<sup>12</sup> Through its Health in All Policies approach, the government has also tried to integrate health considerations into policies across all sectors. State ministries of health are responsible for implementing these national policies and managing secondary and rural hospitals, while local healthcare systems operate health centers and basic health units.

This decentralized system does not work in practice as it does on paper, creating a disconnect between states' constitutional authority to govern healthcare and their capacity to do so. For example, while the national government devolved responsibility for hospitals to the state level, states often cannot generate enough revenue to fund these on their own and do not always receive adequate or

6 UN Refugee Agency (UNHCR), "Sudan Participatory Assessment 2017," September 2018.

7 "Darfur Governors Promise Resettlement for Displaced at States Conference," Radio Dabanga, December 18, 2018.

8 "Sudanese Returnees Face Harsh Restrictions in Blue Nile State," Radio Dabanga, December 3, 2017.

9 World Bank, "Sudan Overview," October 2, 2018, available at [www.worldbank.org/en/country/sudan/overview](http://www.worldbank.org/en/country/sudan/overview).

10 The US put Sudan on its list of state sponsors of terrorism in 1993 and imposed economic sanctions in 1997. The outbreak of conflict in Darfur sparked new sanctions in 2006 and 2007.

11 Aly Verjee, "Sudan after Sanctions: Sudanese Views of Relations with the United States," United States Institute of Peace, May 2018.

12 The new strategic plan (in Arabic) was only uploaded to the Ministry of Health's website in February 2019, available at <https://fmoh.gov.sd/index.php/files/index/93>.

timely national support.<sup>13</sup> States and localities—especially those affected by conflict—also have less capacity to manage healthcare.

This speaks to the chronic underinvestment in Sudan's healthcare system. While the government has made some progress providing free maternal and child medicines and expanding coverage through the National Health Insurance Fund, these programs still do not adequately cover needs, and private insurance is unaffordable to most.<sup>14</sup> The National Health Insurance Fund has also been accused of corruption and is reportedly bankrupt, and doctors often charge patients for ostensibly free services.<sup>15</sup> As a result, the financial burden falls on patients: 74 percent of health spending in 2016 was out-of-pocket—the seventh highest in the world.<sup>16</sup> Public funding for healthcare is also disproportionately skewed toward secondary and tertiary rather than primary care, on current services rather than long-term investment, and on wealthier states with more resources at their disposal.<sup>17</sup>

Sudan's public healthcare system also suffers from inadequate coordination. A National Health Sector Coordination Council, created as part of the Health in All Policies approach, has not stopped most ministries from independently implementing their own plans, and this coordination structure is not replicated at the state level.<sup>18</sup> While intersectoral coordination committees abound, most are ineffective, unaccountable, under-resourced, and not inclusive of civil society.<sup>19</sup> This lack of

coordination has translated into poor information management. Although a standardized system exists, a 2017 review found that there are more than a dozen parallel information systems and that state ministries of health have little capacity or motivation to gather, enter, process, report, or use data.<sup>20</sup> As a result, the data available is out-of-date and unreliable. It can also be hard to obtain, as the government treats some health data as “highly confidential security information,” as one representative of a Sudanese NGO put it.<sup>21</sup>

Poor information management and government sensitivity have undermined the prevention of and response to epidemics. Sudan's national surveillance system covers less than 30 percent of health facilities.<sup>22</sup> Moreover, the government itself has often been unwilling to announce disease outbreaks, including a major outbreak of chikungunya in Eastern Sudan in July 2018.<sup>23</sup> Most notably, the government refused to recognize a cholera epidemic that has been ongoing since 2017, declining to announce test results and actively blocking hospitals, doctors, and journalists from reporting on it.<sup>24</sup>

One of the reasons coordination is so difficult is that the health sector is highly fragmented between different governmental, nongovernmental, private sector, and international actors, particularly in Darfur. Financing is also fragmented, with public health insurance operating alongside parallel funding sources and free services provided by NGOs.<sup>25</sup> Further contributing to this fragmentation

13 See Sudanese Ministry of Finance and World Bank, “The Sudan Interim Poverty Reduction Strategy Paper Status Report,” 2016; Sudanese Federal of Ministry Health, World Health Organization (WHO), Global Fund, Gavi, and UNICEF, “Joint Financial Management Assessment Report,” June 2016; World Bank, “Moving toward UHC: Sudan—National Initiatives, Key Challenges, and the Role of Collaborative Activities,” November 2017.

14 Sudanese Ministry of Health, “Sudan Health Sector: 2016 and 2017 Joint Annual Review Report,” November 2017; World Bank, “Moving toward UHC,” November 2017; Anas Mustafa Ahmed Salim and Fatima Hashim Mahmoud Hamed, “Exploring Health Insurance Services in Sudan from the Perspectives of Insurers,” *Sage Open Medicine* (2018).

15 Sudan Democracy First Group, “The Demise of the Healthcare System in Sudan: A Narrative of Corruption and Lack of Transparency,” 2017; phone interview with representative of an international NGO in Khartoum, January 2019.

16 WHO, “Global Health Expenditure Database,” available at [https://apps.who.int/nha/database/country\\_profile/Index/en](https://apps.who.int/nha/database/country_profile/Index/en).

17 Sudanese Ministry of Health, “National Health Sector Strategic Plan II (2012–2016)”; Sudanese Ministry of Finance and World Bank, “The Sudan Interim Poverty Reduction Strategy Paper Status Report,” 2016. According to 2008 data, per capita public spending on healthcare was 7–10 Sudanese pounds in South Darfur, North Darfur, and South Kordofan but 28 Sudanese pounds in Khartoum. World Bank, “Sudan State-Level Public Expenditure Review: Meeting the Challenges of Poverty Reduction and Basic Service Delivery,” Report No. ACS8803, May 2014.

18 Sudanese Ministry of Health, “Sudan Health Sector: 2016 and 2017 Joint Annual Review Report,” November 2017.

19 Abdalla Elhag, Mohamed Elabassi, and Hind Merghani, “Sudan's Health in All Policies Experience,” in *Progressing the Sustainable Development Goals through Health in All Policies: Case Studies from around the World*, by the Government of South Australia and WHO, 2017.

20 Sudanese Ministry of Health, “Sudan Health Sector: 2016 and 2017 Joint Annual Review Report,” November 2017.

21 Skype interview with representatives of a Sudanese NGO in Khartoum, March 2019.

22 Government of Sudan and WHO, “WHO Steps Up Efforts to Establish Community Based Surveillance in Sudan,” November 2018.

23 Skype interview with UN official in Khartoum, January 2019.

24 Glenn Kessler, “As the Death Toll Climbs in Sudan, Officials Shy Away from the ‘Cholera’ Label,” *Washington Post*, September 14, 2017.

25 World Bank, “Moving toward UHC,” November 2017.

is the increasing privatization of healthcare, which often goes hand-in-hand with corruption.<sup>26</sup>

Sudan's fragmented, underfunded healthcare system, combined with the effects of decades of armed conflict and economic crisis, result in inadequate access to healthcare across the country. About 36 percent of primary healthcare facilities are not fully functional, while only 24 percent of functional facilities provide the minimum basic healthcare package. Only a third of Sudanese have access to adequate reproductive healthcare.<sup>27</sup> Facilities providing mental healthcare are centralized in Khartoum, and most Sudanese face cultural, financial, and geographic barriers to accessing these services.<sup>28</sup> There is a stark urban-rural divide in access to healthcare across the country.

One of the main reasons facilities are nonfunctional is the shortage of health workers. Sudanese health professionals work in poor conditions and are badly paid—a problem exacerbated by rapid inflation. The result is regular doctors' strikes, high turnover, and migration abroad, particularly to the Gulf countries. In 2014 alone, nearly 5,000 physicians and pharmacists left Sudan, according to government figures.<sup>29</sup> Many health workers also leave the public sector for higher-paying jobs in the private sector or with international NGOs.<sup>30</sup> The government's retention strategy has proven ineffective and does not target those working in primary healthcare facilities, which suffer the most from shortages.<sup>31</sup>

Many facilities also lack medicines and medical supplies. The government has blocked the import of some medicines, allegedly to protect its domestic

pharmaceutical industry.<sup>32</sup> US economic sanctions have also restricted imports; while medical imports were theoretically exempt from the sanctions, obtaining waivers was onerous, and banks often declined to process transactions even with a waiver, preventing hospitals from updating or repairing equipment.<sup>33</sup> Despite the lifting of sanctions, shortages have gotten worse. Foreign currency shortfalls have forced pharmacies to halt imports, making many basic lifesaving medicines unavailable or unaffordable.<sup>34</sup>

## HEALTHCARE IN CONFLICT-AFFECTED AREAS

While the public healthcare system's lack of facilities, personnel, medicines, and supplies affects all Sudanese, these challenges are greater in many conflict-affected areas. At the same time, this is offset to some extent by the international humanitarian response (see below).

In Darfur, about a quarter of primary healthcare facilities are nonfunctional, though fewer than half of these offer the minimum basic service package (see Figure 3). Few facilities in Darfur—and none in Central Darfur—provide mental healthcare, and only around a third provide basic essential obstetric care.<sup>35</sup> While sexual and gender-based violence is prevalent in Darfur, many victims receive no medical care, and almost none receive psychosocial care.<sup>36</sup> Across the region, primary healthcare centers face steep personnel shortages, especially in lower-level facilities.<sup>37</sup> Many health facilities in Darfur also suffer from periodic shortages of medicines and vaccines due to their distance from cities, lack of funding, and insecurity.<sup>38</sup>

26 See Sudan Democracy First Group, "The Demise of the Healthcare System in Sudan," 2017; and Nafeesa Syeed, "Sudan's Hospitals: 'Ravaged by Privatisation,'" *Al Jazeera*, January 6, 2014.

27 UN OCHA, "2018 Humanitarian Needs Overview: Sudan," February 2018.

28 Sara H. Ali, "Barriers to Mental Health Service Utilisation in Sudan: Perspectives of Carers and Psychiatrists," *BMC Health Services Research* 16, No. 31 (2016)

29 Suliman Baldo, "Exodus from Sudan: The Flight of Human Capital and the Growth of a Parasitic Economy," *Sudan Tribune*, November 21, 2015. One study found that more than half of graduates from a family physician training program have emigrated since 2008. Chris van Weel et al., "Primary Healthcare Policy Implementation in the Eastern Mediterranean Region: Experiences of Six Countries," *European Journal of General Practice* 24, No. 1 (2018).

30 Phone interview with representative of an international NGO in Khartoum, January 2019.

31 Sudanese Ministry of Health, "Sudan Health Sector: 2016 and 2017 Joint Annual Review Report," November 2017

32 Interview with donor representative, New York, January 2019.

33 Amy Maxmen, "Sudan Sanctions Deprive 'Whole Nation' of Health Care," *Foreign Policy*, January 14, 2016. The sanctions may also have undermined the response to some communicable disease outbreaks. WHO, "Joint External Evaluation of IHR Core Capacities of the Republic of the Sudan," 2017.

34 "Chronic Life-Saving Medicines in Short Supply in Sudan," Radio Dabanga, January 13, 2019.

