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HYGIENE
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MEDICINE

A POLICY ANALYSIS OF THE DEVELOPMENT OF NATIONAL CONDOM POLICIES AND MANAGEMENT OF MULTIPLE DEMANDS BY SUDAN NATIONAL AIDS CONTROL PROGRAM

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DECLARATION

The work presented in this thesis is my own.

Joann Sy

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ABSTRACT

This Dr.PH is a detailed policy analysis account based on fieldwork collected over an extended period during 2008-2009. It describes how a national government body, the Sudan National Program on HIV/AIDS (SNAP), developed its first HIV prevention policies, and in particular those around condom promotion. Very little was known about how these policies were developed and how SNAP managed contradictory forces in an environment where traditional and religious beliefs played a strong role in social life, dictating collective norms as well as having influence in politics and policy. Despite the thesis now being historical, the insights it offers on these processes is still of relevance today.

Data collection methods included documentary analysis, interviews (semi-structured and in-depth) and observation of actors at SNAP, as well as SNAP's counterparts in national and international organisations. Since the context was composed of these different influences, it continuously evolved and altered. As a result, interventions inevitably had to change and to be reinvented each time. Throughout the thesis, the account of SNAP policy actors occupying a "middle space" has highlighted the continual need to adapt and create new policy responses that are not introduced from "above" or "the outside" but rather genuinely engage with, and reflect, the concerns, beliefs and values of the people they are designed to help.

DOCTOR OF PUBLIC HEALTH (DRPH) SUMMARY STATEMENT

The DrPH programme has two foci: developing expertise to conduct and evaluate research to understand and adapt scientific knowledge for public health gains; and acquiring the analytical skills necessary to be a good leader in public health policy and practice.

The degree has three components:

- Eight months of a taught component that includes study units in research methods and public health policy and management

- A professional attachment that is carried out in a particular public health organisation and requires the production of a Professional Attachment Report

- A research project that leads to the production of a thesis.

Continuing from a philosophy background, the study units taken during the first year of the DrPH allowed me to acquire more knowledge in areas of public health, such as Research Designs and Analysis, Health Economics, Health Policy and Planning and Epidemiology. I also took a course in qualitative research methods where I learned to develop questionnaires and conduct qualitative data analysis. The courses in public health leadership and management and evidence-based public health policy reinforced my previous experience in the Middle East and North Africa but also provided me with the necessary skills and tools needed for the professional attachment. I carried out the professional attachment for seven months at the World Health Organization (WHO) Headquarters in Geneva, at the Department for HIV/AIDS with the aim to develop a better understanding of the functions, organisational structure, and public health strategy development in one of the leading public health institutions. It enabled me to broaden my perspectives on policy-making, leadership and organisational management; and to appreciate the challenges of real-world policy-making, including issues of how policy gets translated into practice. For example, I worked on issues of voluntary testing and counselling and assisted the development of strategies to encourage more people to learn their HIV status. I also gained many valuable insights into development of a number of novel initiatives, including the "3 by 5" initiative, where I experienced first-hand the successes and challenges of such an endeavour.

In my second/third year, I began the research component of the DrPH. The role of this component

is to understand how research can advance public health practice and how indispensable it is to the process of health policy formulation and implementation. During my research, I spent four years in Khartoum with the Sudan National AIDS Control Program (SNAP) where I worked with Sudanese nationals and their international counterparts, including consultation on the national HIV surveillance procedures, focussing on ethical issues; assisted on how to promote condom use in high risk groups; and revised a national monitoring and evaluation framework document. I also acquired valuable learning experience on how a national public health agency conducted their HIV prevention programme, which eventually advanced the data collection and enriched the content of the thesis.

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ACRONYMS AND ABREVIATIONS USED

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
AU	African Union
CPA	Comprehensive Peace Agreement
DHS	Demographic Health Surveys
FSW	Female sex worker(s)
GNU	Government National Unity
GPA	Global Programme on AIDS
HACC	HIV/AIDS Consulting Council
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
IDU	Injecting drug users
IMU	Information Management Unit
IPPF	International Planned Parenthood Federation
MoH	Ministry of Health
MENA	Middle East and North Africa
MSM	Men who have sex with men
NCP	National Congress Party
NGO	Non-governmental organisation
NIF	National Islamic Front
NP	National Policy
NSP	National Strategic Plan
OCHA	United Nations for the Coordination of Human Affairs

PHC	Primary Health Care
PMTCT	Prevention Mother-to-Child Transmission
SCC	Sudan Council of Churches
SLM/A	Sudan Liberation Movement/Army
SNAC	Sudan National AIDS Committee
SNAP	Sudan National AIDS Program
SPLM/A	Sudan Population Movement/Army
SRCS	Sudan Red Crescent Society
STD (s)	Sexually Transmitted Disease (s) (also known as STI(s) – sexually transmitted infection(s))
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMID	African Union/United Nations Hybrid Operation in Darfur
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund for HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

NOTE ON INTERVIEWS AND NATIONAL SUDANESE DOCUMENTS

Interviews were conducted with a number of individuals whose opinions and responses are discussed in the text of this thesis. Anonymity was preserved by appointing all interviewees a number, as well as indicating day/month/year of the interview (e.g. KI#3 17/05/2009). The methods chapter provides a summary of the methodology of the interviews. **APPENDIX C** an introductory sheet; **APPENDIX D** a consent form; **APPENDIX E** interview material (initial semi-structured topic and open-ended questionnaire, sample questions for in-depth interviews, additional questions for donors and international organisations, and list of agencies and organisations contacted for interviews); and finally **APPENDIX F** offering the characteristics of the key informants.

Some internal documents gathered from the research were incomplete in their reference information; for example, some documents did not provide a date of publication. In these instances, the date was calculated according to the context of the text. These estimated dates are specified by a question mark after the date (e.g. Sudan AIDS Control Program 1999?).

PREFACE

During 2008-9, when I was formally conducting the research for this thesis, Sudan was most commonly referred to as a conflict zone, topping the headlines with ongoing violence in Darfur, with its tense relations between the North and South and heightened Islamic political rule. At the time, I had already been working for public health related agencies for five years in the Horn of Africa and the Middle East, including working on issues related to HIV/AIDS. I had, however, reached a point in my professional life when I realised I was no longer learning. Much of my thinking underlying my work decisions relating to programme monitoring and evaluation seemed to be merely mechanical. Essentially, I wanted to understand more about "why I did the things I did', and I wanted to see if there were other ways to understand these concepts differently and more deeply. The DrPH at LSHTM was appealing because it was about cultivating expertise to conduct and evaluate research and develop the skills to make one a better leader in practice. So I enrolled on the degree, and I thought Sudan would be an ideal environment in which to conduct research, given its extremely interesting history and constantly developing public health and policy context.

Living and working in Khartoum was, I must say, quite a different experience from the common international representations of it. The city enjoyed a sense of stability and normality. There might have been hints or signs of conflicts (e.g. large numbers of displaced people now living in the capital), but working with, and more generally engaging with, Sudanese people as a foreigner at the time was a truly rewarding experience. I found my Sudanese interlocutors to be always very curious, and open to intellectual debate. People often asked me afterwards, "How was living in Sudan?" to which I usually replied with much optimism and happiness about the five years I spent there. After having worked and lived in Eritrea and Egypt, Sudan seemed to be more interesting and challenging, especially the work I was doing on issues of HIV/AIDS.

But having now distanced myself from my time in Sudan, I realise I actually have strongly opposing ideas and feelings about the country: love and hate, splendor and simplicity, modern and traditional, ordinary and extraordinary, normal and unconventional. For example, I remember during my first few months of work at WHO in Khartoum, I was going to my first meeting with some colleagues at the Ministry of Education. I walked in and after moments of being in the room, I felt extremely uncomfortable. I quickly understood that I had to cover my hair. As I did not have

a scarf, a female colleague from the Ministry of Education handed me one of hers that was tied around her dress. During the four years working in Sudan, I never again revealed my hair at a Ministry meeting. I found it strange that my colleagues had not warned me before going to this meeting. Perhaps since all my Ministry colleagues were male, and they did not have to cover their hair, they just never paid attention to these types of details. For the years to come, carrying a scarf for such "just in case" circumstances and wearing a hijab during Ministry meetings, became normal and acceptable to me.

Although I was forced to adjust to a certain kind of normalcy, upon retrospect I never felt normal at all. As I reflect more on this, my feelings of Sudan and its contradictions get stronger. On the one hand, I believe that as a foreigner coming into a community, it was up to me to respect the cultural mores of that particular community. But on the other hand, I am still uncomfortable with such things as the idea that I had to cover my hair (when I knew that as a foreign women, I was not under any obligation to wear a hijab). I often experienced these types of moments in Khartoum, when I was struggling with so-called "written" rules and those that were "unsaid".

Sudan, as it was then, now no longer exists. After visiting recently, the country's contradictions seemed to have diminished somewhat. Khartoum as a city no longer has the same sense of splendor or life, and somehow seems more homogeneous and uniform. The social backdrop to this dissertation, therefore, may now no longer exist, or at least have changed greatly. But I hope to show how the insights I gained about policy development in this context remain in sharp focus for me, and that what I learned from working in a health organisation juggling pressures from local, national and international forces, is still highly relevant today.

Joann Sy
November 2017

1. BACKGROUND

As part of a Dr.PH, this thesis presents a detailed policy analysis account based on fieldwork collected over an extended period during 2008-2009. It describes how a national government body, the Sudan National Program on HIV/AIDS (SNAP), developed its first HIV prevention policies, and in particular those around condom promotion. Despite the thesis now being historical, it is still of relevance today. During the early 1990s, most assessments of policy literature were focussed on content and design, ignoring specific processes, the local context and the influences of different actors in developing and implementing policies (Walt 1994). Some argued that this type of investigation would simply not help policy makers make decisions to improve the uptake of policy, and more importantly, could never explain why or how specific policies failed or succeeded (Parsons 1995). In response to this lack of focus, Gilson and Raphaely (2008) undertook a review of published literature between 1994-2007 and reported that most of the studies were on policy implementation, and there was significantly less debate about the actual processes of policy formulation or agenda setting. This study therefore addresses this lack, and consequently provides potential insights into similar issues in different settings and in relation to different policy topics (Gilson and Raphaely 2008). The thesis provides an account that focusses on what I describe as the "middle stages" of policy making: the space between where a policy is initially developed and its actual adoption. It describes how and why condom policies were developed the way they were, and how the local context at the time inevitably redefined and reshaped them through ongoing processes.

There was very little written on Sudan and HIV/AIDS at the time of the research. This thesis will address this gap in the literature. The thesis will first discuss the early years of SNAP and its relation to its national policy development, focussing on the country's first official condom policies within the broader international donor environment. At the time of the research, understanding this potential source of funding and support was new for Sudan, with major donors flooding the country with large sums of money. Although donor relationships with Sudan were relatively new, Sudan was already relying heavily on international funding for HIV prevention (Global Fund 2004, United Nations Development Program 2005, WHO 2007). The main donors for HIV/AIDS at this time were the World Health Organisation (WHO), United Nations Development Program (UNDP) and Global Fund (GF). What was particular about GF's relationship to Sudan was that, although in most countries it usually donated money directly to government, in Sudan it had imposed a

"safeguard measure". This required all funding to go through United Nations Development Programme (UNDP) (named as the "principal recipient" under the guidelines of the GF), to then be distributed by UNDP to the sub-recipients (SNAP and its main partners) (Global Fund 2004).[1] In other words, the allocation of funding was not through normal pathways (i.e. government administered funding) but through a foreign organisation (in this case, the UN). Placing UNDP in the role of main beneficiary ensured a level of transparency and fiduciary accountability. Understanding the role of these donors in relation to policy development forms an important backdrop to this research.

Data collection for this thesis was conducted at a specific and somewhat peculiar historical moment in modern Sudan. During 2004-2010, Sudan was still the largest African country with approximately 70% of its people reported to be Sunni Muslim, 20% Christian and 10% part of traditional tribal religions (Natsios 2012). The diversity of its people, culture and traditions was evident from the presence of more than 597 ethnic and sub-ethnic tribes (Natsios 2012); and, according to the Sudan Institute of Languages, the 132 languages and numerous dialects spoken in the country (Petterson 2003). Perhaps even more significantly, research took place in the context of a unified Sudan made up of northern (predominately Muslim) southern (predominantly Christian) regions. Although Sudan was still one country, by the end of my time there, the country was already separating to become what was soon to be Sudan and the Republic of South Sudan. With growing political tensions, what was striking was that these issues were never discussed, at least in Khartoum, where I was based professionally and conducted most of my fieldwork. There were rarely any references made to Darfur or South/North tensions, and indeed limited discussions on HIV/AIDS or HIV beyond the city and the north. One could go as far as to say that, if you did not read international papers, you might not know that anything was happening outside of Khartoum, despite the ongoing conflicts in Darfur, just beside Khartoum. Within the "bubble" of Khartoum, the only really important discussions were oil, funding and the city of Khartoum itself.

[1] The factors invoking the safeguard policy include significant concerns about governance; lack of a transparent process for identifying a broad range of implementing partners; major concerns about corruption; widespread lack of public accountability; recent ongoing conflict in the grant environment; poorly developed civil society/lack of civil society participation; and lack of proven track record in managing donor funds in the health sector Global Fund (2009). Additional Safeguards: the GF perspective.

A second significant contextual issue is that the research was conducted in a country where the relationship between the government and non-governmental organisations (NGOs) never very distinct in contrast to many other countries where NGOs remain mostly independent, and see their role as outside a government's remit. Moreover, the work of NGOs and government in Sudan at the time seemed to be always almost aligned. These blurred edges of purpose and function resulted in ambiguous ownership of policies: it was difficult to determine the level of national control and whether the work of NGOs was really their own, or merely following what the government directed. As the thesis will describe, this partnership between government and NGOs had major complications for how SNAP operated.

These issues made the time of the research unique and interesting, even if this is in an historical sense. There is no more Sudan, as it was then. It is important to note however that a great deal has nevertheless remained the same and still exists today. Modern Sudan, which was the northern region of old Sudan, is still under Islamic rule and the majority of the population are still Muslim with a minority of Coptic Christians. Moreover, Sudan is still committed to wanting to be seen by the world as an Arab, and not an African, nation.

The thesis is divided into six chapters. This **first chapter** will give background to the thesis by discussing HIV prevention in general at the time and the political and historical background of Sudan. **Chapter two** will present the foundations of the argument developed in the thesis: theories from policy analysis and the potential of qualitative methods to answer certain research questions. Based on the data gathered in this research, **Chapter three** discusses and analyses how the national condom policies were initially developed. **Chapter four** then examines how SNAP reacted or how they brokered with different groups of people to respond to different understandings of the policy and its underlying values. The chapter focusses on the demands of three groups; religious leaders; non-governmental and private organisations; and SNAP personnel, as well as their government partners. **Chapter five** goes on to analyse how SNAP also had to deal with more diffuse and dispersed forces, particularly those rooted in religious beliefs, which were infused throughout areas of Sudanese society. SNAP had to respond to negative perceptions of condom use as a way of promoting family planning, potentially changing the relationship between men and women, and as a way of encouraging sex outside marriage and ultimately promoting promiscuity. To conclude the thesis, **Chapter six** summarises the five

chapters, and then goes on to discuss the potential limitations of the theories initially introduced and areas for further research.

1.1 HIV PREVENTION

The standardization of HIV prevention interventions, grounded only in biomedical evidence was ubiquitous at the time of fieldwork. After 2006, all HIV prevention programmes funded under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (together worth a value of 30 billion USD) were required to follow specific guidance on ABC (Abstinence, Being faithful, and Condom use). The PEPFAR guidance stated that:

> Implementing partners must take great care not to give a conflicting message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that appear to encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices. Thus, marketing campaigns that target youth and encourage condom use as the primary intervention are not appropriate for youth, and the Emergency Plan will not fund them (U.S. Global AIDS Coordinator 2005).

Country teams were instructed to spend 66 per cent of their prevention funds for the interruption of sexual transmission on A and B activities. The remaining sexual transmission funds had to cover testing programmes, condom distribution, and other activities. Additionally, all programmes that discussed condom use had to include abstinence. But crucially, abstinence programmes were *not* required to discuss condoms. The lack of emphasis on "C", both in major international health programmes and in-country funding (pledging 30 billion USD in 2007) (Dietrich 2007) called into question how politically and culturally neutral HIV prevention programmes were given the directives from US funding sources (Jemmot and Fry 2002, Kirby 2002 October, Green 2003, Vasagar and Borger 2005 august 30). It was often equally unclear whether US written policies coincided with their actual implementation, and whether these programmes addressed the local drivers of sexual behaviour (Green 2003). In summary, PEPFAR represented a key founding initiative at the time of the research; it promoted a simple universal set of HIV/AIDS prevention interventions, mostly non-contextualised, which were picked up by other big donors and players in international health, and then supposed to be adopted by all countries receiving any funding.

The case of U.S. State funded PEPFAR and its focus on Abstinence and Being faithful serves as an example of the strength of control and influence donors had over programmes within individual countries, More relevant here, is the question of whether enforcing generic rules of HIV

prevention interventions was really a viable option when health risks and local contexts were so different from country to country, and even community to community. Understanding how politicised HIV prevention was, especially concerning donors and how they envisioned interventions fitting into countries, will be of key relevance to this thesis.

In contrast with these broad, universal approaches I now want to turn to the importance of local context. I will begin by explaining strategies for HIV prevention, focussing on condom use. Because HIV prevention policies are usually related to sexual behaviour, which is difficult to monitor and change, they must be appropriately contextualised for communities in which they are being carried out. Condom use, especially, has been long associated with HIV prevention, but this raises particular tensions with religious beliefs and values in Muslim communities.

Social scientists have often remarked on how the complexity of social life affects HIV prevention (Altman 1992, Kaler 2004, Epstein 2006, Kippax and Stephenson 2012). As Kippax and Stephenson point out, “any prevention strategy, which by necessity involves relationships between different entities (e.g. condoms and people, people and information), all require modifications to behaviour or practice but, more importantly, they all require the active engagement of peoples and communities: the social, cultural, and political dimensions of sexual activity are paramount” (ibid, pg. 782). This suggests that it is essential to incorporate the social, political and legal context into HIV prevention interventions in order to alter or address sexual behaviour (Dean and Fenton 2010).

According to UNAIDS, prevention efforts at the time of this research focussed both on reducing individual risk, as well as addressing structural factors (UNAIDS 2010). Nevertheless, sexual behaviour change was the principle strategy to address the epidemic, seeing the individual as being at risk and therefore responsible. But sexual practice is difficult to change health behaviour (Caldwell 1999, Global HIV Prevention Working Group 2008 August). Some therefore argued that HIV prevention would work best by engaging with the specific social and political lives and contexts of populations and communities (Kippax 2012). Moreover, many experts agreed that unless the local context, including political, cultural and social aspects were taken into account, HIV prevention would not be as effective as it could be (Gupta, Parkhurst et al. 2008, Piot, Bartos et al. 2008). The ability to advocate, initiate, develop and implement revised, localised and

culturally sensitive programmes was felt to be critical to such an approach (Tulchinsky and Varavikova 2000, De Cock, Mbori-Ngacha et al. 2002, Aral, Fenton et al. 2013).

Historically, condom promotion was the centre-point of such strategies (Shapiro and Kapiga 2002, Green 2003, Epstein 2007, Piot, Bartos et al. 2008). A joint statement from UNFPA, WHO and UNAIDS (2004) stated:

> Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. Prevention is the mainstay of the response to AIDS. Condoms are an integral and essential part of comprehensive prevention and care programmes, and their promotion must be accelerated.

Similarly, WHO noted that "condoms, when used correctly and consistently, are highly effective in preventing HIV and other sexually transmitted infections" (WHO). Condoms, however, are often politicised and contested, and can carry negative moral and religious associations (Epstein 28 April 2005, Green 2001, Green 2003, Sarkar 2008).

1.1.1 Condom promotion in religious communities

In this section, I will concentrate on condom use in religious communities, both Christian and Muslim, and some of the general problems that arose during the HIV/AIDS response that formed the context for this research. Although there were many examples of religious leaders in Africa supporting condom use, notably in Gambia (Colombant 16 April 2005), Malawi (Trinitapoli 2006), Kenya (Maulana, Krumeich et al. 2009) and Uganda (Kagimu, Marum et al. 1998), religion appeared to frequently oppose condom use (Goldscheider and Mosher 1991, Schenker and Rabenou 1993, Green 2001, Epstein 2007, Sarkar 2008). Literature often also cited conflict between condom use and more local beliefs and interpretation of religious doctrines (Schenker and Rabenou 1993, Pisani 1999, Gray 2004, Rankin, Lindgren et al. 2008). For example, Epstein (2005) while in Uganda, witnessed religious pastors burning condoms in front of their congregation. Epstein writes:

> One afternoon shortly after I arrived, a pastor from a nearby church marched up to the statue, set a match to the box of free condoms, and then prayed over the fire: 'I burn these condoms in the name of Jesus!' he boomed, and then promised each student a free Bible (28 April 2005).

Ideas of morality and religious faithfulness were often felt to contradict condom use (Smith 2003, Kaler 2004, Kanda, Jayasinghe et al. 2013). Other studies described an association made between

condom use as an infidelity (Pfeiffer 2004, Mantell, Correale et al. 2011). For instance, in one ethnographic study of university students from a Pentecostal church based in Kampala Uganda, where ideals of abstinence and fidelity were preached, one pastor stated:

> Sin is a big problem to God and Christians. The condomised culture is becoming normal but we stick to ABC - Abstinence, Be faithful, Christ! - as the answer. People say 'it's ok as long as you use condoms'. No! The condom culture is not the kingdom culture (pg. S196) (Mantell, Correale et al. 2011).

There are a number of other studies that have reported church leaders associating condoms with promiscuity (Kaler 2004, Pfeiffer 2004, Makahamadze and Sibanda 2008, Aguwa 2010, Olugbenga-Bello, Adekanle et al. 2010, Ucheaga and Hartwig 2010). Authors also noted how negative judgements were made about people who simply carried condoms (Kaler 2004, Ambaw, Mossie et al. 2010). For example, a cross-sectional survey examining 1,986 students from Jimma University in Ethiopia in May 2009, not only identified negative attitudes towards those carrying condoms, but that this condom related stigma was significantly higher among females ($p<0.00$) (Ambaw, Mossie et al. 2010).

Other studies describe how condom use was regarded to be useless (Kaler 2004, Olugbenga-Bello, Adekanle et al. 2010) or immoral (Gilbert 2008, Aguwa 2010). For instance, Pfeifer (2004) examined the Jeito condom social marketing programme in Chimoio Mozambique. The 616 person survey (participants belonging to churches described as Zionist, Apostolic, Pentecostal and Catholic) reported that all of the 18 church pastors interviewed in 1998 and 20 (out of 26) in 2000 used "harsh" terms when referring to the Jeito campaign. Respondents considered pro-condom messages as sinful, countering that people who adhered to church edicts had no need for condoms (Pfeiffer 2004). Campbell (2012) and others consequently argued that linking HIV/AIDS, condom use and immorality, undermined HIV prevention efforts by suggesting that only non-believers were at risk of contracting HIV, leaving church and mosque members less likely to feel at risk or to think they needed to use condoms. Studies also highlighted the stigma linked to condom use in HIV prevention (Singh 2001, Zellner 2003, Ansari and Gaestel 2010). For instance, Ansari and Gaestel conducted interviews with 87 religious leaders in the regions of Dakar, Kaolack and Ziguinchor in Senegal to investigate their perceptions of HIV/AIDS. They reported that nearly all Catholic and Protestant and more than half of Muslim leaders contested condom use and as a result either directly or indirectly stigmatised those who were in favour of condom use (2010).

At the time that this research was being carried out, literature that focussed specifically on Muslim communities was less common than studies looking at Christian communities. The small number of studies that did exist, however, clearly indicated that there were particular problems in carrying out HIV prevention, especially condom promotion interventions. Social stigma linking condoms to adultery and prostitution appeared to be a common theme (Kulczyski 2004, Abu-Raddad, Ayodeji Akala et al. 2010). For example, a study based in the rural area of Zachrani District, part of the South Lebanon governorate, gathered data from 25 focus groups. It found a strong association between Islamic values and the associations people made with condom use (Kulczyski 2004).

A number of other studies have shown similar tensions between religious beliefs and condom use in Muslim communities (Becker 2009, Abu-Raddad, Ayodeji Akala et al. 2010); particularly in Pakistan (Casterline, Sathar et al. 2001, Farid and Choudhry 2003), Senegal (Rosemary, Lagarde et al. 2000) and Indonesia (Kelley and Ebersadt 2005). For example, the study conducted in a rural area of Senegal - Niakhar - enlisted 866 participants to identify psychosocial determinants related to preventive attitudes, the influence of socio-demographic characteristics, and different sources of AIDS information on these determinants. The authors reported that the process of adopting preventative attitudes, including condom use, was most negatively associated among Muslim men (Rosemary, Lagarde et al. 2000).

