Introducing the ‘Third Phase’ of Priority Setting: Advancing Methods for Priority Setting Practice through the Contribution of Systems Theory

Lessons from a Case Study of District Health Planning and Priority Setting in Ethiopia

by

Kadia Petricca

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Institute of Health Policy, Management and Evaluation
University of Toronto

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Abstract

Over the last 20 years, there has been considerable scholarly attention paid to developing priority setting methods with an emphasis on improving the evidence base of priority setting decisions, the use of explicit decision criteria, and the fairness of decision-making processes. Case studies of priority setting in health institutions and systems internationally have identified a variety of factors in practice that influence the effectiveness of these methods. There is a paucity of research, however, that empirically examines how these factors operate and to what extent they comprise enablers or barriers to fair priority setting. The purpose of this dissertation is to advance priority-setting methods by examining how systems theory may inform our understanding of priority setting through a case study of district health planning in Ethiopia.

To fulfill this purpose, three objectives were undertaken. The first objective sought to describe the district health planning and priority setting process in Ethiopia. A qualitative case study of Ethiopian district health planning was undertaken in 2010 and 2011. Methods included 57 in-depth key informant interviews with decision makers, participant observation, and document analysis. The second objective sought to analyze this description through the theoretical lens of Accountability for Reasonableness (A4R) and the Transformative Systems Change Framework
(TSCF). The third objective sought to conceptually synthesize these findings by situating priority setting practice and procedural fairness within a robust understanding of the system.

The study findings reaffirm priority setting is a highly complex process that is value laden and influenced by a multiplicity of system-level factors. Through the application of the TSCF, a nuanced understanding of priority setting practice is understood that situates this process within a system of influencing components that include: norms, operations, regulations, and resources. Analysis reveals a number of system barriers and facilitators that impact not only the implementation of district health planning, but also the degree to which elements of procedural fairness are upheld. In light of these findings, I propose the introduction of a third phase in the priority setting discourse that emphasizes the need for methods and approaches inclusive of system-level considerations. I conclude with the development of a series of practical questions to guide practitioners in the design and implementation of their priority setting methods.
No health-care system can meet all the health-care needs of its citizens, and therefore prioritizing decisions have to be made with a consequent rationing of resources. This is the hardest and most challenging aspect of health planning.

Andrew Green, *An Introduction to Health Planning in Developing Countries* (p.5)

Medicine is both a scientific activity and a cultural form. Most of the ways in which we ration care are invisible, obscured by cultural assumptions, political understandings, and economic realities.

David Mechanic, *Muddling Through Elegantly: Finding the Proper Balance in Rationing.* (p.84)

The more we study the major problems of our time, the more we come to realize that they cannot be understood in isolation. They are systemic problems, which means that they are interconnected and interdependent.

Fritjof Capra, *The Web of Life: A New Synthesis of Mind and Matter* (p.3)

With regards to the prerequisites and contextual factors that may influence successful priority setting; understanding potential precursors and inhibitors (the institutional capacity, and incentives) and the priority setting context (political, economic, social-cultural) would facilitate the development of feasible and context sensitive improvement strategies.

Lydia Kapiriri and Douglas Martin, *Successful Priority Setting in Low and Middle Income Countries: A Framework for Evaluation* (p. 146)
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A PhD is a journey—

filled with inspiring collaborations, occasional obstacles, and the discovery of new knowledge, new friendships, and in many ways, oneself. My journey has left me with many to thank, as the completion of this dissertation would not have been accomplished without the guidance, support, and commitment of many.

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~ Mom, Dad, and Adam ~
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<td>Accountability for Reasonableness</td>
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<tr>
<td>BOD</td>
<td>Burden of disease</td>
</tr>
<tr>
<td>BoFED</td>
<td>Bureau of Finance and Economic Development</td>
</tr>
<tr>
<td>CEA</td>
<td>Cost-effectiveness analysis</td>
</tr>
<tr>
<td>CAS</td>
<td>Complex Adaptive Systems</td>
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<td>DCPP</td>
<td>Disease Control Priorities Project</td>
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<tr>
<td>DLDP</td>
<td>District Level Decentralization Program</td>
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<tr>
<td>EBM</td>
<td>Evidence-based medicine</td>
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<tr>
<td>EBPB</td>
<td>Evidence-Based Planning and Budgeting</td>
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<tr>
<td>EPRDF</td>
<td>Ethiopian People’s Revolutionary Democratic Front</td>
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<tr>
<td>EFMOH</td>
<td>Ethiopian Federal Ministry of Health</td>
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<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>HEW</td>
<td>Health Extension Worker</td>
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<td>HSDP</td>
<td>Health Sector Development Programme</td>
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<tr>
<td>HSEP</td>
<td>Health Service Extension Programme</td>
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<tr>
<td>MCDA</td>
<td>Multi-criteria decision analysis</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>PAR</td>
<td>Participatory Action Research</td>
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<tr>
<td>PASDEP</td>
<td>Plan for Accelerated and Sustained Development to End Poverty</td>
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<tr>
<td>PBMA</td>
<td>Program Budgeting and Marginal Analysis</td>
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<tr>
<td>SDM</td>
<td>Systems Dynamics Modelling</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<td>SSM</td>
<td>Soft Systems Methodology</td>
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<tr>
<td>TSCF</td>
<td>Transformative Systems Change Framework</td>
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<td>WBHSP</td>
<td>Woreda-Based Health Sector Planning</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WJSC</td>
<td>Woreda Joint Steering Committee</td>
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<td>WoFED</td>
<td>Woreda Finance and Economic Development</td>
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<tr>
<td>WorHO</td>
<td>Woreda Health Office</td>
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<tr>
<td>ZHD</td>
<td>Zonal Health Department</td>
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# GLOSSARY OF TERMS

This glossary is meant to act as a reference and is organized alphabetically.

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation as applied to this Dissertation</th>
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</thead>
<tbody>
<tr>
<td>Absorptive Capacity</td>
<td>Cohen and Levinthal (1990) classify absorptive capacity as the ability of an organization to “recognize the value of new, external information, assimilate it, and apply it to commercial ends.” Absorptive capacity is viewed at both the individual and organizational level (pp.128-129).</td>
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<tr>
<td>Adaptive Capacity</td>
<td>Adaptive capacity refers to the dynamic process of a system to continuously learn and adapt if the environment, where the system exists, is changing. In social systems, this process of adaptation is determined by the ability of institutions to learn, store knowledge and experience, and be flexible in problem solving (Staber &amp; Sydow, 2002).</td>
</tr>
<tr>
<td>Accountability for Reasonableness</td>
<td>Accountability for Reasonableness is an ethical framework—founded on the principles of pure procedural justice and democratic deliberation—that operationalizes fair and legitimate priority setting by upholding four conditions (relevance, publicity, appeals, and enforcement) in the decision-making process (Daniels &amp; Sabin, 1998). In addition to the four conditions of A4R, through their research, Gibson et al. (2008b) added a fifth condition—empowerment—that will be conceptually applied within this dissertation.</td>
</tr>
<tr>
<td>Burden of Disease</td>
<td>Also classified as ‘disease burden,’ burden of disease is a measure for capturing the impact of a health problem measured often by financial cost, mortality, and morbidity indicators and quantified in terms of quality-adjusted life year (QALY’s) and/or disability-adjusted life year (DALY’s); both of which quantify the number of years lost as a result of disease. The World Health Organization advocates the use of burden of disease measures as key evidence for health care prioritizing (World Health Organization, 2004).</td>
</tr>
<tr>
<td>Cost-Effectiveness Analysis</td>
<td>Cost-effectiveness analysis is a form of economic evaluation commonly used by health decision makers to evaluate and compare the relative costs and health effects of two or more courses of action. The World Health Organization supports the use of cost-effectiveness analysis in assisting health planners make health priorities.</td>
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<tr>
<td>Deliberative Democracy</td>
<td>Deliberative democracy simply refers to a form of democracy whereby “deliberation” is central to the process of decision-making.</td>
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</table>
Decentralization is regarded as the transfer of decision-making power and administrative responsibility from the central government to the periphery. This transfer of powers commonly involves a range of responsibilities covering public planning, service delivery and fiscal allocation.¹

**Disease Control Priorities Project**

The World Bank spearheaded the Disease Control Priorities Project² in the 1990s (with contributions from the World Health Organization) to provide governments in low-income countries with comparative cost-effectiveness estimates for interventions addressing a full range of important health conditions. Since its inception, key documents have been produced to provide guidance to health planners and policy makers. These include: The first edition of *Disease Control Priorities in Developing Countries (DCP1)*; the second edition of *Disease Control Priorities for Developing Countries (DCP2)*; and a companion volume for policymakers called *Priorities in Health*.

**Distributive Norms**

Distributive norms extend from the concept of distributive justice (i.e., the socially just allocation of resources or goods in a society). Because norms are a standard of behaviour that is designated as normal within a particular group or society, distributive norms are the culturally acceptable ways in which allocation occurs and is accepted as just in society (Deutsch, 1975; pp. 137-149).

**External Stakeholders**

The Ethiopian government classifies stakeholders as either internal or external to health planning. External stakeholders are viewed as those stakeholders who are more peripheral to the decision-making process and include the community at large, the Prime Minister’s officer, other Ministries, and non-governmental organizations (EFMOH, 2007, p. 45).

**Evidence-Based Medicine**

EBM is defined as “the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients (Hayes et al. (1996) in Coulter & Ham, 2000).”

**Explicit Rationing**

Explicit rationing refers to decision-making that follows relatively clear procedures and criteria to guide the process. In contrast to implicit rationing (described below), explicit rationing typically offers decision makers technical and procedural guidance to facilitate health planning in a transparent and accountable fashion.

**Fairness**

Fairness is viewed as a corresponding virtue of justice (Beauchamp & Childress, p. 45). Fairness, as a goal of priority setting, is viewed in this sense as a procedural outcome of decision-making undertaken by fair-minded stakeholders.

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² For further information, see Jamison et al., (2006).
<table>
<thead>
<tr>
<th>Fair-minded</th>
<th>Daniels and Sabin (1998) classify decision makers as “fair-minded” if they “seek to cooperate with others on terms that are mutually justifiable” (p. 51). In the context of priority setting, rationales “should not only be publicly available, but also those that “fair-minded” people can agree are relevant to pursuing appropriate patient care (p. 51).”</th>
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<tbody>
<tr>
<td>Fiscal Predictability</td>
<td>A budget is predictable when the government knows in advance the amount and timing of funding and the disbursement procedures to be used. Predictability makes it possible to look at priorities systematically since a predetermined budget shows how all the planned activities will be financed. As a result, if there is not enough funding, some lower priority activities may be terminated (EFMOHa, 2007, p. 43).</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Flexibility is the degree of freedom that the government has to use development partner/donor resources for priority activities or under-financed areas in the government plan. It is the opposite of earmarking. With a flexible budget, the government can reallocate funds to other health priorities so as long as this is within the broad parameters of the government/partner agreement (EFMOHb, 2007, p. 43).</td>
</tr>
<tr>
<td>Global South</td>
<td>The Global South is a concept that over the past few decades has been used to replace terms such as the ‘third world’ or ‘developing countries.’ It emerges from the discussions of the North-South divide, which is described as a socio-economic and political divide between countries in the North (considered richer, more developed, and politically stable) versus the South (considered poorer, less developed and less stable politically) (Mimiko, 2012, p. 47).</td>
</tr>
<tr>
<td>Harmonization and Alignment</td>
<td>Is a national strategy launched in 2007 by the Ethiopian government to standardize planning, reduce duplication across different levels of government, and align program planning throughout the country.</td>
</tr>
<tr>
<td>Health Sector Development Programme</td>
<td>The Health Sector Development Programme (HSDP) is a twenty-year national health plan and considered the “centre-piece” of Ethiopia’s health policy. Since 2002, the HSDP has represented the health chapter in the government’s Plan for Accelerated and Sustained Development to End Poverty (PASDEP).</td>
</tr>
<tr>
<td>Implicit Rationing</td>
<td>Implicit rationing refers to decision-making structures that tend to follow historical patterns for rationing (i.e. reflecting on what has been previously prioritized). The rationales for such decisions tend to be vague and non-transparent. Implicit rationing has traditionally been responsible for cultivating a lack of accountability within the health system, with decision makers viewed as “gate-keepers” in control of what they deem appropriate and no major overseeing body held responsible for the decisions made.</td>
</tr>
<tr>
<td>Internal Stakeholders</td>
<td>The Ethiopian government classifies stakeholders as either internal or external to health planning. Internal stakeholders are viewed as those stakeholders who are more central to the decision-making process and include all government bodies (including national, regional, zonal, and district health planners) and district administrative council members (EFMOHa, 2007, p. 45).</td>
</tr>
<tr>
<td>Kebele</td>
<td>Amharic term that describes the smallest administrative unit of Ethiopia, similar to a neighbourhood.</td>
</tr>
<tr>
<td>Legitimacy</td>
<td>Legitimacy refers to the moral authority of institutional actors (Daniels &amp; Sabin, 2002, p.43).</td>
</tr>
<tr>
<td>Limit Setting</td>
<td>Limit setting refers to the domain of decision making that is forced to select (or limit) services for some patient groups, in order to provide care to other patient groups (Daniels &amp; Sabin, 2002)</td>
</tr>
<tr>
<td>Low-Income Country</td>
<td>The classification ‘low-income country’ is used throughout this thesis to refer to countries that have a Gross National Income (GNI) of US$1,005 or less (as compared to Lower-middle income GNI between US$1,006 and US$3,975; Upper-middle income GNI US$3,976 and US$12, 275 and High-income GNI above US$12,276) (World Bank, 2013). Given lingering criticisms regarding the classifications ‘developing’, ‘under-developed’ or ‘third world’, this economics-based terminology is used to avoid any paternalistic undertones of the aforementioned (See: World Bank, 2014)</td>
</tr>
<tr>
<td>Macro- / Meso- / Micro-level priority setting</td>
<td>The literature on priority setting commonly identifies three levels of prioritization: (i) macro, (ii) meso, (iii) micro, (i) Macro-level priority setting tends to occur at the international, national or provincial/regional levels). (ii) Meso-level priority setting occurs at the institutional- or district health authority-level. (iii) Micro- (or clinical-) level priority setting occurs at the patient/bedside–level. This study takes place at both the macro (national/ regional) and meso (district health office) levels.</td>
</tr>
<tr>
<td>Mental Models</td>
<td>Senge (1990) describes mental models as cognitive frameworks that are constructed from one’s knowledge, experiences, and assumptions, and play a significant role in guiding our actions and decision-making. Also classified as “mindsets,” mental models can maintain, constrain, and/or determine the status quo within an organization (Senge, 1990, p.198).</td>
</tr>
<tr>
<td>Moral Authority</td>
<td>Morality is viewed as any code of conduct that may act as a guide that all impartial and rational persons may adhere to and not willingly violate. Moral authority, then, is conferred by those who demonstrate sensible, effective, and verifiable claims that most would consider as legitimate claims (Hopgood, 2009, p. 230, 238).</td>
</tr>
<tr>
<td><strong>Multiple-Criteria Decision Analysis</strong></td>
<td>Multiple-criteria decision analysis is a sub-discipline of operations research that advocates for the explicit weighting of multiple criteria in a decision-making process (Baltussen &amp; Niessen, 2006).</td>
</tr>
<tr>
<td><strong>Non-Governmental Organization (NGO)</strong></td>
<td>The World Bank defines a non-governmental organization as being a “private organization that pursues activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development (World Bank, 2002).”</td>
</tr>
<tr>
<td><strong>Normative Ethics</strong></td>
<td>The study of ethical theories that prescribe how people ought to act or govern themselves in society.</td>
</tr>
<tr>
<td><strong>Plan for Accelerated and Sustained Development to End Poverty</strong></td>
<td>The government’s Plan for Accelerated and Sustained Development to End Poverty (PASDEP) is a national macroeconomic and social policy that supports growth and poverty reduction in donor recipient countries.</td>
</tr>
<tr>
<td><strong>Procedural Fairness</strong></td>
<td>In a <em>Theory of Justice</em> (1971), John Rawls uses a variant from social contract theory to provide a solution to the challenge of distributive justice through the development of the theory, “Justice as Fairness”; which deals with the socially just nature of distribution of goods within a society and posits that all societies meet healthcare needs fairly under reasonable resource constraints.</td>
</tr>
<tr>
<td><strong>Program Budgeting and Marginal Analysis (PBMA)</strong></td>
<td>Is a pragmatic economic framework that sets out to identify how resources are being spent and then establishes mechanisms to change service provision in order to increase efficiency of resources into other programmatic areas; thus seeking to maximize benefit and lower the opportunity costs at the margin (Mitton &amp; Donaldson, 2002).</td>
</tr>
<tr>
<td><strong>Reasonable Disagreements</strong></td>
<td>Disagreements between stakeholders are an inevitable part of the decision-making process. Disagreements are viewed as reasonable when relevant considerations in the decision-making process are weighed and compatible with reaching a variety of conclusions (McMahon, 2009).</td>
</tr>
<tr>
<td><strong>Systems Change</strong></td>
<td>Foster-Fishman, Nowell and Yang (2007) classify systems change as “an intentional process designed to alter the status quo by shifting and realigning the form and function of a targeted system.” (p. 197)</td>
</tr>
<tr>
<td><strong>Systems Theory</strong></td>
<td>General Systems Theory was proposed by Ludwig von Bertalanffy (1969) who emphasized that real systems are open to, and interact with, their environments, and can acquire new properties through this interaction, resulting in continual evolution.</td>
</tr>
<tr>
<td><strong>Systems Dynamics Thinking</strong></td>
<td>Systems dynamics thinking is a methodological approach for applying general systems thinking principles to managerial and societal issues through the use of cause and effect relationships within a system to explain system behaviour (Forrester, 1969; Senge 1990)</td>
</tr>
<tr>
<td><strong>Soft Systems Methodology</strong></td>
<td>Soft systems methodology is a methodological approach for understanding human systems that emphasizes the social construction of reality, and the presence of multiple, valid perspectives of a problem situation and its solution (Checkland, 1981).</td>
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<tr>
<td><strong>Systems</strong></td>
<td>A “system” is commonly characterized as a collection of parts that through their interaction, function as a whole (Ackoff &amp; Rovin, 2003).</td>
</tr>
<tr>
<td><strong>Systems Thinking</strong></td>
<td>Systems thinking is viewed as “an approach to problem solving that views “problems” as part of a wider, dynamic system [that understands] the linkages, relationships, interactions and behaviors among elements that characterize the entire system (de Savigny &amp; Adam (eds), 2009).</td>
</tr>
<tr>
<td><strong>Technocratic Approach</strong></td>
<td>In health planning, a technocratic approach refers to an approach that emphasizes economic appraisal (i.e. burden of disease and cost-effectiveness analysis) as the main criteria guiding decision-making (Green, 2007, p.21).</td>
</tr>
<tr>
<td><strong>Transformative Systems Change Framework</strong></td>
<td>The Transformative Systems Change Framework is a systems change framework that marries the concepts of systems dynamics thinking and soft systems methodology to understand a systems parts and interdependencies that can explain how a system functions and highlight barriers to and facilitators of change (Foster-Fishman, Nowell &amp; Yang, 2007).</td>
</tr>
<tr>
<td><strong>WHO-CHOICE (CHOosing Interventions that are Cost Effective)</strong></td>
<td>WHO-CHOICE is an initiative of the World Health Organization to advance health-financing policy to ensure that available resources are used efficiently and equitably. This initiative contributes to the evidence base by assembling regional databases on the costs, impact on population health, and cost-effectiveness of key health interventions.³</td>
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<tr>
<td><strong>Woreda</strong></td>
<td>An Amharic term that means ‘district.’</td>
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<tr>
<td><strong>Woreda-Based Health Sector Planning</strong></td>
<td>A national strategy to standardize district planning processes and strengthen evidence-based planning throughout the entire country.</td>
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</table>

³ For further information on WHO-CHOICE, see: Tan-Torres Edejer et al. (2003).
This dissertation presents the research findings from a case study analysis of district health planning and priority setting in Ethiopia, through a lens of procedural fairness and systems change theory. To illustrate the priority setting challenges faced by district health planners in low-income countries, I open with a composite narrative based on my observations of district health planning during the planning meeting 2010. This narrative illustrates, as once articulated by Soren Holm (1998), that there are “no simple solutions” to setting health priorities, and that strengthening the process of health decision-making cannot be done in isolation from understanding the system in which this process operates. Since its implementation in 2007, Woreda-Based Health Sector Planning (WBHSP) has aimed to standardize planning throughout Ethiopia by providing district health planners with direction on key intervention areas that are aligned with national priorities. Alongside this “harmonization strategy”, the government has also aimed to reduce duplication of reporting at all levels of government, while simultaneously strengthening evidence-based planning to meet district health needs accordingly. This is a milestone in Ethiopian health policy, as few African countries at the time of this study’s commencement, were engaged in the development and implementation of the Evidence-Based Planning and Budgeting (EBPB) tool spearheaded by UNICEF and the World Bank.

Although the following narrative describes one example of district health planning from one district experience, it illuminates numerous complexities and challenges that, while specific to Ethiopia, likely parallel experiences in other low-income settings. These include contextual considerations that influence how and when stakeholders interact, how data is managed and incorporated into planning, which intervention areas are valued and take priority, how material scarcity or minimal training affects technical capacity, and how limited material resources impact health planner morale and overall planning strategies.
Day One

It is the end of March 2010 in Ethiopia and the first of two rounds of district health planning commence throughout the country. In a small rural town, seven hours south by vehicle from the capital city, Addis Ababa, officials from ten districts are to convene in the city’s town hall for the planning meeting. To varying degrees, the meeting can be considered a microcosm of district health planning taking place simultaneously in other districts across the country, as each district is to follow similar procedures over the next five days. By the end of this five-day planning meeting, it is expected that every participating district health office will finalize an annual plan that will outline overall district health goals for the year.

On this brisk morning, as I walk with colleagues towards the town hall, I am struck by how little infrastructure there is at the community level. Goats wander between fruit vendors and buildings constructed of raw materials. While scarcity of material resources is ever-present, the atmosphere is not devoid of lively conversations, the noise of vehicles, and workers busy hammering on the buildings nearby. Further along, we are greeted by the smell of coffee being prepared by a woman who sends us wishes for a good morning and peace, “Endemin aderachihu…selam nachihu.”

Conversing with my colleagues, I learn that this town was chosen to host the planning meeting largely because its town hall was built to accommodate over one hundred people. Since this meeting is to include ten district teams comprised of approximately eight counterparts, this location seems fitting. As we approach the vast steps of the hall, its outside infrastructure has signs of similar wear as many of the surrounding shops. Tall white outer walls, although standing with pride, are surfaced with hairline cracks and dust. Stepping inside, rows of desks and chairs face the front stage where regional facilitators begin to set up their laptops for their presentations.

As eight thirty a.m. approaches, I can already gauge some of the challenges confronting planners. Although participants in this meeting are to include a district health manager,
district health office officials, non-governmental partners, members from the district administration, and district finance office. I soon learn this may not unfold as envisioned. While casually conversing with one zonal organizer, I learn that only half of the participants have arrived as a result of unforeseen traveling constraints, or scheduling conflicts between this and other meetings. Standing beside me, he receives another call from a district manager informing him that they will be unable to attend this first round of planning as a result of another meeting conflict. With a discontent look on his face, the zonal coordinator checks his papers to assess if this district may participate in the second round of planning next week. They can.

As I move to the back of the room and try to be inconspicuous, my presence does not go unnoticed. I am an outside researcher and a Caucasian woman in an environment exclusively comprising Ethiopian men. Although warmly welcomed to participate in the weeklong meeting, I indicate that my goal there is to simply observe how the planning process unfolds. Like many cross-cultural researchers before me, I remain cognizant that my presence may influence interaction patterns between stakeholders. Yet, deducing how and to what extent remains a lingering challenge for any outside researcher.

At eleven a.m., regional and zonal organizers commence the meeting since approximately sixty percent of the intended members are present. PowerPoint presentations are now switched on and attendees are informed in the national language, Amharic, that the meeting is about to begin. Organizers first introduce themselves and run through the intended itinerary that will unfold over the five-day planning session. This meeting, understandably, is almost exclusively conducted in Amharic, and therefore poses a challenge for me, as I rely on my colloquial use of the language and ability to interpret body language in order to infer the content of the discussion. During this time, I also ask my colleagues sitting nearby a variety of clarification questions.

As I remain quietly seated, a quick scan of the room also reveals an interesting contrast in attendance among planners—some district group clusters have only four or five representatives in comparison to eight or nine in others. As the week proceeds, this discrepancy will pose a challenge to those groups with fewer members given the importance of diverse expertise needed during the process. Another observation is the absence of any female planners among the forty-six participants. This is not to suggest that women are actively excluded from engaging in this meeting, but rather an observation that makes me reflect on the extent to which women are actively encouraged or enabled to participate, and whether opportunities exist in the workplace that promote such participation.

As the meeting progresses, sporadic electrical power outages disrupt the flow of the presentation, which understandably flusters the regional presenters. Learning from past experiences, however, they come prepared with handouts for participants to follow. Here, an overview of the entire planning process is discussed as well as the description of tools to be used in this process and expected outputs.

**Day Two**

On day two, district groups engage in what will be a series of four intensive days of setting district health priorities and planning. The process starts with the identification of baseline profiles for each district that includes a “Strengths, Weaknesses, Opportunities and
Threats” (S.W.O.T) analysis, a resource mapping exercise to identify major partners working in their catchment area, and the completion of the Evidence-based Planning Budgeting (EBPB) tool, which is an Excel-based spreadsheet used to guide decision-making and priority setting for each district. This tool incorporates key health interventions areas prioritized in the fourth phase of Ethiopia’s Health Sector Development Program (the primary health strategy guiding health service planning throughout the country). In the EBPB tool, such priorities include exclusive breastfeeding, oral rehydration therapy, family planning, antenatal care, HIV/AIDS prevention and care, immunization, skilled delivery, antibiotics for under-five mortality, and tuberculosis prevention. While these priorities have been set at the national level, the district planners I converse with emphasize that they also have the discretion to tailor priorities and intervention areas according to their district’s need.

As the meeting proceeds, three regional and one zonal mentor are present to offer technical support. Specifically, their role is to guide district planners in understanding planning procedures and to incorporate district-level data into the tool. During this data entry process, I observe many district officials struggling to match district baseline information captured through their own reporting with the indicators identified in the tool. In some cases where data from the district level is missing, zonal facilitators encourage planners to input regional or national statistics, which, as one district participant emphasizes, may underrepresent progress in a particular intervention area for the district health office. Such efforts to reconcile data issues delay the second day of planning and leave participants frustrated.

**Days Three and Four**

On days three and four, the planning meeting continues with the arduous task of the EBPB tool completion. Some planners reveal that they had worked over night given their concern that the five days allocated would not suffice. Yet, this is not the only concern that emerged among them. As I look to my right, I see one district group discouraged since the outlet in their vicinity has no power to charge their laptop. As one member from the team notices me watching with concern, he says with a slight smile, “Qas ba qas enkulal begrewa tehedelech” (translation: “slowly, but surely, we will get there”).

As they collect their materials, and proceed to relocate to another part of the room—some sighing and some laughing it off—I am struck by the importance of collegiality in this process. Each member is part of a team, a cohesive unit, whether comprised of four or eight members. Each member draws from their teammates’ expertise to complete the tool, and actively engages in discussion when determining which resources and health concerns should be prioritized. While active discussions are visible throughout the room, the pace at which each district is able to proceed in completing the tool varies given the absence of some health experts from the district health office and non-governmental counterparts. I learn that this absence may often be the result of a conflict with other meetings rather than an attempt to not participate; although, the latter rationale did surface from discussions as well. Some district health planners even take it upon themselves to contact missing team members to understand the situation and provide updates.

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4 The details of this tool will be further described in Chapter 5, Section 5.1.
members by mobile phone to elicit their feedback on the planning decisions being made and request information when needed.

Throughout this meeting, the head manager of the district health office has played an essential role in guiding their district team through the completion of the EBPB tool spreadsheets and in trouble-shooting any issues that arise, such as missing data or technical issues. As the meeting winds down day four, I sense the energy of regional and zonal trainers waning, as they continue to juggle questions and complaints from each district group.

Day Five

On the morning of the final day of the meeting, participants arriving must relocate to a room in the basement of the hall given an unexpected scheduling conflict with another meeting booked to use the hall’s main room. As we enter the fairly dim and isolated area, each team member scrambles to find a chair. No desks or tables are readily present for planners to work on. While each member proceeds to take out their laptop and papers to finalize their planning, I sense some indignation as a result of this inconvenience.

By the end of day five, no districts have completely finalized their plans or budgets and participants articulate some difficulty with the complexity of the tool that they feel has contributed to their delays. As a result, a zonal coordinator announces an extension of a few days to complete the plan upon returning to their respective district health offices.

As I walk back to my hotel, staring at the unpaved road before me, I reflect on this past week. Throughout this meeting, my mind has been flooded with images from my Canadian context—where travelling to attend a meeting is not limited by one dirt road; where repetitive power outages and computer viruses are not a continuous limitation; where data collection is not restricted, in many cases, to paper-based logs; where filing systems are easily managed electronically and accessed often effortlessly when required; and where a town hall meeting is not limited by too few chairs and tables for meeting participants. Over this past week, I have been starkly confronted with an awareness of how such contextual factors shape how participants convene, engage with each other and, ultimately, plan. During this time, I also find myself reflecting on the concept of “innovation,” a term in the field of global health that has generated increased attention (and funding) over the past five years. What is innovation in global health when what I have largely witnessed this week has been health planners who yearn simply for more of what we in the West consider as administrative basics—better filing systems, functional computers, easier mechanisms to communicate, office supplies, and, well, electricity. Can innovation be as simple as providing infrastructure? Or, are other factors present that shape decision-making that researchers and practitioners should be sensitive to?

In light of such factors, however, planning in Ethiopia continued and the woreda-based annual plan was set through the presence of collegiality, patience, and persistence.

I enter my hotel room. Electricity is out for the night.
This narrative reveals the considerable contextual complexity within which the process of district health planning and priority setting is embedded. In particular, it illustrates how aspects of the process are influenced by a series of context-related features of the ‘system’ and the complex interrelationships between the stakeholders engaged in this process. Such contextual factors have long-term implications on how priority setting procedures transpire, and on the sustainability of policies and/or strategies overall. Therefore, researchers and policy makers must work towards a greater understanding of the system and the overall capacity required to undertake priority-setting procedures. It is the goal of this dissertation to illuminate potential system-level factors influencing the process of Ethiopian district health planning and priority setting and, through this analysis, gather insights that may facilitate improvements to priority setting practice.
CHAPTER 1: INTRODUCTION

1.1. Health Planning and Priority Setting Challenges in Low-Income Countries

The challenges associated with priority setting for health programs have been remarked upon for decades. Although amplified by the current economic climate, it has become widely acknowledged that resources for healthcare can never match the demand for services. Therefore, to ensure the long-term sustainability of a health system, it is imperative that priorities are set among competing health programs (Ham, 1997). Also classified as “rationing” or “resource allocation,” priority setting is defined as the distribution of resources among competing interests (e.g., institutions, programs, people/patients, services, and diseases) (McKneally, Dickens, Meslin & Singer, 1997). As a result, setting priorities has arguably been one of the most difficult and contentious health policy issues faced by decision makers at all levels of the health system. Although substantial work has sought to offer technical or principle-based guidance for these decisions, fundamental questions continue to perplex decision makers in any health system. These include: What process should we use to set priorities among competing health programs or needs? Who should be included in this process? What tools or criteria should be applied? And, which priority setting method will be viewed as fair and legitimate by those who are affected by these decisions?

While the answers to such questions have proven difficult in the context of high-income countries—where data, technical capacity, and opportunities for stakeholder engagement are often readily available—making these decisions in low-income countries is considerably more complex.\(^5\) In these settings, there are concerns for resource scarcity; limited institutional and

\(^5\) Given lingering criticisms regarding the classification of resource-poor settings as “developing”, “under-developed” or “third world”, the term “low-income” will be used throughout this study based on the World Bank’s analytical economic classification. Here, the World Bank defines low-income countries as having a Gross National Income (GNI) of US$1,005 or less (as compared to lower-middle income GNI between US$1,006 and US$3,975; Upper-middle income GNI US$3,976 and US$12,275 and high-income GNI above US$12,276). While the World Bank does classify all low- and middle-income countries as “developing”, they suggest this classification is convenient and not intended to imply that all economies in this group are experiencing the same development or have reached a preferred or final stage of development. One limitation of classification based on income level is that it does not reflect a country’s development status as captured in the United Nation’s Human Development Index (HDI), a compound...
individual capacity; insufficient or poorly managed data available to guide decision-making; earmarked donor funding that impedes prioritization of alternative programs deemed significant; and planning in a health system overburdened by both communicable and non-communicable diseases (Baltussen, Stolk, & Chisholm, 2006; Kapiriri & Martin, 2007; Youngkong, Kapiriri, & Baltussen, 2009). As researchers and health planners therefore aim to strengthen methods for priority setting in resource scarce environments, it is important that we continue to build an empirical database of experience that can inform the application of these methods in practice.

