Exploring Partners' Coordination and Its Effect On Aid Effectiveness In Sudan's Health Sector

Azza Tayfour Osman Wagialla

Sudan

59th Master of Science in Public Health/International Course of Health Development (MPH/ICHD)

2022/2023

KIT (Royal Tropical Institute)

Vrije Universiteit Amsterdam (VU)

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

by

Azza Tayfour Osman Wagialla

Sudan

Declaration

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Master of Science in Public Health (MPH)/ International Course of Health Development (MPH/ICHD)

12 September 2022 – 1 September 2023

KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2023

Organised by:

KIT (Royal Tropical Institute)

Amsterdam, The Netherlands

In cooperation with:

Vrije Universiteit Amsterdam (VU)

Amsterdam, The Netherland

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Abbreviations list:

Abbreviation	Full form
CCM	Country Coordinating Mechanism
CHE	Current Health Expenditure
COR	Commission Of Refugees
CPD	Continuous Professional Development
CSO	Civil Society Organizations
DAH	Development Assistance For Health
EDC	Effective Development Cooperation
EDC	Effective Development Cooperation
EU	European Union
FCAS	Fragile And Conflict-Affected Settings
FMOH	Federal Ministry Of Health
GAVI	Global Alliance For Vaccines And Immunization
HAC	Humanitarian Aid Commission
IDA	International Development Agency
IHP+	International Health Partnerships Plus
INGOs	International Nongovernmental Organizations
KII	Key Informants' Interviews
MDGs	Millennium Development Goals
MOSAIC	Ministry Of International Cooperation
NHSCC	National Health Sector Coordination Council
NHSRRSP	National Health Sector Reform and Recovery Strategic Plan
NHSSP	National Health Sector Strategic Plan
ODA	Official Development Assistance
OOP	Out-Of-Pocket Expenditure
PFM	Public Financial Management
PMU	Project Management Unit
RSF	Rapid Support Forces
SAF	Sudanese Army Forces
SHSPF	Sudan's Health Sector Partners Forum
SMOH	State Ministry of Health
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
USAID	United State Agency for International Development
WB	World Union
WHO	World Health Organization

Abstract:

Background: The global proliferation of donors, fragmentation, and duplication of efforts in the health sector in fragile and conflicted affected settings necessitates the adherence to aid effectiveness principles. Sudan's health sector is committed to implementing those principles to enhance donor coordination. However, aid effectiveness and coordination have been poorly investigated in Sudan.

Objective: To explore the attitude and adherence of development partners to Sudan's coordination mechanisms in terms of aid effectiveness and provide recommendations to the Federal Ministry of Health (FMOH).

Methods: The study used mixed methods to achieve its objectives, including reviewing documents and literature and interviewing eight key informants guided by Walt and Gilson framework.

Results: Sudan's Health Sector Partners' Forum (SHSPF) was established as the main coordination mechanism in Sudan. The Forum strengthened the country's ownership, yet development partners' participation was threatened by continuous political instability. Coordination fragmentation still exists, especially at the state level. The development partners in Sudan are progressing in aligning their priorities with the national priorities; nonetheless, there is limited use of the country's national systems, e.g., procurement and financial systems, due to the weak capacity of the systems. The political dynamics greatly influence the implementation of aid effectiveness principles in Sudan.

Conclusion: The SHSPF provides the FMOH and its partners a platform to pursue aid effectiveness in Sudan. The rapidly changing political dynamics and the limited capacity of the country's systems are factors hindering these efforts. Creating resilient institutions that promote national health priorities in spite of the unstable context will facilitate coordination and aid effectiveness.

Keywords: partners' coordination, aid effectiveness, ownership, alignment, harmonisation, political instability.

Abstract word count: 249 words.

Word count: 13077 words.

Key Terms:

Developmental aid is defined as “aid expended in a manner that is anticipated to promote development, whether achieved through economic growth or other means.” (1).

Aid effectiveness is defined as “delivering the aid in a way that maximises its impact on development and achieves value for aid money.” (2).

Ownership is defined as “partner countries exercise effective leadership over their development policies and strategies and coordinate development actions.” (3).

Alignment is defined as “donors base their overall support on partner countries' national development strategies, institutions and procedures.” (3)

Harmonisation is defined as “donors' actions are more harmonised, transparent and collectively effective.” (3)

Managing for results is defined as “Managing resources and improving decision making for results.” (3).

Mutual accountability is defined as “Donors and partners are accountable for development results.” (3).

Development Health Assistance is defined as “the sum of external financing for health from several different sources.” (4).

Acknowledgement:

In the name of Allah, the most gracious and merciful. I’m thankful for Allah, who provided me with strength, patience, and resilience to pursue this long journey.

I’m grateful to my family, who provided me with endless love and strength and believed in me even through their darkest moments.

To my beloved friends in Sudan, the Netherlands and everywhere else who have been the pillars of support, they are the family that I have willingly chosen. I’m thankful for everything they did.

I would like to acknowledge my academic and thesis advisors for their unwavering support and guidance throughout this journey.

To KIT team, facilitators and Nuffic Orange Knowledge Program who paved the way for this journey. My deepest gratitude and appreciation.

Dedication:

This thesis is dedicated to my late beloved father, ***Tayfour Osman Wagialla****, who supported every single step on this road. His unwavering belief in my abilities, constant encouragement, and limitless love have been the guiding light throughout this academic endeavour. I hope that one day, he will be proud of me.*

Finally, this thesis is also dedicated to my beloved country Sudan, and "to those who endured the sorrows of departure from their homeland, and for those who flames of longing ignited paths of return. For those whose souls were offered as a dowry for peace, and for those who carry their bodies marked by the scars of battles, may the homelands become homelands once again, and may the earth sprout dreams and wheat.".

Chapter 1: Background

1.1. Aid in fragile settings:

Fragile and conflict-affected settings (FCAS) share the characteristics of weak governance and administrative systems. Those settings are usually affected by long-term civil wars or armed conflicts (5). The health finance of the FCAS usually relies heavily on external aid from various donors, necessitating the need for effective coordination to allocate resources efficiently. Despite the global attention to aid effectiveness in those settings, aid coordination remains a crucial obstacle in many FCAS. Several mechanisms have been developed to ensure aid effectiveness and coordination in these settings, e.g., Rwanda, Zimbabwe, Liberia, and South Sudan. Studies about the effectiveness of these coordination mechanisms in using the country's systems to bridge the gap between the humanitarian situation and the country's development needs are limited and are still required to ensure sustainability (6).

1.2. Aid effectiveness principles

Aid is labelled as effective when it's delivered in "a way that maximises its impact on development and achieves value for aid money" (2). The global cooperation history to achieve development can be traced back to the early sixties. This concept continued to evolve until the concept of aid effectiveness became clearer in early 2000. There are four milestones in the history of aid effectiveness, marked by the high-level forums in Rome 2003, Paris 2005, Accra 2008, and Busan 2011 (7). Five principles of aid effectiveness were identified in the second high-level forum in Paris, including the country's ownership, alignment, harmonisation, results, and mutual accountability. Ownership is defined as the countries taking the lead in setting their development priorities and strategies, where alignment is aligning donors' support with those priorities. Harmonisation is defined as having all the donors' efforts harmonised and transparent. Moreover, managing for results is mobilising all the resources to achieve development results, and mutual accountability is having both the countries and donors accountable for those development results (3).

In 2011, the fourth high-level forum in Busan marked a turning point in the history of global cooperation; aid effectiveness evolved into effective development cooperation. The five principles were refined, and new actors were introduced as prominent players, including the South-South cooperation, civil society, and the private sector (8). The environment of these principles is dynamic, having peaked in 2008 with the start of the internalisation of the concepts but then faded due to the lack of political will and volatile atmosphere. However, they were revitalised in 2011 with the introduction of the Global Partnerships for Effective Development Cooperation to support the implementation of aid effectiveness (9).

1.3. Foreign Aid for health, the global context:

Health is one of the main areas of investment in the development area. Over the last decade, the Development Assistance for Health (DAH), which is defined as "the sum of external financing for health from several different sources", has almost doubled, globally reaching $ 62 billion in 2020 (Figure 1) (4)(10).

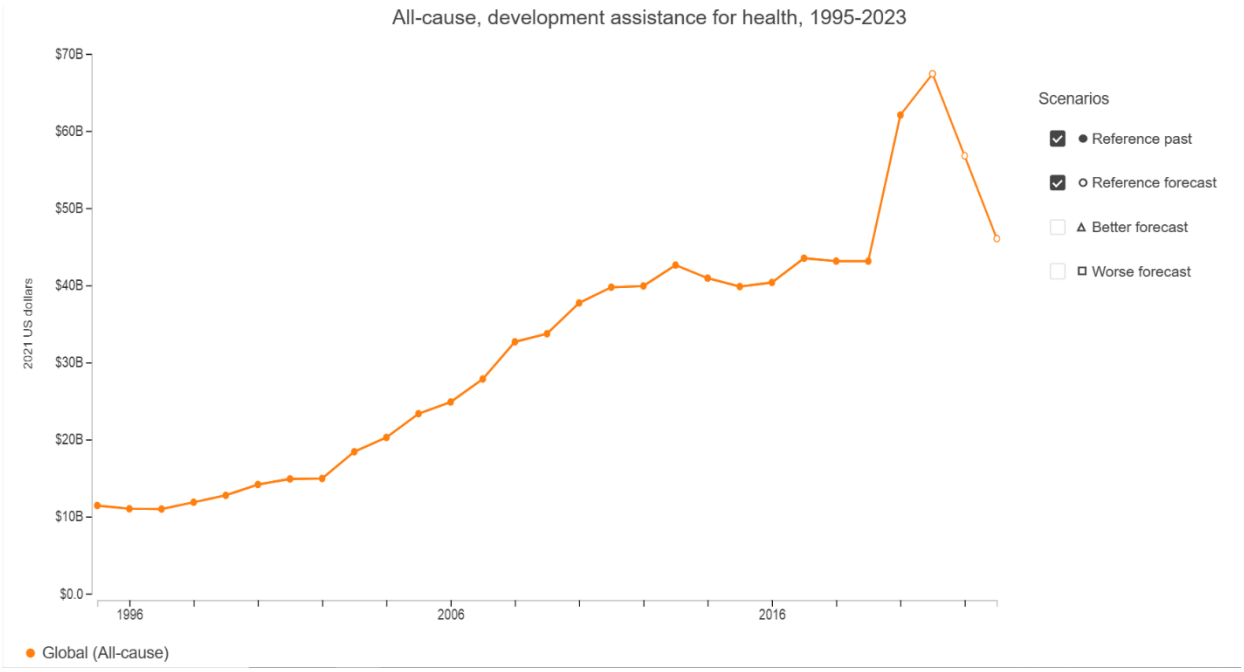

Figure 1: Development Assistance for Health (DHA) from 1995 to 2023 (10)

The health sector has received massive funds with the proliferation of stakeholders, civil society, and the private sector. This has added to the complexity of aid architecture in the health sector, resulting in duplication of efforts and fragmentation, necessitating global coordination (11). Among those stakeholders, the countries with the highest contributions are the United States of America and the United Kingdom, Germany, France, and China. Moreover, Bill and Melinda Gates Foundation, Global Alliance for Vaccination and Immunization (GAVI), and Global Fund, in addition to the World Bank (WB) and World Health Organization (WHO) (12). Due to its attraction to many donors and initiatives, its complexity, and it's changing dynamics, health has been selected among the trace indicators to monitor aid effectiveness. Moreover, experiences from the health sector can inform the inclusion of non-traditional partners[1] and the broader reforms in a country's systems (13).