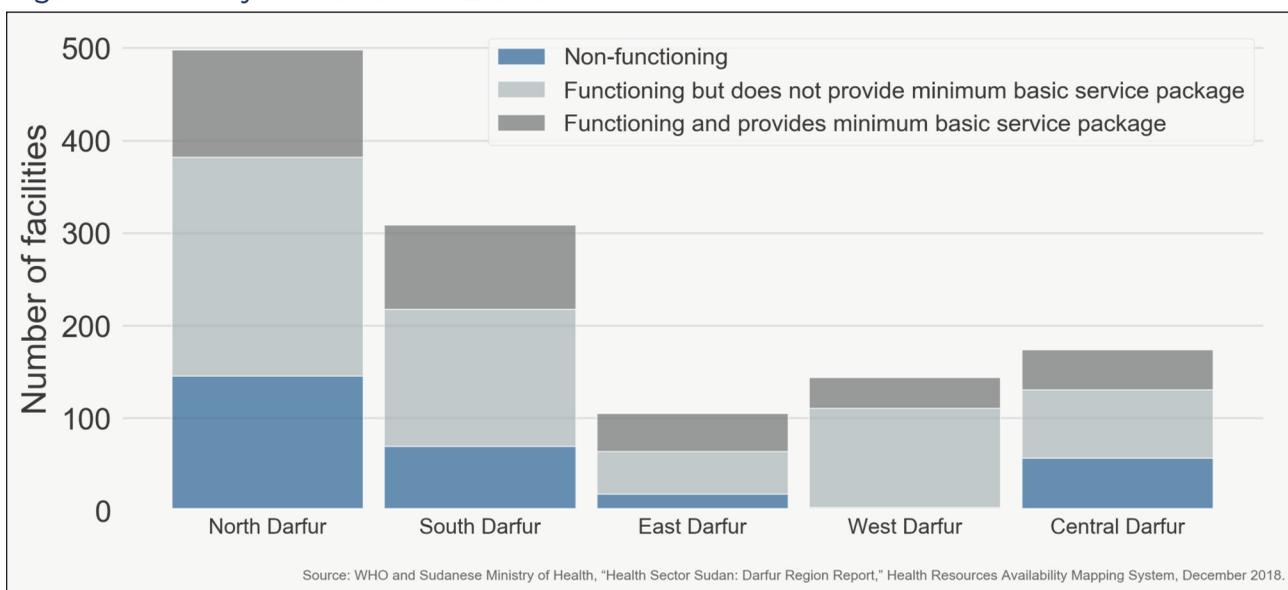
35 WHO and Sudanese Ministry of Health, "Health Resources Availability Mapping System—Darfur Region Report: Quarter 1, 2017," March 2017; "Health Resources Availability Mapping System—Darfur Region Report: Quarter 4, 2018" (draft), December 2018.

36 UN Security Council, *Letter Dated 10 January 2019 from the Panel of Experts on the Sudan Established Pursuant to Resolution 1591 (2005) Addressed to the President of the Security Council*, UN Doc. S/2019/34, January 10, 2019.

37 WHO and Sudanese Ministry of Health, "Health Resources Availability Mapping System—Darfur Region Report: Quarter 4, 2018" (draft), December 2018.

38 Philimon Majwa, Reem Abbas, and Tayseer Abdelsadig, "Evaluation of Humanitarian Action: Child Survival in North Darfur, Sudan 2010–2015," UNICEF, February 2017.

Figure 3. Primary healthcare in Darfur



Within Darfur, access to healthcare is worst in the Jebel Marra region, which covers parts of North, Central, and South Darfur states. Assessment missions beginning in 2017—the first since 2003, in some areas—have exposed a healthcare system that had almost completely collapsed. While some clinics remained operational during the conflict, they had limited capacity, and there were reportedly no facilities providing skilled reproductive care or vaccinations.<sup>39</sup> The parts of Jebel Marra still controlled by the SLA-AW remain cut off from the public healthcare system, though some people are able to cross into areas controlled by the government to access health facilities there.<sup>40</sup>

The healthcare system in government-controlled parts of South Kordofan and Blue Nile is even more degraded than in Darfur. A mission to one locality in South Kordofan in 2018 found that healthcare is unavailable or unaffordable in most communities. There are shortages of health workers, drugs, and medical equipment. Most pregnant women and children do not receive routine vaccinations.<sup>41</sup>

Many facilities do not have electricity to run medical equipment and are difficult to access during the rainy season.<sup>42</sup>

In rebel-held parts of the Two Areas, people have been completely cut off from the public healthcare system since 2011. In these areas, the SPLM-N runs its own system, which the government has repeatedly targeted, damaging or destroying around twenty facilities in bombing raids, according to the SPLM-N.<sup>43</sup> A 2016 investigation found that South Kordofan has around 175 clinics, mostly run by volunteer nurses and community health workers with little training. They do not provide vaccinations and frequently run out of basic medicines. Women and girls have little access to birth control or skilled reproductive healthcare. There are only two functional hospitals, which can take up to two days to reach from some areas and sometimes become inaccessible due to shifting frontlines.<sup>44</sup> In Blue Nile, rebel-held areas have twenty-eight clinics, according to a 2018 assessment, none of which has a qualified midwife. The only accessible

39 UN OCHA, *Humanitarian Bulletin Sudan*, No. 9 (April 30–May 13, 2018); Skype interview with representative of an international NGO in Khartoum, February 2019.

40 Skype interview with UN officials in Khartoum, January 2019.

41 UN OCHA, "Inter-agency Assessment Report: Al Abbasiya Locality, South Kordofan—4–8 February, 2018."

42 Phone interview with representative of a Sudanese NGO in Khartoum, March 2019.

43 Human Rights Watch, "No Control, No Choice": Lack of Access to Reproductive Healthcare in Sudan's Rebel-Held Southern Kordofan," May 2017.

44 Ibid.

hospital is across the border in South Sudan—up to a three-day walk in the rainy season.<sup>45</sup>

## Trends and Challenges in the Humanitarian Health Response

With Sudan's healthcare system unable to cope with the acute level of need, many UN agencies, international NGOs, and national NGOs are providing health-related humanitarian assistance through and alongside public health services. As of early 2018, the UN humanitarian response plan for Sudan had eighty-seven partners.<sup>46</sup>

The humanitarian response is overseen by a joint UN resident coordinator/humanitarian coordinator, as well as a deputy humanitarian coordinator based in Darfur. Recent humanitarian response plans have focused on three priority areas related to health: (1) providing primary healthcare, including reproductive and mental healthcare; (2) strengthening capacities to prepare, detect, and respond to public health risks and events; and (3) increasing maternal and child health services.<sup>47</sup> This section focuses on three broad challenges confronting the humanitarian response: coordination of the international response and cooperation between international and Sudanese actors; restricted humanitarian access; and the effort to shift toward more sustainable approaches.

### MISTRUST-BASED PARTNERSHIPS: COORDINATING THE INTERNATIONAL RESPONSE

With so many actors involved in the international health response, coordination is critical. The main international coordination mechanism is the health

cluster. Partnerships between international health actors, the government, and national NGOs also play a central role but are fraught with complications.

### International Coordination Mechanisms

The humanitarian health response in Sudan is coordinated through the health cluster, which was activated in 2009 in Darfur and rolled out to the rest of the country in 2010.<sup>48</sup> The health cluster is co-chaired by the World Health Organization (WHO) and the Federal Ministry of Health. It includes sixty-seven UN agencies, international and national NGOs, and governmental bodies as partners.<sup>49</sup> The cluster system is replicated at the state level.<sup>50</sup> Many who participate in health cluster meetings describe them as well-attended and useful for deciding who will work where, sharing information, and mobilizing funding, though one UN official raised the need for greater candor.<sup>51</sup> Duplication of efforts was not mentioned as a problem by any interviewees, both due to effective coordination through the cluster and because health actors are spread so thin on the ground.

As co-chair, the Federal Ministry of Health has been deeply involved in the health cluster; one interviewee said his organization attends the meetings partly to avoid displeasing the ministry.<sup>52</sup> National NGOs have to be members of the cluster to receive funding from the Sudan Humanitarian Fund. While many of these NGOs attend meetings, and some actively participate in discussions, international actors tend to dominate because their staff have more technical expertise and better English-language skills.<sup>53</sup>

Many humanitarian actors integrate work on health, nutrition, and waste, sanitation, and hygiene (WASH) in their projects, such as by using

45 Humanitarian Aid Relief Trust, "There Was Nobody to Help Us': Oppression by the Government of Sudan and Food Shortages in Blue Nile, Sudan—HART Visit to Blue Nile," January 2018; South Kordofan Blue Nile Coordination Unit, "Humanitarian Update: January 2019."

46 There were a total of 15 UN agencies, 41 international NGOs, and 125 national NGOs present in Sudan as of 2018. "Humanitarian Response Plan Sudan: 2018," February 2018. As of April, the 2019 humanitarian response plan was not yet finalized.

47 UN OCHA, "Humanitarian Response Plan Sudan: 2018," February 2018.

48 WHO, "Emergency Country Profile—Sudan," 2010.

49 Phone interview with UN official in Khartoum, March 2019.

50 One UN official reported that there have been five subnational hubs within the cluster system since the government created the new states of Central and East Darfur in 2012, bringing the number of states in the region from three to five. Official WHO documents still refer to three subnational hubs. Subnational hubs have not yet been created in South Kordofan and Blue Nile. See WHO, "Country Health Cluster/Sector Dashboard," December 2018, available at [www.who.int/health-cluster/countries/HC-dashboard-Dec-2018.pdf](http://www.who.int/health-cluster/countries/HC-dashboard-Dec-2018.pdf). Phone interview with UN official in Khartoum, March 2019.

51 Skype interviews with UN officials in Khartoum, January and March 2019.

52 Phone interview with representative of an international NGO in Khartoum, January 2019.

53 One representative of a Sudanese NGO disagreed, describing the discussions as "balanced." Skype interview with representatives of a Sudanese NGO in Khartoum, February 2019.

the same facilities to provide both healthcare and nutrition assistance. This integrated approach requires cross-cluster coordination, which has reportedly improved.<sup>54</sup> This inter-sector coordination does not always carry down to the state level, however. A 2017 assessment in North and South Darfur found that while the state-level health clusters effectively coordinate the response, inter-sector coordination is less consistent, resulting in some duplication of health, nutrition, and WASH activities.<sup>55</sup>

While UNAMID contributes to the health response in Darfur through quick-impact projects such as clinic construction or midwife training, it does not participate in the cluster system.<sup>56</sup> It has a technical review committee that decides which quick-impact projects to implement and invites UN agencies (though not NGOs) to participate in these meetings. Lack of coordination with other actors has sometimes undermined these projects (e.g., when a health clinic is built without follow-up arrangements to staff and supply it)—something UNAMID is working to improve through better planning with other actors.<sup>57</sup> Though guidelines on civil-military coordination have been in place since 2008, tensions have historically arisen between UNAMID and humanitarian actors regarding their roles and responsibilities in negotiating and advocating for humanitarian access. However, coordination has improved with the adoption of multi-year integrated strategic frameworks for Darfur, beginning in 2014, and there is a general understanding that the humanitarian country team should lead on humanitarian issues.<sup>58</sup>

### Collaborating with the Government: A Sensitive Partner

The Sudanese government has been deeply involved in the humanitarian response in Sudan, making it an unavoidable partner for both national

and international health actors. These actors have several government counterparts:

- The Humanitarian Aid Commission (HAC)—the main government body coordinating the humanitarian response—participates in the humanitarian cluster system (including the health cluster), registers all international and national NGOs, and approves their work through technical agreements at the national and state levels.
- The Commission for Refugees (COR)—the main government body coordinating the refugee response—co-chairs the refugee consultation forum together with UNHCR.
- The Federal Ministry of Health co-chairs the health cluster together with WHO and approves the health-related work of all international and national NGOs at the national and state levels.
- The Federal Ministry of International Cooperation coordinates international donors.

A National Mechanism brings together all these and other government entities involved in the humanitarian response to provide high-level coordination. To coordinate the health response specifically, the government established a Health Sector Partners Forum under the National Health Sector Coordination Council, created in 2016. This forum is chaired by the federal minister of health and brings together health focal points from relevant ministries as well as international and national partners. One of its four committees is focused on the humanitarian health response and is meant to coordinate with the health cluster, while another committee is focused on the development response to health. With so many government entities involved, however, international partners are sometimes unsure whom to engage with.<sup>59</sup>

OCHA works closely with the National

54 Skype interview with UN official in Khartoum, January 2019.

55 The assessment also found some duplication of immunization work in North Darfur. Majwa, Abbas, and Abdelsadig, "Evaluation of Humanitarian Action: Child Survival in North Darfur, Sudan 2010–2015," UNICEF, February 2017.

56 UNAMID usually does not directly provide health services or supplies to communities except in emergency situations when the mission might treat evacuated civilians at its clinic or provide tents to temporarily accommodate a health facility that was destroyed. Sometimes UNAMID contingents also present medical kits or other items to communities as gifts from their countries—something frowned upon by humanitarian actors. Phone interview with UN official in Darfur, March 2019. Some quick-impact projects involve direct provision of healthcare, as when UNAMID conducted a free health clinic in an IDP camp in West Darfur in 2018. UNAMID, "UNAMID Conducts Free Medical Clinic in IDP Camp in West Darfur," October 1, 2018.