In sum, at the time of my research, it was already known that there were problems with condom use and religious beliefs. Literature reported problems in both the Christian and Muslim communities in terms of the uptake of HIV preventive programmes, including clashes between religious values and condom use. However, two things are worth noting: first, it appeared that the local religious responses to condoms varied, and it was not clear if these were particular, general obstacles that could be addressed; and second, this emerging research had not yet influenced the major funders, and their drive for single solutions.

1.2 A BRIEF HISTORICAL AND POLITICAL OVERVIEW OF SUDAN

Given that it is important to understand the local context when dealing with HIV prevention strategies, this next section will offer some background of Sudan at the time, highlighting the historical and political situation and noting the North-South conflict and Darfur in more detail. As

I have already mentioned, despite the relative importance of the two conflicts in the country, there seemed to be limited reference to the tensions outside of Khartoum.

Administratively, at the time of this research, the country was divided into 25 states. There were 15 states in North Sudan (See **APPENDIX A** for a map of Sudan and its districts, before separation), each with a local administration. Sudan was made up of two very distinct regions: north and south. The north, which is known today was Sudan is predominantly "Arabized"[2] in culture, and mostly Muslim (Holt and Daly 2000, Salam Sidahmed and Sidamhed 2005, Natsios 2012). As Natsios (2012) stated: "Most Northern Nile River Arabs are not Arabs but instead Arabized Africans, mostly from the Nubian tribes of the Northern Nile River valley who adopted Arab culture and language" (pg. 11). Despite this unifying "Arabness", people in the north were not a homogeneous society and had considerable diversity (Mosley 1988). In fact, there was on-going fighting among some Arab tribes such as the Misiriyya and Rizaiqat. There were also non-indigenous communities that had political significance, mainly the small Coptic (Christian) community in Khartoum, primarily from Egypt; Muslim migrants from West Africa (Hale 1997); as well as approximately 1.2 - 1.5 million internally displaced persons (IDPs) living in greater Khartoum (population 8 million) (Landinfo 2008). By contrast, most of the inhabitants of the South of Sudan, which is now the Republic of South Sudan, were Christians (Deng 1995, Jok 2007), although there was also a great variety of ethnic groups and cultures (Holt and Daly 2000). For example, amongst one of the larger tribes of the south – the Dinka tribe - many of the sub-tribe spoken dialects were not understood by each other and there were many rivalries amongst the sub-tribes (Natsios 2012). Unlike the northerners, the people of the south were not generally Muslim but Christian, although they identified themselves culturally with Africanism (Holt and Daly 2000).

Khartoum was the official capital of Sudan. According to the 2009 census, 88.6% of its inhabitants were reported to adhere to Islam (Population Census Council April 2009). The numbers of Christians (11.2%) can be attributed to the massive influx of displaced and refugee groups from southern Sudan and the Naba area over the previous decade. At the time of the research, greater Khartoum was formally divided into three sub areas or "three towns": Khartoum (south bank of

[2] A number of authors (Mosely Lesch 1998; Holt and Daly 2000; Salam Sidahmed and Sidamhed 2005; Hasan 2005; Natsios 2012) use the term "Arabized" to denote a cultural "Arab influence".

the Blue Nile), Omdurman (across the White Nile to the west and north-west of Khartoum), and Khartoum North (opposite Khartoum on the north bank of the Blue Nile) (Cockett 2010). To most Sudanese people, Omdurman, with approximately 2.4 million people, was the 'real' capital, mainly because of its association with Mahdi. Mahdi or the 'guided one' was responsible for defeating and killing British General Gordon in 1885 (Cockett 2010, Natsios 2012).

Khartoum itself, with approximately 2 million people, was where the central government offices, the judiciary and the headquarters of most political parties (if permitted) were based. One could see much of this activity, especially foreign investment from the oil industry. This was especially obvious when one saw the newly built Burj Al-Fateh hotel, otherwise known as the 'egg', situated at the juncture of the White and Blue Nile, built by a Libyan government-owned holding company. As Cockett (2010) points out, most of what was built in the 2000s was paid for entirely by foreign investment, including the Malaysians, Chinese, Kuwaitis and Libyans. He states, "Sudan's story was still dominated by overseas money and power – the influences that have always shaped the country's destiny" (pg. 15). The rapid development of Khartoum, and the wealth that it attracted, had the effect of ensuring that not only was it the centre of the country, but that the country seemed like a "one-city state" (Crocket 2010).

Khartoum North, however, did not show the same splendour. Most people remember this area because of the Shifa pharmaceutical factory that was bombed by US missiles in 1998 (Collins 2008), which was thought to be a terrorist bomb-making site. A few years later, the United States recognised their error and made an official apology to the Sudanese government (Collins 2008). Like many of the buildings in Khartoum North, the ruins of the Shifa factory remained in stark contrast to its neighbour, Khartoum.

1.2.1 Sudanese conflicts

Sudan's complicated history and its cultural and social diversity hampered efforts to resolve 21 years of civil war. There had always been a divide between the people of Sudan, with their Arab traditions, and the people of The Republic of South Sudan, with their African ones (Salam Sidahmed and Sidamhed 2005, Jok 2007). In Sudan, race and culture have even affected the meaning and use of everyday Arabic words. As Natsios (2012) points out, Southerners refer to northern Arabs as *Jallaba*, which means 'Arab trader' but colloquially carries an implication of

"conniving" or "untrustworthy" behaviour. In northern Sudan, *a'bid*, the word for low-caste black slaves in Arabic, is used to describe southerners (Natsios 2012). Many forms of oppression, including enslavement, have contributed to feelings of mistrust between the north and south (Petterson 2003). As Natsios (2012) states: "the political history of Sudan, is a story of rebellions, insurrections and civil wars, layered on top of each other," (pg. 12) which have destabilised the country since its independence in 1956 (Jok 2007).

Since then, three tribes from the Nile valley –the Ja'aliyiin, the Shaiquiyya and the Danagla (which collectively make up 5.4% of the population of historic Sudan) - have dominated the country (Cockett 2010, Natsios 2012). According to Natsios (2012), "the Three Tribes solution to centrifugal forces bearing on Sudan has been a campaign of forced Islamisation and Arabisation in the South and Arabisation of the non-Arab Muslim people in the North" (pg. 12). According to experts of the region, two main conflicts had created obstacles for peace: the North-South conflicts and the Darfur conflict (Cockett 2010, Natsios 2012). Each will be described briefly below.

According to the former UN Special Adviser for the Prevention of Genocide and diplomat, Dr Francis Deng, much of the historical process separating the Arab Muslim North and African South has its roots in the Arabisation and Islamisation of the north and in the resistance to those forces in the south (Deng 1995). At the time of independence in 1956, there were rumours that Arab soldiers would be replacing the British and Egyptian officers in Sudan. Even before 1956, a mutiny of southern soldiers in the Equatorial Corps at Torit wanted to fight against the northern Islamic rule. The Torit mutiny escalated into a southern-wide rebellion and started the first North-South civil war which lasted seventeen years (Johnson 2003). Jok (2007) writes that the north continued to try to Arabise the south by dismissing Christian missionary societies, changing schools to Islamic schools and making it compulsory for non-Arabic speaking children to learn Arabic. Attempts were made to outlaw the expression of religious and cultural differences and generally to put pressure on the south to conform to Islamic standards. According to Jok (2007), there seemed to be a perception in the northern political discourse on the conflict, that there was a "southern problem", which was not just delaying development but also "tearing at the fabric of the nation's unity" (pg. 61).

Change arrived in 1969 when Nimeiri came into power and ruled Sudan through an uncompromising military junta called the Revolutionary Council.[3] However, contentious issues remained, including demarcation of the border between Sudan and the Republic of South Sudan, international arbitration of the status of the oil-rich district of Abyei, and clashes over oil and its revenues.[4] During the research, some areas of the former South Sudan were still overrun by armed militias and the crisis in Darfur has continued to accelerate (UNMIS 2007, Economist 2012). More alarmingly, fighting between Sudan and the Republic of South Sudan has weakened the seemingly fragile peace process. On 10 April 2012, South Sudanese troops advanced into Sudan to acquire its most valuable oil field, in the biggest clash since the south succeeded from the north in July 2011 (Economist 2012).

1.2.2 Darfur

At the time of the research, while Darfur was not directly related to the developments in the south, longstanding tensions had an influence on feelings in the southern region in the months up to the national elections and the referendum (de Waal 2012, Natsios 2012). In 2003, rebels took up arms in Darfur over scant resources in the western region. They accused the government

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[3] In 1972, a peace agreement was signed in Addis Ababa to end the war between the Government and the first southern based rebel movement, called *Anya Nya*. However, the agreement was disregarded and never implemented. Ten years later, Colonel John Garang created the Sudan Popular Liberation Movement/Army (SPLM/A), fighting the central government and striving for a reformed unified Sudan (Mosley Lesch 1998; Woodward 1998)

Meanwhile in Khartoum, in June 1989, General Omar Hassan Ahmed al-Bashir successfully overthrew elected Prime Minister Sadiq (Petterson, D 2003). Before Bashir seized power, the National Congress Party (NCP) was formed (which is an upshot of the Muslim Brotherhood founded by Hassan al-Turabi. Economic growth in southern Sudan was severely weakened and because a large part of the North's resources was focused on the war effort, famine spread throughout the country (Martin 2002; Jok 2007). Since then, North-South relations have been increasingly strained and hostilities have continued (Petterson, D 2003). According to most experts of the region, Sudan, therefore, already functioned as two separate nation-states deep in conflict, maintaining separate legislative bodies, armed forces, cultural identities and economies (Hale 1997)

In January 2005, however, the NCP and SPLM/A signed a peace deal which theoretically ended the longest civil war in Africa. During the key period of this research, 2008-2009, the peace agreement recommended two separate consultation processes. First, a national election to choose an Executive President, National Assembly and the Assembly in the former South Sudan. Sudan's incumbent president, Omar Hassan al-Bashir, won with over 68% of the vote, several of his opponents dropping out of the race shortly before voting day (The second recommendation concerned sovereignty - a "self-determination referendum" held in southern Sudan to determine whether southern Sudanese people would choose between unity or separation from the North. The southern Sudanese voted by a large majority for separation. On 9 July 2011, South Sudan became independent and formed the 54th state in the African continent.

[4] The Comprehensive Peace Agreement established mechanisms to resolve the border issue, but those mechanisms have proved difficult to implement, especially in the crucial oil-rich area of Abyei. (The border commission's report was rejected by the President and his National Congress Party advisors.) One international expert appointed to the border commission has argued that Abyei and the oil fields issue could be the breaking point of the entire Comprehensive Peace Agreement (Douglas H. Johnson 2008). This possibility was underscored by the events of May 2008, when armed clashes took place between national government forces and those of the Government of South Sudan (GoSS) in Abyei town itself.

based in the north of arming Arab militias, known as *Janjaweed*, in order to "ethnically cleanse the area" (Dagne and Everett 2004). These accusations, however, were denied by the National Congress Party (NCP) (Human Rights Watch 2007, United Nations Office for the Coordination of Humanitarian Affairs (OCHA) 2007). At the time of the data collection, there was nevertheless increasing tensions between Arab-Arab factions, which added more complexity to the crisis (Kellenberger 2007). According to Natsios (2013), tribes in Darfur identified themselves as either Arab or Africans, even though "everyone professed themselves to be Muslim" (pg. 121).

In May 2006, after two years of negotiations, the Government of National Unity (GNU) and the Sudan Liberation Movement/Army (SLM/A) signed the Darfur Peace Agreement (Dagne 2011). Soon after, in an effort to stop the conflict, the UN Security Council authorised the deployment of a robust peacekeeping force to Darfur consisting of a joint peacekeeping operation of 26,000 personnel (Ban Ki-moon 2007). At the time of the research, the situation in Darfur was the world`s largest humanitarian project, with more than 1 million people living in camps since the autumn of 2008 (United Nations Humanitarian Affairs Office 2013).

Here, my focus has been to describe the local context of Sudan and its socio-political background emphasising the historical and complex difficulties within the country, including its the turbulent South-North relations and the Darfur conflict. The overall purpose of providing this historical summary is to demonstrate that since it has achieved its independence in 1956, Sudan had been mostly engulfed in civil conflict, not only between Sudan and South Sudan but also within various factions and tribes within the regions. Although during the data collection, the conflicts drew much international attention, within the country, these tensions were rarely addressed explicitly. In fact, during the fieldwork, the issues of Darfur and North-South conflicts were never mentioned by any of the participants based in Khartoum. This observation is key to my research; those working on HIV prevention, based in Khartoum somehow managed to 'bracket off' the on-going political tensions and conflicts that shaped the lives of people beyond the capital. By doing so, the introduction of a public health initiative was divorced from the many other political dimensions that constituted the general context of Sudan.

1.3 Political Islam and Sudan

Although the above account related tensions within Sudan in terms of ethnic politics, a further dimension is of course the role of religion. The relationship between Islam and the state has been a source of intensive debate in relation to the constitution of Sudan (Salam Sidahmed and Sidamhed 2005, Cockett 2010). Beginning in the 1950s, there was a push for Islamisation throughout the country by the government. In September 1983, the Sudanese President Ja'afar Muhammad Nimeri issued a presidential decree to implement *shari'a* (Islamic law) (Cockett 2010, Natsios 2012). A new penal law code, which included some of the Islamic criminal penalties known as *hudud,* such as flogging, amputation for theft and execution for apostasy, was established in Sudan (Hale 1977, Holt and Daly 2000). Nimeri ruled until he was overthrown in 1985 by a popular uprising that led to elections won by Sadiq al-Mahdi. By this time, Islamisation was well integrated into the politics of the state and society.

In June 1989, General Omar Hassan Ahmed al-Bashir, with his Islamic mentor Dr Hasan al-Turabi, led an *inqaz* or "salvation revolution" and successfully overthrew Prime Minister Sadiq al-Mahdi to overturn any shift away from religious law (Hale 1977, Holt and Daly 2000, Petterson 2003). All unions and political parties were banned and their property confiscated; moreover, all newspapers except *al-Guwat al-Musalaha* (The Armed Forces) were closed down and radio and television were placed under government supervision (Collins 2008). The Bashir regime launched a massive campaign to assure the Sudanese that *shari'a* would remain the law of the land and that they would be committed to "orthodox Islam, Islamic law, and Islamic dress" (pg. 187). In fact, there was an unprecedented effort to crush any dissent. The infamous "Ghost Houses" (*bayt al-ashbah)* were created as detention centers (as a special branch of the Minster of Interior), where people were interrogated and tortured (e.g. electric shock, use of drugs and mock executions).

Since this time, *shari'a* has been strictly enforced and mechanisms put in motion for developing an Islamic state. As Dr Francis Deng (1995) stated for the northern Sudanese:

> Islam became identified with the local community and rapidly ceased to be regarded as alien. Today, a glance at northern Sudan shows that Islam has so filled the lives of its inhabitants and acquired such tenacious hold that it renders them impervious to other religious influences (pg. 45).

According to Holt and Daly (2000), measures to implement Islamisation included attempts to indoctrinate the public via state sponsored media, education and cultural institutions. For example, there was reformation of education curricula at all levels, and the teaching of Islamic principles through numerous religious programmes on television and radio. There was also a rise in the creation of mosques and increased importance placed on congregational prayer, especially in the workplace and other public places (Salam Sidahmed and Sidamhed 2005).

During the period of my fieldwork, therefore, Sudan was unquestionably under Islamic rule. Despite the existence of other religions, particularly in the south, Islam and politics were conceived to be one and the same by those in power. The chapter began by introducing PEPFAR's focus on abstinence and being faithful programmes internationally, significantly limiting any focus or funding on condom use promotion. This was an example of how donors and powerful players applied certain values and expectations HIV promotion programmes without much thought of the local context of recipient countries. I went on to give some background to HIV prevention interventions and the emergence of condom use as a primary method. Although by then literature highlighted that there were problems carrying out condom use interventions, especially in religious communities, this had little influence on the drive for singular solutions to the rising epidemic. The political and social history of Sudan is complicated and so it was only possible to briefly touch upon it here, within the scope of the present research. Having some insight into the Sudanese context, however, highlights the complicated nature of Sudan at this time. Not only had Islam been institutionalised by the government, from the perspective of those in Khartoum it often seemed like a "one-city state". In light of this, this thesis will argue that the Sudanese context, with its highly influential religious institutions and conservative traditions, shaped public health promotion significantly at the time this research was carried out. Specifically, it will demonstrate that the role played by SNAP in developing and rolling out Sudanese policies—and in particular condom use—was heavily influenced by a social context with a long history of politicised contestation.

2. FOUNDATIONS

The previous chapter gave an overview of the socio-political landscape of Sudan up to the time of my study: as one country, under Islamist rule, facing civil war in Darfur and on-going tensions in the south. This chapter will move away from the local context, introducing the theoretical background of the thesis. First, an outline of policy theories: how policies get written, what happens to a policy after it has been written, and how the policy comes to be used. This section will offer some theoretical insights on policy research in general, as well as discussion about how actors often deal with different demands when implementing policies. Second, there will be a short section on this theory and what aspects of this academic literature might apply to the focus of this work, SNAP. Based on my two research questions, the chapter will go on in the third section to explain why my methods were chosen and best suited for my particular focus. In relation to to this, I will also describe some of the context in which I was working during the data collection period.

In this way, the chapter will describe how policy analysis tools were used as a point of departure to investigate the processes through which SNAP developed its national condom policies. However, because the political and social environment was heavily influenced by religion, there was a complex accumulation of contextual factors that affected how formal policies were developed. This study therefore addresses how people managed the conflicting demands in their daily lives when working with these polices. As such, the rest of the thesis will explore the usefulness, and limitations, of these policy analysis tools, and the extent to which the specifics of the local context meant there was no simple linear process of development, refinement and implementation.

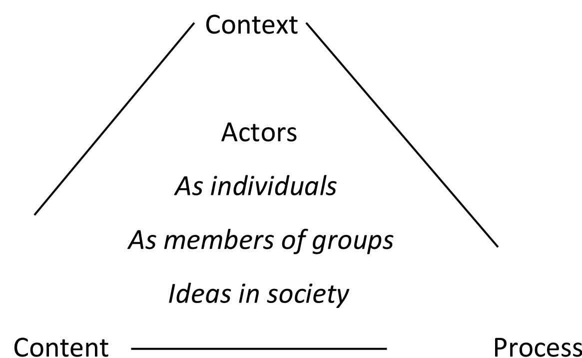
2.1 POLICY ANALYSIS

According to Heidenheimer et al., (1986) researching public policy is “the study of how, why, and to what effect governments pursue particular courses of action and inaction” (pg. 3). Parsons (1995) adds that the aim of public policy research is to integrate and contextualise models. As Wildavsky (1979) notes, however, that the content of such models cannot be determined by disciplinary boundaries, but by whatever appears appropriate to the circumstances of the time and the nature of the problem” (pg. 15).

A frequent concept drawn on for the development of such models in the notion of "policy space". For example, Grindle and Thomas' (1991) framework highlights the analysis of the factors in which local tailoring of policies is constrained. Specifically, they speak of "policy space" as "this room for manoeuvre and influence of policy" (pg.8), and go on to say it consists of "the range of options that could be introduced without major adverse consequences for policymakers, the regime or the policy itself" (pg.8). Policy space, however, also determines the limits of what is feasible and can be manipulated using the technical, economic, political and bureaucratic resources of policy elites and other actors. The space may be narrow or wide, depending on the potential to utilise information and form or undermine relationships with national or international actors.

Drawing on this work, Walt and Gilson (1994) developed a framework specifically for policy analysis, which is now widely applied to the study health policy (Buse, Mays et al. 2006). It focusses on four concepts: context, content, actors and process. This framework is said to capture the dynamism of policy-making in a simple, but at the same time comprehensive and structured, way. They argue that in order to analyse policy, the analysis must go beyond just the content of policy or answering the "what", to ask questions concerning, "who?" or "how?" For instance, which actors make the decisions on what or not to include in the policy, or what kinds of things affect the decisions of actors when developing or implementing policies (Walt and Gilson 1994). Although the four factors – context, content, actors and process – can be conceptually separable, they should be seen as distinct but also as parts of a whole, as represented in **Figure 1**.

Figure 1: Gibson/Walt (1994) – model for policy analysis



For Walt and Gilson, process refers to the way "a government or a society sets its activities and allocates resources" (pg.207) (Foltz 1994). It is about the way policies are initiated, developed or

formulated, negotiated, executed and evaluated (Hogwood and Gunn 1984). Thus, in addition to the actual content of the policy, the framework introduces other areas for consideration. Local factors can include elements such political, cultural and socio-economic or historical factors. As the previous chapter pointed out, religion may play an important role, while international factors can include relationships between national and multilateral/bilateral organisations and funding commitments by the government or international actors (Grindle and Thomas 1991).

Key to this approach, however, is the importance given to actors, summarised by Walt and Gilson (1994) in the following way:

> A descriptive framework becomes an explanatory framework as we explore who has wielded power in order to influence change in the world of infectious diseases, why some issues regarding infectious diseases have made the policy agenda above others, and how public policies have been negotiated between different groups… (pg. 68) (Ibid.)

A key category of actor within the policy space is what Grindle and Thomas describe as policy elites. How this group perceives and shapes the dynamics of decision-making is central. For example, if policy elites consider a matter to be one of crisis, they will act with urgency and prioritise certain issues over others. Relevant to this thesis is the idea of policy elites (Lasswell 1936, Grindle and Thomas 1991, Barkan 2009), which can be defined as specific actors "who hold high positions in an organisation and often privileged access to other top members of the same and other organisations" (pg.5) (Buse, Mays et al. 2006); and whose responsibilities include affecting or making important decisions in the policy arena (Grindle and Thomas 1991). In this way, they do not simply enact content, but play an important role in defining its content.

So far, I have presented the policy arena as comprising of context, content, processes and actors. These issues are important as they individually affect actors' actions but together create an environment specific to the context, and shape the dynamics of decision-making prior to policy outcomes. Although there are some contextual factors such as pre-existing circumstances within which policy processes occur, Grindle and Thomas (1991) remind us that it is important to remember that these factors are also constantly changing, which can also constrain or expand the policy space.

2.2 POLICIES IN ACTION

This section will focus on approaches that attempt to address this point about the continuous change. I draw on Bennet's (1991) theories of policy transference; how policies are altered through top-down and bottom-up influences; and how actors deal with actual polices within their work environment, especially the multiple demands put on them (Bennett 1991).

A further dimension to the analysis of a policy space is therefore that it can be expanded to include the relationships between different actors and what they do. In such situations, Bennett's (1991) framework of processes through which convergence theories are particularly relevant to structure the analysis to help illustrate how policies can be developed. It focusses specifically on local and national contexts where policies are transferred between different groups. Bennett notes that in situations where there is a large international presence, policy formulation often consists of four processes: emulation, communities and elite networking, harmonisation and penetration. *Emulation* is defined as the process of borrowing or adapting structures and policies from other nations or societies. *Communities and elite networking* concentrates on interactions between main actors. This type of convergence results from the "existence of shared ideas amongst a relatively coherent and enduring network of elites engaging in regular interaction" (pg. 224). This concept overlaps with the work of a number of other authors, who refer to the groups in question as 'policy networks' (Parsons 1995, Borzel 1998, Thatcher 1998, Howlett and Ramesh 2003), or 'policy communities' (Kingdon 1984, Marsh and Rhodes 1992). *Harmonisation* concentrates on the relationships between national and international actors and facilitates convergence through a coherent group of transnational actors, including intergovernmental organisations, relying on each other for the performance of tasks to develop policy, where 'cooperation' and 'interdependence' are the driving forces. And finally, *penetration* focusses on donor influence or donor-recipient relations, whereby policy transfer involves externally based actors participating in the domestic policy process" (pg. 227) (Bennet 1991).

There is a wide pool of literature on the complexity of donor-recipient relationships (Standing 2002). International actors often take control and power away from local authorities, which leads to the "blurring" of the lines between domestic and foreign policy (Kaul, Grunberg et al. 1999).
This chapter drew upon policy analysis theories to offer a basis for the thesis as they could point to ways in which the policy space could be affected by actors, content, context and especially how

local tailoring of policies might be constrained. Similarly, Bennett's convergence theories could help to understand more the classification of ways actors played key roles in the process of policy development and how local context might be ignored.

However, in addition to accounts about how actors are involved in policy-making, there is also a body of work that focusses on how actors manage competing demands when using policies. In particular, many implementation theorists agree that actors at all levels of the process have the capacity to resist, transform or create their own versions of policies (Barrett and Hill 1984, Hill 1993, Crosby 1996).