1.2. Overcoming Priority Setting Complexity: Three Phases in the Priority Setting Discourse

In his article, Goodbye to the simple solutions: the second phase of priority setting in health care, Soren Holm described what he referred the first two phases in the evolution of priority setting thinking (1998, pp.1000-1002). The first phase focused on the establishment of technocratic and principle-based approaches to provide decision makers with concrete evidence, guidelines, and criteria needed to make complex decisions. It was believed that through the provision of tools and information, decision makers would be in a position to rationally decide where best to allocate resources and, as a result, make justified and legitimate decisions. The concept of devising a “simple set of rules” to guide decision makers was however recognized as flawed given the complexity of the decision-making “process” itself. Numerous stakeholder interests and values, coupled with challenges in the use and interpretation of data and criteria were a few of the dimensions of decision-making complexity that surfaced. Through these challenges, Holm described a second phase in the priority setting discourse that focused on procedural-based approaches to resolve these issues. During this second phase, a number of case studies advanced our understanding of procedural components necessary for transparent, inclusive, and fair processes of decision-making. A process however does not operate in isolation from the context within which it is embedded. Many of the investigations have increasingly acknowledged that

indicator that incorporates income per capita (gross domestic product), life expectancy, rate of literacy, etc. Generally, “developing” countries are classified as those that have not reached a significant degree of industrialization. However, much criticism persists as to its use given underlying implications of inferiority and striving for a desire to “develop” along the traditional “Western” model of economic development that distances itself from low value added sectors such as agriculture.
context is a large predictor in how priority-setting procedures will unfold. How and why these contextual features interact are less investigated. In this dissertation, I argue that we are entering a third phase in the priority setting discourse, whereby the need for greater attention to system-level factors and dynamics are imperative as we seek to improve strategies and procedures that may strengthen priority setting practice. Through an application of systems theory on district health planning and on procedural fairness in Ethiopia, I seek to advance methods for priority setting as we move forward in the third phase of this complex discourse.

1.2.1. Phase One: Minimizing Priority Setting Complexity by Strengthening the Evidence Base and Technical Rigour of Priority Setting

In phase one, researchers and decision-makers believed that the complexity of priority setting could be simplified through the development of a “rational” priority setting method guided by evidence, decision rules, and decision-making tools or algorithms (Holm, 1998, pp. 1000-1001). In support of this view, Alan Williams, a prominent health economist, maintained that the inadequacy of information regarding costs and outcomes was one of the underlying factors impeding decision makers from making rational decisions about scarce resources (Klein & Williams, 2000, p. 15). Practical efforts to improve the evidence base and rationality of priority setting decisions emerged in the early 1990s, including methods such as cost-effectiveness analyses (CEA), systematic reviews, burden of disease (BOD) weighting, and other scoring systems to rank priorities. The development of the Disease Control Priorities Project (DCPP) in 1993, for instance, sought to strengthen evidence-based strategies for health decision-making through the use of CEA and BOD in low-income countries.

Although such technical approaches to priority setting garnered significant scholarly and decision-maker interest and contributed to improving evidence-base of priority setting (Youngkong et al., 2009), the concept of devising a “simple set of rules” to guide decision makers was recognized as insufficient given the complexity of the priority setting process arising from conflicting stakeholder values and overall challenges distilling the evidence. (Holm, 1998, p. 15).

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6 Affiliated with the DCPP included: the World Bank, the World Health Organization, the Gates Foundation, the Fogarty International Center (National Institutes of Health), and the Population Reference Bureau.
Holm (1998) described the entrance into a second phase of priority setting as resulting from the realization that devising a simple set of rules to guide priority setting was flawed and that attention should now focus on “the priority setting process itself and its transparency” (p. 1000).

1.2.2. Phase Two: Minimizing Priority Setting Complexity by Strengthening the Priority Setting Process

In this second phase of the priority setting discourse, researchers argued that if the legitimacy of complex decisions could not be achieved through the use of specific rules and guidelines, then perhaps what was needed were a set of overarching “meta-rules” that would govern the process of priority setting (Holm, 1998, pp. 1000-1001). Rudolf Klein, another scholar in this field, emphasized the notion that priority setting is heavily intertwined with policy making and, as a result, its complexity “does not stem […] from a lack of information, but from a lack of consensus on how to use information and interpret it” (Klein & Williams, 2000, p. 20). He maintained that the key to minimizing priority setting complexity was getting the “institutional setting right” so that individuals may synthesize and digest the information needed to set priorities through an inclusive and participatory process that reconciles value conflicts and, thus, leads to more “socially acceptable answers” (Klein & Williams, 2000, p. 21). Aligned with this thinking, Coulter and Ham (2000) further acknowledged that while explicit rationing does involve the use of techniques to improve the information base for decision-making, the application of judgment is equally as important in the process (pp. 5-6). However, it is in the uncertainty of determining whose judgment has moral authority, and to what extent, that ultimately reveals the ethical nature and complexity of the priority setting process.

Given the lack of agreement on substantive principles for distributing health care services, Daniels and Sabin (1998) argued that the challenge in the priority setting discourse has been to define conditions under which it is ethically acceptable for institutions to set such limits. In their book Setting Limits Fairly: Learning to Share Resources for Health, they maintain that when we “lack consensus on the principles that tell us what is fair, and are burdened by reasonable disagreements on how they apply, we should rely on a fair decision-making process” (Daniels &
Through this lens, a fair process—not substantive principles of distributive fairness—is what determines a fair priority setting outcome. To guide decision makers in defining a fair and legitimate priority setting process, Daniels and Sabin (1998) outlined four procedural conditions in the ethical framework Accountability for Reasonableness (A4R) that if met, would constitute fairness in the outcome decision. Since its development, A4R has been widely applied to assess procedural fairness of health priority setting in both high- and low-income country contexts (examples to be detailed in Chapter 2). Yet, while A4R has advanced the conceptualization of procedural fairness, challenges have emerged in real-world settings that highlight the influence of context on the priority setting process and on the manifestation of procedural fairness (Gibson et al., 2005b; Maluka, 2011). The reality is that context exerts considerable influence on these processes, including the extent to which they can be implemented as they were intended, and the extent to which they afford the benefits or outcomes for which they were designed.

1.2.3. Introducing Phase Three: Minimizing Priority Setting Complexity through an Understanding of the System

In recognizing the first two phases of the priority setting discourse described by Holm (1998), I argue that we are entering a third phase of this discourse that requires greater acknowledgment, assessment, and leveraging of the context within which priority setting unfolds. To date, minimal work has been done in this area, particularly in understanding how priority setting is shaped by the context and how context may be conceptually incorporated into priority setting thinking and practice. Kapiriri and Martin (2007) have argued that sustainable strategies to improve priority setting will only be achieved once researchers, practitioners, and stakeholders fully understand how the features of a context influence both the capacity for and governance of

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7 Traditionally, decision makers have relied on a variety of ethical principles to assist in guiding health decision-making. Although not exhaustive, these have commonly included: (i) Beneficence (maintaining highest quality of safe and effective care); (ii) Utility (maximizing the greatest possible good for the greatest possible number of people); (iii) Utilitarianism (outcome decision benefits the majority); (iv) Equity (decisions promote just or fair access to resources across all groups); and (v) Stewardship (careful and responsible use of resources that are available).

8 Distributive justice (concerned with a fair outcome) is often contrasted with procedural justice (concerned with a fair process) and will also be further discussed in the Chapter 2 literature review.

9 Chapter 2 will provide a detailed description of each condition of A4R.
decision-making. To draw our attention to various contextual features, Mitton and Donaldson (2003) and Mitton and Prout (2004) identified institutional facilitators and barriers with respect to health planning and priority setting (detailed in greater depth in Chapter 2). While their research highlights a variety of important context-specific factors influencing the priority setting process, the ability to facilitate change is limited by a lack of overall understanding of how the context itself is shaped and functions (i.e., identifying the interrelationships between each contextual feature and how these features may impact health priority setting). For instance, the lack of technical and managerial capacity at both the national and district levels, the dominant role of national governments, and power asymmetries across stakeholders have been increasingly cited as binding constraints on district health planning (Egger, Travis, Dovlo & Hawken, 2005; Kapiriri & Martin, 2007; Balabanova McKee, Mills, Walt, & Haines, 2010; Gibson et al., 2005b). A greater understanding is therefore required of the contextual factors that shape these structural relationships, the nature of their interaction, and the values and other norms that underpin them.

With the publication of the World Health Organization’s *Systems Thinking for Health Systems Strengthening* (2009), the concept of “systems thinking” has been identified as one of the four key elements that can contribute to identifying broader, contextual factors that may influence program development and implementation (de Savigny & Adam, 2009). This perspective involves taking a holistic view of the context in which the health system operates and examining the dynamics and interrelationships between the identified component parts. Work in systems theory therefore offers a potentially useful approach to understanding these empirical phenomena. Organizational contexts are complex and dynamic, and systems theory describes the importance of the interactions across actors, niches, and activities in a large system comprised of smaller organization systems (Foster-Fishman & Behrens, 2007).

Drawing from the two systems theories, namely systems dynamics thinking (Forrester, 1969; Senge, 1990) and soft systems methodology (Checkland, 1981), Foster-Fishman, Nowell, & Yang (2007) conceptualized the Transformative Systems Change Framework (TSCF) to guide our understanding of the fundamental system parts that can: (i) explain how a system functions, and (ii) highlight barriers and facilitators needed for systems change. More specifically, Foster-
Fishman et al. (2007) argue that the TSCF attends to both the deep and apparent structures—such as dominant normative, resource, regulative, and operational characteristics—that dictate behaviour and the lived experiences of systems members. For the purpose of this dissertation, the TSCF was applied as a means to guide the conceptualization of system-level influences that exert influence on the Ethiopian health planning and priority setting process. To date, no theory of priority setting exists that engages these system-level considerations. I argue that a more robust analysis of the system and, its overall impact on priority setting, is therefore needed as researchers aim to strengthen priority setting practice and procedural fairness.

1.3. Research Aims and Objectives

In light of the preceding discussion, there are two overarching aims of this study that I sought to investigate:

**Aim 1:** To advance knowledge of district health planning and priority setting in low-income contexts through a case study investigation of Ethiopian district health planning under the health policy regime of Woreda-Based Health Sector Planning (WBHSP).

**Aim 2:** To advance methods for priority setting by examining the potential contribution of the TSCF to understand the influence of system factors on priority setting practice.

To achieve these aims, I undertook three main objectives. The first objective sought to describe the district health planning and priority setting process in Ethiopia (to highlight successes and challenges experienced devoid of any guiding framework). The second objective sought to analyze district health planning and priority setting in Ethiopia through the theoretical lens of A4R (to provide insight to procedural fairness within the Ethiopian context) and the TSCF (to provide insight to the systemic factors influencing district health planning and priority setting processes). And, the third objective sought to investigate the development of a Phase 3 priority setting approach that integrates conceptual and pragmatic considerations of district health planning, priority setting, and procedural fairness within a robust understanding of system factors.

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10 Chapter 2 will provide greater depth of the TSCF stages and their application.
1.4. **Overview of this Dissertation**

Figure 1.1 (refer to p. 11) presents a schematic representation of the conceptual thinking underpinning this study. It incorporates pertinent contextual factors grounded in the literature that have been documented to influence the priority setting process, and finds linkages across procedural justice theory (with an emphasis on A4R) and systems theory (with an emphasis on the TSCF). To be clear, this schematic overview is not causal, but offers an amalgam of key concepts, frameworks, and processes that are relevant to district health planning and priority setting. It is divided into three main clusters: (I) a context cluster (outlined in red), (II) an ethics cluster (outlined in blue), and (III) a systems cluster (outlined in green).

With the implementation of the WBHSP strategy in Ethiopia, the *context cluster* illuminates the importance of the socio-cultural, political, and environmental context that any strategy or policy encounters as it enters a system (Mitton & Prout, 2004; Kapiriri & Martin, 2007; and Maluka, Hurtig, Sebastian, Shayo, Byskov, & Kamuzora, 2010). Factors such as financing structures, existing policies and procedures, actors, and institutional capacity are identified as having significant influence on the regulations and resources that impact the health planning process and overall implementation of the district-based planning strategy. It is here where the importance of the system emerges (in the lower-half systems cluster), as it goes beyond these contextual factors and looks to the interrelationships and dynamics between stakeholders and procedures that influence how decision-making processes transpire. The systems cluster draws attention to two systems theories—soft systems methodologies and systems dynamics thinking—that were conceptually integrated to conceptualize the TSCF and guide our understanding of the system’s structure and its dynamics.

Simultaneously, district health priority setting is also an ethical issue (as noted in the *ethics cluster*), characterized by conflicting stakeholder interests and values, as well as a lack of consensus around what is deemed a fair priority-setting outcome. In light of this, procedural fairness is a philosophical stance that emphasizes the importance of relevant, transparent, and inclusive decision-making processes as central to a fair outcome. To operationalize these principles, A4R was selected as the conceptual framework in outlining key conditions that
constitute fair and legitimate priority setting. It is important to recognize, however, that such conceptualizations (of fairness and legitimacy) are also influenced by the norms and values that underpin the unique decision-making culture present within a context. The systems cluster also acknowledges this by incorporating these multiple stakeholder realities that shape the politics, belief systems, and procedures of the health-planning context.

Through the **systems cluster**, the interconnectivity between contextual and ethical factors is illustrated within a very complex process of health planning. Overall, this conceptual map guides our thinking around the salient factors influencing district health planning and priority setting practice, and draws our attention to applicable theories and practical frameworks that will facilitate analysis around systemic barriers and facilitators. In addition, this conceptual map further emphasizes gaps in the scholarly literature that would bridge our understanding of how and to what degree systemic factors (through the application of the TSCF) influence fairness and legitimacy (through the lens of A4R).

### 1.4.1. Chapter Organization

The following dissertation is organized into seven chapters:

**Chapter 1** provided an overview of the rationale and purpose of this study. This included a discussion on the ethics and complexity of health care planning and priority setting, and situated this discussion within the context of Ethiopia. This chapter also introduced two conceptual frameworks (A4R and the TSCF) that were used to guide this investigation, and described the research aims and objectives that will contribute to advancing our scientific and theoretical understanding of priority setting practice, procedural fairness, and systems theory.

**Chapter 2** presents a comprehensive review of the literature focused on priority setting complexity, procedural fairness through the lens of A4R, and systems change theory through the lens of the TSCF. Pertinent examples are presented from the literature to examine the application of each framework, and a series of research gaps are identified.
**Chapter 3** provides an overview of the Ethiopian context. In addition to an overview of the demographic, economic, political, and historical context, this chapter describes the health policy and planning environment prior to the implementation of WBHSP.

**Chapter 4** explains the methodology and methods used in this qualitative case study. The rationale behind the use of a case study research design is described as well as the methods used to collect multiple sources of data corresponding to each objective proposed. In addition, data analysis techniques are further outlined and methods to uphold scientific rigor are discussed.

**Chapter 5** presents the empirical findings (related to Objective 1) that detail the district health planning and priority setting process in Ethiopia from 2010 and 2011 data collection. This chapter first provides a descriptive account of the district health planning process under the WBHSP strategy that draws from document analysis and participant interviews and, second, discusses emergent common themes among participants.

**Chapter 6** presents the findings for Objective 2, which involves an analysis of the district health planning process through the conceptual frameworks, A4R and the TSCF. In addition, this chapter also presents findings related to Ethiopian conceptualizations of fair and legitimate priority setting to reflect on the level of conceptual congruency between A4R and Ethiopian views.

**Chapter 7** discusses an advancement of methods for priority setting by examining the potential contribution of the TSCF to understand the influence of system factors on priority setting practice and procedural fairness. This chapter concludes with a series of empirical and practical contributions and implications for future research.
Figure 1.1. Schematic Overview of this Dissertation
Chapter 2 presents a review of the literature indicated in the overview in Figure 1.1. Throughout this chapter, the three clusters presented in this framework—context, ethics, and systems—will be explored to highlight their significance in this study and to identify associated gaps in the scholarly literature. This chapter is divided into five parts: Section 2.1 provides an overview of health planning and priority setting complexity to illustrate the process and challenges that have confronted decision makers. Section 2.2 is guided by the ethics cluster of Figure 1.1 to provide an in-depth review of justice theory, procedural fairness, and Accountability for Reasonableness (A4R). In addition, the application of A4R is discussed to ground this framework in real-world experiences. Section 2.3 draws on the context cluster of Figure 1.1 to provide an in-depth overview of the contextual features documented in the literature as impacting the health planning and priority-setting process. Section 2.4 draws from the systems cluster of Figure 1.1 to discuss the systems literature by providing both a theoretical background and practical understanding for the use of systems theory. The Transformative Systems Change Framework (TSCF) is also described, theoretically and practically. Finally, Section 2.5 provides a summary of this literature overview and sets the stage for its framing of the study.

2.1. Priority Setting as a Complex Challenge

As aptly described by Norheim et al. (2014), “priority setting of health interventions should seek to achieve health system goals, broadly defined as maximization of health, reduction of inequities in health, and financial protection against the costs of ill health” (p. 18). In an era of advancements in medical technology, increasing incidence of disease, and overburdened health systems, setting priorities for health programs remains a cornerstone for healthcare sustainability (Martin, 2007; Glassman & Chalkidou, 2014). Given pervasive resource constraints, however, the process by which priorities are set has arguably been one of the most complex organizational aspects that decision makers confront (Kapiriri & Martin, 2006; Glassman & Chalkidou, 2014). In every health system, priority-setting decisions are being made simultaneously at the macro-
These decisions commonly involve the allocation of operational funds, services, technologies, and pharmaceuticals (Patten, Mitton & Donaldson, 2006; Glassman & Chalkidou, 2014).

Traditionally, a common form of health care priority setting has been to allocate resources on the basis of historical funding patterns, also referred to as implicit rationing (or “hidden rationing”). Through this form of rationing, resources are typically allocated to programs already funded, through the discretion of policy makers, health planners, and clinical experts (Mitton & Donaldson, 2004; Lauridsen, Norup, & Rossel, 2007). Such funding patterns, however, tend to have implications on the redistribution of funds that may be required in light of new priority programs. While some researchers have argued that an implicit mode of rationing is less messy than more explicit procedures of allocation, implicit modes of rationing are inherently at odds with planning procedures that support public disclosure, stakeholder engagement, and overall transparency. In addition, researchers argue that implicit rationing may not generate good outcomes, use resources appropriately, or enable decision-making to meet requirements of accountability (Lauridsen et al., 2007).

In light of these issues, the call for explicit priority setting procedures emerged with an emphasis on tools and criteria to provide more precise and transparent guidance on how to allocate resources (Peacock & Richardson, 1998; Gaminde, 1999; Breyer & Schultheiss, 2002; Mitton & Donaldson, 2004; Rudan, Kapiriri, Tomlinson, Balliet, Cohen, and Chopra, 2010). Holm (1998) classified this shift as the first phase in priority setting thinking, whereby legitimate decisions were viewed as derived from rational priority setting methods guided by evidence, rules, and decision-making tools or algorithms. To guide this process, some of these explicit measures have drawn

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11 Aaron and Schwartz (1984) reveal that programs that are costly and burdensome on the health care system may not be prioritized if historical patterns of funding tended to prioritize “run-of-the-mill” diseases that were viewed as more easily treatable. Grimley Evans (1993) also describes some of the implications of implicit rationing on the well-being of the elderly and most vulnerable (such as marginalized populations, women, and the disabled).

12 Hunter (1995) and Mechanic (1997) argue that implicit rationing allows clinicians to consider the specifics of each individual patient rather than rationing in accordance with explicit pre-defined rules.

13 Lauridsen et al. (2007) argues that informed consent and public deliberation constitute benchmarks for rationing if individual and political autonomy are viewed as central values in health care. Implicit rationing, therefore, does not appear to be compatible with respect for autonomy as it restricts the conception of democracy (pp. 706-707).
from: (i) **economics**, through the use of approaches such as program budgeting and marginal analysis (PBMA) and cost-effectiveness analysis (CEA), to support planning efficiency;\(^{14}\) and (ii) **medicine**, through the use of evidence-based medicine (EBM), to augment our understanding of clinical effectiveness, benefits, and harms.\(^{15}\)

In their book, *The Global Challenge of Health Care Rationing*, Coulter and Ham (2000) provide a consolidation of research and work capturing experiences of priority setting explicitness from both high-income country contexts (including Canada, the United States, Finland, New Zealand, Norway, the United Kingdom and The Netherlands) and low-income country contexts (specifically, Pakistan). Through these and other case studies documented in the scholarly literature, decision makers, at all levels, have drawn from discipline-specific strategies to improve explicit measures to setting priorities. Macro-level studies, for instance, have included investigations to describe tools used for the selection of new technologies and pharmaceuticals (Oortwijn, Vondeling, van Barneveld, van Vugt, & Bouter, 2002; Anell, 2004; Douw, Vondeling & Oortwijn, 2006; Lilford et al., 2014). Meso-level analyses have drawn our attention to institutional priority setting within hospitals or regional health authorities, highlighting explicit economic approaches to priority setting (Mitton & Donaldson, 2002; Gallego, Taylor, McNeill & Brien, 2007; McDonald & Ollerenshaw, 2011; Mitton, Peacock, Storch, Smith & Corneilissen, 2011; Mitton, Dionne, Damji, Campbell & Bryan, 2011). At the micro-level, other rationing considerations have been documented with respect to drug or surgical allocation (McKneally, Dickens, Meslin, & Singer, 1997; Kapiriri & Martin, 2007a).

For decision makers in low-income countries, the Disease Control Priorities Project (DCPP) was an extensive initiative spearheaded by the World Bank in the early 1990s to increase the availability of information through technical approaches. This strategy included providing national decision makers with cost-effectiveness data and burden of disease information to capture priority health issues through morbidity and mortality data (Baltussen & Niessen, 2006). To further augment the evidence-base used for priority setting, the WHO later implemented WHO-CHOICE

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\(^{14}\) For relevant literature, see Mitton & Donaldson (2002); Anell (2004); Peacock et al. (2006); and Schultz Hansen, & Chapman (2008).

\(^{15}\) For relevant literature, see Nunes (2003) and Claeson & Alexander A (2008).
CHOosing Interventions that are Cost-Effective, which aimed to further guide planners on intervention cost-effectiveness and impact on population health (through the development of regional databases). This DCPP approach was adopted in many countries to guide rationing procedures that included Kenya, Uganda, Eritrea, and Ethiopia (Bobadilla, Cowley, Musgrove, & Saxenian, 1994; Kapiriri, Norheim, & Heggenhougen, 2003).

In addition to this approach, another major initiative was the implementation of the Tanzania Essential Health Interventions Project (TEHIP), which, over a ten-year period, tested the application of these techniques to improve evidence-based decision-making. Led by the Tanzanian Ministry of Health and Social Welfare and the Canadian International Development Research Centre, two-districts—Rufiji and Morogoro—were selected to analyze how decision makers use information and how district-level evidence and cost data could improve the alignment between selected health priorities and district need (de Savigny, Kasale, Mbuya, & Reid, 2004). Upon the completion of TEHIP, a few key lessons emerged. While it illustrated that evidence-based planning and resource allocation in alignment with priority health needs may yield large improvements in health outcomes, it also revealed that values of efficiency and cost-containment (as largely emphasized through burden of disease and CEA criteria) only represent a few values for judging whether an intervention has merit. Equity, for one, surfaced as an additional concern among stakeholders; such that while providing the same services to rural areas may be less cost-effective (since fewer patients are seen and fewer staff likely available), it may be more worthy of public investment by virtue of the fact that it is equitable (de Savigny et al., 2004, p. 22).

Balancing the myriad of values in priority setting practice spurred researchers to look for practical approaches that could balance these multiple criteria in priority setting practice. Baltussen and Niessen (2006) argued that decision-making complexity is largely the result of planners simultaneously drawing from a variety of criteria and disciplinary approaches when prioritizing health services.

The underlying problem is that decisions on the choice of health interventions are complex and multifaceted. [...] Many criteria, or factors, play a role, and present the type of problem that behavioral decision research shows policy makers are typically quite bad at solving, unaided. [...] They tend to use heuristic or intuitive approaches to simplify complexity, and in the process, important information is ignored. (p. 3)
In other words, the use of one criterion for priority setting was determined as inadequate to satisfy the varied considerations required of real-world health priority setting (Baltussen and Niessen, 2006). In recent years, researchers have argued for decision-making strategies, such as multiple-criteria decision analysis (MCDA) that allow policy makers to interpret the multiple criteria typically considered in real-world priority setting (Baltussen & Niessen, 2006; Tromp & Baltussen, 2012; Youngkong, Teerawattananon, Tantivess, & Baltussen, 2012) In Figure 2.1, Baltussen and Niessen (2006) pay specific attention to the modes by which these criteria have been used, distinguishing primarily between ad hoc (typically random) versus rational (more-structured) processes of priority setting. While both processes may be guided by similar multiple disciplinary considerations, the differentiating feature is that the explicit nature of prioritization is less structured in ad hoc decision-making.

Figure 2.1. Ad Hoc Priority Setting and Rational Priority Setting (Excerpted from Baltussen & Niessen [2006, p.2])

Although the aforementioned strategies highlight explicit attempts to guide decision makers, researchers recognized that the concept of devising a “simple set of rules” to guide priority

16 Baltussen and Niessen (2006) cite the experiences captured in: Kapiriri & Norheim (2004); Mills, Bennett, Bloom, & Gonzalez-Block (2004); Ham (1997); Robinson (1999). Refer to reference list for full citation.
setting practice was increasingly flawed given the complexity of the “process” itself. Despite the benefits of MDCA, stakeholders require guidance on how to achieve a process of decision-making that is ethically fair, deliberative, and accountable. Numerous stakeholder interests and values, coupled with challenges in the interpretation and use of data and criteria across varied stakeholders have been a few of the dimensions of priority setting complexity that have surfaced in the literature. What is recognized in the literature is that decision-making complexity necessitates weighing a complex milieu of multiple values that are often at odds with each other (Baltussen et al., 2013). This awareness taxes the limits of technocratic tools. A vivid example arises in situations where consensus around whether to provide limited vaccines to children and the elderly, versus the working majority, cannot be easily achieved. These values may include supporting the vulnerable (as advocated by certain interests groups), while other groups may lobby for more equitable distribution. What these challenges reveal for priority setting practices are that explicit tools alone cannot reconcile these challenges. Holm (1998) classified this recognition as the second shift in priority setting thinking, whereby legitimate decisions were viewed as derived from a priority setting “process” characterized by transparency and accountability. To reaffirm the salience of Klein’s argument highlighted in Chapter 1, decision-making complexity is not only the result of a lack of information, but also a lack of consensus on how to use and interpret this information (Klein & Williams, 2000 in Coulter & Ham, p. 20). Klein (2000) acknowledges the difficulty in achieving the “right” answer, and maintains that through the improvement of procedural and institutional mechanisms that promote inclusivity and debate, we can produce more “socially acceptable answers” that minimize the contentious nature of health decision-making (p. 21).

To advance methods in support of procedural-based approaches to priority setting, researchers turned to: (i) political science, through the use of frameworks that promote democratic deliberation, to provide guidance on who should be included in decision-making and to what extent; and (ii) philosophy, through the use of ethical theories of distribution (i.e., utilitarianism, egalitarianism, and libertarianism), and procedural justice, to assist in resolving value conflicts.

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17 For relevant literature, see Fleck (2009); Gutmann & Thompson (2004)
Section 2.2 turns our attention to the field of ethics that has sought to advance thinking and methods in phase two of the priority setting discourse. These methods have focused on how to strengthen the procedural fairness associated with priority setting. Figure 2.2 provides a summary of key points focused on health planning complexity that draws our attention to the first two phases in the priority setting discourse described by Holm (1998). The following section explores scholarly advancements in the second phase of priority setting methods that have sought to strengthen the process.

**Figure 2.2. Health Planning Complexity: Summary of Key Points**

- Historical “implicit’ rationing at the discretion of decision makers minimizes planning consistency and accountability.
- To strengthen accountability, a focus towards more explicit forms of rationing emerged based on tool and criteria development.
- In Phase one of priority setting thinking, it was believed that technocratic tools (such as CEA, BOD, and PBMA) would reconcile priority setting complexity.
- Information is only one input into a complex priority setting process for which there are no “simple technical solutions.”
- Priority setting is influenced by values that may be competing.
- In Phase two of priority setting thinking, legitimate decisions are viewed as derived from a correct priority setting process that is characterized by transparency and accountability.

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18 For relevant literature, see Beauchamps & Childress (2007, pp. 268-281); and Gibson, Martin, & Singer (2005a).
2.2. **Priority Setting as an Ethical Issue**

**Figure 2.3.** Ethics Cluster Excerpted from Schematic Dissertation Overview

Excerpted from Figure 1.1, Figure 2.3 draws our attention to the ethical nature of district health planning and the focus to strengthen procedural fairness in priority setting practice. As previously described, conflicting stakeholder interests and values reveal the ethical implications of health priority setting. Daniels and Sabin (1998) maintain that there will always be moral disagreement in priority setting decisions. For instance, balancing between competing values (e.g., equity versus efficiency), the conflict between best outcomes versus fair chance, and the “aggregation problem” (i.e., small benefits for many versus large benefit for few) yields varying ethical implications associated with the priority setting process (Daniels, 1994, pp. 27-29). This “priorities problem” aptly reveals the morally challenging and value-laden dimensions that inherently make “just” priority setting extremely complex in any context (Daniels & Sabin, 1998, 2008). Is it morally possible to balance between resource provisions for society’s worst-off patients versus maximizing the total benefit for all in health care expenditure? Ultimately, resource constraints will require reasonable judgment regarding which medical needs are deemed “more important” than others.

To reconcile these conflicts, scholars have drawn from Rawlsian justice theory—“justice as fairness”—to strive for socially just measures by which goods may be distributed in society (Rawls, 1971). This entails a wise use of resources (i.e., channeling monies where legitimately needed), avoiding waste (i.e., limiting duplication of programs), and...
getting value for money (i.e., interventions sought will result in favourable outcomes). Extending to health and health care distribution, Daniels (1985) offered seminal work in applying “justice as fairness” by maintaining that a “just” health care system is one that strives to provide access to health services and social conditions that are necessary to protect normal human functioning in society, and, therefore, a “fair equality of opportunity” (p. 26). Through this lens of distributive justice, what constitutes “fairness” is the outcome decision itself that has traditionally been justified by burden of disease principles and/or modes of historical rationing patterns. While relying on such distributive principles for allocation has been an approach many scholars and practitioners have drawn upon, such procedures do not minimize the contentious nature of decision-making. This lack of consensus is largely due to the fact that what is considered as a “fair” decision differs depending on one’s conception of fairness. Such a conception is also inherently influenced by the set of distributive norms unique to a particular context (Deutsch, 1975, pp. 137-149). Relying solely on distributive principles for allocation, therefore, has not reconciled these conflicts nor minimized the contentious nature of decision-making.

2.2.1. Justice as “Procedural” Fairness

In a context of “reasonable disagreements,” this lack of consensus around distributive principles has challenged researchers and decision makers to define conditions in which it is ethically acceptable for institutions to set such limits (Daniels & Sabin, 2008, pp. 2-4). Contrasted with distributive justice, procedural justice concerns itself with the fairness and transparency of the processes by which decisions are made (Rawls, 1971). Rawls (1971) outlined three pathways of procedural justice—perfect, imperfect, and pure—that serve as a guide in assessing fairness. Both

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19 In a *Theory of Justice* (1971), John Rawls uses a variant from social contract theory to provide a solution to the challenge of distributive justice through the development of the theory, “Justice as Fairness.” This deals with the socially just nature of distribution of goods within a society and posits that all societies meet healthcare needs fairly under reasonable resource constraints. Two principles are derived from a “Justice as Fairness:” (i) the liberty principle, which states that each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others; and (ii) the difference principle, which posits social and economic inequalities are structured in a way that (a) they are to be of greatest benefit to the least-advantaged members of society and (b) offices and positions must be open to everyone under conditions of fair equality of opportunity (pp. 47-52).

20 Daniels (2008) maintains that justice does not resolve the controversies associated with limit setting. Furthermore, “the opportunity principle simply cannot answer a central resource allocation question such as ‘How much priority should we give to treating the sickest or most disabled patients?’” (pp. 105-108)
perfect and imperfect procedural justice suggest an approach where, although the outcome may be known (for instance, taking a utilitarian approach to allocation, whereby the greatest overall good is sought), the procedure to arrive at such decisions may or may not be considered to follow a “just” process (pp. 73-77). A pure procedural pathway, on the other hand, stresses that, although the end decision may not be considered pre-determined, a “just” outcome is the consequence of a “just” process; that is, justice is inherent in the rules and any procedure that implements the rules will be “just” no matter what the outcome (pp. 75). Through this lens, procedural justice holds that a fair process will determine whether a particular allocation of resources is fair (Daniels & Sabin, 2008, p. 43). It is here where an emphasis on procedural justice becomes prominent in the hope that consensus on what constitutes a fair process of decision-making (i.e., how priorities are set) be less contentious (p. 4).

Applying these principles to health care, Daniels (2008) maintains, “when we lack consensus on the principles that tell us what is fair, and are burdened by reasonable disagreements on how they apply, we may opt for a procedure that most who are affected would accept as fair” (p.4). In this framing, procedural justice holds that a fair process largely determines what is considered as a fair outcome. As a result, legitimacy and fairness are central to priority setting—the former concerned with the conditions under which authority over priority setting should be placed in the hands of a particular organization, group, or person, and the latter concerned with the circumstances under which a patient or clinician would have sufficient reason to accept a decision as fair (Daniels & Sabin, 1998, p. 52; Gibson, Martin, & Singer, 2002). By strengthening procedurally fair and legitimate mechanisms for health decision-making, transparency and democratic deliberation become critical features of this process and provide a more solid decision-making platform in support of good governance (Daniels, 2008, p. 253).21

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21 Daniels (2008) is explicit in his position that the “theory of just health” does not appeal to benchmarks for measuring accountability beyond that of “accountability for reasonableness.” He maintains that broad notions of accountability are a part of good governance and, while the “theory of just health” does not specifically address these components, there is an underlying compatibility in its propositions. The focus on transparency, for instance, is “not only a presupposition of democratic governance in general, but also a specific requirement of justice […] which affirm that the terms of social cooperation must be ones that people can generally agree on” (p. 253).
2.2.2. A Framework for Procedural Fairness: Accountability for Reasonableness

To guide decision makers in cultivating a fair and legitimate priority setting process, Daniels and Sabin (1998) proposed Accountability for Reasonableness (A4R), an ethical framework founded on principles of pure procedural justice. A4R has been widely applied to facilitate learning on fair and legitimate priority setting practice, and to strengthen patterns of democratic deliberation among stakeholders.22,23 The framework was first developed in the context of the American private insurance market, whereby insurers had the decision-making capacity to limit coverage that could yield negative consequences on its patient subscribers. As a result of the less inclusive nature of decision-making at the time, and the lack of explicit mechanisms for rationing, a climate of distrust emerged among stakeholders and the public. To address this issue, A4R was conceptualized to include four conditions that, if met, would eliminate public distrust by ensuring a fair and transparent planning process for resource distribution (Daniels & Sabin, 1998). These conditions included:

(i) **Relevance**: Priority setting decisions should be based on evidence, reasons, and principles accepted as relevant by a wide range of stakeholders.

