السودان وحدة مبادرة

Unite Sudan Initiative

Dignity, Justice, and Peace

Sudan's Children:

A National Framework for Trauma Recovery and Psychological Healing

A Sudanese-Owned Strategy for Confronting the Psychological Wounds of War

Classification: For Government Leadership, UN Agencies, and Sudanese Civil Society
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Table of Contents

Executive Summary

Sudan is raising a generation of children who have watched their homes burn, buried relatives in unmarked ground, or gone weeks without a full meal — and almost none of them will ever sit in front of anyone qualified to help them process it. This framework sets out a Sudanese-owned, government-anchored system for identifying and treating that trauma at national scale. It does not propose a new institution. It proposes wiring together the ministries, clinics, schools, and communities Sudan already has into one system with shared standards, instead of the fragmented, mostly voluntary patchwork that exists today.

The Crisis in Numbers

8 million school-age children out of school — the largest such crisis in the world	**5m+** children displaced inside Sudan, many more than once, since April 2023	**2** certified child psychiatrists remaining nationwide	**16%** of UNICEF's 2026 Sudan appeal funded as of early this year

A 2024 clinical survey of displaced children in White Nile State found that 14.3% met the criteria for probable PTSD and 67.3% showed at least mild anxiety, using standard diagnostic checklists. National surveys of the wider population have found PTSD prevalence ranging from roughly a third to more than half, depending on displacement history. Sudan entered this war with only 34 psychiatrists and fewer than one mental health worker per 100,000 people; today, just 79 psychotherapists are known to be working across nine states, and two child psychiatrists serve the entire country.

Our Approach

Rather than layering another standalone project onto an already crowded and disconnected response, this framework links four levels of care that already exist in some form — family and community structures, schools, primary health facilities, and social welfare case management — under one national coordination body co-led by the Federal Ministry of Health and the Ministry of Social Affairs, with WHO and UNICEF providing technical backbone and funding architecture.

Key Components

- **Community-Based Psychological First Aid (Months 1–6):** a single national curriculum delivered by trained volunteers, teachers, and camp focal points, replacing the current mix of competing, uncoordinated approaches.
- **School-Based Trauma-Informed Support (Months 1–18):** trauma-informed teacher training folded directly into ongoing return-to-learning programmes, so a child's school and their psychosocial support become the same doorway.
- **Primary Health Care Integration (Months 6–18):** mhGAP-trained health workers in Ministry of Health facilities able to identify and manage cases beyond first aid, extending the reach of Sudan's two remaining child psychiatrists through supervision rather than direct caseload.

- **Specialized Referral and Case Management (Months 12–36):** Ministry of Social Affairs case workers handling the most complex cases — unaccompanied children, survivors of grave violations — with a shared referral form used by every partner in a given location.
- **National Coordination and Data System (standing, Months 1–36):** one committee, one set of standards, one dataset — feeding directly into the national mental health strategy currently under revision.

Expected Outcomes by Month 36

- At least 2 million children reached with some form of structured psychosocial support.
- mhGAP-trained mental health provision in at least 75% of primary health facilities across priority states.
- A functioning child-protection referral pathway operating in at least 14 of Sudan's 18 states.
- Trauma recovery formally embedded in the national mental health strategy, with a recurring government budget line rather than dependence on a single emergency appeal.

Implementation Requirements

Leadership: Federal Ministry of Health and Ministry of Social Affairs, co-convened with WHO and UNICEF. Financing: an estimated $82 million over 36 months, detailed by component in Part VIII. Timeline: 36 months from committee formation to a system embedded in national structures and budget. Coverage target: 2 million children reached; at least 15,000 community-level first responders trained and certified.

1. Scale of Exposure

Three years into the war, the numbers are no longer abstract. Sudan has more out-of-school children than any other country in the world, and nearly half of school buildings across the country no longer function as classrooms. In Darfur alone, close to three quarters of schools have been damaged, destroyed, or occupied. UNICEF recorded at least 245 child casualties in the first 90 days of 2026 alone, and has verified more than 5,700 grave violations against children since the war began — killing, maiming, recruitment, and abduction among them. Famine has been confirmed in Al Fasher and Kadugli. Every one of these figures describes direct exposure to the kind of experience that, left unaddressed, hardens into long-term psychiatric illness and broken family and social bonds.