According to Parsons (1995), the study of policy implementation grew from a body of literature that primarily tried to explain why policy programme goals were not being achieved. Before the 1970s, policy theorists paid little attention to its actual implementation (Lipsky 1976, Lipsky 1980, Hogwood and Gunn 1984, Howlett and Ramesh 2003), leaving this topic to the fields of administration, organisational behaviour and management (Howlett and Ramesh 2003). It was assumed that once policy decisions had been made, the administrative or managerial arms of a government would simply carry out the policies; thus, policy implementation was viewed as the set of events that take place after policymaking is finished (Anderson 1975, Hargrove 1975, Grindle and Thomas 1991). However, once it was recognised that these were many complex and subtle dimensions to the role of bureaucrats, and how they managed their work, discussion focussed on both top-down and bottom-up perspectives.

The top-down perspective looks for explanations as a rational process composed of a series of chains of command, in which actors give policy preferences which are then carried out through the administrative machinery (Parsons 1995, Hill and Hupe 2002). Success is determined by a generalised list of conditions and by the degree of control that the policymakers have over the implementing agencies (Van Meter and Van Horn 1975, Mazmanian and Sabatier 1981). If implementation fails i.e. there is a gap between policy objectives and outcomes, it is attributed to failure in planning (Van Meter and Van Horn 1975). Top-down perspectives of implementation were developed to address the "gap" between what was intended by policy formulators and the reality of what was delivered.

In contrast, the bottom-up perspective shifts focus from policy formulators to implementers (Lipsky 1971, Barrett and Fudge 1981, Barrett and Fudge 1981, Hjern and Porter 1981, Hjern and Hull 1982, Ham and Hill 1997). Lipsky (1980) was one of the first authors to focus on actors on the bottom or front-line (Edwards and Sharkansky 1978). Lipsky coined the term "street-level bureaucrats" to refer to "public service workers who interact directly with citizens in the course of their job and who have substantial discretion in the execution of their work" (pg.3) (Lipsky 1980). According to Lipsky (1980), "the routines they establish and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out" (pg.xii).

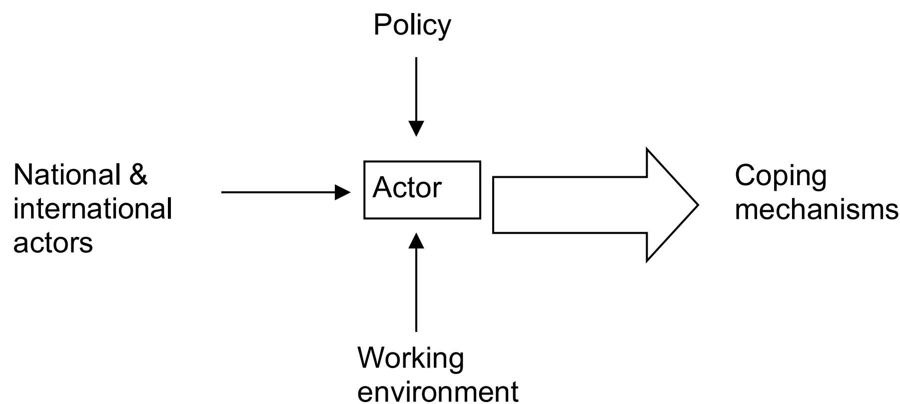
These two perspectives emphasise different aspects of the policy space. The first assumes what is written will be implemented on the ground; while the second emphasises how people on the ground can change or have discretion over policy in order that it is adopted to. However, in addition to the flow of a policy, there is often a middle group of actors involved. They both contribute to the development of written policies and its implementation in local settings.

Significantly, much of the literature does not take into account these middle intermediary processes in which actors can change the actual adoption of a particular policy. Of particular relevance to this study is a focus on these "middle stages" of policy development and the space between policy development and the actual adoption of policy. This intermediary space often includes the life of a policy and its changes; in fact, this middle realm is where actors can most easily respond, tweak, and eventually change policies that were introduced from actors above.

Because of this role, Sorg (1983) calls the middle manager "the implementing manager". These mid-level bureaucrats undertake certain roles, such as building coalitions (Lambright 1977), issuing and enforcing directives, disbursing funds, making contracts and hiring personnel (Edwards and Sharkansky 1978). Crosby (1996) points out that the implementing manager can be characterised as a "coordinator, broker or perhaps a facilitator" (pg.1405), often between the stakeholders at the top and those at the bottom. Kiggundu (1996) notes that the implementing manager is particularly important in agencies within developing countries, where matters relating to policy development are often a question of managing external relationships and interdependencies while also assuring that basic operational or coordination tasks are completed.

Identifying this group of actors as influential raises the question of how they deal with different demands. Lipsky (1980) argues that street-level bureaucrats have to cope with the uncertainties of the work environment and work pressures as well trying to meet their own ideals. In environments where there are multiple and often conflicting demands, they often adopt coping behaviours to manage; and ultimately, through these behaviours, reinterpret and reshape policy in unexpected ways (ibid.). Hill (1997) describes such coping behaviours as "rule breaking or careless rule interpretation, officious rule enforcement which make it difficult for the public to secure entitlements, failing to give information about entitlements and slow practices which impose implicit rationing through delay" (pg. 223). **Figure 2** summarises the forces put on those actors.

Figure 2: Multiple demands



Specific examples of such coping mechanisms have been seen in a number of cases in nursing studies, organisational settings (Erasmus and Gilson 2008) and the health sector (Schneider and Gilson 1999). But these are substantially fewer examples of the coping strategies of mid-level bureaucrats (Scott, Mathews et al. 2012). Jones et al. (2013) gives one example, which concentrates on the behaviour of service employees working directly with the public and the way local managers responded to the many changing and sometimes conflicting they were meant to implement policies. Another study conducted by Scott et al. (2012) explored the values and relationships of mid-level managers and nurses and how they affected the adoption of policies; specifically, a staff allocation policy in South Africa . One finding that was particularly relevant to this thesis was that mid-level managers were juggling multiple and sometimes conflicting demands, including the need to support equitable management practices along with financial

administrative responsibilities and concerns about the wellbeing of their staff. Scott et al. (2012) found that these mid-level managers' decisions were also influenced by their sense of loyalty to their district, and they eventually discarded the effort to allocate resources fairly (Scott, Mathews et al. 2012).

Considering decision-makers more broadly, Lin (2003) adds a related concept which focusses on how mid-level managers cope with their environment through her theory of "competing rationalities". Although this was developed to understand the relationship between evidence and health policy development, it is relevant for this thesis because it emphasises the significance of actors' agency, their "rationality" and how this affects their decision-making in the policy process.

Lin argues that actors— whether policy makers, managers or implementers— are subject to multiple pressures, and they adopt several ways to rationalise these pressures. She presents three types of rationalisation: 1) cultural, which focusses on values, ethics and perceived societal opinions, and vary across gender, class, age, ethnicity and place; 2) political, which is concerned with the distribution and management of power and creation of legitimacy through policy-makers in various contexts, where interest groups participate and influence the policy process; and 3) technical, where research evidence plays an important role (Lin 2003). Actors adopt different rationalities to address these. But Lin points out: "Although the boundaries for each rationality may blur or merge, there are dominant tendencies for distinct group of players. They are propelled by different imperatives, socialised into different ways of thinking and behaving and aim to achieve different objectives" (pg. 15).

I have introduced literature pointing to coping mechanisms as a way for street-level bureaucrats or middle managers to respond to competing demands, contradicting pressures, and their overall intermediary position within the policy space. The thesis will draw on these in its account of SNAP. Members of this organization had specific roles and responsibilities but simultaneously were also part of a wider community responding to HIV/AIDS, which consisted of diverse views about condoms, their importance and their social and health value.

2.2 Research focus

This approach identifies decision-makers as influential in shaping, negotiating, pursuing and sustaining policies. I will draw on it to guide my research by highlighting the importance of actors and their choices in the design and pursuit of policies. But crucially it suggests the various constraints that limit what actors are able to do. Simultaneously, some consider the societal factors (historical, cultural and international contexts) that shape the perceptions, options and actions of those who make the decisions (Grindle and Thomas 1991). Policy space analysis provides a useful framework for understanding how policies get on the policy agenda and how they get changed by the dynamics and decision-making of policy elites and other actors, by focussing attention on how they interact or negotiate with other actors to expand or constrain the policy space.

The thesis will concentrate on the intermediary space between policy development and the adoption of actual policy, particularly focussing on the relevant actors and their environment. This is key to understanding how national condom policies were initiated, how and why they developed, as well as the ways the content itself was shaped over time. This refers not only to national policies but also documents that affected how condom promotion was framed. This is especially important because the wording of text would eventually assist SNAP to effectively deal with a number of competing demands. The term "actors" in the thesis refers to employees in government ministries and SNAP civil servants, as well as those from international bodies, including non-governmental organisations (NGOs). These international actors are present across a large spectrum of organisations, from small national based organisations (e.g. Lokita or Sudan Family Planning) to larger international organisations (e.g. Save the Children or CARE) and multi-lateral organisations (e.g. UNFPA or WHO). There were 61 registered organisations such as this at the time of my research (Sudan AIDS Network (SAN) 2008).

This intermediary zone within the policy space offers a way to understand many of the different demands, both in terms of the – rather Khartoum-centred— north, and also various individuals and groups from above and below. In addition, however, in this example, policy space can be seen like a balloon, which could expand and shrink, depending on where the context and actors put pressure. For example, the religious mores compressed the policy space by limiting people's

actions, especially with respect to condom use, while international actors were sometimes intent on expanding the policy space to include as much as possible.

Grindle and Thomas' policy space concept is used because it allows the analysis to conceptualise how different factors (i.e. cultural, political or historical) shaped SNAP's actions, and how these demands played out. This is acutely relevant to SNAP since it had cope to with demands from many international actors, especially donors, shaping HIV prevention in Sudan, as well as internal forces. As I will show, because religious and moral concepts had been integrated into the political sphere in Sudan, SNAP routinely had to negotiate these with their commitment to introduce an effective HIV prevention policy.

I will address two research aims:

1. To analyse the process of national condom policy development by the Sudanese National AIDS Program.
2. To examine the extent to which these policies were managed by the Sudanese National AIDS Program.

Issues relevant to the first aim will include which actors were involved, how and why they were involved, and the main factors affecting the decision-making of the actors. I draw on document review and interviews, both semi-structured and in-depth. To explore the second aim, the context in which SNAP operated is key, including ideas, groups of people, and individuals, and how they affected SNAP's activities.

2.3 Methods and ethics

This section will explain the choice of methods, and how they were best suited to address the above-mentioned aims. It will begin by describing each method adopted before going on to reflect on the positionality of myself as the researcher in order to make clear the limitations, as well as strengths, of the approaches adopted in this particular research context.

Documents were gathered not only to review policy content, but also to examine how they developed, and especially to identify similarities between the national policy and documents from international organisations. I paid particular attention to the wording of the documents. Documents were identified from and acquired through 1) interviews, 2) SNAP civil servants, 3) the

"document centre" at SNAP and 4) national and international organisations. However, the data collection process was not straightforward. There was no tradition of record-keeping at the Ministry of Health (MoH) or at national organisations in Khartoum, and as a result, some written materials were difficult to obtain. Frequently, interviewees would say that they had documents, but the documents rarely materialised, even from those who promised them repeatedly. Documentation that was eventually obtained included SNAP documents, bio-behavioural studies, a household survey, ANC sentinel sero-surveillance surveys, memos (from government ministries, national and international organisations), religious documents, donor evaluations and organisational plans or papers. Some documents existed only in Arabic, but English translations were eventually provided, either by SNAP members or independent Arab-English translators.

In addition to the range of documents, qualitative interviews were conducted to attain individual accounts of how policies were developed and implemented, including which actors were involved and in what way, and the effect perceptions of individual actors had on their actions. The initial approach taken was to conduct semi-structured interviews, based on a topic and issue guide. For some research questions, however, these early semi-structured interviews did not deliver the relevant information. As a result, more open-ended in-depth interviews were employed, which were more effective at obtaining the pertinent information. A preliminary list of people to interview was generated through an initial review of the national policy documents and speaking to SNAP staff. Contact was made in one of two ways: either an email was sent with the information sheet (see **APPENDIX C**) along with an endorsement letter from SNAP; or alternatively, people were telephoned to introduce the project and potentially make an appointment for the interview. Often, the best way to contact people was through telephone or to visit the interviewees' office; e-mail replies were rare. At first, it was not easy to arrange interviews; sometimes it took weeks to contact the individuals and set up an interview. In these cases, especially if the interviewee was a high-ranking civil servant, a SNAP programme officer called to organise a meeting. Using snowball sampling, more people were identified and interviewed based on the recommendation of existing participants.

This project draws upon eighty-nine interviews conducted with individual respondents from July 2008 to February 2009. 44 national organisations, 40 international organisations and five independent nationals were represented (see **APPENDIX F** for more details). Notes were taken

contemporaneously and all but five interviews were audio-recorded and then transcribed on the day of the interview or the following day. Those five interviews were not recorded because the interviewees did not give permission. Only two interviewees wanted to remain anonymous. Participants were subsequently provided with summaries of their interviews to allow them the opportunity to correct inaccurate reporting or qualify original responses; rarely did respondents change the content of their interview.

Semi-structured interviews were used to address questions set by myself in terms of the topics and issues covered (see **APPENDIX E** for more details), but permitted the interviewee to determine the answers given and the relative importance of them. In the case of ambiguous policy documents, it was necessary to understand how users understood and applied them. Semi-structured interviews facilitated investigation of this by maintaining the focus while at the same time allowing more open-ended responses to afford the respondent the opportunity to give a free account when they felt it was necessary.

In-depth interviews enabled the research to focus on specific issues, allowing interviewees time to develop their own accounts of the issues important to them (See **APPENDIX E** for more details). Where necessary, further questions were used to probe for more information. By using in-depth interviews, it was possible to investigate the different opinions of key actors involved in the formulation of the national policies, though their own understanding of what was most relevant, and who else was involved.

These two forms of interviews provided a comprehensive exploration on how policy was developed by SNAP, as well as giving insights to how it dealt with other actors (both national and international) and the environment in which they worked when trying to deal with condom promotion policies.

2.3.1 Observation and positionality

One of the main criticisms of interviews as a research method is that what people say is not necessarily what they do in practice (Seale 1998). Participant observation brings the researcher into direct interaction with people and their activities. There exists a broad literature on participant observation (Charmaz 1983, Hammersley 1992, Mason 1996, Denzin and Lincoln 2000), predominantly in the field of social science research, and especially sociology and

anthropology (Hammersley 1992, Mason 1996). Green and Thorogood argue that: "observational methods allow the researcher to record the mundane and the unremarkable (to participants) features of everyday life that interviewees might not feel were worth commenting on and the context within which they occur" (pg. 132) (Green and Thorogood 2004). The authors suggest it is therefore the "gold standard" of qualitative research. I spent a significant amount of time with participants in their natural setting (work environment), as well as becoming integrated into their everyday lives and culture. However, only some aspects of participant observation were used, because the aim of this study was not about examining culture (Bowling, Bond et al. 1999) or to "come to an understanding of a community's beliefs, social structure, kinship structures, religious, cultural and material beliefs" (pg. 135) (Green and Thorogood 2004). Rather, it was to determine the issues surrounding how policies were developed and actors managed these policies in a specific context, and not more holistically.

A key issue when conducting any observational research is how the researcher themselves relates to the field. Positionality refers to assumptions and prior experiences that may have 48 months, as well as the 10 months spent conducting interviews. Access was facilitated by an initial introduction by the Director of HIV/AIDS at the World Health Organisation (WHO) in Khartoum, who was a well-respected expert among those working in the HIV/AIDS/health communities and often seen as "one of them,"[5] at the annual strategy meeting of key stakeholders. Once associated with the Director of HIV/AIDS at WHO, integration into the HIV/AIDS working community and SNAP was relatively easy. Observation was conducted in an overt way – it was known to SNAP staff and their colleagues that research was being conducted for the purpose of a doctoral thesis. But it may well be that as a result of this introduction, workers saw me as some-how associated with the Director.

As a part of the observation period at SNAP, I also developed professional working relationships with other organisations, and consultancy work was done at some UN agencies (WHO and UNAIDS). This work enabled me to examine how the personnel at SNAP worked together and the

[5] "One of them" was usually depicted by interviewees as someone being an integral part of the community; or alternatively, not seen as a foreigner or an outsider. In this particular case, despite the WHO director coming from Uganda, he was not seen as an outsider but as a "Sudanese". There was a particular dynamic between nationals and internationals - the feeling of "us against them" was frequently documented by observation and referred to by interviewees. There was suspicion towards the West and its hidden agenda. See **Chapter Four** for more details.

dynamics of their working relationships with other organisations, as well as gaining some perspective on the complicated professional context in which all actors were working. Much of this time was spent working in the same office as the SNAP interviewees, thus maximising the time spent observing them in their work setting. In addition, time was also spent leading and participating in workshops on HIV surveillance, and working on studies focusing on vulnerable populations— especially female sex workers and men having sex with men— with SNAP members.

Most of the observation time was spent at the SNAP office, focussing on their everyday activities, including meetings between national and international actors involved in HIV, and the general working environment, which consisted largely of NGOs and international organisations. This time allowed me to also observe civil servants, facilitated by the open-plan arrangement of desks in the office, and encouraged regular invitations to attend meetings taking place at SNAP.

Having these two roles, as a researcher and a professional working at SNAP, created an inevitable tension. It was important for me to be constantly aware of my position, and how others perceived me. To counteract any potential bias in data interpretation, a log was maintained, recording any reactions to events occurring during the period of the research. However, recognising potential biases did sometimes lead to new ways of interpreting the data (Denzin and Lincoln 2003). Although I was quite familiar with the day-to-day work of SNAP and relationship of SNAP to other organisations (especially international ones) I was always an "outsider". Being foreign and a female conducting a doctoral thesis may well have affected how data was gathered in three main ways. Seeing me as a foreigner or outsider, interviewees might not have spoken so freely about some issues, especially those concerning the tensions between national and international actors. Equally, not being able to speak fluent Arabic might have affected my findings. Many interviewees wanted to carry out the interview in English, meaning they might have been less spontaneous in a second language with their answers or might not have been able to express themselves as easily as in Arabic. That said, however, the intersection of these issues, being a foreign woman and therefore not part of the Sudanese society, might actually have enriched the data collection. Sudanese males were surprisingly frank when discussing sensitive issues in interviews, especially issues on sexuality and condom use. The key point is that although the issue of condom use was

not a subject normally discussed between Sudanese women and men, respondents seemed to be open to talk to me, as a foreigner, about such issues.

Ethical Issues

The research was approved by the Ethics Committee at the London School of Hygiene and Tropical Medicine on 25 June 2008. In addition, the research was ethically and technically approved by the Sudan Research Council Committee on 3 July 2008.

It is difficult to guarantee complete confidentiality in policy research, especially when there are a small number of people involved. For example, there were some offices in Khartoum where there was only one manager. As a result, in this situation, the identity of the person interviewed would have been obvious. Many interviewees gave permission to be quoted in the thesis; however, as stated above, two decided to remain anonymous. Protecting the interviewees' anonymity was important primarily because there were real risks to speaking out against the government. When speaking of sensitive issues such as sex and condom use, participants might have been hesitant to discuss such issues for fear of losing their job (Interviews in 2008). All names were therefore removed from the thesis, numbers were allocated to interviewee and date of interview (d/m/yr) added e.g. key informant (KI) #3 12/12/2008. To improve confidentiality, any data that might identify them indirectly has been removed. Informed consent was obtained from all respondents, which allowed them to choose how to be quoted (by position, agency, type of agency) or to be excluded from the analysis (for more details, see **APPENDIX D** for the consent form). Although all respondents signed a consent form for interview, those at SNAP and other relevant organisations were made aware that observational work was being carried out by a researcher working on a doctoral thesis.

This chapter outlined the key policy analysis theories used to guide the project and analysis of the data. In particular, I presented Grindle and Thomas' policy space and Bennett's theory of policy transfer as especially relevant. These theories provided the project with a set of reference points to study policy content, processes, and actors in order to understand the relationship between condom policies and how they altered to the Sudanese context. Helping to address my second research objective, insights on the roles and responsibilities of mid-level bureaucrats and how

they manage multiple competing needs were drawn from a body of implementation studies. Focussing on coping strategies points to the ways SNAP workers were situated in an intermediary policy space.

The latter section described the methods used to address the research aims and how theories from policy analysis helped guide the analysis. Three qualitative methods presented were: document review, qualitative interviews and observation. Document review shed light on how national condom policies (e.g. communication within or outside their organisations, drafts of previous policies etc.) were developed; it also offered a method to closely analyse specific words and how they were used. These data collection methods were complemented by two types of interview: semi-structured and in-depth, which were conducted amongst a range of participants. Using these different ways of interviewing not only maintained the focus of the research but also ensured flexibility. Since the limitations of interviews as a source of data means that sometimes a view is only provided on what people say, and not necessarily what they really do, observation was also utilised. Observation provided insight into the real-life context of participants (e.g. insights into their relationships with other actors and how actors deal with important issues within their context), and also helped verify people's verbal accounts.

3. DEVELOPMENT OF POLICIES

This chapter is about the development of the national policies in Sudan around HIV/AIDS prevention. It is a story of the major influence of international donors and their funding over the content of national policies. Two forms of influence will be described. The first, policy emulation, was where Sudanese policy makers directly drew on existing international texts, which were originally developed to provide standard and universal approaches to HIV prevention. The second, and more interesting indirect form of influence is that of "pre-emptive action" where SNAP seemed to predict what the external donors may have wished for. This second form was indeed remarkable because it demonstrated the extent to which the Sudanese policy-makers internalised international expectations and assumptions in order to secure financial support.

In this account of policy development, the chapter will also describe how SNAP ignored national evidence: categorically ignoring MSM as a high-risk group in the national policy; and further omitting a potential area of concern of the international community, despite the evidence already officially recognizing high-risk groups being explicitly mentioned in national documents. This indicates that national HIV/AIDS policy, and SNAP itself, was not simply the result of external pressures and inducements; it increasingly had to adjust, and navigate, internal social and cultural values. This general theme will be explored in further detail in Chapters 4 and 5.

3.1 Before Sudan National AIDS Program: Sudan National AIDS Committee

In 1986, in response to the first identified AIDS case in Sudan, the government established a new body to work on the national response to HIV/AIDS: the Sudan National AIDS Committee (SNAC) (Sudan National AIDS Committee 1989b). One interviewee who was involved in the creation of SNAC stated: "*We* created *SNAC because we were reacting to the first AIDS case. Our ministry was small but we had strong civil servants, mostly made up of those with a medical background"* (KI#16, 27/8/2008). SNAC was an informal group made up of a couple of people working under Federal Ministry of Health (FMoH). Moreover, the research found limited information on exactly why and how SNAC was established but the literature supports the idea that it was an opportune time for FMoH Khartoum to establish a national AIDS programme. It is well known that during the 1980s, AIDS reached epidemic levels in Africa, beginning in the east, working its way to the west and finally to the south (Carael and Holmes 2001). It seems that, although WHO's Global

Programme on AIDS (GPA) was slow to react to the growing epidemic, they swiftly raised money to help prevention and educational efforts, with Africa as a priority (Carael and Holmes 2001).

Shortly after SNAC was created, it published its first *Policy Statement of the Sudanese National AIDS Committee* (1989), in which they acknowledged the first cases of AIDS in the country, as well as the threat of HIV/AIDS. The policy stated five main policy issues to guide the country, one of which was the "Prevention of sexual transmission" (Sudan National AIDS Committee 1989b). On this particular issue, the policy recommended prevention methods "focus on changing behaviour of those at risk and preventing adoption of risky behaviours" (Sudan National AIDS Committee 1989b). Under prevention, the three main priorities of the 1989 policy were: education to increase public awareness in the general population, schools, and media institutions; education and counselling of high-risk groups; and the promotion of condom use and distribution to high-risk groups (Sudan National AIDS Committee 1989b).

In 1989, SNAC developed the *Medium Term Plan* (MTP) (MoH and WHO 1989), outlining the current and projected HIV/AIDS problem, control activities and target populations. One of the programme goals of the MTP included prevention of HIV through sexual transmission (Sudan National AIDS Committee 1989a). One of the MTP's strategies to prevent sexual transmission of HIV was to promote information, education and communication about HIV/AIDS, including a condom promotion strategy for prevention of sexual transmission among high-risk groups, which were identified as: a) street youth/homeless youth, b) truck drivers, c) prisoners, d) persons with multiple sex partners, e) displaced persons and f) military personnel (Sudan National AIDS Committee 1989a).