57 UNAMID usually identifies national NGOs to implement the projects, though some are undertaken directly by the mission's military component or by UN agencies. Phone interview with UN official in Darfur, March 2019.

58 The current framework is for 2017–2019. Inter-agency Standing Committee, "Review of the Impact of UN Integration on Humanitarian Action," September 2015; United Nations, "United Nations Civil-Military Coordination Guidelines for Sudan," 2008, available at [www.unocha.org/sites/dms/Documents/Sudan%20UN-CMCoord%20GLs%20\(23%20April%202008\).pdf](http://www.unocha.org/sites/dms/Documents/Sudan%20UN-CMCoord%20GLs%20(23%20April%202008).pdf).

59 Skype interview with UN official in Khartoum, January 2019.

Mechanism, particularly HAC, in developing both the annual humanitarian needs overview and the annual humanitarian response plan. The data in these documents comes from humanitarian partners and the government, while OCHA independently determines the overall number of people in need by sector and locality. The government's approval is sought prior to releasing the needs overview and response plan, which has often delayed their release until well into the year (the 2018 plan was released in March of that year, the 2017 plan in May, and the 2016 plan in July; the 2019 plan had not yet been released as of April). This delay poses a particular challenge for mobilizing resources.<sup>60</sup> One representative of a Sudanese NGO described the lack of reliable data as the biggest problem facing his organization.<sup>61</sup>

The delays largely result from “protracted consultations on needs-based figures,” in the words of one UN official: HAC is “very, very, very sensitive to the way the situation is portrayed.”<sup>62</sup> To back up the narrative that the security situation has improved, the government has been particularly keen to play down internal displacement while simultaneously emphasizing Sudan's role as a host state for refugees. As a result, it took three months for humanitarian partners and the government to agree on the figures for the number of IDPs, refugees, and returnees for the 2018 humanitarian response plan.<sup>63</sup> Beyond figures, the government has also been sensitive about humanitarian actors discussing the economic crisis or addressing topics such as female genital mutilation and sexual exploitation and abuse; international NGOs are not

permitted to report on rape cases, and health clinic registration books and official reporting systems omit data on sexual and gender-based violence.<sup>64</sup> Most health actors toe the government line in referring to cholera as “acute watery diarrhea”; WHO and the US Agency for International Development were among the agencies that declined to confirm the ongoing cholera outbreak, citing the government's stance.<sup>65</sup>

Acquiescence to government-preferred numbers and terminology may be understandable considering Sudan's history of expelling humanitarian NGOs and international staff. The biggest blow came in 2009 when the government kicked out thirteen international NGOs and shut down three national NGOs after the International Criminal Court issued its arrest warrant for President Bashir. This move compromised 50 percent of humanitarian aid in Sudan and affected health services for 1.5 million people, according to WHO, leaving many without healthcare.<sup>66</sup> The government expelled seven more NGOs from Eastern Sudan in 2012, followed by the International Committee of the Red Cross in 2014 and the NGO Tearfund in 2015. The government has also directly targeted the UN, expelling the head of OCHA in 2016—the fourth senior UN official forced to leave in two years.<sup>67</sup> While some of these NGOs have since returned, the expulsions left a pall over the humanitarian community and have forced humanitarian actors to walk a fine line: one of the biggest challenges is “ensuring a principled humanitarian response while also being successful,” according to one UN official.<sup>68</sup>

60 Interview with UN official, New York, January 2019.

61 Skype interview with representatives of a Sudanese NGO in Khartoum, March 2019.

62 Skype interview with UN officials in Khartoum, January 2019.

63 Ibid. UNHCR adds a caveat to its official calculation of the number of South Sudanese refugees in Sudan (848,091, as of January 31, 2019) that “additional sources estimate that there are 1.3 million South Sudanese refugees in Sudan; however, data requires verification”—a nod to the government's higher estimate. As for IDPs, the 2018 humanitarian needs overview includes the government's figure of 2 million with the caveat that “the UN and partners will continue to work with the Government to verify these numbers.” The Internal Displacement Monitoring Centre views this as an underestimate, noting that figures from Blue Nile are based on registration information from the International Organization for Migration and HAC rather than key informant interviews or beneficiary lists from humanitarian partners; parts of Darfur, South Kordofan, and West Kordofan are not covered; and there is no information on IDPs living in or around Khartoum. “Sudan: Global Report on Internal Displacement 2018.”

64 Email exchange with representative of an international NGO in Khartoum, April 2019; Skype interview with representative of an international NGO in Khartoum, February 2019. Protection is another sensitive topic; the reason the humanitarian clusters in Sudan are referred to as “sectors” is that the government associated the term “cluster” with protection and therefore rejected it, according to one UN official. Skype interview with UN officials in Khartoum, January 2019.

65 The head of WHO faced particular criticism, as he had previously been accused of covering up a cholera outbreak as minister of health in Ethiopia. Kessler, “As the Death Toll Climbs in Sudan, Officials Shy Away from the ‘Cholera’ Label,” *Washington Post*, September 14, 2017.

66 Wairagala Wakabi, “Aid Expulsions Leave Huge Gap in Darfur's Health Services,” *The Lancet* 373, No. 9669 (March 28, 2009).

67 UN OCHA and UN Country Team in Sudan, “Statement Attributable to the Humanitarian Country Team in Sudan on the De Facto Expulsion of UN Senior Official and OCHA Head of Office Mr. Ivo Freijesen,” May 22, 2016.

68 Skype interview with UN officials in Khartoum, January 2019. One NGO that had been targeted in the past declined to be interviewed for this research so as not to jeopardize its recently rebuilt relationship with the government.

On a day-to-day basis, interactions with the government are often dependent on individual relationships. While some interviewees said their government counterparts were unwilling to cooperate, others said they had worked with competent and committed government staff, especially in the Federal Ministry of Health: “In many ways we’re a team,” said one representative from an international NGO.<sup>69</sup> However, these relationships are regularly disrupted by high turnover among government officials, especially at the technical level, and this problem has reportedly gotten worse. One donor representative based outside of Sudan related how the health focal points in the government left immediately after his organization conducted a mission to the country, requiring his team to start over again.<sup>70</sup> Staff changes also make it difficult for international partners to know who is who and whom to liaise with. This problem carries up to the most senior level: there were six ministers of health between 2015 and early 2019, and the ongoing political transition is likely to usher in further shake-ups.<sup>71</sup>

### Partnering with National NGOs: A Forced Marriage

The government put in place a “Sudanisation Plan” in 2009, requiring all UN agencies and international NGOs to partner with Sudanese NGOs. Until recently, the government played a heavy-handed role in the selection of these national partners; in one extreme case, up until 2016, it required UNHCR to channel all its assistance to South Sudanese refugees through the Sudanese Red Crescent Society (see Box 1).<sup>72</sup> While the government still pressures international actors to pick its preferred national partners, organizations are now able to conduct independent selection processes. Still, all national NGOs have to be registered with HAC, so international actors do not perceive them as independent or representative of Sudanese civil society: they are sometimes “just extensions of the government,” as someone from one international NGO saw it.<sup>73</sup>

While some Sudanese NGOs are capable and competent, most lack the capacity to provide

#### Box 1. Reaching South Sudanese refugees in Sudan

Beyond its nearly two million IDPs, Sudan hosts around a million refugees—most from South Sudan (see Figure 2).<sup>74</sup> About a quarter of South Sudanese refugees live in eleven camps, all of which are overcapacity and suffer from poor conditions. The rest live in more than 100 out-of-camp settlements, mainly in slums around Khartoum and in impoverished border areas.<sup>75</sup>

Government policy has been a major barrier to South Sudanese refugees accessing healthcare in Sudan. While Sudan maintained an open border when the conflict in South Sudan broke out in 2013 and announced that South Sudanese could use public health services, the government initially refused to consider South Sudanese to be refugees or to allow the opening of camps. Instead, it called them “arrivals” and placed some in “holding stations” that they needed permission to leave. Public services proved to be impossible or difficult for many to access.<sup>76</sup>

69 Skype interview with representative of an international NGO in Khartoum, March 2019.

70 Phone interview with donor representative in Washington, DC, January 2019.

71 Skype interview with UN officials in Khartoum, January 2019.

72 Jock Baker and Iman L. Elawad, “Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018),” UNHCR, August 2018.

73 Skype interview with representative of an international NGO in Khartoum, January 2019.

74 As of February 2019, Sudan hosted 844,000 South Sudanese refugees, 118,000 from Eritrea, and smaller numbers from several other countries. The numbers of non-South Sudanese refugees are from August 2018, while the number of South Sudanese refugees is from February 2019. UNHCR, “Sudan: Refugees and Asylum-Seekers as of 31 August 2018”; UNHCR, “Sudan Population Dashboard: Refugees from South Sudan as of 28 February 2019.”

75 The number of annual arrivals from South Sudan peaked at nearly 200,000 in 2017 and has since decreased significantly. UNHCR, “South Sudan Regional Refugee Response Plan January 2019–December 2020.”

76 Idris Salim ElHassan, “South Sudan ‘Arrivals’ in the White Nile State (Sudan): Not Citizens, Not IDPs, Not Refugees—What Are They?” Chr. Michelsen Institute, December 2016.

This policy also constrained humanitarian access. Because South Sudanese were not considered refugees, HAC (rather than COR) oversaw camp management, which it turned over to the Sudanese Red Crescent Society. While UNHCR was coordinating the humanitarian country team's refugee response, HAC did not allow the agency or its NGO partners to access camps for South Sudanese. This prevented UNHCR from gathering first-hand information, resulting in what some saw as an initial mismatch between the aid provided and the needs on the ground.<sup>77</sup>

International humanitarian actors only gained access to these camps in 2016 when the government finally agreed to recognize South Sudanese as refugees through a memorandum of understanding between UNHCR and COR.<sup>78</sup> While this paved the way for the first international assessments of refugees' needs, access remained restricted. UNHCR was not allowed to assess conditions in the so-called "open areas" around Khartoum until late 2017—a process that, from initial site visit to government approval of the assessment mission to government approval of the mission's findings to finalization of the response plan, took nearly a year.<sup>79</sup> Registration of refugees is also reportedly slow, and asylum seekers wait in poor conditions with no humanitarian aid.<sup>80</sup>

UNHCR, which coordinates the refugee response, has a history of tension with other humanitarian actors in Sudan. One 2018 evaluation found "broad consensus" among other UN agencies and donors that UNHCR did not demonstrate teamwork or leadership, leading to gaps in the refugee response in White Nile state.<sup>81</sup> Cooperation improved with the launch of the refugee consultation forum in 2016, which UNHCR co-chairs with COR. The forum includes a technical advisory group for health and nutrition and has established refugee working groups in every state that hosts South Sudanese refugees.<sup>82</sup> It is linked to the cluster system through the refugee cluster and participates in cross-cluster mechanisms and the humanitarian country team.<sup>83</sup> Despite improvements in cooperation, some believe the refugee response should not be coordinated separately from the rest of the humanitarian response; one UN official said this "segregates" the response to refugees from the response to other communities.<sup>84</sup>

Despite improved access, the international refugee response remains inadequate, and conditions and services in refugee camps are reportedly worse than in IDP camps. While the UN reports that 85 percent of refugees have access to primary healthcare, the quality of care is often low.<sup>85</sup> Very little of UNHCR's funding has gone toward health, according to a 2018 evaluation of the refugee response in White Nile state. All health facilities there are temporary structures, most of which are substandard and lack even basic hand-washing facilities.<sup>86</sup> One NGO worker described finding just a small health center with a couple staff and not enough medicine in a South Sudanese refugee camp he visited—a level of service he described as typical. Non-health services were even worse, with inconsistent food deliveries and no one providing water, sanitation, or shelter: "We really felt alone—like a very small drop," he said.<sup>87</sup>

77 Baker and Elawad, "Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018)," UNHCR, August 2018.

78 UN OCHA, *Humanitarian Bulletin Sudan*, No. 35 (August 22–28, 2016). Even then, refugee status was only granted to South Sudanese who had entered the country after the outbreak of the conflict in 2013. Those already present in the country were granted refugee status in 2017, leading to a sharp increase in the official number of refugees. Baker and Elawad, "Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018)," UNHCR, August 2018.

