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Sudan's health sector partnership: From confined progression to openness and hope to uncertain demise

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Abstract

Motivation: Despite the signature of the 2005 Paris Declaration on Aid Effectiveness and subsequent adoption of the principles of effective development co-operation (EDC) for better health co-operation, there is a gap in documenting the challenges to implement these commitments at country level. Sudan represents an interesting case study. The country adopted a local health compact in 2014, but for much of the time since the regime had been under sanction. Sudan witnessed a revolution in 2018, followed by a counter-coup in 2021.

Purpose: We aim to explore the evolution of the relationships, perspectives, and compliance of Sudan's health sector partners in terms of the EDC principles of ownership, alignment, and harmonization, while accounting for underlying processes and context changes between 2015 and 2022.

Methods and approach: We collected data through two rounds of interviews, in 2015 (16) and 2022 (8), with stakeholders within the Sudan Health Sector Partnership. We used the framework method for data analysis where responses are coded and then sorted into themes.

Findings: Before the 2019 revolution, co-operation was progressive but restricted, with civil society marginalized and a dominating government. The EDC principles, especially ownership, were misused and misaligned with national priorities driven by donors' interests and conditions.

The transition period (post-revolution) witnessed an influx of partners, characterized by their openness, but unstable leadership and subsequent changes in priorities led to wasted opportunities.

Following the coup, donors adopted a no-contact policy towards the de facto government. The expectation was that civil society organizations would replace the government as the main implementers. Overall, limited co-ordination capacity and no sustainability measures were present throughout.

Policy implications: Much of what was observed was due to the often complicated and difficult context of the governance of Sudan.

However, general issues arose, including the government's ability to co-ordinate policy and implementation; the need for stable, legitimate arrangements; and the need to define the role of civil society and empower civil society organizations. In a complex and volatile context, revisiting partners' commitments through joint compact reviews and transparent EDC progress monitoring is crucial.

KEYWORDS
alignment, co-ordination, effective development co-operation, framework analysis, harmonization, health sector, ownership, partnership; Sudan

1 | INTRODUCTION

Following the adoption of the Millennium Declaration in the year 2000, debate on what is needed to implement effective development co-operation and hence have better partnerships for global goals has intensified (Vandemoortele, 2011). Criticism of the paternalistic nature of aid relations led to a greater focus on local ownership in contrast to a "donors know best" attitude (Deutscher & Fyson, 2008). Thus, initiatives started to lead to universal partnership agreements such as the Paris Declaration on Aid Effectiveness (OECD, 2005). Although both the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) have included partnership as a goal (UN, 2015), the transition to the SDGs has witnessed a shift from aid effectiveness terminology to effective development co-operation (EDC) principles.

The foundation of effective development co-operation remains the Paris Declaration on Aid Effectiveness with its five core principles (ownership, alignment, harmonization, managing for results, and mutual accountability). The central theory of the Declaration framework is that certain behavioural changes in the practices and relationships among the partners are necessary to achieve the development goals.

Ownership, defined in the Paris Declaration as respecting the leading role of recipient countries in defining their priorities, strategies, and operational frameworks, requires partners to adhere to them—hence *alignment* of the aid with those priorities and frameworks while strengthening recipients' capacities. The relationship between these two affects *harmonization*, which entails co-ordination between partners to eliminate duplication of efforts. The development partnership needs to function within a framework that focuses on results and uses information to improve decision-making through transparent measures/standards that enhance the accountability of partners (managing for results and mutual accountability).

Although ownership has been central to all EDC debates and commitments this century, the definition of the concept following the Paris Declaration has witnessed major contestations. For instance, Keijzer and Black (2020) pointed to the wide range of meanings associated with ownership in academia, reaching from leadership to participation and even broad-based consensus. Furthermore, while the Paris Declaration assumed stability and recipient state legitimacy (Brown, 2020), subsequent global deliberations from the Accra Agenda for Action (OECD, 2008) and the Busan Partnership for Effective Development Cooperation (OECD, 2011) put forward the concept of democratic ownership that entails an augmented role for robust parliaments and civil society organizations (CSOs) to bring societal voices beyond their reliance on the government alone. This was meant to facilitate an emphasis on human rights, local participation, and accountability as measures to address legitimacy, trust, and hence sustainability within changing political dynamics.

Considering the large number of partners working in the health sector globally and the varying modalities of co-operation in health, the International Health Partnership (IHP+) was established in 2007, adopting in its global compact identical values to those of the Paris Declaration (Alexander, 2007). The IHP+ and its compact continued to evolve, establishing further co-operation agreements while keeping the core five principles at its heart, later

transforming to become the Universal Health Coverage Partnership (UHC2030, 2016a) following the initiation of the SDGs and the global consensus on universal health coverage (UHC) as the main health target.

Despite the high number of signatories to the Paris Declaration and the IHP+ compact, there is a lack of research on the practical reality of these agreed principles and behaviours. Furthermore, there is a weak understanding of how development co-operation evolves in practice and how partners respond to the changing environment. This study tries to contribute to the knowledge on these aspects by providing an overview of the evolution of partnerships within a volatile and complex context, namely Sudan.

2 | SUDAN: A CHALLENGING AND EVER-CHANGING PARTNERSHIP CONTEXT

Sudan presents an interesting case within the international development co-operation scene. Many factors affect the status of health and partnership in Sudan, such as disease diversity and protracted health emergencies (Health Cluster, 2023), frequent political turmoil, long-term internal conflicts, poor economic status, and volatile international relations (WHO, 2021). Sudan is the third largest country in Africa by area, and has a population of 43 million and remarkable religious and cultural diversity. The country is classified among the low-income nations, with a life expectancy of 65 years (World Bank, 2022).

South Sudan seceded from Sudan after a referendum in 2011 following the signing of the comprehensive peace agreement. Since then, Sudan has suffered a lack of funding due to the loss of oil export income, as the major oil fields were concentrated in the south and the international community has provided less support due to problematic relations with the Sudanese regime (Lyman, 2013). In 2009, the government of Sudan decided to expel 13 large international non-governmental organizations (INGOs) from Sudan (Pantuliano et al., 2009), which drastically affected health system support, among many other sectors. This added to ongoing conflicts, humanitarian crises, and health emergencies (Lyman, 2013).