2. What the Evidence Shows

The clinical picture, where it has been measured, is stark. A 2024 study across eleven displacement camps in Al Jabalain, White Nile State, screened 223 children using the PTSD Checklist and Hamilton Anxiety Scale: 14.3% met the threshold for probable PTSD and two thirds showed measurable anxiety, with older children, girls, and children separated from close family members most affected. A separate multi-state study found that 87.6% of children surveyed had directly witnessed an act of armed conflict. These are almost certainly undercounts — they measure only the children reachable by a research team, in a country where an estimated 5 million or more children have been displaced.

The workforce available to respond has moved in the opposite direction. Sudan's 2008 national mental health plan already rated the country's workforce as critically thin: 0.92 mental health workers per 100,000 people, 34 psychiatrists nationwide, and only two certified child psychiatrists in a population of over 40 million. Since 2023, many of those professionals have been displaced or have left the country entirely; recent tracking counts just 79 psychotherapists still working, spread across nine states, in a country of eighteen. A child showing signs of trauma today is, in practical terms, more likely to be seen by an untrained camp volunteer than by anyone with clinical training — and in most locations, not seen by anyone at all.

3. Why the Current Response Falls Short

Where support exists, it works. Camp-based volunteers, community groups, and school staff have kept some children afloat through sheer improvisation. But three structural gaps limit what that effort can achieve.

- **No shared standard:** different actors run different curricula in adjoining camps, with no agreed minimum content for what a psychosocial first-aid session should cover.
- **No referral pathway:** a volunteer who identifies a child needing more than first aid typically has nowhere formal to send them — no link to a primary health center, no link to a Ministry of Social Affairs case worker.

- **No data and no funding floor:** there is no shared system tracking who has been reached, which leaves the response unable to demonstrate results or attract sustained financing. UNICEF's 2026 Sudan appeal, which includes child protection and mental health components, stood at only 16% funded as of March.

None of this is a criticism of the people doing the work. It is a description of a system that was never built to operate at this scale, under this ministry structure, with this little coordination. That is precisely the gap this framework is designed to close.

4. Vision

A Sudan in which every child affected by this war — displaced or not, in a camp or a host community, inside the country or across a border — has access to a recognized pathway of psychosocial support, delivered by Sudanese institutions and sustained beyond the life of any single grant.

5. Guiding Principles

- **Government ownership, not parallel systems:** every component is designed to strengthen a Ministry of Health, Ministry of Social Affairs, or Ministry of Education structure that already exists, not to build around it.
- **Community and family first:** most children recover through stable relationships and community support, not clinical intervention. The system is built bottom-up, with specialist care reserved for the cases that need it.
- **Integrated, not standalone:** psychosocial support is delivered through the doorway a child already uses — school, health post, or camp committee — not through a separate structure competing for the same time and trust.
- **Culturally grounded:** community and religious leaders, extended family structures, and traditional coping practices are treated as partners in recovery, not obstacles to a clinical model imported wholesale.
- **Do no harm:** every frontline worker — community volunteer, teacher, or health worker — is trained and vetted in child safeguarding before contact with children begins.
- **Built to last:** the test of success is not how many children are reached during the emergency phase, but whether the system still exists, staffed and funded, in five years.

The system has four tiers of care, plus a coordination body that connects them. Each tier already exists in some partial form in Sudan or in a neighboring context; the task is to link them with shared standards, not to invent new institutions.

6. Tier 1 — Family and Community

The foundation of the system is psychological first aid delivered close to where children actually are: camp committees, host-community structures, and existing women's and youth groups. Volunteers and community focal points — many already active informally — are trained on one shared, simplified national curriculum, replacing the current mix of competing approaches. This tier is deliberately low-cost and high-reach: it is the layer capable of reaching millions of children, and it is also the filter that identifies which children need more than first aid.