79 UNHCR, "Inter-agency Response Plan for South Sudanese Refugees in Khartoum's 'Open Areas,'" August 2018.

80 Phone interview with representative of an international NGO in Khartoum, January 2019.

81 Baker and Elawad, "Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018)," UNHCR, August 2018.

82 UNHCR, "South Sudan Regional Refugee Response Plan January 2019–December 2020."

83 The needs of refugees and the refugee response are also included in the humanitarian needs overview and humanitarian response plan.

84 Skype interview with UN official in Khartoum, January 2019.

85 UNHCR, "Sudan," available at [http://reporting.unhcr.org/node/2535#\\_ga=2.252272969.1909366374.1548442329-2012290657.1547584987](http://reporting.unhcr.org/node/2535#_ga=2.252272969.1909366374.1548442329-2012290657.1547584987).

86 Government of Sudan, World Food Programme, and UNHCR, "Joint Assessment Mission, White Nile, 26 November–1 December 2016—Final Report," August 2017.

87 Phone interview with representative of an international NGO in Khartoum, January 2019.

anything but basic health services, and they suffer from high turnover: “Some are just people moving around with bags,” as one UN official put it.<sup>88</sup> Due to their low capacity, many national NGOs have difficulty accessing international funding, and this lack of funding perpetuates their lack of capacity. There are some capacity-building initiatives, such as a proposal-writing training WHO conducted through the health cluster.<sup>89</sup> Many partnerships between international and national NGOs also include a capacity-building component, and some donors provide funding for this purpose.<sup>90</sup> Nonetheless, a representative of one Sudanese NGO stressed his organization’s need for more training and support, especially in communication and fundraising.<sup>91</sup>

Partnership arrangements vary. Some international NGOs delegate limited activities to their national partners, supervise them closely, and pay their salaries and operating costs, essentially treating them as a team within the organization. Others outsource entire projects to national partners in areas where they lack an on-the-ground presence and conduct periodic site visits to monitor them.<sup>92</sup> National NGOs usually focus on community-level activities such as health education campaigns, training of community-based health volunteers, immunization campaigns, or community-based surveillance for epidemic outbreaks—sometimes things they were already doing before their international partner arrived. Increasingly, however, the government has pushed for national NGOs to be directly involved in running primary healthcare facilities.<sup>93</sup>

Because most international actors see Sudanese NGOs as close to the government and lacking in

capacity, they often mistrust them: “It’s not the most sincere starting point for cooperation,” as one donor representative put it.<sup>94</sup> Some interviewees from international NGOs made it clear that the “choice is by default,” and they are only working with local partners because they have to.<sup>95</sup> Others, however, see the value of national NGOs. A representative of one international NGO described the requirement to work with national partners as “constructive and in line with humanitarian principles,” even if flawed in implementation.<sup>96</sup> One representative of a Sudanese NGO described his organization’s work with its international counterpart as an “equal-power partnership,” with programs developed collaboratively from the bottom-up.<sup>97</sup> National NGOs emphasize that they know the local context and needs, have better access, and can more easily communicate with local leaders, helping expand the reach of programs at the community level.<sup>98</sup>

#### THE LONG STRUGGLE FOR HUMANITARIAN ACCESS

Historically, humanitarian actors in Sudan have faced serious, and sometimes insurmountable, constraints to accessing those in need. Many of these have been directly imposed by the government, which has had an often tense—and occasionally antagonistic—relationship with certain UN agencies, foreign governments, and international NGOs.<sup>99</sup> While humanitarian access has improved since 2016, barriers remain, and the impact of the political transition is uncertain.

Government restrictions are not the only barrier to access. Cash and fuel shortages resulting from Sudan’s economic crisis also constrain the operations of humanitarian actors. They have

88 Skype interview with UN officials in Khartoum, January 2019.

89 WHO trained fifty NGOs on proposal writing, and fifteen submitted proposals. WHO then helped eight of them revise their proposals, and two ultimately received funding. Skype interview with UN official in Khartoum, January 2019.

90 Interview with UN official, New York, January 2019.

91 Phone interview with representative of a Sudanese NGO in South Kordofan, March 2019.

92 One interviewee reported being “shocked” by some international NGOs’ lack of supervision of their national sub-grantees. Skype interview with representative of an international NGO in Khartoum, January 2019.

93 Skype interview with representative of an international NGO in Darfur, March 2019.

94 Interview with donor representative, New York, January 2019.

95 Phone interview with representative of an international NGO in Khartoum, January 2019; Skype interview with representative of an international NGO in Darfur, March 2019.

96 Skype interview with representative of an international NGO in Khartoum, March 2019.

97 Skype interview with representatives of a Sudanese NGO in Khartoum, March 2019.

98 Phone interview with representative of a Sudanese NGO in South Kordofan, March 2019.

99 Skype interview with representatives of a Sudanese NGO in Khartoum, February 2019.

delayed trainings, immunization campaigns, transport of supplies, and monitoring activities. Cash shortages have also made it difficult for humanitarian organizations to buy supplies from local vendors.<sup>100</sup> Poor infrastructure is another constraint, particularly in the Two Areas, with some health facilities inaccessible during the rainy season.

### Sudan's Humanitarian Directives: Some Improvement, but a Long Way to Go

The thorny partnership between the government and humanitarian actors is both reflected in and exacerbated by operational restrictions on the ground. All humanitarian actors in Sudan are required to sign technical agreements with the government for every project they implement. For health actors, these agreements are signed by the state ministry of health and approved by the state-level HAC before being sent to Khartoum for approval by the Federal Ministry of Health and national-level HAC. The National Intelligence and Security Services (NISS) are also involved in approvals behind the scenes.<sup>101</sup> With so many actors involved, “you don't know who decides against or for,” according to one representative of an international NGO.<sup>102</sup>

These agreements are required under HAC's humanitarian directives, which it has used not only to expel or shut down NGOs but also to restrict humanitarian operations on a day-to-day basis. In December 2016, HAC released a new set of humanitarian directives meant to ease restrictions. This move coincided with discussions with the US on lifting economic sanctions, which were predicated in part on the government's role in restricting humanitarian access.<sup>103</sup> The new directives state that humanitarian organizations

can select their own staff and partners, travel freely to non-conflict-affected states, and publicly report on humanitarian needs. They also set timeframes for the approval of technical agreements (a maximum of thirty-five days).<sup>104</sup>

With the introduction of the new directives, restrictions quickly eased. More international staff have been authorized to work in Sudan, and they have been able to obtain visas and approval for internal travel more readily.<sup>105</sup> Technical agreements have also been approved more quickly—in as little as a few weeks (in line with the new directives) though often still several months, and the whole process of starting a new project still usually takes more than six months from assessment to implementation.<sup>106</sup> Relations with HAC have also improved: “Collaboration has really changed,” according to one representative of an international NGO.<sup>107</sup> Acknowledging these improvements, the UN country team released a statement in June 2017 expressing hope “for a positive decision on US sanctions relief”—a hope that was realized four months later.<sup>108</sup>

After the first year, however, implementation began to “lose steam.”<sup>109</sup> It has also been uneven from organization to organization and from state to state. This consistent discrepancy in implementation among states results both from different conditions on the ground and from state-level personnel interpreting the directives differently. With so much up to individual interpretation, personal relationships tend to matter more than formal processes in securing approval.<sup>110</sup> Even when approval is received, government officials from relevant ministries accompany all assessment missions.

While Sudanese staff do not generally require

100 UNICEF, “Sudan Humanitarian Situation Report: December 2018–Year End”; Skype interview with representative of a Sudanese NGO in Darfur, March 2019.

101 Skype interview with representatives of an international NGO in Khartoum, February 2019.

102 Skype interview with representative of an international NGO in Khartoum, February 2019.

103 The weakening of rebel groups in recent years also likely made the Sudanese government more open to the presence of humanitarian organizations and thus more willing to play this bargaining chip. International Crisis Group, “A New Roadmap to Make U.S. Sanctions Relief Work,” Briefing No. 128, September 29, 2017.

104 HAC's 2016 humanitarian directives are available at [www.humanitarianresponse.info/en/operations/sudan/document/amended-hac-directives](http://www.humanitarianresponse.info/en/operations/sudan/document/amended-hac-directives).

105 Past restrictions are still evident in the balance of international versus national staff: 96 percent of all humanitarian personnel in Sudan were Sudanese nationals, as of early 2018. OCHA, “Humanitarian Response Plan Sudan: 2018,” February 2018.

106 Skype interviews with representatives of international NGOs in Khartoum and Darfur, February and March 2019.

107 Phone interview with representative of an international NGO in Khartoum, January 2019.

108 UN Country Team in Sudan, “Statement Attributable to the United Nations Country Team in Sudan: United Nations Hopes for Positive Decision on US Sanctions Relief,” July 10, 2017.

109 Skype interview with representative of an international NGO in Khartoum, March 2019.

110 Phone interviews with representatives of international NGOs in Khartoum, January and March 2019.

authorization to travel, travel restrictions for international staff remain in place.<sup>111</sup> International staff no longer need travel permits, but they still need to submit “travel notifications,” which require getting the same signatures from the same people and can take the same amount of time as the permit process.<sup>112</sup> In some ways, travel has gotten even more difficult. Whereas international staff could previously fly directly from Khartoum to towns in conflict-affected states, the government now routes all flights through state capitals. This requires humanitarian workers not only to take two flights but also to request two travel authorizations—one at the national and one at the state level—a process that can add several days to a trip.<sup>113</sup>

Transporting medicines within Sudan also requires approval from HAC, the state ministry of health, and NISS, no matter the distance, though this approval is usually received the day-of.<sup>114</sup> Importing medicines from other countries is even more complicated. Many donors require procurement of medicine on the international market, but medicine imports are subject to government restrictions. A representative of one international NGO described how it took several months to clear a shipment of medicines through customs, even with WHO advocating to the government on the organization’s behalf.<sup>115</sup> HAC, the Federal Ministry of Health, WHO, and other partners have been discussing ways to update these regulations.<sup>116</sup>

Despite their uneven and inconsistent implementation, the new humanitarian directives have opened previously inaccessible parts of Darfur and the Two Areas to international actors. To respond to the needs of these new populations, the UN developed rapid response plans. However, the parts of Jebel Marra controlled by the SLA-AW and those of the Two Areas controlled by the SPLM-N still remain inaccessible. Continued constraints on

access in Darfur and the Two Areas are distinct due to their different experiences with conflict and with the international response.

### Humanitarian Access in Darfur: The Drawdown of a Mission with a Mandate to Protect

In many parts of Darfur, humanitarian actors have been present for years despite restrictions on access. Most international NGOs in Darfur directly manage government facilities—mostly primary healthcare facilities but also some hospitals. A 2018 assessment found that while the state ministries of health run almost all rural hospitals (92 percent), they only run 78 percent of basic health units and 56 percent of primary healthcare centers. In recent years, the proportion of facilities run by NGOs has increased in most of Darfur’s states (see Figure 4).<sup>117</sup> These numbers may even underestimate the involvement of international NGOs, which do not always run health facilities directly: while some hire and pay health workers themselves, others provide training and incentives to personnel hired by the government. By one estimate, 70 percent of health facilities in Darfur are run with the support of international NGOs.<sup>118</sup>

Health facilities run by international NGOs generally provide better health services than those run by the government. Because NGOs focus on more accessible areas with the highest concentrations of people in need—typically IDP camps and cities or larger towns—remote communities that rely on government services can be left behind. The humanitarian presence also means that parts of Darfur have access to better healthcare than other parts of the country where fewer NGOs are present: 49 percent of functional healthcare facilities in Darfur provide the minimum basic healthcare package—nearly double the national average.<sup>119</sup>

111 Sudanese staff have sometimes also required authorization to travel near rebel-held areas. Skype interviews with representatives of Sudanese and international NGOs in Khartoum, February and March 2019.