Sudan joined the IHP+ in 2011, influenced by these problems and their health sector needs, in order to adopt similar principles, facilitate the co-operation process and help with the complexity of the funding modalities, according to Ministry of Health officials. Sudan's partners in the health sector signed an EDC-based local health compact in 2014, and EDC evaluations were carried out to track progress (Republic of Sudan Federal Ministry of Health et al., 2014; UHC2030, 2016b). Within the Sudan Health Compact, there was agreement on commitments, including the move towards having a joint health sector plan and a joint annual review process to improve ownership and alignment while strengthening and utilizing national systems for enhanced harmonization, management for results, and accountability, along with documentation of their progress. Similarly, there were official commitments to engage national CSOs, strengthen their role, and enable them to organize themselves and hence align work and build capacities. Nonetheless, Sudan's political context has continued to change over the last decade, from being under sanctions from the United States and other global powers to post-revolution openness and an influx of partners, and finally to stringent international relations after the 2021 coup (Osman et al., 2021). Appendix 1 details the Sudan Health Compact partner categories and commitments, and outlines the health partner context in Sudan.

This study explores the evolution of Sudan health sector partner relations, perspectives, and adherence to the EDC principles of ownership, alignment, and harmonization while accounting for underlying processes and the changes in context during the period 2015–2022. Specifically, the study tries to answer the following questions:

- How has the relationship between health sector partners evolved within the Sudan context since 2015?
- What are the changes in the perceptions and practices around the principles of ownership, alignment, and harmonization subsequent to the context changes?
- What challenges and opportunities face the different health sector partners in Sudan on the path to attaining the EDC compact commitment targets?

3 | METHODS

3.1 | Study design

We applied a qualitative case study design to enable exploration of the evolution of partner relationships, attitudes, and adherence to the EDC principles and the challenges they faced. The study relies mainly on interview analysis; we later triangulated this with observations of co-ordination meetings and a review of relevant documents gathered throughout the study period.

We conducted the interviews and meeting observations during two time periods:

1. Data from 2015–2016 were gathered and analysed, looking at how signing the Sudan Health Compact, including commitments to a better partnership and EDC, influenced Sudan health partners' relationships, attitudes, and adherence to the EDC commitments.
2. Data from the years 2021–2022 were gathered to explore changes in the partnership environment, attitudes, and practices after the revolution in Sudan and the later coup of 2021.

We used a semi-structured interview guide based on the EDC commitments with a focus on the three principles of ownership, alignment, and harmonization (see Annex 2). We continuously amended the guide during the study process as, after each interview, the revision of the interview and the notes continued to inspire us to make changes.

3.2 | Data collection and study participants

In 2015, we conducted 16 in-depth interviews during the months of July and August. After conducting a quick scan and analysis of stakeholders, we purposively chose a list of potential participants to cover different stakeholders who could represent distinct perspectives, including in the list of interviewees high-level staff from the following partner categories:

- Sudan government
- Bilateral donors
- Development banks
- UN agencies
- International agencies and INGOs
- CSOs

We identified potential interviewees and agencies based on their being active actors in the Sudan health sector and within the definition of partners as per the Sudan Health Compact (Republic of Sudan Federal Ministry of Health et al., 2014). We acquired a list of health partners from the Directorate of International Health, the Ministry of Health, and the World Health Organization (WHO) office in Sudan and welcomed suggestions from respondents during the interviews who mentioned others who could be relevant respondents: this helped with the selection and contacting of respondents. We finalized a list of 24 potential interviewees and contacted all of them. Of these, we interviewed the 16 who responded positively. We conducted all interviews in participants' offices as we felt that their natural work setting would help improve their sense of comfort and consequently facilitate the free exchange of information.

We also used other data sources for triangulation to confirm and complement the findings to ensure validity and reliability, thereby making it possible to check partners' inputs thoroughly. We conducted participatory

observations and took notes of two co-ordination meetings during the same period. Additionally, we reviewed documents we found relevant to the study or were suggested by the interview participants.

For the second set of data (2021–2022), we conducted more interviews with relevant respondents from the various constituency groups that the Sudan Health Compact defined until reaching saturation level after eight interviews. We applied the same process that we utilized in the first round.

3.3 | Analysis

We applied the framework analysis technique for data analysis. Gale et al. (2013) define the methodology as "a set of codes organized into categories that have been developed by the researcher(s) that can be used to manage and organize the data." The codes are descriptive or conceptual "labels" that are assigned to the excerpts of raw data. They are then processed for entering into the framework matrix, a spreadsheet containing numerous cells into which summarized data are entered by codes (columns) and cases (rows representing the respondents and allowing comparison of inputs within the two datasets). Finally, themes are developed as interpretive concepts or propositions that describe and explain aspects within the data. Themes are developed by interrogating data categories through comparison between and within cases. This allowed careful comparison not only between participants' inputs but also within the same participants/constituency representatives over the two data collection periods. We used a combined approach to analysis in this study, enabling the development of themes both inductively from the accounts of participants and deductively using the framework for the Paris Declaration commitments for understanding and evaluation (Booth & Evans, 2006). We first transcribed recorded interviews verbatim and then revised them by listening to the recordings and rereading the transcripts to ensure proper transcripts and to familiarize ourselves more with the data, incorporating notes and short memos within this process. Using OpenCode 4.03 (2013), we performed line-by-line coding of the interviews. Initially, two researchers were involved: one insider (HA) who conducted the study and carried out the interviews and was familiar with the context, and one outsider (DT, see acknowledgement) who was not involved in this topic and study area before conducting open coding of two interviews as close as possible to the data. We first read and open coded separately without any briefing or interaction, then later worked jointly to pool results and debate diverse codes. During this process of discussing open codes, as the two researchers had different perspectives, they produced different codes for the same idea/line. We had to discuss and agree on the final codes. Often, we agreed to use in vivo codes such as "Owner of the house has the responsibility to coordinate" and "If Ministry of Health wants a pink building, we do it pink." DT repeatedly asked for clarification on terminologies, raising the need for memos in addition to those recorded at the data collection stage. Figure 1 shows two examples of memos.

