Sudan Journal of Medical Sciences
Volume 19, Issue no. 3, DOI 10.18502/sjms.v19i3.17216
Production and Hosting by KnE Publishing

Editorial

Resilience in Chaos: Sudanese Actors Shock Absorber in Catastrophes

Mohamed Elsheikh [1]*, Mona Ibrahim [2], Abi Walton[2], and Alhadi K Osman[3]

[1]Department of Physiology, Neurosciences and Behavioral Sciences, St. George's University, Grenada
[2]Department of Social Policy and Intervention, University of Oxford, United Kingdom
[3]Said Business School and Nuffield Department for Primary Healthcare, University of Oxford, United Kingdom

As Sudan approaches the second year of widespread armed conflict, this editorial piece reflects on the current state of the crisis, its impacts on health and public services, and proposes an opportunity for novel, responsive, and transformative health system strengthening.

An already fragile humanitarian context has been pushed into a state of catastrophic public sector failure in Sudan. With over ten million people forced to flee their homes, the country now has the highest number displaced in the world (accounting for 13% of all displaced people globally) [1], almost seven million people exposed to sexual violence [2], and alarming food insecurity and starvation rates [1]. The collapse of public services has further disrupted surveillance, prevention, and responses to these compounding inequalities.

Corresponding Author:
Mohamed Elsheikh; email: melshei1@sgu.edu

Received: 20 August 2024
Accepted: 20 August 2024
Published: 30 September 2024

Production and Hosting by KnE Publishing

Editor-in-Chief:
Prof. Nazik Elmalaika Obaid Seid Ahmed Husain, MD, M.Sc, MHPE, PhD.

1. An Ongoing Debate: The Current State of the Sudanese Health System

It is challenging to accurately understand the function of the Sudanese health system today, but what we know is that it looks radically different than it did two years ago in 2022. On one hand, international reports from reputable agencies have emphasized a "catastrophic collapse" of health services [2, 3] – however, most of these reports appear to be either from conflict epicenters and/or intended to advocate for increased investments into the humanitarian response. On the other hand, through various informal channels, including social media, there are increasing reports of state-level leadership of devolved Ministries of Health, civic coordination mechanisms, and diaspora-funded clinics that continue to uphold basic health services across the country [4, 5]. While these appear contradictory, it is likely that the country's health responses have become too diverse to capture through individual organizations and networks.

If we take a step back, a system is defined as "an organized set of ideas or theories or a particular way of doing something" [6]. This article puts forward a theory that while the current health responses in Sudan do not align with the global consensus on a health system structure, they may meet the definition of a system, albeit an untraditional one.

2. Back to Basics: The Origins of Sudanese Health Movements

Over recent history, Sudanese communities have been among the first to respond to crises and health emergencies. The "nafeer" movement – locally defined as the "the call to mobilize" – was often the first to respond to floods, tribal conflicts, and infectious disease outbreaks over the past three decades. This has ranged from large-scale health intervention, for example, cholera and COVID-19 outbreaks, to contextualizing national health responses to local populations [7]. With decades of plummeting trust in national governance, these movements have been growing incrementally, with sentiments ranging from religious principles to help one's own community, to more pessimistic, yet pragmatic, realizations that no one is on their way to help.

What is unique about these local values, which have upheld basic health response, is that: (A) they do not comfortably fall under a tradition ministerial or sectoral structure of operations and (B) they provide an opportunity to re-imagine what a health system could look like in Sudan.

The first Ministry of Health in Sudan was established in 1949 by Dr Ali Badri which built on the preceding structure of the Sudan Medical Services (est. 1924) – prior to the Sudan's independence a few years later in 1956 [8]. The first Ministry of Health mirrored the ministerial structure of Sudan's neighboring countries with somewhat colonial guidance on which sectors should have independent ministries, as evident by the influence of the Kitchener School of Medicine at the time. While it was seen as a breakthrough establishment at the time, this structure did not consider the unique strength of leveraging the Sudanese "nafeer" movement, nor was that integrated later on in its development.