In 2007, 26 partners from developing countries, in addition to multilateral, bilateral agencies, private sector, and global initiatives, signed what was called the International Health Partnership Plus (IHP+). At that time, the IHP+ aimed to assure aid effectiveness in the health sector and to support the achievement of the Millennium Development Goals (MDGs). This partnership continued to grow, reaching 66 partners from different backgrounds with the same motive to maximise their efforts to achieve sustainable development. In 2016, after the Sustainable Development Goals (SDGs) launch, the IHP+ was transformed into UHC 2030 to support achieving health-related SDGs (14). The IHP+ aims to enhance the harmonisation of the partners and their efforts to attain results by having a country-led compact outlining each party's commitments. The compact's goal is to support implementing one country's strategic plan, one results framework, and one budget, leading to better health outcomes (15). After its establishment, IHP+ has contributed to strengthening the country's ownership by having one strategic plan with clear priorities and enhancing the principles around mutual accountability. Furthermore, the development partners were keener to align their efforts with national plans (16).

[1] Donors who are not part of the Development Assistance Committee of the Organization for Economic Cooperation and Development

1.4. Sudan's context:

1.4.1. Geography and population:

Sudan is a North African country which shares its borders with six countries: Egypt, Eritrea, Ethiopia, Chad, Central African Republic, and South Sudan (Annexe for the map). The country has a distinct mix of ethnic, cultural, and religious backgrounds. Sudan has 18 states, with the capital in Khartoum state (17). In 2022, the country was inhibited by 46,874,204 individuals in those 18 states. According to the statistics, Khartoum is the densest state, with more than seven million inhabitants (17)(18). 36% of the population lives in urban areas, while the rest are distributed among the different rural areas (19).

1.4.2. Economic and political overview:

Sudan is considered a low-income country with 1,102.1$ GPD per capita, a 138.8 % inflation rate and an 18.7% unemployment rate, according to the latest statistics in 2022 (20). According to the multidimensional poverty index, 52.3% of the Sudanese are multidimensionally poor (21).

This economic situation is further underlined by political instability and a long history of civil wars. The country gained its independence from British colonial rule in 1956. Sudan's political history was marked by four military coups obstructing democracy (22). The 1989 military coup by which the Al-Bashir regime took over had several consequences, the Darfur conflict, the separation of South Sudan, and the United States sanctions. Those consequences have affected the international relationships of Sudan and its position in the global arena. In April 2019, a youth-led revolution managed to remove the dictatorship, paving the way for a transitional civilian government led by prime minister Dr. Abdallah Hamdok (23). On the 25th of October 2021, a military coup led by General Abdel Fattah Al-Burhan and General Mohamed Hamdan Dagalo (Hemedti) halted the civilian democratic transition that the country was undergoing (24). Moreover, the coup jeopardised the efforts of the transitional government to bring Sudan back to the international community. It ceased the international assistance that was aimed at supporting the country in different sectors and to revitalise the country's economy (25). On the morning of the 15th of April 2023, a violent war erupted between the Sudanese Army Forces (SAF) led by General Al- Burhan and the Rapid Support Forces (RSF) led by General Hemedti (26). The ongoing conflict overtook the Sudanese capital Khartoum as its battlefield; hundreds were killed, thousands fled, and the country's systems collapsed (27).

1.4.3. Foreign aid in Sudan:

Amid the political turmoil, Sudan continued to receive fluctuated development assistance from the international community over time; this assistance reached its peak in 2021 with 3.56 billion, according to the latest statistics (28). In 2021, 7% of the official development assistance (ODA) was allocated to health. Moreover, the International Development Agency (IDA), United Arab Emirates, the United States, and European Commission were among the top ten donors to Sudan (29).

1.4.4. Health status and health system:

The Sudanese population suffers from both communicable and non-communicable diseases creating a double burden of diseases. Among the top ten causes of death and disability in 2019 were cardiovascular diseases, neonatal disorders, lower respiratory tract infections, HIV, and road traffic accidents (30). COVID-19 also hit the already burdened health system leaving more than five thousand deaths and 63,993 confirmed cases until the 19th of July, 2023 (31).

The health system in Sudan is functioning through Federal, State, and local levels. Health is provided through primary, secondary, and tertiary levels (32). The Federal Ministry of Health (FMOH) is responsible for setting the national plans and priorities, whereas the States ministries are the ones who plan at the state level, manage the budget and allocate resources, and then the locality level takes the lead on implementation and delivering services to the population (33). In June 2022, during the 2nd health forum, FMOH endorsed its National Health Sector Reform and Recovery Strategic Plan (2022–2024) (NHSRR-SP) after an extensive consultation process that gathered the different partners in the health sector to ensure the country's ownership, alignment, and harmonisation between actors (34). The NHSRR-SP has set nine priorities for the health sector during the transitional period. It also reaffirmed the adoption of the "one plan, one budget, and one report" framework, in addition to the "health in all" policy that the FMOH adopted in its previous national plan in 2016 (35).

Regarding financing the health sector, the Latest National Health Accounts in 2018 revealed that the total health expenditure (THE) was 4.57% of the GDP. Furthermore, out-of-pocket expenditure (OOP) was estimated at 69.31% of the current health expenditure (CHE), while public funding constituted 24.06%, and the rest was from external donors' funds (36).

Chapter 2: Problem statement, justification, and objectives

2.1. Problem statement and justification:

Sudan's government has committed to achieving Universal Health Coverage (UHC) by 2030 as a part of its global commitment. Since its commitment, the FMOH has exerted efforts to reform the entire health system to ensure service availability, decrease financial hardship, and coordinate between different parties to utilise all possible efforts, paving the way for UHC. There is also an evident reform in governance as the government is improving its alignment and harmonisation with national and international partners by creating the National Health Sector Coordination Council (NHSCC) as an intersectoral coordination mechanism (37). Moreover, in terms of ensuring effective partnerships in the health sector, the government signed the IHP+ in 2011; this was followed by the endorsement of the local health compact in 2014, which aims to ensure the implementation of the aid effectiveness principles by the government and different development partners in the health sector. The national health strategy also highlighted the installation of Sudan's Health Sector Partners Forum (SHSPF) as a coordination mechanism between the stakeholders in the sector (35).

However, despite global commitments, statistics are not showing significant improvements in reaching global targets. The UHC service coverage index was 44 in 2021; more than 69% of CHE is OOP, 18.4% of the population is dealing with catastrophic health expenditure spending more than 10% of their salaries on OOP (36)(38). Furthermore, the joint financial management assessment in 2016 identified the weaknesses of the existing donor coordination mechanisms in the health sector at the time. It also highlighted the fragmentation and the overlap of coordination at different levels, as many entities are involved in the process, such as FMOH, the Humanitarian Aid Commission (HAC), Commission of Refugees (COR). Furthermore, there were parallel coordination mechanisms that existed, adding up to the complexity of the scene. Examples include the Health Cluster, which coordinated the humanitarian action led by WHO; also the Country Coordination Mechanism (CCM) of the Global Fund; and the GAVI coordination mechanism. This fragmentation often leads to the duplication of efforts and the wastage of valuable resources that could have been utilised to support the fragile health system. The health sector lacked the existence of a comprehensive coordination mechanism that gathers all the donors at one table. There was an attempt to formulate a council of donors in 2014 under the governance of FMOH, but there were no regular meetings of this council (39). In 2016, Sudan Health Sector Partners Forum was established to serve as a platform for all the actors in the health sector, including the donors, private sector, civil society organisations (CSOs) and related governmental entities (40).

Despite their limited contribution to health financing with 6.63%, donors are contributing significantly through funding immunisation, tuberculosis, and HIV programs and recently in supporting and strengthening the system (36)(39). Furthermore, after the Sudanese revolution, the international community had the appetite to support the transitional government and the health sector, and this was translated by a massive influx of partners and funds (41). Nonetheless, this area was hardly investigated or analysed, especially in the context of the changing political and economic dynamics that Sudan underwent. Studying the current coordination mechanisms that exist in the health sector, the partners and government's interest and commitments to adhere to the Effective Development Cooperation (EDC) principles and how the political turmoil has

affected those processes will shed light and provide scientific evidence that can better inform this crucial area.

2.2. Objectives:

2.2.1. General objective:

To explore the attitude and adherence of development partners to Sudan's Federal Ministry of Health coordination mechanisms in terms of aid effectiveness.

2.2.2. Specific objectives:

1. To describe the current health sector coordination mechanisms, focusing on the current mechanism (Sudan Health Sector Partners' Forum).
2. To identify the factors influencing adherence of the development partners and government to the aid effectiveness and coordination mechanisms.
3. To analyse the effect of political dynamics on aid effectiveness and coordination mechanisms.
4. To provide recommendations to the Ministry of Health to ensure coordination and aid effectiveness.

Chapter 3: Methodology

3.1. Study design and analytical framework:

This is a mixed methods study that aims to examine the dynamics around the aid effectiveness principles. More specifically, the study focuses on analysing the institutional arrangement of implementing those principles by examining Sudan's Partnership Compact for Health and SHSPF. The study used various data collection methods, including Key Informants' Interviews (KII), documents, and literature reviews. An adapted framework from Walt and Gilson (1994) was used to develop the topic guide and analyse the data of the study (Figure 2) (42). This framework captures the interaction between the evolving context of Sudan, the content and the processes that influence the actor's dynamics around aid effectiveness in Sudan and the coordination mechanisms. Although the framework posits that these dimensions actively interact to shape the environment around the aid effectiveness policies in Sudan, they are initially presented separately to organise the flow of information.