Comparing the different codes and reflecting on these and the memos inspired the grouping of codes into categories in a deliberate process, going forward and back, revising the categories and the fit of the codes on each category and their relevance to the data.

For the rest of the interviews, we used more selective coding based on the Paris Declaration, the Sudan Health Compact, and their specific commitments, with a focus on the three principles and the preliminary open code directions. HA continued the process of coding (systematically applying coding labels, identified by the framework method as indexing in a deductive manner) while trying to keep attention to recognize emerging codes and issues. We added codes emerging from the transcripts to the now deductively decided list of codes.

We then grouped coding labels together conceptually into categories (using a tree diagram), which changed over time, becoming successively clearer through coding additional interviews. This formed a working analytical framework that we only closed after analysing all the data. The final framework contained 58 coding labels grouped into nine categories as seen in the tree diagram in Appendix 3. Table 1 shows how some of the coding labels in the "Leadership" category are defined.

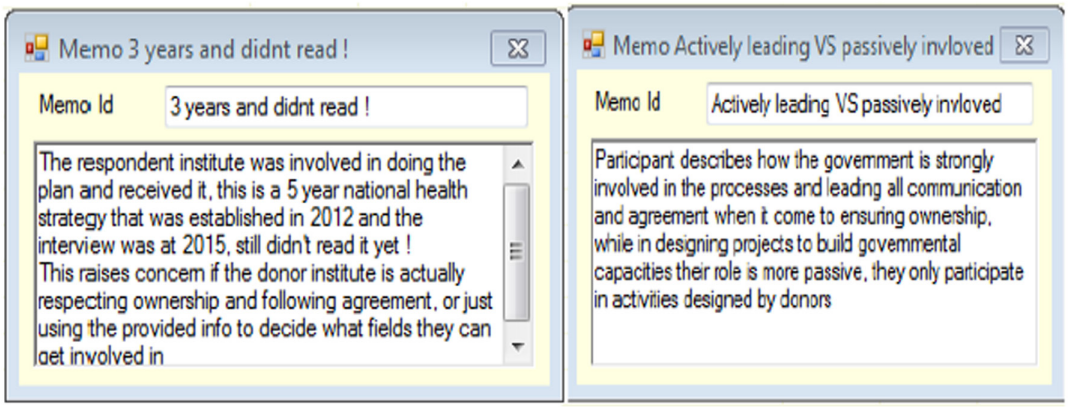

FIGURE 1 Examples of memos.

TABLE 1 Coding label definitions from the "Leadership" category.

CODING LABEL	DESCRIPTION
Ownership importance	Respondents' perception of the importance of ownership, whether important or not, reasons and motives for this.
Taking the lead	Inputs on who is taking the lead on ownership and co-ordination between different partners, in what domains, and how.
Roles and responsibilities	Perception of own or others' roles and responsibilities, including leading, supporting, implementing, guiding, and directing, among others.
Government capacities	Views on the government's ability to take the lead, advantages and gaps within the system and personnel, and ability to build relationships.

We used Microsoft Excel spreadsheets to generate a matrix and charted the data into this matrix. The cells included illustrative quotations or parts of texts under each coding label (column) for each respondent/case (row). We used a separate sheet for every category. Then, looking into patterns within each group of coding labels and comparing the responses of different interviewees and the different partner categories assisted in interpreting the analysis framework matrix. We developed themes based on these patterns, assisted by the memos and notes written in the various stages, as well as comparing with observation reports and reviewed document contents. In this process, the focus was on going beyond simple descriptions to explanations of differences and the reasons behind attitudes and acts linking the different parts of responses. We present an illustrative example of the matrix content in Annex 4.

The second set of data had a more focused analysis, comparing the data with the first-round analysis in 2016 and building on it, while keeping an eye open for any issues arising. The focus was on defining any changes from 2015–2016 to report and relate them to the policy and contextual changes for Sudan (revolution then coup) and the health sector.

3.4 | Methodological considerations

We applied several measures to increase the trustworthiness of the study (Dahlgren et al., 2007, pp. 44–53). The reason for choosing semi-structured interviews as the main data collection technique was to ensure the

credibility by providing data that address what we are really examining. Intensive discussions between the two analysts (HA and DT) took place in the preliminary stages, and there were constant comparisons and trials to avoid using preconceived ideas to increase the fit of the results to the data. The research team initially tried to extract codes directly from the data distant from any conceptual frames and used in vivo codes when appropriate. HA, as an insider, used notes written during data collection and discussions with outsiders that led to memos that assisted in these processes. The purpose of trying to extract codes that were as neutral as possible was to ensure the relevance of the study and that it stemmed directly from the interviewees' views. In order to clarify the findings of the study, we provide a contextual background to ensure flexibility to adapt and compare within other contexts. We used other data collection methods in addition to interviews to ensure triangulation and improve the credibility of the study. We recorded observations of partners' meetings and reviewed documents. We also recorded different personal notes with the aim of keeping them for possible inquiry audits and a decision trail. There were more interviews conducted during the first data collection stage, which explains the extensive data and results compared to the second data set. The large number of interviews and the difficult partnership context after the coup, created difficulties for the study, but also enriched the results and enabled views and actions to be compared within a changing and challenging environment. The central role of the first author (HA) within Sudan health sector partnerships and the good relations with various partners facilitated the high engagement rate from the targeted key actors. Within this process, the framework analysis proved its fitness for comparison within each respondent's input and between respondents, as well as over the timeline.

4 | RESULTS

The overall themes resulting from the analysis indicate a challenging health sector partnership journey, from confined progression to hopeful openness and then uncertain demise, throughout the three political transition periods, as outlined in Figure 2.