3. Civic Adaptation and Community-level Leadership

Across Sudanese communities, there is an observed unique and responsive adaptation of health service delivery, particularly in regions with high levels of societal cohesion, medical staff returnees back to their home townships, and where civil society is the most active. While it is not what a ministerial office may have imagined it to be, nor is this adaptation fully understood at this point, it is clear that there basic health functions may be retained in different areas of the country.

When compared to other public services – for example, primary education, social services, infrastructure strengthening, and energy – it becomes clear that health responses have had a higher level of resilience to the breakout of conflict. This is evident by the widespread collapse of other sectoral responses, especially those that rely on a centralized ministerial structure. Civic relief, humanitarian responses and even townhall meetings have been reported to use primary healthcare services as a platform to deliver their services. While this is well-known across Sudanese communities, there is limited formal documentation on where and how this was conducted; although, global literature suggests that communal health structures like this may have ripple impacts on social cohesion and state-building [9].

With increasing operationalization of decentralized health services, through a combination of formal and informal actors, it is crucial to consider whether the current adapted health structure could be an opportunity to establish a conflict-sensitive health system now and in the future.

4. Stories of Resilience

Even if we use the classic building blocks of the health system, we can identify several in which the community health system has survived. For example, in the financing component, the local communities (in collaboration with the Sudanese diaspora) created parallel funding mechanisms targeted at health and humanitarian interventions. A recent estimate suggested around $ 553,000 has been fundraised for Sudan emergency response, this number was likely an underestimate. Similarly, the community also played a key role in health information systems, especially the input side, providing critical information about health indicators (mortalities amongst civilians and potential outbreak signals). For example, the ERRs in Sudan have been providing systemic reports on hunger, humanitarian needs, security, and other things. However, the component of health service delivery has witnessed a grave success. For example, Alnao Hospital and other health facilities in Omdurman have sustained their medical services provision despite the conflict and managed to provide critical health services in the tensest war situations. The aforementioned points out to effective health governance role and proactive leadership the community took in coordinating the health system in war zones as well as in zones that were not directly affected by the conflict.

5. From the Ground Up: Reconstructing Sudan's Health System

This editorial urges academics, policymakers, and international actors to understand, support and reinforce community-led health responses. This approach would not only support immediate lifesaving measures across the country, but also allows for longer-term health system decentralization, conflict-sensitivity, community ownership, and leadership – including in the most dangerous areas in the country, and possibly, in the world.

References

[1] OCHA. (2024). *Sudan*. https://reports.unocha.org/en/country/sudan

[2] VaccinesWork. (2023). *Sudan conflict leaves health system in "total collapse"*. https://www.gavi.org/vaccineswork/sudan-conflict-leaves-health-system-total-collapse

[3] Badri, R., Dawood, I. (2024). The implications of the Sudan war on healthcare workers and facilities: A health system tragedy. *Conflict & Health*, *18*, 22. https://doi.org/10.1186/s13031-024-00581-w

[4] Birch, I., Carter, B., & Satti, H. A. (2024). *Effective social protection in conflict: Findings from Sudan* (Working Paper). https://doi.org/10.19088/IDS.2024.011

[5] reliefweb. (2024). *Diaspora humanitarian engagement in Sudan [EN/AR]*. https://reliefweb.int/report/sudan/diaspora-humanitarian-engagement-sudan-enar

[6] Chang, A., Ogbuoji, O., Atun, R., & Verguet, S. (2017). Dynamic modeling approaches to characterize the functioning of health systems: A systematic review of the literature. *Social Science & Medicine*, *194*, 160–167.

[7] Nasr Elsheikh, M., Ackley, C., Hall, V., & Zaman, S. (2023). 'Because people here are ignorant': The failure of a community intervention to prevent mycetoma in Sudan. *NIHR Open Research*, *3*, 2. https://doi.org/10.3310/nihropenres.13330.1

[8] Devex. (n.d.). *Federal Ministry of Health (Sudan)*. https://www.devex.com/organizations/federal-ministry-of-health-sudan-124194

[9] Kruk, M., Freedman, L., Anglin, G., & Waldman, R. (2010). Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. *Social Science & Medicine*, *70*(1), 89–97.