112 Skype interviews with representatives of international NGOs in Khartoum, February and March 2019.

113 Skype interview with representative of an international NGO in Khartoum, February 2019.

114 Skype interviews with representative of international NGOs in Khartoum and Darfur, February and March 2019.

115 Skype interview with representative of an international NGO in Khartoum, February 2019.

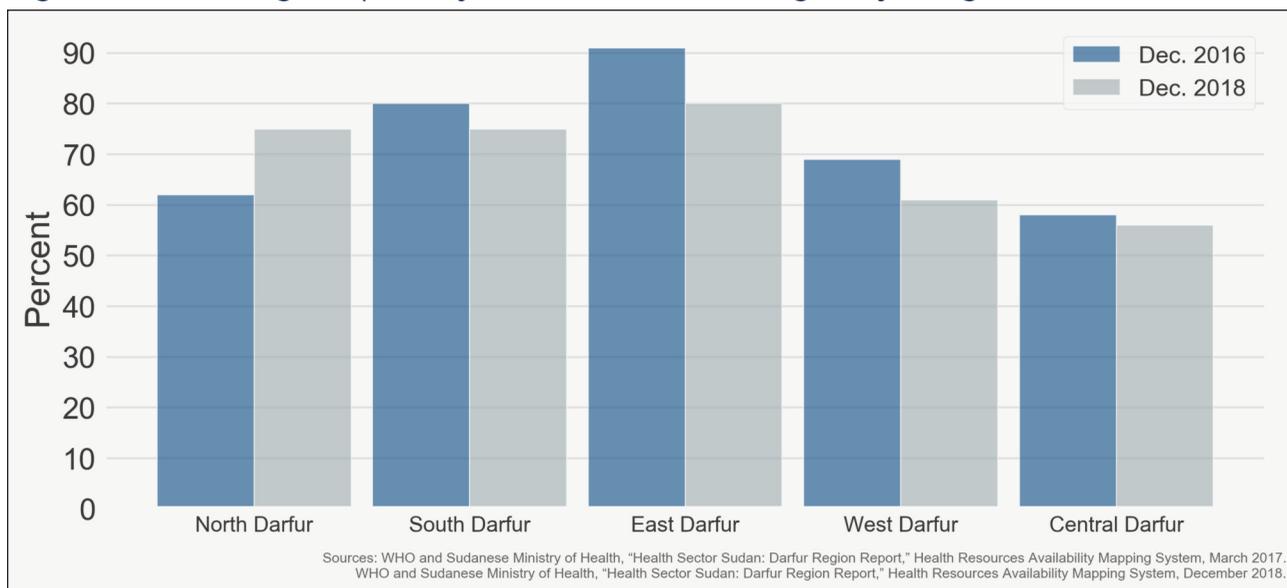
116 WHO, “Federal Ministry of Health, Federal Humanitarian Aid Commission and WHO Meet to Update Pharmaceutical Supplies Regulations Law in Sudan,” August 2, 2018.

117 WHO and Sudanese Ministry of Health, “Health Resources Availability Mapping System—Darfur Region Report: Quarter 4, 2018” (draft), December 2018.

118 Sudanese Ministry of Health, “Sudan Health Sector: 2016 and 2017 Joint Annual Review Report,” November 2017.

119 WHO and Sudanese Ministry of Health, “Health Resources Availability Mapping System—Darfur Region Report: Quarter 4, 2018” (draft), December 2018.

Figure 4. Percentage of primary health facilities managed by the government



Since the new humanitarian directives were put in place, humanitarian actors have been able to access some parts of Jebel Marra that had been cut off from aid for years, though areas controlled by the SLA-AW remain largely off limits.<sup>120</sup> Health actors are only able to access rebel-held areas indirectly during immunization campaigns, when the government allows the delivery of some vaccines and the training of health workers on how to use them—work that is not publicized.<sup>121</sup> An interagency team was also able to deliver basic supplies and treat the injured and ill in some villages in Jebel Marra hit by mudslides in September 2018 after the SLA-AW announced a two-month cease-fire to allow access.<sup>122</sup> Sudanese NGOs are able to access Jebel Marra more easily than international actors, with one reporting that it is the only organization present in some parts.<sup>123</sup>

Citing safety and security concerns, the government tells humanitarian actors they need armed

escorts to travel in Darfur. Accordingly, many international NGOs and all UN agencies operating in Darfur use escorts, which are provided by the Sudanese police or UNAMID.<sup>124</sup> Provision of humanitarian escorts is central to UNAMID's mandate, which requires it to "give priority in decisions about the use of available capacity and resources to... ensuring safe and unhindered humanitarian access, and the safety and security of humanitarian personnel and activities."<sup>125</sup> OCHA coordinates requests for UNAMID escorts, submitting a plan for where and when to deliver or monitor assistance or conduct interagency assessments. In 2018, UNAMID provided 189 uniformed and 41 police escorts to humanitarian actors.<sup>126</sup> Beyond escorts, UNAMID also facilitates access by accommodating humanitarian personnel in its "team sites" across Darfur.

Not all agree that escorts are necessary. While low-level crime is relatively common, attacks and

120 The UN reported that authorities denied UN agencies access to fourteen locations in Jebel Marra in June 2018 alone. USAID, "Sudan: Complex Emergency Fact Sheet #5," August 14, 2018. The boundaries of this rebel-controlled area are fluid and reportedly difficult for non-locals to discern. Phone interview with UN official in Darfur, March 2019.

121 Skype interviews with UN officials in Khartoum, January 2019.

122 UN OCHA, *Sudan Humanitarian Bulletin*, No. 16 (August 20–September 23, 2018).

123 Skype interview with representatives of a Sudanese NGO in Khartoum, February 2019.

124 The determination on where escorts are required is made by the UN Department of Safety and Security, whose security assessments sometimes delay humanitarian missions. See, for example, UN OCHA, "Inter-agency Assessment Report: Kutum Locality, North Darfur—3–5 January 2017." Some areas, particularly in West Darfur, have been deemed secure enough that escorts are no longer required. Phone interview with UN official in Darfur, March 2019.

125 UNAMID is also mandated to prioritize the protection of civilians. UN Security Council Resolution 2429 (July 13, 2018), UN Doc. SC/13422, para. 13.

126 UN Security Council, *African Union–United Nations Hybrid Operation in Darfur—Report of the Secretary-General*, UN Doc. S/2019/44, January 14, 2019.

abductions targeting UN and humanitarian actors have gone down (none were recorded in 2018 or early 2019).<sup>127</sup> Moreover, this heavy security presence can constrain the work of humanitarian actors, and the occasional unavailability of escorts can restrict their movement. One representative of an international NGO alleged that the government has told the UN and NGOs they need escorts partly because the UN has negotiated per diems for the Sudanese police; as a result, humanitarian escorts “have become a business” for police, who can make a tenth of their monthly salary in one day serving on an escort.<sup>128</sup> It is possible to get clearance to travel without an escort, though government representatives still always accompany assessment missions.<sup>129</sup>

UNAMID escorts require approval from NISS or Sudan’s Military Intelligence and have repeatedly been blocked.<sup>130</sup> These restrictions have eased along with those on humanitarian actors, and UNAMID reported a significant decrease in the number of access restrictions in 2017 and 2018, though the rebel-controlled parts of Jebel Marra remain largely off limits.<sup>131</sup> However, some are concerned that UNAMID’s drawdown over the course of 2019 and 2020 could again diminish access.<sup>132</sup> At the same time, even as UNAMID withdraws from other areas, it constructed a new base in Central Darfur in 2018—something the government agreed to following joint advocacy by UNAMID and humanitarian actors. This base should allow peacekeepers to respond to escort requests more quickly in the surrounding areas, which are among the most insecure in the region. It is too early to know the effects of the drawdown on the broader security environment in Darfur, especially because

the government has not allowed UNAMID to return to assess the sites it has vacated.<sup>133</sup> If UNAMID’s departure does increase insecurity, humanitarian access could quickly deteriorate.

#### Humanitarian Access in the Two Areas: A New Opening, within Limits

The new humanitarian directives have also expanded access in the Two Areas, where it had previously been even more restricted than in Darfur; in many places, national NGOs were the only humanitarian actors present.<sup>134</sup> The government only started authorizing interagency needs assessments in the Two Areas in 2018.<sup>135</sup> As more assessments are conducted, international humanitarian actors have started to reach remote communities that had not received aid in seven years or more. Despite these new assessments, some express a lack of confidence in their findings: “We usually have to lie on the assessment reports,” said one representative of an international NGO, because the presence of government staff on the mission makes it impossible to reach a representative sample of the population.<sup>136</sup>

As access opens and assessments are completed, many international health NGOs have launched new programs in the Two Areas since 2018. Government officials in HAC and the state ministries of health have even reportedly been “welcoming” of humanitarian actors and “happy” to sign technical agreements—though NISS remains reluctant and can drag out the approval process.<sup>137</sup> To maintain these good relations, some NGOs are reportedly focusing on projects that will have a quick, demonstrable impact.<sup>138</sup>

Overall, however, the response still falls far short

127 This is according to the Armed Conflict Location and Event Data Project (ACLED). There were three incidents recorded in 2017, though none resulted in fatalities.

128 Phone interview with representative of an international NGO in Khartoum, January 2019.

129 Ibid.

130 Government restrictions prevented UNAMID from facilitating 133 out of 542 access requests between January 2014 and July 2015. UNAMID and Office of the UN High Commissioner for Human Rights (OHCHR), “The Human Rights Situation of Internally Displaced Persons in Darfur 2014–2016,” November 2017.

131 UN Security Council, *Special Report of the Chairperson of the African Union Commission and the Secretary-General of the United Nations on the Strategic Review of the African Union-United Nations Hybrid Operation in Darfur*, UN Doc. S/2018/530, June 1, 2018.

132 The World Food Programme, for example, reported that UNAMID’s drawdown has forced it to prioritize areas that do not require escorts. World Food Programme, “Sudan Country Brief: October 2018.”

133 Phone interview with UN official in Darfur, March 2019.

134 This was because the government reportedly had not wanted a repeat of the international response in Darfur, with NGOs moving in for the long term. Skype interview with representative of an international NGO in Khartoum, March 2019.

135 UN OCHA, “Inter-agency Assessment Report: Al Abbasiya Locality, South Kordofan—4–8 February, 2018.”

136 Skype interview with representatives of an international NGO in Khartoum, February 2019.

137 Skype interviews with representatives of international NGOs in Khartoum, February and March 2019.

138 Phone interview with representative of an international NGO in Khartoum, January 2019.

of the level of need and has not yet reached many remote areas. Few humanitarian actors (none of the UN agencies and only around a third of the NGOs present in South Kordofan, as of January 2019) have a physical presence outside the state capital. There were only fifteen non-Sudanese UN or NGO staff based in South Kordofan as of January 2019 (versus 566 Sudanese) and only one in Blue Nile as of April 2018 (versus 330 Sudanese).<sup>139</sup> With such a capital-centric presence, local communities are not always aware of what NGOs are working on: “You can see signs with the names [of the organizations] on them, but people don’t know what they do,” according to one representative of an international NGO.<sup>140</sup>

As in Darfur, improved humanitarian access in the Two Areas does not extend to areas outside of government control. These border areas are accessible only from South Sudan or Ethiopia. The SPLM-N encourages humanitarian actors to provide cross-border aid, but this is not authorized by the government. Few NGOs are willing to take the risk, and many donors will not fund this work.<sup>141</sup> These programs offer lifesaving medical care but are unable to reach the whole population and have limited supplies.<sup>142</sup> Health actors in rebel-controlled parts of the Two Areas have also come under attack by the government, which bombed a hospital run by Médecins Sans Frontières in South Kordofan in 2014 and 2015.<sup>143</sup>

Humanitarian access to the Two Areas has long been a feature of the on-and-off cease-fire negotiations between the government and the SPLM-N. These negotiations reportedly picked up after the US sanctions were lifted, but major sticking points remain. In September 2018, the government authorized the World Food Programme to deliver aid to rebel-controlled parts of the Two Areas, but

only from Sudanese territory. The SPLM-N has rejected this proposal, as it did a similar US proposal from 2016, insisting that at least part of the aid come across the border from Ethiopia. Despite the lack of a breakthrough, the negotiations have allowed the UN to speak more openly with the SPLM-N with the knowledge of the government, something it had previously had to do covertly.<sup>144</sup>

## TOWARD A SUSTAINABLE, ACCOUNTABLE APPROACH

With so many areas only recently accessible, Sudan still faces elevated and unmet humanitarian needs. Nonetheless, after more than a decade and a half of an international humanitarian presence, there is a push for longer-term approaches to humanitarian needs. Even many humanitarian actors see an excessive focus on humanitarian assistance that has weakened long-term investment in Sudan’s public healthcare system.<sup>145</sup> Following a visit to Sudan in 2018, the UN emergency relief coordinator, while advocating for more aid in the near term, concluded that “humanitarian assistance is not the answer.”<sup>146</sup> This is gradually leading to a new approach to the humanitarian health response in Sudan that prioritizes sustainability and accountability.