These documents were skeletal in content with little reflection of what was happening in Sudan: there was limited local information on HIV, albeit the two cases on AIDS found between 1996 and 1997. While there seemed to be government documents on how to prevent HIV in high-risk groups, information on HIV knowledge, including transmission attitudes and sexual behaviour, were unknown.

3.2 THE CREATION OF SUDAN NATIONAL AIDS PROGRAM

After the development of the MTP, SNAC changed its name to Sudan National AIDS Program (SNAP); it was not clear exactly when, but documents dated around 2002 use SNAP instead of SNAC. At that time, SNAP was composed of a few experts in the government who knew how to formalise the national AIDS response. As one of the first civil servants to join SNAP stated: "*I think there were mainly 5 persons, myself and my boss included. There were some people in the states but it was limited in its capacity and resources"* (KI#1 27/08/2008). Another civil servant close to the process reiterated: "*We had to make our group real. There were burgeoning interests coming from the Ministry. It was the right time*" (KI#4 2/5/2008).

SNAP's official first document was the Sudan National Policy and Guidelines on HIV/AIDS and STIs Control (2002 document). The 2002 policy was very similar to the 1989 document, albeit with some restructuring and minor changes to content. Most of the content included under each of the policy issues remained the same as it had been in the 1989 policy. For example, under the heading of prevention of sexual transmission, the 2002 document replicated the 1989 wording with one addition: where the 1989 document advocated condom promotion to high-risk groups, the 2002 policy went one step further and added that the condoms should be

> Of high quality and sufficient quantity to be made available as required and at minimal service charge at STIs clinics, AIDS programmes, authorised health facilities and other agreed upon distribution channels by the National Council on HIV/AIDS[6] targeting high-risk groups (Sudan National AIDS Control Program 2002a).

The prevention sections of the MTP in the 1989 and the 2002 documents all intended to increase awareness of HIV through schools, universities, media institutions and specific groups and organisations (including religious groups). All of the documents also addressed condom promotion, specifically distribution among high-risk groups, but no specific interventions to enact condom promotion/use/distribution.

[6] This Council was formed in 2001 as the highest advisory body in the country on all matters relating to HIV/AIDS. Its role is primarily to advise the government on policy and to streamline all HIV/AIDS activities throughout the various sectors of the government. This body is chaired by the MoH and consists of 36 members, including government representatives at federal ministerial level, NGOs, private sector members, and representatives of youth organisations.

Up to this point, policy-making seemed to be mechanical with little reflection on the local situation of HIV in Sudan. Policies were essentially a biomedical response to a global HIV problem, and not a localised response to HIV in the country.

3.3 INFLUENCE OF DONORS OVER NATIONAL POLICY-MAKING

National Strategic Plan (NSP) 2003-2009

The process of developing the National Strategic Plan (NSP) most likely began in 2001-2002[7]. The NSP was Sudan's first strategic plan. The goal was to "reduce the prevalence of HIV/AIDS to a level that renders HIV/AIDS not to be a public health problem through a multi-sectoral national response" (Sudan National AIDS Control Program 2004a).

The NSP was divided into two main sections. The first section offered a brief summary of the national response. This included background on the HIV/AIDS problem in Sudan and the national actors' response, as well as a description of the goals and objectives and the six areas of focus. Prevention, care and support comprised the main foci, which included promoting condom use to high-risk groups (Sudan National AIDS Control Program 2004a). The second part of the NSP laid out five-year strategic plans for most of Sudan's government ministries. Only three ministries addressed condom use: MoH, Ministry of Interior and Police Forces and Ministry of Defence (MoD). The MoD stated: "Prevalence of safe and positive behaviours increased in the general population, especially the use of condoms with non-regular partners" (pg. 18) (Ministry of Defence 2007).

Parallel to the development of the NSP, UNAIDS published their yearly results of HIV/AIDS statistics and reported that Sudan had a prevalence of 1.6 %. This was not a particularly accurate estimation since this included South Sudan, which was assumed to have a higher prevalence rate (UNAIDS 2003). Nevertheless, the prevalence seemed to be quite low in Sudan compared to other surrounding countries. An interviewee working for the UN stated: "*We moved on developing a HIV policy because we were getting a load of funding. Why wouldn't we have done it?*" (KI#51 14/02/2009). Another colleague at the same organisation reiterated: "*HIV is scary but it is not here. We went through the motions of developing a strategic plan but the country doesn't need it.*

[7] The exact timing of the commencement of NSP development is not known. Most interviewees say the process began in 2002, but we cannot know for certain. It is known that the process ended in 2002 (Interviews in Sudan, 2007 & 2008).

We don't have a real problem of AIDS here" (KI#50 14/2/2008). A civil servant from FMoH also mentioned: "*While we work on many health issues, AIDS is not one of our priority areas*" (KI#10 30/03/2008). FMoH did not seem to see HIV as an important issue to Sudan until donors flooded the country with funding. The impetus for developing a HIV/AIDS polices came primarily from external donors who encouraged them to do so.

As more donors entered the HIV arena in Sudan in the early 2000s, particularly the Global Fund (GF), donor importance became apparent, especially with respect to policy development. When the GF invited submissions of proposals for Round 3 GF grants, one of the requirements was for the country to have a National Strategic Plan (NSP); some interviewees verified the stipulation of having a NSP for funding (KI#19, 18/3/2008; KI#3 16/10/2008; KI#41 17/9/2009). A SNAP behavioural specialist present at the beginning of the NSP development commented: "*Since we didn't have a NSP, we wanted to develop a plan because we knew we couldn't get HIV/AIDS funding without it*" (KI#15 23/4/2008). A former SNAP Information Education Communication (IEC) specialist stated: "*We had to come up with a strategic plan to get the funding"* (KI# 22/3/2008). A UNAIDS official participating in the process of developing the NSP stated: *"Internally and externally, people were asking them whether they had a strategy or not.... The external pressure was high, especially from us [UN agencies]*" (KI#50 14/2/2008).

National Policy (NP) 2004

Once the NSP was developed, there was a quick move within SNAP to develop the National Policy (NP) on HIV/AIDS. The NP was intended to serve as an introductory document for all actors involved in HIV/AIDS prevention in Sudan, including UN agencies and national and international organisations.

The NP was divided into seven sections. It began with an introduction to a specific HIV/AIDS situation in Sudan; this section included an explanation of the need and justification for a comprehensive NP. The plan stated:

> A supportive policy environment is crucial to the implementation of successful programmes that prevent the spread of the virus, deliver care to those infected and mitigate the impacts of the epidemic. An appropriate policy environment is essential in supporting efforts to ensure that human rights are respected and eliminating stigmatisation and discrimination associated with HIV/AIDS (Sudan National AIDS Control Program 2005b).

The next six sections discussed monitoring of the HIV/AIDS epidemic: care and support for those infected or affected by HIV/AIDS, HIV/AIDS prevention, sectoral roles, special topics in relation to HIV/AIDS, and the national response. Each section discussed the particular issue and its effects on Sudan, followed by guidelines for the work to be undertaken. The fourth section of the NP, dedicated to HIV prevention, stated the following:

> Public awareness of the risk and change of behaviours that put individuals at risk of contracting or transmission of HIV and other sexually-transmitted [infections] should be the cornerstone of the response, in order to reduce the spread of the epidemic. Transmission of HIV is greatly increased for those who have multiple sex partners and engage in unprotected sex (Sudan National AIDS Control Program 2005b).

We know that in the 1980s, many African countries were developing HIV/AIDS national policies and WHO's Global Programme on AIDS (GPA) was strongly influential in this process (Green 2003, Walt, Lush et al. 2004, Parkhurst 2005, Pisani 2008). As such, it is likely that in Sudan too, WHO's GPA was influential. Indeed, interviews and document reviews present evidence of WHO's influence in the late 1990s in Sudan. During this period, a former SNAP official working at that time stated:

> Donors were arriving in Sudan. We began to rely on them for our work in HIV/AIDS – not only for the funding of our activities but also for some direction on what to do. Without them we wouldn't have any running programmes (KI#13 26/9/2008).

Donor influence was also apparent in the development of the NP. A UNAIDS official recalled that even before completion of the NSP revision process, UNAIDS had begun to lobby for an NP and was willing to give financial and technical support to the effort (KI#19 18/3/2008). Justification for the NP was based on the theory that it would be a more strategic and political document and could be used to convince high-ranking officials, including both political and religious leaders, that HIV was a genuine and serious problem in Sudan (KI#38 18/3/2008). One actor at UNAIDS said:

> The NSP does not fully show the direction of the government's position. So we needed a policy to diminish resistance. There was a gap of direction, sense of positioning of certain issues of the government. It made sense to have a [national] policy (KI#63 4/10/2008).

A SNAP planning officer present at the time also noted: "*As soon as the NSP was developed, we were already being encouraged by the international organisations to write the NP*" (KI#20 15/10/2008).

SNAP developed the NP in 2003 and completed it in 2004. The goals were:

> To give vision and guiding frameworks to all stakeholders working in HIV/AIDS … to enable the country to achieve its objectives in improving the welfare and the quality of life of [the] Sudanese people [by preventing] potential impact of [the] epidemic (Sudan National AIDS Control Program 2005b).

Interviewees often cited donors as being an important part of this national response. A SNAP programme officer responsible for surveillance remarked: "*We have to be dependent on international funding, otherwise, we would have no running programmes*" (KI#7 16/11/2008). The head of the HIV/AIDS division at a non-governmental organisation (NGO) explained:

> A big part of our programme depends on what donors say. [Donors] guide us on what types of programmes to conduct in our communities (KI#37 26/9/2008).

A national consultant at the University of Khartoum reiterated: "*The national programme would be lost without international guidance, especially donors, who have expertise on HIV issues and funding*" (KI#30 15/10/2008). Similar statements came from other representatives of SNAP members, UN agencies, other national and international organisations, and NGOs.

Throughout the late 1990s many donors were present in Khartoum. WHO GPA was still part of the national response, but UNAIDS and the GF were becoming more influential with regards to funding and expertise in the national programme, driving an increasingly large portion of the policy activity. The GF went a step further to impose the development of the NSP as one of their requirements to attain funding. This influence of donors offers a good example of how they managed to expand the policy space, by not only giving the national programme the appropriate funding, but also guidance on what should be included. In fact, the context of international donors becoming more involved in such processes shifted and changed and eventually expanded the policy space. This might explain the gap between 1989 and 2002 in terms of policy development until donors began to arrive in the early 2000s. The arrival of new donors, especially the GF, sparked significant policy activity, which was notable after a gap of more than ten years.

3.3.1 Evidence of emulation

As the foundations chapter stated, this thesis draws from policy analysis theories to help understand the process of the development of national condom policies, and how SNAP undertook its public health remit when trying to manage multiple and sometimes conflicting

demands. Walt and Gilson (1994) developed a framework for policy analysis, which is a widely applied to study health policy. Their framework captures the dynamism of policy-making in a simple yet comprehensive and structured way, which incorporates politics into health policy. They argue that to analyse policy, analysis has to go beyond simply the content or answering the "what" questions to ask further: "who?" or "how?" For instance, which actors make the decisions on what to or not to include in the policy, or what kinds of circumstances affect the decisions of actors when developing or implementing policies. Although Walt and Gilson's four factors— context, content, actors and process— are conceptually separable, they should be seen parts of a single set of processes.

One of the key processes described here is that of emulation: the process by which a country looks externally (to other countries or organisations), eventually duplicating them internally. In such cases, one would expect common ideas and themes in both donor documents and national policies. Indeed, a number of examples can be found of terminology, concepts or ideas in SNAP policies that we can assume have been imported from elsewhere.

In 1989, WHO's GPA published "Guidelines for reviewing national AIDS programmes", and then in 1993, "A training course for national AIDS programme management". The former began with a framework of what policies should include for programme reviews. They also included an annotated list of contents, which detailed the suggested strategies and interventions to prevent HIV infection and reduce the personal and social impact of HIV infection (WHO's Global Programme on AIDS 1989b). The purpose of "The training course for national AIDS programme management" was to 1) present a systematic process for developing and managing a comprehensive national AIDS prevention and control programme; and 2) provide an opportunity to increase knowledge and practise skills, comprised of four modules created for country programmes (WHO Global Programme on AIDS 1993). This training course included suggestions on what kinds of interventions and policies, programme prevention priorities and targets to promote; how to promote safer sexual behaviour; ways in which to prevent HIV; and how to develop national strategic plans and policies (WHO's Global Programme on AIDS 1993). These donor documents were compared with national policy texts. Not only were a number of overlaps were found but also there were identical phrases taken from international policies made into national Sudan HIV policies. See **APPENDIX B** for more detailed examples of these.

3.3.2 List of high-risk groups in national documents: ignoring the evidence

1989 – 2002 policy documents: emulation

The use of "high-risk groups" is commonly used in international documents referring to issues concerning HIV/AIDS. For most countries, knowledge of how HIV is spreading locally is generally accepted as a prerequisite for use of this categorisation. However, in Sudan, little was known about HIV and who is infected; yet, national policies discuss high-risk groups and how to target them. This raises questions about how Sudan selected the characterisation of high-risk groups - particularly how donors affected the targeting of these groups in Sudan. This section draws from international documents, mainly from UNAIDS and WHO, as well as interviews to examine how SNAP developed its high-risk characterisation.

Early on, the policies (the MTP, 1989 policy and 2002 policy) characterised high-risk groups exactly the same (Sudan National AIDS Control Program 2002a): "STD patients, truck drivers, prostitutes, displaced populations, refugees, street children, suspected AIDS cases, military and prisoners" (Sudan National AIDS Committee 1989a, Sudan National AIDS Committee 1989b).

Comparing the SNAC policies to international documents published around the same time, the high-risk groups are almost identical. For example, 1989 WHO guidelines on how to review national programmes suggested the following high-risk groups: "STD patients, drug addicts, truck drivers, prostitutes, men having sex with men, displaced populations, refugees, street children and suspected AIDS cases" (WHO's Global Programme on AIDS, 1989b). Furthermore, a 1993 training programme for national programme officers cited high-risk groups as: "STD patients, drug addicts, truck drivers, prostitutes, men having sex with men, sexually active youth, military, population receiving blood transfusions, prisoners, migrant workers, industrial workers, women of child-bearing age (15-49 years)" (WHO's Global Programme on AIDS 1993). When listing high-risk groups, all three Sudanese policies were very similar to the international guidelines of the GPA and not based on national data. This seems to show that donor ideas were not necessarily challenged and, in this case, WHO's GPA ideas were taken up without critical reflection.

As the conceptual framework from Chapter two points out, emulation of policies could have happened for two reasons. One reason may simply have been limited institutional capabilities. In this instance, it could be argued that SNAC/SNAP had little experience. Having just been

established, they had limited understanding of the HIV/AIDS situation in Sudan. Since WHO's GPA was one of the major players working with the national programme, it made sense that SNAC/SNAP would turn to them for direction on policy content (KI#28 23/4/2008). For instance, one interviewee at that time noted: "*We needed help; we didn't know what we were doing. We were lucky to have such experts at WHO, they knew what to do*" (KI#33 30/10/2008). A second reason could have been the *timings* at which problems arose, along with demands to create policy-led solutions. Bennet highlights timing as important to emulative policy transfer, postulating that: "The more urgency to come up with a solution that is perceived, the more likely will be the imitation of solutions without lengthy analysis and investigation" (Bennett 1991). Upon discovering a case of AIDS in the country, SNAC/SNAP might have wanted to act quickly to develop national policies to give some direction to the HIV/AIDS work. One interviewee present at that time commented: "*We had to get things moving, there were already AIDS cases and we had no policies and no programme really*" (KI#28 23/4/2008).

Classification of high-risk groups in NSP & NP: non-use of data

By 2002, Sudan had completed its first epidemiological and biological survey. The analysis consisted of a survey collecting information about the knowledge, attitudes and behaviour of HIV and HIV prevalence in different population sub-groups in 11 out of 15 states in the north and three states from the south. The overall sample size in the survey was 7,385. **Table 1** below describes the sample sizes and HIV prevalence found in different sub-groups (Sudan National AIDS Control Program 2002b). Based on interviews and national documents (NSP and NP), this information gathered from the 2002 survey (especially the prevalence rates) formed the basis of the NSP and NP.

Table 1: The 2002 National Survey Results

Population group	*Sample size*	*Numbers of HIV +*	*HIV prevalence*
ANC	3355	30	1%
Truck drivers	300	3	1%
Prisoners	**200**	**4**	**2%**
Tea sellers	**512**	**13**	**2.5%**
Soldiers	377	2	0.5%
Displaced populations	417	4	1%
TB patients	367	6	1.6%
STI patients	362	4	1.1%
Street children	**265**	**6**	**2.3%**
Suspected cases	24	6	25%
University students	369	4	1.1%
FSW	**367**	**16**	**4.4%**
Total	*7385*	*118*	*1.6%*

*Those groups in bold are the high-risk groups (higher than the average HIV prevalence) according to the 2002 survey.

The high-risk groups identified in the NSP and NP were STD patients, truck drivers, FSWs, displaced populations, street children, university students, prisoners, tea sellers, soldiers and TB patients (Sudan National AIDS Control Program 2002b, Sudan National AIDS Control Program 2005b).

According to the 2002 survey, however, data showed prisoners, tea sellers, street children and FSWs to be the only groups to be higher than the average HIV prevalence. But the NSP and NP added STD patients (1.1%), truck drivers (1%), displaced populations (1%), military (0.5%) and TB patients (1.6%) suggest that if one compares this classification to international documents, emulation of policy seems to have happened. For example, a 1997 joint UNAIDS/WHO document, “Sexually transmitted diseases (STDs): polices and principles for prevention and care” discussed prevention activities and targeting of services for STDs and stated “potential vulnerable groups” to be:

1. Sex workers (prostitutes) – female and male; Identifiable groups of clients of prostitutes, such as military personnel, long-distance truck drivers, tourists/business men, seafarers, migrant workers, refugees, displaces persons, single men in urban

2. Men who have sex with men (MSM), such as self-identifying homosexual men and bisexual and covert homosexual men

3. Substance users, e.g. injecting drug users and their sexual partners (particularly of importance where there is a high HIV level amongst injecting drug users and/or where prostitution is used to support a drug habit)

4. Prisoners, especially where juveniles are mixed with long-stay inmates

5. Young people (10-24 years), especially when out of school and unemployed (e.g. street children) (UNAIDS and WHO 1997).

Another UNAIDS provisional report, published in 1998, "The status and trends of the HIV/AIDS epidemics in the world" stated some vulnerable populations to include sex workers, factory workers, military, fishermen and truckers" (UNAIDS 1998). Finally, "Monitoring the declaration of commitment on HIV/AIDS. Guidelines on construction of core indicators", published by UNAIDS in 2002, stated "IDUs, men having sex with men, sex workers, youth, mobile populations and prison inmates" to be especially vulnerable to HIV/AIDS (UNAIDS 2002). The key point is that comparing the UNAIDS/WHO's description of high-risk groups - mainly STD patients, truck drivers, displaced populations, refugees and the military - to the NSP and NP, it seems the national policies added UNAIDS/WHO's suggestions of high-risk groups to their own local definitions. This seems to be an example of the uptake of international norms at odds with national data.

Prioritising social and moral pressure: MSM

What is of particular significance in this account is that in the listing of the high-risk groups, there was no mention of MSM, nor was this group mentioned in any of the national HIV/AIDS policies. Considering that there had been a local study showing a relatively high prevalence of HIV among MSM (9.3%) compared with the general population (Mustafa Elrashied 2006), which was four times higher than most groups and more than twice as high as the next highest group (FSWs),

there was almost no information on this population at all. According to Mustafa Elrachied (2006), MSM was not a new phenomenon in Sudan, but had always been denied because of religious prohibition. This is replicated in other countries where Islam and same sex relationships often conflict (Sudan National AIDS Control Program 2005c, UNAIDS 2006a, Abu-Raddad, Ayodeji Akala et al. 2010). The deliberate omission by SNAP of MSM in its listing of high-risk groups appears to be an active exclusion of an illegal and morally controversial group, who should in fact, according to the national data, have received the most attention. In this instance, local conservative traditions and religious doctrine took precedent over international guidelines and even national data.

The listing of high-risk groups in the Sudanese national policies therefore reflected two different processes. First, the acceptance of categories of high-risk groups even if they were not relevant to the Sudanese context, and second, the omission of a category that was potentially problematic and controversial. This shows that SNAP was not always willing to accept or act on the evidence, but rather gave in to moral and religious pressures, eventually ignoring the evidence and omitting a group that should have been included. Even after the 2002 situational analysis, which yielded prevalence rates for certain groups in Sudan, the policies did not use the national data but opted for data from international guidelines. As well as this, there was overwhelming evidence that MSM was a high-risk group but SNAP chose not to include it. In this way, the shape of the policy space shifted through policy content by using international recommendations on the characterisation of high-risk groups and applying them to national high-risk groups without considering the local context. Moreover, the high-risk group classification was important because the condom promotion debate from the point of view of the nationals was focused on whether condoms could be promoted only to those groups or promoted more broadly.

There was clearly heavy donor influence in these early policies. My document review found strikingly similar texts between the national policies and the guidelines of WHO's GPA. Considering there had been few studies that could have indicated the most appropriate preventative programmes for Sudan, it made sense that emulative policy transfer generated the prevention sections of SNAC/SNAP's HIV/AIDS policies. Since most of the funding came from donors, SNAP seemed to focus primarily on satisfying the demands of foreign donors to guarantee funding rather than understanding its own epidemic with context specific prevention policies.

These external policies were secular, neutral and biomedical in responses to HIV within specific groups, which allowed SNAP access to and a stake in the international debate to develop a universal standard HIV policy, which promised an increase in funding and prestige. International ideas seemed to be largely copied and transformed into national policies without considering the local context.

3.4 Condom policies

The HIV NP included the country's "policy guidelines for condoms" (pg. 24-25). It states:

1. Sudan National AIDS Control Program (SNAP) has to develop clear plans and strategies to ensure the availability of good-quality condoms, including needs assessment, supplies, storage, cost, financing, distribution, monitoring and evaluation
2. There is a greater need to ensure availability of condoms at places and times where they are needed; including hospitals, STI clinics, primary health care (PHC) units, health centres, university clinics, counsellling centres and private clinics of medical practitioners
3. Availability of condoms in the drug and medical stores should also be ensured for use among sexually-active people and risk groups
4. SNAP should promote development of culturally acceptable information packages about the efficacy of condoms to achieve the policy objectives
5. While ensuring availability of condoms, it is equally necessary to see that the quality and reliability of condoms are also guaranteed
6. For some risk and vulnerable groups such as truck drivers, sex workers, seasonal workers and refugees, a community distribution system through volunteers and peer educators should be developed under supervision of SNAP and the State AIDS Program
7. Condom distribution and plans should by no means affect the promotion of the more culturally sensitive and acceptable abstinence and fidelity that are deeply rooted values in the Sudanese society (Sudan National AIDS Control Program 2005b).

These guidelines were meant to support the main actors in HIV prevention in Sudan. The section in the NP began with a discussion of the prevention of STIs generally, in which condom use was advocated (Sudan National AIDS Control Program 2005b).

My account of policy-making in Khartoum had, up until this point, been relatively straightforward: it was developed in a top-down way and led mostly by the donors. SNAP was encouraged by donors to develop NSP and NP in order to attain on-going funding for the national HIV programme. Similar to other sections of national documents from 1989-2001, these condom policies seemed to also mimic ideas and even phrases from international guidelines or policies. The first three statements or policies by SNAC and SNAP use many of the key words and phrases from WHO's GPA 1989 and 1993; these are highlighted in **blue** in **Table 2** below.

Despite the evidence that SNAP borrowed from international guidelines to develop their own national condom policies, its initiation was entirely by SNAP. According to interviewees, in the early stages, donors were rarely directly involved in the push for developing the policies. As one civil servant at SNAP argued: "*There was a weird alignment among us after the donors came. It was like we were ready for it. Condom promotion was key to the NP*" (KI#67 27/4/2008). Another said, "*I remember the time of the development of the NP, condom promotion was set by us*" (KI#68 18/4/2008). Specifically, a couple of SNAP staff verified that most of them in the national programme seemed to agree to put the promotion of condom use in the NP without guidance from donors; many of the interviewees confirmed this (KI#70 10/4/2008; KI#45 13/2/2009; KI#24 24/03/2009; KI# 56 20/6/2008). As one SNAP officer said: "*We wanted to develop HIV policies for condom promotion to exist, since condom use was in most HIV prevention policies around the world*" (KI#75 13/4/2009). One FMOH declared: "*How could we not include condom use in our national policies? Donors would be interested no*" (KI#45 13/2/2009). SNAP almost pre-emptively understood that funding would continue if there were condom policies in their national policy. As one donor openly said,

> We didn't even mention condom use. We wanted them to understand what kind of policies the country wanted to develop. Those at SNAP understood that more funding would come (KI#71 18/8/2009).