7. Tier 2 — Schools

For the roughly half of Sudan's children still able to attend some form of schooling, the classroom is the most reliable point of daily contact available. Trauma-informed teacher training is folded directly into the return-to-learning programmes already being funded by UNICEF and Education Cannot Wait, rather than run as a separate initiative. Teachers are trained to recognize signs of distress, run structured psychosocial classroom activities, and refer children showing more serious symptoms into Tier 3.

8. Tier 3 — Primary Health Care

Sudan cannot rely on psychiatrists it does not have. The mhGAP model — the WHO's Mental Health Gap Action Programme, already used successfully in Unity State, South Sudan — trains primary health workers already staffing Ministry of Health facilities to identify, manage, and refer common mental health conditions, including childhood trauma responses. This tier extends the effective reach of Sudan's two remaining child psychiatrists by putting them in a supervisory and training role rather than a direct-care role they could never scale to meet demand.

9. Tier 4 — Specialized Care and Case Management

A minority of children — those who are unaccompanied, separated from family, survivors of grave violations, or showing severe and persistent symptoms — need more than mhGAP-level care. This tier sits with the Ministry of Social Affairs, whose case workers already hold the legal mandate for family tracing, reunification, and child protection case management. A shared referral form, used by every actor at every tier, ensures a child identified by a camp volunteer can actually reach this level of care rather than the process stalling at the first handoff.

10. National Coordination Body

A National Child Trauma and MHPSS Coordination Committee, co-chaired by the Federal Ministry of Health and the Ministry of Social Affairs, with a technical secretariat provided jointly by WHO and UNICEF. Standing members include the Ministry of Education, state-level counterparts in priority

states, and operational partners delivering services at community level. The Committee's core functions are narrow and concrete: agree the shared curriculum, maintain the shared referral form, track coverage against the indicators in Part VII, and feed findings directly into the national mental health strategy currently being redrafted by the Federal Ministry of Health and WHO.

11. Phase 1 — Emergency Stabilisation (Months 1–6)

- **Month 1:** Coordination Committee formally established; shared curriculum and referral form adopted.
- **Months 2–3:** first cohort of 2,000 community first-aid trainers trained across priority states — Darfur states, Kordofan, greater Khartoum, White Nile, and Gedaref.
- **Months 4–6:** community-level rollout reaches an initial 300,000 children; MH GAP training curriculum finalized and first health-worker cohort scheduled.

Success benchmark: shared curriculum and referral form in active use in at least six states by month 6.

12. Phase 2 — System Building (Months 7–18)

- **Months 7–12:** MH GAP training scaled across primary health facilities in priority states; school-based trauma support integrated into ongoing return-to-learning programming.
- **Months 13–18:** Ministry of Social Affairs case-management units established or reinforced in priority states, staffed and trained against the shared referral form.

Success benchmark: 800,000 children reached cumulatively; MH GAP-trained staff present in 40% of primary health facilities in priority states; referral pathway functioning in at least 6 states.

13. Phase 3 — Institutionalization (Months 19–36)

- **Months 19–30:** national coverage expansion beyond initial priority states; independent mid-term review at month 18 used to correct course.
- **Months 31–36:** trauma recovery formally embedded in the national mental health strategy, with defined civil-service positions and a recurring government budget line; handover planning from emergency to development financing.

Success benchmark: 2 million children reached cumulatively; MH GAP-trained provision in 75% of priority-state facilities; referral pathway functioning in at least 14 of 18 states; the system reflected in the national mental health strategy and budget.

Governance and Stakeholder Roles

This is not a call for a new organisation. It is a call to formalise what already half-exists — turning parallel, disconnected efforts into one system with shared standards and a single point where government, UN, and operational partners account for the same children.