(ii) **Publicity**: Priority setting decisions and their rationales should be made publicly available to stakeholder groups, so as to cultivate a transparent decision making process.

(iii) **Appeals and Revision**: There should be mechanisms present for stakeholders to dispute and challenge decisions, and revise them in light of further arguments.

(iv) **Enforcement**: There must be public or voluntary regulation of the priority setting process to ensure that the first three conditions are met.

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22 Daniels and Sabin (2008) argue that a “fair process must enable public deliberation and democratic oversight for health care limits” (p.4).

23 In their book, *Democracy and Disagreement*, Gutmann and Thompson (2004) view deliberative principles around the central concept of reciprocity when reflecting on the conditions necessary for justifying laws and policies. Here, “reciprocity, publicity, and accountability are the chief standards regulating the conditions of deliberation. […] And] the basic premise of reciprocity is that citizens owe one another justifications for the institutions, laws, and public policies that collectively bind them” (pp. 132-135). Appeals and revision, therefore, are viewed as key features of a decision-making process that is seen to be democratic and deliberative.
2.2.3. Application of A4R: Experiences and Challenges

Over the past decade, researchers have described how the principles of A4R might be operationalized in practice. Martin and Singer (2003) proposed a research-based quality improvement approach using A4R as a conceptual framework. The approach comprised three steps: (1) case study research to describe the priority setting process, (2) interdisciplinary research to evaluate or assess this description against the conditions of A4R, and (3) action research to improve priority setting based upon identified areas for priority setting process improvement. To date, a number of case studies using this approach have been conducted in diverse contexts, including priority setting at macro-, meso- and/or micro-levels in low, middle, and high income settings (Martin, Giacomini, & Singer, 2002; Reeleder, et al., 2006; Jansson, 2007; Schlander, 2007; Walton, Martin, Peter, & Pringle, 2007; Kapiriri, Norheim, & Martin, 2009; Stellan, Omnell-Persson, Tinghog, Omar, & Carlsson, 2013). The majority of these case studies have spoken to the initial two steps—first, describing the priority setting process and, second, evaluating it against the conditions of A4R. Through an assessment, many of these case studies have revealed lessons for improving the fairness and legitimacy of the decision-making process, such as: improving the explicitness of the decision criteria stakeholders would use in the priority setting process (i.e., relevance) strengthening dissemination strategies of the priority setting decisions and the reasons underpinning those decisions (i.e., publicity); increasing opportunities for iterative review of decisions (i.e., revision), and improving regulative measures that uphold the aforementioned conditions (i.e., enforcement) (Martin, Hollenberg, MacRae, Madden & Singer, 2003; Gibson, Martin, & Singer, 2005a; Madden, Martin, Downey, & Singer, 2005).

Emergent from its empirical application, Gibson, Martin, and Singer (2005b) recognized that while improved stakeholder inclusivity and participatory dialogue were important features in ensuring procedural fairness (i.e., through the relevance and publicity conditions), power differentials across stakeholders were also apparent and required consideration (given that divergent power structures may hinder some stakeholders from actively participating). This acknowledgment of a wider contextual feature highlighted a conceptual weakness within A4R that

led to the conceptual innovation of a fifth A4R condition: empowerment. Through the empowerment condition, a decision-making process upholds fairness and legitimacy if mechanisms are in place to minimize power differentials across stakeholders by encouraging active participation. Given the importance of such a characteristic within all priority-setting processes that seek to promote democratic deliberation, the A4R framework in this study was augmented conceptually to include the empowerment condition (Table 2.1).

Table 2.1. Augmented Conceptual Framework of Five A4R Conditions used in this Dissertation (adapted from Daniels & Sabin, 1998; *Gibson et al., 2005b)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>The rationales for priority-setting decisions should be based on evidence, reasons, and principles that fair-minded people can agree are relevant to meeting health care needs fairly under reasonable resource constraints.</td>
</tr>
<tr>
<td>Publicity</td>
<td>Priority-setting decisions and their rationales should be made publicly accessible, so as to stimulate public debate on the decisions.</td>
</tr>
<tr>
<td>Appeals and Revisions</td>
<td>There should be a mechanism in place for challenging and revising decisions in light of new information or arguments that stakeholders may arise.</td>
</tr>
<tr>
<td>Empowerment*</td>
<td>There should be efforts to optimize effective opportunities for participation in priority setting to minimize power differentials across all stakeholders present at the decision-making table.</td>
</tr>
<tr>
<td>Enforcement</td>
<td>There must be public or voluntary regulatory measures in place to ensure that the aforementioned conditions are met.</td>
</tr>
</tbody>
</table>

Focused on low-income country contexts, the emphasis to approach priority setting from an ethical lens of procedural fairness has continued to grow. Over the past decade, experiences of applying A4R have been captured from low-income country contexts as both a normative lens under which to view the priority setting process, and as implementation tool to guide fairer processes of decision-making. As a normative lens, two case studies from Uganda applied A4R at both the micro- and meso-levels to evaluate the fairness and legitimacy of priority setting for the
selection of anti-retroviral drugs, and for prioritizing a hospital strategic plan, respectively (Sofaer, Kapiriri, Atuyambe, Otolok-Tanga, & Norheim, 2009; Kapiriri & Martin, 2006). Both studies revealed limitations to procedural fairness in practice. Kapiriri and Martin (2006), for instance, highlighted weaknesses in stakeholder engagement and in publicizing decisions and their rationales to pertinent stakeholders. Such experiences were also captured by Sofaer et al. (2009), who also described limitations to publicizing decisions and their rationales as well few mechanisms to support the challenging of decisions, as final decisions were considered unchangeable.

In 2006, the REACT study\(^\text{25}\) (REsponse to ACountable priority setting for Trust in health systems) sought to advance the practical application of A4R principles in three low-income country contexts: Zambia, Tanzania, and Kenya (Byskov et al., 2009). This project was grounded in the realization that previous technocratic approaches to support priority setting had not attained the level of improved health planning that was sought, and, as a result, greater attempts were required to strengthen the process through attention to fairness and transparency. Through this investigation, a few key findings emerged. For one, there appeared to be conceptual resonance between with the principles of A4R and the values within the context. In Tanzania, decision makers accepted the A4R approach as an effective means to achieving wider stakeholder participation, transparency, and scrutiny of relevant criteria. However, decision makers also viewed A4R as conceptually technical and complicated to operationalize in priority setting practice. Some decision makers focused on the challenges of disclosing the reasons underpinning decisions, since criteria were already dictated from higher authorities. Other decision makers highlighted the difficulty in bringing varied stakeholders together with differing levels of knowledge, skills, and expertise, while others further described the financial expenses associated with such an undertaking (Mshana et al., 2007). One nurse respondent commented that should community members now be engaged in the process, the ‘traditional’ practice of government officials making unrealistic promises to community members could backfire. Additionally,

\(^{25}\) The REACT study was a five-year collaboration between the Centre for Health Research and Development, University of Copenhagen and the Ministry of Health in Zambia, Tanzania, and Kenya. The main objective of the study was to strengthen health sector performance in resource poor countries through the improvement of fairness and legitimacy of priority setting. For further information, see Byskov et al., (2009).
stakeholders questioned if the application of A4R would result in increased tension between planners—26 and politicians at different levels of government (Mshana et al., 2007; Maluka et al., 2010)—a valid concern in such contexts where corruption and power differentials have historically had a significant role in decision-making dynamics (Szeftel, 1998). Such findings reveal sensitivity to contextual factors that should be considered in understanding how fair processes and the procedures associated may be realized. Attention to context, however, is not a feature presently acknowledged in A4R. It is a process-driven conceptual framework that lacks attention to system-level social, cultural, and/or political features that may have a significant bearing on how procedural fairness manifests and unfolds. Such a finding was illustrated by the work of Maluka et al. (2011) who highlighted a number of contextual factors that either positively or negatively influenced the implementation of the A4R conditions. For instance, while the presence of participatory and collaborative structures under Tanzania’s decentralization framework facilitated the operationalization of the relevance and appeals conditions, limited public awareness, centralized decision making structures, and inadequate resources also appeared to have constraining factors on the operationalization of the A4R conditions (Maluka, 2011). Figure 2.4 provides a summary of contextual factors—enabling and constraining—that influenced the conditions of A4R. Maluka et al. (2011) conclude that the system context (i.e., technical and management capacity), power asymmetries, and the diversity of stakeholders involved influence, not only the process, but also the utilization of strategies to guide fair and legitimate priority setting.

Given the socio-cultural and political differences unique to each context, it is important to reflect on these influencing factors in order to deepen our understanding of how these ethical principles are conceptualized, understood, and practiced within particular setting. It was therefore an aim of this study to uncover how a deeper comprehension of the system would enhance our understanding of the translation of A4R principles within Ethiopia. Such factors may include the values and interests driving decision-making, as well as the influence of social norms and belief systems that would define how stakeholders convene and interact (Kapuriri & Martin, 2007b).

26 Some participants also alluded to the potential conflicts that could arise out of increased stakeholder engagement if, for instance, stakeholders do not have the knowledge, skills, or experience to effectively contribute to priority setting.
As one seeks to apply A4R in low-income settings, such as Ethiopia, a key consideration is whether principles of democratic deliberation and fairness are intrinsic to priority setting decision makers. It is most evident that the historical context and politics of Sub-Saharan African (SSA) countries have evolved differently compared to Western countries. The increasing dominance of state rule in many of the SSA countries has only recently (within the last 20-30 years) become more democratic (Thomson, 2000, p. 230). Given the recent dominance of such concepts of democratization and transparency within Ethiopian policies and health reform, it was believed that there may be a growing acceptability among stakeholders to strengthen these concepts in practice. However, the extent to which the principles of A4R align with the Ethiopian conceptualization of fairness remained uninvestigated. Figure 2.5 provides a summary of key points focused on the ethical nature of priority setting that draws our attention to the significance of procedural mechanisms to achieve deliberative and transparent decision making and the importance of understanding how contextual factors influence the priority setting process.
• Priority setting decisions can be evaluated on the basis of a fair outcome or fair process.

• Distributive justice, or fairness of the outcome, is concerned with defining substantive criteria for defining a fair priority setting outcome.

• Procedural justice holds that a fair outcome is derived from a fair decision-making procedure.

• Experience shows that it is often difficult to reach agreement on what the right priority setting decision should be; however, it may be possible to reach agreement on how priority setting decisions should be made.

• Accountability for Reasonableness (A4R) is a prominent ethical framework comprised of four conditions—relevance, publicity, appeals, and enforcement—to operationalize fair and legitimate priority setting.

• Gibson et al., (2005b) propose the addition of a fifth condition, empowerment, to address the weakness in A4R to minimize power differentials across stakeholders. This condition draws attention to power structures, thus moving in the direction of the third phase approach.

• Attention to context is not a feature presently acknowledged in A4R. Thus, further research that acknowledges the impact of contextual features in decision-making can inform our understanding of how context influences procedural fairness.
2.3. **Priority Setting as a Contextual Issue**

Whether improving the evidence-base through technocratic approaches (e.g., CEA or BOD) or strengthening the fairness and legitimacy of the priority setting process itself, the literature reveals that ultimately, the setting health care priorities is heavily influenced by the socio-cultural, political, and historical context. Kapiriri and Martin (2007b) maintain that sustainable strategies to improve priority setting in low-income countries will only be achieved once researchers, practitioners, and stakeholders fully understand how the features of a context influence both the capacity for and governance of decision-making. Figure 2.6 draws our attention to the context cluster of the schematic overview of this dissertation. This segment illustrates how the socio-cultural, political, and historical contexts define the underlying values, policies and procedures [that define how processes should unfold], actors involved [who shape regulations and financing structures], and overall institutional capacity [which define how information is collected, managed, and shared].

**Figure 2.6.** Context Cluster Excerpted from Schematic Dissertation Overview
To date, there is a dearth of scholarly literature that has analyzed how and to what degree contextual features shape priority-setting processes. Further, there is even less scholarly literature, which speaks to the contextual influences on fair and legitimate health planning through the lens of A4R. Some research has highlighted a series of contextual influences on the priority-setting process (Mitton & Prout, 2004; Kapiriri & Martin, 2007b; Maluka et al, 2011). Mitton and Donaldson (2003) and Mitton and Prout (2004) published scholarly research that identified facilitators and barriers with respect to health planning and priority setting. Mitton and Donaldson (2003), for instance, drew attention to the organizational barriers and facilitators such as leadership, managerial structures and the overall learning culture as the key factors influencing the integration of new frameworks and strategies used in setting priorities (such as PBMA).

Augmenting these observations, Mitton and Prout (2004) divided these barriers and facilitators into three overarching categories: *structural, attitudinal*, and *external*. In a case study of priority setting in the South West Area Health Service of Western Australia, examples of *structural* barriers included: (i) limited communication between management of the organization (which appeared to foster an overall lack of transparency among decision makers); (ii) the use of inappropriate data; and (iii) a perceived limited role of Health Service Managers (HSMs) in the priority setting process (as members of Executive Management articulated a desire for HSMs to be more engaged).

*Attitudinal* barriers that emerged largely included: (i) resistance to change among stakeholders (as a result of limited stakeholder buy-in and commitment); (ii) the existence of power asymmetries across stakeholders; and (iii) an overall perceived lack of “credible commitment” to decisions made. Lastly, *external* barriers focused on: (i) the lack of an explicit process (which both weakened community views on the decision-making process and were seen to influence the political context in which priority setting decisions were made); and (ii) budgetary constraints.

Contextual facilitators were also identified that focused on the presence of strong leadership in support of a decision-making culture willing to learn and earmarked resources that could easily support the process.

These findings are congruent with those that emerged at the Provincial Health Services Authority (PHSA) of British Columbia, whereby the move towards an explicit priority setting process revealed a series of strengths and weaknesses (Teng, Mitton, & MacKenzie, 2007). Two
key strengths identified focused on organizational stability through the development of PHSA’s Strategic Plan and the implementation of an explicit decision making process that focused decision makers towards a common goal. Teng et al. (2007) further categorize weaknesses as both “systemic” and “individual.” Systemic weaknesses were those within the domain of the organization that spoke to the structure, policy, or systems of the organization. In this domain, weaknesses to priority setting focused on centralized decision making resulting in the disempowerment of some stakeholders, confusion across roles, and lack of true accountability structures. At an individual level, decision makers articulated a lack of management training limiting their skills in this process, a fear for too much immediate organizational change, and a lack of shared vision.

Figure 2.7 summarizes the barriers and facilitators associated with an explicit priority setting process from the experiences drawn from Mitton and Donaldson (2003), Mitton and Prout (2004), and Teng et al. (2007). What is particularly noteworthy is that a number of “input” barriers and facilitators and “output” barriers and facilitators remained consistent across all three studies.

With respect to input facilitating features, strong leadership, a culture of learning, and earmarked resources in support of the process were consistent features acknowledged across all three studies. With respect to input barriers, no genuine buy-in among stakeholders was a ongoing limiting feature. Across each of these three studies, output facilitators focused on the importance of earmarked resources for follow-up along with an organizational culture open to change. Output barriers, on the other hand, focused on organizational politics that may override technocratic planning and on vertical funding structures. While each process of decision making is unique, the aforementioned illustrate commonalities across all three priority setting experiences that speak to the salience of recognizing the structural, attitudinal, and external barriers and facilitators that exist at both the start of an explicit priority setting process and at its completion (Mitton & Prout, 2004, p. 307).

To facilitate an understanding of the role of context in policy decisions generally, some researchers have turned to policy analysis to elucidate the ideas, interests, and institutions underpinning health planning and priority setting (UNFPA, 2006; Maluka et al., 2011). The Walt and Gilson (1994) policy triangle, for example, has become a common policy framework for
understanding the content, context, and process of policy making (or health planning), and to guide our understanding of how the actors and interests within the context further influence the priority setting process. Using the policy triangle as a guide, an example of priority setting for reproductive health services in Ghana revealed that while reproductive health is a stated priority at the national and district levels, priority setting itself is still largely driven at the national level (UNFPA, 2006). Therefore, to improve the process of prioritizing for reproductive health services, researchers recommended that district health authorities and reproductive health advocates play a larger role in policy development at the national level, and that strategies to procure drugs and supplies for health institutions at the district level be strengthened (pp. 18-20). Still, the question remains: what factors may potentially facilitate and/or constrain district health authorities from engaging in policy development?

**Figure 2.7.** Barriers and Facilitators to Priority Setting (excerpted from Mitton & Donaldson, 2003*; Mitton & Prout, 2004 †; Teng et al., 2007 §)

<table>
<thead>
<tr>
<th>Facilitators</th>
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<tbody>
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<td>- High level champion; strong leadership* † §</td>
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<tr>
<td>- Culture of learning * † §</td>
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<tr>
<td>- Earmarked resources for the process * † §</td>
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<tr>
<td>- Consistent with managerial activity *</td>
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<tr>
<td>- Faced with actual decision to be made †</td>
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<tr>
<td>- Commitment to the process §</td>
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<tr>
<th>Facilitators</th>
<th>Facilitators</th>
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<tr>
<td>- Earmarked resources for follow-up * † §</td>
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<tr>
<td>- Culture open to change * † §</td>
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<tr>
<td>- Real decision has to be made *</td>
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<tr>
<td>- Integrated budgets *</td>
<td></td>
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<tr>
<td>- Incentives for change †</td>
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<td>- Consistent application §</td>
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<td>- Demonstrated results §</td>
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<tr>
<td>- Incentives for change §</td>
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<tr>
<th>Inputs</th>
<th>Explicit priority setting process</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>Barriers</td>
<td>Ideal process §</td>
<td>Barriers</td>
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<tr>
<td>- No genuine buy-in * † §</td>
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<td>- Too many other demands * †</td>
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<tr>
<td>- Politics prevents evaluation * †</td>
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<td></td>
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<tr>
<td>- Discontinuity of personnel †</td>
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<td>- Lack of skills in priority setting §</td>
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<td>- Lack of shared vision §</td>
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<td>- Competing priorities §</td>
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<tr>
<th>Inputs</th>
<th>Explicit priority setting process</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>Barriers</td>
<td>Ideal process §</td>
<td>Barriers</td>
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<tr>
<td>- Clear communication of vision</td>
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<td>- Integrate strategic goals</td>
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<td>- Time sensitive</td>
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<td>- Evidence-based</td>
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<td>- Input from stakeholders</td>
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<thead>
<tr>
<th>Inputs</th>
<th>Explicit priority setting process</th>
<th>Outputs</th>
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<td>Barriers</td>
<td>Ideal process §</td>
<td>Barriers</td>
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<tr>
<td>- Vertical budget silos* † §</td>
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<td>- Politics trumps evidence based medicine* † §</td>
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<td>- Lack of trust between stakeholders *</td>
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<td>- Physicians not on board *</td>
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<tr>
<td>- Misalignment of incentives *</td>
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<td>- No (real or perceived) authority to change *</td>
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<td>- Lack of allocation experience *</td>
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<td>- Vertical budget silos †</td>
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<tr>
<td>- Vested interest §</td>
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</tbody>
</table>
In addition, Maluka et al. (2011), as previously described, used the policy triangle to examine the process, actors, and contextual factors shaping decentralized health care priority setting in Tanzania, and more specifically, the manifestation of the A4R conditions. While the policy triangle has helped to underscore the importance of context-specific factors, it fails to provide further guidance on how the context itself is conceptually shaped and functions (such as, identifying the interrelationships between each contextual feature and how they impact on health priority setting). For instance, while the policy triangle may identify a lack of technical and managerial capacity at both the national and district levels and power asymmetries across stakeholders as binding constraints to district health planning (Egger, Travis, Dovlo, & Hawken, 2005; Kapiriri & Martin, 2007b; Balabanova, McKee, Mills, Walt, & Haines, 2010), it is not sufficient by itself to identify the root causes shaping these structural relationships, the nature of their interaction, and the underlying embedded values. Organizational contexts are complex and dynamic and only through the interaction and interdependencies across actors, niches, and activities, do their characters emerge (Foster-Fishman & Behrens, 2007).

In my dissertation, I contend that the next phase of priority setting methods—Phase 3—should focus on improving methods for understanding the influence of contextual factors, including their interactions, on priority setting in practice. Specifically, I argue that systems theory offers a useful theoretical lens to capturing the underlying systemic dynamics. Foster-Fishman and Behrens (2007) oppose the synonymous usage of context and system, suggesting that the term system “better captures the ecological and social change emphasis of [the] field than the more often used term context” (p. 191). They further define a system as a set of parts that interact together and function as a whole (Ackoff & Rovin, 2003 as cited in Foster-Fishman & Behrens, 2007, p. 191). Kemmis (1991) adds:

[…] while the term context can also connote this complexity, [context] more typically refers to a discrete environmental (e.g. neighbourhood, school, organization, community) characteristic that has influence on the phenomenon of interest. Sense of community, classroom size, leadership style and decision-making opportunities are all examples of contextual characteristics that [while] valuable foci for research and intervention, do not capture the overall purpose and essence of the contexts within which they are embedded. (p. 9)
In the case of implementing the WBHSP strategy in Ethiopia, for example, this process would include understanding the system constraints and enablers to policy implementation and strengthening fair processes of decision-making given contextual processes and features. This view reveals another broad gap in the literature that this study attempted to address. Figure 2.8 provides a summary of key points that focus on the salience of context in understanding how the health planning process unfolds, and further draws our attention to the significance of a systems perspective to advance our theoretical and practically understanding of this process.

**Figure 2.8. Priority Setting and Context: Summary of Key Points**

- The setting of health priorities is heavily influenced by the socio-cultural, political, and historical context.
- There is a dearth of scholarly literature that has analyzed how and to what extent contextual factors shape priority-setting processes, and even less scholarly literature that speaks to the contextual influences on fair and legitimate planning processes through the lens of A4R.
- Case studies from the literature draw our attention to organizational, structural, attitudinal, and external barriers and facilitators that exist as input and output features of a decision-making process (Mitton & Donaldson, 2003; Mitton & Prout, 2004; Teng et al, 2007).
- The Walt and Gilson (1994) policy triangle has been a useful conceptual lens to identify key contextual factors influencing health planning.
- Maluka et al. (2010) used this conceptual guide to describe enablers and constraining factors influencing the operationalization of A4R conditions.
- The priority setting discourse is evolving towards a third phase priority setting approach that acknowledges contextual factors and the nature of their interaction.
- I propose the application of systems theory as a potentially useful guide to facilitate this systemic understanding of district health planning in Ethiopia.
2.4. **Priority Setting as a Systems Change Issue**

Excerpted from the schematic overview, Figure 2.9 draws our attention to the systems cluster of the analytical framework, which focuses our attention on the importance of the system structure in our investigation of systemic influences on district health planning and priority setting. In this diagram, two theories, namely Systems Dynamics Thinking and Soft Systems Methodology, inform the conceptualization of the Transformative Systems Change Framework (TSCF) proposed by Foster-Fishman et al. (2007). Through the TSCF, we are able to gain a more nuanced understanding of the system structure in order to analyze system characteristics and interaction patterns to help identify the systemic barrier and facilitators of district health planning implementation and fair priority setting.

**Figure 2.9. Systems Cluster Excerpted from Schematic Dissertation Overview**
In relation to understanding and improving health-planning processes and procedural fairness, there is little scholarly literature that applies the perspectives of systems theory. With the release of the WHO’s *Systems Thinking for Health Systems Strengthening*, the concept of “systems thinking” has emerged as one of the four key elements that can contribute to the process of transforming health and health systems (de Savigny & Adam (Eds), 2009). Systems thinking is viewed here as “an approach to problem solving that views ‘problems’ as part of a wider, dynamic system [that understands] the linkages, relationships, interactions and behaviors among elements that characterize the entire system” (p. 33). Given that modern health systems are not monolithic, and that systems analyses have been noted to be conceptually and methodologically complex, their utility may have great bearing on advancements in the field of system-wide strategy implementation (p. 32). Ultimately, health systems are complex, constantly changing, loosely or tightly-linked to other sub-systems, governed by feedback, and historically and politically influenced (Sterman, 2006, p. 32; Meadows et al., 1982, p. 42 as cited in deSavigny & Adam, 2009, p. 40). Through this understanding, systems theory presents considerable untapped potential when seeking to understand the interconnected layers within a system and, for the purpose of this study, how these layers may impact the ability to undertake health priority setting and strengthen procedural fairness. Without a clearer understanding of a system’s “adaptive capacity” and “absorptive capacity” to incorporate Woreda-Based Health Sector Planning (WBHSP) into practice, researchers and health planners may continue to struggle with both the design and

27 The other elements identified were as life sciences, information and communication technology and social justice and equity.

28 Simply meaning, the systems capacity to adapt to the addition or presence of new policies and interventions introduced within it. Jackson (2003, p. 89) also refers to this concept as an organization being adaptive to changes in the social environment.

29 Cohen and Levinthal (2007) classify absorptive capacity as the ability of an organization to “recognize the value of new, external information, assimilate it, and apply it to commercial ends” (p. 2). Absorptive capacity is viewed at both the individual and organizational level. At the individual level, prior related knowledge and diversity of background have a huge bearing on the assimilation process and influence capacity at the organizational level, which is highly influenced by expertise and performance history. In the context of district health planning in Ethiopia, the absorptive capacity is seen here as highly influenced by the technical skills and capacity of the health planners themselves, but also the organizational context which also influences individual behaviour, the ability to process information, and governance structures.
implementation of interventions that aim to strengthen health planning processes and improve the health of the populations they seek to serve.

2.4.1 The Role of Systems Change Theory

As governments and organizations implement policies and strategies that seek to improve processes of health service delivery, whole systems change has emerged as a dominant frame through which to view this process of change (Foster-Fishman et al., 2007, p. 197). Hirsch, Levine, and Miller (2007) describe systems change as a process that “deals with changing the root causes of a problem through actions, policies, and the new infrastructure” (p. 240). They further acknowledge that it takes place “when there are substantial changes in the structural, relational, or institutional makeup of a system or its subsystems” (p. 240). Rooted in systems theory, whole systems change treats modern health systems as complex adaptive systems. Through this lens, a strategy, policy, or intervention is viewed as entering a complex system that requires an “integrative and iterative process of learning and adaptation by organizational decision-makers as they expand the uptake of innovations across organizations, sectors and/or communities to improve the effectiveness and efficiency of the health system” (Edwards, Marck, Virani, Davies, & Rowan, 2007, p. 2). This conceptual lens therefore focuses not only on the system-level features influenced by the intervention, policy, or strategy, but concerns itself with the ways in which the health system adaptively responds to the planned and unplanned change (p. 3).

In their report, Whole Systems Change in Health Care, Edwards et al. (2007) acknowledge that little consensus has been reached on a universal definition for whole systems change (p. 46). They describe whole systems change as lying on a continuum that reflects the different stages of development and integration of programs (such as planning) from the early stages of implementation or integration, all the way to fully implemented or integrated (p. 47). While no standard operational definition for whole systems change exists, for the purpose of this study, we use the classification described by Foster-Fishman et al. (2007): an “intentional process

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designed to alter the status quo by shifting and realigning the form and function of the targeted system” (p. 197). Similar to the views of Edwards et al. (2007), this definition emphasizes the fluidity of system interactions to impart change. Whole systems change, in this case, then, is not viewed as static but as a “continually evolving dynamic process of system improvement” (p. 47). Edwards et al. (2007) cite an example of scaling up HIV/AIDS programs in Haiti as a process of continual whole systems change; whereby the success of a pilot HIV/AIDS program in one site served as a platform for learning and up scaling of HIV/AIDS service provision in other sites of Haiti. Ultimately, each part (whether a person, group, function, product, or service) is an element within the system and, if altered, can change the equilibrium or balance of the entire system. Whole systems change deals with two aspects of organizational culture: the “apparent” organization (which refers to the more formal structure of the organization; its hierarchy; the official roles, functions, and job descriptions; the facilities and equipment used; and the policies, goals, and standards) and the “below the surface” organization (which refers to the informal components that are shaped by styles and values of its leaders and by its history). Ford (2007) acknowledges that while the “below the surface” characteristics of an organization are less visible and, often overlooked, they can be particularly informative given that they frame individual morale in the workplace (p. 322).

To advance the field of “systems thinking” and “systems change,” a number of lessons have been captured in the scholarly literature that broaden our understanding of the theoretical, methodological, and empirical applications of this approach. In this attempt, the American Journal of Psychology (2007) dedicated a journal issue to systems change, reflecting on case studies, advancements, and challenges. From this synthesis, Foster-Fishman and Behrens (2007) highlighted a variety of key insights that underpin an effective systems change endeavour and consolidated these lessons into the Transformative Systems Change Framework (TSCF) to guide practitioners in undertaking a systems analysis. In addition to this synthesis, Edwards et al. (2007) conducted a comprehensive literature review, identifying case studies that describe the implementation process of whole systems change and identify a number of key lessons. The

31 For further information, see Koenig Leandre and Farmer (2004)
following sections describe the TSCF in greater details and provide a summary of the application of systems change theory.


As previously alluded, Foster-Fishman et al. (2007) drew lessons from the application of two systems theories (Systems Dynamics Thinking [Forrester, 1969; Senge, 1990] and Soft Systems Methodology [Checkland, 1981]) and conceptualized the TSCF to guide our understanding of fundamental system parts that can: (i) explain how a system functions and (ii) highlight barriers and facilitators needed for systems change. More specifically, the TSCF attends to both the deep and apparent structures (such as dominant normative, resource, regulative, and operational characteristics) that dictate behaviours of systems members. In the case of health planning and priority setting in Ethiopia, the utility of the TSCF lies in its ability to guide our understanding of the system structure and, through this, the input and process features that impact district health planning. To understand the system, its dynamics, and opportunities for change, the TSCF is comprised of four stages (see Table 2.2). The first two stages involve binding the system (i.e. the scope of the problem) and understanding the systems structure (or fundamental system parts). Once a holistic picture is captured of the systems structure, system interactions are conceptualized to offer insights as to where change can be leveraged across its parts or interactions.
2.4.3. Application of TSCF: Experiences and Challenges

Beyond that of Foster-Fishman et al. (2007), the empirical application of the TSCF has not been documented in the field of district health planning nor within a low-income country context. As described in Table 2.2, the TSCF is divided into four stages and, for the purpose of this dissertation, was viewed as an appropriate conceptual framework to guide the examination of the system influences that may bear on the health planning and priority setting process. Foster-Fishman et al. (2007) argue that the TSCF “attend[s] to the normative, resource, regulations and organizational characteristics that dictate behaviour and [the] lived experience of system members”

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Table 2.2. Transformative Systems Change Framework (Foster-Fishman et al., 2007)

<table>
<thead>
<tr>
<th>STAGE 1: BINDING THE SYSTEM</th>
<th>STAGE 2: UNDERSTANDING SYSTEM STRUCTURE (FUNDAMENTAL SYSTEM PARTS AS POTENTIAL ROOT CAUSES)</th>
<th>STAGE 3: ASSESSING SYSTEM INTERACTIONS</th>
<th>STAGE 4: IDENTIFYING LEVERS FOR CHANGE</th>
</tr>
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<tbody>
<tr>
<td>• Defining the Problem through stakeholder perspectives</td>
<td>• System Norms (Underpinning values, ideologies)</td>
<td>Identification of:</td>
<td>Identifying Parts to Leverage for Change</td>
</tr>
<tr>
<td>• Identification of the levels, niches, organizations, and actors relevant to the problem</td>
<td>• System Regulation (Existing policies and procedures)</td>
<td>• Reinforcing and balancing interdependencies</td>
<td>• Exerts or could exert cross-level influences</td>
</tr>
<tr>
<td></td>
<td>• System Resources (Includes human, social and economic capital available)</td>
<td>• System feedback and self-regulation</td>
<td>• Directs system behaviour</td>
</tr>
<tr>
<td></td>
<td>• System Operations (Particularly power, decision-making processes and structures)</td>
<td>• Interaction delays</td>
<td>• Feasible to Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identifying Interaction and Patterns to Leverage for Change</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• System differences that create niches compatible with systems change goals</td>
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<td></td>
<td>• Long standing patterns that support or hinder change goals</td>
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<td></td>
<td></td>
<td></td>
<td>• Gaps in system feedback mechanisms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cross-level/actor connections that are needed</td>
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</tbody>
</table>
(p. 213), This system lens of inquiry was viewed as having the potential to uncover system-level impacts on the priority setting process. As researchers continue to strengthen health-planning processes to become more transparent, inclusive, and evidence-based, a more robust analysis of the system within which priority setting takes place is warranted. Excerpted from Figure 1.1, Figure 2.10 highlights a gap in the literature that this dissertation aimed to address; namely that focused on integrating lessons from the systems theory application in this dissertation with those lessons inferred from the application of A4R.

**Figure 2.10.** Conceptual Gap Between the TSCF and A4R to Advance Methods for Priority Setting

### 2.4.4. Application of Systems Change Theory: Lessons Derived

Although the application of the TSCF is limited, a number of lessons related to systems change generally have been documented in the literature. The following sub-sections serve as a platform for understanding the application of and lessons derived from the application of system theory.