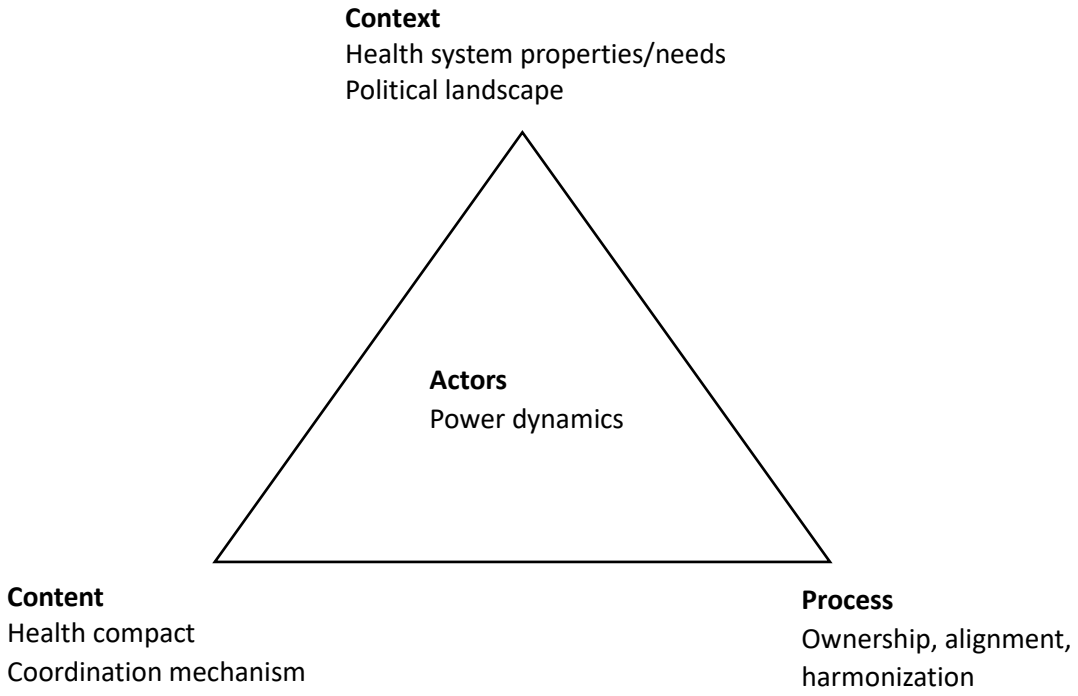

Figure 2: Adapted framework from Walt and Gilson (1994)

3.2. Operationalization of the analytical framework:

For the **content**, the study looked at Sudan's Partnership Compact for Health and the current coordination mechanism under the compact, which is SHSPF. The motivations and interests that drive both parties to participate in the coordination mechanism and the opportunities and challenges perceived around it were examined. Moreover, due to the complexity of examining the aid effectiveness principles of 'managing for results' and 'mutual accountability'. The **process** focused on the three interrelated aid effectiveness principles, 'ownership', 'alignment',

and 'harmonisation'. The definitions of principles, attitudes, and the existence of other parallel mechanisms to the forum were explored. Within the **context**, the study investigated the effect of evolving political sphere on the previously mentioned principles and the relationship between the partners and the government. The study focused mainly on the periods following the 2018 revolution, the civilian transitional government, and the 25th of October coup in 2021. The study also shed light on the current ongoing conflict in Sudan. Furthermore, for **actors**, the study probed the roles and responsibilities of the government and the different partners. We also identified the influential stakeholders in Sudan's health sector and their representation in the forum, and their attitude and influence on the forum.

The framework was employed to answer the study objectives as the content will describe the coordination process, the analysis of the actors and process will provide an overview of the factors influencing coordination, aid effectiveness, and lastly, the political dynamics will be captured under the context (Table 1):

Table 1: The link between the framework and objectives

Objectives	Framework	EDC principles
Objective 1	Content	Descriptive (compact and coordination mechanisms)
Objective 2	Process + actors	Ownership, Alignment, and harmonisation
Objective 3	Context	Managing results and accountability

3.3. Data collection

3.3.1. Key Informants' interviews:

Eight interviews were conducted during July 2023. The interviewees represented the different stakeholders in Sudan's health sector (government, United Nations agencies, development banks, donors, and bilateral agencies). The interviewees were selected through purposive sampling, and snowballing was also employed. The participants were selected according to their participation and involvement in SHSPF before/since 2018 and until the current conflict. A list of the participants is provided in (Table 2). The interviews focused on ownership, alignment, and harmonisation principles.

Table 2:list of the participated entities

Institutions	Number of interviewees	Code
Donors	1	Donor representative
Bilateral agencies	2	Bilateral agency representative
Multilateral agencies	1	Multilateral agency representative
UN agencies	2	UN agency representative
Government	2	Government representative, FMOH

The interviews were conducted through Microsoft Teams due to the critical situation in Sudan during the time of the study. Semi-structured interviews were led through a topic guide developed according to the analytical framework (Table 3). The interviews were conducted in English, recorded, and then transcribed after each participant obtained consent. The interview duration ranged from one hour to one hour and a half.

Table 3: themes, subthemes, and questions

Themes	Subthemes (topic)	Questions
Content	Coordination mechanisms	- Has your organization signed the health compact in 2014, if so, what are the current coordination mechanisms that you're participating in? - What motivates your entity to participate in such coordination mechanisms? - What are the challenges and opportunities you perceive in the current coordination mechanism (Sudan Health Sector Partners forum)?
Actors	Roles	- What are the roles and responsibilities of different stakeholders, including the government, and civil society organizations in promoting and maintaining the previously discussed EDC principles? - From your perceptive, who are the influential stakeholders involved in Sudan's health sector? Are there any who are not represented in Sudan's Health Sector Partners Forum? - How do the stakeholders use the forum? Do they exert influence (positive or negative) on the aid effectiveness principles outside of the Sudan Health Sector Partners forum?
Process	Ownership Alignment Harmonisation	- How would you define country ownership in the context of development cooperation? What does it entail for the Sudan health sector? - Are there any mechanisms that have empowered or enhanced the ownership of the Sudanese government and local stakeholders in the health sector? - How can development partners effectively support and facilitate country ownership without undermining the local context and priorities in the Sudan health sector? - How do the priorities of Sudan's health system are set? Are you one of the development partners participating in developing those priorities? And if so, at which stage? - How does your organisation align its priorities with Sudan's Ministry of Health priorities? Can you give an example? - What is the experience of your organisation in the use of country systems (e.g., procurement, public financial management, etc.)? Can you elaborate mentioning what motivates/ hinders the use of such systems? - Is there a channel of coordination between your organisation and other partners in the health sector at the national/ subnational level other than the health sector partners forum? If so, please describe it and why?
Context	Political sphere	Sudan has gone through different political turmoil since the revolution in 2018 and until the current ongoing conflict. - What is the position of your organisation/government on engaging directly with the Sudan government and its subsidiary institutions? Has this changed during the past five years? How/why? - What were the effects of those instabilities on the development cooperation

		in Sudan's health sector in terms of ownership, alignment, and harmonisation? - How do you perceive the effect of the political instability on the future of partnerships in Sudan's Health sector?

3.3.2. Documents and literature review:

To understand the process of aid effectiveness and coordination mechanisms, several documents were reviewed. These documents were collected through purposive sampling, either guided by my previous experience within the ministry or by the KII. A list of the documents reviewed is below:

Table 4: list of documents reviewed

Document name	Document version
Sudan's Partnership Compact for Health	2014
Sudan Joint Financial Management Assessment Report	2016
IHP+ monitoring rounds - Sudan country report	2016
The owner of the house has the responsibility to coordinate but must be in the position to do that: Sudan health sector development partners' attitude and adherence to the development effectiveness principles- Dissertation	2016
Sudan Health Sector Partners Forum Operational Manual	2017
Sudan Health Sector Partners Forum Operational Manual	2021
Sudan Health Sector Partners Forum reports	2021-2022
Sudan National Health Sector Strategic Plan	2022-2024
Effective partnerships paper	2022
Country Cooperation Strategy for WHO and Sudan	2022–2025

The literature included in this study consisted of peer-reviewed articles, dissertations, grey literature, WHO reports and publications, in addition to FMOH reports. Both published and unpublished materials were included, whether in English or Arabic language. The literature was searched from different sources, including Vrije University Library, PubMed, the Google search engine and Sudan's Health Observatory. The study focuses mainly on the studies published after the Paris Declaration of 2005. Keywords for searching the literature included, for example, "aid effectiveness", "cooperation", "development assistance", "ownership", "alignment", "harmonisation", "political instability", and "coup" (see Annexe for the complete table of search terms).

3.4. Data analysis:

Data was analysed using *NVivo* software. The interview guide was used to code the transcripts through deductive coding. Any emerging themes were added as they emerged during the coding process. After analysis, the data was summarised to identify the main findings of the study.

3.5. Ethics:

A waiver was obtained from the Research Ethics Committee (REC) (see Annexe). Informed consent was obtained from each participant, and their confidentiality was maintained.

Chapter 4: Results

This chapter discusses the combination of the findings from the documents review, literature, and key informants' interviews. It's organised according to Walt and Gilson's adapted framework that was explained in the methodology chapter under the operationalisation of the analytical framework.

4.1. Content:

The content examines the institutional arrangement and operationalisation of the aid effectiveness and coordination mechanisms in Sudan's health sector. This was done by examining Sudan's Partnerships Health Compact as the main guiding document and then the different coordination mechanisms exploring their functionality, opportunities and challenges perceived from the key Informants' perspectives.

4.1.1. Sudan's health compact:

As a step to institutionalise the concept of aid effectiveness and in the light of its commitments to the Paris Declaration in 2005 and the IHP+, the government of Sudan represented in FMOH, and the development partners signed Sudan's Partnerships Health Compact in 2014. The compact aims to ensure adherence to the aid effectiveness principles, and it defines the commitments of each party. The main objectives of the compact are to ensure the central role of the government and its leadership in any development endeavours in the health sector. It advocated for the alignment of the partners' efforts and contributions with Sudan's priorities and the National Health Sector Strategic Plan (NHSSP) (2016) at the time of signature. The compact also promoted the use of the country's local systems and emphasised mutual accountability between the parties. This document was signed by different actors in Sudan's health sector, including development banks such as the WB, Multilateral agencies such as the EU, bilateral agencies, international nongovernmental organisations (INGOs), and civil society organisations. It's worth noting that this is not a legally binding document but rather a mutual agreement between the parties. The compact also identified the National Medicines Supply Fund as the main national procurement agency. Furthermore, a set of indicators were established to ensure the implementation of the compact by the government and the partners. Although the compact was developed to support the NHSSP 2016, its lifetime was beyond the plan itself. It received further recommendations for updates and reviews in the following years (43).

During the interviews, all the partners with different affiliations emphasised their commitment to the health compact except for one bilateral development agency that didn't have any mutual agreement with the government of Sudan due to the no-contact policy that their country had with the Sudanese government since the early nineties. Moreover, the compact was considered as closely as to a legally binding commitment between the various parties despite the fact that it is not.

"Health Compact 2014, and I am carefully curating the words as close as possible to legally binding because then it's driven by the let's say the willingness to ensure mutual participation and mutual partnership between partners and the Ministry of Health."

- Government representative, FMOH

The WHO provided technical support for FMOH to develop the compact, assuming the neutral role of a mediator between the ministry and the partners to navigate the complex political relations the international community had with the ruling regime at the time. Nevertheless, the implementation of its commitments was always undermined by the rapidly changing political context of Sudan. In 2021 the Directorate General of International Health (DGIH) in FMOH revised the 2014 compact document to accommodate the changing contextual dynamics, but this was never officially endorsed by the ministry.

"The compact was a very strong initiative in terms of coordinating all development partners in Sudan, yet it's not effectively, let's say, conducted in a way that could boost the development wheel in Sudan and which also didn't help in terms of achieving the compacting objectives. But I believe this was directly linked to the political instability that the country faced since 2014, the economic problems, and inflation-related issues."

- UN agency representative

4.1.2. Coordination mechanisms in the health sector:

Throughout the years, several coordination mechanisms have been adopted by the FMOH to support the health sector. A list of several coordination mechanisms and authorities besides FMOH is collected from different resources, including documents review and interviews (Table 5).