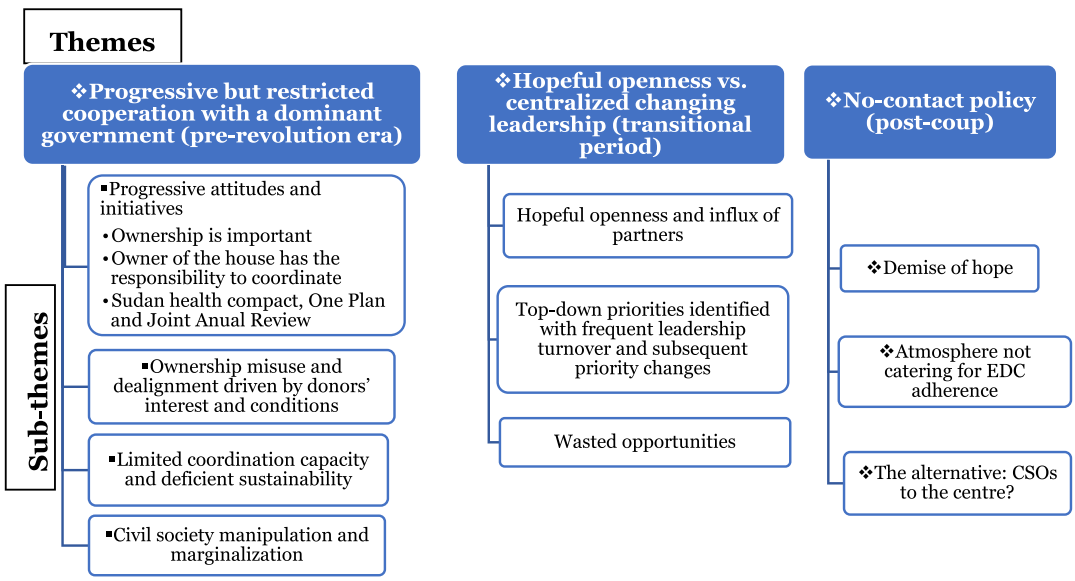

FIGURE 2 Themes and sub-themes of the challenging partnership journey of Sudan health sector.

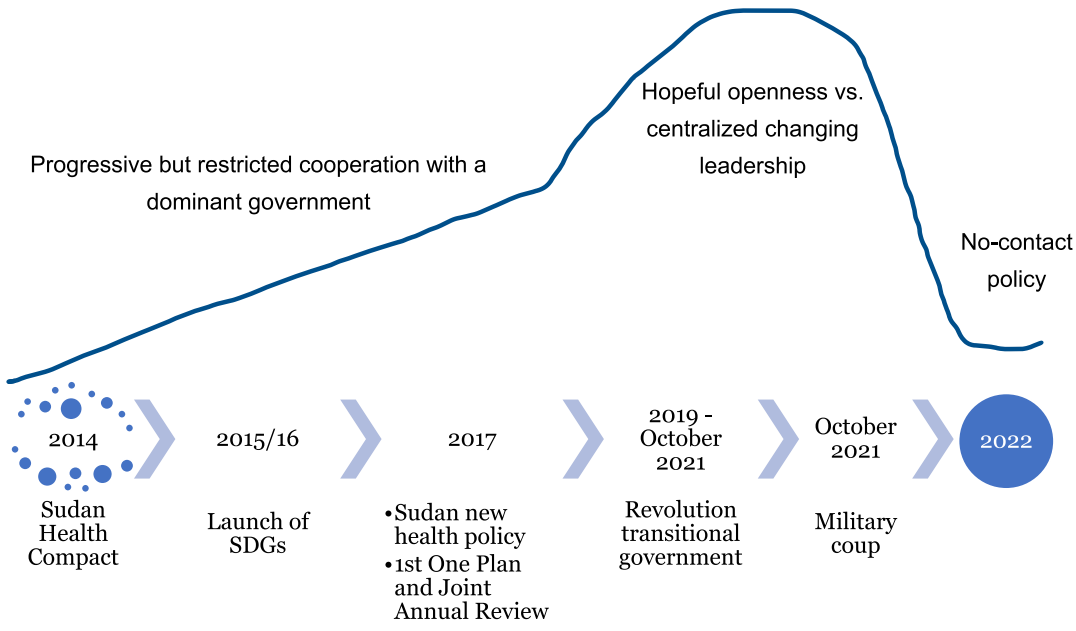

FIGURE 3 Timeline of Sudan's partnership with the health sector and EDC journey within major events.

Articulating this journey against the major events within these three political periods led to the development of Figure 3, which depicts the intensity of progress on the attitudes and practices of the EDC over time.

4.1 | Progressive but restricted co-operation with a dominant government (pre-revolution era)

4.1.1 | Progressive attitudes and initiatives

There was agreement between all the development partners on the importance of ownership and its application, mainly to ensure the commitment of the government to the priorities and its consistent engagement with the development project's plans and processes. It was also seen that aligning with the country's owned priorities would enable all development partners to complement each other's work with efficient resource allocation and raise the level of accountability of all partners to the results:

> *Ownership is of course important; it enhances the government's commitment as they need to be continuously engaged in the process and as partners can use the two concepts of ownership and alignment to complement the work of each other.*
>
> (Development Bank 1)

National ownership, taking the lead, and subsequently ensuring partner engagement was seen as the only approach to ensure the success and sustainability of development efforts:

> *[Ownership] has to happen to achieve and sustain the hoped-for results, but the government should have all the elements of ownership, including the ability to estimate and state priorities from grassroots and commitments, especially on human resources management and governance.*
>
> (UN Agency 5)

The partners believed mutually that the government of Sudan, through the Ministry of Health and other entities, should take the lead in co-ordinating the different health partners. As one donor expressed it:

> *[The] owner of the house has the responsibility to co-ordinate but must be in a position to do that.*
>
> *(Bilateral Donor 1)*

All partners saw the health sector during the pre-revolution period as being in a better position when it came to effective co-operation and achievement than other sectors, bearing in mind the introduction of the EDC principles through the Sudan Health Compact, bringing partners closer together. Similarly, the participatory approach to formulating and reviewing the Sudan health strategy encouraged higher expectations and hopes among partners for further advancements.