Another donor AP reaffirmed: "*It was a peculiar period for us and our relationship with the Ministry. We didn't push SNAP on the content of policies but they were smart and we knew they would produce condom promotion for HIV prevention*" (KI#29 4/9/2009). Although donors did not overtly ask SNAP to develop condom promotion policies, it was to understand that developing them would garner the financial support necessary to continue with national plans for a more comprehensive HIV prevention strategy.

Despite condom policies being initiated by national counterparts, there was still a high level of doubt as to the efficacy of such policies in Sudan. Interviewees reported that many felt the

Table 2: A Comparison of International Guidelines and National Guidelines Related to condom promotion

Condom promotion	Guidelines for Reviewing National AIDS Programme of WHO's GPA 1989	A Training Course for National AIDS Programme Management of WHO's GPA 1993	Policy Statement of the Sudan National AIDS Committee 1989	Mid Term Plan (MTP) 1989	Sudan National Policy and Guidelines on HIV/AIDS and STIs Control 2002
	Promotion of safer sexual behaviours: information, education, communication (target groups: general public, youth in and out of school, people practising high-risk behaviours (e.g. prostitutes, clients of prostitutes). Condom procurement and distribution systems should be included in policies, priorities, targets, quality insurance (i.e. high quality) and sustainability of systems.	Strategy: To prevent sexual transmission of HIV Intervention 1: Promote safer sexual behaviours. The purpose of this intervention is to promote five safer sexual behaviours. The five behaviours (or elements) are: a) Correctly use a condom every time an individual has sexual intercourse of risk (including vaginal and oral intercourse). A condom is used correctly when it is put on prior to penetration and removed only after penetration has finished. b) Decrease the number of non-regular sexual partners. That is, an individual will have fewer non-regular sexual partner(s) in the future than at present. c) Practise mutual fidelity. That is, an individual will only have sexual intercourse with a specified person such as a spouse (or, for example, with several spouses in polygamous societies) who is also only having sexual intercourse with that individual. d) Engage in safer sexual acts. e) Abstain from sexual activity.	Promote safer sexual behaviours through: Education and counselling of high-risk groups (prostitutes and clients of prostitutes) under prevention of sexual transmission. Condoms will be included in strategies and targets, and be of high quality will be made available as required.	Targeted risk reduction education under prevention of HIV. Syphilis rates are significantly elevated and may be a co-factor for HIV infection. SNAC proposes to develop 3 new pamphlets targeting: women, men and youth at risk especially people practicing high-risk behaviours (e.g. prostitutes and clients of prostitutes). Specific information regarding the prevention of HIV, especially the promotion of safer sexual behaviours, will be included. Condoms shall be included in national strategies and targets, of high quality will be made freely available at clinic sites for all sexually active persons.	To promote safer sexual behaviours: Education and counselling of high-risk groups under prevention of sexual transmission. Condoms: Condoms shall be included in policies, priorities, targets and be of high quality and in sufficient quantities will be made available as required and at minimal service charge at STI clinics, family planning, AIDS programs, authorised health facilities and other agreed distribution channels by the National Council on HIV/AIDS targeting high-risk groups (prostitutes, prostitutes' clients). People should use condoms correctly, decrease number of non-regular partners, practice mutual fidelity, abstain from sexual activity and generally engage in safer sexual acts

promotion of condom use was irrelevant in Sudanese society. A national Sudanese stated: "*We have to work on prevention of HIV/AIDS. We hardly have any infections but numbers infected will*

rise if we don't address issues like prevention and protecting people" (KI#23 15/6/2008). An FMoH civil servant working on communicable diseases confirmed:

> HIV is on the rise. We have the money to do something really important. I am involved more than I was in the beginning. I was sceptical of the process because of the low HIV prevalence but we have to get ahead of the problem. Get condom use in now while we are still low in the numbers" (KI#70 10/4/2008).

The top stakeholders in the government, however, still wanted to move forward to work with donors on HIV and condom policy:

> We received more money than we can handle to support our HIV programme. We cannot have a programme without policies that support HIV/AIDS interventions, especially condoms. We need to build upon our knowledge of HIV in the country and develop a policy for the foundation of that programme" (KI#72 6/6/2009).

SNAP seemingly acted as an impetus for the development of condom promotion and pre-emptively developed policies donors would support and give more funding to.

This policy development was not an easy process for SNAP, however; there were clear lines against the inclusion of condom policies in any national policies. According to interviewees, many of the top policy-makers believed that Sudan should not have condom promotion policies. An epidemiologist working at the MoH in Khartoum stated: "*We don't need condom interventions. We need to teach people abstinence. Even partner reduction is better than telling people to use condoms*" (KI#46 3/4/2008). Another civil servant reiterated: "*Most of the people think condoms should not be on the top of our strategy. But we have to talk about B [be faithful), A [abstinence]* (KI#49 4/6/2008).

Although condoms were available, they were only readily so to high-risk groups through "community distribution systems" to "truck drivers, sex workers, seasonal workers, refugees and IDPs" (pg. 39) (Sudan National AIDS Control Program 2004a). These groups were characterised as risky and vulnerable. The general population had access to condoms only through medically related establishments, which represented a significant barrier. Even more striking, these systems of distribution had been developed under the supervision of SNAP. Delegating condom promotion primarily to high-risk groups was also a way for SNAP to present condom promotion "outside" and beyond the "normal" Sudanese community.

The guidelines for condom promotion were nevertheless was quite vague, employing a degree of constructive ambiguity that left room for different interpretations and approval by different actors. Here, SNAP was able to offer a solution that was not definitive, thereby allowing it to be more flexible and have “chameleonic” characteristics, allowing national condom policies to be interpreted in different ways to satisfy all actors involved.

This chapter has described and analysed the processes of developing the first HIV prevention written policies in Sudan. WHO drove the initial imperative, but as more donors became interested in Sudan in the early 2000s, this influx of donors expanded policy development. Through emulation, donors affected the content of national policies. WHO and UNAIDS were particularly important: in fact, some policies were similar or identical to WHO guidelines. Inevitably, international ideas were implanted into policies that appeared to be at odds with the local context. These inaccuracies may derive from emulation without sufficient contextual consideration. With extremely high amounts of funding available, Sudan unsurprisingly emulated pieces of international policies to make them their own. Eventually, however, SNAP also took what I describe as pre-emptive action, developing policies according to what it presumed international expectations were, or would be.

This was underscored by adoption of the classification of high-risk groups. However, in this instance the deliberate exclusion of MSMs showed how SNAP also pre-empted local religious views and concerns. This limited the policy space, especially with respect to the extent of inclusion of condom promotion. Moreover, these different dimensions of policy transference illustrate the different pressures that started to emerge.

4. THE NATURE OF SNAP: PERSISTING, ADAPTING AND COPING

The last chapter focussed on the development of policies: how SNAP developed policies initially via a top-down process and then a more creative mode of foreseeing first what the donors wanted and then what they felt would be acceptable to the community. This move, to independently develop condom policies in a context where there was limited information on the HIV situation yet strong cultural and religious influences, led SNAP to ignore national data and respond to internal social and religious pressures. Nevertheless, in this instance, SNAP demonstrated a strong adaptive acumen for adjusting to complicated conditions.

This chapter will focus in more detail on how SNAP brokered with different groups of people to adjust the common understanding of the role of condom use in the response to HIV. The demands of three groups— religious leaders, non-governmental and private organisations— and SNAP personnel, as well as their government partners, required different tactics because each held different priorities. Religious leaders wanted to be empowered and have influence, non-governmental and private organisations desired SNAP's approval and validation of their programmes related to condom use, and SNAP personnel and their government partners wanted verification of their own dislike of condom use and its incompatibility to the Sudanese context. Although SNAP came up with the suitable responses to each, they were never able to consolidate the issues and became committed to an on-going process of brokering.

4.1 RELIGIOUS LEADERS: LOCAL POLITICAL LEADERS

Religious leaders were powerful actors in private life but equally in public life. This section will draw from data concerning religious policy elites, their power, and their need for SNAP to abide by their rules or perspectives. SNAP had to influence these religious policy elites by affirming their power and convince them in their own way of the positive features of their own beliefs.

Generally there were two groups of religious leaders: those who were part of the general community and were in charge of their own mosques, and a second group who were part of a community of policy elites. Those that were a more integrated into their own community were actively more opposed to condom promotion. For example, there were instances of religious leaders preventing implementers from carrying out condom promotion activities. A UNDP HIV/AIDS officer stated:

> We have a lot of problems with religious leaders. Most do not believe that we have a problem with HIV so promoting condom use does not make sense to them. In the field, one of our officers was told to leave the community after mentioning the word condom to prevent HIV/AIDS as a part of her discussion (KI#18 20/8/2008).

A Lokita (a local NGO) health specialist reiterated: "*Religious leaders are our biggest opposition when it comes to talking about condoms*" (KI#58 4/12/2008). ACORD also confirmed religious leaders to be an obstacle to promoting condom use (KI#22 17/2/2008). A religious leader working in a mosque in Omdurhaman affirmed:

> We don't believe in condom use. In fact, it is haram and unacceptable to use. The condom leads to sin and as Muslims it is forbidden. This is the teaching of the Qur'an (KI#53 30/8/2009).

Another religious leader in Khartoum East claimed: "*Even if we wanted to tell people (which we don't) to use a condom, the people wouldn't. They are holy and understand the teachings of Allah. We do not promote condom use*" (KI#9 20/8/2009). There were many instances in the data where religious leaders not only did not believe condom promotion should be part of the HIV response, but actively stopped condom promotion activities.

The second group of religious leaders were fewer in number and were a fragment of a particular section of society: policy elites. Policy elites can be defined as specific actors "who hold high positions in an organisation and often privileged access to other top members of the same and other organisations" (pg.5) (Buse, Mays et al. 2006); and whose responsibilities include affecting or making important decisions in the policy arena (Grindle and Thomas 1991). There are many studies pointing to policy elites and how they facilitate policy development and implementation (Sabatier and Mazmanian 1981, Lee, Lush et al. 1998). Particularly in Sudan, some of these policy elites were religious leaders and had influence over the everyday functioning of society. SNAP was able to convince some of these policy elites close to the government that HIV was not only a problem, but that the country needed data and policies, including condom policies, on the situation before meaningful progress could be made (KI#4 2/5/2008; KI#53 30/8/2009). A SNAP civil servant stated: "*He [policy elite] had the ear of the president. They talked amongst each other and [the policy elite] was able to reassure the government of the importance of [the NSP]*" (KI#26 22/3/2008). With the support of SNAP, this gave them tools to persuade others that HIV was a problem; one policy elite exclaimed, "*We have to go to others and encourage them of the importance of recognition of HIV in the country. As well, how condom use and being faithful are*

part of the prevention of HIV" (KI#78 6/6/2009). Data referred to a few religious policy elites believing in the effectiveness of condom use (KI#37 26/9/2008; KI#60 8/11/2008).

Many interviewees spoke about religious policy elites trying to convince the so-called *moataalimin* to promote the development of the NSP. There is no literal translation for *moataalimin* but according to interviewees, it could mean 'enlightened people', 'not closed' or characterising someone who has a 'general openness'. Moreover, those who were 'enlightened' were often physicians, religious policy elites and those in or close to the government who were open about issues to do with HIV and its prevention via condom use. The term 'enlightened people' was even used in the national documents. For example, when discussing how to assess knowledge and attitudes of high-risk groups, the MTP described: "selected enlightened individuals, especially, physicians and other health workers and particular religious policy elites will conduct interviews" (pg.20) (Sudan National AIDS Committee 1989a). One actor when discussing *moataalimin* spoke of those "*who were more open*" or "*more knowledgeable*" (KI#4 2/5/2008). The same interviewee also made comparisons between the "*traditional*" and those who are "*enlightened*" (KI#4 2/5/2008). Another interviewee spoke of enlightened people as "*Those you can approach, to convince; those who are not blind*" (KI#30 15/10/2008). Likewise, another interviewee stated that: "*If you can persuade people of this calibre, we would make a breakthrough in HIV/AIDS. People will follow*" (KI#5 6/10/2008). Those 'enlightened' actors included some government officials and religious leaders, who helped to facilitate the formulation of the NSP. The implication is that if the religious policy elites could succeed in convincing *moataalimin*, they would consequently succeed in producing the NSP with condom promotion as one of its pillars of HIV prevention.

Religious leaders were especially against condoms being included in the NSP (KI#33 30/10/2008). One religious leader based in Omdurman commented: "*Why do we have to have condom promotion. It is not our way of doing prevention. It is about faithfulness not about having sex with others*" (KI#80 18/3/2009). Another religious/community leader stated: "*We will not tell our people to use condoms. It is against Allah*" (KI#57 27/8/2009). Even for family planning, condom use was prohibited: "*We let Allah choose for us. We have no right to limit the wonderful gift of children. It is haram to even think of it*" (KI#34 14/05/2009). The use of the word *haram* or illicit

was used in two other interviews when speaking of condom use and contraception (KI#9 20/8/2009; KI#45 13/2/2009).

Related to family planning and marriage, condom use proved even more difficult to promote among polygamous marriages. Sudan had legalised a growing transformation of family life: polygamy. Men having up to four wives in Sudan was common practice. Moreover, despite religious connotations underlining polygamy, it was not enforced by the Qur'an: the *Hanbali* law permits a "*Legally binding clause of monogamy to be written into the marriage contract on the premise that God allowed polygamy but did not command it*" (pg.55) (Fleuhr-Lobban 1987). *Shari'a* law has insisted on the consent of the woman or her *wali* (marriage guardian), who should be her father or relative, on whether her husband can marry another woman. If the wife refuses, a *Shari'a* judge can act in this capacity. It is well known, however, that if a woman refuses her father's choice of a husband, there is a big possibility that she would be isolated from her family. It seems that polygamy is interpreted more as customary law than *Shari'a* or law in the country (van de Donk, Hancher et al. 2006). Marriage was thus shown to be a deeply complicated cultural system, involving family ties, tradition, modernity and Islam.

Polygamy seemed to exist throughout all levels of society. A reproductive health monitoring and evaluation researcher working for an NGO stated: "*There are many men practicing polygamy, especially farmers. Men in these situations need the children to upkeep the land*" (KI# 67 6/5/2008). A Ministry of Health civil servant working on communicable diseases pointed out that:

> There are complications on how to conduct our prevention activities in our department, for example on the prevention of STIs, some wealthy men are married to a number of women and having sex with them without using a condom. Some of the women are quite young. Knowledge of STIs, HIV, pregnancy and communicable diseases in general is unknown (KI#28 23/4/2008).

The spheres of religious and public life intersected in many ways making it difficult for SNAP, as well as religious policy elites to manoeuvre. In addition to the influence of international guidelines, policy elites were also influential on the development of policies from a national level. Policy elites expanded the policy space partly due to contextual factors that were changing rapidly: the HIV landscape in Khartoum was transforming into a more international arena with many interested donors and organisations. As a result, the religious policy elites had the power

to seize the opportunity to progress its national interests to a combined international and national endeavour. Moreover, the policy elites' "openness" to condom promotion as a part of the national policies allowed them to influence key actors, who were initially more hesitant to the idea, to accept condom promotion as a national strategy in HIV prevention.

SNAP could use the power of these selected religious policy elites to their advantage to negotiate and adapt with those against condom use, especially some religious leaders. One SNAP policy analyst stated: "*We cannot constantly fight with the religious leaders. We are on the same side but we have to use religious policy elites to convince others of the importance of preventing HIV and ways in which to do it*" (KI#67 27/4/2008). Another SNAP member said: "*We must use our resources in the best way possible. Our religious elites are those people. They are the key to community to accept*" (KI#31 14/4/2008). SNAP understood the power of religious policy elites but chose the appropriate ones to carry the messages SNAP wanted.

Lipsky (1980) refers to actors having to cope with difficult environments such as the one described here, especially those in which the work atmosphere is unpredictable. He refers to these actors as often trying to cope or manage their work life and pressures against their own ideals. In other words, actors must deal with challenges arising from their working environment, especially organisational mandates or the general work context of the country, which sometimes clash with their own values and preferences. They must also cope with the demands of other actors, which might take many different and sometimes opposing shapes and forms. Here, SNAP dealt or coped with the opposition of condom use from some religious leaders by strategically using policy elites to persuade them that condom use should in some way be part of HIV prevention.

Religious leaders have a significant influence on the acceptability of condom promotion in HIV prevention, because, as well as guiding people spiritually in Sudan, they also guide people in everyday decisions. SNAP members managed religious leaders' resistance to condom promotion by manipulating the written policy so that it was accepted by religious policy elites.

4.2 NON-GOVERNMENTAL AND PRIVATE ORGANISATIONS

Non-governmental organisations (NGOs) had a particular relationship with SNAP, which contrasted significantly from the one that religious leaders had with the programme: they not

only needed the approval of SNAP of programme initiatives but also their validation of their interventions. NGOs relied heavily on working with SNAP on the progress of their projects. NGOs can be defined as

> Groups of individuals organized for the myriad of reasons that engage human imagination and aspiration. They can be set up to advocate a particular cause, such as human rights, or to carry out programs on the ground, such as disaster relief. NGOs are usually independent from government (pg. 186) (Charnovitz 1997).

The state played an extremely important role in every aspect of life in Sudan. It was in charge of macro-economic policies, determined law and order, and, at the time of this research, had taken over health, education and agriculture. The state also acquired a greater role in taking over economic, political and cultural and social functions, which played out within NGOs and private organisations (Tandon 1991). This particular dependency that NGOs and international organisations had on SNAP was often difficult to manage. Negotiating the inclusion of condom use in the NP often aggravated the already tenuous relationship between international organisations and NGOs.

In contrast to other countries working on HIV and the promotion of condom use, NGOs and the government were working extremely closely together on these programmes. Interviews in Khartoum indicated that NGOs seemed to be not only working *with* the government, but also were quite *dependent* on approval of the government for the implementation of programmes. For example, a health specialist working for a national NGO stated: "*Our entry way to the people is through our leaders and policy people, really the government officials and religious leaders. So first we have to convince the leaders then to the people*" (KI#27 7/2/2008). A former SNAP worker:

> When you work in prevention, if the government doesn't think that it is a priority, you will find many constraints and then you will be trying to make the constraints go away. The government must be agreement. The religious leaders have just as much power as politicians because they trust each other. The imam speaks and believes in their beliefs. But the politicians are important has facilitators, to move things, to move constraints, to do something that NGOs cannot do (KI#13 26/9/2008).

Another local organization reiterated similar sentiments about approvals from SNAP:

> We work closely with the government. We have to. We don't move unless the government allows us to. Once they say OK, we can move on the intervention but they usually send someone during the intervention to see if we are really doing what we say we did (KI#48 17/2/2008).

Other partners working on HIV and condom use had similar experiences and dependencies on SNAP. There were many examples of such relationships between NGOs and SNAP. Even private organisations had a good working relationship with SNAP. DKT International was one of the private organisations SNAP worked regularly with and had a good working relationship. As one programme implementer confirmed:

> All implementation of programmes have to be pre-tested. Each programme has to be circulated through the religious people, politicians, ministries, including Ministry of Health, Ministry of Guidance. All messages, small or big, or programmes go through to them and if the governments and religious leaders feel the message or programme is ok, it and can be communicated without any problems (KI#37 26/9/2009).

Despite the good relationships NGOs maintained with SNAP on the formulation and implementation of programmes, difficult discussions occurred between NGOS and SNAP. NGOs seemed to be in agreement with the inclusion of condom promotion in the national policies. As in the NSP, according to interviewees, NGOs wanted to put condom use explicitly in the NP as a means of prevention against HIV/AIDS early in the formulating process (KI#19 18/3/2008; KI#23 15/6/2008). According to a reproductive health programme officer working for a national NGO, "*Sudan needed condom use in the policies for preventing HIV/AIDS. Not having condom use was unheard of in a national prevention policy*" (KI#65 16/7/2008). On the other side, it seemed that SNAP did not want to appear so 'open'. As one SNAP official closely involved in the development of the NP remarked:

> We are very cautious when we discuss condom promotion. We fought to make a very neutral, less volatile statement on condoms that would allow us to include a section on condom use strategically and not to provoke people. It would affect the whole HIV response negatively if faced with confrontations from influential people. We made a lot of compromises when we developed the guidelines on condom use but the word condom is in the policy (KI#16 27/8/2008).

In trying to manage this struggle between a government body and national organisations, SNAP has had to change some established and approved protocols in relation to condom promotion activities of organisations, which required some struggling on SNAP's part about what they wanted, represented or even wanted to push as a common agenda. Respondents reported that SNAP had advised NGOs not to promote condom use as an HIV prevention strategy and sometimes advised them not to even discuss condoms in certain communities. For example, an HIV/AIDS health specialist working for an international organisation focusing on health stated:

> *SNAP told us to stop giving out condoms to [X] community. We had to move the funding to another part of the prevention programme. It was a real mess because we worked very*

> *hard on getting the awareness and distribution done in an appropriate way* (KI#14 28/9/2008).

The relationship between NGOs and other organisations and SNAP could be described as a mutual dependency: NGOs and other organisations wanted approval from SNAP on most projects dealing with condom use; SNAP needed them to move forward with their programme, meaning NGOs and private organisations had to change some of their positions on condom use interventions to accommodate SNAP; SNAP had to not only support these organisations, but also act as the lead on HIV programme in the country.

4.3 Government

Most government counterparts wanted verification from SNAP on what they themselves believed in: that condoms were not appropriate for the country. SNAP was therefore in a difficult position because they wanted to push for condom use to be included in the policy. In response, SNAP pushed for control and kept their government counterparts in check by foregrounding discourses from the global political sphere attached to condom use and HIV prevention.

According to interviewees, many of the top policy-makers within the Ministry of Health (MoH) believed that Sudan should not have condom promotion policies. An epidemiologist working at the MoH in Khartoum stated: "*We don't need condom interventions. We need to teach people abstinence. Even partner reduction is better than telling people to use condoms*" (KI#46 3/4/2008). Another civil servant reiterated: "*Most of the people think condoms should not be on the top of our strategy. But we have to talk about B [be faithful), A [abstinence], then C [condom use]. It is not acceptable to talk about reduction of partners, because we just have wives and husbands*" (KI#34 14/5/2009).

Even within SNAP, there was opposition to condom use being part of the national programme. A former head of SNAP also said:

> Condom use is not a relevant strategy for us. It is too sensitive. Let's focus on being faithful. As an Islamic country – you don't talk about abstinence, no way. Because our religious leaders encourage youth to go marry. There is no room to talk about being abstinent. So being faithful is the only option (KI#47 16/11/2008).

There was strong resistance from national actors who believed that condom promotion was contrary to the traditions of Sudan and closely related to promiscuity, immorality and sin (KI#46 3/4/2008; KI#1 27/08/2008; KI#8 30/9/2008). Often, the objection from some SNAP civil servants

was: "*We don't need condom promotion, we are religious*" (KI#25 17/2/2008); or "*condom use will increase sexual immorality*" (KI#45 13/2/2009). A national consultant who was present at the time commented:

> There was a clear distinction between us and them: the nationals believed that because we were not having extramarital sex, we did not need condoms; and *khawaja* just wanted to include condoms at whatever cost (KI#36 26/2/2008).

The word *Khawaja* was used by some interviewees to refer to "foreigners" in a negative sense. Since there is not a direct translation of *khawaja*, it usually meant 'outsider' or 'those outside to us [Sudan]'. In the particular case of condom policy, *khawaja* were the ones promoting condom use and thus were outside of the traditions and morality of the Sudanese community.

Many people believed that condom use was a way for foreigners to control Sudan and its HIV national response. One Sudanese employee at DKT claimed: "*Foreigners tell us what to do with condoms and how to use condoms. Many of us don't want that control over us. We want control but we don't have the power*" (KI#32 8/12/2008). A UN interviewee working on condom distribution in Sudan stated: "*There is a fear of condoms [in] Sudan. People think it is westerners bringing in condoms to prevent Muslims from making babies. People are scared*" (KI#12 14/2/2008). An UN interviewee goes on to say,

> This type of resistance is based in the community, due to religious perceptions, due to the conservative nature of people in the country. Some people at the community level do not want to see the volunteers speaking about condoms or providing condoms to the people. It is because of foreigners. It is them bringing sin to us (KI#12 14/2/2008).

As more funding became available, however, SNAP and FMoH began to take more control of the process and seemed to realise the importance of addressing the condom issue: the development of NP with the inclusion of condom promotion, as well as understanding the sensitivity of the issue. A former head of SNAP confirmed:

> Because condoms are a very very delicate issue. And if you don't approach it properly, you can desensitize the people against our condom campaign. Condoms have to be part of our prevention plan. There is no other way. We have to put the condom in the prevention package. We have to speak about it … Here in Sudan, an Islamic country, there is no room to talk about having sex ... So to talk about sex is not accepted here (KI#47 16/11/2008).