Actor	What They Hold That No One Else Does
Federal & State Ministry of Health	Clinical authority, MH GAP rollout, and the legal legitimacy to make services permanent rather than project-based.
Ministry of Social Affairs	Case management, referral for unaccompanied and separated children, family tracing, and social protection systems that outlast any grant cycle.
Ministry of Education	Access to children through schools, and control of the curriculum into which trauma-informed teaching is integrated.
WHO	MH GAP technical standards, national mental health strategy authorship, and clinical supervision architecture.
UNICEF	Child protection mandate, large-scale funding channels, and linkage to existing return-to-learning programming.
State governments (priority states)	Local implementation authority and knowledge of which localities are reachable at a given time.
Operational partners	Reach into camps and hard-to-access areas, and the trust of families that government and UN actors often have to build from scratch.
Community and religious leaders	The credibility to reduce stigma and encourage families to engage with support their children need.

Risk Management

Risk	Mitigation
Active conflict blocks access to priority areas	Negotiated humanitarian access; remote supervision and telemedicine links where physical access is not possible; phased rollout prioritising currently reachable areas.
Continued attrition of trained health and social workers	Task-shifting to community and primary-care level reduces dependence on scarce specialists; modest retention incentives for trained staff in priority states.
Funding shortfall, as seen across the wider humanitarian appeal	Integration into existing appeals (UNICEF, Education Cannot Wait) rather than a standalone ask; phased budget allowing partial funding to still deliver Tier 1 and Tier 2 coverage.
Fragmentation among operational partners persists	Adoption of the shared curriculum and referral form made a condition of Coordination Committee membership and of continued funding eligibility.
Stigma discourages families from seeking support	Community sensitization led by trusted local and religious leaders; framing support in terms of resilience and recovery rather than illness.
Child safeguarding risk during rapid scale-up	Mandatory safeguarding training and vetting for every frontline worker before contact with children; a standing complaints and reporting mechanism from month 1.

Monitoring and Evaluation

A single shared, anonymized case-management dataset underpins the entire system, feeding quarterly public reporting and an independent review at month 18. The core indicators:

Indicator	Month 18 Target	Month 36 Target
Children reached with structured psychosocial support	800,000	2,000,000+
Primary health facilities with mhGAP-trained staff (priority states)	40%	75%
Community first-aid providers trained and certified	8,000	15,000
States with a functioning referral pathway	6	14
Ministry of Social Affairs case workers trained	300	800

Resource Requirements

An estimated $82 million over 36 months, structured to deliver partial coverage even if funding arrives in stages rather than all at once.

Component	36-Month Estimate
Tier 1 — Community psychological first aid (training, delivery, materials)	**$18 million**
Tier 2 — School-based trauma-informed support	**$24 million**
Tier 3 — mhGAP integration into primary health care	**$20 million**
Tier 4 — Specialised referral and case management	**$12 million**
Coordination, data systems, and monitoring	**$8 million**
Total	**$82 million**

Financing sources: integration into UNICEF's 2026 Sudan appeal and Education Cannot Wait's return-to-learning funding stream, rather than competing with them; UN pooled funds including the Sudan Humanitarian Fund and CERF; bilateral and multilateral grants; and, from Phase 3 onward, a defined line within the federal health budget signaling government ownership beyond the emergency period.

The Cost of Waiting

This framework does not require Sudan to build anything from nothing. Every tier described here already exists in partial form — a volunteer running informal sessions in a camp, a health worker who could be trained under mhGAP, a Ministry of Social Affairs office with a mandate but no shared referral form to work from. What is missing is the connective tissue between them, and that is a governance and coordination problem, not a resource problem beyond Sudan's reach.

The most useful next step is a joint technical meeting between the Federal Ministry of Health, the Ministry of Social Affairs, WHO, and UNICEF, to test whether this framework can be built directly into the national mental health strategy the Ministry and WHO are already redrafting this year — rather than launched afterward as a separate initiative competing for the same attention. That meeting should be convened within the next 30 days, while the strategy is still in draft and genuinely open to shaping. A two-page terms of reference for the Coordination Committee — co-chairs, standing members, and the shared referral form — could realistically follow within a month.

Every month this stays fragmented is another month in which a child in a camp in Darfur, or Kordofan, or White Nile State sits with a volunteer doing their honest best, with nowhere further to send her. Sudan does not lack people willing to help its children. It lacks a system that lets them.