> *The Federal Ministry of Health…they have first joined the International Health Partnership, and then developed the Sudan Health Compact, and I think this Compact is bringing all actors together towards the national priorities.*
>
> (Development Bank 2)

The government of this era also tried to take things further in terms of operationalizing the agreements and institutionalization of EDC commitments like having a joint "One Plan":

> *On operational aspects of transferring these conceptual issues into practice, we can talk about institutionalizing the concept of One Plan… it is a very important element for both ownership and alignment, so in the last years the ministry here moved towards One Plan rather than the fragmented plans with each partner. There is progress despite interruptions. People now understand what One Plan is…people at the beginning saw this just as bureaucracy…One Plan will allow government departments and partners to see what others are doing.*
>
> (Government 2)

4.1.2 | Ownership misuse and dealignment driven by donors' interest and conditions

The Sudanese government expressed a strong opinion on its role as a leader of co-operation and how partners should comply with its conditions regarding security concerns and national sovereignty:

> *As far as we are talking about the sovereignty of the nation, we have the right to select the area in which we need this assistance—geographic or thematic area—rather than letting any international donor work where they want… Also, security is of course an issue here, as part of the country's right to safeguard processes.*
>
> (Government 1)

However, concerns were raised about the government of Sudan's understanding of ownership during the pre-revolution period, described as strange and alarming:

> *The main problem with ownership here in Sudan is it being perceived in a very strange way by the Ministry of Health… Usually if somebody told you that you have weaknesses in this area…for example, in financial management, then you try to mitigate these weaknesses… The government instead perceived it as lack of ownership; they don't usually take it as sort of constructive criticism.*
>
> (UN Agency 2)

> *[ownership calling] was a sort of way to grasp money: they were talking about ownership in terms of "give us the money", even knowing that we couldn't.*
>
> (Bilateral Donor 1)

Partners seemed to cope with this dominant attitude, bearing in mind previous experiences:

> *If the Ministry wants a health centre building that is pink, we do it pink.*
>
> (Bilateral Donor 1)

> *If we want to bring a consultant from outside Sudan, we have to get the government's approval, or they can delay the process. The government can decide everything.*
>
> (CSO 2)

However, despite the consensus on the importance of ownership and the role of the government in ensuring it, adherence to this in practice by different donors varied greatly. Though consideration of the government's plans and priorities was stated, many partners created their own plans parallel to the national health strategy, rather than being in line with it:

> *[The bank] follows its country brief…to define the fields it can work on".*
>
> (Development Bank 1)

The above respondent even indicated that, although the Bank had received the strategy, which had been adopted three years before the interview date, they had yet to read it despite being responsible for aligning bank plans. Other implementing partners, who indicated that donors could influence the country's planning and prioritization and deviate the process away from its original conception, elaborated further on this behaviour:

> *Donors, according to their area of interest, might dictate the decision-making. People are developing their proposals sometimes based on calls from donors.*
>
> (INGO 1)

Another stated reason for bypassing identified country priorities was the mismatch between these and the donors' favoured fields during the pre-revolution period:

> *I think the donors, bilateral and foundations, are interested in issues that are not favoured in Sudan. There are a lot of funds available for human rights and empowering key populations, gender diversity, and such issues that are not seen by the country as priorities…sometimes government push aside priorities because they are not politically correct.*
>
> (UN Agency 3)

4.1.3 | Limited co-ordination capacity and deficient sustainability

Issues with the government's leadership and co-ordination, despite expectations that it would fulfil these functions, were apparent in the lack of follow-up for the different processes, including co-ordination forums.

> *The [partners' co-ordination] secretariat which should be through the Ministry of Health International Health Department is not so systematically effective in calling for meetings, gathering people, taking the leadership and so on.*
>
> (Bilateral Donor 1)

Many respondents reflected on the fact that there are very few staff in the International Health Department and those that are there have limited capacities. Respondents added that even within the available capacity-building initiatives, partners were leading the way, while the government was only participating passively, providing no guidance or direction to this work:

> *The government only participates in activities designed through partners for institutional capacity building.*
>
> (Development Bank 1)

A participant from the United Nations expressed frustration over the way that the emerging workload distracting from the follow-up process:

> *'Ideally, there should be regular follow-up on the processes, but we don't do that. People become busy… outbreaks happen…many other things…ideally, we are supposed to meet every quarter to review the implementation… [The] last meeting was… [9 months ago].*
>
> (UN Agency 1)

The struggle to co-ordinate was even harder at lower levels due to subnational level staff capacity issues and the weak system of governance, with policy incoherence further complicating the situation. The government representative clearly acknowledged this:

> *If you go down to states and localities, then I don't think we have the needed capacities…I think the [co-ordination] process is a bit slow, and this is due to our capacity to do this process.*
>
> (Government 1)

People saw the co-ordination mechanism, the Health Sector Partners Forum established in 2016, as a possible way forward, but it was not properly functional in a sustained manner. However, this forum was a national policy coherence body that required further technical forums in order for it to be functional. The sustainability dilemma was also visible in terms of the absence of follow-up of initiatives:

> *We were part of the joint annual review done by the government. Unfortunately, it was done only one time, the same as all those initiatives coming from the government.*
>
> *(Bilateral Donor 1)*

Thus, people believed that progress required a lot of effort, collaboration, commitment, clarity, and time to achieve the EDC commitments, as the process implied big behavioural changes:

> *Progress needs effort, collaboration, commitment, clarity, and time, also because for many years the agencies and the health departments got used to this project or agency-based co-ordination bodies…it is about behavioural change, both institutional behaviours and individual behaviours, at the government and at the agencies.*
>
> (Government 2)

This matter transcended the level of the Ministry of Health as even a ministry official criticized how the mandate of co-ordination with INGOs bypassed them to an alternative government body:

> *We have some problem with the international NGOs as the mandate for co-ordination with them is in another ministry…we think this area needs better arrangement*.
>
> (Government 1)

4.1.4 | Civil society manipulation and marginalization

Generally, civil society was weakly involved in the planning, assessment, and implementation of projects during this period. People felt that only international community pressure motivated the government's efforts around CSO engagement rather than reflecting partners' strength, abilities and respect for their role:

> *[In] the joint review by the IHP+, one of the major things they found was that the involvement of civil society and the private sector wasn't that great*.
>
> (UN Agency 1)

> *As civil society, still the government doesn't give us that space. The only space they give us is because they are enforced by the donors that they have to involve the civil society.*
>
> (CSO 3)

Even the donors themselves seemed not really to consider CSOs as genuine partners:

> *We have some civic society organizations as beneficiaries but not partners as such at the moment*.
>
> (Bilateral Donor 1)

However, when engaged in processes relevant to the EDC commitments with government and partners, this engagement was felt to be only partial and to sometimes arrive at a late stage after the formulation of plans, with the CSOs being there just to convey artificial consensus.