#### 2.4.4.1. Theoretical Lessons drawn from applying Systems Change Theory

Parsons (2007) describes that system theories may act at both a theoretical and/or methodological level when seeking to uncover systemic patterns influencing an outcome (p. 405). The implications of this blurred distinction are that generating lessons with clear theoretical and methodological implications may be challenging for researchers. From a theoretical standpoint, Foster-Fishman and Behrens (2007) emphasize that a change in a system level outcome (i.e., a component of the system) neither guarantees, nor is the same as an entire systems change. The concept of systems change speaks to the long-term, sustainable change that materializes from a
change in policy or from the application of a new intervention. The authors emphasize the utility of systems thinking to facilitate the identification of system level parts and interaction dynamics that either directly, or indirectly contributes to the change sought (p. 194). Furthermore, Edwards et al. (2007) acknowledge the importance of organizational theory in this process of understanding whole systems change (p. 46). They cite the work of Hasselback et al. (2003) who, in reference to systems change in primary care, argues for the utility of organizational theory to identify other organizational dynamics influencing outcomes:

[…] just as important as the outcomes of this project, this study has captured some important information on the dynamics to do a project of this nature. Issues of professional identity, leadership, power shifting, organizational trust, stress in the worksite, organizational culture, organizational structure, and integration were all noted during the project. Healthcare managers would benefit from understanding and embracing organizational theory as it applies to radical change within the healthcare system (p.18).

Prior to the assessment of dynamics, Foster-Fishman and Behrens (2007) emphasize the importance of binding the system as a precursory step in any system’s change endeavour. This action assists in clarifying the key features most important to the issue under investigation and allows practitioners to channel their efforts within pertinent and confined parameters (Checkland, 1981; Midgley, 2000). Clarity around system boundaries may also facilitate the transferability of findings to other contexts (although scientific efforts in this regard remain in their infancy) (Foster-Fishman & Behrens, 2007, p. 193). Figure 2.11 provides a summary of key theoretical lessons described.

**Figure 2.11.** Key Theoretical Lessons derived from the application of Systems Change (adapted from Foster-Fishman & Behrens [2007] and Edwards et al. [2007])

- A change in a system level outcome is not the same as, nor does it guarantee, system change.
- Understanding organizational dynamics provide critical insight into systemic elements in the change process.
- Attention to system’s boundary and the processes used to define it can improve the efficacy of systems change endeavours.
2.4.4.2. Practical Lessons drawn from applying Systems Change Theory

Both Foster-Fishman and Behrens (2007) and Edwards et al. (2007) speak to a variety of practical lessons that advance our thinking around the factors that either facilitate or impede effective systems change. Foster-Fishman and Behrens (2007) categorize these lessons into three overarching themes that are salient in a systems change effort:

(i) The utility in targeting key levers of change within a system;
(ii) The salience of shifting the skill sets and mindsets of system members (Ford, 2007); and
(iii) The necessity to engage system members in a discourse process of learning that may contribute to discovery and altering ones worldview.

As identified through scholarly case studies, one practical lesson of effective systems change involves the targeting of “levers” (i.e., “parts” within a system) to trigger shifts across system components. For instance, Ford (2007) and Suarez-Balcazar et al. (2007) identify the importance of effecting change through levers of organizational policies. Ford (2007) describes how the implementation of policies and altered practice as a result, led to significant changes in community policing efforts (pp.327-329). Further, Suarez-Balcazar et al., (2007) describe the positive impact that altering vending machine policy had on hindering access to unhealthy food options and the positive changes associated with altering organizational initiatives to increase access to healthier foods (pp. 340-341). Additional levers in the literature were captured such as infusing new or different resources, which also had a significant impact on systems change. Suarez-Balcazar et al. (2007), for instance, describe scenarios where the presence of added financial resources assisted, not only in achieving programmatic activities, but also heightened the visibility and awareness of the project, which further facilitated uptake of the intervention (p. 339).

In addition to targeting levers for change, a second practical lesson focuses on altering the “mental models” of system members (Ford, 2007). Senge (1990) describes mental models as the cognitive frameworks constructed from one’s knowledge, experiences, and assumptions, and play a significant role in guiding our actions and decision-making (p. 198). Also classified as “mindsets,” mental models can maintain, constrain, and/or determine the status quo within an organization (p.198). These models may therefore have a significant bearing on the success or
failure of a systems change effort, and consequently, have been acknowledged as a key consideration in the change process (Senge, 1990; Foster-Fishman & Behrens, 2007; Ford, 2007; Evans & Baker, 2012). Ford (2007), for example, describes how staff mental models—regarding the construction of hierarchy within the workplace—needed to be shifted from an environment where upper level management would allow lower level staff to embrace more authority in the workplace. This shifting of mental models therefore required the implementation of collegial activities that would afford lower level staff with greater clout in decision-making within the police department (p. 324). Similarly, Evans and Baker (2012) describe the implications of varied mental models within the realm of health service integration and develop the Mental Models Of Integrated Care (MMIC) to organize our thinking when analyzing key components of effective versus ineffective integration.

Lastly, a third practical lesson for effective systems change focuses on the consistency and quality of the dialogic process itself. Here, effective system change appears more probable when system members are engaged in a discourse process of learning that may facilitate in altering the mindsets of system members (Ford & Behrens, 2007, p. 195). Foster-Fishman and Behrens (2007) describe this discourse process as a dialogic process of “honest, frank discussions that strive to generate new understandings about organizational and community life” (p. 195). Through this lens, the cultivation of an inclusive process of reflection and debate is central to the systems change effort. Such experiences have been noted in the scholarly literature: Suarez-Balcazar et al. (2007) speak to the value of discourse processes towards systems change across Chicago Public Schools to minimize obesity through the establishment of changed dietary practices. In order to alter the status quo and change existing practices, it was recognized that the establishment of a task force would be critical to continuously engaging varied stakeholders in this process. In this case, a health expert was brought into the process to facilitate the provision of new knowledge among teachers and students in order to raise awareness and stimulate dialogue (pp. 340-343).

To guide a systems change effort, the added value of an external “change agent” was also noted in the area of children’s mental health and foster care. O’Connor (2007) describes her consultancy work as a change agent to operationalize a Systems Guides (SG) Intervention Model
to identify gaps with stakeholders in order to strategize an effective plan moving forward (pp. 393-403). Through the SG Intervention Model, the goals, standards, and norms of the system and its members are clearly identified in a dialogic forum so that all participating stakeholders can assess where potential barriers lie in minimizing the systems change effort. In the case of foster care and children’s mental health, this model acted as a helpful guide for collectively bringing together actors in the health system who could *detect* the various sub-systems, document discrepancies in practice, and *disseminate* to relevance system participants (pp. 401-402).

Further augmenting our understanding of the essential factors influencing systems change, Edwards et al. (2007) undertake a review of the literature and identify a series of change barriers and facilitators that influence the intervention process. A consolidation of these key findings is summarized in Table 2.3. Through a variety of different literatures, facilitators to systems change were commonly cited to include efforts for: (i) ongoing stakeholder consultation, (ii) consensus building among stakeholders; (ii) active leadership and facilitation, (iii) existing interorganizational knowledge and capacity; (iv) clarity of stakeholder roles, authority, and accountability; (v) and adequate human resource and technical capacity to accommodate the transition. In addition to these facilitators, key barriers to change have also been documented, and include: (i) passive dissemination of the intervention or policy; (ii) limited organizational capacity to implement lessons learned; (iii) unclear authority and accountability structures; (iv) ongoing financial restraints; (v) high management and staff turnover; and (vi) uncoordinated training and transitioning towards the change efforts.

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32 Within a system, a variety of sub-systems may exist. These sub-systems can take many forms, such as organizations, collections of groups, and so forth.
Table 2.3. Key Facilitators and Barriers Influencing the Interventions Process (Informed by a literature summary consolidated by Edwards et al. [2007, pp. 88-114])

<table>
<thead>
<tr>
<th>Change Facilitators</th>
<th>Change Barriers</th>
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<tbody>
<tr>
<td>• <strong>Ongoing stakeholder consultation and buy-in</strong> (Hasselback et al., 2003; Daniels, et al., 2005; Koenig et al., 2004)</td>
<td>• <strong>Passive dissemination</strong> of intervention or policy (Daniels, et al., 2005; Pariyo et al., 2005; Lemieux-Charles, McGuire, &amp; Blinder, 2002)</td>
</tr>
<tr>
<td>• <strong>Consensus building</strong> among stakeholders (Bogue, Antia, Harnata &amp; Hall, 1997; MacLean, et al., 2003; Nyonator, Awoonor-Williams, Phillips, Jones &amp; Miller, 2005)</td>
<td>• <strong>Limited organizational capacity</strong> to implement lessons learned (Markoff, Finkelstein, Kammerer, Kreiner, &amp; Prost, 2005)</td>
</tr>
<tr>
<td>• An <strong>active leader/facilitator</strong> to serve as an opinion leader (Sonnad &amp; Matuszewski, 2006)</td>
<td>• <strong>Unclear authority and accountability structures</strong> between different levels of the system (Neville, Barrowman, Fitzgerald, &amp; Tomblin, 2005; Hasselback et al., 2003)</td>
</tr>
<tr>
<td>• <strong>Existing interorganizational knowledge and capacity</strong> to internalize new knowledge foundational in a change effort (Lemieux-Charles, McGuire, &amp; Blinder, 2002)</td>
<td>• <strong>Ongoing financial restraint</strong> (MacLean, et al., 2003; Neville, Barrowman, Fitzgerald, &amp; Tomblin, 2005)</td>
</tr>
<tr>
<td>• <strong>Clarity of stakeholder roles, authority, and accountability</strong> (Neville, Barrowman, Fitzgerald, &amp; Tomblin, 2005)</td>
<td>• <strong>Management and staff turnover</strong> (MacLean, et al., 2003; Huicho, Davilla, Campos, Drasbek, Bryce &amp; Victoria, 2005; Kestler, Valencia, Del Valle &amp; Silva, 2006)</td>
</tr>
<tr>
<td>• <strong>Human resource and technical capacity to transition towards the change effort</strong> (Pariyo et al., 2005; Libamba, et al., 2005)</td>
<td>• <strong>Trainings and transitioning not well coordinated</strong> (Huicho, et al., 2005)</td>
</tr>
</tbody>
</table>

Both Foster-Fishman & Behrens (2007) and Edwards et al., (2007) identify a number of empirical lessons that inform our understanding of the contextual ingredients—whether social, organization, political, or fiscal—that influence how and if change will take place. Figure 2.12 provides a summary of these lessons that are required to facilitate effective change within a system.
2.4.4.3. **Methodological Lessons drawn from applying Systems Change Theory**

In reflecting on methodological lessons, Foster-Fishman and Behrens (2007) call for methods that may equip researchers to capture a system’s complexity as a result of varied stakeholder interactions and diverse worldviews (p. 194). To capture such complexity, the authors cite three system approaches that advance our methodological thinking on the manner in which a system is constructed and its parts interact: Complex Adaptive Systems (CAS); Systems Dynamic Modeling (SDM); and Soft Systems Methodology (SSM). For the purpose of this dissertation, I highlight SDM and SSM since the TSCF is grounded in these two approaches.

### I. **Systems Dynamics Modeling (SDM)**

Developed by Jay Forrester in the late 1950s, systems dynamics is considered an action research approach to studying complex systems, such as household units, communities, and organizations (Forrester, 1969). It emerged as a methodology for applying general systems thinking principles to managerial and societal issues through the use of cause and effect relationships within a system to explain system behaviour (Forrester, 1969; Jackson, 2003; Senge, 1990). In particular, SDM may provide valuable insights to understanding the system’s behaviour and the feedback mechanisms that are assumed to underlie the system’s behavioural patterns (Hirsch et al., 2007, p. 240). Through this structural understanding, one is able to gain further knowledge about patterns of behaviour by focusing on how components within a system

<table>
<thead>
<tr>
<th>Key Empirical Lessons</th>
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<tr>
<td>Levers targeted for change need to have cross level influences within the targeted system.</td>
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<tr>
<td>Systems change requires a shift in “skill sets and mindsets” of its system members (Ford, 2007).</td>
</tr>
<tr>
<td>Discourse processes are salient to engage system members in active learning, consensus-building, and ongoing consultation.</td>
</tr>
<tr>
<td>Human resource and technical capacity is necessary to accommodate the change effort.</td>
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</tbody>
</table>
interact and the role each play. This perspective departs from the conventional view of system performance and behaviour as merely the result of events and their causes. Systems dynamics theorists’ focus on understanding root causes underlying a given issue (i.e., the originating factors within a system that give rise to an identified problematic outcome).

Methodologically, systems dynamics build on sources of data (related to the system’s structure), in order to develop models of interaction based on feedback processes for problematic behaviour (Hirsch et al., 2007, p.241). Figure 2.13 displays a causal loop diagram focused on educational reform and student performance (adapted by Hirsch et al., [2007, p. 241] from the work of Roberts [1976]). Here, a variety of variables additional to educational reform interact to influence student performance. These include: teacher’s perception of student needs, teacher time allocated to attend to student needs, and student’s perceived need for help. Given these categories, one is able to model how these variables interact (negatively or positively) with student performance to either enhance or limit it. Through the development of a causal loop diagram, systems dynamics modeling highlights that all systems, no matter how complex, are comprised of two patterns of interactions: (1) balancing, and (2) reinforcing loops (Kim, 1999;
These loops provide information to the system, serving to either escalate or stifle system behaviour. Balancing loops attempt to counteract change by bringing the system back to the status quo if a change in a variable occurs. A reinforcing loop, on the other hand, amplifies directional change leading to an ever-increasing escalation of a given outcome, creating either a virtuous or vicious cycle (Foster-Fishman et al., 2007; Hirsch et al., 2007). As an example, consider a system model of a classroom setting whereby we seek to understand the factors influencing student performance (Roberts, 1976; Hirsch et al., 2007): balancing loops would be those interactions that act to keep the students performance in a state of equilibrium (e.g., the number of teachers).

To represent the nature of the change relationship between two variables, system dynamics modelers use a sign system of “S” or “O.” For example, if a change in one variable generates a change in the “same” direction, an “S” or (+) is used. Conversely, if a change in a variable yields a change in the “opposite” direction, then an “O” or (-) is used. Developing a model that outlines systems interactions is complex and challenging. Hirsch et al. (2007) recommend that it be a participatory process that is undertaken in a series of stages. Initially, model building may rely on “in-depth review of existing empirical and theoretical literature, the collection of new qualitative data, secondary data analyses, or on the experiences and opinions of people who are close to the process of interest” (Hirsch et al., 2007). Although widely used in the field, a number of limitations with the systems dynamics approach have been noted (Hirsch et al., 2007). For one, although system dynamic models may produce a relatively accurate portrayal of the complex process under investigation, it may never capture the full complexity of the process. Second, systems dynamics models are only as insightful as the conceptualization and assumptions that underlie them. While it is imperative that the views of multiple stakeholders weigh into this process, no model may ever satisfy all critics. Third, a systems dynamics model is not a prediction but a model that simulates a scenario captured at that point in time (p. 253).

II. **Soft Systems Methodology (SSM)**

To solve real-world problem situations, researchers cannot rely solely on the narrow views, interpretations, or perspectives of a few actors. Originating with Checkland (1981), soft
systems methodology (SSM) is an approach for understanding human systems that emphasizes the social construction of reality, and the presence of multiple, valid perspectives of a problem situation and its solution (pp. 34-36). A primary goal of SSM is to generate a rich picture of multiple stakeholder views (to provide a voice to diversity) that can ultimately inform the systems change effort. To provide a more holistic understanding to the problems under investigation, this technique has been a popular methodological tool in capturing the varied opinions of multiple stakeholders. Suarez-Balcazar et al. (2007), for instance, apply this method when trying to develop an intervention to address obesity in schools. In applying this method, they aptly describe:

The issue of overweight children is the result of a complex set of problematic situations comprising several levels of influence, not just one (i.e., family environment, school environment, food guidelines and policies). Therefore, interventions that are targeted at several of these levels of influence are more likely to produce a synergy that encourages and sustains healthy behaviour change (McLeroy et al., 1998). Furthermore, from SSM, the problem is even more complicated because every set of activities related to every level of influence (e.g., providing a school lunch) has different meaning according to different stakeholders. [...] Each stakeholder will see the issue and the problem from their own perspective and are likely to support their own priorities. (p. 306)

Although many researchers have spoken to the utility of SSM in guiding their systems analysis (Checkland, 1999; Suarez-Balcazar, 2007; Zhang, 2011), this methodology is not without limitation. One of the major limitations is the iterative process of methodological engagement required with participants. Although ongoing engagement is a valued and important feature to the validity of conceptual models (Checkland, 2000), methodological challenges may lie in the ability to secure ongoing interviews for continual feedback with the same counterparts (Zhang, 2011, p. 89).

**Figure 2.14.** Key Methodological Lessons derived from the application of Systems Change (adapted from Foster-Fishman & Behrens [2007] and Edwards et al. [2007])

- Systems change agents and researchers need methods that are equipped to capture system complexity, such as systems dynamics modeling, and soft systems methodology.
2.4.4. Limitations of Systems Change Theory

Although the field of systems theory and systems change has advanced theoretically over the past twenty years, the practical application of these concepts has only come into prominence recently (Foster-Fishman & Behrens, 2007). There is therefore a need for more empirical applications of systems theory in order to derive pragmatic and theoretical lessons. Documented in the scholarly literature, a few researchers have highlighted various challenges to applying systems theory to assess systems change efforts (Ellsworth, 2000; Foster-Fishman & Behrens, 2007; Suarez-Balcazar et al., 2007). Two of the longstanding limitations have been the complexity of undertaking a systems change endeavor, and the dearth of literature that speaks to the key elements required for successful policy or intervention implementation (Foster-Fishman & Behrens, 2007). Although both Foster-Fishman and Behrens (2007) and Edwards et al. (2007) provide a consolidation of key features that support an effective change endeavour, there remains a gap in the scholarly literature that harnesses and applies lessons empirically.

In addition, a few researchers also speak to issues related to the “researcher” or the “consultant” acting as a “change agent” or a mediator between ongoing iterative learning and application (Janzen, Nelson, Hausfather, & Ochocka, 2007; Staggs, White & Schewe, 2007). While some researchers argue that this important role be nurtured in the change process (Staggs, et al., 2007), others have recognized the implications to sustainable change should the external change agent be removed from the process (Campbell, Nair, & Maimane, 2007).

Overall, although the utility of a systems analysis is hugely informative to understanding the barriers and facilitators to change, ultimately, a systems change effort is no easy feat. As articulated by Ellsworth (2000), “change, by definition, disturbs the status quo” (p. 152). As a result, many systems efforts have often been met with resistance by the individuals and organizational sub-systems within the system (Ellsworth, 2000, pp. 165-168; Suarez-Balcazar et

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33 Staggs et al. (2007) describes the “incubation approach” to systems change, whereby change agents are encouraged to collaboration with project staff to nurture, or “incubate,” feasible and warranted change in target systems (p. 365).

34 Campbell et al. (2007) acknowledge that without external change agents engaged in the change process of reducing HIV/AIDS stigma, little sustainable change may arise to support community efforts that support those with the disease (pp. 354-5).
Ellsworth (2000) alludes to the work of Zaltman and Duncan (1977), who, in their book, *Strategies for Planned Change*, describe 18 factors that commonly underscore resistance/barriers to change (pp. 166-167). These barriers are particularly insightful as they underscore a series of common characteristics that may impede the success of a systems change effort. These characteristics are categorized as *cultural, social, organizational, and psychological*, and include:

I. **Cultural barriers to change**, which are rooted in the values and traditions of the client system: These barriers include: (1) values and beliefs; (2) cultural ethnocentrism; (3) saving face, and (4) incompatibility of a cultural trait with change (Zaltman & Duncan, 1977, pp. 68-72);

II. **Social barriers to change**, which focus more on the characteristics of how individual intended adopters of change react as members of a social system. These barriers include: (5) group solidarity; (6) rejection of outsiders; (7) conformity to norms; (8) conflict; and (9) group introspection (Zaltman & Duncan, 1977, pp. 72-75);

III. **Organizational barriers to change**, which emerge when characteristics of the client system are resistant to change. These barriers would include: (10) threat to power and influence, (11) organizational structure, (12) behaviour of top-level administrators, (13) climate for change in the organization, and (14) technological barriers for resistance (Zaltman & Duncan, 1977, pp. 75-81); and finally,

IV. **Psychological barriers to change**, which exists solely in the individual, and are often the most difficult to detect. These barriers to change include: (15) perception, (16) homeostasis, (17) conformity and commitment; (18) and personality factors (Zaltman & Duncan, 1977, pp. 81-88).

As one seeks to use systems theory as an analytical framework for understanding the system components that influence change, it is important to remain reflective as to the type of information one seeks to capture and the scope of its application moving forward. In light of this view, it is important to mention here that it is not the intent of this dissertation to insight change in Ethiopia. Rather, it is an attempt to explore the system elements that influence the uptake of change (i.e., implementation of a district health planning strategy) and uncover parts of the system associated with district health planning that influence how this process unfolds. The process of change is a complex undertaking in all contexts and the associated dimensions of change are not fully understood. Inevitably there will be a number of “invisible” or “hidden” variables that will influence stakeholder interactions and our understanding of decision-making. These may be
associated with historical power relations, power differentials related to a traditional society moving into 21st century western expectations, or the particular variable of a Caucasian woman from a foreign country as the primary investigator. While it is unclear what influence these hidden variables may directly or indirectly have, I remain receptive to these issues and the implications they may bear on this analysis and on conclusions inferred. Reflections on these elements will be described in Chapter 4 methods.

2.5. Advancing Methods for Priority Setting and Procedural Fairness through a Systems Lens

As noted in this literature review, over the past ten years, case studies have emphasized the growing significance of context on priority setting practice. However, absent in the literature is a rigorous examination of context and its influence on priority setting. In this dissertation, I argue that to approach context rigorously requires taking a holistic view of the system and examining the dynamics and interrelationships between its components parts. Systems theory therefore offers an opportunity for conceptual and methodological guidance on how to view context and these associated complexities.

Novel to the field of priority setting would be to view the system—under which priority-setting methods are applied—as complex and adaptive. Such a lens is particularly relevant in the field of priority setting, whereby methods, approaches, and processes enter within a system that must adapt (and in many cases, change or alter) to accommodate new procedures and processes. The selection of the TSCF is viewed as particularly relevant in this quest to conceptualize and understand the system, as it attends to both the apparent structures of the system (regulations, resources, operations) and the ‘below the surface’ structures of the system (operations and norms) (Ford, 2007). Drawn from lessons of what comprises an effective systems change, the TSCF is conceptually positioned to facilitate a greater understanding of how components within a system may adaptively respond to the planned change. Furthermore, A4R is an inherently normative framework and the TSCF is offers a descriptive analysis regarding how norms operate to influence change in a given context. Hence, there is a complementarity between the two frameworks that will be explored in greater detail in Chapter 7.
2.6. Literature Review Summary

This chapter presented a review of the literature by describing the three clusters—ethics, context, and systems—in greater theoretical and empirical depth. First, this literature review provides a theoretical understanding of procedural fairness by drawing from its philosophical roots in justice theory and presents an ethical framework, A4R, which has been applied in a number of settings and was selected to guide the analysis of procedural fairness in Ethiopian district health planning. Second, this literature review illustrates the salience of a context analysis, and reflects on the inadequacy of previous contextual analyses to uncover system-level dynamics. Through a reflection on the systems literature in this chapter, clarity is provided on the utility of its use in my dissertation—to identify the deeply rooted barriers and facilitators in a health planning process and the dynamics between parts of the system that may influence these interaction patterns. A number of theoretical, methodological, and empirical lessons are described and provide a platform for understanding various approaches in this discipline. Based upon the lessons emergent from their review, Foster-Fishman et al. (2007) proposed the TSCF as a systems conceptual framework, which was selected for use in this study. Three main gaps in the literature were identified in this Chapter: (1) There is a paucity of research that speaks to the Ethiopian experience of district health planning and priority setting through the lens of A4R; (2) We lack an understanding of the Ethiopian conceptualization of fairness and legitimacy and whether this conception aligns with the principles of A4R; and (3) There is limited scholarly literature that has furthered our understanding of how systemic factors influence procedural fairness within a priority setting process. My dissertation responds to these gaps in Chapters 5, 6, and 7.
**CHAPTER 3: THE ETHIOPIAN CONTEXT**

*Qas be qas enkulal begrewa tehedalech*

- Ethiopian Proverb

_Slowly, but surely, we will get there—that is the essence of the above Ethiopian proverb (also introduced in the opening prologue). Its literal translation, “an egg walks slowly by itself,” underpins the notion that prior to the chicken walking, the egg must undergo a slow process of transformative change; ultimately appreciating that change requires patience, perseverance and time. Throughout my time in Ethiopia, this proverb was applicable in many situations: when intermittent power outages prevented the completion of meetings; when computer programs crashed; when delays in the retrieval of health data hindered the progression of health planning efforts; and, even, applicable when stuck in traffic. It is a proverb that, in many subtle ways, is intricately linked with the Ethiopian conceptualization of patience—that although things may proceed rather slowly, the progress one desires will eventually be reached._

Over the past twenty years, Ethiopia has undergone significant changes in health policy reform, governance structure, and health service delivery. These changes have been rooted in the government’s overall aim to improve the health status of its population, despite limited resources. While much work is still required to improve the health status of its people, it is believed that through continued efforts, huge strides will be achieved in health care policy, and health service provision and access. Chapter 3 provides a brief overview of the Ethiopian context—geographic, demographic, economic, governance, health policy, and health financing—to situate the health planning processes described in the subsequent chapters.

### 3.1. Geography, Demography, and Economic Context

The Federal Democratic Republic of Ethiopia is located in the horn of Africa, and is landlocked by the five surrounding countries of Sudan, Eritrea, Djibouti, Somalia, and Kenya. Geographically, Ethiopia is comprised of nine regions, which include: Tigray, Afar, Amhara,
Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples Region (SNNPR), Gambella and Harari, as well as the two city administrations of Addis Ababa and Dire Dawa (Figure 3.1). Although rich in cultural diversity, tradition, and history, Ethiopia remains significantly materially under resourced. The 2013 UNDP Human Development Index ranked it 173 out of 187 countries, emphasizing ongoing limitations to health and access to education (World Bank, 2011). Such widespread poverty—rooted in the majority of the population on subsistence farming, poor access to education (particularly for women), inadequate access to clean water and sanitation, and limited access to health services—continue to result in high morbidity and mortality rates (Central Statistical Agency, 2012).

**Figure 3.1. Ethiopia Regional Boundaries (IDP, 2013)**

While economists have hailed Ethiopia as having one of the fastest growing economies (African Development Bank Group, 2014), an ongoing challenge to address the lack of health

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35 To appreciate the significance of the difference across the HDI ranking of other randomly selected countries: Norway (1 out of 187); Canada (11 out of 187); Jamaica (86 out of 187); Uganda (161 out of 187); and the Democratic Republic of the Congo (186 out of 187).

36 The Ethiopian gross domestic product (GDP) is presently estimated at $103.1 billion (Central Intelligence Agency, 2012). Ethiopia’s economy is largely reliant on agriculture, which accounts for 46.6% of its GDP; industry, which
services has been accommodating the needs of its large population, estimated at 91 million (Population Institute, 2013);\textsuperscript{37} where approximately 85\% of the population resides in rural and remote areas, and nearly half (47\%) live below the poverty line (UNDESA, 2010).\textsuperscript{38} This rural/urban divide has implications for planning health services to meet the needs of populations residing in geographically disparate areas of the country. Furthermore, with a population growth rate of 2.7\%, Ethiopia’s population is projected to reach 140 million by 2050, which raises the concern for strengthening economic opportunities for citizens, as well as improving access to and the provision of health care services.

As is characteristic of many African countries, the Ethiopian population is comprised of youth, with 64\% under the age of 24 years (Ravallion, Chen, & Sangraula, 2009).\textsuperscript{39} The average life expectancy at birth is currently estimated at 57 years, in comparison to roughly 80 years in many Western countries (Central Intelligence Agency, 2012).\textsuperscript{40} In spite of Government attempts to improve primary, secondary, and tertiary education policy throughout the country, literacy rates are still considered low; the adult literacy rate is estimated at 38\% (50\% for males and 26.6\% for females), which ultimately influences the overall understanding of disease, acceptability of health practices, and the utilization of health services (Central Statistical Agency, 2012). This is further complicated by the fact that Ethiopia’s population is highly diverse, containing over 86 cultural groups. Major ethnic groups include: Oromo (17,080, 318), Amhara (16,007, 933), Tigray

\textsuperscript{37} Ethiopia’s population size makes it Africa’s second most populous country next to Nigeria (estimated at 173.6 million as of 2013).

\textsuperscript{38} The poverty line or threshold is the minimum level of income deemed adequate in a given country. While it is not to suggest that even meeting this threshold is justifiable, to simply live, the common international poverty line is $1.25a day (estimated at 2005 purchasing-power parity). (Ravallion, Chen, & Sangraula, 2009)

\textsuperscript{39} The prominence of such demographic characteristics is largely a trend promulgated by the HIV/AIDS pandemic, which has primarily affected the adult population and contributed to lowering the life expectancy rates in many Sub-Saharan African countries.

\textsuperscript{40} To appreciate the significance of difference, the life expectancy at birth across the same HDI countries referenced are: Norway (80 years); Canada (81 years); Jamaica (73 years); Uganda (53 years); and Democratic Republic of the Congo (56 years).
In addition, Ethiopia is a country comprised of several religions, including: Ethiopian Orthodox Christians (43.5%); Muslim (33.9%), traditional (2.6%), Catholic (0.7%), and all others (0.6%) (Central Statistical Agency, 2007). From a health service provision standpoint, a “one-size fits all” approach has been inadequate to account for the varied needs and cultural differences among Ethiopia’s heterogeneous population.

Table 3.1. Population Estimates and Land Area by Region
(adapted from Garcia & Rajkumar, 2008)

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Area (km²)</th>
<th>% of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Tigray</td>
<td>4,314,456</td>
<td>41,409.95</td>
<td>5.8</td>
</tr>
<tr>
<td>Afar</td>
<td>1,411,092</td>
<td>72,052.78</td>
<td>1.9</td>
</tr>
<tr>
<td>Amhara</td>
<td>1,721,058</td>
<td>154,708.96</td>
<td>23.3</td>
</tr>
<tr>
<td>* Oromia</td>
<td>27,158,471</td>
<td>284,537.84</td>
<td>36.7</td>
</tr>
<tr>
<td>Somali</td>
<td>4,439,147</td>
<td>279,252 (est.)</td>
<td>6.0</td>
</tr>
<tr>
<td>Benishangul Gumuz</td>
<td>670,847</td>
<td>50,698.68</td>
<td>0.9</td>
</tr>
<tr>
<td>* SNNP</td>
<td>15,042,531</td>
<td>105,887.18</td>
<td>20.4</td>
</tr>
<tr>
<td>Gambella</td>
<td>306,916</td>
<td>29,782.82</td>
<td>0.4</td>
</tr>
<tr>
<td>Harari</td>
<td>183,344</td>
<td>333.94</td>
<td>0.2</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>2,738,248</td>
<td>526.99</td>
<td>3.7</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>342,827</td>
<td>1,558.61</td>
<td>0.5</td>
</tr>
<tr>
<td>Special enumeration</td>
<td>96,570</td>
<td>N/A</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>73,918,505</td>
<td>1,020,749.75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Represents regions of focus in this study

3.2. History, Politics, and Governance

Although subject to a brief occupation by Italian forces from 1936-1941, Ethiopia remains the only African country to have escaped European colonial invasion during the late 19th century Scramble for Africa.41 Over the past few centuries, the country has undergone a series of political eras that have each contributed to its current social, geo-political, and economic environment.

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41 The Scramble for Africa (also known as the “Race for Africa” or “Partition of Africa”) was the invasion, occupation, colonization, and annexation of African territory by European powers during the New Imperialism period between 1881 and 1914. In 1896, the Battle of Adwa took place when Italian colonial forces sought to invade Ethiopia. They were defeated.
During the 19th and 20th centuries, Ethiopia was primarily governed by indigenous state-builders—Emperor Tewodoros II in the 1850s, Menelik II in the early 1900s, and Haile Selassie in the mid-1900s—whose regimes each fostered, to varying degrees, the imposition of centralized power and political rule (Dickovick & Gebre-Egziabher, 2010, p.2). Under Emperor Haile Selassie’s imperial government, administrative decentralization was enacted in 1942 that established the presence of provincial governments to act on behalf of the Emperor who ultimately had final say on all aspects of administration (Assefa & Gebre-Egziabher, 2007, p.110). This structure led to the emergence of the woreda administration, whose goal was to facilitate central administrative duties at the district levels (i.e., administer law and order and the collection of taxes).

Decentralization was expected to devolve administrative power to the district level to also encourage citizen empowerment. These goals, however, were only partly realized as a result of the dominance of centralized control (Gebre-Egziabher & Kassahun, 2004).

In 1974, the Derg (colloquial for the Provisional Military Administrative Council) took power after ousting the imperial government. Under its Marxist-Leninist vanguard regime, the Derg embraced a communist ideology of militarized rule, “v villagization,” and the development of rural peasant associations and village development committees (i.e., grassroots extensions of the formal government structure in urban and rural areas). Dickovick and Gebre-Egziabher (2010) describe the Derg period as a “significant break from the past,” since the imposed militarization,

42 These efforts for more centralized political control through these regimes ended a long period of “warlordism” by princes and elites (Dickovick & Gebre-Egziabher, 2010, p. 2)
43 Imperial Government of Ethiopia, Negarit Gazeta No. 6 of 1942, Article 1, Parts 7 & 31 cited in Assefa & Gebre-Egziabher (2007).
45 The “Derg” is the short form for “Dergue,” meaning “committee” or “council” in Amharic.
46 Marxism-Leninism is a political ideology—combining the scientific concepts theorized by Karl Marx and Friedrich Engels, known as Marxism, and the concepts developed by Vladimir Lenin, known as Leninism—to describe a regime of government that aims to establish or develop into socialist republic through the leadership of a revolutionary vanguard. For further reference see Albert and Hahnel (1981, pp. 24-25).
47 Villagization refers to the enforcement of citizens into concentrated villages—as opposed to scattered settlements—with the intent to typically ensure more efficient control and distribution of services (such as health care, agriculture, and education).
mismanagement, and constant guerilla warfare resulted in both political instability and a drastic reduction in the productivity of food and cash crops. The famine of the mid-1980s brought the Ethiopian situation to the fore of international awareness, which resulted in the provision of food and assistance through numerous global charity efforts and NGOs. Over the past 10 years, the extent of the Derg’s power and control were further criticized as speculation of clandestine corruption emerged through the misallocation of aid perceived to be used in support of the Derg’s “enforced resettlement programs,” under which thousands of people were displaced and killed (Rief, 2005). In 1987, regional insurgent movements—led by the Ethiopian People’s Revolutionary Democratic Front (EPRDF)48—united, and ultimately overthrew the Derg government in 1991; promising a more democratic policy environment.