As one SNAP programme officer, looking after partnerships with government agencies and other sectors, mentioned,

> We didn't know what to do. There was a lot of resistance from some on condom promotion. We were moving too fast in the direction of sex and condoms and some were not ready for this. Some of us were reluctant and we knew that we could not rush it (KI#44 4/9/2008).

As Chapter three pointed out, the policy included some discussion on condom use, mainly on availability and distribution. Some SNAP actors believed that it was imperative that the policy fit with Sudanese circumstances. For instance, two civil servants working for SNAP referred to the condom section as a '*harmless policy*' (KI#16 27/8/2008; KI#31 14/4/2008). Regarding the condom recommendations, a civil servant of MoH stated: "*We tried to please everybody, in a way, but we first value abstinence and being faithful and the condoms are only for targeted groups, most at risk populations. Thus we focussed on condoms but observed the values of society"* (KI#16 27/8/2008).

The "harmless policy" on condom use seemed to work reasonably well for SNAP and MoH. On the one hand, the presence of the word "condom" in the prevention package was SNAP's pre-emptive and predicted expectation of the donors to find condom use as an HIV prevention strategy included in the NP. On the other hand, a certain amount of strategic vagueness about how to promote condoms not only satisfied the government actors but also allowed the reader to interpret the policy freely. If SNAP had decided to write the policy differently, for example, insisting on condom promotion more explicitly, SNAP's government partners participating in the policy development might not have endorsed the policy and would therefore have set process back.

To cope with the challenges of balancing different partner preferences, one official remarked:

> You have to understand SNAP has two faces. When they are sitting with the UN, they are open about the policy, condoms and sex. But when they are sitting with ministers or government, they take a totally different position (KI#19 18/3/2008).

Another NGO HIV specialist commented:

> [SNAP] has to be flexible when they deal with the HIV community. There are many players: donors, HIV workers, nationals, ministers and the government. Condom promotion is a positive thing for most of us but within government circles, it is something else. It is difficult for SNAP. SNAP has to advocate for different issues in prevention, but often they are in a sensitive position. On one hand, they are on board with us; and on the other hand, they have to keep the balance on how they can negotiate and discuss with government partners (KI#50 14/2/2008).

SNAP's "two faces" underlined the important difference of reaction to its government partners. The government partners needed to know SNAP was not going against them. The process of involving various actors in the development of these policies, each contributing different perspectives, was identified in the conceptual framework as "harmonisation", which focusses on the national and international dynamic through interdependence and cooperation of others (Lasswell 1936) performing their own task (Bennett 1991).

This notion of a more flexible policy reiterates Smith's (2013) "chameleonic ideas", where she argues that actors seek to shape policies in various ways so to allow different interpretations appropriate to specific actors. As actors are faced with different pressures, Smith (2013) states: "these pressures seem likely to have contributed to the development and promotion of ideas with mercurial, chameleon-like qualities, which adapt to survive in a variety of settings, being easily interpreted and applied in different ways" (pg. 198) (Smith 2013). Again, the NP offers another example of donor and international influence during the early formulation of the policy. However, SNAP was able to manipulate the situation to benefit itself and at the same time allow different players to interpret the policy in a way that aligned with their position in a limited policy space, ultimately showing the importance of national actors in the process of policy development. Seen this way, national and international actors seemed to have a good understanding of what was at stake and negotiations were possible because they both had something to gain from a policy that included condom use. SNAP inevitably emerged as a critical broker of compromise in this challenging situation.

A more flexible policy could also address the diversity of culture, religion and tradition in Sudan. It should be noted, however, that during the in-country data collection process, there was no mention of these differences, highlighting again the possible neglect of the local context as a whole. Questions of why the vast difference in peoples' cultures and traditions were not addressed could be explained by the very Khartoum-centred orientation of the north, known as the "one-city state" as explained in the background chapter. Similarly, the data seemed to show similar patterns with a focus on Khartoum center, which neglected even those communities very nearby (i.e. Omdurman and Khartoum North).

The move to develop a condom promotion strategy was indeed seen as a push originating from the Sudanese nationals to construct their own National HIV strategy. In this way, HIV/AIDS being construed in national and nationalist terms seemed to be concurrent with a process of pushing Sudan onto the international stage. HIV/AIDS could be seen as a metaphor for threats to a nation and this was a way to unite and pull the country together. Developing an HIV/AIDS strategy, including a condom promotion package, and working with international agencies could be seen as a way for Sudan to gain international recognition. This was a strategy in which SNAP could lead the way for a strong national front against HIV/AIDS. Developing these policies enabled the country to attain a significant amount of funding for HIV/AIDS.

This idea of a national front against HIV/AIDS called into question the extent to which the policy was a national one. In Khartoum, there was limited information on HIV, the care and treatment of AIDS, or how this related to Sudanese knowledge and behaviour, and there was even less information outside of the capital city. Hotspots like Darfur or South Sudan were home to organisations focusing on the emergency issues; as a result, HIV/AIDS was a low priority for the region.

SNAP was officially responsible for the whole of Sudan: South Sudan, which was predominantly Christian and North Sudan, which was Muslim and Arab-speaking. Technically, being responsible for the AIDS response for the entire country, HQ – SNAP would work closely with all branches/offices in the country, including South Sudan. There were questions over whether SNAP was really a national HIV/AIDS programme dealing with both North Sudan and South Sudan. On one hand, many of civil servants working at SNAP reiterated that SNAP was indeed a national programme: A SNAP official stated,

> I have been working with HIV since 2001. Most of my career experience has been in HIV/AIDS in this program National Program on HIV/AIDS in Khartoum… In the beginning, SNAP was mostly made of some people in the states but it was limited in its capacity and resources. And I could see the difference now, SNAP as an institution and we are the national response to HIV/AIDS (KI#1 27/08/2008).

A team director at the MoH confirmed: "*SNAP is a national programme, one that addresses all states and formulates policies for action*" (KI#11 5/8/2008). Discussing the different roles of SNAP: a civil servant at SNAP stated, "*My duties were to conduct prevention, awareness sessions and to supervise the other two people in my unit in our national HIV/AIDS programme. We had to stop*

HIV nationally and quick before it got worse" (KI#3 16/10/2008). Another civil servant at SNAP echoed: "*We had to develop a plan of action and then a strategic plan (national, state and sector levels)*" (KI#15 23/4/2008).

On the other hand, SNAP did not refer to anything outside of Khartoum, questioning the very nature of SNAP's mandate as a national programme. It was established that SNAP was a national programme but there were rarely references to anything outside of Khartoum. After the formulation of the National Strategic Plan for HIV/AIDS remarked, *"All the HIV/AIDS work is in Khartoum. Even so there are aspects of the epidemic around Khartoum we knew nothing of"* (KI#4 2/5/2008).This particular interviewee continued to discuss aspects of problems in Khartoum and no other states. When conducting the interviews on HIV policies and implementation of these policies, they were also Khartoum-centred. A planning officer working closely with procurement stated:

> I deal with all procurement procedures – review the data from all the sites, manage all the procedures. For the condom programming, in 2004, I was bringing condoms through UNFPA for Khartoum. It was a huge step for Sudan (KI#20 15/10/2008).

Similarly, there were rarely discussions on anything outside of Khartoum. It should be noted that at the time of the interview, Darfur was an area that should have attracted lots of public health attention: there were many international observers (UNAMID) (at the time, it was the biggest UN humanitarian force in the world) and the HIV epidemic in Darfur was unknown. HIV infection rates among members of the military are usually higher, and this generally increases infection in the civilian population, especially among young women. Based on the interviews, however, there was no reference to anything outside of Khartoum, including Darfur and its HIV situation. An interviewee working on dissemination of HIV information to the states specified, "*We work mostly on Khartoum because this where the manpower is*" (KI#2 4/09/2008).

It took time for the main stakeholders to agree on the inclusion of condom promotion in the way SNAP envisioned. Understanding how condom promotion was integrated into Sudanese society was key to persuading important stakeholders to accept such policies. Moreover, despite getting approval from SNAP on most activities, national and international organisations faced social resistance when implementing condom promotion activities. In addition to community opposition, however, the resistance extended to law enforcement. However, the status of NGOs,

national, and international organisations in Sudan placed them under further scrutiny by state security. In managing these multiple demands, SNAP revised, reprioritised and eliminated aspects of its policies. In doing this, condom promotion became more applicable to the local context.

The manner in which SNAP was able to convince government officials and religious leaders in different strategic ways to eventually come to a compromise demonstrated the continued importance of the national level. The way in which the national and private stakeholders were forced to conform to national needs by adapting to the local context demonstrates the need for, as well as the results of, mediation through the middle space between the 'top' policy-making processes and 'bottom' policy-making processes.

Examples of different strategies as a way to manage the demands and forces highlight how this complicated setting necessitated SNAP to creatively think of ways to handle their work environment. The approaches used to deal with these situations underlines the importance of SNAP's influence over how the policy was developed, revised and used by attending to multiple pressures in ways through "chameleonic" and "rationalising" mechanisms. Having varying perceptions of a flexible policy allowed SNAP staff to manipulate the various situations in order to mediate better with different actors and consider their needs to further the acceptance of condom policies.

5.THE MULTIPLE OF USE OF CONDOM PROMOTION

The previous chapter investigated how SNAP brokered and managed three distinct influences of power and politics from religious leaders, NGOs and private organisations, and government partners. SNAP was able to remain relatively stable in its role as mediator despite having to accommodate and broker different demands of various groups of people and individual actors working on condom promotion. In contrast, this chapter analyses how SNAP tried to deal with more diffuse and dispersed forces, particularly those rooted in religious beliefs, which were infused throughout Sudanese society.

First, I will explore arguments that saw condom use as promoting family planning. I will discuss how religious leaders, based on Qur'anic teachings, did not want people to prevent pregnancy and therefore generally forbade the use of condoms as a form of contraception. Next, the chapter will present viewpoints that saw condom promotion as affecting the relationship between men and women. It will focus specifically on the way in which women lived in Sudan at the time of the research: within a male-centred society, in which they had limited control over their choices, especially with regards to their bodies. I will address issues of female genital mutilation/cutting (FGM/C) and female sex workers (FSWs) as two examples that illustrate the extent to which many women lacked the ability to make their own choices about their bodies and health. The third part of this chapter will then present ideas about condom use as encouraging sex outside of marriage, and ultimately promoting promiscuity. It will explore the societal assumption that if there were easy access to condoms, it would encourage people to have sex.

There were many ways in which SNAP responded to these various forces embedded in Sudanese society. The Khartoum declaration and the letter to *Mujama al farhim* will be presented as two examples that illustrate how SNAP responded in various ways. Together, SNAP used these two documents to navigate and respond to these religious and cultural issues. The key point here is there was no simple way to promote condom use: SNAP's response was multiple, requiring them to play with text or strategically omit text.

To better understand better the context in which condom use was seen by different groups, and how SNAP responded to these issues, it is crucial to consider the social and cultural climate in Sudan at the time of the research. As Chapter One highlighted, there was little distinction

between state and religion at the time. Lines between public and private life were often blurred, and the distinction between government ministries and NGOs was similarly indistinct. Given that there was also limited separation between faith and state (Deng 1995, Holt and Daly 2000, Natsios 2012), the Qur'an constituted not only a religious text, but also a guide to legal matters, and the authority on social behaviour.

Amn al mojtama, or "the social police", offer a good example of this fuzzy demarcation. After the "salvation revolution" in 1989, the government formed a body responsible for control of social behaviour, *amn al mojtama*, translated as "security of the society" or more commonly known as the social police, which was an informal body of the Ministry of Interior. The social police wore civilian clothing rather than uniform, and they enforced a mode of conservative Islamisation, monitoring everyday life across all strands of Sudanese society (Salam Sidahmed and Sidamhed 2005). Many interviewees spoke of the social police (KI#27 7/2/2008, KI#19 18/3/2008, KI#31 14/4/2008, KI#59 12/12/2008). The social police made sure that people were abiding by *shari'a*; many interviewees confirmed similar sentiments (KI#10 30/3/2008; KI#26 22/3/2008, KI#31 14/4/2008; KI#34 14/5/2009; KI#7 16/11/2008). According to interviewees, the social police observed, for example, alcohol consumption, physical contact between men and women and women's dress (Informal discussions 2008).

There were examples of *amn al mojtama* hindering organisations' activities on condom promotion. Many organisations (10 out of 19 interviewed on the subject) reported confrontations with the *amn al mojtama.* According to an HIV/AIDS officer who worked for SCRC: "*Social police are against condoms. One of our doctors in the field was stopped by the social police because he was seen holding condoms. If the social police find condoms on you or they know you are using them, they will punish you*" (KI#73 2/9/2008). While there were no interviewees who were actually arrested or detained for condom possession, there were some reports of this threat deterring organisations from discussing condom use in the wider community. As the head of an organisation working closely with government explained:

> If the social police catch you with a condom, this is considered as evidence that you are intending to participate in sex. If you have a condom, you will have sex. On the religious side, it means you are having sex outside legal sex. If you are having sex like that, you will be punished. The social police have not caught you having sex but you are intending to have sex and this is a crime in Islam. So the social police uses the condom as a method of proving that you were intending to have sex and you will be punished" (KI#37 269/2009).

An organization working on reproductive health confirmed:

> A national staff working on HIV has been stopped by the social police. Someone in the village spoke out and told the police that there were people from an organization passing out condoms. The national staff who was stopped were held for almost 6 hours questioned by the police. He was scared and felt like he was treated very badly (KI#33 30/10/2008).

Another example of blurred lines between public and private life in the Sudanese context was illustrated by the situation of public life for men and women. At the time, Islamisation affected all aspects of life. In 1996, Sudan began to implement a "public order law", shaping the gender order at the public level (Nageeb 2004, Cockett 2010). For example, transportation became segregated between men and women. There were individual cabins just for men and other cabins for women. Also, in some instances, parties and public spaces had to have separate seating; all public service establishment and institutions that require individuals to stand in line had to provide a separate line for each sex. The effects of the separation of men and women in public places entered into the private spaces of Sudanese communities. A male interviewee working at a local NGO claimed:

> [Men] need our own space. Sometimes [men] cannot talk freely with women around. Our cafes are becoming more open with some mixing among the younger population. But there are many more eating places and cafes where women are not welcome to be so close to us (KI#76 7/9/2008).

Similarly, women wanted to have their own space. A participant reiterated this in an interview:

> We need our own space. Women are not part of any real discussion. So we have to make our own. But this is what we have become. We have gone back in time and only think we are forward looking and modern (KI#60 8/11/2008).

An interviewee from a national organisation working on family health argued:

> We [women] are not a part of our laws. They are made for men and not for women. Family health laws go to the extreme and protect men and promote our masculine values with no thought of how women are affected. This is what we need to address— not condom use (KI#54 3/4/2009).

Other interviewees verified the space between men and women in public space. Women felt isolated and not a part of the lives of men; at the same time, however, they were resigned to this fact and accepted it. As this section has dealt with issues in the public space, the next part offers examples of societal and cultural values having influence over more "private spaces" of individuals

and their actions. There was a lack of boundaries between social and private life; religious values were expected to be obeyed, not only within social interactions, but also by individuals.

5.1 Condoms and Family Planning

In this section, I will address arguments that see condom use as promoting family planning. I will discuss how religious leaders, based on Qur'anic teachings, did not want people to prevent pregnancy and therefore generally forbade the use of condoms as a method of contraception.

At the time of the research, religiosity in Sudan was very high. Religiosity has many definitions: it can be defined as a number of dimensions associated with religious beliefs and involvement, or as "the degree of being religious" (Madni, Hamid et al. 2016), or "the degree to which beliefs in specific religious values and ideals are held and practiced by an individual" (Mokhlis and Terengganu 2008).

Under Islamic law, contraception is not advised. The Qur'an does not refer to contraception explicitly but some Muslim scholars opposed to birth control often quote the Qur'an as saying "*You should not kill your children for fear of want*" – Qur'an: 17:31, 6:151 (Atighetchi 1994, McCarthy 2011). Muslim opinion with respect to contraception is divided, with a minority arguing that it is categorically prohibited, whilst the majority opinion is that contraception is allowed but discouraged, referring to family spacing (Ebrahim 1998, Dhami and Sheikh 2000). Most scholars, however, agree that there are clear lines when discussing condom use to prevent pregnancy: it is strictly forbidden to prevent people from having children (Schenker and Rabenou 1993).

Considering that there seemed only to be a minority of scholars that believed contraception to be forbidden, interviews in Khartoum confirmed the negativity towards using any form of contraception. When discussing condom use and family planning, an interviewee working with another government sector related to health said: "*We cannot prevent our wives from having children. It is against Allah, our religion, our traditions* (KI#62 3/2/2008). A national consultant verified: "*We are not allowed to prevent pregnancy. Children are a gift from God*" (KI#79 08/09/2008). Various interviews with the MoH and other ministries confirm that contraception is forbidden in the Sudanese context; an expert on family planning in the MoH stated: "*Our communities are strictly following the Qur'an. They don't sway away from the teachings of Allah.*

The teachings do not tolerate the use of contraception. Our society adheres to that" (KI#60 8/11/2008). When asked about specifically about condom use: one civil servant at a Ministry argued: "*Condom use to prevent pregnancy is forbidden. The more children you have – the more blessed you are by and the more blessings you will receive from Allah"* (KI#19 18/3/2008). Another indicated the same sentiments and added: "*A Sudanese would never jeopardise the loss of God's gift. It is haram!*" (KI#15 23/4/2008).

The research noted that these same reactions were common among religious leaders. As one religious leader explains:

> We cannot dictate what God wants us to do. We don't have control over many things. This is especially true when we speak of pregnancy. God offers us gifts and it is our duty to accept them (KI#42 18/6/2008).

Other interviews referred to teachings on Friday and referred to their Imams who strongly taught against contraception (KI#64 17/6/2008; KI#39 19/7/2008; KI#12 14/2/2008). One community leader recalled:

> During Ramadan, at a discussion with a smaller group of people with the Imam after prayers, we spoke about contraception. Our Imam made us understand the problem with preventing a gift from God come into the world, especially boys. We are blessed to have such a generous God (KI#55 23/5/2008).

Another interviewee who regularly participated in a discussion with Imam during Ramadan claimed:

> Condom use is loaded with un-Islamic connotations…promoting condoms as a contraception is corrupt and offensive to our faith" (KI#78 6/6/2009).

Also when interviewing organisations implementing condom distribution programme in the communities realised quickly that condom distribution should not be associated with family planning. For instance, a person in charge of attaining the condoms from their headquarters for distribution in Khartoum noted: "*We have strict instructions from headquarters not to discuss family planning and condom use in Sudan. Condoms should only protect people from sexually transmitted infections or HIV*" (KI#40 3/9/2008).

Interviews made clear that religious leaders, Imams at the time did not approve of condoms as a means of contraception. Based on the interviews, promoting condoms as a form of contraception was very un-Islamic.

5.2 Condoms and Gender

This section will endeavour to describe how promoting condom use was felt to challenge existing gender relations. It will argue that women had limited control over their choices, especially their own bodies. The Sudanese context excluded women from the debate when discussing condom use because these types of conversations were only ever had between men. Beginning with a general account of dress-code, I will draw on two radical examples, female genital mutilation/cutting (FGM/C) and female sex workers (FSW) in order to demonstrate the more general situation women in Sudan found themselves in.

Through the process of Islamisation, the government began to impose a "modest" dress code on women. Specifically, women had to cover their hair with the *hijab* or the veil in public space. A Sudanese civil servant working for MoH reiterated, "*All women wear the hijab now. The women who don't wear the hijab are not considered proper women* (KI#23 15/6/2008). Significantly, this was presented as a means to ensure Sudan was a modern Muslim state. Interviewees indicated mixed feelings about women and the *hijab*. One person working for an international organization, said: "*I like wearing my hijab. It allows me to discuss almost everything, including sensitive issues more freely. I don't think I could do this without my hijab"* (KI#35 4/6/2008). Another woman working for the Ministry of Health reiterated, "*We are encouraged to wear the veil but I would anyway. It is in our culture and way of being now. And it allows us a sense of freedom among our male colleagues. Something we didn't have before*" (KI#49 4/6/2008).

It is certainly the case that some literature points to positive effects of the Islamisation project on women (Westerlund and Rosander 1997). For example, women were not allowed to vote during the reign of the Muslim Brotherhood but after the 1980s, were able to be quite vocal at the public level. In fact, the leader of NIF, el-Turabi, pointed to 30 women being appointed to public office (Lowrie and Turabi 1993). With women wearing Islamic dress, Nageeb (2004) argues that women could then interact with men in public. It was said that that the *toob* (traditional dress) was not negative and decreased the social space between women and men.

There were other views, however, that did not conform to the sentiments of "freedom" or "ease" arising from wearing a veil. For instance, a Sudanese UN reproductive health claimed:

> We are forced to wear the veil. If we don't wear it, the social police will tell us to put a scarf on and say how one is disrespecting the Qur'an. We must be able to be free. This is not freedom. I'm not sure I would wear my *hijab* if I didn't have to. But it doesn't matter I guess whether we want to wear it or not. The situation is the way it is. Even when we, just my girlfriends, get together we wear the hijab. It is normal now (KI#4 2/5/2008).

Another Sudanese women working for the UN stated: "*We all have to wear a veil. It is a part of our tradition now. But I do remember, women not wearing them. It was easier back then. Women had the choice*" (KI#50 14/2/2008).

There were, therefore, mixed views on how these new roles affected women and in public space. At the time of data collection, most women wore the veil and some even in a *burqa* (full dress). The social police appeared to be active and ready to reprimand women if they were not dressed appropriately. But women seemed to be able to navigate this complex context of "Islamization". There were those who accepted the new rule of wearing a veil and welcomed it as a way to be more comfortable with sensitive issues. But there were others who did not readily accept the ruling even if they abided by it, and eventually resigned themselves to wear what was dictated.

Although I did not collect data about FGM/C, I make reference to it here because it is illustrative of how women had limited control over their choices, especially concerning their own bodies, thereby revealing a more general view of what issues women were experiencing at the time of the research. Sudan had one of the highest prevalence rates of FGM/C. Nearly nine out of 10 women aged 15-49 in Sudan had been cut (UNICEF 2013), with 37% of girls affected being under the age of 14 (UNICEF 2013). Sexual problems for women attributable to infibulation have been recognised in the literature (El Dareer 1983, Hosken 1993).

According to Hosken (1993), the rigidly defined roles for men and women instilled the belief that in order to fulfil the masculine role, the bridegroom must inflict pain, and the woman, in her role, must suffer. Women often said that their penetration was terrible, agonizingly painful, and frequently resulted in haemorrhage or prolonged infection. Some women saw this as a positive aspect of FGM/C (Hosken 1993). There was also the characteristically Sudanese notion of renewable virginity and a reassertion of the husband's role of male dominance, which required

him to inflict pain on his bride. Behind it all, there was the irrefutable fact that without a tight repair, the condition of the woman's sex organs (sooner or later) made her an ostensibly inadequate sex partner. This was a source of great worry to all women, as multiple marriages are permitted to the Islamic man, and a wife feared having to share with another wife. Hosken has consequently argued that the reconstitution of a pinhole-sized vaginal opening was thought to insure the wife's position by providing her husband with a “virgin” hole again.

Although some Islamic scholars have denied that Islam mandates FGM/C (Almroth, Almroth-Berggren et al. 2001, Almroth, Almroth-Berggren et al. 2001, Gruenbaum 2006), studies found that at a local level, Sudanese Muslims who practice FGM/C believe that it was required or at least permitted under Islam (Herieka and Dhar 2003, Sargent 2006). For example, a study conducted by Herieka et al. (2003) assessed the knowledge, attitudes and perceptions of FGM/C in Khartoum among university students; they found that the students who favoured the practice believed that it was a religious mandate (77.4% of males and 50% of females), and that this belief was especially concentrated among Muslim students.

In light of these studies, there appear to be complex reasons as to why FGM still continued. FGM/C seemed to be a long standing established practice related to sexuality, but which was also tied to cultural, social, religious and traditional values in the Sudanese context. FGM/C appeared to have been a good example of how even women already at a very young age did not have any influence over their choices, especially over their bodies.