> *We have been involved in some parts, but not in the overall strategy development, like malaria and other subcommittees according to the area of speciality. We have been invited for the validation of the final outcome strategy.*
>
> (CSO 3)

The treatment CSO amounted to not just marginalization but also disregard for their autonomy and saw major interference from the government as it introduced political bodies to the civil context.

> *The government used to make their own organizations—we call them government NGOs, GNGOs [laughs]…there was conflict on how to choose the CSOs to participate in the global fund mechanism, for example. In the end, people decided in one of the [Country Co-ordination Mechanism] meetings that we have to formulate a network to know which organizations are genuinely working on health… The network is generally dominated by GNGOs*.
>
> (CSO 3)

4.2 | Hopeful openness vs. centralized changing leadership (transitional period)

4.2.1 | Hopeful openness and influx of partners

The December 2018 revolution presented a hopeful window of opportunity that many were looking for inside Sudan and from external partners. International partners welcomed the transitional government with open minds:

> *Since 2019, the scene was getting wider because, as you know, for the international community [the transitional] government is an approachable entity, and so this allowed us to speak loudly while interacting with the federal ministry. Before, we couldn't.*
>
> (Bilateral Donor 1)

The government also confirmed a clear change relating to the implementation of a high influx of new partners, projects with increased budgets, and more flexible modalities:

> *There were a lot of partners who were new…new organizations, new CSOs, and private sector partners were approaching [the government].*
>
> (Government 2–1)

An apparent sign of this change was the transparency and openness in discussing issues that were previously sensitive or censored in both the political and health arenas. This change assisted openness in providing funding in more flexible modalities like budget support:

> *The narrative changed, hence [we] talk openly, so [we] do not have to go through some treaties. The International Criminal Court (ICC) and how it's openly mentioned by authorities, while in the past it couldn't be talked about… [after the revolution] we are talking the same language, we are not talking any more of acute watery diarrhoea, we're saying cholera: it's a clear change in the transparency. Now we are considering starting a sector budget support; we provide money to the sector directly…and we then enter just in sort of steering committee or monitoring mechanism.*
>
> (Bilateral Donor 1)

4.2.2 | Top-down priorities with frequent leadership turnover and subsequent changes in priorities

During the transition period, alignment and respect for country ownership was more apparent to the government and partners. However, there were issues about having a top-down strategy development process, complicated by unstable leadership that caused frequent reviews of previous strategic priorities. Hence, there was no clearly agreed national health strategy, which hindered timely alignment:

> *In 2021 I believe that ownership was obvious because I could see that a lot of support and programmes were actually directed within the areas that the Ministry wanted support in. Still, I have a concern about the process [of identifying priorities] and the involvement of the people at the locality level. I think that the*

process wasn't done from bottom to top, it was top to bottom. Also, the frequent changes at leadership level have caused delays in the strategy release and caused multiple modifications to the priorities set.

(Government 2–1)

Rapid turnover and loss of trained government staff were the main issues raised during this period. People believed that this had an enormous effect on progress towards the EDC:

Often there is the element of turnover, so the head of the department doesn't stay long enough in the position…they do not succeed in reaching the full capacity to facilitate the relationship.

(Bilateral Donor 2–1)

The general view was that there were multiple reasons for this churn, including political instability and leadership changes, in addition to the poor economic situation and low wages.

4.2.3 | Wasted opportunities

Despite the opportunities to provide more support in terms of funding with better modalities, including direct sector budget support, donors complained that the government was not prepared and did not take advantage of these new opportunities:

There were delays in materializing the commitment of the donors…the government was not up to the expectation and this led to delays in the implementation of strategic plans for different sectors, including the health sector.

(Donor 2–2)

Partners raised issues of late and partial involvement, which led them to not being fully on board:

We were engaged [in the strategy development] as part of the health sector partners' forum, but I think not at the level of creation rather than the level of consultation.

(Donor 2–2)

We were contacted maybe because we are also an old long-standing partner…I saw the Japanese and us. I didn't see any other big partner out of the UN agencies.

(Bilateral Donor 2-1)

Although, according to reports, young and enthusiastic professionals were leading the latest work, the political turmoil had left gaps, especially at senior level, thereby affecting the overall performance of the government:

I have seen super clever and smart guys, very conversant with all the dynamics. They had very nice collaboration, exposed to international partners—but they were very young, missing coaching or supervising. I didn't see those seniors… maybe because they are in the diaspora or part of the old regime. They are not accepted to do these jobs right here anymore. I don't know the reasons they were removed from their positions, but this is creating a weakness.

(Bilateral Donor 2–1)

4.3 | No-contact policy (post-coup)

4.3.1 | Demise of hope

The coup of October 2021 brought about the demise of the promising post-revolution plans and necessary funds, as described by all respondents:

> *All these [better co-operation efforts] were interrupted by the coup; the funds were suspended, and co-operation again returned to the period before the revolution in 2019.*
>
> (Donor 2–2)

> *After the coup we had a lot of support that has been frozen from different entities, such as the World Bank, European Union, USAID, and so many others. Many entities and donors are reluctant to deal with the government… many clearly stated that they are not able to deal directly with the coup government…I can see clearly the end of the [partners'] influx.*
>
> (Government 2-1)

Many donors and international agencies declared a policy of not meeting anyone from the government leadership and frequently boycotted co-ordination meetings called by them. The government respondent went on to say this no-contact policy was due to "trust issues," explaining that donors were reluctant to channel their support within national institutions, fearing it could be used in ways other than those agreed. Meanwhile, the rationale presented by the donors and global partners was different. There was a fear of uncertainty about investing within such a volatile context with continuous changes in the actors and policies. The decision to delegitimize the coup government, taken by their respective entities, also influenced them through minimizing contact and cutting the direct flow of funds.