In 1994, a new Ethiopian Constitution was drafted that outlined the existing federal democratic government structure, and divided the country into the nine ethnically affiliated regional states (p. 3). This division radically redefined Ethiopia’s citizenship, politics, and identity on the basis of ethnic grounds, and serves as a prime example of “ethnic federalism” (Dickovick & Gebre-Egziabher, 2010, p. 1). The implications of such division were significant, as the geographical divide now increased ethnic tension that had some historical presence. Dickovick and Gebre-Egziabher (2010) alluded to ethnic tension during the historical kingdoms of Shewa and Abyssinia that carried forward into the regime of Haile Selassie I, which was viewed by many non-Amharic elites as favouring the region Amhara (p. 2). Over the past decade, the EPRDF has been criticized for being largely a “Tigrayan” government whose political actions have favoured the region (Clapham, 2009, p. 1). These national regional states and the city administrations were further divided into 62 zones and 801 administrative woredas. The woreda is the closest decentralized administrative unit to the community and has an administrative council comprised of elected members. The 801 woredas are further divided into roughly 15,000 kebeles (similar to neighbourhoods) and have an average population of just over 110,000 people (FMOH, 2010).

48 The EPRDF formed with the union of the Tigrayan Peoples’ Liberation Front (TPLF) and the Amhara National Democratic Movement (ANDM) in 1989 and were then joined by the Oromo Peoples’ Democratic Organization (OPDO) and the South Ethiopian People’s Democratic Front (SEPDF).
While the new EPRDF constitution sought to reject the centralized power structures that had dominated with the Derg, over the years, the EPRDF has been judged for displaying “democratic rhetoric [that] has not been matched by democratic practice” (Clapham, 2009, p. 5). As described by Vaughan and Tronvoll (2003), in *The Culture of Power in Contemporary Ethiopian Political Life*, experience of arbitrary government repression has minimized the engagement of many Ethiopians in politics. Such an aura of disengagement emerged when some international bodies criticized the elections as undemocratic (Vaughan & Tronvoll, 2003; Clapham, 2009). Many citizens avoid openly engaging in such discussions, it is important to recognize that significant political and ethnic tensions exist in contemporary Ethiopian society (Clapham, 2009).

Although such criticisms loom, the EDPRF has been lauded for its commitment to social development and efforts to strengthen health care (Clapham, 2009). The health system reform over the past twenty years is a prime example of intensive political effort to mobilize capacity in strengthening health service provision throughout the country. In addition, such reform has contributed to the institutionalization of democratic principles in policies and strategies, such as the Health Sector Development Programme (HSDP).

### 3.3. Ethiopia’s Health Policy Development

Ethiopia’s health care system remains one of the least developed globally. Although the Derg government (1974-1987) did attempt to develop the health sector—through the expansion of primary health care and rural health services—low health spending, coupled with a non-existent health policy, hindered health sector progress during that communist regime (Hodes & Kloos, 1988). With the fall of the Derg in 1991, and with the ratification of Ethiopia’s first health policy in 1993, a fundamental shift in the health system emerged—as values supporting democracy, efficiency, collaboration, and community participation were at the fore (FMOH, 1993). The Ethiopian health policy explicitly emphasized:

[…] democratization within the health service system by establishing health councils with strong community representation at all levels […] to participate in identifying major health problems, budgeting planning, implementation, monitoring and evaluating health activities [and] decentralization [to be] realized through [the] transfer of major
parts of decision-making, healthcare organization, capacity building, planning, implementation and monitoring to the regions with clear definition of roles (FMOH, 1993, p. 6).

To operationalize this policy and guide planning, development, and implementation of health services, the Health Sector Development Programme (HSDP) strategy was formulated in 1997, and has been considered the “centerpiece of [Ethiopia’s] health policy” (FMOH, 2007, p. 14).” The HSDP includes a 20-year national health policy plan that prioritizes for reproductive health, maternal and child health, and a variety of communicable and non-communicable diseases as well as a series of health system strengthening efforts (FMOH, 2010).

### 3.3.1. Health Sector Development Programme: Goals and Priorities

All stakeholders involved in health sector planning from the district to federal level are to be familiarized with the objectives and content of the HSDP. Overall, the goal of the HSDP is “[t]o improve the health status of the Ethiopian peoples through the provision of adequate and optimum quality of promotive, preventive, basic curative and rehabilitative health services to all segments of the population” (HSDP-IV, p. 6). Contributing to the overall goal are three sub-goals identified at both the international level (through the Millennium Development Goals), and at the national level, (through the HSDP). These sub-goals include: (i) improving maternal health; (ii) reducing child mortality; (iii) and combating HIV/AIDS, malaria, TB, and other diseases. To contribute to the achievement of these sub-goals, a variety of interventions are prioritized that include: increasing the number of health workers deployed in rural villages, strengthening access to services, improving both health service delivery and quality of care, strengthening provision of pharmaceuticals, and improving access to information, education and communication.

The HSDP has been structured into four phases. Under the first phase, HSDP-I (1997/8-2001/2), disease prevention and decentralization of health services took precedence (FMOH, 1997). Unable to meet some of its targets, the HSDP-II (2002/3-2004/5)\(^4\) took a more inclusive

\(^4\) Since 2002, the HSDP-II has represented the health chapter in the government’s Plan for Accelerated and Sustained Development to End Poverty (PASDEP), a national macroeconomic and social policy that supports growth and poverty reduction in donor recipient countries. Developed in consultation with partners at the World Bank and International Monetary Fund, it is updated every three years through the production of annual progress reports.
approach by encouraging the participation of non-governmental organizations in the implementation of basic health services (FMOH, 2002). Building on these efforts, the HSDP-III (2005/6-2009/10) emphasized the need to increase national health spending and collaborative partnerships between government and non-governmental partners to plan and implement healthcare, particularly at the woreda level (FMOH, 2005). During the empirical component of this study in 2010, the HSDP was approaching the completion of its third phase, and in 2011, entered its fourth and final phase.

Key Point Relevant to this Study
Both the Ethiopian Health Policy (1993) and the Health Sector Development Program (1997-present) emphasize the importance of enhanced stakeholder inclusivity, and community engagement in support of democratized decision-making.

3.3.2. International Policy Discourse and Woreda-Based Health Sector Planning

The development and implementation of Woreda-based Health Sector Planning (WBHSP) emerged from an international policy context that was focused on strengthening harmonization, alignment, and accountability in health sector development. The CATO Institute’s Monetary Conference in 2001, and the High Level Forum on Harmonization in 2002, called for improved efficiency in health planning and financing by way of increasing harmonization and alignment between donor planning efforts and in-country national plans. Here, the concept of harmonization and alignment was viewed synergistically in that donor efforts should augment government plans through increased alignment with funding and national development priorities. Such conditions were acknowledged as prerequisite for the effective use of external assistance to alleviate poverty and to achieve the MDGs (FMOH, 2007). A high point of international consensus arose when Ministers from high- and low-income countries announced the Paris Declaration on Aid Effectiveness (2005). This declaration established a platform for stakeholders to discuss clear pathways for accountability between donors and their recipient governments by setting an agenda
linked to indicators, timetables, and targets (OECD, 2005). From this declaration, five core principles emerged that included: (i) *ownership*, so that aid recipients were able to forge their own national development strategies; (II) *alignment*, so that donors support these strategies; (iii) *harmonization*, so that donors work to streamline their efforts in-country; (iv) *results*, so that development policies be directed to achieving clear goals and for progress towards these goals to be monitored; and (v) *mutual accountability*, so that donors and recipients alike will be jointly responsible for achieving these goals.

In 2005, the Ethiopian government embraced the international Paris Declaration’s call to pursue harmonization and alignment in health sector planning through the development of the HSDP Harmonization Manual (HHM) (2007) that would influence all future policy-making in Ethiopia. Such a strategy emerged in an effort to curtail fragmented health decision-making that historically left districts planning in an ad hoc fashion with minimal guidance and capacity. The HHM now emphasized that a strong planning, priority setting, and implementation system required solid linkages vertically, from facilities, kebeles, to woredas, (zones), regions and the federal level, and horizontally and across the various stakeholders at each level (e.g., government, donor, NGOs, etc.). The “HHM was about improving the whole system of health sector planning and implementation. Without it, the health sector plans will not be implemented systematically” (p. 9). Without the establishment of strong linkages across each level, it was believed that planning and implementation gaps would continue to arise as well as a duplication of planning efforts. A prominent goal of the harmonization and alignment movement was to strengthen legitimacy of overall health decision-making to the international donor community. In the HHM, the Ethiopian government acknowledges its heavy reliance on donor funding and international support to achieve its health aims. As a result,

[…t]he health sector needs to be able to demonstrate [to international donors] that it can plan effectively, implement its plans and report on the achievements and costs of this implementation …[The] FMOH needs to have a complete picture of achievements and resource use in the health sector. This is partly to inform its strategic planning and prioritizing. But is also vital for the credibility of the health sector in Ethiopia (FMOH, 2007, p. 9).
In 2007, the emergence of the WBHSP strategy was rooted in the government’s aim to operationalize harmonization and alignment in order to enhance the capacity of district health planners. The government proposed that WBHSP would improve: (i) coordination between national and district planning; (ii) the management of health information; and (iii) channels of communication across all levels. As a result, WBHSP emerged as a key strategy to assist in guiding regional and district health planners on how to strategically align national priorities with the health needs identified by the districts. Further, it was believed that harmonization principles, through WBHSP, would facilitate greater alignment between NGO programmatic plans and the government’s goals. Chapter 5 details the goals and processes of WBHSP as they were envisioned and how they transpired in practice. Figure 3.2 displays a timeline of international and national policy development related to the implementation of WBHSP. What is consistently visible in this timeline is that over the past 20 years, there has been an overall international and national progression towards strengthening in-country ownership for health planning and resource allocation.

3.4. Decentralized Health Planning and Procedures

To achieve the above goals of the health sector over the past twenty years, fiscal and political decentralization were viewed as an essential step; particularly to enhance the delivery of care to rural populations. The impetus for decentralization, in line with the Constitution, was to dissociate from the overall record of centralized control and resource allocation that had previously ignored the needs and preferences of the district communities (Garcia & Rajkumar, 2008). In 1991, Ethiopia implemented an ambitious decentralization program that devolved authority to autonomous regions and then sub-regional (district) governments. In the late 1990s, decentralization was implemented in two phases. As highlighted in Figure 3.3, the first phase created a four-tier governance structure consisting of a central unit, comprised of the region, zone, and woreda (Garcia & Rajkumar, 2008). During this phase, the Regional Health Bureaus (RHBs) were given responsibility for delivering all health services and education (minus tertiary and secondary teacher training). Evaluation of this structure, however, revealed an inability of the RHBs to meet all the specific needs at the woreda level, which resulted in limiting public
Figure 3.2. Timeline of International and National Policy Development Related to WBHSP

**INTERNATIONAL CONTEXT**

- **1993**
  - Ethiopian Health Policy
  - Founded on principles of democratic participation, community engagement, equity, and inter-sectoral collaboration.

- **1997**
  - HSDP –I (1997/98)
  - Prioritizing disease prevention and decentralization of health services.
  - Government begins harmonization process through Sector Wide Approach Program (SWAP)

- **2001**
  - ROME DECLARATION at the High Level Forum on Harmonization
  - HARMONIZATION

- **2003**
  - PARIS DECLARATION ON AID EFFECTIVENESS
  - Ownership, Harmonization, Alignment, Results and Mutual Accountability

- **2005**
  - Sustainable Development and Poverty Reduction Report (SDPRP)
  - Recognizes the need to improve governance to further development.

- **2010**
  - HSDP –IV (2009/10)

**ETHIOPIAN CONTEXT**

- **2003**
  - ROME DECLARATION at the High Level Forum on Harmonization
  - HARMONIZATION

- **2004**
  - Ethiopian Health Policy
  - Founded on principle of democratic participation, community engagement, equity, and inter-sectoral collaboration.

- **2005**
  - HSDP –III (2005/6)
  - Need for increased national health spending, NGO delivery of care within districts and NGO collaboration.

- **2007/8**
  - Plan for Accelerated and Sustained Development to End Poverty (PASDEP)
  - Second draft etched out a greater blueprint for Ethiopia’s development plan.

- **2008**
  - Sustainable Development and Poverty Reduction Report (SDPRP)
  - Recognizes the need to improve governance to further development.

- **2009**
  - Woreda-Based Health Sector Planning
sector efficiency, grassroots empowerment, and accountability (Garcia & Rajkumar, 2008). In response, the government initiated a second phase of decentralization in 2002/03, classified as the District Level Decentralization Program (DLDP), whereby control was further devolved to the woreda. Woreda Administrative Councils now function as the district government unit within each region and are assigned significant responsibility to plan and allocate resources accordingly. This new governance structure was intended to improve accountability mechanisms for better service delivery by meeting district needs more readily (Garcia & Rajkumar, 2008).

Figure 3.3. Ethiopian Decentralized Governance Structure (adapted from Yilmaz & Venugopal, 2008)

Through the current decentralized health system, and coupled with the implementation of the HHM strategy and block grant funding structures, regional and district stakeholders have been given greater autonomy when aligning resources with national HSDP priorities. This structure has, in turn, influenced decision-making processes for the development and implementation of health policies that are now to be shared between the Federal Ministry of Health (FMOH), the RHBs, and the Woreda Health Offices (WorHOs). As of 2010/11, RHBs had the power and duty to: (i) assist
in the preparation of the health care plan for the region and implement it when was approved; and (ii) organize and administer hospitals, health centres, clinics, and research (EFMOHa, 2007). Although current governance around health policy and technical support are coordinated at the FMOH and RHB level, WorHOs now have a stronger role in the management and coordination of health planning at the district level (EFMOHa, 2007). As described in the World Bank report, *Achieving Better Service Delivery through Decentralization in Ethiopia* (Garcia & Rajkumar (eds), 2008), a greater understanding is still required around the responsibilities across tiers of government, which further brings into question the role and capacity of district stakeholders to manage, plan, and implement health programs in light of changing accountability structures.

### 3.4.1. Scope of Stakeholder Roles

Overall, the attainment of the HSDP mission and objectives are dependent on the collective efforts and roles played by different stakeholders (EFMOHa, 2007). When studying the district health planning process involving numerous actors, acknowledging the scope of roles and responsibilities is particularly salient. The Ethiopian government classifies stakeholders involved in the implementation of the HSDP as either “internal” or “external” (EFMOHa, 2007, p. 45). “Internal” stakeholders are viewed as those stakeholders that hold the primary responsibility of planning, implementing, monitoring, and evaluating HSDP programs. These stakeholders include top management and civil servants of the FMOH, RHBs, Zonal Health Departments (ZHDs), WorHOs, and other affiliated government health institutions. “External” stakeholders, on the other hand, include the community-at-large, non-governmental partners, the Prime Minister’s Office, Council of Ministers’ and the House of People’s Representatives and various sector Ministries (e.g., Ministry of Finance and Economic Development, Ministry of Education). This study sought to capture the health planning experience at the level of internal stakeholders (who have the primary responsibility for health planning). Clarifying the role of stakeholders and their associated responsibilities is therefore important for defining the boundaries of actors in the health system and identifying contributions expected from each (EFMOHa, 2007).
3.5. Overview of Health Service Delivery and System Structure

The Ethiopian health system is structured into a three tier health system comprised of: (i) primary level health care services (that include rural health services, such as health posts servicing 3,000–5,000 people) and health centres servicing 15,000-25,000 people, and primary hospital reaching out to 60,000-100,000 people); and an urban and rural health centre servicing 40,000); (ii) secondary level health care (that include a general hospital servicing 1-1.5 million people); and (iii) tertiary level health care (that includes a specialized hospital servicing 3.5-5 million). Figure 3.4 provides a diagram of the Ethiopian health tier system.

Figure 3.4. Ethiopian Health Tier System (modified from the FMOH, 2010, p.74)

Ethiopia’s healthcare system has always consisted of a mixture of public, private, and non-governmental health providers and, in recent years, these partnerships have grown significantly to meet the expanding needs of the population. Table 3.2, excerpted from Wamai (2009), reveals the
growth in overall health facility number provided by both the government and non-governmental organizations from 1996-2002. To meet the needs of its largely rural population, the government adopted the Primary Health Care movement since the late 1970s in order to increase access of health services to rural populations, and enhance community participation in planning, implementing, and maintaining health services. Through the health policy in 1993, an increased emphasis emerged to promote prevention and health promotion in the health services provided. This initiative was in response to the fact that between 70%-80% of diseases that affected the population were largely preventable through the use of simple methods (e.g., malaria and bednets).

**Table 3.2.** Growth of Functioning Health Facilities in Ethiopia Established by Government and NGO Providers (excerpted from Wamai (2009, p. 281)).

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>46</td>
<td>59</td>
<td>55</td>
<td>64</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>NGO</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Number of health centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>241</td>
<td>262</td>
<td>294</td>
<td>344</td>
<td>369</td>
<td>384</td>
</tr>
<tr>
<td>NGO</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>23</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>Number of health stations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>2,202</td>
<td>2,173</td>
<td>2,118</td>
<td>2,031</td>
<td>2,019</td>
<td>2,019</td>
</tr>
<tr>
<td>NGO</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>268</td>
<td>374</td>
<td>312</td>
</tr>
<tr>
<td>Number of health posts</td>
<td>76</td>
<td>164</td>
<td>373</td>
<td>893</td>
<td>1,063</td>
<td>1,193</td>
</tr>
<tr>
<td>Total</td>
<td>2,600</td>
<td>2,694</td>
<td>2,878</td>
<td>3,640</td>
<td>3,927</td>
<td>4,020</td>
</tr>
</tbody>
</table>
| Number of health facilities       | 4.5     | 4.5     | 4.5     | 5.7     | 6       | 6       | per 100,000 population

To improve outreach of rural services, the government launched the Health Services Extension Program (HSEP). Through the HSEP, individuals from the community have been trained as Health Extension Workers (HEWs) to provide a number of health service packages at the household level. These packages have included: (i) disease prevention and control (e.g., TB, HIV/AIDS, malaria, and STI prevention and control); (ii) family health services (e.g., maternal and child health, family planning, immunization, adolescent reproductive health, and nutrition); (iii) hygiene and environmental sanitation (e.g., water supply and safety measures, excreta disposal, food hygiene and safety measures, personal hygiene, etc.); and (iv) health education and
communication. While a number of challenges have been acknowledged in implementing the HSEP, it has been hailed as an overall success to strengthening rural health service provision throughout the entire country (Bilal, Herbst, Zhao, Soucat, & Lemiere, 2011, pp. 441-443).

**Key Point Relevant to this Study**
With respect to health planning, health extension workers play a role in the collection of pertinent epidemiological health data and data regarding health service administration for the purpose of planning at the level of the WorHO.

### 3.6. Financing Structure and its Impact on Health Planning

Prior to launching into a discussion of district health planning, it is important to reflect on health care financing structures since fiscal resource flows inherently impact which health programs are prioritized (EFMOHa, 2007). Ethiopia is one of the fourth largest recipients of Official Development Assistance (ODA), which translates into significant investment of the donor community in the health sector (Pereira, 2009, p. 11). With regard to public services, financing flows from four major pathways, including: (1) the federal and regional governments; (2) bilateral and multilateral donors (grants and loans); (3) non-governmental organizations; and (4) private contributions (EFMOHa, 2007, p.71). All development partners are to coordinate their work and funding through the Development Assistance Group (DAG), which is the highest-level coordinating group comprised of twenty-five donor agencies.\(^{50}\)

Secondary to the DAG are 11 technical working groups that relate to a variety of differing service areas (e.g., equality, health,

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\(^{50}\) DAG is comprised of 25 donor agencies providing development assistance to Ethiopia under the principles of the Paris Declaration on aid effectiveness and harmonization. These members include: The African Development Bank; Austrian Development Cooperation; Belgian Development Cooperation Agency; Canadian International Development Agency now known as Department of Foreign Affairs and International Trade; Danish Embassy, Department for International Development (DFID); European Commission; Finland Embassy; French Embassy; German Embassy; GTZ-Ethiopia; Indian Embassy; International Monetary Fund; Irish Aid; Italian Development Cooperation; Japanese Embassy; Japan International Cooperation Agency (JICA); KfW (Development Bank), Dutch Embassy; Norwegian Embassy; Swedish International Development Agency; Spanish Agency for International Development Cooperation; United Nations Development Programme (UNDP); USAID and the World Bank. The DAG is set by the Executive Committee who include the UNDP and the World Bank as DAG co-chairs, and three representative DAG members on a rolling one-year basis.
governance, etc.) (EFMOHa, 2007, p. 11). Since the implementation of the HHM strategy, greater emphasis has been placed on the “one budget” principle that emphasizes an integration of donor funding within federal funding block grants for disbursement to the regions and districts (EFMOHa, 2007, p. 41). This vision of fiscal harmonization has aimed to reduce the transaction cost of delivering aid and services. When the system is fragmented, situations arise such as having too many resources for one technical program and too few for another (EFMOHa, 2007, p. 41).

Presently, there are three channels under the Ethiopian funding structure: Channel 1a (unearmed), Channel 1b (earmarked), Channel 2 (used by bilateral and multilateral agencies), and Channel 3 (used by most UN agencies and some bilateral donors). For a further description of each channel, please refer to Appendix 3 (EFMOHa, 2007, pp. 80-82). Of particular importance here are the concepts of “predictability” and “flexibility” for Ethiopian decision makers. A budget is “predictable” when the government has prior knowledge of the amount and timing of funding and the disbursement procedures. Such fiscal predictability cultivates an environment of systematic health prioritizing since decision makers have awareness of what health programs can be accommodated financially, should they be selected. Additionally, fiscal “flexibility” is also important as it relates to the degree of freedom under which governments are granted with the autonomy to channel pooled unearmarked funds into emergent priority service areas (EFMOHa, 2007, p. 43). To increase both predictability and flexibility for planning and prioritizing, the Ethiopian government has been working towards Channel 1a, thereby granting government greater autonomy to allocate funding according to need (EFMOHa, 2007, p. 41).

Although strategies to implement basket-funding mechanisms to strengthen government autonomy and financial predictability have been underway, the success of such fiscal harmonizing has been limited (Pereira, 2009, p.12). Development partners still contribute a large portion of funding to achieve overall health activities and, given ongoing political disagreements in the area of human rights, have not been as amendable to such pooling strategies (Pereira, 2009, p. 13).51 Presently, regions and districts receive resources through a number of different channels including

51 As describe by Pereira (2009), “political disagreements resulting from the Government’s poor record on human rights are holding back advances on alignment and harmonization. […] In addition, vertical donors remain outside alignment and harmonization efforts, hence limiting the amount of progress which could be achieved (p. 13).”
the regional Bureau of Finance and Economic Development (BoFED) and Woreda Office of Finance and Economic Development (WoFED) and at different times for differing purposes and with differing monitoring requirements. This limited predictability holds many implications to health planning and, as detailed in the HHM strategy, “does not make for good planning, because it is impossible to make sensible decisions about priorities and their implementation when no one has a complete knowledge of all the resources that are available” (EFMOHa, 2007, p. 10).

To ensure all stakeholders buy into this process of harmonized financing, all main donors in the health sector are encouraged to sign a Code of Conduct in which they agree to follow the principles of harmonization and alignment. The HHM (2007) states:

Donor support should follow the priorities and procedures specified in this plan. Government and donors are expected to engage in active debate about the contents and implementation of the plan, as there should be greater coordination of reports, analytical work, reviews, missions and finances [emphasis added]. Single-donor activities should be kept to a minimum; wherever possible donors should work together on particular issues (EFMOHa, 2007, p.14).

The extent to which donors function within this code of conduct was beyond the scope of this dissertation, and warrants a deeper analysis of actual patterns of fiscal allocation subsequent to this study.

3.7. Ethiopian Context Summary

This chapter describes Ethiopia as a context rich with cultural diversity, historical complexity, and on a recent political evolutionary course towards democracy. In relation to district health planning, Ethiopia provides a unique setting in which to explore various issues associated with health care priority setting. At the time of this study, the government had begun the implementation of WBHSP, which offered a rare glimpse into the implementation of a national district health planning process. Given the emphasis on democratic health planning in the WBHSP strategy, this study also serves as an opportunity to empirically examine how Ethiopian decision makers conceptualize fairness and legitimacy (through a lens of procedural fairness). And from a systems lens, to uncover how systemic factors influence the planning process and the manifestation of fairness in decision-making. The details of these findings will be presented in Chapter 5 and 6.
Such powerful qualitative traditions produce distinctive findings that [can] offer unique insight into the organizational contexts and decision-maker behaviour for priority setting. (Smith, Mitton, & Peacock, 2008)

Chapter 4 describes both the underpinning qualitative epistemology and subsequent research design and methods that shaped this study. To achieve this study’s central aim of uncovering system factors influencing district health planning and priority setting, as well as gain a deeper understanding of factors that influence procedural fairness, three objectives were undertaken: (1) describe Ethiopian district health planning; (2) analyze this process of health planning against the Accountability for Reasonableness (A4R) framework and the Transformative Systems Change Framework (TSCF); and (3) synthesize these analyses to advance methods for priority setting.

Drawing on qualitative methods and ethical normative inquiry, this chapter describes the way in which each objective was achieved and discusses relevant ethical issues and methodological limitations, where present. Section 4.1 describes the use of qualitative inquiry as a methodological backbone of this study. Section 4.2 details the methods used to undertake objective 1, which sought to describe the district health planning and priority setting process in Ethiopia. These methods included qualitative key informant interviews and thematic data analysis. Section 4.3 details the use of the analytic frameworks in advancing our understanding of procedural fairness and system-level barriers and facilitators to district health planning. Finally, as a map for the reader, Section 4.4 details the organization of the the study findings within Chapters 5, 6, and 7.

4.1. The Use of Qualitative Inquiry

As described in the opening quote of this chapter, qualitative research has become a valuable mode of analysis for researchers wishing to explore the social reality of a given phenomenon. In the case of this research, the first hand experiences of health planners and stakeholders during a priority setting process (Smith et al., 2008). Through this mode of inquiry,
researchers are able to gain a more in-depth understanding of human behaviour and the reasons that govern such behaviour (Morse & Richards, 2002; Willis, 2007). Denzin and Lincoln (2005), who have written extensively on qualitative research, define qualitative research as a:

[...] situated activity that locates the observer in the world [and] consists of a set of interpretive, material practices that make the world visible. [The researcher] turns the world into a series of representations, including field notes, interviews, conversations, recordings and memos [and] attempts to make sense of or interpret phenomena in terms of the meanings people bring to them. (p. 3)

In developing a qualitative study, Creswell (2007, p. 37) describes this process as beginning with the definition of an epistemological orientation that will guide the research design, then outlining a theoretical lens or methodology to further frame the conceptual thinking (although, this is not always the case as in grounded research), and ultimately concluding with the definition of methods that will uncover the meaning individuals or groups ascribe to a social or human problem under investigation. These processes are seen as essential in establishing both theoretical and methodological rigor to a qualitative inquiry (Carter & Little, 2007; Creswell, 2007).

In Figure 4.1, a diagrammatic representation of the relationship between epistemology, methodology, and methods is provided. Carter and Little (2007) argue that attention to all three domains of qualitative inquiry is essential to strengthening both the internal consistency and rigor of a study. Ultimately, “methodologies justify methods, and methods produce knowledge, so methodologies have epistemic content” (p. 1320). Given that all researchers operate from a distinct epistemological point of view, the necessity for explicitness in a researcher’s orientation is rooted in the belief that overall research findings and proposed solutions are inextricably linked to such philosophical assumptions (Smith et al., 2008). Lack of attention, in this regard, impacts the quality, validity, and rigor of the study, therefore making it difficult for the reader to not only obtain a sense of how knowledge was generated, but also in understanding how it will be evaluated and applied (Guba & Lincoln, 1994; Denzin & Lincoln, 2005; Creswell, 1998, p. 8). The following sections detail these three domains—epistemology, methodology, and methods—as they applied to undertaking this study.

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52 “Epistemology” here refers to the nature of knowledge, what constitutes valid knowledge, identifying the parameters of what can be known and who can be the knower (Willis, 2007, p. 8).
4.1.1. Defining Epistemology in Qualitative Inquiry

As a qualitative researcher, Guba and Lincoln (1994) emphasize that “no inquirer [...] ought to go about the business of inquiry without being clear about just what paradigm informs and guides his or her approach” (p. 116). The identification of the overarching epistemology is critical in qualitative research as it has three influences on a study. First, it influences the relationship between the researcher and the participant. Second, it influences the form, voice, and representation of study participants. Third, it influences the ways in which the quality of methods will be demonstrated or determined (Carter & Little, 2007, p. 1321). Guba and Lincoln (1994, p. 109) distinguish between three dominant paradigms of inquiry—post-positivism, interpretivism, and critical theory that have been dominant in qualitative research. Briefly, under a post-positive paradigm, the purpose of research is to find universals that allow one to generalize across contexts; and this can be achieved through the identification of data using propositions that can be validated and identified across other cases (Willis, 2007, pp. 74-76). Through this paradigm of inquiry, the researcher remains an objective observer to the study and its participants. In contrast, an interpretivist analysis does not seek one universal truth; rather it appreciates the multiple realities of an experience (Creswell, 1998, p. 8). To arrive at such conclusions, the researcher positions themself as a co-creator of meaning through participant claims; in this way, they remain reflexive to their influence on the study’s development, data collection, and analysis. Critical theory, on the
other hand, has a specific agenda to confront injustices in society. It therefore brings a certain standpoint and theoretical orientation to its research questions by remaining attentive to the economic, political, and ideological forces shaping the phenomenon under investigation (Guba & Lincoln, 1994.)

Within the field of health planning and priority setting, research has traditionally involved a wide spectrum of qualitative investigations and case studies to elucidate strategies in order to improve the decision-making process (Ham & Robert, 2003; Astley & Wake-Dyster, 2001; Mitton & Proust, 2004). While not typically explicit in their orientation, many of these studies appear to have been informed by post-positivist epistemological assumptions based on the generalizations that are usually sought through the identification of one truth to priority setting and through the use of A4R, procedural fairness (Smith et al., 2008). This proposed research aimed to analyze: (1) the system-level barriers and facilitators that impacted the implementation of Woreda-Based Health Sector Planning (WBHSP) in Ethiopia; and (2) the systemic factors that further impacted the potential to strengthen fairer and legitimate processes of health decision-making. From the outset, a critical theory orientation would not apply. A post-positivist lens in this case would facilitate in the identification of “universals” (whether beliefs, concepts, and/or ideas) through the use of theory previously tested that would espouse, for instance, the notion of what a fair and legitimate process of decision-making looks like. To provide conceptual guidance to this analysis, then, two frameworks were selected: A4R and the TSCF. A deficiency in using this epistemological approach, however, lies in its inability to appreciate the diversity of multiple realities in what constitutes procedural fairness within an Ethiopian context. Through interpretivism, theory is not used as a guide, but rather, participant experiences are organically weaved together to conceptualize how stakeholders view fair and legitimate health planning. This approach may be of particular importance in other settings where Western conceptualizations of fairness and legitimacy may diverge from those espoused in the framework.

The use of theory in this dissertation is to guide our thinking around what defines procedural fairness and to determine which elements should guide our systems analysis. It also requires attentiveness to other system structures and factors that influence health planning and procedural fairness. In this way, we can recognize that multiple realities of procedural fairness could exist,
making the use of an exclusively post-positive lens limiting to this investigation. It was not the intent of this study, however, to experience health-planning processes through the in-depth experience of a select few district decision makers and to understand how participants view their social world (i.e., their health planning experience) and their role within it. In undertaking the research objectives of this dissertation, it was important to have a conceptual guide related to procedural fairness and yet also be in a position to incorporate potentially diverse views in how stakeholders conceptualize fairness and legitimacy. It was through these theoretical insights that a more pragmatic qualitative approach was sought as the epistemological guide.

4.1.2. Generating Knowledge through Pragmatism

Outside the traditional post-positive and interpretive paradigms, Wicks and Freeman (1998) add pragmatism as a third alternative to qualitative inquiry. The essence of pragmatism is action and change—humans acting in a world that is in a constant state of becoming (Blumer, 1969). Blumer (1969) argues, “[t]o be understood, a society must be seen and grasped in terms of the action that comprises it” (p. 71). In this case, it is important to comprehend the way health planning unfolds as influenced by a fluid system of interaction that must be grasped. Ultimately, a pragmatic qualitative research approach is concerned with action and change, and the interplay between knowledge and action; making it an appropriate base for studies that intervene in the world (and are not merely observing it). The key idea of inquiry is to create knowledge with the interest of change and improvement. The knowledge aspect of pragmatism is not restricted to providing explanations (post-positivism) and understanding (interpretivism), but it further seeks other knowledge that is prescriptive (e.g., giving guidelines), normative (e.g., exhibits values) and prospective (e.g., suggesting possibilities) (Goldkuhl, 2012). According to Cherryholmes (1992), Murphy (1990), and Creswell (1998), pragmatism is not committed to any one system of philosophy or reality; rather, it opens the door to multiple methods, different worldviews, and different assumptions. For pragmatists, knowledge claims arise out of actions, situations, and consequences than antecedent conditions (as in post-positivism). The central aim of pragmatism is to solve problems that are not necessarily committed to one philosophical truth or reality.
The central aim of this study’s investigation was to gain a deeper understanding of the system-level barriers and facilitators that impact both the implementation of the district-based health sector planning and the ability to strengthen fair and legitimate health decision-making. To achieve this aim, through a pragmatic approach, it was essential that the study be constructed in a fashion so as to elicit first-hand accounts of health planning through the experience of health planners (at national, regional, and district levels) and their non-governmental counterparts. In addition, it was essential that this be coupled with an observation component in order to triangulate data and visually capture barriers and facilitators to health planning and priority setting beyond those described by participants interviewed. The use of theory was also essential to pragmatically guide our understanding of fair and legitimate planning (through the A4R framework), as well as to aid in the conceptualization of the system structure (through the TSCF) under investigation.