Table 5: List of coordination mechanisms in Sudan's health sector

Coordination mechanism/ authority	Mandate	Timeline
Humanitarian Aid Commission	Coordinate Humanitarian interventions across all the sectors	1985- to date
Commission of Refugees	Coordinate Refugees related interventions, including migrant health	1967- to date
Global Fund Country Coordination Mechanism (CCM)	Coordinate and oversee grant implementation on behalf of their countries	2002- until now
Interagency Coordination Committee GAVI	Coordinate GAVI immunisation activities with the Expanded Immunization Program	2003 Merged with CCM in 2010 Merged with SHSPF in 2017
WHO Health Cluster	Coordinate humanitarian health interventions by gathering all the partners	2009 Merged with SHSPF in 2017
N-ITAG	Coordination and technical assistance for the Expanded Immunization Program	2009 Reactivated in 2018

National Health Sector Coordination Council	Intersectoral coordination	2011-2018 Reestablished in 2016 with the "Health in All" policy.
Sudan Health Sector Partners Forum	Replace the fragmented coordination mechanisms and serve as a single platform that gathers all the different stakeholders	2016- to date
Scale Up Nutrition	Coordination platform for nutrition-related activities	2018- to date

In 2014, the health compact made provisions for the creation of Health Steering Committees as the main coordination mechanisms between the government and partners on both the federal and state levels. These committees were, in turn, supported by technical sub-committees. However, the compact came short of providing an actionable framework for organising these mechanisms, their specific mandates, or functions (43). The NHSCC council was originally established in 2011 and revised in 2014, and when Sudan adopted the 'Health in All' policy in 2016, it reintroduced the NHSCC as an intersectoral coordination mechanism. Unlike the compact steering committees, there is a clear mandate and structure for the NHSCC. The council is chaired by the president of Sudan, and federal ministries and state governance are the members, in addition to other relevant governmental entities. FMOH is responsible for ensuring that the health sector policies and regulations are supported by the other sectors (44).

The joint financial management assessment in 2016 highlighted the degree of fragmentation in the donor coordination mechanisms in the health sector. The absence of a unifying platform for the partners and the government has led to inefficiency, waste of resources and duplication of efforts. At that time, the Ministry of International Cooperation (MOIC) was responsible for donor coordination. Additionally, HAC was also coordinating humanitarian activities across all sectors (39). It's important to note that MOIC was not a constant ministry in the cabinet's structure. In 2019, it was merged with the Ministry of Foreign Affairs in the last cabinet of Dr. Abdallah Hamdok.

4.1.3. Sudan Health Sector Partners Forum:

Several attempts were made to establish one coordination body. In 2017, the FMOH endorsed its unified partnership coordination mechanism. The SHSPF aimed to replace the fragmented coordination mechanisms and to serve as an inclusive platform for all the different stakeholders and coordination efforts. It has four functional committees:

1. Oversight Committee: its main function is to supervise the forum activities and the activities of the subcommittees.
2. Technical Assistance and Resource Mobilization Committee: the main goal of this committee is to facilitate the achievement of UHC 2030, and other health-related SDGs commitments made by Sudan. It aims to ensure the ministry's different departments have a technical assistance plan, for which then resources will be accordingly mobilised. Furthermore, the committee is responsible for advocating for a sustainable political commitment to support healthcare and the SDGs.

3. Development Programs Steering Committee: This committee serves as a gate for all the partners' development programs. The committee reviews partners' plans and reports in addition to monitoring and evaluating their activities. In the long term, partners such as GAVI, Global Fund, and UNFPA must initially run their reports by the committee before submitting them to their donors.
4. Emergency Humanitarian Cluster Committee: This committee is unique, as it's co-chaired by WHO. It holds the same terms of reference as the WHO health cluster, and it aims to harmonise all the humanitarian work in Sudan's health sector while emphasising the local ownership of Sudan.

The forum has 43 members representing different entities, including FMOH, HAC, multilateral and bilateral agencies, the UN, CSOs, Academia, and the private sector (45). The joint annual review in 2017 showed that the establishment of the forum had strengthened the coordination between the government and the development partners. It also indicated that the Ministry of Health is actively engaging other ministries to implement the "Health in All" policy (46). To accommodate the 2018 revolution's contextual changes and the massive influx of partners supporting the health system, the operational manual of the forum was revised in 2021. The most notable change in the revised version is the upgrade of the Oversight Committee to a higher position serving its main mandate. Furthermore, the Humanitarian Development Peace Nexus (HDPNx) Committee was added as a fifth committee, with the aim of implementing the Nexus approach in Sudan's health sector. HDPNx committee aims to bridge the gap between humanitarian and development actors by directing all the partners to operate towards a shared strategy through one multiyear framework. The structure of the forum is provided in Figure 3 (47). It was reported by the DGIH that despite the efforts and the clear structure of SHSPF, the committees of the forum remained either fully or partially dormant. The only fully functional committee was the Emergency Humanitarian Cluster Committee, which was operated by the WHO. The directorate also emphasised the importance of higher leadership support at FMOH to ensure the functionality of the forum is strongly emphasised (48).

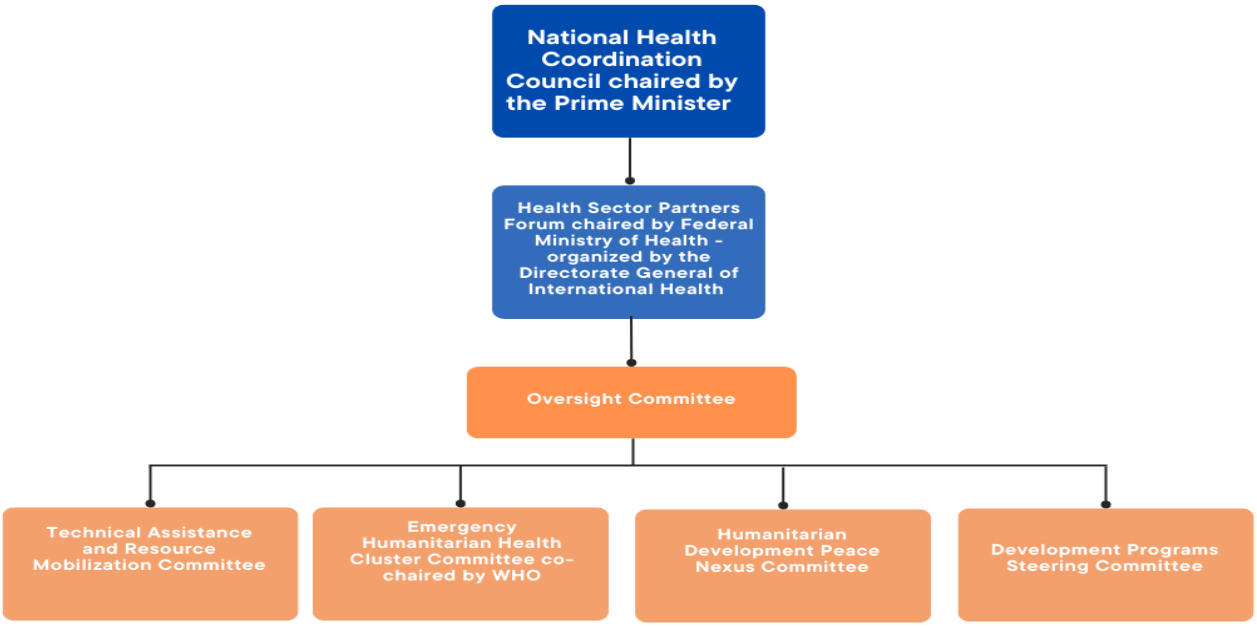

Figure (3): Sudan Health Sector Partners Forum Structure

Furthermore, there was a consensus among the key interviewees on the significance of the forum's role in implementing the partnership principles and achieving preferable outcomes.

"Health Sector Partners Forum, which is an operationalisation one, it's one operational arm of the health compact."

- Government representative, FMOH

"There are several coordination mechanisms; the idea, I mean from the beginning, is to unify and improve synergies between coordination structures which were counted, I mean, at the time when the compact developed, there were over 22 coordination mechanisms at the Ministry of Health and that one all resulted in inefficiency, so it was proposed after the Compact to establish the Health Partners Forum."

- UN agency representative

The wide participation in the health forum was underlined by different motives from different entities. The government approached the forum as a tool to ensure its ownership, where it can present the country's national strategy and priorities to the partners. Moreover, it utilises the platform to pave the way for the implementation of the "one plan, one budget, and one report" approach by encouraging collaborative work. On the other hand, donors perceive the forum as a tool to stay informed on the country's priorities, to align their efforts to those priorities and address the sector's needs. Some partners are motivated by their institutes and governments' obligations to support and strengthen the country's health system.

" That motivation is more of an obligation than a motivation, being our agency, a public and governmental institution, we have the obligation for the full alignment; one of the elements of the Paris Declaration is the full alignment and even to obey the concept or to strengthen the concept of the ownership, so to be part of such a kind of mechanism is a part of our duty in the way we provide support to department country of this kind in this case, Sudan."

- Bilateral development agency representative

"It is also some kind of monitoring element, so you will also be able to monitor together with those partners their projects and resource mobilisation platform as well through it if you have any kind of beside of the course of mobilisation of resources for your strategic objective."

- Government representative, FMOH

Key informants identified numerous opportunities in the SHSPF. The forum served to strengthen the sense of ownership and emphasise the central role of the FMOH, especially being a government-led platform. Moreover, at the time of forum reactivation, the ministry had the semi-finalized version of the National Health Strategy (2022–2024), which was later endorsed. This provided leverage for the ministry to clearly communicate its priorities with the partners and for the partners to have clear guidelines to align their efforts. The forum was a mutually driven platform, especially at the stage where Sudan's transitional government was re-engaging with the international community. The partners had the affinity and provided logistic and technical support to the forum secretariat. Another opportunity mentioned by both the government and some of the partners is that the forum added a layer of accountability where all the partners are obliged to report to the government and vice versa.

The forum also gathered many essential partners in the health sector with various affiliations, and this was considered an opportunity by some partners. However, this large number of partners was also perceived as a challenge by a bilateral partner who considered the forum to be *"too much large"* and criticised the presence of parties with minimum contribution in the health sector.

Additionally, other challenges were pointed out by the informants. The high turnover in leadership due to changing political context in Sudan resulted in unclear priorities, as every minister had a different vision of the national strategy. This led to a delay in the endorsement of the strategy and, thus, in having a clear vision for the sector's priority. The efforts of partners were therefore undermined as there were no formal guidelines to support the sector. The technical staff was also affected by the turnover but to a lesser degree, the root causes for their turnover varied between the lack of financial stability and the overall political dynamics. The turnover at this level has affected the sustainability of the forum itself. Moreover, the flexibility of the government in dealing with partners was questioned by one of the bilateral agencies, stating that *"the fact that always the ministry wants control over the funding given over for programs which are not feasible".* Among the partners, there was a perception of the detachment of the forum from the process of monitoring and evaluation and the lack of consistent annual reporting of the forum activities, which created a gap in communication between the different entities.

Furthermore, in adherence to what was found through the document review, informants confirmed that the only fully activated forum committee was the Emergency Humanitarian Cluster Committee. This was explained by the nature of the cluster itself as it was established even before SHSPF; unlike the forum, the cluster has a full-time, fully funded staff supported by the WHO.

On the aspect of coordination at the state level, the health compact stated that the federal mechanism, i.e., SHSPF, should be replicated at the state level. Nonetheless, this is yet to be fully realised, as reflected by key informants during the interviews that there was no clear structure for partnerships' coordination in some states, and this was considered a major obstacle.