> *I don't think that [this change in co-operation practices] is related to the system or trust. As donors, we were always aware of the issues of weaknesses of the system…I think the coup is creating an environment of uncertainty not just for the donors in developmental co-operation but even for the private sector level and so on. Also, part of the issue is probably political, related to a high-level decision not to legitimize this coup regime.*
>
> (Donor 2–2)

4.3.2 | Atmosphere not catering for EDC adherence

The political implications of the coup and the looming threat of returning sanctions were worrying. Within the context following the coup, many felt that adopting EDC commitments, especially ownership and alignment, was going to be very difficult, if not impossible. With many international partners refusing to engage with the post-coup government, it was not possible to fully exercise the leadership and co-ordination role.

> *Many of the partners, especially donors, believe that EDC principles will not be catered for in such an atmosphere as we have now after the coup…If the government is not being engaged, then how can we discuss EDC and have government in a leadership role?*
>
> (Government 2–1)

As a result of the above issues, collaboration between the partners became messy. There was a lack of clarity as to how the situation would evolve, which hindered further EDC progress:

I think it is very difficult for the key global development partners—those having presence here—to improve their adherence to the Health Compact commitments without them either ignoring the situation, or then the government side to have some change.

(Government 2–2)

4.3.3 | The alternative: CSOs moving to the centre?

The coup brought forward a new strategy of international partners working further with local NGOs and other CSOs to implement projects rather than working through the government. This led to CSOs being more at the centre of the health sector co-operation scene compared to previous periods:

Since the coup, NGOs have been a little bit more empowered to play major roles.

(INGO 2–1)

What I'm seeing now is that the donors and some of the international NGOs who were working with the government before, they started to look at local NGOs as a replacement to do the work, because now there's nothing going on with the government and some of them even stopped having any sort of contact with government.

(CSO 2-1)

After the coup, we lost much of what we had agreed as many partners are opting for models that depend on direct implementation and working directly with CSOs.

(Government 2-1)

5 | DISCUSSION

This study shows the complexity of the relationships between partners and EDC commitments in Sudan. While global and local compacts and EDC agreements assume fitting contexts, goodwill and intentions, the case of Sudan highlights how changing the political environment affects the exercising of EDC commitments and their understanding.

5.1 | Evolution of partner relationships

The relationships of Sudan's health partners have changed over time. The pre-revolution era witnessed clear domination by the government, with other partners showing a willingness to co-operate, albeit limited by many conditions such as economic sanctions and the complexity of bilateral and multilateral agreements, given the Sudan regime situation with the International Criminal Court (ICC) (Verjee, 2018).

Central to this is the dilemma of partnering with a regime that has a record of human rights violations. Notably within this period the universal signature on a local compact by all major partners allowed progressive activation of co-ordination platforms and subsequent frequent monitoring of partnership practices included in the compact. However, it seems that this was only done under pressure from the heavy-handed government at this time, and the international partners showed covert resistance as they were not truly abiding by the agreement but

maintaining a façade—as indicated by the comment that international partners would in practice bypass the priorities likely to be problematic in terms of human rights and gender equality.

The transition period, on the other hand, saw a high degree of openness and transparency among all partners with the various partners demonstrating friendly relations, and an influx of peak partners who were willing to follow the government's lead and provide increased flexible resources.

In contrast, the post-coup era witnessed a complete loss of contact and co-operation, with international partners—influenced by donor countries' policies—deciding not to deal with the government at all.

Various studies have shown that context significantly affects the real ways in which actors co-operate within a partnership. Keijzer and Black (2020) summarized multiple case studies on ownership in a post-aid effectiveness era:

> the conditions under which development co-operation operates, and the policy and political realities to which it relates, have effectively marginalized these principles and with it, the broader aid and development effectiveness agenda to which it is anchored.

Pallas, Khuat et al. (2015) reported that changes in the economic status of Vietnam and across the world, coupled with a readjustment of global political interests, affected donors influx into the country and their later withdrawal when Vietnam became a middle-income country, advancing competing countries' priorities for donors. While these factors affect the partnership scene in Sudan, they also support the argument that contexts have a major influence on the real interplay of partnership relations.

The relationship between Sudanese CSOs and the other partners has also seen major shifts within the contextual changes. During these changes, it seems that other more powerful actors looked at the CSOs as tools to achieve targets rather than as partners. The government during the pre-revolution era tried to show that it respected the commitment to support the CSOs, but meanwhile it had high control over them through introducing government-created NGOs and giving them more opportunities to grow and lead. The same power relations and dynamics explain the donors' move to rely on the CSOs as the new main implementers instead of the government of Sudan once the relationship with the latter was on hold, whereas they had not even treated them as genuine partners in previous periods.

Although the 2016 EDC assessment (UHC2030, 2016b) indicated progress in engaging the CSOs, the previous misuse of CSOs were a cause for concern. The government needed to find a balance within its role, co-ordinating efforts, motivating the evolution of co-ordination bodies, and strengthening CSOs, while at the same time distancing itself from being directly involved in the work of CSOs. The new post-coup donors' view of CSOs threatens to lead to further competition among CSOs over resources given the increased demand, while proper organizational and co-ordination structures for CSOs are lacking. One can predict this on the basis of the hostility and competitiveness seen among other implementing partners in comparable cases (Pallas, Khuat et al., 2015; Pallas, Nonvignon et al., 2015; Sundewall et al., 2010). All of this implies that, for different reasons, the expected role of CSOs as both key implementers and main actors ensuring ownership by representing the voice of the rights holders was not realistically attainable either pre- or post-revolution.

5.2 | EDC perceptions and changes of practice

The perception and practice of EDC principles has reflected the above changes in partners' relationships and stances. The pre-revolution era, despite contextual challenges, saw efforts to impose the exercising of EDC principles of ownership and alignment, with advanced initiatives like the One Plan and Joint Annual Review.