4.1.2.1. The Role of the Researcher: Positionality and Reflexivity

Under a pragmatic approach, the researcher is engaged with understanding the research and the change process. While the intent is not to necessarily co-create meaning through discussions with research participants, a pragmatic approach still warrants a level of researcher reflexivity. In an effort to uphold objectivity and position myself (the researcher) within the context of the study, it is important that I detail previous experiences that may have had bearing on how the study was designed, conducted, and analyzed. Prior to the commencement of this doctoral degree and research, I had worked as both an intern and researcher in Ethiopia for three years. My first work experience in Ethiopia was as a Junior Professional HIV/AIDS Consultant for the United Nations Development Programme. During this work placement, I had worked alongside government, multilateral, and donor officials, and was in a position to gauge some of the deeply embedded challenges associated with managing and disbursing fiscal resources. Many of these challenges I noted appeared to be largely rooted in weak managerial structures that were unable to effectively monitor and track funds. It was recognized at the outset of this study that there was distinct possibility that many of these constraints may exist within the government system, including the district level. As a result, while many challenges to health planning would likely naturally emerge
through study participant accounts, questions posed in the interview guide were fashioned in a non-biased manner.

Building upon my interests in public health in Ethiopia, I completed my Master’s thesis at the community-level in rural Jimma, where I gained both an appreciation for conducting qualitative research in a cross-cultural setting and, a continued awareness of the additional resource constraints that limit health staff in providing care to patients seeking it. Such considerations shaped my interests in health planning and health services research. In particular, I was interested in gaining a deeper understanding of how resources are allocated and how health priorities are determined. It was also through these initial experiences where I became acquainted with the concept of “ferenji fatigue.” 53 The term itself describes an overall “fatigue” described by Ethiopian counterparts who often get frustrated with the surge of foreign researchers and volunteers who enter the country for “their own purpose,” and never return for follow-up, research dissemination, or sustaining collaborations. This notion had a lasting impression on me, further cultivating my values in global health initiatives that support sustainable and collaborative partnerships. In designing this study, it was therefore important that my Ethiopian counterparts found value in this work through their overall buy-in and participation in the research ideation process. This approach translated into a series of meaningful discussions with Ministry of Health and Regional Health Bureau counterparts from 2007-2009—regarding which sites should be included in the study and how best to conduct the in-depth qualitative interview component (given my limitations with the National language, Amharic, and my dubious position as a foreign interviewer asking questions related to decision-making and governance.)

Prior to the start of my doctoral program, I worked as a Research Assistant for the Joint Centre for Bioethics. During this time, my work focused on resource allocation ethics, which heightened my interests in Rawlsian justice theory, procedural fairness and, in particular, the ethical framework, A4R. In particular, I became interested in understanding if and how each condition of A4R would resonate with the concepts of fair and legitimate decision-making in a

53 The term “ferenji” is commonly used as slang in reference to international non-Ethiopian workers, volunteers, or tourists in Ethiopia.
low-income country setting, such as Ethiopia. At the time, given the limited scholarly literature that spoke to its application within such settings, I began to consider the development of a study that bridged my previous interests and knowledge of the Ethiopian context with that of strengthening ethically fair and legitimate health planning processes (as conceptualized by A4R). To ensure that Ethiopian stakeholders and health planners would find meaning in this work, I traveled four times to Ethiopia prior to the commencement of data collection to engage in a series of research discussions with government officials.

In 2010, my thesis committee underwent restructuring: my thesis advisors became Dr. Whitney Berta (an expert in organizational behaviour and systems theory) and Dr. Jennifer Gibson (an expert in priority setting and organizational ethics). Through discussions that emerged from our initial meetings, it appeared that a weakness in the previously conceptualized study on procedural fairness in Ethiopia was its lack of attention to the contextual or system-level features and dynamics that may shape a planning process. Dr. Berta offered insights from the systems theory and whole systems change literature that would act as the backdrop for the contextual analysis piece of the study. Through further investigation, I became aware of the Transformative Systems Change Framework—a framework conceptualized to guide one’s understanding of fundamental system parts that explain how a system functions and undergoes change. This framework was viewed as particularly applicable to this investigation since, at the commencement of this study, the Ethiopian health planning system was undergoing significant change through the adoption of the WBHSP strategy. Dr. Gibson, with her substantial experience applying A4R within organizational settings, emphasized the potential contribution of systems theory within the priority setting literature. In addition, another thesis committee member, Dr. Clare Pain (a clinician with more than 30 years experience working in Ethiopia), continuously offered constructive feedback regarding the cultural sensitivity and applicability of this work.

In summary, the conceptualization of this study was informed, directly and indirectly, by my previous work and research experiences in Ethiopia, the guidance of my thesis committee (who supported its theoretical and methodological development) and through the guidance of my Ethiopian counterparts (who played a strong role in the identification of district sites and gauging the study’s applicability). When conducting any study in a cross-cultural setting, particularly
around sensitive issues, such as local modes of governance, it is prudent to acknowledge the presence of invisible variables that may influence how stakeholders interact, how decision-making unfolds, and to what extent a foreign researcher will be able to capture these processes. Invisible variables may be associated with historical power relations across local groups, power differentials related to a traditional society moving into 21st century western expectations, or the nebulous role/identity of a foreign Caucasian female researcher as the primary investigator. While it will be unclear what influences these hidden variables may have yielded on this study, I remained reflective to these issues and further discuss their implications on my findings in Chapter 7.

4.1.3. Methodology: A Case Study Research Design

Epistemology guides methodology, which shapes the research objectives, questions and overall study design (Carter & Little, 2007). To pragmatically guide this investigation of district health planning, I undertook a case study research design. The case study research approach has been widely used within the field of health planning and priority setting and has been undertaken under any of the aforementioned paradigms (Cavaye, 1996; Smith et al., 2008). Having written extensively on case study research, Yin (2009) classifies it as a research design that investigates a contemporary phenomenon within its real-life context, where the boundaries between phenomenon and context are not clearly defined. In this sense, a case study is an ideal qualitative mode of inquiry when one wishes to uncover contextual conditions that would be particularly pertinent to the phenomenon of interest (such as in this study, whereby district health planning would be studied in conjunction with other contextual features). In order to arrive at meaningful insights, a case study research design typically combines data collection methods such as interviews, participant observation, questionnaires, and document and text analysis (Guba & Lincoln, 1994; Yin, 2009, p. 13).

When formulating a case study research design, there are three variations: (i) a single instrumental case study (in which the researcher focuses on an issue or concern and then selects one bounded case to illustrate this issue); (ii) a multiple case study (in which the research focuses on one key issue, but selects multiple cases to illustrate the issue); and (iii) the intrinsic case study (whereby the focus is on a unique situation of the case itself). To capture the experience of district
health planning and priority setting in Ethiopia, a case study research design of three districts was selected to illustrate this experience. As it was not the intent of this study to compare the three districts selected against one another, the inclusion of each district (i.e., case) acted as a mechanism to broaden our scope of understanding the health planning and priority setting experience, as it played out in different regions of the country. The subsequent sections will discuss the use of theory under a case study research design, considerations to research quality, and outline the methods used to collect data.

4.1.3.1. The Role of Theory

Before launching into a detailed explanation of the study’s theoretical approach, it is important to note that theory can be used in a number of ways and for different purposes in case study research (Creswell, 1998). Social science theories may be absent from the study, with a greater focus being placed on the description of cases and its issues (Creswell, 1998). Theory can also be introduced at the initial formulation of the study to guide the research in an explanatory way, or it may be brought in at the cessation of the study in order to make sense of the findings (Creswell, 1998). For the purpose of this research, applying the A4R lens at the outset of the study provided pragmatic conceptual guidance in our understanding of procedural fairness in this context. This stage of framework introduction was particularly valuable to inform the framing of research questions posed in the interview guide. In addition, the application of the TSCF after phase one of data collection was introduced to gain a deeper understanding of systemic barriers and facilitators impacting district health planning and procedural fairness.

4.1.3.2. Judging the Quality of Case Study Research

To establish the quality of empirical case study research at different phases of the research process, Yin (2009) outlines both validity and reliability strategies (p. 40). With regards to research design, external validity considerations are of central concern as they primarily deal with the issue of knowing whether a study’s findings are generalizable beyond the immediate case study (p. 43). In qualitative research, this process is commonly referred to as transferability (i.e., the extent to which the findings can be applied in other contexts or with other respondents). While generalizability is not the main goal of a qualitative case study, case studies do rely on analytic
generalizations where the investigator is striving to generalize a particular set of results to some broader theory (Yin, 2009). Various qualitative researchers have further proposed that the prospect of transferability in qualitative research should not be immediately rejected, as some generalizations may be inferred across similar contexts (Stake, 1994; Denscombe, 1998). Guba and Lincoln (2005) assert that it is the responsibility of the investigator to ensure that sufficient contextual information about the fieldwork site(s) are provided to enable the reader to make such a transfer. Respecting this directive, I have provided details of all participating institutions and on the individuals who were selected for interviews and why they were chosen. Furthermore, Chapter 3 of this dissertation provided a detailed background on the Ethiopian historical, political, and economic context to further situate this investigation within the research setting. If similarities or contrasts in practice or process emerged, these differences were documented and reflected upon in data analysis, but not explicitly detailed in writing, as comparison across districts was to be avoided. Through the selection of three cases, it was hoped that general features would emerge and speak to a variety of similar or differing issues influencing district health planning.

4.1.4. Informed Consent and Ethics Approval

This research was approved by the University of Toronto Research Ethics Board and the Ethiopian Ministry of Science and Technology National Research Ethics Review Committee. The research protocol submitted included the proposal of work to be completed and details of obtaining informed consent from research participants during the qualitative interviews. Hired data collectors and interviewers were trained to ensure that interview participants were informed of the study, goals and objectives, informed of any associated risks and benefits from the study, and the measures being taken to ensure privacy and confidentiality. Written and/or verbal informed consent was obtained from all participants. In cases where written consent was not possible, such as with interviews over the phone, verbal consent was requested.

As indicated in all submitted ethics documents, participant confidentiality was fully upheld. Only the primary researcher (Kadia Petricca) and Ethiopian data collectors had access to the identity of interviewees. All data were kept strictly confidential and available exclusively to this
research team. Throughout the preparation of this dissertation and in any dissemination of this research, anonymity of participants has been and will continue to be strictly protected.

4.2. Objective 1: Describing District Health Planning and Priority Setting in Ethiopia

To capture the experience of district health planning and priority setting in Ethiopia, a qualitative case study was undertaken in three districts of Ethiopia during the 2010 and 2011 district health planning cycles. The following sections describe the methodology and methods used to guide data collection and analysis to achieve Objective 1.

4.2.1. Methods: Data Collection and Thematic Analysis

Methods are an extension of the methodology selected and are seen as the techniques used for gathering evidence (Carter & Little, 2007). To guide our understanding of health planning and priority setting for the district annual plan, three primary sources of data were collected for this case study: (i) documents (inclusive of national, regional, and district-level strategic planning reports and guiding policies); (ii) qualitative one-on-one interviews (with key informants inclusive of district, regional, and national health planners, as well as with members of the district cabinet and district finance office within each of the three districts, and NGO counterparts); and (iii) participant observation (of a district annual planning meeting). Data collection took place in two phases. Phase 1 detailed the district health planning process of the woreda annual plan for 2010, and Phase 2 involved follow-up and supplementary data collection during the woreda annual plan 2011.

Phase 1 – Woreda Annual Plan 2010

The Phase 1 description of the district health planning and priority setting process in Ethiopia was conducted during the 2010 district health planning cycle. The following sections detail the research design and methods that were used to collect data for this first phase of Objective 1.
4.2.1.1. Document Analysis for Phase 1

Documents were obtained from the Ethiopian Ministry of Health website and hand collected from the Federal Ministry of Health office and each Regional Health Bureau (RHB) during June 2008 to April 2010. Documents selected included all pertinent health planning reports and strategic documents that would provide insight into the health planning context and process within Ethiopia. In total, four key documents were collected that included: the Health Sector Development Program strategy (HSDP), the HSDP Harmonization Manual (HHM), the Woreda-Based Health Sector Planning (WBHSP) Training manual, and the Ethiopian Constitutional Health Policy. All documents were analyzed for information related to how decisions are expected to be made, what structures are to be in place, who is to be included in the planning and priority setting process, how revoked decisions may be handled, how the strategy is disseminated, and what overall values may guide decision-making. In addition to general thematic analysis, document analysis also applied a conceptual lens of A4R to assess normative elements that spoke to procedural fairness in planning.

4.2.1.2. Qualitative Interviews for Phase 1

Prior to conducting qualitative interviews with stakeholders, districts were selected for inclusion in the study and data collectors were hired.

I. District Selection

As a result of the current political structure of districts housed within regions, buy-in for this research investigation was initially sought from RHBs. From October-December 2009, meetings were held with the Head of Planning at three RHBs in Ethiopia to discuss the scope of the study and to finalize the districts that would be selected for inclusion. The selection of each district within each of the three regions was guided by the following criteria: (i) no travel advisories within the selected district; (ii) RHB approval; (iii) a willingness of the district managers to participate in the study at the district-level. Each head of planning at the RHB ultimately authorized selection of each district. Upon identification, the district managers from each Woreda Health Office (WorHO) were then contacted and introduced to the primary
investigator. Based on the aforementioned inclusion criteria, it was proposed that Hintalo-Wajerat district (in the Tigray region), Shebedino district (in the SNNP region) and Lume district (in the Oromia region) would serve as the district case studies in this study investigation. Letters of support from each Regional Head of Planning were collected to present to district representatives upon entry at the district-level.

II. Recruitment of Ethiopian Data Collectors

To describe the priority setting process for the district annual plan, qualitative interviews were conducted between March and April 2010 (Phase 1) and 2011 (Phase 2). To conduct one-on-one key informant interviews, two English speaking Ethiopian data collectors were hired per region. Both data collectors were initially selected by the heads of planning from each of the three respective RHBs. To ensure consistency across all six data collectors, the primary investigator conducted one-hour meetings with each regional pair to review the project aim, objectives, and go through interview guide. To ensure clarity and understanding of the study, each question in the interview guide was carefully reviewed and discussed. Additionally, the interview guide was also screened by each head of planning and all data collectors to ensure cultural sensitivity. Probing techniques were also included in the interview guide in case study participants were unclear about the direction of a question and to guide interviewers on appropriate probes that should be used in such scenarios (Table 4.1). All data collectors (and, when required, translators) were asked to sign interviewer confidentiality forms, which outlined their role, financial compensation, confidentiality considerations, and expected outputs (Appendix 4A).

III. Sampling and interviewing

A purposive sampling strategy was employed in this study to select those stakeholders with the primary responsibility for health planning and priority setting. By using a purposeful sampling strategy, the aim is to target individuals with both intimate knowledge and direct involvement in the district priority setting and planning process. Sampling of participants was strategized with data collectors and each head of planning to include members from the Woreda Cabinet Administration, Woreda Office for Finance and Economic Development (WoFED), Woreda
Health Office (WorHO) and non-governmental organizations working at the district level. All heads of planning and interviewers agreed that individuals based within each of these settings would be directly involved in the planning for the district annual plan.

Prior to conducting interviews, each data collector provided each participant with a translated consent form that sought to ensure understanding of the study objectives, how the participant was selected, risks and benefits associated with participation, and confidentiality considerations (see Appendix 4B for the English version of consent forms). To guide our understanding of Ethiopian health planning and the priority setting process, an interview guide was developed to direct data collecting, which was then subsequently translated into Afan Oromo for the Oromia region, Tigrigna for the Tigray region and Amharic for SNNP region by each pair of data collectors (see Appendix 4C for an English version of the interview guide). Table 5.1 includes the 17 qualitative in-depth questions that key informants were asked.

After each day of data collection, the primary investigator met with each pair of data collectors (in-person or via phone) for a 1-2 hour debriefing on key themes, issues with the questions posed and/or restructuring the interview guide, where needed. In some cases, additional probes were added to strengthen the understanding of the question across interviewees. For example, in question 6 (What is considered in this decision-making process for the Annual Plan?), it was noted that further clarification was needed around the term “considered.”; Therefore, probes associated with this question included terms such as “criteria and/or information.” Interviews were tape-recorded in Shebedino and Lume districts, and transcribed and translated into English. In Hintalo-Wajerat district, data collectors did not feel that study participants would feel comfortable with their interviews being tape-recorded and, so, the data collectors opted to conduct interviews in pairs to ensure the collection of all material. All interview transcripts were provided to the primary investigator in English from each data collector.

IV. Sample Size

Since the goal was to describe current district-level health planning and priority setting from the perspective of decision makers, sample size was not formally calculated. In total 41 interviews were conducted with: 20 district health planners, 6 district Woreda Council members, 5
district finance members, 1 NGO counterpart, 1 Zonal Department representative, 7 Regional Health Bureau officials, and 1 Federal Ministry of Health counterpart. In terms of overall district representation, 13 participants were from Lume district, 13 participants were from Hintalo-Wajerat district, and 14 participants were from Shebedino district.

4.2.1.3. Participant Observation

Across all regions of Ethiopia (inclusive of Oromia, SNNPR, and Tigray regions), planning meetings for the district annual plan occurred in two rounds, both of which involve a background knowledge training component and, then, a practical planning component. Within each region, one group of districts were scheduled to have their planning meeting during Round 1 (March 22-26, 2010), and the remaining districts were then scheduled for Round 2 (March 29-April 1, 2010). Organization and scheduling of districts to participate in either Round 1 or 2 was established by the RHB and each Zonal Health Department (ZHD). Each region is subdivided into a series of zones, which are then comprised of districts. Since Hintalo-Wajerat, Lume, and Shebedino districts were all scheduled for the first round of planning within their respective regions (and the structure and process is to now be standardized throughout the country), the primary investigator attended the Shebedino district planning meeting in the Sidama zone during March 22-26, 2010. During this five day planning meeting, each day was active from 8:30 AM to 5:30 PM. Participant observation of the planning meetings was undertaken to provide a richer understanding of the health planning and priority setting experience of districts, as well as triangulate findings with the empirical description drawn from documents and qualitative interviews.

4.2.2. Data Analysis Techniques for Thematic Coding

A distinctive feature of all qualitative research is its emphasis on interpretation during data analysis. As previously described in Section 4.1.2, the degree of interpretation can vary across each of the aforementioned paradigms. Interpretivism is much more reliant on the subjectivity of the researcher versus post-positivism, for instance, where data are commonly interpreted relative to

54 Regions are further divided into zones and Shebedino district falls within the geographical boundary of Sidama zone. Alongside Shebedino, 11 other districts participated in district health planning within Sidama zone.
a theory (Willis, 2007, p. 77). Although each district will vary, one goal of this investigation was to build a general narrative that captures the experience of each individual case (i.e., district) (Yin, 2009, p. 140). Coding of qualitative data in this study proceeded in two ways. First, under pragmatism, thematic coding was undertaken to derive common themes experienced across all three districts included in this study. This step was completed in an effort to generate an overall narrative that spoke to the complexities and successes experienced across participants. Second, as it applies to Objective 2, data were also selectively coded against each of the two frameworks—A4R and the TSCF—to gain deeper insights into procedural fairness and systems theory. A description of this process will be presented in sections 4.2.1 (related to A4R), and 4.2.2 (related to the TSCF).

**Table 4.1. List of Qualitative Interview Questions in the Interview Guide**

1. How do you set priorities the woreda (district) Annual Plan for health services?  
   *Probe: Describe the entire planning process.*

2. Who is involved in this planning process?  
   *Probe: Involvement of which stakeholders—donors, NGOs, community members?*

3. How is participation ensured across all stakeholders involved in the planning process?

4. Who leads the planning of the Annual Plan? And in what capacity?  
   *Probe: What is their role?*

5. How can leadership be strengthened at the district-level?

6. What is considered in this decision-making process for the Annual Plan?  

7. How do you disseminate or publicize these decisions and to whom?  
   *Probe: Are there any groups in particular who you wish to review the decisions?*

8. What happens when someone disagrees with the decision?  
   *Probe: Can the decision be changed or revised? If so, how?*

9. What are some of the challenges you experience during the health planning process for the Annual Plan?

10. What do you think is necessary to lessen these challenges?

11. What are the characteristics of a fair decision-making process?

12. Was there fairness in your planning process or do you feel improvements can be made?  
   If improvements can be made, how would you improve the fairness of decision-making?

13. What are the characteristics of a legitimate decision-making process?
To facilitate thematic coding, all interview data were imported into NVivo Qualitative Software to organize and manage data and thematic coding. In addition, all documents collected and participation observation notes were further analyzed to thematically code and elicit emergent themes. To guide inductive thematic coding, interview manuscripts were first reviewed via a conceptualization technique for the first level of coding abstraction. Data from interview manuscripts, documents, and participant observation notes were reviewed in NVivo and conceptually fractured by identifying chunks of data that related to a particular concept or idea. The emergent codes reflected the techniques, processes, and decision-making domains of national, regional, and district health planners and NGO partners. As an example, “improved data quality and management” emerged as a common theme to capture any data that spoke explicitly to strategies that participants identified as supporting the improvement of data collection and management. To demonstrate this theme, the following quote would be representative of this idea:

Therefore, in order to get a real and achievable plan, concrete evidence is very crucial. For these reasons, the government has been trying to get data from the kebele and woreda levels. The recently started woreda based planning is one of the examples. Data are specifically collected for planning purposes. Improvement through health management information is what is needed to enhance overall planning procedures. (Member, WorHO)

Upon the completion of inductive coding, a microanalysis of the date resulted in the identification of additional relationships and the merging of similar conceptual themes. For example, the initial emergent themes (that included “more community involvement,” “improved multistakeholder engagement,” “collective decision making,” and “multistakeholder participation”) were later grouped into the dominant theme, “Decision making climate supportive...
of stakeholder inclusivity.” Within this larger theme, quotes in support of that theme (or any derivation of the original sub-theme) will be provided. For instance, to describe the importance of enhanced multistakeholder engagement, the following quote would be selected:

It is important that all stakeholders come together to actively participate in the woreda annual plan. This improves deliberation since many ideas are raised when members come for the meeting. Everyone wants to reach decisions according to their own interests. But increased multistakeholder dialogue allows everyone to respect each other’s views by giving more time for deep discussions. Majority vote during this time is the goal and ensures that everyone involved is aware of what is being planned and why. (Member, WorHO)

This merging process led to the identification of eight dominant themes that highlighted contextual factors impacting WBHSP implementation (Figure 4.2) and five dominant themes related to the benefits since the emergence of the WBHSP strategy (Figure 4.3). Each theme will be described through the use of verbatim quotes from participant interviews in the results Chapter 5.

**Figure 4.2. Eight Dominant Themes that Describe Contextual Factors Impacting the Implementation of WBHSP**

1. Limitations to managerial capacity, organizational empowerment, and leadership
2. Limitations to technical capacity to manage the tool
3. A shared belief in multistakeholder engagement as a means to improve health planning
4. Insufficient time allocated to complete the plan
5. Milieu supportive of stakeholder inclusivity
6. Presence of tangible resources
7. Limitations to the presence of timely and complete data
8. Planning under fiscal uncertainty
4.2.2.2. Judging the Quality of Data Collection and Analysis

During the data collection phase, Yin (2009) emphasizes the importance of ensuring construct validity and reliability. Construct validity seeks to establish whether what was intended to be measured was in fact measured. In qualitative research, this process is commonly referred to as ensuring credibility. Essentially, the researcher must consider: is there compatibility between the constructed realities that exist in the minds of the study participants and those realities that are attributed to them? To ensure the alignment of these realities, a series of steps (as described below) can be taken that focus on enhancing conceptual measurement and broadening the scope of reality constructions. From a measurement stand-point, researchers should define what is intended to be measured, in terms of specific concepts that relate back to the original aim and, secondly, identify operational measures that match the concepts (preferably through a citation of published studies in the literature).

To strengthen credibility in this sense, the concepts embedded within both theories guided the measurement of fairness and legitimacy and systems barriers and facilitators. To measure fairness and legitimacy in decision-making, the five conditions defining the A4R framework were used as primary guide (i.e., relevance, publicity, appeals, leadership, and empowerment). While these conditions (i.e., concepts) have been accepted and used by researchers to measure fairness and legitimacy, one common critique documented in the literature has been the elusiveness in the conceptual parameters to measure the extent of each condition. For instance, how is a researcher
able to claim with certainty that a condition has been satisfied? Addressing this type of methodological concern had implications for both data collection and analysis.

To overcome these constraints, researchers have typically structured questions around the scope of each condition, so as to ensure that information would directly speak to that condition. To explore the concept of publicity, for example, the question, “How do you disseminate or publicize these decisions and to whom?” was posed to identify practices related to transparency and public dissemination. In addition, to explore the concept of appeals and revision, posing the question, “What happens when someone disagrees with the decision?” aimed to extract information related to the scope to which decisions may be revoked or revised. Similarly, to measure system barriers and facilitators, the TSCF provided a conceptual guide to measure key components of a system’s structure that was believed to influence the process of systems change (e.g., systems norms, operations, regulations and resources). A series of questions were used to elicit information related to each system structure measure. For instance, to facilitate our understanding of systems resources—such as the human, social, and economic capital that were present—questions included: “How has WBHSP changed the health planning process?” “What have been some of the major successes with implementing WBHSP?” and “What has facilitated in this success?”

To augment the aforementioned measurement techniques, data source triangulation with multiple sources of information was another important strategy. This process was undertaken as a way to validate interview manuscripts with practice described in documents and with actual practice witnessed through participant observation. To further ensure accuracy and credibility of findings, Yin (2009) suggests peer briefing and member checks. To ensure that data translated into English from the interviews was accurately described, a previous colleague of mine reviewed two interviews from Shebedino district, and another colleague reviewed two interviews from Lume district. During qualitative thematic coding, one of my thesis supervisors, Dr. Whitney Berta, and I independently analyzed a sample of three interview manuscripts to ensure credibility of the inductive thematic coding. Any discrepancy between coding and themes developed were discussed in order to reach consensus.
Reliability is another strategy used to assess the quality of a study and has implications on data collection. As outlined by Yin et al. (2009, p. 45), the objective a reliable study is to ensure that if a later investigator was to follow similar data collection and analysis procedures that were undertaken—with respect to districts selected, questions asked, participants interviewed, and documents analyzed—that the same conclusions would result. Guba and Lincoln (2005) assert that while reliability and validity are essential criteria for quality in quantitative research, in qualitative research, credibility, dependability and transferability are essential criteria for quality. In particular, they associate the term reliability with that of “dependability” in qualitative research. In order to strengthen dependability, detailed notes were recorded to document specific procedures taken that outline the steps to questionnaire development, participant selection, and data gathering.

4.3. Objective 2: Framework Analysis using A4R and the TSCF

Objective 2 involved analyses of the data collected in Phases 1 and 2 of Objective 1 against the frameworks A4R and the TSCF. Sections 4.2.1 and 4.2.2 detail the analysis undertaken using both A4R and the TSCF, respectively.

4.3.1. Analysis using A4R

To draw inferences related to procedural fairness, data were analyzed through the ethical lens of A4R. As previously discussed, A4R is a prominent ethical framework that has gained prominence for offering conceptual guidance on how to ensure fairness and legitimacy throughout a health planning and priority setting process. In addition to the four conditions proposed by Daniels and Sabin (1998) (relevance, publicity, appeals/revision, and endorsement), a fifth condition of “empowerment” (Gibson et al., 2005b) was added to address power differentials across stakeholders. While a lack of explicit measures that gauge how and to what extent each condition has been satisfied has been elusive in the literature, Gibson et al. (2005b) offered guidance on key characteristics in support of each condition. Table 4.2 presents the A4R evaluation guide used in this study (inclusive of these operational characteristics described by Gibson et al. [2005b]). To establish a case for the following five conditions, documents were thematically analyzed to uncover how government values and policy intent aligned with planning.
principles in support of fairness and legitimacy. Interview transcripts with study participants were also analyzed to facilitate an understanding of how principles of fairness and legitimacy transpired in practice. I concluded a condition was satisfied if measures existed in support of each of the characteristics described in Table 4.2.

Table 4.2. A4R Evaluation Guide for Assessing Procedural Fairness

<table>
<thead>
<tr>
<th>Scale of Measurement – A4R Condition</th>
<th>Data Analysis Technique</th>
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<tr>
<td><strong>1) Relevance</strong> calls for reasonableness in priority setting. Therefore, there is a positive association between legitimacy and fairness when decisions uphold the relevance condition, meaning that decisions are based on evidence and principles of the organization and are made by fair-minded people.</td>
<td>To assess <em>relevance</em>, data were analyzed to uncover the rationale, principles and/or reasoning underpinning health priority setting. - Were criteria inclusive of the mission, vision and values of WBHSP? - Were decisions based on reasonable evidence and/or an apparent need? - Did multi-stakeholder engagement exist with internal and external stakeholders to ensure the relevance of decision criteria?</td>
</tr>
<tr>
<td><strong>2) Publicity</strong> underpins explicitness and transparency and is positively associated with both legitimacy and fairness. The publicity condition would be satisfied if the reasons are made publicly available to stakeholder groups, various decision-makers and patients/the public in order to stimulate public debate on priority setting decisions.</td>
<td>To assess <em>publicity</em>, data were analyzed for various publicity elements (or transparency) within the priority setting process. - How were decisions and their rationales shared among internal/external stakeholders? - Was there an effective communication strategy present to engage stakeholders?</td>
</tr>
<tr>
<td><strong>3) Revisions and Appeals</strong> requires that there are mechanisms for stakeholders and decision-makers to challenge and revise decisions in view of new evidence. This feature would provide stakeholders with an opportunity to voice their opinions and subsequently, enhance fairness.</td>
<td>To assess <em>revisions and appeals</em>, data were analyzed for any mechanisms that incorporated opportunities for iterative review of decisions and if there had been mechanisms to develop a formal decision-review process based on explicit decision-review criteria.</td>
</tr>
<tr>
<td><strong>4) Empowerment</strong> holds that a fair and legitimate process should ideally minimize power differentials across stakeholders at the table and optimize effective strategies for stakeholder participation.</td>
<td>To assess <em>empowerment</em>, data were analyzed to assess the presence of power differentials based on participant interviews and direct observation. Data were also analyzed for mechanisms to support leadership development and minimize power differentials.</td>
</tr>
</tbody>
</table>
5) Enforcement would be satisfied if there is institutional leadership to ensure/enforce the first four conditions of relevance, publicity, appeals, and empowerment are upheld.

To assess enforcement, data were analyzed to ascertain the enforcement/leadership mechanisms in place during the priority setting process and how this feature was upholding the aforementioned conditions.

4.3.2. Analysis using the TSCF

Phase 2 – Woreda Annual Plan 2011

Phase 2 involved the application of the TSCF. To analyze system-level barriers and facilitators to district health planning, this phase involved an iterative process of coding previous data collected from Phase 1 to identify gaps in the analysis that required further probing through the use of the TSCF. Data collection for Phase 2 was conducted during April and May 2011. Through the TSCF, Foster-Fishman et al. (2007) describe a series of four stages in the TSCF that include: Stage 1 (binding the system); Stage 2 (understanding system structure); Stage 3 (assessing system interactions); and Stage 4 (identifying levers for change). Data analysis proceeded in these four analytical steps.

4.3.2.1. Stage 1: Binding the System

Primary to any systems analysis, it is imperative that boundaries of the system be set in order to isolate the problem under investigation, determine who the players are, and identify which key factors within this bounded system are relevant. This step involves defining the problem through stakeholder perspectives and identifying the levels, niches, organizations, and actors relevant to the problem under investigation. Many systems theorists argue that establishing these boundaries is one of the most critical and defining processes in any systems analysis (Foster-Fishman et al., 2007). For instance, Midgley (2000) stresses that while system boundaries are an arbitrary construction, their development is of critical importance, and how they are defined can pose significant implications for what is considered in the scope of the analysis. When defining a system’s boundary, Foster-Fishman et al. (2007) stress the importance of defining the “problem situation,” which “represents one worldview of the present problem and a potential solution within a given context” (Foster-Fishman et al., 2007, p. 203). Through this process, one may capture and
synthesize multiple participant views into one overarching problem statement for analysis.

As described by Foster-Fishman et al. (2007), binding the system takes place in two steps: Step 1—to identify the problem that should be targeted for assessment and intervention; and Step 2—to define who and what is contained within the system given the targeted problem. In Step 1, to identify the Problem Definition, Foster-Fishman et al. (2007) call for a dialogic process of inquiry (such as focus group discussions) that may elicit multiple stakeholder perspectives on emergent challenges of the change initiative; in this case, the implementation of WBHSP. For the purpose of this study, however, focus group discussions were not viewed as an appropriate method due to the sensitivity of openly discussing government policy implementation and governance-related issues. Instead, data analysis from Phase 1 key informant interviews was undertaken to draw from questions capturing participant experiences with the WBHSP strategy. During this analytical process, it was apparent from participant manuscripts that early experiences with WBHSP had revealed both strengths (successes) with WBHSP implementation, as it had challenges. In defining the Problem Situation for this system binding, it was viewed that focusing solely on challenges would narrow the scope of analysis of the system. The Problem Definition in this study was therefore categorized or “constructed” around the implementation of WBHSP (i.e., the change initiative itself). To finalize binding of the system, Step 2 drew from document analysis and participant interviews to further establish which actors, organizations, and levels of government were viewed by participants as key in this “system change” process.