### The Humanitarian-Development Nexus: Translating Sustainability into Practice

The Multi-Year Humanitarian Strategy for 2017–2019—the first multi-year strategy developed for Sudan—is central to the shift toward a longer-term approach to addressing Sudan’s needs.<sup>147</sup> The humanitarian country team developed the strategy in collaboration with the government, humanitarian actors, and the team developing Sudan’s 2018–2021 UN development assistance framework (UNDAF), with which the strategy’s outcomes are

139 UN OCHA, “Sudan: South Kordofan—Programme and Physical Presence (3Ws) as of January 2019,” March 2019; “Sudan: Blue Nile— Programme and Physical Presence (3Ws) as of 1 April 2018,” April 2018.

140 Phone interview with representative of an international NGO in Khartoum, January 2019.

141 One person who has made several trips to the region was only aware of four NGOs providing cross-border aid. Samuel Totten, “Tragedy in the Nuba Mountains: Hunger and Starvation Are Constants,” *The Conversation*, July 17, 2017.

142 Human Rights Watch, “No Control, No Choice: Lack of Access to Reproductive Healthcare in Sudan’s Rebel-Held Southern Kordofan,” May 2017.

143 Médecins Sans Frontières, “MSF Hospital Bombed in South Kordofan,” Press Release, January 22, 2015.

144 Skype interview with UN official in Khartoum, January 2019.

145 This sentiment is not universally shared among humanitarian actors. One interviewee saw the shift toward development as not only unrealistic but problematic due to the ongoing level of humanitarian need. He saw the humanitarian sector getting “left behind,” a development that “disturbed” him. *Ibid.*

146 Mark Lowcock, “Interview: Development Is the Long-Term Solution to Sudan’s Humanitarian Crises, Outlines Top UN Relief Official,” *UN News*, June 13, 2018.

147 As of January 2019, the humanitarian country team was still deciding whether to develop another three-year humanitarian strategy for the period after 2019. Interview with UN official, New York, January 2019.

meant to align.<sup>148</sup> It aims to enhance the humanitarian-development-peace nexus, strengthen partnerships with and capacities of national actors, and make humanitarian funding more predictable.<sup>149</sup>

The multi-year strategy does not address the health sector specifically, but Outcome 2 focuses on “equal, sustainable access to essential assistance based on vulnerability targeting” as well as “equal, sustainable access to quality basic services.”<sup>150</sup> Vulnerability targeting—providing aid based on people’s needs and vulnerabilities rather than their status (e.g., as IDPs or refugees)—is one of the ways humanitarian actors are trying to make their response more sustainable. To implement this approach, humanitarian and development actors in Sudan are working with the Joint IDP Profiling Service to analyze the living conditions of IDPs in North and Central Darfur and better understand their needs. This approach is reflected in the 2019 humanitarian response plan, which targets “the most vulnerable 4.4 million people in Sudan.”<sup>151</sup>

Sudan is also a pilot country for the New Way of Working (NWOW)—an initiative emerging from the 2016 World Humanitarian Summit to guide efforts to implement the humanitarian-development nexus. There is a lot of interest in the NWOW in Sudan. The Office of the Resident Coordinator/Humanitarian Coordinator created a humanitarian-development nexus adviser position and a senior advisory team to facilitate joint analysis, planning, and programming. The office also has an interagency information-management

working group to ensure baselines and indicators are interchangeable between the humanitarian and development sides of the UN country team. In May 2017, a “humanitarian-development nexus/coordination review mission” traveled to Sudan to “unpack” the NWOW in the Sudanese context.<sup>152</sup>

At the core of the NWOW are “collective outcomes” for both humanitarian and development actors.<sup>153</sup> These outcomes encompass both “protracted humanitarian needs that are currently under [the humanitarian response plan] but that require a longer-term approach and financing” and “elements of the UNDAF that are not purely development.”<sup>154</sup> While there is reportedly enthusiasm for these collective outcomes, and initial versions exist on paper, they have not yet been finalized, and outstanding questions remain: Where does humanitarian work end and development work begin? What is the architecture for the outcomes? How will funding be coordinated? How will information be exchanged?<sup>155</sup>

Another challenge to implementing the NWOW is that existing humanitarian coordination mechanisms do not involve development actors.<sup>156</sup> The health cluster is trying to address this challenge by encouraging development partners to engage in its meetings, sensitizing health cluster partners on prevention and preparedness, and integrating universal healthcare into its work.<sup>157</sup> The government has also sought to improve coordination with development actors. Its Health Sector Partners Forum, created in 2016, aims to bring together humanitarian and development actors working on

148 UN OCHA, “Sudan Multi-Year Humanitarian Strategy 2017–2019,” December 2016. The UNDAF’s health-related focal areas include stopping and reversing the spread of communicable diseases and strengthening health surveillance systems; controlling noncommunicable diseases; supporting national institutions to develop integrated maternal, adolescent, and child healthcare packages; developing the capacity of health sector staff; and promoting health-seeking behavior at the community level. UN Country Team Sudan, “Sudan United Nations Development Assistance Framework 2018–2021.”

149 This is variously referred to as the “humanitarian-development nexus” and the “humanitarian-development-peace nexus,” but interviewees tended to focus on the humanitarian and development components.

150 UN OCHA, “Sudan Multi-Year Humanitarian Strategy 2017–2019,” December 2016.

151 UN OCHA, “Sudan Humanitarian Snapshot,” March 1, 2019.

152 The mission included the global cluster leads, the Inter-Agency Standing Committee Task Team on Strengthening the Humanitarian-Development Nexus, and the UN Working Group on Transitions. Marta Ruedas, former RC/HC for Sudan, “Humanitarian Development Nexus: What Is the New Way of Working?” May 10, 2017, available at <http://s3-us-west-2.amazonaws.com/deliveraidbetter-wp/wp-content/uploads/2017/05/29092015/P2P-Support-Webinar-Summary-NWoW-Part-1-and-2.dotx.pdf>.

153 Collective outcomes are defined as “the result that development and humanitarian actors (and other relevant actors) contribute to achieving at the end of 3–5 years in order to reduce needs, risk, and vulnerability.” Agenda for Humanity, “Initiative: New Way of Working,” available at <https://agendaforhumanity.org/initiatives/5358>.

154 Four collective outcomes are being developed for Sudan, two of which (Outcomes 2 and 4) relate to the health sector and are meant to align with the government’s National Health Policy 2017–2030 and Health in All Policies approach. WHO, “Health Cluster Forum, 26–28 June 2018, Geneva, Switzerland,” available at [www.who.int/health-cluster/capacity-building/HC-forum-2018-report.pdf](http://www.who.int/health-cluster/capacity-building/HC-forum-2018-report.pdf).

155 Skype interview with UN official in Khartoum, March 2019; interview with donor representative, New York, January 2019.

156 Swedish International Development Cooperation Agency, “Sudan: Humanitarian Crises Analysis 2018,” December 2018.

157 WHO, “Health Cluster Forum, 26–28 June 2018, Geneva, Switzerland.”

health. That same year, three-quarters of development partners in Sudan signed a local compact under the International Health Partnership, an “effort to institutionalize monitoring of effective development cooperation practices among the different sector partners.”<sup>158</sup>

In line with the Multi-Year Humanitarian Strategy and NWOW’s commitment to longer-term approaches, Sudan’s government has been eager to shift toward recovery and reconstruction, especially in Darfur. As early as 2012, the government launched a fifteen-year Darfur Early Recovery Strategy for Health and Nutrition as part of its Darfur Development Strategy.<sup>159</sup> Signaling a shift away from a humanitarian approach, the government announced in early 2018 that its Voluntary Return and Resettlement Commission would take over from HAC in co-leading West Darfur’s recovery, return, and reintegration cluster—the cluster most closely situated between humanitarian assistance and development.<sup>160</sup> Accordingly, the government is pushing international humanitarian and development actors to help returnees, though this is often a challenge, as the villages can be hard to access, and people are still being newly displaced.<sup>161</sup>

As the government starts converting IDP camps into permanent villages, it has also been pushing health actors to construct or repair health facilities and turn them over to the government. For example, several UN agencies launched a project in 2018 to rehabilitate thirty health facilities in Darfur and hand them over to the state ministries of health.<sup>162</sup> This gradual replacement of tents with permanent health facilities has reportedly improved healthcare.<sup>163</sup> Similarly, UNHCR is promoting an “alternatives to camps” policy for refugees—an idea that has broad support but is not

tied to a Sudan-specific plan like the Multi-Year Humanitarian Strategy.<sup>164</sup>

This focus on recovery and reconstruction does not always advance sustainability. Paradoxically, as the government converts camps to villages, the burden for managing health facilities is reportedly shifting even more onto international NGOs.<sup>165</sup> The government’s push for international health actors to provide more services through Ministry of Health personnel can also inadvertently undermine the public healthcare system: when the Ministry of Health seconded personnel to international NGOs, those NGOs pay them “incentives,” often in US dollars, making these jobs more attractive and drawing the best health workers away from more remote government-run clinics. As noted by one representative of an international NGO, “The international response can’t be sustainable just by interacting with the government workforce.”<sup>166</sup> Sudan’s public healthcare system suffers from larger structural problems that can only be fixed through increased funding and systemic change.

### The Gap between Humanitarian and Development Funding

With the push for recovery and reconstruction, and as conditions improve in areas such as West Darfur, humanitarian funding has stagnated, even as improved access exposes new needs. This is not a new problem; Sudan’s humanitarian response plan has consistently been underfunded, and donor attention has waned as the years drag on. As the UN emergency relief coordinator put it, “If it were a new crisis, the dimensions of it, the scale and need of it, would be such that it would be one of the biggest crises in the world.”<sup>167</sup> But due to donor fatigue, a record-low 54 percent of the \$1 billion appeal was funded in 2018 (see Figure 5).<sup>168</sup> The health cluster’s appeal, which amounted to around

158 Sudanese Ministry of Health, “Sudan Health Sector: 2016 and 2017 Joint Annual Review Report,” November 2017.

159 WHO, “Working towards Darfur Recovery: Mapping an Implementable Health and Nutrition Strategy,” October 25, 2012. Around the same time, a 2013–2019 Recovery and Reconstruction Strategy was also launched.

160 UN OCHA, *Sudan Humanitarian Bulletin*, No. 1 (January 1–14, 2018).

161 Skype interviews with representatives of international NGOs in Khartoum, February 2019.

162 UN OCHA, *Sudan Humanitarian Bulletin*, No. 2 (January 15–28, 2018).

163 Skype interview with representative of an international NGO in Khartoum, February 2019.

164 Baker and Elawad, “Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018),” UNHCR, August 2018.

165 Skype interview with representative of an international NGO in Khartoum, February 2019.

166 Skype interview with representative of an international NGO in Khartoum, March 2019.

167 Lowcock, “Interview: Development Is the Long-Term Solution to Sudan’s Humanitarian Crises, Outlines Top UN Relief Official,” UN News, June 13, 2018.