" Some states, for instant, have a partnership office, and this partnership office is responsible for the engagement of partners within the ministry, and they do this coordination meetings and so on; others have this partnership office that could be a whole general directorate, others can have this partnership office at the level of emergency department only, some can have it at the level of PHC only, and when you have that, some can have it in the planning, and that's I think that's the best model, but when you have a partnership officer or office at the level of PHC or the level of emergency, that means you have limited the work of your partners to that directorate or to that level."

- Government representative, FMOH

4.2. Actors:

This section aims to provide an overview of the different stakeholders in the health sector, their respective roles and responsibilities, and the dynamics between these actors. This will be done by examining the mandates, roles, and responsibilities which were stated in different documents and will be further explained by the findings from the interviews.

4.2.1. Main stakeholders:

Sudan's health sector attracted a wide spectrum of partners, whether they were traditional or non-traditional partners. Traditional partners included development banks such African Development Bank (AfDB), EU, WB and different cooperation agencies. Moreover, the presence of non-traditional partners, e.g., China, the Kingdom of Saudi Arabia and Gulf countries, was increasing throughout the years. The extent of partners' engagement with the government was affected by the ruling regime, yet partners continued to support the system (39)(49).

4.2.2. Roles, responsibilities, and power dynamics:

The FMOH is the gatekeeper for any partner operating in the health sector, in addition to its main mandate in planning and setting national priorities (44). Within FMOH, the DGIH is the entry point for partners and is responsible for the coordination and oversight of their activities (34).

The informants agreed that most of the stakeholders in the sectors are influential actors in terms of their contribution to the development of the sector and the implementation of EDC principles. Nonetheless, when it came to the government side, it was mentioned that the momentum to implement those principles effectively and maintain high levels of coordination was related to the leaders themselves, not the institutes.

"What I can say is that here there is another level of sort of detachment between the institutions and the individuals, where the individuals are more than institutional, making the history of the coordination, so stakeholders are having a very motivated individual leading for the driven attitude, they were impacting more than the institution itself."

- Bilateral development agency representative

Moreover, the role of the DGIH as the main entry point was sometimes overlooked either by the partners or by other directorates of the ministry itself, despite the clearly defined roles and channels of communication.

The membership of SHSPF was inclusive to all health actors; it included donors, UN agencies, development cooperation agencies, INGOs, and multilateral and bilateral agencies. Moreover, the academia, CSOs and the private sector were also members (45)(47). However, the compact identified the role of CSOs as implementing partners without giving these organisations room in the decision-making process (43). A study conducted by H. Aweesha investigated the role of CSO in the health sector. The study reported the weak presence of CSOs on the planning table and even through the implementation of projects. It was mentioned that their presence was a kind of routine procedure, as it is a prerequisite for any INGO to have a counterpart local CSOs to implement their activities (50). The same was reported by FMOH, the role of the CSOs and the private sector was quite vague in supporting the health sector with no clear setup or regulations, despite their crucial existence (48).

There was a general agreement among the interviewees on the inclusion of most partners in the forum membership, yet their active participation was questioned. Among those who were missed despite their contributions is the academia, namely the Continuous Professional Development Department (CPD). Furthermore, there was a consensus between both the partners and the government on the neglect of CSOs and the private sector. Despite the crucial role of the private

sector in the functionality of health sector in Sudan, they were not engaged in the forum except during the time of COVID-19. The capacity of the CSOs was also criticised by some of the informants, and it was always an obstacle for them to actively engage with most of the local CSOs. The government was also aware of this gap and considered it as one of the areas for improvement.

"I think that each entity can voice their views and bring their contribution, that one needs to make sure that each entity is represented as much as we represented and also capacitated in a certain way, technically, but also has the room and the space to contribute when it's needed this is not necessarily the case."

- Donor representative

"CSO's role is a very important role, where their strength is that they have this direct one with the Community, and this itself is a gap when we talk about ministries and communities, and we come up here so as a kind of link between these two entities. But at the same time, you want to make sure that, as a government, you give CSOs the tools where they will be able to implement. That means you need to make sure that they have strong systems and that they are well trained on whatever response they are you are planning with."

- Government representative, FMOH

Another interesting finding is the intersecting roles of HAC and COR in the health sector. It was reported that both FMOH and the state's Ministry of Health (SMOH) faced obstacles in terms of overlapping mandates with relevant governmental entities, such as HAC and COR. In the context of technical responsibilities, it could lead to duplication, poor coordination and inharmony in partners' work. In 2022, there was an agreement on the roles of each entity; FMOH remained the entry point represented by DGIH. HAC and COR roles were mainly defined in constructing the technical agreements, whether at the federal or state level. Figure 4 summarises the agreed-upon standard procedures (51).

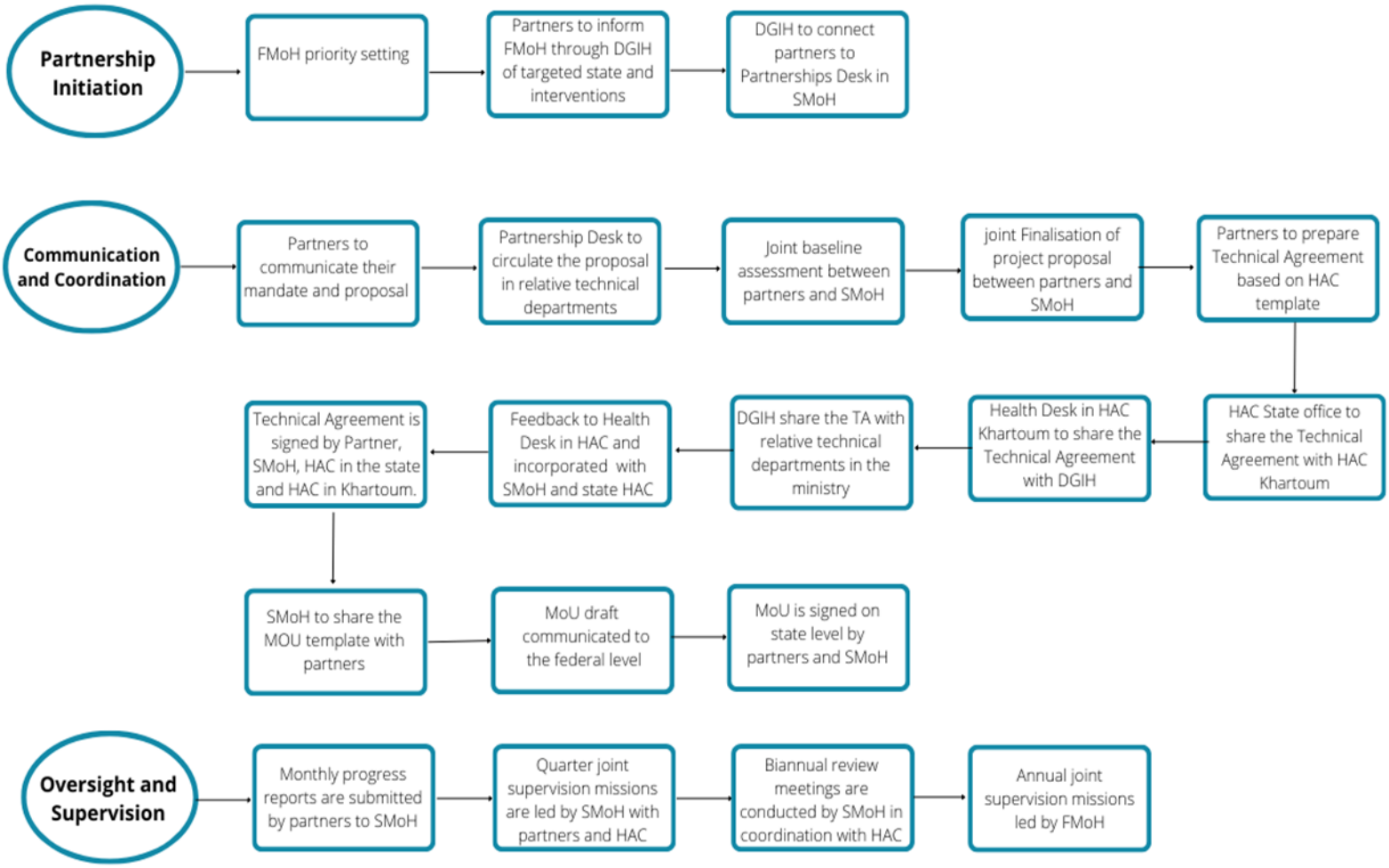

Figure 4: Standard Operational Procedures streamlining the roles of FMOH, SMOH, HAC, COR and partners (51)

4.3. Process:

This section of the results focuses on examining the aid effectiveness principles, with emphasis on ownership, alignment, and harmonisation. Each principle will be examined by summarising the commitments of each party around it from the compact, examining the EDC assessment round, the literature and then the informants' interviews.

4.3.1. Ownership:

For the government, ownership entails its leadership in the development and implementation of national health plans and strategies, setting clear priorities for the health sector with targets and identified budgets to operationalise these national plans. The ownership of the government also requires an equipped, skilled senior leadership, which will ensure the functionality of coordination mechanisms, in addition to the active inclusion and participation of all the partners. On the other hand, the development partners committed by signing the compact to respect the

leadership and ownership of the Sudanese government and support it by different means (43). The EDC assessment round in 2016 showed improvement in terms of strengthening the ownership by having one single national strategic plan, which the partners aligned their priorities with and supported. And the encouragement of some partners to use the country's national systems. Nevertheless, this round was attended by only six development partners (52). On the other hand, an in-depth qualitative study by Aweesha showed that despite the cruciality of ownership in Sudan's health sector, the government needs to exert more effort to coordinate the partnerships, as many concerns were raised regarding this issue (50).

All the informants agreed on the importance of country ownership and defined it as the government taking the lead on setting its own goals and priorities, followed by the partners' role in supporting this ownership. Despite this consensus, one of the bilateral development agencies' representatives highlighted that in the context of Sudan, there is always an excuse for the partners to implement their agendas and escape the government, whether in terms of readiness of the country systems, coordination, or capacity at federal or state level. According to informants from both the government and the partners' side, clear priorities and strong coordination mechanisms internally within the government and externally, in addition to solid accountability mechanisms, are prerequisites to ensure the country's ownership. This is in line with what had been reported by Aweesha in 2016 on the need to invest in the basics to achieve the maximum outcome on ownership and the rest of the effectiveness principles (50).

"it's about you having the ownership, you directing the resources, then comes the flexibility and the alignment that also you need to respect the donors' priorities, but these priorities, at the same time, should fulfil your certificates, so this is where alignments and harmonisation comes."

- Government representative, FMOH

"The ownership is to make sure that the government is not only in the driving seat but also has the capacity and capability and tools to be in the driving seats and so one of the main aspects of ownership."

- UN agency representative

The development partners stated that they are supporting the country's ownership as a part of their governments' and entities' commitment to strengthen the overall health system. Moreover, government and partner representatives mentioned that the EU was one of the main entities that supported FMOH in implementing the Paris Declaration principles. Starting with ownership despite Sudan not being a signatory country to the Cotonou agreement, which is an agreement between the EU and African, Pacific, and Caribbean countries receiving aid from the European Commission. The EU delegation in Sudan was engaging FMOH throughout its projects and providing technical support to the ministry. Yet this was influenced by the political dynamics of Sudan. Furthermore, according to the perception of a donor representative, the prolonged humanitarian action in Sudan contributed to making it harder for them to concentrate efforts on supporting the country's ownership.