4.3.2.2. Stage 2: Understanding the System Structure

Upon identification of the system boundary, a conceptualization of the system’s structure was sought. Foster-Fishman et al. (2007) stress the importance of identifying essential system parts as a critical mechanism to explain the system’s purpose, define roles for system members, and build structures for systems operations. Within the TSCF, four key system parts or components are identified that include: (1) System Norms (including attitudes, values and beliefs); (2) System Regulations (e.g., policies and procedures, roles, and responsibilities); (3) System Resources (i.e., available resources such as human and social capital); and (4) System Operations (such as power and control structures). To guide the conceptualization of the system structure, Table 4.3 provides
a list of open-ended questions that were adapted from Foster-Fishman et al. (2007) and applied within this study during Phase 2 participant interviews.

**Table 4.3.** Adapted TSCF Qualitative Interview Questions to Define the System Structure (modified from Foster-Fishman et al., 2007)

<table>
<thead>
<tr>
<th><strong>Systems Norms</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1) What current assumptions support the implementation of WBHSP or may impede its success?</td>
<td></td>
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<tr>
<td>2) What are the values guiding current practices of WBHSP?</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Systems Regulations</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Have there been any major inconsistencies with what is written in the WBHSP document and what can actually be implemented?</td>
<td></td>
</tr>
<tr>
<td>4) Are there any other current policies or practices that would impede successful implementation?</td>
<td></td>
</tr>
<tr>
<td>5) What practices are not in place, but are possibly needed to fully support the goals of the implementation?</td>
<td></td>
</tr>
<tr>
<td>6) How has WBHSP changed the health planning process?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Systems Operations</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7) How has WBHSP altered decision-making structures and power dynamics across stakeholders?</td>
<td></td>
</tr>
<tr>
<td>8) What types of information and resources are most important and who controls access to these?</td>
<td></td>
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<tr>
<td>9) How do all planners communicate?</td>
<td></td>
</tr>
<tr>
<td>10) Is there anyone missing from the decision-making process?</td>
<td></td>
</tr>
<tr>
<td>11) Does everyone participate equally in the planning process?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Systems Resources</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
</tr>
<tr>
<td>12) As a result of WBHSP, are there any new expectations for each health planner at the national, regional and district level? If so, how has the role of planners changed at each level?</td>
<td></td>
</tr>
<tr>
<td>13) Do system members have the necessary skills now required?</td>
<td></td>
</tr>
<tr>
<td>14) Have there been identified local champions for implementation?</td>
<td></td>
</tr>
<tr>
<td>15) What is needed to help system members develop this understanding?</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Social Resources</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16) What have been some major successes with implementing WBHSP? And what has facilitated in this success?</td>
<td></td>
</tr>
<tr>
<td>17) How have relationships among stakeholders been altered? In what way has this impacted implementation?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Economic Resources &amp; Opportunities</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19) What new resources or opportunities are needed to support WBHSP?</td>
<td></td>
</tr>
</tbody>
</table>
To guide Phase 2 data analysis, I drew from key informant interviews, documents of Ethiopian policies, grey and scholarly literature (that captured Ethiopian cultural and social values), and informal discussions from participants during participant observation. Discussions with stakeholders during participant observation and informal conversations with participants further guided the formulation of a dominant context for contextualizing matters of governance, authority, and power. A normative context is presented that provides a deeper understanding of the power structures that may influence district health planning between decision makers, technical capacity of decision makers, and issues surrounding data management for decision makers. In undertaking such an analysis, three major obstacles may limit the inferences derived from this context. First, as an outsider to the Ethiopian system, the portrait of social and cultural norms and values is particularly challenging, as the primary researcher does not wish to paint an inaccurate representation of this context. Second, Vaughan and Tronvoll (2003) emphasize that the varied ethnic groups and cultures within Ethiopia creates a level of complexity when offering generalizations to overarching “Ethiopian” social and cultural norms. They state:

The cultures encompassed within Ethiopia’s borders are extremely rich, complex, and varied in the range of their practices and traditions of authority and power, so that any kind of generalization is difficult. The oral and articulate cultures of the Somali and Afar [Eastern most regions] have an extreme sensitivity towards kinship and clanship in organizational models (and not confined territory/spaces); the open and plural cultures of the south, compare with the more closed, inward–looking and territorially-based organizational features of the highland cultures of Amhara and Tigray […] and are] known for [their] strict hierarchical order, where social conduct is defined and delimited by an individual’s rank (according to kinship, age, sex, social/material resources, religion, etc.). The cultural background and upbringing of Ethiopia’s citizens fundamentally influences their way of thinking about ‘modern’ concepts such as ‘democracy’ (p. 38).

And finally, a third challenge lies in extrapolating pertinent social and cultural norms that may specifically guide our understanding of district health planning processes, and issues of capacity-building and data management. Through this recognition, I, therefore, have an acute awareness of the potential to make erroneous inferences from observations of such a culturally diverse and politically complex setting.
4.3.2.3. **Stage 3: Assessing System Interactions**

In Stage 3 of the TSCF, systems dynamic loop models were conceptualized using the qualitative data provided by participants. Models focused around the problem issues identified in the binding of the system (e.g., limited technical capacity and challenges with data collection, management, and use) to gain a more conceptual and empirically embedded understanding of the dynamics associated with each phenomenon under investigation. First, a reinforcing causal loop was modeled to identify the sustaining patterns of interaction that appeared to sustain system behaviour leading to either limited technical capacity of district health planners or challenges experienced with data management. In opposition to this view, a balancing causal model was conceptualized using empirical suggestions that emerged from study participants to strategize what interventions may be needed to strengthen improvements in the problematic areas identified. The two models were then conceptually linked together to provide a snapshot of the system under which district health planners felt they lacked the technical capacity required for planning or the capacity to manage and use the data collected.

4.3.2.4. **Stage 4: Identifying Levers for Change**

Based upon the two conceptualized models in Stage 3, “levers for change” were identified, which were also empirically grounded in participant accounts of where improvements would be required to yield positive change. A series of questions posed by Foster-Fishman et al. (2007) further contributed to a more reflective understanding of the levers proposed. For identifying levers for change in system parts, reflective questions included: (1) Which system parts are currently inconsistent with the systems change goal; (2) Which parts support the systems change goal; (3) Which parts are most likely to trigger system wide change; (4) Which of the above desired levers for change can actually be altered or strengthened given current resources and understandings; and (5) What impact will the shift in the targeted system parts have on other system parts, interactions and the problem situation? Additional questions for reflection questions included the following three questions (and are addressed in Chapter 7 discussion): (1) What differences with the system could serve as leverage points for change; (2) What enduring patterns within the system will likely impede change or the targeted systems change goal; and (3) What
linkages between system parts could be created or altered to align system functioning with the system change goals?

4.4. Objective 3: Conceptual Synthesis

To advance methods for priority setting through systems theory, a conceptual synthesis was undertaken of the previous literature reviewed in Chapter 2, and the empirical findings that emerged from inductive thematic coding (Objective 1) and framework analysis (Objective 2). A conceptual synthesis provides an overview of the literature in the field and embeds this work within the empirical findings to provide a broader and richer understanding to a particular discipline or field of research. As applied to this study, the conceptual synthesis facilitated a wider reflection on the dimensions of procedural fairness (as viewed through the conceptual lens of A4R) and systems theory (as viewed through the lens of the TSCF).

4.5. Results Chapter Organization

The next two chapters, 5 and 6, will present the findings emergent from this study. Chapter 5 will present the findings associated with Objective 1, which sought to describe district health planning and detail common themes that emerged from participant interviews. Chapter 6 will present the findings that emerged through the application of the two theoretical frameworks, A4R and the TSCF. Chapter 7 will discuss these findings, derive key lessons, and orient these findings and lessons within the greater literature. Figure 4.4 provides a diagrammatic representation of each of these chapters and the associated analysis that will be detailed.
**Objective 1:** Description of Ethiopian district health planning and thematic analysis

**Objective 2:** A4R (Ethiopian planning process analyzed through procedural fairness lens)

**Objective 2:** TSCF (Ethiopian planning process analyzed through systems theory lens)

**Objective 3:** Advance methods for priority setting through empirical and conceptual considerations of district health planning, procedural fairness, and systems theory.

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**Figure 4.4.** Diagrammatic Representation of Data Collection, Analysis, and Results

- **Phase 1:** Annual planning cycle 2010
  - Conducted
  - Undertook
  - Analyzed
  - Government policy and strategy documents
  - Key informant interviews
  - Participant observation

- **Phase 2:** Annual planning cycle 2011
  - Conducted
  - Undertook
  - Analyzed
  - Government policy and strategy documents
  - Key informant interviews
  - Participant observation

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**Chapter 5**

**Chapter 6**

**Chapter 7**
Governance in the context of HSDP means how the development and implementation of the plan is organized, managed, and communicated—the responsibilities of the different organizations involved, the mechanisms for policy-making, planning, monitoring and evaluation, and coordination among them. This is not just about government officials—citizens, NGOs, and donors all have a relevant role to play in the governance of HSDP. Governance is important to ensure that plans are actually owned and implemented—and it is particularly important that governance responsibilities are clear [emphasis added] in a highly decentralized country, such as Ethiopia.

Ethiopian Ministry of Health, *HSDP-IV* (p. 68)

As noted in the above quote excerpted from the Health Sector Development Programme (HSDP-IV), the Ethiopian government clearly recognizes the importance of multistakeholder inclusivity in health governance. Here, the HSDP-IV specifically outlines that all health matters be planned, organized, and implemented by all pertinent actors in the health sector, beyond that of the government alone. Through multistakeholder inclusivity, the government also recognizes the importance of a clear division of responsibilities among stakeholders. The development of the Woreda-Based Health Sector Planning (WBHSP) strategy has been a major step forward in providing district health planners with more structured guidance on annual health planning and governance at the district-level.

Chapter 5 presents a description of Ethiopian district health planning based on document analysis, in-depth qualitative interviews, and participant observation. It is divided into three main sections. Section 5.1 provides a general overview of district health planning and priority setting under the WBHSP strategy. Section 5.1.1 first describes how the government envisioned the WBHSP strategy and, second, Section 5.1.2 examines how this process unfolded in practice through qualitative interviews and participant observation. Section 5.2 identifies and describes key themes that emerged from qualitative interviews with government and non-governmental stakeholders. Section 5.3 concludes with reflections on the district health planning process, and presents a visual illustration of the findings based on the previous two sections.
5.1. Description of Ethiopian District Health Planning

At the time of the 2010 and 2011 interviews, the WBHSP strategy had entered its second and third cycle of implementation, respectively. As a result, stakeholders involved in the district health planning process had had a few years to internalize this new process and were therefore, well positioned to provide reflection upon their experiences. To gain deeper insight into the health planning process, and acquire a more comprehensive understanding of the absorptive capacity of districts to integrate WBHSP into practice, the following sections describe and examine the health planning and priority-setting experience in Ethiopia.

5.1.1. Woreda-Based Health Sector Planning as Envisioned

The Ethiopian government describes the WBHSP strategy as a breakthrough planning process that seeks to align district priorities vertically (with those of the national government) and horizontally (across stakeholders working in the districts) (EFMOHb, 2007, p. vii). As detailed in the WBHSP Training Manual, it is believed that this strategy, and the implementation of its associated Evidence-based Planning and Budgeting (EBPB) tool will strengthen the coordination of planning at all levels of government (EFMOHb, 2007, p. 7). Ultimately, the implementation of WBHSP hinges upon the recognition that effective health planning relies as much on increasing capacity through the development of tools to improve the evidence-base as it does on strengthening procedural measures to support stakeholder inclusivity, transparency, and public engagement.

The WBHSP strategy comprises a fourteen-step process that includes four steps: profiling each district (“woreda”), completing the EBPB tool, finalizing the budget, and preparing the report. Under this new harmonized model of health decision-making, there are two health plans: (i) the strategic plan (developed every five years to outline broad government health goals); and (ii) the annual plan (produced annually that emerges from the broader objectives, priorities, and targets of the strategic plan). As detailed in Chapter 4, the empirical data collected from health planners is in reference to the annual plan during the 2010 and 2011 planning cycle. While there may be minor procedural variations across districts when developing the annual plan, the six principles
guiding WBHSP are the same throughout the country (EFMOHb, 2007, pp. 6-9). These principles shape the development of health decision-making procedures and include:

(i) **The One Plan Principle**, which aims to mitigate redundancy and systematize health planning by ensuring that all stakeholders—including government, donor partners, and district communities—agree on one health sector plan. This collective decision-making aims to minimize the presence of separate, single-donor plans that often interrupt health sector goals and, in turn, aims to encourage alignment between NGO goals and those of the government. Through this principle, the health sector is to have one countrywide plan—the HSDP—and each project planned at the district level must fit within this one plan.

(ii) **The One Budget Principle** aims to ensure that at all incoming funding for health activities be pooled and channeled through government channels. Critical to both the one budget principle and the one plan principle is the notion that all funders agree on the terminology, priorities, and targets of the Strategic and Annual Plans, and relinquish control of resources to the Ethiopian Chart of Accounts.

(iii) **The One Report Principle**, aligned with the One Plan Principle, aims to minimize the duplication of reporting required to monitor and evaluate the achievement of the HSDP indicators. Reports generated will be based on these indicators without duplicating channels of reporting.

(iv) **The Resource Constraint Principle** acknowledges the strong link between resource capacities required to complete the activities setout in the plan. While plans should be needs based and will likely have ambitious targets, the WBHSP strategy recognizes that the government plays a large role in ensuring the mobilization of required resources to undertake the initiatives prioritized.

(v) **The Result-Oriented Budgeting Principle** recognizes that the allocated government budget must directly link to results. Through this principle, resources must be linked to outputs rather than inputs, which will influence whether outputs are achievable.

(vi) **The Evidence-based Planning Principle** supports health sector planning that is to be guided by complete, reliable, and timely information. Through this principle, it is stressed that information must also be coupled with a logical and systematic approach to define goals, objectives, and targets.
(vii) **The Flexibility Principle** identifies the importance of the plan to have a degree of flexibility, such that it may be open for potential revision. Since planning engages elements of estimation and forecasting, it is recognized that complete confidence in planning is rare.

Together, these principles emphasize values of efficiency (in that planning aims to remove duplication, is targeted, grounded in evidence, and aligned at all levels) and deliberation (in that planning seeks to encourage and cultivate a forum for stakeholder dialogue to address any revisions). Figure 5.1 provides an illustrative depiction of the district health planning process under the WBHSP strategy and identifies the contextual principles that are to guide the planning process.

**Figure 5.1.** The Fourteen-Step District Health Planning Process under WBHSP, inclusive of the Aforementioned Seven Principles (adapted from EFMOHb, 2007)

To operationalize these seven principles, three approaches to health planning are adopted under WBHSP that include: (i) a top-down and bottom-up approach; (ii) an evidence-based planning and budgeting approach; and (iii) a balanced scorecard approach to improve quality of health service provision.

**5.1.1.1. Top-Down and Bottom-Up Approach of WBHSP**

To achieve aligned, harmonized, and targeted planning, the WBHSP strategy is designed in a top-down and bottom-up fashion. It seeks to ensure that plans developed at the district level are
driven by and aligned with national strategic plans and targets outlined in the national HSDP policy. Through the One Plan Principle, all stakeholders (including government, donor, NGOs, and the community) agree to be part of a broader sectoral plan (EFMOHb, 2007, p.22). Each Regional Health Bureau (RHB) is to work in consultation with the Federal Ministry of Health (FMOH) and other stakeholders to develop their own regional Strategic Plan. The Strategic Plan is to reflect key targets, priorities, and activities of the HSDP. Upon completion, it is to be submitted to the FMOH for review and discussion. Zonal Health Departments (ZHDs) and Woreda Health Offices (WorHO) are also required to produce a Strategic Plan (that is a reflection of the regional Strategic Plan). Each WorHO is to consult with individual health facilities and the community in the development of their five-year objectives (EFMOHb, 2007, p. 26). Upon the completion of the Strategic Plan, programmatic aims and objectives are further broken down into annual targets and activities at each level for the Annual Plan. The WBHSP Training Manual (2007) states:

The annual plan should be the governing plan of the health sector at each health service delivery level. Hence, the planning exercise should be participatory and inclusive; whereby all stakeholders (the government, donors, NGOs, and the communities) are actively involved. The whole planning process should be led by the heads of the public sector at all levels. (EFMOHb, 2007, p. 12)

Similar to the strategic plan, the development of the annual plan takes place within a top-down and bottom-up structure. The annual plan is developed in two stages: (I) the indicative core plan (which involves the mainstreaming of priorities and national targets); and (II) the annual “comprehensive” plan (which includes contents of the indicative core plan plus the detailed plan that includes other activities of district relevance). The first stage, the development of the indicative core plan, is created at the federal level and then communicated to the regions. The RHBs then use the federal indicative core plan as a guide in formulating their own indicative core plans (that account for pertinent regional considerations) and communicate this indicative core plan to their respective woredas (See Figure 5.2).

55 Through this planning structure, separate single-donor plans are to be resisted, as donors are now encouraged to assess how their inputs fit within the broader sectoral plan. To achieve this process, agreements with all funders need to reflect the terminologies, priorities, and targets of the strategic and annual plans. As well, finances from all sources must be translated into the Ethiopian chart of accounts and fiscal year. All donors are to sign the Health Sector Code of Conduct (EFMOHa, 2007, 2007, p. 22).
The second stage in the annual plan development begins at the woreda level during the WBHSP five-day planning meeting and involves consultation with major stakeholders (such as relevant government institutions, donors, and NGO partners). This process is represented in Figure 5.2, with an emphasis added in blue brackets to highlight the level at which the five-day district health-planning meeting occurred (previously outlined in Figure 5.1). Participant observation also took place at this level. During this WBHSP planning meeting, the development of the district annual plan consolidates the core and detailed plan. The content of each annual comprehensive plan is reviewed and validated by the Woreda Administrative Council (WAC) and Woreda Finance and Economic Development Office (WoFED) and subsequently given channeled to the upper government to inform the regional and federal annual comprehensive plan. As displayed in Figure 5.2, both the strategic and annual plans are to be: (i) linked to resource mapping at each level of government (which includes financial and non-financial resources); (ii) approved by the relevant district government authority; and (iii) comprehensive (in that all relevant activities in the health sector are covered by the government, NGOs, and the private-sector).

**Figure 5.2.** Annual Planning Cycle (Modified from the EFMOHb, 2007, p. 10)

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56 This process is linked to the one budget principle.
To support this process, the HSDP Health and Harmonization Manual (HHM) outlines the key responsibilities of major stakeholders involved in development of the annual plan. In Table 5.1 it is evident that while the WorHO is to have a more prominent role in the development of the Annual Plan, the process, overall, is shared and collective across all members of government.

**Table 5.1.** Key Responsibilities of Major Stakeholders involved in Development of the Annual Plan (modified from the EFMOHa, 2007, p. 27)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Activities for which Stakeholders are responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Donors</strong></td>
<td>Work with the FMOH and the RHBs to ensure that all-donor funded activities are included in the strategic plans and resource mapping exercises.</td>
</tr>
<tr>
<td></td>
<td>Ensure that all staff and consultants working in the health sector have copies of HSDP-III and the HHM manual</td>
</tr>
<tr>
<td><strong>Federal Ministry of Health</strong></td>
<td>Develop the HSDP</td>
</tr>
<tr>
<td></td>
<td>Secure approval of the plan by the Central Joint Steering Committee</td>
</tr>
<tr>
<td></td>
<td>Share the plan with RHBs</td>
</tr>
<tr>
<td></td>
<td>Support the regions in the development of their strategic and annual plans.</td>
</tr>
<tr>
<td></td>
<td>Ensure that regional plans are consistent with national priorities.</td>
</tr>
<tr>
<td></td>
<td>Ensure all RHBs and senior Federal managers have copies of all pertinent national documents related to planning.</td>
</tr>
<tr>
<td><strong>Regional Health Bureaus</strong></td>
<td>Develop and implement the Strategic Plan</td>
</tr>
<tr>
<td></td>
<td>Secure approval of the plan by regional government</td>
</tr>
<tr>
<td></td>
<td>Share plan with the FMOH and WorHOs</td>
</tr>
<tr>
<td></td>
<td>Support WorHOs in the development of their Strategic and Annual Plans.</td>
</tr>
<tr>
<td></td>
<td>Ensure all WorHOs and senior RHB managers have copies of pertinent health planning documents.</td>
</tr>
<tr>
<td><strong>Woreda Health Office</strong></td>
<td>Develop and implement Annual Plan with involvement of community and partners</td>
</tr>
<tr>
<td></td>
<td>Secure approval of strategic plans by the woreda government</td>
</tr>
<tr>
<td></td>
<td>Share plan with the Regional Health Bureaus (or ZHD)</td>
</tr>
</tbody>
</table>

5.1.1.2. **Evidence-Based Planning and Budgeting Under WBHSP**

During the woreda five-day planning meeting, health-related data and resource mapping information are collected and used. To guide the use and analysis of this data, the World Bank, UNICEF, and the Ethiopian Ministry of Health collaborated to develop the Evidence-Based
Planning and Budgeting (EBPB) tool. This Excel-based tool drives an analytical planning, costing and budgeting process to help district health planners plan and forecast the potential cost and scaling-up of investments. This process refers to Steps 3-12 in Figure 5.1 previously presented. The EBPB tool acts as a critical guide in directing district health planners through the various steps required to profile district capacity and need. The tool is largely guided by the HSDP service areas, which are formatted and outlined as categories within the tool. Table 5-2 details the core priorities documented in the EBPB tool to guide district health planners. As will be discussed in Section 5.2, all district health planners interviewed in this study highlighted varying degrees of technical competency with the EBPB tool. Given the central role of the tool in the implementation of WBHSP, I reflect briefly on its structure and function to appreciate these technical constraints that were experienced by planners.

Table 5.2. HSDP Core Priorities Documented in the EBPB tool

| (1) Strengthening implementation capacity; |
| (2) Expansion of primary health care coverage |
| a) Health Extension program |
| b) Strengthening and expansion of health center services |
| (3) Strengthening hospital services |
| (4) Promoting maternal and adolescent health services |
| (5) Promoting child health services |
| (6) Promotion of nutrition |
| (7) Strengthening hygiene and environmental health service |
| (8) Prevention and control of major communicable diseases |
| a) Malaria prevention and control |
| b) TB prevention and control |
| c) HIV/AIDS prevention and control |
| d) Prevention and control of other communicable diseases |
| (9) Prevention and control of non-communicable diseases |
| (10) Strengthening monitoring and evaluation and operational research |

I. **EBPB Tool: Design and Structure**

A defining characteristic of the EBPB tool is the embedded Marginal Budgeting for Bottlenecks (MBB) analysis that is contextually adapted to ensure that target areas within the
HSDP are accounted for at the district level. Through this analysis, decision makers are able to assess the allocative and input efficiency of various health resource utilization scenarios and are provided with a menu of evidence-based high impact interventions to guide prioritization.

Conceptually, the MBB analysis focuses district health planners on five key questions to identify where best to invest programmatic effort to strengthen the health system. These questions include:

(i) What high impact interventions can be integrated into existing providers/service delivery arrangements to accelerate progress towards the Millennium Development Goals (MDGs)?

(ii) What are the major hurdles or “bottlenecks” hampering the delivery of health services, and what is the potential for their improvement?

(iii) What could be achieved in terms of health outcomes by removing the bottlenecks?

(iv) What additional financial resources are needed for the expected results?

(v) What amount of financing could be mobilized and how should additional funding be allocated?

In addition to these questions, the analysis includes a component to understand the country’s health system structure, organization, and human resource requirements. It is believed that such an analysis provides a deeper understanding of the system’s constraints (“bottlenecks”) and helps decision makers effectively strategize improvements to health outcomes. To guide planning, the MBB analysis uses the HSDP guidelines and programmatic areas as a method to customize, and subsequently guide district health planning. Excerpted from the HSDP-IV, Table 5-3 highlights the core priorities of the MBB analysis. These core priorities are organized by service delivery mode and service sub-packages.

In reference to the 14-step process of WBHSP, steps 4-12 focus on conducting the MBB analysis (Step 3 simply involves opening the EBPB tool and selecting the woreda for which the analysis will be associated). Within the MBB analysis, there are 27 Excel worksheets that are grouped into (i)-Input, (M)-Modeling, (O)-Output and (R)-Reference sheets. Steps 4-12, in particular, involve the completion of these worksheets (each colour-coded to its affiliated Step in Figure 5-3). Specifically, the (ii)-Input worksheets (Steps 4-9) involve the data required to estimate impact in terms of mortality reduction and the additional cost of removing health system constraints; (M)-Modelling worksheets (Step10) calculate the impact and cost of increased
coverage of the service packages for four MDG$^{57}$ areas (MDG1, MDG4, MDG5, and MDG6); (O)-Output worksheets (Step 11) displays the impact and costs generated; and (R)-Reference worksheets (Step 12) provide a summary of the evidence and country data used to assess impact.

**Table 5.3. Core Priorities Organized by Service Delivery Mode and Service Sub-Packages**
(excerpted from FMOH, 2010, p. 93).

<table>
<thead>
<tr>
<th>Family oriented community-based services</th>
<th>Family preventive/Water, Sanitation, and Hygiene (WASH) services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family neonatal care</td>
</tr>
<tr>
<td></td>
<td>Infant and child feeding</td>
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<tr>
<td></td>
<td>Community management of illnesses</td>
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<tr>
<td>Population oriented schedulable services</td>
<td>Preventive care for adolescent girls and women</td>
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<tr>
<td></td>
<td>Preventative pregnancy care</td>
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<tr>
<td></td>
<td>HIV/AIDS prevention and care</td>
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<tr>
<td></td>
<td>Preventative infant and child care.</td>
</tr>
<tr>
<td>Individual oriented clinical services</td>
<td>Clinical primary level skilled maternal and neonatal care</td>
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<tr>
<td></td>
<td>Clinical management of illness at primary level</td>
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<tr>
<td></td>
<td>Clinical first referral illness management</td>
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</tbody>
</table>

**5.1.1.3. Balanced Scorecard Approach under WBHSP**

Finally, the balanced score card approach (BSC) under WBHSP is valued by the government as a strategic management strategy to link the government’s aims and programmatic goals with overall performance. This approach, first conceptualized by Kaplan and Norton (1992), ensures that the government remains reflective on what services and benefits are needed to preserve the health of their citizens, while accounting for a system that is accordingly able to manage public and donor resources accordingly. As described in the WBHSP Training Manual (EFMOHb, 2007, p. 11), the BSC is developed from four perspectives: (i) the customer; (ii)

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$^{57}$ MDG 1: Eradicate extreme poverty and hunger; MDG 4: Reduce child mortality; MDG 5: Improve maternal health; and MDG 6: Combat HIV/AIDS, malaria and other diseases.
Figure 5.3. Modified Fourteen-Step District Health Planning Process (modified from EFMOHb, 2007).
financial stewardship; (iii) internal processes; and (iv) learning and growth. The WBHSP strategy now ensures that convening decision makers demonstrate a commitment to strategic planning that builds alignment of programmatic activities with a shared vision for improving community well-being. The BSC is selected as a measurement tool and is directly linked to the formulation of the Annual Plan at all levels (EFMOHb, 2007, p. 11).

Throughout Section 5.1.1, the principles and procedures guiding the vision of WBHSP planning strategy have been described. Through this discussion, it has been evident that with the implementation of the WBHSP strategy, the government has placed a strong emphasis on standardizing and synchronizing district-level procedures throughout the country, while simultaneously placing a greater emphasis on evidence-based planning to guide both planning and priority setting processes. The following section seeks to augment this description with an analysis of how district health planning unfolded in practice. Specifically, it will highlight how the guiding principles of WBHSP have influenced processes and procedures in practice through the views of district health planners and other relevant stakeholders in the health system.

5.1.2. Woreda-Based Health Sector Planning as it Unfolded

Based on participant observation and qualitative in-depth interviews, it appeared that the district health planning process aligned quite closely in practice with the overall vision and principles set out by the government. The seven principles previously described—One Plan, One Budget, One Report, Resource Constraint, Results-Oriented, Evidenced-Based Planning, and Flexibility principles—were all operationalized to varying degrees. Rooted in the government’s harmonization agenda, the adoption of the one plan, one budget, and one-report principles set in motion a systematic approach to align national health policy goals with district level planning while minimizing duplication of planning efforts across each level of government. This approach was primarily observed through the adoption of the EBPB tool, which aligned planning in a targeted fashion by laying out a set of health indicators in-line with the HSDP. Through this tool, district planners set their district plans in a manner that advances the national agenda to reach and measure the attainment of the MDGs, while also planning in accordance with their district need
To gather insights into the planning process, quotes and reflections are drawn from qualitative interviews, wherein key questions were posed and answered. These included inquiries such as, “how do you set priorities for the woreda annual plan for health services?” As well, through the subsequent probe, participants were asked to “describe the entire planning process.” In addition, they were asked, “What are some of the challenges and strengths you experienced during the health planning process for the annual plan?” “What impact has the evidence-based planning and budgeting tool had on your planning process?” And, “who leads the planning of the woreda annual plan and what is their role?”

Throughout the following chapters, the classification of “participant” refers to any individual who participated as an interviewee in this study. Participants included different members from government (i.e., FMoH, RHB, ZHD, WorHO, WoFED and WAC), and NGO partners. The discussion henceforth provides a general overview of participant views regarding this process, which support the emergent themes subsequently described. The quotations selected are the most illustrative of points shared by many participants. In addition, to preserve anonymity, all participants will be referred to as “member” and will be categorized according to their organizational affiliation. Since participants in the study either held a technical or programmatic role with respect to planning, classifying them as “member” does not limit our understanding of their role within the planning process. What is of particular importance is the level of government to which they are affiliated. To further preserve participant anonymity, no mention of their district affiliation is acknowledged.

5.1.2.1. WBHSP Planning Processes in Practice

When asked to describe the district health planning process, participants emphasized that since the adoption of WBHSP, “health decision-making has become a much more structured process that aligns with democratic, evidence-based, and seemingly more accountable processes” (Member, RHB). During participant observation, this belief was also evident in my discussions with regional and district stakeholders who felt WBHSP was a strategic policy initiative with the
impact for long-term sustainable change. In practice, the top-down/bottom-up approach appeared to function as the government had intended. During participant interviews, health planners detailed similar planning processes in designing the comprehensive Annual Plan that emphasized the federal government’s primary role in guiding the identification of health priorities through the HSDP and EBPB tool. As previously described, the EBPB tool operationalizes the top-down/bottom-up approach by guiding district health planners to incorporate and align their district health needs within the structure of the government’s health priorities. One member from the WoFED described this integrative process and the effectiveness of the EBPB tool to effectively capture district priorities:

Policy and direction from our country’s health priorities is used as a guide in the tool for the development of the annual plan. Now, through district based planning, we are using these as a target to guide our planning. Previously, we were being dictated by the upper levels to allocate where it was thought funds were needed. Now, we know through the EBPB tool that we are planning according to the needs of the communities because if one section of the tool shows more need, we divert attention to that area. (Member, WoFED)

When detailing the health planning process itself, many participants spoke to the importance of establishing a district baseline assessment prior to the setting of health priorities. This assessment was described as important in capturing a thorough understanding of the previous year’s accomplishments and to identify the existing capacity and resources of the district. During participant observation, this precursory step included a Strengths, Weaknesses, Opportunities, and Threats (S.W.O.T) analysis (referring to a process that identifies strengths, weaknesses, opportunities, and threats in the development and implementation of the plan) and a Stakeholder Analysis (to map out stakeholders working in the district and assess the scope of their capacity). To achieve these analyses, questions included: (i) what was achieved in the previous fiscal year; (ii) where gaps existed in service provision; (iii) which stakeholders could assist in meeting prioritized health goals; and (iv) where opportunities could be leveraged to realize these goals. Succinctly describing this process and conveying a solid understanding of these procedures, one member of the district health office stated:

First, we review the previous year performance to use it as a base for the plan to be done. Individuals involved in the performance review are health extension workers, woreda
health office workers and representatives of the woreda. If there are activities performed in a good way, we will take it as a positive, and if not, we will try to explore the reason why the activities were not performed as planned and intended. At the same time, we could try to gather information that will be used for planning while conducting [the] S.W.O.T analysis [that] will be used as an input for the planning. We will conduct community conversations\(^{58}\) in different kebeles or use [other] opportunities like shengo\(^{59}\) meetings for the sake of identifying real problems of the community. We always communicate with the community through three ways—health extension workers, community conversations and through shengo meetings. At the shengo meetings, we try to identify those activities that were supposed to be done, but were not. Then the planning team of the woreda health office will discuss on the identified issues. We will then try to see the magnitude, feasibility and resource availability for prioritization of the other identified activities/problems. When the planning process is finished, health extension workers and others will come together and discuss on the issues again. They comment critically and revision might be done accordingly. Each health centre will then be informed to plan their yearly activities and the woreda health office will compile all and approve. At the end, one general and complete plan will be prepared and given to health centres and health posts. (Member, WorHO)

Further expanding on this description, a member from the RHB detailed the five-day planning meeting by highlighting various core phases of the planning process. They explained:

At the beginning, a training of trainers was conducted, and then, responsible individuals were informed to get prepared early and to come to the meeting with necessary documents. Training about the planning process and preparing the planning document itself, are among the major activities performed at the meeting. If there is [missing] data about [health information pertaining to] the woreda, data of the zone and/or the region was taken on behalf of the woreda’s data. Indicators were set after background information, and baseline data were entered. A strength, weakness, opportunity and threat analysis of the Woreda was conducted taking the context of the woreda into consideration beside to that of stakeholder analysis. Then activities selected by the Federal Ministry of Health as focus areas, were given to the participants in the EPBP tool to be used as an indicator. Then, major interventions were selected. Root causes of the problem, with their probable solutions were identified as well. Then, finally we tried to validate and classify the summary into quarters. (Member, RHB)

Building on this description, another member from the WorHO spoke of the criteria used for decision-making and emphasized the importance of establishing a baseline:

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\(^{58}\) “Community Conversations” represents a popular public health strategy in Ethiopia to engage with the community to generate conversations on salient health concerns.