168 The total funding received was greater than in 2017, however, as the appeal was around \$200 million higher.

Figure 5. Humanitarian funding for Sudan

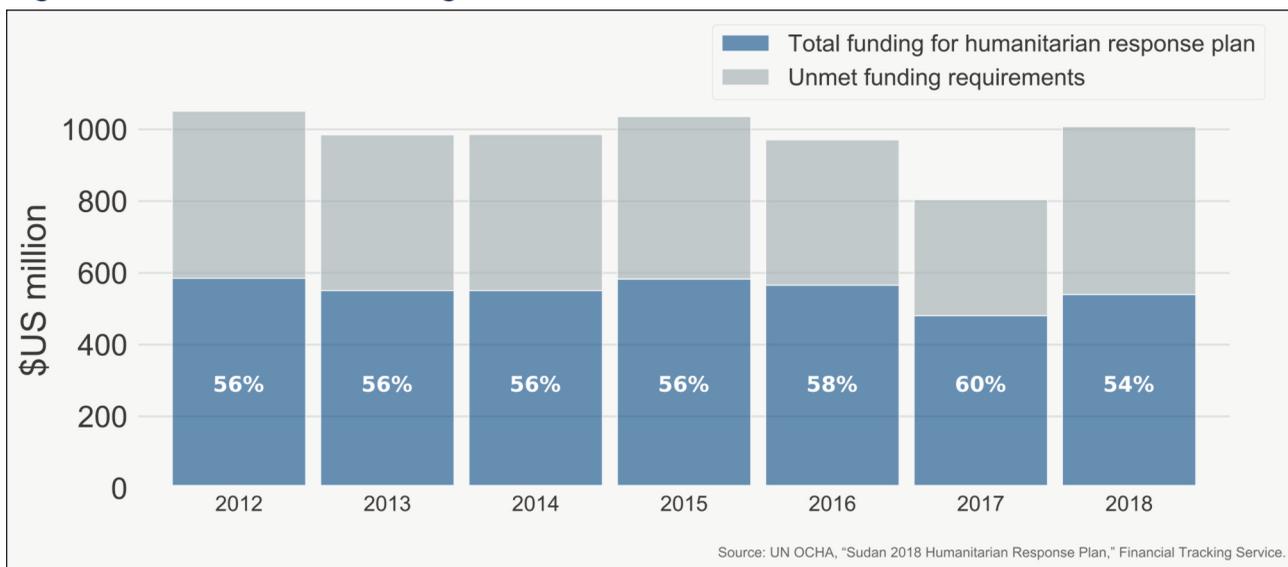
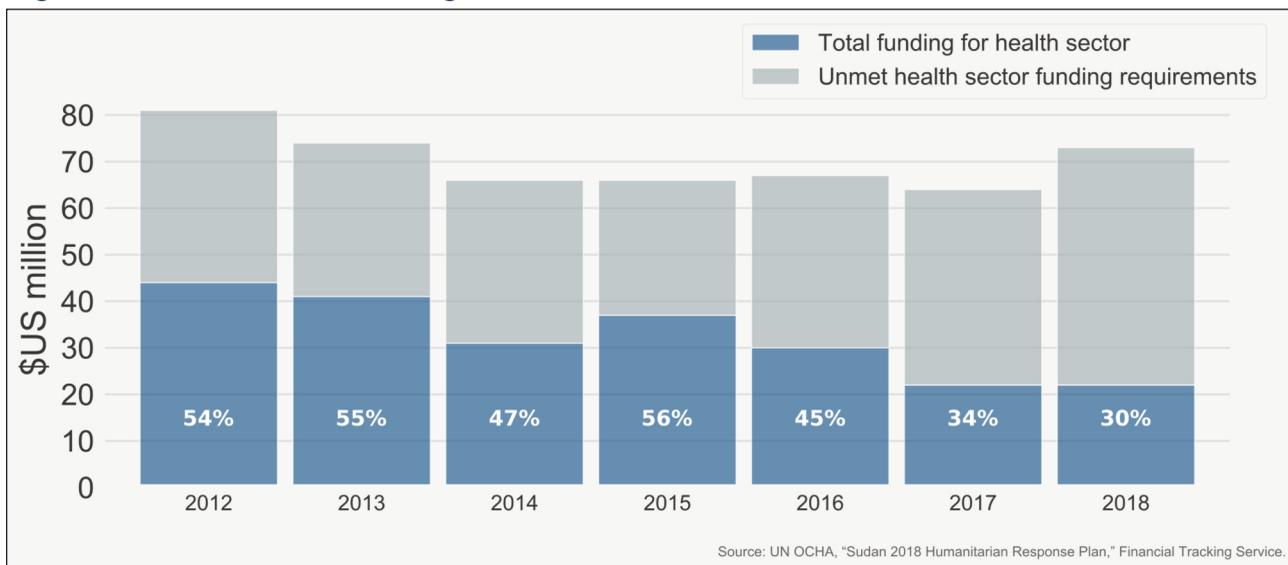


Figure 6. Humanitarian funding for health sector in Sudan



5 percent of the total, was only 30 percent funded (see Figure 6), while the multi-sector refugee response was less than 24 percent funded.<sup>169</sup> The Sudan Humanitarian Fund—a pooled fund established in 2016 and reportedly an effective mechanism for prioritizing assistance—also receives insufficient contributions.<sup>170</sup> To help

bridge these financing gaps, especially as improved access exposes new needs, the UN activated the Central Emergency Response Fund for Sudan in 2018.<sup>171</sup>

Funding shortages have forced NGOs to pull out of some areas and turn over health facilities to the government. Even back in 2015, five international

<sup>169</sup> The US is by far the largest humanitarian donor, providing more than half of all funding in 2018, followed by the UK and European Commission. Substantial funding is also received by some Gulf countries that do not contribute as part of the humanitarian response plan. UN OCHA, "Sudan 2018 Humanitarian Response Plan," Financial Tracking Service, available at <https://fts.unocha.org/appeals/635/summary>.

<sup>170</sup> Interview with donor representative, New York, January 2019; phone interview with donor representatives in Washington, DC, February 2019.

<sup>171</sup> UN OCHA, *Sudan Humanitarian Bulletin*, No. 15 (August 6–19, 2018).

health NGOs were forced to pull out of West Darfur—the least conflict-affected state in the region—due to lack of funding.<sup>172</sup> Oftentimes, state ministries of health lack the budget or capacity to manage facilities vacated by NGOs, and few development actors are present to support them. One NGO still operating in West Darfur reported a spike in referrals to its health clinics after other NGOs left, exposing the gap left by the humanitarian pullout.<sup>173</sup> “The humanitarian-development nexus is not realistic because there are no development actors to take over,” according to one donor representative.<sup>174</sup>

The main reason more development actors are not present in Sudan is the lack of development funding: “There is a sense we are stuck,” according to one UN official, with a general recognition of the need to move beyond humanitarian approaches but an inability to do so because there is so little development funding.<sup>175</sup> Per capita official development assistance fell by two-thirds between 2008 and 2016, with a sharp drop following the secession of South Sudan, and stands at less than half the average for Africa and the Middle East.<sup>176</sup> In the period 2016–2017, more than two-thirds of bilateral aid was humanitarian, one of the highest proportions in Africa.<sup>177</sup> In both 2016 and 2017, Sudan received only around \$39 million for health-related development programs, very few of which targeted conflict-affected states.<sup>178</sup>

The only donors to have increased development funding are the Gulf countries, which do not coordinate with other donors and are not included

in official development assistance figures.<sup>179</sup> One of the main development donors in Darfur has been Qatar, the sole contributor to the UN Fund for Recovery, Reconstruction, and Development in Darfur, a pooled fund managed by UNDP to support the government’s Darfur Development Strategy.

The disproportionate share of development funding coming from the Gulf reflects many Western donors’ reluctance to engage with the Sudanese government—a reluctance that deepened after the government cracked down on protesters in 2018 and 2019: “There is a downward trend in relations with the government as a development partner,” according to one donor representative, speaking before the overthrow of President Bashir.<sup>180</sup> The lack of a comprehensive peace agreement in Darfur and the Two Areas has further discouraged development funding.<sup>181</sup> Some interviewees also blamed lack of reliable data and dedicated communications staff, which makes it difficult to demonstrate and convey to donors both the level of need and the impact and value of existing programs.<sup>182</sup>

On top of this, Sudan is cut off from several funding streams available to most developing countries. Sudan’s continued listing as a state sponsor of terrorism makes it difficult to receive funding and debt relief from the International Monetary Fund and World Bank.<sup>183</sup> The World Bank can only provide small-scale, short-term funding, such as through the joint UN–World Bank Humanitarian-Development-Peace Initia-

172 UNAMID and OHCHR, “The Human Rights Situation of Internally Displaced Persons in Darfur 2014–2016,” November 2017.

173 Save the Children, internal document, February 2019. This also reflects the findings of a 2017 evaluation of UNICEF’s work, which found that “the concept of early recovery needs to be more nuanced within emergency response programming” and that while early recovery has become more incorporated into programming, “the lack of an enabling environment has undermined the realization of this programming in practice.” Majwa, Abbas, and Abdelsadig, “Evaluation of Humanitarian Action: Child Survival in North Darfur, Sudan 2010–2015,” UNICEF, February 2017.

174 Interview with donor representative, New York, January 2019.

175 Skype interview with UN officials in Khartoum, January 2019.

176 World Bank, “Net ODA Received per Capita (Current US\$),” available at <https://data.worldbank.org/indicator/DT.ODA.ODAT.PC.ZS?locations=SS-SD>.

177 OECD, available at [www.oecd.org/dac/stats/aid-at-a-glance.htm](http://www.oecd.org/dac/stats/aid-at-a-glance.htm).

178 In 2017, around half of health-related development funding was from Italy, mostly grants to the government and UNDP to improve hospitals in Port Sudan, Kassala, and Gedaref. The only health-related funding targeting a conflict-affected state was a small grant from Norway to a Sudanese NGO in South Kordofan to train health workers and raise health awareness. OECD, available at <https://stats.oecd.org/Index.aspx?QueryId=58193>.

179 Elfatih Ali Siddig and Elmoiz Ismail, “Preliminary Development Finance Assessment,” United Nations and the Government of Sudan, April 2018. While the EU has recently ramped up its funding for Sudan, this is focused on stemming migration through the country. See Caitlin L. Chandler, “Inside the EU’s Flawed \$200 Million Migration Deal with Sudan,” IRIN News, January 30, 2018.

180 Phone interview with donor representatives in Washington, DC, February 2019.

181 Ibid.

182 Skype interview with UN official in Khartoum, January 2019; phone interview with donor representative in Washington, DC, January 2019.

183 Sudan is one of just three countries (along with Eritrea and Somalia) still eligible for debt relief under the Heavily Indebted Poor Country Initiative. See [www.worldbank.org/en/topic/debt/brief/hipc](http://www.worldbank.org/en/topic/debt/brief/hipc).

tive.<sup>184</sup> Because Sudan passed the threshold to lower-middle-income status, Gavi, the Vaccine Alliance, is also winding down support, with all funding expected to end in 2025.<sup>185</sup> With the drawdown of UNAMID, Sudan is losing not only a security provider but also another funding source in the form of the mission's quick-impact projects.<sup>186</sup>

With limited access to development funding, many health actors are using humanitarian funding to start laying the foundations for development work. Using humanitarian funding in this way leads some NGOs to tweak their language to appeal to the ears of humanitarian donors, for example by talking about “rehabilitating” health clinics instead of “reconstructing” them.<sup>187</sup> The short-term, inflexible nature of humanitarian funding also makes it ill-suited to this sort of work, though the Multi-Year Humanitarian Strategy is providing impetus to shift toward more long-term humanitarian funding. The Sudan Humanitarian Fund, for example, is aligning its allocations with the multi-year strategy and earmarked around a quarter of its funding for two-year projects in 2017.<sup>188</sup>

The lack of long-term development support and funding restrictions have left humanitarian actors to address crises that non-humanitarian health actors could have averted. One example is the August 2018 outbreak of chikungunya in Eastern Sudan. This outbreak could have been brought under control much earlier, but under WHO guidelines “not one dollar could be allocated to [the response] unless people were dying,” and chikungunya is not usually fatal.<sup>189</sup> As a result, humanitarian actors were left “addressing a crisis that wasn’t humanitarian” and that could have been prevented.<sup>190</sup>

There is also a need for more coordination

between humanitarian and development donors. Historically, even those overseeing humanitarian and development funding within the same government or institution would not always talk to each other. The past several years have reportedly seen improved cooperation: “The silos have been reduced,” according to one UN official.<sup>191</sup> For example, the various pooled funds have sought to work in concert; in one case the Sudan Humanitarian Fund supported an initial project then transferred it to the Darfur Community Peace and Stability Fund for follow-up.<sup>192</sup> There are regular meetings between humanitarian and development donors, and in 2017 Sudan received a joint mission from the UN and the Organisation for Economic Co-operation and Development (OECD) to help develop a financing strategy in line with the collective outcomes.<sup>193</sup>

#### Involving Local Communities: A Growing Focus on Accountability

The shift in focus—if not always in funding—toward a more long-term, sustainable approach has gone hand in hand with an increased focus on accountability to affected populations. This is one of the crosscutting issues at the center of Sudan’s Multi-Year Humanitarian Strategy, which commits to the “participation of affected people... to ensure their feedback is taken into account and that the response addresses their concerns in an appropriate and sustainable way.”<sup>194</sup>

While donors such as the Sudan Humanitarian Fund require all grantees to implement mechanisms for ensuring accountability to affected populations, these have historically been weak. A 2018 assessment of UNHCR’s refugee response, for example, found that communication, participation, and feedback mechanisms were all lacking, with interventions largely devoid of input from either

184 See World Bank, “The Humanitarian-Development-Peace Initiative,” March 3, 2017, available at [www.worldbank.org/en/topic/fragilityconflictviolence/brief/the-humanitarian-development-peace-initiative](http://www.worldbank.org/en/topic/fragilityconflictviolence/brief/the-humanitarian-development-peace-initiative).