There was also a general agreement that the existence of SHSPF as the main coordination mechanism and endorsement of NHSSP, though delayed, had positively affected the sense of ownership as there was one platform where the government was clear about its priorities.

Nonetheless, the continuous turnover, whether it was at a higher leadership or technical positions, in addition to the continuously changing political dynamics, were perceived as the main obstacles to any improvement where confidence and trust are always needed.

"At the governance level, changes occurred quite a number of times, this didn't eventually help to smoothly transition from one person to another, but they didn't lose the momentum."

- Donor representative

4.3.2. Alignment:

When it comes to alignment, the government's commitments are to organise joint annual planning and review meetings where partners are invited to participate in setting the priorities and reviewing the activities to enhance partnerships and have a common mutual understanding of Sudan's priorities. The government must also ensure implementation of its budget in line with priorities, strengthening the country's systems, increasing the budget allocated to health to reach the Abuja agreement 15% benchmark and conducting annual national health accounts review. Partners committed to; (i) participate in all the joint plans and reviews, support and align their priorities with NHSSP, (ii) ensure the predictability of their funds and their flow to address the identified gaps under partners' specific mandate, (iii) providing timely financial reports and to align their planning and other procedures with the government and (iv) investing in strengthening the country's national systems to ensure this alignment (43).

It was reported that despite Sudan having its well-structured national plan and strategies, there is still limited utilisation of the country's systems, for example, in terms of using the public financial management system (PFM). Donors mostly provide their support through off-budget channels which makes it difficult for the government to predict their contributions and integrate them into resource planning (39). Moreover, according to the latest EDC assessment round in 2016, only 3% of the development partners were using the country's procurement and PFM systems. This was related to the system's capacity and the bureaucratic procedures, in addition to a lack of communication and coordination between those systems (52). A qualitative study conducted in 2016 by Aweesha revealed that despite the existence of national health plans and priorities, the majority of partners tend to create their parallel plans (50). The practice of priority setting in Sudan isn't well documented, yet the NHSSP 2022-2024 has identified a set of clear priorities and engaged the partners in this process of priority setting to align their support (35).

The informants from the bilateral agencies' side reported two contradicting observations. One of the entities was engaged with the FMOH in terms of priority setting process and alignment of their priorities with the government ones. Contradicting this was the other agency that hadn't participated with the ministry at any stage, and they provide their support vertically to those who need it, as the agency still abides by the no-contact policy with the Sudanese government. On the other hand, both UN entities were among the main stakeholders that participated in drafting the country's priorities and national strategic plan; they even went a step further by providing technical support to FMOH in conducting baseline surveys prior to the priorities and strategic plan.

"The agency does not have any priorities. We are supporting a government's priorities, but we are doing this through supporting the government and partners to come up with these visions and policies and strategies that are based on evidence."

- UN agency representative

The donor representative mentioned that they didn't participate in the drafting of the national health strategy, but they were able to review it. According to them, they have their priorities according to their global agenda, but they are trying to simultaneously support the FMOH priorities and move from a vertical to a horizontal approach in conducting their projects and supporting the system.

On the use of country systems, there was a general agreement that it's one of the main pillars of the overall system strengthening, and one of the partners reported it as one of their main goals.

"Our intervention was strengthening the system, and when we were talking about strengthening the system. The health system and the pillars, and we were strengthening all the pillars, including the procurement."

- Bilateral development agency representative

However, the donor entity reported that they don't use any of the country's systems due to the political atmosphere of Sudan. Moreover, the UN agencies were mostly inclined to use the national systems and to invest in strengthening them, but there were occasions when their donors refused to utilise these systems.

Informants also mentioned that the weakness of the system and the long bureaucratic procedures between FMOH and the Ministry of Finance were among the obstacles to using the country's systems. The government informants further added the shortage in human resources, lack of regulations and limited use of technology to the obstacles that the FMOH needs to overcome to attract partners to use these systems. Nonetheless, the model of the project management units (PMUs) that GAVI and Global Fund implemented in collaboration with FMOH was a successful example of the use of the country's systems, as these entities were completely under the governance of FMOH, and they utilised the country's systems. GAVI had its financial auditing unit that was also functioning under the PMU and eventually invested in system strengthening.

"For example, like GAVI, the money is completely run internally, and then the reporting is done internally back to GAVI. Of course, there has been instruction of a compliance agent in recent years, but then again, I can say and attest to the fact that it's a government led."

- Government representative, FMOH

4.3.3. Harmonisation:

In terms of harmonisation, the ministry committed to activating the coordination mechanism in the health sector at different levels. The partners were also committed to participating in the government's coordination mechanisms and providing technical and logistic support to avoid fragmentation (43). The competition between the implementing partners to secure funds and the humanitarian situation in Sudan were considered obstacles impeding harmonisation (50). Furthermore, the DGIH stated that despite its clear mandate as the entry point to the sector, many

partners were overstepping and implementing directly with other relative directorates or even directly at the targeted states (48). As the forum is the main coordination mechanism for the health sector, the WHO health cluster was eventually added to the forum committees. However, the cluster is still functioning under the WHO and adding up to the fragmentation of the sector coordination. The cluster was formulated in 2009 to coordinate the humanitarian response in Sudan's Health Sector, and since that time, 62 partners with different affiliations have been actively engaged, including donors, INGOs, National NGOs and FMOH (49).

A government representative defined harmonisation as the highest and complete level of coordination, which necessitates the existence of a clear framework of coordination by which the entities will be able to jointly plan and monitor their activities. Moreover, the role of DGIH as the gate to the sector was occasionally ignored, as it was mentioned in 4.2.2. Another government representative considered this as one of the main challenges to harmonisation.

"Global Health Directorate[2], which is and by its normative function definition is the Directorate that is responsible for leading that agenda on behalf of the Ministry of Health. However, this was ever challenged by the later dialogues that were happening with different partners across different programs and directorates in the Ministry of Health. So, you could see that there was still practised parallelism in engaging partners with other directorates."

- Government representative, FMOH

The gap in coordination between the federal and state level was also considered a bottleneck from the perspective of the donor, bilateral agency, and government representatives; this was discussed formerly in 4.1.3.

The existence of parallel coordination platforms to SHSPF was reported among different entities. The WHO health cluster was identified as one of those mechanisms; when investigated, the donor representative justified their use of such a platform with the need to engage with all the other implementing entities to be able to monitor and track their funds and resources. It was also mentioned by a bilateral agency representative that the use of the cluster is more of operationalised coordination among the partners. There was also the question of the underlying reasons for having the health cluster, which is technically a part of SHSPF committees, but more active and popular than the forum itself. An informant explained:

" maybe just for clarification, the health cluster was there before the establishment of the forum, however, when the forum developed or established, and the Sudan endures the Humanitarian Development Nexus approach so the decision and the recommendation by WHO and the agreement from the government is to have it one of the four committees for the forum, but you are right, this is a correct observation, the first point that it's well established as one secretariat, full time staff, unfortunately the forum is struggling to have this full time secretariat and very high frequent turnover of the staff and the secretariat then the second reason maybe also the nature, I mean, this is a humanitarian platform and although the government is ideally basic, ideally the clusters should be called by WHO and Ministry of Health, but in most of the cases it's,

[2] Directorate General of Global Health is the former name of Directorate General of International Health

I mean, the presence of the Ministry and government in the cluster is not strong all the time it depends greatly on the people on their understanding of their roles"

- UN agency representative

In addition to the cluster, there were other relatively smaller coordination bodies mentioned by the informants. These were technical bodies concerned with nutrition, immunisation, and COVID-19. Through the information gathered during interviews, table 5 lists the different coordination mechanisms and authorities besides FMOH.

4.4. Context:

This section will provide an overview of the political changing atmosphere affecting the health sector coordination and aid effectiveness. Since this area is poorly documented, the section is mainly relying on emerging findings from the key informant interviews.

4.4.1. Effect of political instabilities on coordination and aid effectiveness:

The local health partnerships compact of Sudan was signed in 2014; this step was part of Sudan's global commitment and joining of the IHP+ in 2012 (39). In 2017, the establishment of SHSPF occurred to avoid fragmentation and create a unified platform for coordination; even though there was a council established with the signature of the compact, it was mostly inactive (39)(45). Another important step in the initialisation of aid effectiveness principles was the joint annual review (JAR) conducted in 2016-2017. The JAR was among the agreed commitments between the government and partners to achieve the managing for results and accountability principles (46).

During this period, Sudan was ruled by Al-Bashir regime, which continued to have power from 1989 until 2019. After the revolution and the establishment of a transitional civilian-led government, Sudan and its health sector received a high influx of international support, and then the operational manual of SHSPF was updated to accommodate the contextual changes (47). The coup on the 25th of October negatively affected the relationship of partners with FMOH. It was reported that the turnover that occurred at the highest level delayed the endorsement of the semi-finalized strategic plan at the time. The partners shifted their support to more humanitarian activities and chose to implement them directly through INGOs and CSOs instead of engaging with FMOH. Moreover, an approximate three million USD fund to the ministry was suspended (48). A. Osman et al. reported the same finding in their paper and concluded that there is an urgent need for civilian government formulation to gain the trust of the partners and sustain their support (41). The evolution of different coordination mechanisms, in addition to related political dynamics, is described in Figure 5.

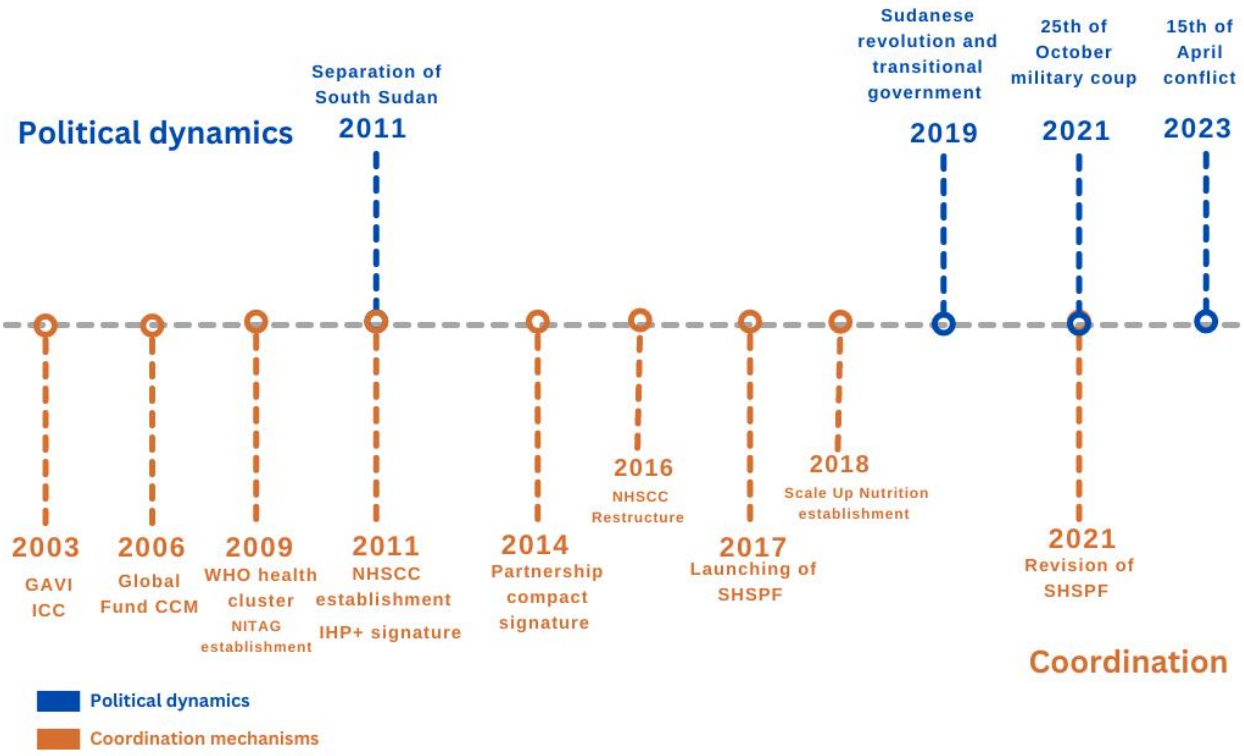

Figure 5: Evolution of coordination mechanisms with the political dynamics

Among the informants, there was a consensus that the political instability that Sudan has gone through since 2018 and until the recent ongoing conflict had negatively affected the health system in general and the partners' relationship in particular. The partners had to deal with the continuous turnover, which had negative consequences in terms of trusting the one behind the wheel and the disruption that followed in the planning processes. This was mentioned by most of the partners and government representatives.