Whilst undoubtedly it is possible to adopt a relativist stance, and highlight how – in the context of many other pressing health concerns – FGM/C may not be as central a risk as Westerners often proclaim (Parker 1995), what is of relevance is the extent to which this practice reproduces more general issues about women’s control and agency. My argument here is that the widespread practice makes it clear just how little involvement women in Sudan could have in any matter relating to gender politics and sex, including condom use. They therefore relied on what men or someone else (in the case of FGM/C, it was usually an older female family member) wanted and decided, even if this affected the risks they might face from HIV infection

As with the FGM/C example, I did not study female sex workers (FSWs) specifically, but similarly, FSWs were included here as an example case because they also offered a glimpse of what women were experiencing in this context. More specifically, they offered an example of how women had limited choices. In a study investigating investigating FSWs, including attitudes to and behaviours with condom use in Khartoum, part of the research was to discuss condom use and their experiences with their clients (Sidahmed Abdelrahim 2010). During a discussion with FSWs promoting condom use as one of the ways to prevent HIV, the primary investigator for the study recounted:

> Of course you can talk about condom use among female sex workers but not everyone will accept it. For the ones who don't accept it, it is because their clients don't want to use it. This prevents the use of a condom every time (KI#74 20/10/2008).

Another SNAP officer working on the same project affirmed: "*We should be promoting condom use to FSWs but many of them would not use condoms. They often say that condoms prevent them from getting paid*" (KI#34 14/5/2009). One discussion with one of the main SNAP officials connected to the study on FSWs reaffirmed: "*Even if FSWs want to use condoms, clients refuse. It is the nature of the business*" (KI#60 8/11/2008).

Drawing from these three examples of the hijab, a more visible demonstration of a strong influence over women, and more private or hidden examples of FGM/C and FSWs, I have offered perspectives on a general set of values around women and how women have limited agency over choices in their lives and their own bodies. FGM/C was not a choice made by the girl but a choice made by people closest to her; FSWs, in the same way, reported they did not have a choice to use a condom. Regardless of arguments that see women wanting to wear the veil or FGM/C in a positive light, these examples together demonstrated an important point about the cultural and social values of Sudan. These examples emphasised how a policy on condom use was really based in a context where society revolved around men and male behaviour and women were expected to comply; they exemplified a certain control over women and the lack of power that women had over their own bodies.

5.3 CONDOMS AND SEX OUTSIDE OF MARRIAGE

This section will cover discussions surrounding condom promotion, which framed the practice as a way to increase promiscuity. Condom use in this way related to sex outside marriage and inevitably opened up wider debates about youth and sexuality. On one side, what was known or

"spoken" about in society was that youth were not having sex and people were not having sex outside of marriage. On the other side, there existed a public secret that everyone seemed to know and understand: people were having sex outside of marriage, but no one wanted to admit it. The assumption in society was having easy access to condoms or promoted condom use, would encourage people to have sex outside of marriage.

In this way, there can be two main ways to see sex and condom use in the context of Sudan: the official way and unofficial way. The official line on condom use states that no young people are having sex and therefore there is no need to promote condom use, whilst the unofficial way understood the reality and recognized youth were having sex, as well as people having sex outside of the marriage.

In the first way, the official way: many believed youth were not having sex. For instance, one SNAP civil servant stated: "*Our kids are not having sex. This is especially true now. Religion here in Sudan is strong and we abide by Islamic law*" (KI#34 14/05/2009). It seemed common knowledge that people believed kids were not having sex; and men were not having sex outside of marriage. Religious edicts were strong influences over why people thought kids were not having sex. Another civil servant working for another ministry commented:

> Our kids don't have sex and if they did, they would be married. People outside our country don't understand how the religious life takes us. Our children are brought up in a strict Muslim way. There is no question (KI#56 20/6/2008).

Some interviewees questioned the official view of sex and condom use; a Sudanese health care worker with an international organisation stated:

> Kids aren't supposed to be having sex. Religion is so strong here. You can be put in jail for even having a condom if you are caught by the social police. Kids are not talking about sex or condom use. No one talks about it. Does it exist? We are in denial about it (KI#43 15/3/2008).

This quote accurately showed the contradiction: against the background of high level of religious belief by the community, on one hand, the belief was kids were not having sex. On the other hand, people were in denial about it and no one spoke about it. Another interviewee reiterated: "*Our kids are not supposed to have sex but they are like kids everywhere, they are having sex but nobody talks about it*" (KI#2 04/09/2008). An M&E expert in one of the ministries claimed: "*Everyone*

knows kids and adults are having sex outside of marriage. We are Muslim yes, but let's be realistic. Sex exists" (KI#21 4/5/2009).

Based on these interviews, there was an unofficial way of seeing pre-marital and extra-marital sex and condoms: many people acknowledged that kids were having sex and people were having sex outside their marriage. One interviewee working for the Ministry of children and youth stated:

> We know very well our youth are having sex. Are they using condoms, nobody knows. There is a deep denial within the community. We aren't supposed to talk about it. But we all know sex is happening (KI#41 17/9/2009).

There is a tension between what is official and what is really going on. There is a silence, a public secret, about the unofficial way of thinking about sex and condoms. Based on interviews, the public secret of sex and condoms is carefully managed by all sectors of society. One interviewee points out:

> We don't really know whether there is sex outside of the marriage. Our denial feeds into this. The Qur'an forbids it. But who suffers? The youth. We have to protect them quietly (KI#72 6/6/2009).

There was a tension between what is official and what is really going on. This contradiction was not easy to handle by SNAP and organisations generally: on one hand, one acknowledged the secret if one promoted condom use, which prevented people from promoting condom use. When one talked about condom use, one was actually talking about people having sex. In a country where religion played an important role in everyday life, discussing condom use and marriage were taboo because inevitably discussions centred around people having pre-marital sex and sex outside marriage and these issues had moral consequences. People went along with this paradox: if people were using condoms they were having sex.

This public secret was managed carefully by SNAP. Being able to discuss people having sex required constant brokering across lines – "how do we acknowledge people having sex when it is difficult to speak about condom use?" It was a vicious circle. There was a constant need to broker across the lines. If professionals said condoms were being used, it meant kids were having pre-marital sex or husbands/wives were having sex outside of marriage. However, this was never acknowledged in public because people were not supposed to be having sex before or outside marriage.

5.4 Condoms and Responding to Different Forces by SNAP

This section will use two documents to demonstrate how SNAP responded to these different ways of seeing how condoms were used: encouraging family planning methods, empowering women or changing the relationship between men and women, and promoting promiscuity. SNAP used strategic devices that allowed sufficient interpretation of what was true by using ambiguity and omission of information within the texts to respond to these ways of seeing how condoms were used.

First, interpreting the Khartoum Declaration was illustrative of how SNAP was able to craft text or phrases to be flexible, or more open to interpretation, when dealing with the realities of the social and cultural context and trying to reassure and placate through caveats in the text. Second, responding to the letter of *Mujama al farhim* was a way to reassure Ministry of Guidance that their condom promotion was in agreement with the social and cultural mores of Sudan, providing condoms to high-risk groups only.

Interpreting the Khartoum Declaration

Analysis of the Khartoum Declaration will demonstrate how SNAP found a way to navigate these different forces. They were able to use an official document and not mention the word "condom" in the document, enabling different interpretations to help them manoeuvre different concerns and what they needed. SNAP adopted a strategy of what could be called "strategic ambiguity" or "complete omissions" in the wording to address these different forces, specifically on issues of family planning and sex outside of marriage.

In 2008, a multiparty initiative, funded by UNDP, Ministry of Guidance & Endowment (MoG&E), HIV/AIDS Consulting Council and SNAP, worked with religious leaders to raise their awareness on HIV/AIDS prevention strategies. The objective of the project was to develop a culturally sensitive kit for both Muslim and Christian leaders to use when discussing HIV/AIDS. As part of the kit, the religious leaders wrote the Khartoum Declaration stating the "*Basic Religious Principles and Values in Combating AIDS*" (Ministry of Guidance and Endowment 2008). This declaration covered many topics, but key area two— a discussion on how to protect oneself from HIV/AIDS— was most relevant to this thesis (Ministry of Guidance and Endowment 2008).

By the end of the process, the agreed content of the declaration on how to protect oneself from HIV/AIDS stated:

1. A good family is the nucleus of building and protection of society. Therefore, we must encourage formation of families in accordance with teachings of heavenly religions and to remove all obstacles from the way of building families;
2. The platforms of mosques, churches and other institutions must be used to enlighten believers about how to fight AIDS with weapons stemmed out of the original religious principles coupled with scientific tools to innovate new ways on how to deal with serious challenges;
3. Ensure that chastity and loyalty are the two essential components of our call for protection; and
4. We do appreciate the goals of the call made by medical doctors and specialists for the use of various protection instruments to alleviate danger against self and others, while watching out for those who, intentionally or otherwise, transmit infection by not using every possible means of protection that do not infringe upon religious teachings (pg.2) (Ministry of Guidance and Endowment 2008).

Point one advised readers to "encourage formation of families in accordance with the teachings of heavenly religions and remove all obstacles from the way of building families". Although it did not mention condom use as a family planning method, it implied that one should not prevent children. According to the document, the point of having families was to "build" and "protect" society and thus society must "build families". As a result, according to this declaration, condom use for family planning was not permitted. **Point two** emphasised the use of religious platforms to preach on how to protect one's self from HIV through "weapons stemmed out of the original religious principles coupled with scientific tools". The use of "scientific tools" could be seen as condom use acting as a protective role against HIV/AIDS. **Point three** was related to point two by emphasizing "chastity and loyalty" to protect oneself. Putting in this way could be viewed as reinforcing ideas of abstinence and faithfulness in society and therefore discouraging sex outside of marriage. Related to "scientific tools" in Point three, **Point four** above specifically noted that 'various protection instruments' can be used. Overall, language proved sufficiently vague to allow different levels of interpretation. Of the ten participants working on this project I interviewed, ranging from SNAP members to international actors, eight referred to particular ways they could be "flexible with" (KI#16 27/8/2008; KI#17 24/8/2008), "guide" (KI#26 22/3/2008), "mould" (KI#32 8/12/2008), "influence" KI#34 14/5/2008, and "shape" (KI#26 22/3/2008; KI#5 6/10/2008) the vocabulary, and "encourage" (KI#26 22/3/2008; KI#30 15/10/2008) religious leaders to move towards supporting a document acceptable to all parties, which addressed HIV prevention and

condom use (KI#31 14/4/2008; KI#34 14/5/2008; KI#19 18/3/2008; KI#30 15/10/2008). One SNAP researcher steering the discussion confirmed:

> We had to come up with something. There was a lot of pressure from all sides to deliver a statement that the religious leaders would support. It was a challenge we were ready to take on (KI#16 27/8/2008).

The *Khartoum Declaration*'s implicit references to issues of family planning, sex outside marriage and the use of vague terms adequately reassured the MoG&E that SNAP did not promote condom use as a family planning method and that it too encouraged chastity and faithfulness (in other words, that they believed in the public secret of no sex outside marriage).

Responding to Mujama al farhim

Similarly, a letter sent to *Mujama al farhim* by SNAP demonstrated a form of "strategic omission" to confirm to MoG&E that condom use was not generally promoted in society, which touched on issues of gender and sex outside of marriage. This letter reassured the MoG&E that condom promotion was only for high-risk groups, who were already not a part of mainstream society; that those groups had already been agreed to in the national policies; and that condoms were not accessible to the general public outside of marginal communities. Condom distribution would only be supported through authorised bodies. Also, it served as necessary clarification for NGOs and other organisations on condom use promotion and the exclusion of contraception in condom promotion interventions. On the other hand, it kept the context of Sudan safe from threatening issues, including the empowerment of women.

In September 2007, SNAP received a letter from *Mujama al farhim*. According to interviewees, the *Mujama al farhim* was officially part of Ministry of Guidance & Endowment (MoG&E) and commonly seen as a religious covenant: a group overlooking the general morality of individuals (KI#44 4/9/2008; KI#31 14/4/2008; KI#34 14/5/2009; KI#39 19/7/2008). It was reported that the letter had questions about SNAP's condom policy and promotion activities. The letter requested clarification of SNAP's stance on condom use and acted as a catalyst for other questions, including how SNAP and its implementing partners promoted condom use on the ground and what kinds of activities SNAP supported.

Shortly after SNAP received the letter, other organisations heard about it and also questioned SNAP's stance on condom use. As one SNAP research focal point representative stated: "*When people received wind of the letter from the MoG&E, people started asking more questions on condom use, including what kinds of activities were acceptable by SNAP. We were all surprised by the letter*" (KI#77 20/10/2008). SNAP responded by arguing that first, condom use was only promoted for high-risk groups; second, even if condoms were promoted to high risk-groups, condoms would only be for the prevention of HIV.

The third aspect of the letter referred to the distribution of condoms: whether they would only be sold through authorized bodies approved by the government, which included like health institutes, STI clinics and pharmacies (farhim 2007). In this case, we know that women were not allowed to buy condoms at pharmacies and women believed that they would be judged harshly if they were seen taking condoms from clinics (informal interviews 2008/2009). The problems of women having low access to condoms reinforced ideas of women and their struggle to have control over practices around condom use and sexual behaviour.

Unlike the previous chapter, notions of condom use were infused into different aspects of the Sudanese community. Although condom use was seen in diverse ways, all were seen specific to an outcome: as promoting family planning, disrupting the "harmonious" relationship between women and men by empowering women, and encouraging promiscuity. There was no simple way to respond to condom promotion in the context of these public beliefs. SNAP had to create and craft responses to deal with how condom use was seen. The Khartoum Declaration and the letter to *Mujama al farhim* were two examples of how SNAP responded to questions around how condoms were used. Addressing these issues through ambiguity and omission of text, SNAP—via the Khartoum declaration— confirmed to the MoG&E that condoms were only promoted to high-risk groups to prevent HIV, while still promoting "religious teachings of chastity and loyalty" to promote family values. Similarly, through the letter to *Mujama al farhim,* SNAP used strategic manoeuvres to give reassurances to their government and HIV partners that there was specific targeting of delivery and supply of condoms: only approved high risk groups would have access to HIV prevention.

6. DISCUSSION

In **Chapter Two**, I listed my two research aims:

1. To analyse the process of national condom policy development by the Sudan National AIDS Program.
2. To examine the extent to which these policies were managed by the Sudan National AIDS Program.

The first part of the thesis was concerned with analysing the process of how SNAP developed its own national condom policies from the international expectations of major funders. Forces affecting the formulation and actual content of condom promotion policies, such as the role of donors and their relationship to SNAP, national and international actors in terms of influence, and how international guidelines came to be taken up as national policies, were critical to the analysis.

The second part of the thesis explored the Sudanese context to investigate how SNAP had to manage multiple and conflicting demands when using the policies. For most countries where religion and conservative moral practices dominate the social sphere, condom use is a difficult HIV prevention method to promote (Epstein 28 April 2005, Kats 1983, Schenker and Rabenou 1993). For over 28 years, under *shari'a* law, the Sudanese government had established institutions to govern the adherence to *shari'a*. The government had deployed *amn al mojtama* or social police to monitor the social mores of society, including women's dress (i.e. dressing modestly) and social activities in general (e.g. condom possession). Adherence to these strict beliefs governed not only the spiritual, but also social and political spheres of daily life.

This in turn raised questions about how SNAP developed the policies and promoted condom use. Moreover, factors influencing how SNAP officials managed their work environment and how they adapted to the context as well as to diverse demands of other actors when using national condom policies, were important to investigate and understand.

6.1 CHAPTER SUMMARIES

I will begin by reviewing the chapters in the thesis; followed by explaining some limitations of the theories presented in **Chapter Two**. I will then conclude with some suggestions for further research.

Chapter One discussed the literature on HIV prevention and the political history of Sudan, including the country's rule under *shari'a*. I argued that HIV prevention interventions at the time

of this project were often politicized. However, frequently, little attention was paid to the specific local context. Although there was already some literature on condom use and HIV prevention in Muslim countries, which reported tensions between condom use and its promotion for HIV prevention, this had little influence on the international stage. The chapter went on to discuss the complicated political history of Sudan, emphasising its historical focus in the north, and specifically, the way that Khartoum was viewed as a “one city state”. The two on-going conflicts, North-South and Darfur, reflected long-standing religious and ethnic tensions against the backdrop of a recent history of Islamisation.

Chapter Two offered the theoretical foundations of the thesis based on policy analysis research, including accounts of how policies are transferred and implemented, and how actors in the intermediary space between ‘top’ and ‘bottom’ deal with the different pressures and demands. The chapter then concluded with a description of the methods used for the empirical work.

Chapter 3 focused on the development of policies, first through emulation and then in a more dynamic and interesting way, which I described as pre-emptive action. SNAP’s pre-emptive action demonstrated the way in which it internalised international expectations to secure further funding for their HIV programme. This chapter also highlighted MSM as a high-risk group that SNAP ignored despite national data that was available concerning the high HIV prevalence within this group, which was another example of SNAP’s pre-emptive action in relation to local and religious concerns. The chapter emphasised how SNAP was able to manage and formulate a set of condom policies that allowed flexibility to navigate the different internal social and traditional pressures.

Chapter 4 investigated how SNAP reacted to three groups of people: religious leaders, NGOs and private organisations; as well as SNAP civil servants and other government partners. Each group wanted something specific from SNAP, so SNAP had to respond differently to each of them. Using these coping mechanisms and being able to reinterpret policies according to different rationalities to manage the (sometimes contradictory) demands, underlined the complicated setting in which SNAP was engulfed. Although SNAP provided a suitable response for each group, it was never completely able consolidate issues.

Chapter 5 was less about SNAP's response to specific groups, and more about how it dealt with more diffuse or dispersed forces, particularly those rooted in religious and traditional ideas. These shaped how different people saw condom use in a variety of ways. The chapter addressed arguments that presented condom use as: promoting family planning, changing existing gender relations, and increasing promiscuity. These different ideas of condom use were present throughout the society. The chapter then described two ways in which SNAP responded to these matter: through re-interpreting the Khartoum Declaration and responding to the *Mujama al farim*. These examples embodied SNAP's creative and strongly crafted responses to how condom use could be seen.

6.2 LIMITATIONS OF THEORY

Policy transfer and pre-empting

Based on the interviews and document review, the research found that elements of international guidelines or concepts became embedded in the national policies, through a process of emulation. This type of linear transference was described by Bennett (1991) to explain how countries or governments borrow policies directly from others. However, in this case, emulation seemed to be most prevalent during the development of the early policies, when those responsible for writing them directly looked to guidelines of international donors. Over time, however, as the visibility and influence of SNAP increased, it developed condom policies in line with what it thought would be expected. This pre-emptive action by SNAP shaped the eventual national policies adopted. What began as a top-down process, importing international guidelines with little relevance to the local context, changed significantly as SNAP adopted a clearer intermediary role with the policy space in order to facilitate acceptance by the local Sudanese communities.

As part of this process of policy development, SNAP produced guidelines that were either both vague or focused exclusively on high-risk groups, allowing it to promote condom use for HIV prevention against the backdrop of multiple resistance. Framing prevention in this way allowed SNAP to either promote condom use as a practice that sat outside of the general population, deflecting criticism, or avoid the conflation of HIV prevention with issues relating to family planning, promiscuity and gender politics. In this way, Sudan was able to continue to attract

international funding as well as technical expertise while also responding to local concerns and contestations.

By describing this more complex, non-linear, set of processes, it became clear that policy transference theory was not sufficient to explain the development of the national condom policies in Sudan. Instead, what began as a relatively straightforward process of direct copying, became a more on-going and iterative process of negotiations and revisions. SNAP tweaked and reshaped the policy to make it locally acceptable, yet always ensured that the international funders remained happy and that the policies aligned with their directives.

Strategic role of the intermediary

As I introduced in **Chapter Two**, SNAP had to constantly cope with a range of forces, and that this did not end once a policy had been written. The second research objective focused on the role of SNAP in the actual application of national condom policies within the local context. The literature often discusses how coping strategies are developed by so-called bottom-level actors when trying to manage their work environment (Walker and Gilson 2004, Kamuzora and Gilson 2007) (Weatherly and Lipsky 1977, Walker and Gilson 2004, Kamuzora and Gilson 2007). Faced with competing demands or conflicting values, actors have to creatively adapt their actions to manage their situation. However, only a limited number of studies have been carried out to investigate the development of coping mechanisms among mid-level actors. This thesis examined the strategies used by SNAP as an organization of intermediary actors, when trying to manage the different demands from their HIV partners, demonstrating that SNAP had to deal with different groups of actors, both above and below. Those actors from above consisted mainly of donors, UN organizations and other government partners; those below were mainly NGOs, and private organisations and local political-religious groups.

In addition to having to tackle actors and their needs at different levels, they also had to manage the broader environment in which they were operating. Contextual influences heavily shaped how SNAP managed actors and the policies themselves. Depending on whom SNAP was meeting with, it shifted its method and approach. As we have seen, the particular local context of Sudan includes religious and traditional beliefs, which dominate everyday life and dictate certain social norms as well as politics and policies. The way in which SNAP and its HIV partners found ways to reconcile the needs of different national and international actors with these forces was key to its overall response, and the on-going work it conducted.

The multiple meanings of condom use

The promotion of condom use presented SNAP with an intractable set of problems. In a country where there were strong religious and traditional ideas not only surrounding private life, but also embedded in public life, meant that the promotion of condom use was fraught with difficulties. There were many different interpretations of how condoms were used, as **Chapter Five** discussed: mainly there were arguments seeing condom use as a way to promote family planning, increase promiscuity, or alter existing gender roles and relationships. The research revealed that this forced SNAP to respond differently to each concern and the many individuals and groups who demanded to have a voice.

Simply appreciating the context was insufficient to conduct condom use promotion that was acceptable to the community in Sudan. It required multiple reactions at different levels and was a never-ending process, and SNAP's balancing act was not always executed proficiently. Even where SNAP adapted, tweaked and reinterpreted its work in order to be more favourable to community expectations, it nevertheless had to push them to the boundaries of people's ideas of condom use and maneuverer in different ways to make condom use acceptable, even in a limited way.

At the beginning of this thesis, I argued that appreciating that the context of Sudan at the time was crucial. Nevertheless, it was often difficult to acquire this kind of general information gained during the interviews. Sophisticated and nuanced knowledge of the context of Sudan was mainly developed through my general observations of the surroundings, doing the research and working with SNAP, and living day-to-day in Khartoum. In fact, much of the context was in the periphery during more focused attempts of data collection: sometimes it was what was *not* said or *how* it was said that was key. Observing everyday life in Khartoum fed into my understanding, informed what I then interpreted from interviews. Ultimately, this was how I came to understand the role and work of SNAP, in a nation that was both struggling internally but also keen to present itself internationally as united.

6.3 SUDAN AND THE PRESENT

Since the separation in 2011, Sudan has lost most of its oil reserves. More alarmingly, Amnesty International has reported that the Sudanese government has been accused of using chemical

weapons against people in Darfur: according to the report, 250 people have been killed by chemical weapons since the Sudanese military campaign in January (Amnesty International 2017).

Sudan remains under Islamic rule. SNAP still exists but has severely decreased their HIV/AIDS activities, not only because funding has declined but key personnel have also moved into other organisations or out of the country. Currently, in Khartoum, many of the other organisations have also diminished their presence; some have moved to the south. For example, UNAIDS is now a national organisation with no international staff, which is quite unusual for a UN agency to do. The key policy documents, however, have remained the same: particularly the National Strategy on HIV (2003-2009), as well as no reported new studies on incidence or prevalence of HIV (SNAP seems to be still using the behavioural study from 2002).

6.4 Further research

This research has shed light on the complexities of developing formal policies and how SNAP managed and developed and then implemented its national condom policies. Although framed as a retrospective study of the period 2007-2009, the issues described are not only relevant for Sudan in the present, but also many other contexts. The account points to a series of new questions, which warrant further study.

6.4.1 National policies to include the larger local context of Sudan

Throughout this thesis I have stressed the complex political, historical and religious context in Sudan, including SNAP, which is so Khartoum-centered, and avoidant of interventions that target specific high-risk groups, MSM. As the early literature pointed out, in order to appropriately address the HIV epidemic, context specific prevention strategies have to be developed. Throughout data collection, however, regional differences (in language, culture, religion, tradition and HIV epidemic) were also ignored or omitted by many local policy makers. Interviewees did not refer to the communities or districts beyond those associated with Khartoum. So although HIV prevention interventions that consider local context may be more effective at addressing the needs of a community, this approach needs to be adopted even within a country, especially one as heterogeneous and divided as Sudan was at the time this research was conducted.

6.4.2 Increase roles of religious leaders

When investigating how Sudanese national condom promotion policies were developed, the research highlighted the importance of religious and community leaders and their influence over the local community with regard to their beliefs about the acceptability of condom use. Organisations like SNAP could learn more about how condoms could be integrated into religious teachings by engaging with religious leaders from the start, which might potentially develop ways in which condoms might be endorsed, rather than rejected. One entryway for religious leaders could be through Islamic texts. Rather than seeing religious beliefs as a problem, SNAP could perhaps have drawn on Islamic teachings and the involvement of Muslim leaders to find more areas of alignment, and identified specific words or concepts that might have proved particularly useful and productive.