185 UNICEF, “Immunization Financing in MENA Middle-Income Countries,” May 2018.

186 Phone interview with UN official in Darfur, March 2019.

187 Skype interview with representative of an international NGO in Darfur, March 2019.

188 UN OCHA, “Sudan Multi-Year Humanitarian Strategy 2017–2019,” December 2016.

189 Skype interview with UN official in Khartoum, January 2019.

190 Skype interview with UN officials in Khartoum, January 2019.

191 Skype interview with UN official in Khartoum, January 2019.

192 The Darfur Community Peace and Stability Fund is a small pooled fund managed by UNDP. Interview with donor representative, New York, January 2019.

193 UN and OECD, “From Funding to Financing: Financing Strategy Mission Report—Sudan,” May 2017; Marta Ruedas, former RC/HC for Sudan, “Humanitarian Development Nexus: What Is the New Way of Working?” May 10, 2017.

194 UN OCHA, “Sudan Multi-Year Humanitarian Strategy 2017–2019,” December 2016.

refugees or host communities. The result was “a lack of ownership of community structures, including frequent theft of community goods, decreased cost effectiveness of interventions and a growing dependency on external assistance and support.”<sup>195</sup>

By all accounts, however, things have improved in the past few years. Health actors in Sudan use a variety of mechanisms to promote accountability to affected populations, not all of them equally effective.<sup>196</sup> Many organizations put up boards or stickers with a phone number or email address in communal areas or health facilities. Complaint or suggestion boxes are another common mechanism, while questionnaires on patient satisfaction are a newer tool and not yet widely in use. Some interviewees said people use these feedback mechanisms and that all feedback is diligently followed up on; others described them as not widely used, either due to lack of awareness that they exist or for cultural reasons, as most people prefer engaging face-to-face.

For this reason, in-person accountability mechanisms seem to be more effective. Many health actors have long been consulting with communities before and during projects. These consultations include individual interviews, focus group discussions, meetings with community leaders, and community-wide meetings. Many interviewees said they make sure these consultations are representative in terms of gender and age, and some organize separate meetings for women. While generally seen as useful, consultations are sometimes undermined by a climate of fear, with community members reluctant to speak their mind and foreign aid workers distrustful of the information received.<sup>197</sup>

Some NGOs also create more formal committees to substantively involve communities in project implementation. One representative of a Sudanese NGO described the local committees his organization has been setting up for more than ten years.

The members of these committees have well-defined roles and responsibilities, and membership has been diversified over the years by adding quotas for women and youth and by having members elected rather than appointed. Some of these committees are now official entities registered with the Ministry of Health.<sup>198</sup>

## Conclusions

The humanitarian health response in Sudan is stuck: most agree on the need to move beyond short-term approaches, but the national capacity and development funding needed to make this transition are missing. At the same time, with newly accessible areas exposing unmet needs and conflict and displacement ongoing, a robust humanitarian response is still desperately needed. While moving toward a sustainable, accountable healthcare system will ultimately require action far beyond the scope of the humanitarian health community, the UN, donors, and health NGOs can continue building on recent initiatives that move in the right direction.

### RESPONDING TO NEEDS WHILE STRENGTHENING THE SYSTEM

Sudan's health crisis cannot be resolved until Sudan's public healthcare system has the capacity to take over from humanitarian health actors. This is widely recognized, and initiatives such as the Multi-Year Humanitarian Strategy and collective outcomes are important steps toward this goal. Moving forward with these initiatives will require addressing questions such as how to prioritize and structure the next phase of the humanitarian strategy after 2019 and how to operationalize the collective outcomes. It will also require international health actors to work in partnership with the Ministry of Health and national NGOs. But the way these partnerships are structured matters; forcing international actors to outsource their work to national actors is not a quick recipe for a sustainable response.

195 Baker and Elawad, “Independent Evaluation of the UNHCR South Sudanese Refugee Response in White Nile State, Sudan (2013–2018),” UNHCR, August 2018. There have been efforts to standardize the approach to accountability to affected populations through the cluster system, but these have not gone anywhere. Skype interview with representative of an international NGO in Khartoum, March 2019.

196 There have been efforts to standardize the approach to accountability to affected populations through the cluster system, but these have not gone anywhere. Skype interview with representative of an international NGO in Khartoum, March 2019.

197 Skype interview with representative of an international NGO in Khartoum, March 2019.

198 Skype interview with representatives of a Sudanese NGO in Khartoum, March 2019.

When it comes to partnerships between international health actors and national NGOs, these should be based on recognition of the comparative advantages of each. Sudanese NGOs are often well-placed to carry out community-based activities, particularly as Sudan works toward a nationwide surveillance system for communicable disease outbreaks. They can also help hold international organizations accountable to communities through local consultations, committees, and other mechanisms. At the same time, these partnerships should include a strong capacity-building component so Sudanese NGOs benefit from the medical expertise and communications and fundraising experience of their international counterparts.

Partnerships between international health actors and the government should be grounded in an understanding of Sudan's healthcare system as a whole—its policies and strategies, human resources, financing structure, information management, medicine-distribution systems, and infrastructure. Such a “health systems approach” can help ensure all efforts contribute to building healthcare capacity in Sudan and avoid inadvertently undermining it. For example, the government and international health actors should avoid ad hoc incentive schemes for government health workers without considering their potential to exacerbate geographic inequality, leave behind host communities, and undermine the sustainability of the response. Similarly, the government, donors, and WHO should continue working together to identify solutions to the fragmented health financing system to ensure all Sudanese have access to a free basic healthcare package—whether at an NGO-run clinic in an IDP camp or at a remote government facility through the public health insurance scheme.

### INCREASING AND COORDINATING FUNDING

Apart from Sudan's deep-seated political and economic challenges, the main barrier to shifting toward a longer-term approach is the lack of funding. On the one hand, it is too early for

humanitarian donors to cut back, especially as improved humanitarian access exposes new needs. Even existing needs are not yet adequately met, with the attention of donors dissipated among the world's numerous humanitarian crises. The response to South Sudanese refugees, in particular, is dramatically underfunded. At the same time, development funding—both from international donors and from the Sudanese government itself—needs to increase to strengthen Sudan's healthcare system. While Western donors are unlikely to increase development funding as long as Sudan remains on the list of state sponsors of terrorism, they could start preparing for a political future with fewer funding restrictions.<sup>199</sup> The political transition following the ouster of President Bashir presents both an opportunity for engagement and an impetus for planning.

In the meantime, because much of the development funding will likely continue to come from the Gulf, coordination mechanisms are needed to ensure that funding provided by these “nontraditional” donors complements official development assistance. Humanitarian and development donors could also improve their coordination—particularly in relatively stable areas like West Darfur—to avoid gaps from humanitarian funders pulling out before development funders are ready to step in. Toward this end, humanitarian donors could align their funding with longer-term approaches, as the Sudan Humanitarian Fund is already doing. In Darfur, the other two pooled funds—the UN Darfur Fund and the Darfur Community Peace and Stability Fund—could also help fill gaps, especially as UNAMID withdraws.

### MAINTAINING, AND EXTENDING, HUMANITARIAN ACCESS

The most urgent problem facing the health response in Sudan is restricted humanitarian access. While access has improved since 2016, there is no guarantee these improvements will endure. The new humanitarian directives are seen as having been put in place for political rather than humanitarian reasons and could easily be reversed. Some also see humanitarian access as falling down

<sup>199</sup> For example, the recent UN-OECD financing mission to Sudan recommended a phased approach: a first phase of taking “readiness” actions to prepare for the scaling up of funding, and a second phase (after Sudan's removal from the list) centered on the collective outcomes. UN and OECD, “From Funding to Financing: Financing Strategy Mission Report—Sudan,” May 2017.

the list of international priorities.<sup>200</sup>

The ouster of Bashir presents an opportunity to de-securitize the government's approach to humanitarian access. Improvement will likely depend on the handover to a new civilian government—a new military government would be no more naturally inclined toward humanitarianism than Bashir. Even then, much will depend on the future structure and role of Sudan's security institutions, especially the National Intelligence and Security Services (NISS), which have persistently been involved in decisions on access behind the scenes. The UN humanitarian country team and foreign governments should advocate for de-securitizing humanitarian access across Sudan as

an integral part of the transition.<sup>201</sup> Important points of leverage remain to support this advocacy, including Sudan's removal from the list of state sponsors of terrorism and debt forgiveness.

Ultimately, the only way to ensure long-term humanitarian access is to move beyond temporary, unilateral cease-fires toward comprehensive political agreements. With greater certainty that peace will hold, development donors might be more willing to engage. The future of healthcare in Sudan will ultimately depend on the direction taken by the country's political transition and what impact this has on efforts to bring to an end its decades of armed conflict.

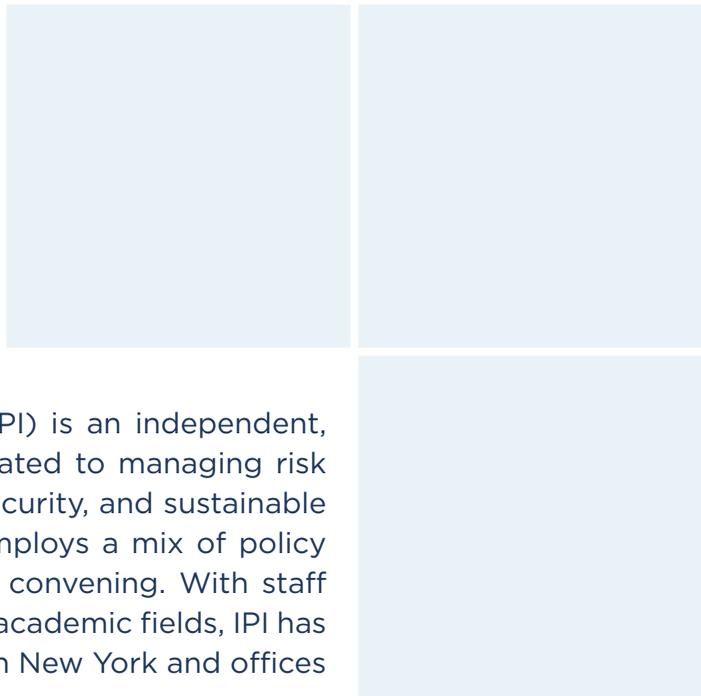
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200 Caitlin L. Chandler, "Six Months after US Sanctions Lifted, Promised Aid Access in Sudan Remains Limited," IRIN, April 11, 2018.

201 Promisingly, in a joint statement on April 14, 2019, the UK, the US, and Norway "call[ed] on the Transitional Military Council to meet the needs of all people of Sudan by ensuring humanitarian access to all areas of Sudan." See [www.gov.uk/government/news/troika-statement-on-the-current-unrest-in-sudan](http://www.gov.uk/government/news/troika-statement-on-the-current-unrest-in-sudan).







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