"Ministry of Health and other partners had to accommodate and deal with that involved the constant change at political leadership as well as Minister of Health, senior management level, that has influenced the coordination with partners, I can say significantly, the institutional document keeping administer of health isn't well developed to endure with resilience such rapid changes."

- Government representative, FMOH

Moreover, consistent with what has been reported in the literature, the direct engagement with FMOH and the government of Sudan was in jeopardy. Most of the partners didn't deal with the government directly at the time of Al-Bashir due to their countries' no-contact policy. During the transitional period, the no-contact policy changed, and there was a general direction to support the transitional government through technical and logistical support. FMOH was central to this support. Then this was again disrupted with the coup in 2021, despite the FMOH efforts to advocate for maintaining the coordination momentum. The degree of engagement varied; according to the informants from the donor side, they maintained their communication at the technical level as they believed in the central role of FMOH. However, the bilateral agency had

completely ceased any interactions with FMOH. While the other continued, it was exclusively at the technical level. As for the UN and another multilateral agency, they continued their engagement with FMOH though it was distorted for a while.

"Till 2021, the dialogue was still good, and the expectations are that Sudan had a bright future there."

- Bilateral agency representative

"As you know, many donors disengaged from the federal ministry after the coup of 2021, so the impact of the health compact, because I recall it was a donor-driven activity whereby donors pledged that kind of collaboration with the ministries and with the government."

- Multilateral agency representative

According to the informants, this had affected the sense of the country's ownership; as partners were not properly engaged with the ministry, it also affected the alignment and harmonisation as the national strategy remained ad hoc for months until the new minister's cabinet reactivated the endorsement of the strategy. The forum meetings were conducted, but the participation of the partners was not always guaranteed. A government representative explained:

" Unfortunately, after the turnover of the military coup on the 25th of October in 2021, the situation was actually flipped upside down because we are faced with the situation where now these donors don't want to deal directly with the government … they had their own concerns that whatever money is going to be pulled in the government, this is going to be pulled to the army … so having this issue, imagine that you have partners working on projects, responding to health issues, but you're not able to meet them and to sit with them in one table."

- Government representative, FMOH

"It has actually a great impact on the implementation and realisation of these principles, if we talk, for instance, of the principle of alignment, so if you don't have priorities and great priorities, it would be very difficult to ask people on partners to align their support without having these priorities timely, without doubt, the risk of fragmentation."

- UN agency representative

The political turmoil continued until the outburst of the current conflict on the 15th of April, 2023, when most of the partners suspended their activity in Khartoum. Nonetheless, the UN agency representatives reported that the number of partners is increasing with the emergency and humanitarian state that the country is going through, yet the matter of coordination is a bottleneck. Especially considering the disruption the country is witnessing at all levels, including FMOH and its coordination mechanism SHSPF despite their central role, particularly during such a crisis.

"With the current situation, what's happening is that these are all life-saving interventions. I wouldn't say that there would be something that fulfils the strategic directions or strategic objectives; I'm aware that the ministry now they're trying its best to have good coordination with the partners on the field; they're really working so hard to have accurate reports every week on the situation in Sudan. But unfortunately, the response, as I said, is usually humanitarian is pure life-saving responses."

- Donor representative

As a concluding remark, the future of the partnerships with the current political situation was investigated from the perspectives of both the partners and the government. There is a general agreement that there might be room for restoring the coordination, yet this might take a considerably long time even if the war stopped immediately now, as one of the informants explained.

"I think the international community is very keen, once there is some level of authority to actually work with an authority, the international community is not keen to continue to have parallel systems, so once Sudan gives some sort of an internal settlement, its own situation, I think the international community will re-engage and will coordinate."

- Multilateral agency representative

An informant described the situation as follows:

"Like a grey sky where you would wish to see the sun coming out of the cloud."

- Donor representative

Chapter 5: Discussion:

This chapter discusses the findings on the aid effectiveness and coordination mechanisms in Sudan's health sector. Analysis of the factors affecting the aid effectiveness and coordination mechanisms is guided by the policy triangle framework to reflect the dynamics and interaction between the content, context, process, and different actors.

The signing of the IHP+ in 2011 and the local health partnerships compact in 2014 signalled Sudan's commitment to ensure aid effectiveness. Several mechanisms have been explored to coordinate humanitarian and development activities implemented by different actors across the country. Nevertheless, despite several attempts to have one functioning coordination body for the different partners in the health sector, coordination remains fragmented in Sudan. This analysis assessed the coordination mechanisms explored in Sudan and their effect over the years and showed that political instability influences aid coordination and effectiveness. The ownership of FMOH was strengthened by the existence of the SHSPF and the endorsement of the national health strategy 2022-2024. Moreover, the partners tended to align their priorities with the national priorities, yet there was limited utilisation of the country systems. However, the existence of parallel coordination mechanisms remained the main bottleneck challenging harmonisation.

The results of the EDC assessment rounds in 2012, 2014 and 2016 revealed that the signing of the IHP+ and the compact consequently was positively associated with the aid effectiveness in Sudan. The analysis showed that development partners are committed to supporting national health strategies and exerted efforts to align their operationalisation priorities with the national ones. Moreover, there was a consensus on supporting national systems strengthening, e.g., procurement and PFM system, but still, their utilisation was limited by the partners. This is consistent with the findings of a study conducted in 2012 to assess the impact of IHP+ signing in 10 developing countries, including Ethiopia, the Democratic Republic of Congo (DRC) and Nigeria, where it was reported that signing of IHP+ increased the alignment of the partners and their support to the national strategies (16).

Donors' coordination in Sudan's health sector was marked by fragmentation in coordination mechanisms. The coordination was technical in nature, where mechanisms acted as a shortcut for the partners to implement their projects with minimum involvement from the FMOH. The factors leading to fragmentation are the existence of a variety of donors with different interests, their global agenda, and the competing humanitarian and development needs of Sudan. The absence of a consolidated coordination mechanism led to a high degree of aid fragmentation which eventually resulted in duplication and waste of resources. SHSPF was perceived as a successful substitute for the fragmented mechanism, especially after the 2018 revolution, as the political atmosphere was attracting more partners to engage directly with the government without political restrictions. Comparatively, evidence shows that Ethiopia, which shares many similarities with Sudan, as both countries struggle with civil unrest and conflicts, and the high number of donors, on the contrary, had a more resilient and stronger coordination mechanism (Joint Consultation Forum). The mechanism managed to gather all the different partners and positively influenced the aid effectiveness in the health sector (53). The progress of the SHSPF was likely undermined by the military coup in 2021 and the recent war in 2023. The high turnover at the higher leadership and technical levels was the main hindrance to the sustainability of the forum. On the

partners' side, this reflected in a level of mistrust in the ministry, adding up to the general political atmosphere, which jeopardised the direct engagement with the government and resulted in minimising the forum's resilience and effects.

Unlike Sudan, the Ethiopian health sector wasn't much affected by the political dynamics and had less leadership turnover, with only three ministers leading the sector during the last decade. In Sudan, the same number of ministers headed the ministry during the last four years (53). Like Sudan, Burundi signed IHP+ in 2007; however, due to the weak capacity at the government level, donor coordination remained fragmented. The political fragility of the context directed donors' support to the short terms interventions, which further weakened the coordination (54).

The SHSPF membership consists of a variety of partners contributing to the health sector, including donors, INGOs, and multilateral and bilateral agencies. Nonetheless, a gap was evident in the limited participation of CSOs and the private sector. However, CSOs played a vital role in the health sector, especially in conflict-affected areas, as they were the implementing arm for the donors' projects, besides their basic functions in serving the community. The weak capacity of the CSOs and the competing priorities of the public and private sectors could be considered the root cause of their limited participation. An assessment conducted by the United States Agency for International Development (USAID) on the organisational capacity of CSOs revealed that Ethiopia and Sudan scored relatively low organisational capacity index (55). This might explain the limited participation of the CSOs in both contexts (53). Moreover, this limited participation is not unique to the FCAS or Low and Middle-Income Countries; it was also found that even globally, the participation of CSOs is still limited in terms of planning and policy setting, and their contribution was mainly in the implementation of the projects (56). The engagement of the private sector was found to be crucial in achieving better health outcomes and reaching UHC, especially in Africa, where the public sector cannot achieve this on its own (57). Rwanda, for example, managed to encourage the engagement of the private sector successfully due to the government investment in the PFM system (58). In Sudan, the private sector is a key element in the health sector, yet there is limited engagement of the private sector by the FMOH. Among the different actors, the role of WHO and the EU in supporting the implementation of the Paris Declaration principles in Sudan is apparent. This aligns with the findings about the main actors in donor coordination in fragile states where the EU and UN agencies, in addition to the WB, were the main entities involved in the coordination (59).

The ownership of the Sudanese government wasn't questionable according to the evidence gathered in this study, yet there were concerns that the capacity of the government needed investments to strengthen the principle of ownership. The observation, however, was that the entire process of coordination and adoption of the aid effectiveness principles in Sudan was more dependent on individuals than on institutions. Thus, installing the institutional agreements of the principles remains key to their sustainability. The SHSPF was a strong tool in strengthening the ownership of the Sudanese FMOH, considering that this tool was government-led with the engagement of development partners. Furthermore, the development partners themselves were keen to support the FMOH ownership despite the continuous political changes. Similarly, in Ethiopia, the health sector coordination mechanism was also a "homemade" country-led mechanism and was able to increase the ownership of the ministry in the health sector (53). Sudan's FMOH ownership allowed a level of flexibility in accommodating a wide range of donors; the opposite was reported in Rwanda, where the government exerted a strong level of

ownership with minimum flexibility. This was considered a paradox as some donors expressed their concerns about this limited flexibility (58).