6.5 CONCLUSION

This study sheds light on how the political and cultural context shaped the content of national condom policies and how these policies engaged with local people. It therefore illustrates how public health policy makers often have to deal with numerous and conflicting demands. In the case of condom promotion policies these demands often have moral implications, raising additional questions about how public health approaches can genuinely take into account religious and cultural concerns in HIV prevention strategies.

Sudan was and is unique in many ways. In so far that it has included condom promotion as part of an HIV/AIDS national strategy, it was already extraordinary. The HIV/AIDS response in Sudan could thereby be used as a test case for other Arab and Muslim countries where condom use is a problematic issue. In countries relying on significant international funding and donors' influence over what is done, there would be similar questions about who makes the decisions about which public health goals are promoted, and what interventions are most appropriate.

This study also raised questions of ownership and control over the national programme. In the beginning of the national HIV response, SNAP depended heavily on international donors for their financial and technical support. As a result, the national programme seemed to be driven by external actors. But as SNAP grew and acquired more expertise, however, it gained more control over its policies and activities. Despite the on-going dependence on international funding, SNAP, through adapting its actions when managing difficult situations, achieved what it thought was

best for the country or at least the Khartoum-North. Although SNAP continued to struggle with appeasing international actors, especially donors and their national HIV/AIDS partners, I would argue that it managed, at least partially, to gain some ownership over time.

During this research, I came to realise that context is not just the background or the periphery to the policy space but the centre of what was happening. The context was everywhere: within the range of actors, cultural and traditional norms, and religious beliefs of the country. All these different forces shaped the national condom policy. Since context was composed of these different influences, it continuously evolved and altered. As a result, interventions inevitably had to change and to be reinvented each time. Throughout the thesis, SNAP found itself manoeuvring and tweaking policy, always reacting to different individuals or communities. The account of policy actors occupying a middle space has highlighted the continual need to adapt and create new policy responses that are not introduced from “above” or “the outside” but rather through genuinely engaging with, and reflecting, the concerns, beliefs and values of the people they are designed to help.

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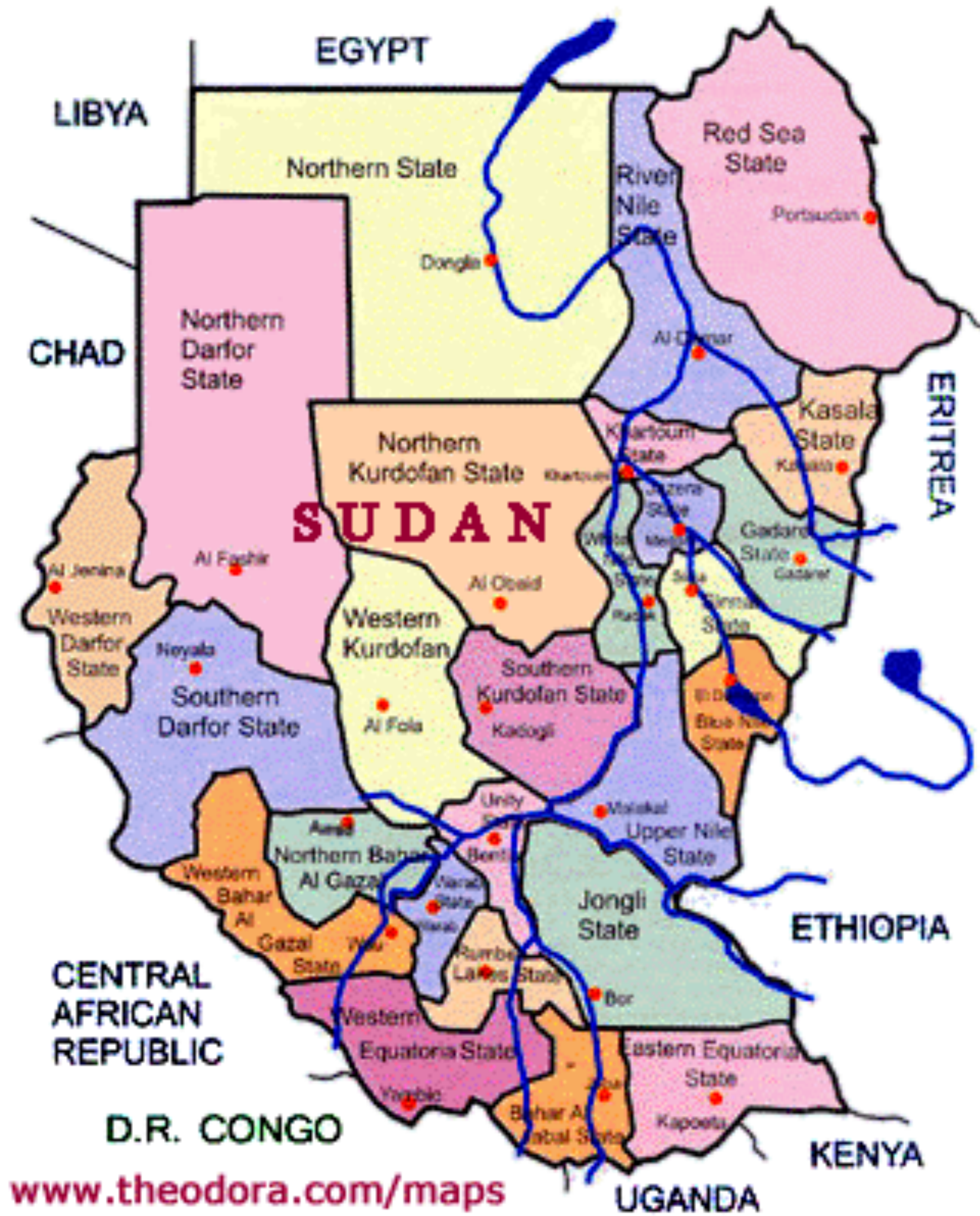
APPENDIX A: MAP OF SUDAN (BEFORE SEPARATION 2011)



APPENDIX B: COMPARISON WHO AND SUDANESE NATIONAL DOCUMENTS

Topic	Guidelines for Reviewing National AIDS Programme of WHO's GPA, 1989	A Training Course for National AIDS Programme Management of WHO's GPA, 1993	Policy Statement of the Sudan National AIDS Committee, 1989	Mid Term Plan (MTP), 1989	Sudan National Policy and Guidelines on HIV/AIDS and STIs Control, 2002
Objectives for National Programme	1) To prevent human immunodeficiency virus (HIV) infection. 2) To reduce the personal and social impact of HIV infection.	To prevent HIV infection: prevent sexual transmission of HIV; prevent HIV transmission through blood; and prevent perinatal transmission of HIV.	Prevention of HIV infection through: 1) Prevention of sexual transmission. 2) Prevention of blood and blood products transmission. 3) Prevention of prenatal transmission.	Prevention of HIV infection through: 1) Prevention of sexual transmission. 2) Prevention of transmission through blood. 3) Prevention of perinatal transmission. 4) Prevention of the impact of HIV infection on individuals, groups and communities.	Prevention of HIV infection through: 1) Prevention of sexual transmission. 2) Prevention of blood and blood products transmission. 3) Prevention of prenatal transmission.
Strategies under Objective 1	To prevent HIV infection: 1) prevent sexual transmission of HIV; 2) prevent HIV transmission through blood; 3) prevent perinatal transmission of HIV				
Prevention of sexual transmission of HIV	Promote safer sexual behaviours; provide condoms and provide STD care.	Promote safer sexual behaviours; provide condoms and provide STD care.	Promote safer sexual behaviours; provide condoms and STD care.	Further safer sexual behaviour (e.g. be faithful); promotion and distribution of condoms; and provide STD care.	Promote safer sexual behaviours; provide condoms and STD care

Topic	Guidelines for Reviewing National AIDS Programme of WHO's GPA, 1989	A Training Course for National AIDS Programme Management of WHO's GPA, 1993	Policy Statement of the Sudan National AIDS Committee, 1989	Mid Term Plan (MTP), 1989	Sudan National Policy and Guidelines on HIV/AIDS and STIs Control, 2002
Prevention of Sexually Transmitted Diseases (STDs)	The purpose of this intervention is to increase appropriate utilization of STD care services. People at risk of acquiring an STD will be educated regarding condom use as a prevention tool and the signs and symptoms of STDs, the possibility of being infected without being aware, the relationship of other STDs to the transmission of HIV and the need to seek care if the risk of acquiring an STD has been taken.	In view of the overlapping activities required for control of HIV/AIDS and those required for control of STD, such as education, promotion of safer sexual behaviours and provision of condoms, the two programmes should ideally be fully integrated with a single AIDS/STD manager. The main aims of STD control are: interrupting the transmission of sexually transmissible infections and reducing the risk of acquiring and transmitting HIV. These aims may be achieved through primary and secondary prevention activities. Primary prevention activities include promotion of safer sexual behaviours, promoting condom use and provision of condoms. Secondary prevention activities include promotion of health care seeking behaviour, directed toward those at risk of acquiring STD and provision of accessible, acceptable and effective services.	Because of their close association with HIV transmission, sexually transmitted diseases will be targeted for improved prevention, to promote condom use and treatment efforts, including increased health education and upgraded training of health-care workers.	Individuals with a history of sexually transmitted diseases (STDs) will be targeted for improved promotion of safer sexual behaviours, especially through clinics and hospitals. It will be important to reach persons most at risk of infection of HIV, especially those with STDs, through acceptable services, especially through local level community members (trained by health workers). These community members will be educated about the risks of HIV/AIDS and STDs and will then in turn use their own culturally relevant and creative medium, through music, performance arts or whatever, to convey appropriate HIV and STD prevention messages.	Because of their close association with HIV transmission, STIs will be targeted for improved prevention and treatment efforts including increased health education, upgraded training of health care workers and adoption of standards of management protocols. The main aims of STI control is to reduce STIs by promoting safer sexual behaviour, including promoting condom use and health care seeking behaviour.

Topic	Guidelines for Reviewing National AIDS Programme of WHO's GPA, 1989	A Training Course for National AIDS Programme Management of WHO's GPA, 1993	Policy Statement of the Sudan National AIDS Committee, 1989	Mid Term Plan (MTP), 1989	Sudan National Policy and Guidelines on HIV/AIDS and STIs Control, 2002
Prevention of HIV through blood	Promotion of safe blood: Rational and efficient use of blood: based on international standards, guidelines and training. Screening and testing of blood and blood products: international based procedures, screening sites. Blood donations from uninfected individuals: policies and regulations for donors, recruitment and selection of donors. Policies should address: systems, management, quality, sustainability, target groups, targets.	Safe blood supply: Motivate, recruit, and retain low-risk donors (those donors who give regularly and are chosen from low-risk populations). Screen blood and blood products for HIV. Provide aseptic conditions for invasive skin-piercing, surgical, and dental procedures to prevent HIV transmission in health care and other settings.	Prevention of HIV through blood: The risk of HIV transmission through routine use of skin-piercing instruments is small but concern about this risk poses a threat to immunization and other healthcare programs. Healthcare workers will provide aseptic conditions for invasive skin piercing and surgery to prevent HIV transmission.	To increase a safe blood supply: Develop a questionnaire, which will exclude high-risk individuals from donating blood and therefore only receive blood from low risk individuals. Make certain that all laboratories provide an aseptic condition for drawing and keeping blood. Strengthen facilities and further implement the screening of all blood donations for HIV and Hepatitis B antigen.	Prevention of transmission through blood transfusion can effectively be accomplished through screening and testing of blood. Sites: all healthcare settings will be sterile and health care workers will be trained on how to screen, take and store blood. To enable an effective programme of blood screening while ensuring the pool of potential donors from low risk groups (not high-risk populations, including prostitutes, STD patients, and youth). Public education will be used to increase the pool of potential donors and to assure them that blood donation is not a risk factor for HIV transmission.

Prevention of perinatal transmission	Provision of information to HIV+ women and discordant couples: Provision of counselling; family planning services; HIV testing and counselling to women and men planning to have a child; risks of breast feeding. These policies must address target groups, targets.	Interventions to prevent perinatal transmission of HIV: Provide information about HIV prevention, perinatal transmission, risk of breastfeeding and family planning. Provide healthcare services, including counselling to women known or thought to have HIV infection.	Prevention of perinatal transmission will rely principally on prevention of transmission to women of child-bearing age through: Pregnancy prevention for HIV-infected women: HIV-infected women of child-bearing age will be educated about the risks of perinatal transmission and offered the option of contraception. Breastfeeding: because the risk of HIV transmission through breastfeeding is very much lower than the risk of death from diarrheal and malnutrition for non-breastfed infants, HIV-infected mothers will be encouraged to breastfeed if they are physically fit.	N/A	Generally the prevention of mother-to-child transmission will principally depend on the prevention of transmission of women at reproductive age and should be given special attention in the fight against HIV/AIDS. HIV infected women at reproductive age whether pregnant or not will be educated on safe reproductive means and counselled about the risks of mother-to-child transmission. Benefits of anti-retroviral drugs and the option of contraception will be offered. Breastfeeding infected mothers should be provided with all the necessary information about the implications of breastfeeding and HIV transmission in order to be able to take decisions that are appropriate to their situations following HIV/breastfeeding guidelines. This doesn't mean discouraging breastfeeding in general.
Condom promotion	Promotion of safer sexual behaviours: information, education, communication	Strategy: To prevent sexual transmission of HIV	Education and counselling of high-risk groups under	Targeted risk reduction education under prevention of HIV.	Education and counselling of high-risk groups under

Topic	Guidelines for Reviewing National AIDS Programme of WHO's GPA, 1989	A Training Course for National AIDS Programme Management of WHO's GPA, 1993	Policy Statement of the Sudan National AIDS Committee, 1989	Mid Term Plan (MTP), 1989	Sudan National Policy and Guidelines on HIV/AIDS and STIs Control, 2002
	(target groups: general public, youth in and out of school, people practising high-risk behaviours (e.g. prostitutes, clients of prostitutes)). Condom procurement and distribution systems should be included in policies, priorities, targets, quality insurance and sustainability of systems.	Intervention 1: Promote safer sexual behaviours. The purpose of this intervention is to promote five safer sexual behaviours. The five behaviours (or elements) are: a) Correctly use a condom every time an individual has sexual intercourse of risk (including vaginal and oral intercourse). A condom is used correctly when it is put on prior to penetration and removed only after penetration has finished. b) Decrease the number of non-regular sexual partners. That is, an individual will have fewer non-regular sexual partner(s) in the future than at present. c) Practise mutual fidelity. That is, an individual will only have sexual intercourse with a specified person such as a spouse (or, for example, with several spouses in polygamous societies) who is also only having sexual intercourse with that individual. d) Engage in safer sexual acts. e) Abstain from sexual activity.	prevention of sexual transmission. Condoms of high quality will be made available as required.	Syphilis rates are significantly elevated and may be a co-factor for HIV infection. SNAC proposes to develop 3 new pamphlets targeting: women, men and youth at risk. Specific information regarding the prevention of HIV will be included. Condoms will be made freely available at clinic sites for all sexually active persons.	prevention of sexual transmission. Condoms: Condoms of high quality and in sufficient quantities will be made available as required and at minimal service charge at STI clinics, family planning, AIDS programs, authorised health facilities and other agreed distribution channels by the National Council on HIV/AIDS targeting high-risk groups.

APPENDIX C: INTRODUCTORY SHEET

I am a researcher at the London School of Hygiene & Tropical Medicine (LSHTM), London UK. My research topic is a policy analysis of the development and implementation of HIV prevention polices by the Sudan National AIDS Control Program'.

This study aims to build an understanding of how HIV prevention policies are developed and put into action by the government through an analysis of the case study of the Sudan.

The research will provide a better understanding on how HIV prevention policies are seen and taken up by stakeholders in the country. Also the study will contribute to a gap in knowledge on HIV-prevention programmes to increase public awareness and debate on related issues in the country and to ultimately assist the national programme on their HIV/AIDS prevention strategy.

The research will consist of an analysis of documents and observation of and interviews with actors at the Sudan National AIDS Control Program (SNAP), as well as SNAP's counterparts in national and international organizations. In this respect, your participation is important because it will give the research the necessary information for a thorough analysis.

Participation is entirely voluntary and you can withdraw at any possible time without having to give a reason. There will be no negative consequences. If you choose to participate in this study, your interview will be at your convenience. The interview should only take approximately 45 - 60 minutes. If you agree, the interview will be tape-recorded. All information will remain confidential (you will have the choice of not being quoted at all, anonymously quoted, attributed by a number, or not included in the analysis at all). I will be responsible for the confidentiality, and anonymity for all materials gathered in this study.

The ethical approval of this study was approved by LSHTM on 25 June 2008 and the Sudan Research Council Committee on 3 July 2008.

APPENDIX D: CONSENT FORM

Study topic:
A policy analysis of the development and management of multiple demands by the Sudan National AIDS Control Program.

I have been informed about the nature and aim of the study, and about issues of confidentiality and anonymity.

I have read the information sheet concerning this study [or have understood the verbal explanation] and I understand what will be required of me and what will happen to me if I take part in it.

I understand that I may at any time withdraw from this study without giving any reason.

I hereby agree to take part in this interview.

I understand that all information will remain confidential. I
□ consent to the interview and agree to be recorded.
□ consent to the interview and agree NOT to be recorded.
□ consent to be quoted by anonymously.
□ consent but would not like to be included in the analysis.

Signed ………………………………………………………………………..

Institute/Organization: …………………………………………………

Address: ……………………………..…………………………………..…

Date…………………………….

Witness ………………………

Principal Investigator:
Joann Sy
London School of Hygiene and Tropical Medicine
Keppel street London
WC1E 7HT United Kingdom

APPENDIX E: INTERVIEW MATERIAL

A. INITIAL SEMI-STRUCTURED TOPIC AND OPEN-ENDED QUESTIONNAIRE

1. Please tell me a little about yourself.

Policy Development

2. Who were the main actors in the national HIV/AIDS response?
3. Were you around when the policy was being developed?
   What was the environment like when the policy was being developed (relationship between national/international)?
   Who was leading the response?
4. Were there circumstances that brought attention to create these policies?
5. What was the context in which these policies were being formed (cultural/situational/international factors)?
6. Who were the main actors involved in the process of developing these policies?
   Was SNAP involved?
7. Were there some actors more influential than others?
8. Do you want to add anything?

Management of policies

9. What are the roles and responsibilities of SNAP?
10. What do you think of the policy?
11. Do you refer to the (written) policy when dealing with your HIV working partners? If yes, how? And if not, why?
12. What is your relationship to other organisations?
13. Do you want to add anything?

B. SAMPLE QUESTIONS FOR IN-DEPTH INTERVIEWS

1. What do you think of the policy?
2. What were your reactions to the policy (positive/negative), and why?
3. Do you remember the reactions of other actors to the policy?

C. ADDITIONAL QUESTIONS FOR DONORS

1. What is the mandate of X, specifically for Sudan?
2. What is your role and responsibility at X?
3. How is your work going (drawing on your experiences with your projects, your Sudanese counterparts and the context of Sudan - for example, generally, issues in Sudan are high on the international agenda; there exists a strong religious and cultural environment)?
4. Do any issues come up when dealing with your work in Sudan (any problems)?

5. Is there anything specific about Sudan that makes your work difficult/easy?
6. What is your relationship to SNAP?
   Do you work with SNAP?

D. ADDITIONAL QUESTIONS FOR INTERNATIONAL ORGANISATIONS

1. Can you tell me a little about yourself?

   What is your organization?

   What are your responsibilities?

2. What kinds of programmes do you have?

3. How is your work going?

4. What is your relationship to SNAP?

   How is your relationship to other organisations (national/international)?

E. AGENCIES AND ORGANISATIONS REPRESENTED IN THE INTERVIEWS CONDUCTED

Presidential Office of Sudan and other Government Ministries
Office of the President
Ministry of Health
Ministry of Guidance & Endowment
Ministry of Defence
Ministry of Youth
Ministry of Information and Communication
Ministry of Youth and Sport
Ministry of General Education
Ministry of Higher Education
Sudan National AIDS Program
National Council on AIDS
National Executive Council on HIV/AIDS

International Organisations (Multilateral and Bilateral - local offices)
UNAIDS (Sudan, Somalia and Egypt)
UNDP
UNMIS
WHO
UNHCR
WFP
UNICEF
USAID (United States Agency for International Development) (phone)
DFID (UK Department for International Development) (phone)

NORAD (Norwegian Agency for Development Cooperation)
BBC Trust

Embassies
United Kingdom of Great Britain (phone)
France
United States of America (phone)

Religious Based Institutions
Sudan Council of Churches
CARE
As well as religion leaders, Imams and priests without formal organisational affiliation

Secular NGOs
Sudan AIDS Network
Sudan Family Planning
Rufaida
Sudan Red Crescent Society
International Federation of Red Cross
ACORD
Planned Parenthood
GOAL
Lokita

Private Sector
DKT International

Academic/Research Based Organisations
University of Khartoum

APPENDIX F: CHARACTERISTICS OF KEY INFORMANTS

Key Informant #	International organisation = 1 National organisation = 1	Expat = E National = N	Senior = S Junior = J	Bilateral = B Multilateral = M Donor = D	Date dd/ m/yr
1	N	N	J		27/8/2008
2	N	N	S		4/9/2008
3	N	N	S		16/10/2008
4	N	N	J		2/5/2008
5	N	N	J		6/10/2008
6	N	N	J		12/10/2008
7	N	N	S		16/11/2008
8	I	N	J		30/9/2008
9	N	N	S		20/8/2009
10	N	N	S		30/3/2008
11	N	N	J		5/8/2008
12	I	E	S		14/2/2008
13	N	N	S		26/9/2008
14	I	I	J		28/9/2008
15	N	N	J		23/4/2008
16	N	N	S		27/8/2008
17	N	N	S		24/8/2008
18	I	N	J		20/8/2008
19	N	N	J		18/3/2008
20	N	N	J		15/10/2008
21	N	N	J		4/5/2009
22	N	N	S		17/2/2008
23	N	N	S		15/6/2008
24	I	E	S	M	23/3/2009
25	N	N	S		17/2/2008
26	N	N	J		26/3/2008
27	N	N	J		7/2/2008
28	N	N	J		23/4/2008
29	I	E	S	M	4/9/2009
30	N	N	S		15/10/2008
31	N	N	S		14/4/2008
32	I	N	S		8/12//2008
33	N	N	S		30/10/2008
34	N	N	J		14/5/2008
35	I	N	S		4/6/2008
36	N	N	S		26/2/2008
37	N	N	J		26/9/2008
38	I	E	S		18/3/2009 *not recorded
39	I	E	S		19/7/2008
40	I	E	S		3/9/2008
41	N	N	S		17/9/2009
42	N	N	J		18/6/2008
43	I	N	J		15/3/2008
44	N	N	J		4/9/2008
45	N	N	J		13/2/2009
46	N	N	S		3/4/2008 *not recorded
47	N	N	S		16/11/2008
48	N	N	S		17/10/2008
49	N	I	J		4/6/2009
50	I	N	S		14/2/2008
51	I	E	J		14/2/2009

Key Informant #	International organisation = 1 National organisation = 1	Expat = E National = N	Senior = S Junior = J	Bilateral = B Multilateral = M Donor = D	Date dd/ m/yr
52	I	E	S		14/5/2008
53	N	N	S		30/8/2008
54	N	E	S		3/4/2009
55	N	N	S		23/5/2008
56	N	N	S		20/6/2008
57	N	N	S		27/8/2009
58	N	N	S		4/12/2008
59	N	N	S		12/12/2008
60	N	N	J		8/11/2008
61	N	N	J		17/2/2008
62	N	N	J		3/2/2008
63	I	N	S		4/10/208
64	I	E	S		17/6/2008
65	N	N	J		16/7/2008
66	N	N	S		13/4/2008
67	N	N	S		27/4/2008
68	I	E	S	B	18/4/2008
69	I	E	J	B	1/13/2009
70	N	N	S		10/4/2008
71	I	E	S	B	18/8/2009
72	N	N	S		6/6/2009
72	I	E	S		10/8/2008
73	I	N	J		2/9/2008
74	N	N	S		20/10/2008
75	I	E	J		15/2/2008
76	N	E	J		7/9/2008
77	N	N	J		20/10/2008
78	N	N	S		6/6/2009
79	N	N	J		8/9/2008
80	N	N	S		18/3/2009
81	N	N	J		13/4/2008
82	I	N	J		5/11/2008
83	N	N	J		4/12/2008
84	I	N	J		10/11/2009
85	N	N	S		28/3/2009
86	N	N	S		22/8/2008
87	N	N	S		27/8/2008
88	I	E	S		23/7/2009
89	N	N	S		17/2/2008