However, according to reports, the government was abusing the concept of ownership to dictate the partnership. Similarities to the government's tendency to use development effectiveness principles strategically

to increase its control over aid were reported in the study of Vietnam by Pallas, Khuat, et al. (2015), where donors were pushed to different areas from their original funding interests, while the government resisted any co-ordination or information sharing among donors and centralized all transactions through its departments. Whitfield (2009, p. 4) pointed out that it is challenging to define ownership boundaries, thereby obfuscating debate around decision-making processes in development policy. The mismatch between donors' preferred fields of interest and the national priorities declared during this era clarifies issues on how serious partners are—globally and in Sudan—about adhering to agreed commitments. Ownership, which implies legitimacy and representation, was clearly deficient during this period, with neither rigorous parliamentary representation within the democratic process nor a strong CSO setup being present. Within such a context and under a sanctioned regime with a record of human rights violations, it is unrealistic to expect ownership to be respected.

The transition period witnessed partners' improved willingness to align and follow national priorities and support the leadership of the health sector. The generally held view was that this was related to the changing political relationship with the Sudan government, as well as the openness of the government of Sudan on information sharing and dialogue. However, there were concerns that the government's process of identifying priorities was top-down and constantly changing, preventing any proper stable alignment by the other partners.

The coup era—and, primarily, the no-contact policy—entailed risks to EDC commitments, including duplication of partner efforts, wasted resources, and a focus on non-priority work, all due to the loss of a leading entity and co-ordination. A debate around case studies from Cambodia and the Philippines by Hughes and Hutchison (2012) questioned whether "donors' relations with recipient governments implies new relations of equality or simply a new form of donors' control," a pertinent question in light of the shift of position with political changes and the scrutiny of how political positions affect the exercise of EDC commitments within Sudan. Moreover, if the current military coup continues, there is a risk of regressing into a worse form of sanctions and authoritarian control, bringing back actions like the 2009 expulsion of INGOs (Pantuliano et al., 2009). This being said, the government dominance and control witnessed in the pre-revolution era is not yet apparent following the coup, which could be due to the loose grip the coup regime had on the country at the time this study concluded.

5.3 | EDC targets: Attainment challenges and opportunities

The tense global relations with the government of Sudan and the sanctions imposed on it were major challenges in the pre-revolution era, caused by the government's ways of dealing with partners inside Sudan and the global political environment. The weak varying capacities in terms of personnel further complicated this, as did the frail system procedures, a feature that continued through the other two periods under scrutiny. This is consistent with the findings for similar countries, such as Ghana's "weak, uneven implementation capacity and ineffectual co-ordination, exacerbated by administrative weaknesses" within the public sector when it comes to development co-operation (Black, 2020). Despite the fact that capacity improvement is a responsibility of the government, further co-operation in national capacity building from other partners will boost the partnership efforts.

The political power struggle witnessed during the transitional government led to political instability within the government, as it included a wide range of entities and parties. This period saw four Ministers of Health within a period of two years and many subsequent changes at senior levels of the Ministry of Health (Osman et al., 2021). This continuous upheaval in the health sector and the lack of a unified vision has hindered the optimal use of opportunities, including the influx of partners and funding, and the promised flexibility in financing modalities. To render the context more favourable again—and to regain the interest and willingness to co-operate in funding the Sudan health sector could take longer in light of the need to rebuild trust in the political context—the solidity and stability of the sector leadership will be vital. There is a need to find a clear strategic direction that is properly designed for the real needs and priorities and to call for partners through regular co-ordination forums supported

by a highly capable secretariat. Partners will then need to be fully engaged and informed about all issues, and openness and accountability will help regain trust.

The differences between respondents from the government and international partners in terms of their understanding of the reasons behind the no-contact policy and the post-coup cutoff of funds clarified an important and extremely concerning gap as regards mutual understanding.

Important changes had occurred by the time we submitted this article, with an escalation of conflict between Sudan's armed forces and the Rapid Support Forces (paramilitary militia), leading to the eruption of tribal conflicts, thousands of deaths, and the incapacitation of the health system. It is too early to see the effect of this on the partnership environment, but we note major movement in humanitarian action.

6 | CONCLUSION

The country context is an apparent determinant of progress in attitudes and adherence to EDC commitments; therefore, some degree of stability is crucial to achieve the targets. Even times of extreme openness and outstanding opportunities are not sufficient to change the whole partnership context, unless coupled with a highly capable government with a clear vision. The lessons of this study go beyond Sudan to reflect on many countries within Africa and elsewhere that experience political instability.

The partners had high, but sensible, expectations from governments as the main body responsible for coordinating and leading the development efforts within the country. Therefore, better attitudes, capacities, and actions from the recipient governments are necessary, requiring flexible and responsive authority within the different government entities. Capacity building and the presence of stabilizing technical staff are crucial for partnership efforts to be fruitful, and it is important to tackle these issues jointly and actively, along with ensuring stable leadership, vision, and partnership arrangements.

The importance of respecting the role of civil society without interventions or manipulations, and to support it with capacity building is widely acknowledged. Moreover, CSOs need to organize themselves voluntarily to gain the necessary respect and to be able to avoid the hostility and other threats their expanding role might bring. Other partners, especially the government, must maintain the proper participation of CSOs.

Reviewing the Health Compact and renewing the commitments within it, given the change in context, the rising need to revise some elements including CSOs and the private sector, and the movement towards the SDGs, might be helpful once a political window opens. The approach of building partnership compacts with clear commitments can be used in countries where this does not exist. This approach must go beyond the interplay of actors' power and enforcement capacity. This also entails further work on good practices such as having a joint “One Plan” and joint review, as well as information-sharing platforms and regularly sector co-ordination meetings. However, these recommendations can only be fruitful under stable democratic governance.

AUTHOR CONTRIBUTIONS

Huzeifa Aweesha and Miguel San Sebastian performed the initial design of the study, HA collected all data and ran the analysis and writing up of the results, while the review and writing of the article were guided by Anna-Karin Hurtig, Anni-Maria Pulkki-Brännström, and Miguel San Sebastian.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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