Country's ownership isn't a stand-alone principle. It's directly intersecting with setting priorities and the alignment of partners with national priorities. This study examined alignment by assessing the aligned priorities of partners and their use of the country's systems. Sudan National Health Sector Strategic Plan provided a clear set of priorities developed by the government with the participation of the development partners at different stages of the strategy drafting. The study found that most of the partners align their priorities with those of the country, despite the variations between the different entities in these priorities. The global agenda of the partners also drive their priorities, but it wasn't found to be conflicting with their alignment with the national ones. However, in the contexts of South Sudan and Liberia, they were faced with the partners' influence on the priority-setting process to leverage their priorities or even operate parallel to the governments and thus jeopardising the country's ownership (60)(61).

On the use of the country's national systems, the study found that the limited use of these systems was an obstacle to the alignment process, despite how crucial it is for aid effectiveness. The weak capacity, long bureaucratic procedures, and cooperation concerns are perceived as driving factors for the partners to bypass the country's systems. The findings align with what had been reported in Sierra Leone and Malawi, where partners used parallel systems to overcome the weak capacity of the national ones. This led to aid fragmentation and poor coordination of the sector, which in turn further weakened the country's systems (62)(63).

Achieving of harmonisation principle in Sudan has been impaired by the fragmented coordination mechanisms. Despite the SHSPF forum being the main mechanism, many mechanisms were still functioning parallel to the forum (i.e., health cluster, CCM, Scale Up Nutrition and NITAG). Moreover, the absence of clarity in the mandates and roles of HAC, FMOH, and SMOH led to the overlap between the entities and further fed the fragmentation. In addition, factors including geographical variations of the country, protracted crisis and humanitarian needs contributed to the fragmentation and consequently resulted in poor harmonisation. On the contrary, Afghanistan's aid harmonisation was relatively strong, as the Ministry of Health ensured its central role in aid coordination and mobilised resources to strengthen the existing capacity to achieve harmonisation (64). Globally, the proliferation of partners, their self-interest, and concerns of accountability are recognised among the leading causes to aid fragmentation (65). The coordination at the state level is a weak part of coordination in Sudan due to the lack of clear mandates and the weak staff capacity. Similarly, in Kenya, coordination at the county level was also weak despite the existence of coordination mechanisms at the national level, leading to duplication of efforts and fragmentation (66).

The effect of the political dynamics inspired by the consistent leadership turnover led to a leadership vacuum, which resulted in delays in approving the country's strategic plan for more than three years. The transitional period was marked by the influx of international support and increased donors' appetite to participate and align their work with the transitional government's priorities. After the military coup in 2021, direct engagement with the government was suspended by many partners in addition to their funds. Moreover, the partner's participation in the SHSPF also deteriorated. The reluctance of the partners was explained by the lack of trust in the ministry. This has completely jeopardised the country's ownership, as well as alignment and

harmonisation. Similar situations were documented in Myanmar, Zimbabwe, Mali and Afghanistan after the Taliban takeover, confirming that political instability is the main threat to aid coordination and effectiveness (68-70). The recent ongoing war in Sudan leaves the efforts of coordination and aid effectiveness hanging, yet it's important to recognise the crucial role of FMOH in coordinating the donors' contributions. On the other hand, Rwanda, which also suffered from long political unrest, had managed to establish a successful donor coordination mechanism. The government of Rwanda had a strong political commitment to develop the social sectors, including health, and invested in strengthening the country's systems to ensure and govern donor coordination (71).

5.1. Relevance of Walt and Gilson policy triangle:

The use of the policy triangle framework assisted in analysing the coordination and aid effectiveness in Sudan's health sector. The area of coordination of aid, especially in complex contexts such as Sudan, is highly dynamic and affected by the interaction of the context with the dynamics between the different stakeholders. Thus, the use of the Walt and Gilson triangle helped to provide a simple analysis of the interaction between the changing political atmosphere of Sudan, the variety of actors and their interactions, the content of the coordination and its mechanisms, and then their implication on the aid effectiveness principles. Nonetheless, the framework was adapted to answer the key objectives of the study. The **content** focused on the coordination nature, the **context** of the political dynamics and the **process** of ownership, alignment, and harmonisation where the **actors** remained focused on the power dynamics.

5.2. Strengths and limitations of the study:

Using a multi-method approach to investigate this research's objectives is the main strength of this study. The data was collected from a variety of sources, including a range of unpublished documents, published reports and studies, in addition to triangulation with key informants' interviews. To my knowledge, this is the first study conducted to examine the coordination mechanisms and aid effectiveness in Sudan's health sector using this approach. Moreover, the study took into consideration the changing Sudanese political scene throughout the years and until the recent conflict. However, there are also limitations related to the selection bias of the informants due to the current critical situation in Sudan. There was limited representation of donors and multilateral agencies in addition to the development banks. Moreover, there was no representation of state authorities and HAC, which might have provided additional perspectives to the study findings. Furthermore, the accessibility to some documents was also hindered as the official website of FMOH has been inactive since the 15th of April, 2023. The positionality of the researcher affected the study positively, as my previous position in DGIH gave me a good familiarity with the coordination context and accessibility to documents and informants. Nonetheless, this might also result in an unintended bias.

Chapter 6: Conclusion and recommendations

6.1. Conclusion:

The study found that Sudan had made significant steps in terms of donor coordination and implementation of aid effectiveness principles. The signature of the Sudan's Partnerships Health Compact followed by the establishment of SHSPF were crucial steps to overcome the fragmentation in the coordination mechanism and thus improve resource mobilisation and aid effectiveness. Despite the forum being the main coordination mechanism yet parallel coordination bodies continued to exist.

SHSPF membership included various actors in the health sector. Nonetheless, the engagement of CSOs and the private sector remained an obstacle. The SHSPF managed to strengthen the country's ownership of its development agenda. Health sector partners participated in the identification of national health priorities through the national health strategic plan 2022-2024 at different stages. The partners exerted efforts in aligning their plans with the national priorities. The use of the country systems, e.g., procurement system and PFM system, is very limited. This was explained by the weak capacity of these systems, yet partners and governments are investing in strengthening those systems. Harmonisation in the health sector is jeopardised by the existence of parallel coordination mechanisms. Furthermore, within the government itself, there is unclarity in the roles of different actors like HAC and COR. Coordination at the state level is undermined by the capacity of staff and the absence of a fixed structure for partnerships and coordination at the state level.

The political instability affected aid coordination and effectiveness throughout the years. Sudan was taking steps toward reintegration into the international community after the revolution and civilian government in 2019. FMOH was engaging in high-level dialogues with different development partners, e.g., the EU and WB aiming to revitalise the health sector. However, the 2021 coup negatively affected the direct engagement of the partners, and the leadership vacuum affected the planning and the trust of the partners. Also, the war in 2023 resulted in uncertainty in future of the partnerships in the health sector. Thus, the aid effectiveness principles were negatively impacted, and FMOH has been trying to bridge the gap.

After analysing all the findings from the document review, literature and KII and reflecting on the experiences of similar settings, this study provides the following recommendations to the government of Sudan represented by the FMOH to ensure the aid coordination and effectiveness.

6.2. Recommendations:

- ***Reviewing and updating the local partnerships compact and SHSPF operational manual*** to ensure institutionalisation of coordination and aid effectiveness. The continuous turnover at the technical staff level, in addition to the higher leadership, is jeopardising the sustainability of the coordination. Thus, the review, update and articulation of the role of actors in guiding documents to accommodate the changing context will enhance the sustainability of coordination.
- ***Exploring private-public partnership (PPP) and CSOs engagement framework.*** The apparent role of those entities in supporting the health sector necessitates the establishment of a clear engagement framework to ensure their alignment and

harmonisation with those partners. The FMOH should start the process of establishing PPP and CSOs engagement framework with the involvement of relative directorates, e.g., DGIH and planning and policy directorate and the technical support of relevant counterparts, e.g., WHO.

- ***Revision of the roles and responsibilities of HAC and COR.*** To minimise the fragmentation and overlap of entities' mandates with FMOH, a set of clear roles and responsibilities should be endorsed and communicated at the highest level. This could be done by the establishment of a joint task force with members representing all the entities, including partners.
- ***Investment in strengthening the procurement and PFM systems.*** The gains from such investment are clear in similar settings. FMOH, in collaboration with the Ministry of Finance and partners, should invest in strengthening the system and provide incentives and exemptions for partners utilising the systems. This will decrease fragmentation and improve alignment and harmonisation.
- The main influencing factor on aid coordination and effectiveness is political instability. It's proven from similar contexts that general political stability is key to ensuring aid effectiveness. Despite its difficulty, FMOH ***should advocate for the independency of health from political unrest and prioritise health as a human right***. This can be ensured by continuous dialogues and the involvement of the technical staff, as they must be less influenced by any political affiliation.
- ***For further research.*** The area of aid and its coordination is poorly documented in Sudan's health sector. Further in-depth research is required to enrich the area with the engagement of more actors from the partners in addition to the state, HAC, and COR levels.

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Annexes:

Annexe 1: Map of Sudan (21)

Annexe 2: table of search

	AND		
OR	Alignment	Coordination Mechanisms	Sudan
	Ownership	Coordination	LMIC
	Harmonisation	Donors	FCAS
	Management for Results	Partners	Sub Saharan Africa
	Accountability	Procurement systems	
	Joint Annual Review	Public Financial Management	
		Local compact	
		IHP+	
		Cooperation	
		Development assistance	
		Coup	
		EDC assessment rounds	
		Joint annual review	

Annexe 3: Waiver letter

RESEARCH ETHICS COMMITTEE

Contact: Sandra Alba
s.alba@kit.nl

To: Azza Wagialla
a.wagialla@student.kit.nl

Amsterdam, 7-7-2023

Subject Decision Research Ethics Committee regarding S-223

Dear Azza Wagialla,

The Research Ethics Committee (REC) of the Royal Tropical Institute has reviewed your application for a waiver for your thesis research for the Master of Science in Public Health, thatwas originally submitted on 6 July 2023 (S-223). The objective of the study is to understand adherence of development partners to Sudan's Federal Ministry of Health coordination mechanisms and effective development cooperation principles.

Your proposal has been exempted from full ethical review based on the following considerations:

1) the participants will be involved in their professional capacity only; the issues tobe covered in the topic list cover information related to the duties of the respondents and information in the public domain; questions related to any personal questions are not included;
2) the participants will be asked informed consent before the data collection. This to make sure voluntary and informed participation is taking place and the participant can decide to decline or withdraw participation at any moment duringthe process without any effect on reputation, or other consequences;
3) participating in this study does not bear any physical, psychological and/or socio-economical risk or discomfort;
4) all information will be derived, processed, stored and published anonymously;
5) the research has important social, educational or scientific value.

This exemption means the REC has not conducted a full ethical review, which would include anassessment of the technical soundness of the research methodology. This waiver should thus not be interpreted as a full ethical clearance. Rather, based on the considerations above, the REC sees the risks for the participants as minimal in relation to the social, educational, or scientific value of the research.

The Committee requests you to inform the Committee if substantive changes to the protocol are made. Moreover, the Committee requests you to send the final report of the research containing a summary of the study's findings and conclusions to the Committee, for research managing and training purposes of the REC.

Wishing you all the best with your research,

Sandra Alba
Co-chair of the KIT REC