\(^{59}\) Shengo is a group of people elected or appointed for a specific task by the community for a specific task such as an advisory or legislative body. The composition of each shengo may vary across districts, but it is typically non-discriminatory to gender or religion, as long as its members are loyal to the ruling party.
Previously, direction for planning was sent from higher officials by indicating details where the woreda should focus. This process was creating a problem, as it does not consider local conditions. But this time, planning is made based on the interest of the woreda and this gives us an opportunity to observe locally available problems. Generally we try to see the following before we plan: first, human resource availability and requirements; second, baseline information in the district that includes population number, infrastructure and disease trends; third, relevant documents, previous plans and achievements; fourth, health gaps or problems in the woreda; fifth, potential of stakeholders and the possibility of support to the health services, especially from nongovernmental organizations. Also we must consider the financial capacity and the importance of the issue to the community. And last, it should be important to progressing the millennium development goals. We collect this baseline information and discuss where gaps prevented performance in the previous year. Having all the required information, we then go to the meeting and start to plan for the woreda needs. (Member, WorHO)

With respect to the BSC approach, no participants made reference to this process during any of the interview discussions nor during participant observation. This observation could be indicative of either a minimal understanding across participants, or a less apparent role of the BSC approach during the WBHSP process, suggesting a need for further research.

5.1.2.2. Roles, Responsibilities and Autonomy

The introduction of the WBSHP strategy has provided district health planners with a more structured and systematized mode for setting priorities for their Annual Plan. During the district health planning process, the WorHO is considered the key district government unit within each region that has significant responsibility for planning and implementing basic health services. Related to planning and delivery, the RHBs also have the power and duty to contribute to the preparation of the health care plan. With respect to the ZHDs, in most regions, they are arms of the regional governments with no administrative or decision-making authority for health services. During the planning meeting, members from the ZHD had a collaborative role with the RHB to coordinate the schedules for woredas to participate in the meeting, as well as to provide technical guidance during the planning meeting. As previously outlined in Table 5.1, the key responsibilities of each major stakeholder did, for the most part, align with responsibilities operationalized in practice. During the 2010 and 2011 planning cycles, many participants acknowledged the WorHO as the primary leader in guiding annual plan development. One member at the WorHO stated that although plan consolidation is derived largely from the inputs
of all stakeholders, the WorHO plays a primary role in leading the identification of district priorities:

The plan is really consolidated by the inputs of many members from all government and non-government levels. But, in fact, it is the woreda health office that has the primary role to identify the district problems and indicate its future directions and finally presents the plan to the woreda council. (Member, WorHO)

Although many participants believed that the WorHO was leading Annual Plan development, consensus on this issue appeared blurred by many other participants who stressed a stronger leadership role at higher levels of government (namely the ZHDs, RHBs and FMOH). One member from the WorHO conveyed that, although each level of government has a large role in the development of the plan, he viewed both the FMOH and ZHD as taking the leadership role in guiding annual plan development. He explained:

Although district health planning is interconnected across all levels of government, the federal and zonal level are really taking a leadership role in organizing what we plan and how we plan. The federal ministry lead the development of the EBPB tool, which dictates to us where to allocate funds accordingly. Similarly, the zonal health department teaches us how to use the tool and has assisted in the coordination of invitation letters for the NGO partners. During the meeting, they supported us on how to use the tool, explained the indicators, and explained about the focus areas of the HSDP-IV and MDGs. They also show how the targets are set and how the program software is use. (Member, WorHO)

It was further conveyed by some district-level participants that without each of these aforementioned bodies, district health planners would lack the capacity to undertake WBHSP. While the central government has therefore intended to strengthen district ownership through the implementation of WBHSP, participant accounts acknowledged that the need for ongoing federal leadership in the WBHSP process did perpetuate a level of dependency of the woreda level on the central government for ongoing guidance and capacity.

In summary, this section describes three key findings: (i) that Ethiopian participants have a fairly clear understanding of the planning procedures to be undertaken through the implementation of WBHSP; (ii) that the underlying principles of WBHSP are, for the most part, being operationalized in practice; and (iii) that participants lack explicit clarity on who ultimately leads the planning process; thus, posing implications on the scope of practice of each member
and overall accountability within the decision-making process. Building upon this empirical overview, the following sections explore emergent themes that arose from participant accounts, which further illustrate and describe the key findings identified within this section.

5.2. Emergent Themes from Key Informant Interviews

During qualitative interviews a variety of themes emerged that spoke to the contextual factors influencing successful WBHSP implementation as well as emerging benefits of WBHSP since its implementation. In describing these common themes, I gauge the collective thinking participants shared regarding the WBHSP strategy. Although the themes may not speak to all issues prevalent across each of the 770 districts in Ethiopia, thematic saturation was reached and did reveal a series of dominant themes among the three selected districts. There is a possibility that different themes may have emerged had some of the districts included in the study been more remote and disparate in health needs, geography, or infrastructure. However, given the government’s effort to strengthen the capacity of health workers in its most rural and remote woredas, it is suspected that such constraints affecting health planners may have also been lessened (FMOH, 2010, 7).

5.2.1. Contextual Factors Influencing WBHSP

At the time of this study, through the experience of three districts, a variety of contextual factors emerged that influenced how WBHSP transpired. A number of these contextual factors highlighted a considerable number of capacity and resource constraints impeding the flow and process of planning. The opening prologue offers preliminary insights into some of the immediate and lingering limitations confronting stakeholders. The following themes have been categorized into three contextual classifications: (i) Organizational (i.e., themes related to the level of managerial and leadership capacity, the technical capacity to manage the tool, and

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60The government’s:
HSDP planned to cover all rural kebeles with the HEP [Health Extension Programme] to achieve universal PHC [primary health care] coverage by 2008 through vigorous implementation of the HEP […] Until the end of the fourth year of HSDP-III a total of 31, 831 HEWs [health extension workers] were trained and deployed which is above the target set (103%) and a cumulative total of 4,061,532 model households were trained and graduated. […] There was encouraging achievement with regard to construction of health posts meeting 83.1% of the overall HSDP III target at the end of the fourth year. (FMOH, 2010, p. 7)
insufficient time allocated to complete the plan); (ii) *Infrastructural* (i.e., themes related to the presence of required material resources, the presence of timely and complete data, and the presence of an adequate budget); and (iii) *Socio-Cultural* (i.e., themes related to the decision-making climate supportive of multi-stakeholder engagement and inclusivity).

5.2.1.1. *Organizational Context*

Extending from participant interviews, the organizational context related to district based planning emerged as a dominant theme. Three sub-themes emerged in support of this dominant theme that included: (I) limitations to managerial capacity, organizational empowerment, and leadership; (II) limitations to technical capacity to manage the tool; and (III) insufficient time allocated to complete the plan. The following sections detail these sub-themes in greater depth.

I. **Limitations to Managerial Capacity, Organizational Empowerment, and Leadership**

Capacity limitations at the organizational level emerged as a dominant theme impeding effective implementation of WBHSP. The majority of participants spoke of a limited capacity to lead, manage, and undertake the technical aspects associated with the health planning process. This limitation was further stressed at the district-level, where district participants also emphasized a lack of empowerment to lead and manage planning. Many district health planners stressed that while WBHSP was implemented to enhance district capacity for planning, they were still at the whim of the upper government levels for guidance and capacity building to operate the tool and develop their overall plan. One district health office member succinctly described this view as follows:

> […] woreda-based planning has improved a lot, there is no doubt. But we are still dependent on the instructions of higher authorities. Also, we see that the participatory nature has improved and that evidence-based planning is becoming strengthened. But, I find we still, most of the time, expect people from the zones and regions to make woreda-based plan. There is a lingering dependency syndrome, which has remained because adequate trainings or capacity building was not given its due attention at the lower level. (Member, WorHO)
Another member at the WorHO described the vague understanding of leadership identity across health planners at the district level as another underlying limitation of district level management capacity.

The government has made many improvements to build district health planning, but we still feel like they control what is planned for and how we plan, because we are dependent on them for trainings and materials. It is a good question, “who leads the plan?” Maybe we [federal, regional, and districts] all do, but the district definitely does not stand alone as a leader. We [at the district level] do not have strong capacity maybe because all levels lack capacity and so, the government does not know where to channel their efforts. (Member, WorHO)

This concern was further echoed by another member at the district health office who stressed the difficulty in planning as a result of a limited understanding of who leads the planning process (especially since district health planners still feel they are at the whim of upper government in terms of what issues get prioritized). Lines of accountability therefore remain unclear and cause frustration. One district health office member articulated such sentiments by stating:

It is difficult to plan without adequate exposure to management techniques to lead the team. The problem is mostly because we are not familiarized with who is truly leading woreda planning. The districts are to now take the lead, but we are still at the whim of the higher levels, which affects so many aspects of the district planning process from conducting the planning to the evaluation and accountability of how the planning unfolds and what is planned. (Member, WorHO)

To improve the planning process, they suggested, “[i]f district planners were familiarized with what is expected of them and on management styles to improve planning coordination and leadership, then I think the process would run more smoothly” (Member, WorHO). In support of this view, another WorHO member argued that one of the first steps in strengthening leadership is to ensure that planners have a clearer understanding of the scope of planner roles at each level.

How I see it is that leaders are responsible to inform when and where to conduct the meeting with respect to the process of planning. Leaders also guide the whole process from start to dissemination of the final plan to all concerned bodies. In order to strengthen leadership, there should be a clear guideline that could help woreda health office manager to understand their role within this planning process. What is their
responsibility and to give them continuous orientation with leaders at other levels of government (Member, WorHO).

Many other participants, at both the district and regional level, went on to further emphasize that ongoing training for planners at all levels is critical to strengthening leadership and management during the planning process. One member of the RHB maintained that in order to enhance managerial capacity of health planners, “leadership capacity to manage the planning process requires ongoing training for government members at all levels. This capacity requires access to educational workshops that focus on project management skills and must have a strict focus at the district level where planners must be capacitated” (Member, RHB). Another WorHO representative contended that some of these challenges can also “be solved by recruiting employees with expertise on planning, such as those educated on management at the degree level” (Member, WorHO).

Beyond insufficient training, study participants described a variety of other reasons to explain limits to managerial capacity. As a result of high staff turnover rates, for instance, many participants also identified poor institutional memory as a result of minimal documentation at the district level as another underlying cause of poor management capacity. One district health office member described the limited documentation at the district level as a pervasive issue.

A major problem we face is an unavailability of literatures, even the previous plans. When a leader resigns from his or her position, it is rare to get all the necessary documents. As a result, important information will be missed during planning due to the absence of the previous document. (Member, WorHO)

Another district health office member further described the lack of standardized documentation as a significant factor limiting their capacity to plan.

Sometimes the problem is that we lack an awareness of previous planning because we do not have the documentation system in place in the office that allows us to see where the direction of planning is going. […] People leave to take new jobs and do not leave their experiences behind, which impacts us who are coming in and need to be trained and do not know where to begin. It causes unnecessary delays. (Member, WorHO)

To address these limitations, many offered solutions that focused on enhancing the training of planners to improve the documentation system at each level of government. One member from the WorHO offered a solution that focused on retaining original copies of essential
documents within the office so that they are on-hand in the future when the necessity to review them arises.

Documentation problems should be solved by making simple actions. For instance, the documentation office will prepare the document and stamp it and they can then give a copy to the leader. At this time, the original document will be kept in the documentation office. Anyone in need will simply have access. There is a need to strengthen archival systems (Member, WorHO).

Another member from the RHB also noted the importance of strengthening district planner capacity to improve documentation.

From what is viewed during the training meeting, we see that the district level members struggle with limited data management. They are missing data or feel ill informed of what the requirements are needed for the tool. This issue is a managerial one and one of capacity. They need the capacity to manage data documentation. Without on-going training, and manpower, it remains difficult. (Member, RHB)

Enhancing management capacity was largely conceptualized here as a mechanism necessary to improve deficiencies in other areas, such as lack of knowledge around the EBPB tool and capacity to use collected data effectively. “Developing management capacity building for [these areas] and all other health activities is necessary,” argued one member from the district health office. This view included enhancing the capacity of district planners to become more familiarized with the intricacies of the EBPB tool and on how to correctly incorporate data.

Participants also felt that leadership and management could be strengthened through additional guidelines that incorporate management principles to guide planning. One WorHO member stressed, in particular, that:

What we really need is better training on project management, effective communication between all levels of government and how to monitor and track results. Such types of training would increase our capacity to lead and manage this process in a more timely and efficient way. (Member, WorHO)

Another member at the federal level also suggested that, “[i]mproving the academic status of leaders through further education should also be done [as a way to facilitate] leadership and project management skills” (Member, FMOH). It was therefore apparent that the majority of participants believed that a variety of managerial and leadership skills were required to enhance capacity for health planning among district health planners. Many participants also drew attention
to a lack of clarity regarding who leads the planning process, thus bearing implications on who is both responsible and accountable for certain tasks.

II. Limitations to Technical Capacity to Manage the Tool

Participants also spoke extensively of the limited guidance they felt they had on the structure and function of the EBPB tool, and the negative impact that poor technical capacity was fostering among health planners. Many district-level health planners conveyed that they had poor capacity required to complete and manipulate the tool. One WorHO member described the minimal capacity of and training provided for district health planners when navigating the technical aspects of the tool.

The tool has no major problem, unless it is infected by a virus. The problem is with the people manipulating it. Therefore, it is not a problem of the tool, but a problem with us not being experienced to use it properly. We have a lack of awareness and solid understanding of how to manipulate it. The requirement for skilled human resources can be considered a problem of EBPB. (Member, WorHO)

This lack of familiarity with the tool was furthered echoed by another member from the district health office, who maintained: “People [district health planners] were not familiar with EBPB tool before planning, so [they] were facing difficulty to understand it” (Member, WorHO). Similarly, another district program officer framed their lack of capacity as not being familiarized adequately with the tool. They stated: “The EBPB and the people [district health planners] do not know each other. We were struggling to understand the concept of the EBPB” (Member, WorHO).

One member from the ZHD described this lack of understanding of the tool as a by-product of overburdened trainers who are outnumbered by the district health planners in need of guidance. They stated: “The number of mentors [facilitators] per woreda, with existing conditions was not balanced. There might be quality compromising as a result of over-burdening. One mentor for five woredas is very difficult” (Member, ZHD). In order to enhance capacity and understanding, participants contended that on-going training is required to familiarize district health planners on the technical requirements of the tool. This suggestion was noted by one member from the district health office who argued:
We require improved training on the marginal budgeting for bottlenecks tool prior to the planning period. When we presently meet for the planning meeting, we launch right into planning without thorough time allocated to understand the in-depth nature of the tool. Also, we need to provide training on the MBB tool prior to the planning period and training of planning experts on basic computer skills. (Member, WorHO)

Although the majority of participants recognized the pressing need for greater training among district health planners, participants also acknowledged how overburdened facilitators are during the district health-planning meeting. Some participants stressed that the central government capacitate districts to liaise and assist each other in an effort to enhance decentralized decision-making. One WorHO representative succinctly supported this view by stating:

It might be useful for the government to invest in a few selected woreda staff to encourage capacity with the tool. This way, they become the focal persons and it is not draining on the federal government. We [district planners] can interact with each other and learn from each other. (Member, WorHO)

It was clear through this statement that greater mechanisms to support communication across districts would be required and, would perhaps, be strengthened through such horizontal investment.

III. **Insufficient Time Allocated to Complete the Plan**

Many participants also emphasized concerns around an insufficient amount of time allocated to undertake complex decision-making to finalize the plan. Consensus across all regional, zonal, and district planners was that the current allocated time of five days for the planning meeting was insufficient to train district health planners, complete the EBPB tool, and finalize the report. One member from the WorHO spoke to these concerns and described scenarios where planning after hours was also insufficient to complete all the required materials:

They try to fit a lot of material into the five-day meeting—baseline analysis, stakeholder analysis, trainings on the evidence tool and then using the evidence tool to generate the plan. It is too difficult to finish all required tasks during this time. Even we come together to work after hours in the evenings to finish what was not completed and this still is not enough. (Member, WorHO)

Another member of the district health office stated that as a result of the rushed nature of the planning meeting, district planners felt as if they were unable to absorb information and the
process it to the fullest extent: “The training was for a short period and we were unable to fully grasp and capture points from the training and ask questions. It felt very rushed” (Member, WorHO).

To overcome these challenges, participants stressed that it was necessary that the government extend the length of the planning sessions. One district health office member stressed that, “[t]here is a shortage of time and the existence of too many activities to be performed that we are not capable to complete the planning process on time. The planning meeting needs to be extended by a few days” (Member, WorHO). A member at the federal level highlighted that while an extension may be possible, there is an overall restructuring of schedules that would be required to accommodate both round one and two of the planning meeting.

It would be appropriate to extend the planning meeting by two days, but currently, trainers need those two days to prepare for the following round of districts needing to plan. There needs to be a restructuring maybe to accommodate this time constraint. (Member, FMoH)

Therefore, although an opportunity to extend the meeting may be possible, greater discussion around the appropriate time needed and feasibility of this change is required among participants.

5.2.1.2. Infrastructural Context

Extending from participant interviews, the infrastructural context related to district based planning also emerged as a dominant theme. Three sub-themes emerged in support of this dominant theme that included: (I) presence of tangible resources; (II) limitations to the presence of timely and complete data; and (III) planning under fiscal uncertainty. The following sections detail these sub-themes in greater depth.

I. Presence of Tangible Resources

Another dominant contextual theme that emerged addressed the presence of constraints related to tangible resources. One member from the RHB highlighted limited capacity as an issue of resource scarcity. They stated:

What is amazing is that at the root of all these capacity issues is lack of resources and infrastructure. If the districts had adequate facilities to manage data on computers that were
functional and not affected by constant viruses and power outages; if they had more assistance of personnel and even hard materials, like booklets, then capacity limitations may not be such a limiting agent in the mixture. (Member, RHB)

Another member at the district health office spoke to the limitations arising from working in an environment that does not have consistent electricity: “Using the EBPB tool has been a huge step forward, but it is difficult to get to know it well when sometimes we are confronted with power outages” (Member, WorHO). This sentiment was echoed by another member of the WorHO stressed, who highlighted similar issues related to sporadic power outages when consolidating data at the district health office. “On some days, we have no electricity, which limits our ability to import and analyze data and leads to delays and impacts our overall performance” (Program Officer, WorHO).

In addition to problems with electricity, participants also emphasized a lack of material resources (such as laptops and other materials), which they emphasized limited their performance. One member of the WorHO not only focused on computer-related limitations, but also on the lack of training materials needed for capacity building for WBHSP. They argued:

The lack of laptops and anti-virus software poses a large problem for us. Even we only received two copies of the woreda-based planning training manual for the woreda health office. [...] It is difficult to feel capacitated when we are working in such an environment of material scarcity. (Member, WorHO)

Through this discussion of limited resources emerged a wider discussion of its impacts on coordination efforts. One recurring issue focused on delays in submitting letters of invitation to all associated counterparts in the planning process. Some participants highlighted this view as an issue of limited resources that would hinder such invitations from being sent out in a timely fashion; thus hindering stakeholder inclusivity. Although the exact underlying cause of this delay remained less clear, one ZHD member described it as an issue of finance and material scarcity. “There are delays in handing out the letters of invitation for some participants like NGO partners. We get busy and scarcity of funding is an issue “ (Member, ZHD).
II. **Presence of Timely and Complete Data**

In addition to the above resource constraints, further limitations with respect to the presence of complete data required for planning also emerged as a dominant theme among participants at all levels (but with an emphasis among participants at the district-level). The issue of incomplete data was first witnessed during participant observation, where district health planners’ encountered scenarios where they either lacked the data required for the tool (and had to use regional/national estimates) or, alternatively, had too much data inapplicable to the tool. This observation was reinforced by many participants, and succinctly described by one member of the WorHO:

> One of largest challenges is not having data available to guide our planning process. In our woreda, we find it difficult to get quality data for some indicators in the tool. This is largely the result of poor recording and documentation in the health posts. Health extension workers are newly recruited and have no adequate experiences. (Member, WorHO)

The lack of data quality required to undertake planning effectively was also a dominant issue that surfaced among many participants. “Quality,” in this sense, was conveyed by participants as comprised of data that was complete, reliable, and aligned with the requirements of the tool. One WorHO member emphasized weak data recording mechanisms at the district level as a source of the problem:

> Data quality and even sometimes its availability is challenging at the kebele level. If there are data, they are incomplete, full of mistakes and difficult to use for decisions. At the woreda level, there is also poor recording. To improve data quality at the kebele level, capacity building activities are crucial. (Member, WorHO)

Another WorHO representative further described misalignment issues regarding data collection and tool formatting. They highlighted:

> The reporting and planning format is not the same. Health extension workers are collecting the data, but once it reaches the level of the woreda health office, we find it difficult to synthesize the data need for the evidence-based tool. There is too much data and missing information that affects the quality of our planning” (Member, WorHO).

As a result of inadequate or too much inapplicable information captured at the district level, one NGO member highlighted the disrupted flow to the meeting that would result.
During the planning meeting, the contributions of participants were compromised. Some of them were coming back to their office [WorHO] to take data and information. Everyone should have his or her own data information at hand before going to the planning meeting. Everyone should be informed prior [to the planning session], for sake of having more time for early preparation. […] The problem is that we are overwhelmed with too much data and, thus, are unaware sometimes of the necessary data we need for the tool. (NGO partner)

To minimize data gaps while completing the tool, many participants identified scenarios where data from other regional and national estimates were used. One NGO partner stressed, however, that this action was an unacceptable default, as it may misrepresent or underestimate the specific needs of a district. They stated that: “The absence of adequate and available secondary data remains a persistent challenge at the district level that weakens planning. Using old data or alternative district or regional estimates is not the solution. This lack of data affects the quality of health service planning” (NGO partner). To address these concerns, participants described strategies that included refresher trainings for health extension workers and better information management systems that align data from the districts with that needed by the EBPB tool. One member of the WorHO emphasized the importance of enhancing training to capacitate health extension workers to capture quality data to maximize their efforts during the planning meeting:

To improve the availability of data at the kebele level, refresher trainings are required for health extension workers on recording and reporting in a way that is useful to the woreda health office. They also need continuous follow-up, supportive supervision, and on-site trainings would be helpful too. (Member, WorHO)

Another member from the WorHO underscored these data challenges as an issue of overburdened health extension workers not adequately trained to collect robust data and argued for increases to staffing:

Quality of data is a huge impediment and not a surprise because of the lack of capacity to collect data is limited. To address this issue, we need more manpower at the local level. Health extension workers need better and more consistent training. Slowly, we are improving HMIS [health management information systems]. (Member, WorHO)

To also strengthen data collection and management, one WorHO member further emphasized the need for district health planners trained specifically to deal with data issues at the district level.
To ensure complete or better quality of health data, data technicians should be recruited to all health centres and specific technicians should be trained on data management. Regular trainings should be given to build the capacity of employees on how to monitor the completeness of the reports from health facilities and on how to prioritize community health care. (Member, WorHO)

Overall, while participants viewed issues with data collection and management as a health system issue, spanning all levels, many of their recommendations focused on strengthening district level mechanisms to enhance the quality of data from the bottom-up.

III. Planning under Financial Uncertainty

Further to challenges associated with data, planning under fiscal uncertainty emerged as a dominant theme; although not in direct reference to undertaking planning itself, but in reference to the operationalizing their projected plan. Once the excel-based EPBP tool is completed, the tool generates a budget that would be required to meet the requirements of the plan. The majority of district level participants expressed a frustration in using the EPPB tool to forecast a projected amount of funding to implement their plan, only to not receive it. A member at the district health office described it as planning in an environment of the unknown:

A major problem is that we are planning in an environment of unknown fiscal resources. The EBPB tool is supposed to assist with projecting how much we will need, which it does. But, it is still unrealistic, and unmet by the government. (Member, WorHO)

Voicing a similar concern about not knowing if they will receive the monies to undertake their plan, a member from the district finance office commented:

The main challenge created is after the plan is finalized during implementation. We plan for a needed budget, but we are unable to receive it according to our plan from the region. Most of the time the reason mentioned was a shortage of budget at the national level. (Member, WoFED)

As a result of such budget constraints, participants expressed the need to engage in a form of re-prioritization in order to accommodate the lesser budget received. One WorHO member described that typically, when the projected monies are not available, incoming funding is diverted to areas of greatest need and emergency:

Money is not enough all the time. Every year we face a shortage of budget. We plan for budgets according to activities to be performed, but we are not given it according to our plan. It is always replied that there is a budget shortage from the central government.
This is a major challenge to all sectors. For these reasons, we reduce activities by giving priority for life threatening and more urgent health matters, like epidemics in the health sectors. (Member, WorHO)

Some participants further described these challenges as impacting the morale of district health planners. As one member from the district health office succinctly noted:

Sometimes while we are planning, we do not expect to receive the monies that the tool is projecting. We know that in many ways the tool projects an amount that we will not receive. Therefore, we get discouraged while we plan, almost thinking what is the point to plan with this fancy tool, if the amount will not be available at the federal level? (Member, WorHO)

Further reinforcing the challenge of dealing with budget shortfalls, one member from the WorHO outlined the consequence of using a tool that overestimates an unrealistic or unattainable budget required to fulfill the projected plan. “If there are not enough funds to achieve the projected budget, then we have to reduce our targets, which affects the consistency of our planning” (Member, WorHO). This sentiment was further emphasized by another WorHO member who spoke to a lack of clarity of any monies outside of that intended from the government fiscal pool, such as funding from other private stakeholder groups. They maintained:

From my experience, the major challenges faced in the planning process are poor handling of records and reports. Even if there was a responsible person, there was a limited capacity of the workers in developing plans. Plans were mainly based on government budget because it was difficult to know beforehand the amount of money donors will allocate for community level interventions. Also there is difficulty in controlling funds from stakeholders because the harmonization with the government budget is not so strong. (Member, WorHO)

This limitation reveals a greater requirement for increased clarity around who will be providing funds to undertake the plan, what amount is earmarked for each district and, specifically, what amount is related to which health service lines.

5.2.1.3. Socio-Cultural Context

Emergent from participant interviews, the socio-cultural context of district health planning also surfaced as a dominant influential theme. In particular, two sub-themes emerged that highlighted the influence of socio-cultural context on WBHSP implementation. These sub-
themes included: (I) a milieu supportive of stakeholder inclusivity; and (II) a shared belief in WBHSP as a means to improve health planning. The following sections detail these sub-themes in greater depth.

I. **A Milieu Supportive of Stakeholder Inclusivity**

An additional dominant theme that emerged among participants revolved around the importance of multi-stakeholder engagement and the ability to ensure a planning milieu supportive of stakeholder inclusivity. This belief draws from the socio-cultural dimensions of the context that underlie the values guiding the new planning process. Participants, at all levels, appeared to value increased stakeholder inclusivity as a mechanism to enhance deliberation in the planning process. A member of the RHB aptly noted, “[p]lanning with sound evidence is only one aspect of effective planning. Bringing all stakeholders together strengthens the democratic process of planning, which is important for the authenticity of decisions and for ensuring that everyone agrees on the final plan” (Member, RHB). Another member from the WorHO further highlighted the importance of deliberation and ensuring that everyone’s interests are heard:

> There are different ideas raised when members come for the planning meeting. Everyone wants to reach decisions according to their own interest, but what we do is this: we respect each other by giving more time for deep discussions and let everybody support his own idea by concrete evidence. Based on evidence, decisions are reached by voting if different ideas still exist. Mass vote is respected. For example, this year we were split into two by idea on by what percent to increase PENTA 3 [vaccine] coverage. By bringing everyone together who is important to this process, such as technical experts, program officers and NGO staff, we can reconcile our conflicts. (Member, WorHO)

While stakeholder inclusivity was noted as an essential mechanism for deliberative dialogue, ensuring the presence of these key stakeholders in planning was described as a challenge. Various contextual factors emerged that participants argued negatively impacted the ability for stakeholders to convene. Absenteeism, for one, was noted by many participants at the district level as common occurrence due to alternative meeting conflicts that district health planners or NGO partners had to attend in lieu of the woreda-planning meeting. One member from the district health office expressed:
It is important that woreda planning brings all stakeholders together. But sometimes not all members attend and this impacts the overall planning process negatively, causing additional delays when they cannot attend or be reached. Everyone committed to woreda planning has to try to be present. (Member, WorHO)

This concern regarding absenteeism led into another important discussion around the role of NGO partners under the new harmonized district health planning process. Under WBHSP, NGO partners are increasingly expected to align their planning objectives, activities, and funding within that of the government’s planning structure. One member of the WorHO spoke of the importance of NGO inclusion in the planning process as facilitating in meeting these government objectives:

There are many NGOs participating throughout the country. These include: Plan Ethiopia, Save the Children, GOAL, OSSA [Organization for Social Support for AIDS], and Red Cross, to name a few. They align their plans to help us achieve our objectives at the national level. Especially this year, we involved OSSA and Save the Children for the current year of planning. They forward their own organizational plan to us in order for it to be included in the woreda’s plan. The involvement of NGOs in the planning process helps to identify the activities to be performed by them that will help us achieve our goals. (Member, NGO)

While participants emphasized NGO participation as an important component in meeting annual goals of the district, many district health planners cited inconsistency of NGO involvement as an ongoing concern. One member from the WorHO once again highlighted the issue of delayed invitations as an underlying limitation to participation. They stated: “[t]he government is trying to encourage their participation by sending the NGOs a formal invitation to be involved in the planning process. However, sometimes there are delays with inviting the NGO partners that limits their participation” (Member, WorHO). Such delays, however, were only one aspect of the issue described, as one NGO partner indicated that an underlying issue was also attributed to a lack of interest among NGO partners in wanting to participate, for fear that their organizational goals would be absorbed into the government agenda. This NGO member described:

Most of the time, NGOs do not want to participate during decision-making. They do not want to take risks with the public health sector because of their own programmatic accountability issues. Their absence leads to many negative impacts to participatory planning since it limits what is planned and how it [planned activities] will be achieved. (Member, NGO)
Further to issues associated with bringing stakeholders together, study participants also noted challenges in ensuring equal participation across all members in attendance. Findings from interviews illustrated concerns among participants related to differences in social power. One member of the WorHO stated that while every stakeholder was essential to the process, many lacked confidence given a limited awareness as to the scope of their role in the planning process:

Everybody had their own roles and responsibilities, although did not know what was expected of them to the full extent. Therefore, the magnitude of their contribution was not equal. For example the contribution of individuals from the health sector was vast. But even among them their contribution was different. Some felt like they were just sitting there and not as engaged. This was mostly common among the members from the administrative council. Also, non-government partners may feel left out during most of this process. It [the process] can be very technical and until we need them for a specific service area, they can feel distant to this process. (Member, WorHO)

Although participants valued multi-stakeholder engagement, there was an overall consensus among planners to increase efforts that support stakeholder inclusion and active participation. To cultivate a forum for heightened stakeholder engagement, one member from the district health office emphasized that invitation delays should be minimized and clearer descriptions provided on the scope of each member’s role when attending the planning meeting. This WorHO member recommended:

To encourage participation from all attending members, everyone needs to be present first of all. Invitation letters must be sent out early and partners and government planners must make it a priority to be here. Also, expectations from everyone need to be clear. I think many members do not know exactly what is expected from them. They come to the planning meeting knowing that they have to plan with everyone, but maybe do not know the full extent of how they will contribute. (Member, WorHO)

Another member from the RHB emphasized the positive role of what was described as a Partner’s Forum (whereby all NGO partners programmatically functioning in a particular region would convene in a precursory meeting to the planning session) to cultivate collegiality between governmental and non-governmental partners: “There is a partner’s forum every month in our bureau and this forum is a good opportunity to plan jointly […] and it reinforces every partner’s involvement in strengthening harmonized planning” (Member, RHB). It should be noted that at the time of this study, this forum did not appear to be standardized across all regions.
II. A Shared Belief in WBHSP as a Means to Improve Health Planning

Another dominant theme that emerged from participant interviews was an overall stakeholder buy-in and belief in WBHSP as a strategy to improve district health planning procedures. From the outset, participants at all levels of government recognized and spoke to the importance of strengthening district health planning through the adoption of WBHSP. Many participants viewed this strategy as an important step forward in “strengthening multi-stakeholder engagement,” “improving evidence-based planning,” and in “enhancing collective decision-making.” One member from the FMOH succinctly noted that the adoption of WBHSP:

[...] has increased the involvement of political decision makers and created a conducive environment for discussion with the administration and finance offices at all levels of the health system [...] This new planning process has also increased the participation and involvement of stakeholders and through the use of the EBPB tool, helped evidence based target setting, which avoids the traditional ways of more unfocused planning. (Member, FMOH)

Furthermore, each participant, irrespective of their level in the planning process, had a sound understanding and appreciation of the goals and mandates of WBHSP. Some participants alluded to a belief that WBHSP would facilitate “more strategic health planning.” One program officer working at the WorHO emphasized the strategic nature of WBHSP:

The annual plan decision-making process takes into account the national vision, strategy and targets, availability of enough financial budget, human resources, medical logistics to implement the plan; health facilities, including health centres and health posts; strengths and weaknesses on the previous year’s performance; needs, opinions and expectations of the community and other stakeholders. Also, the annual planning process uses baseline data and considers possible challenges that can result in executing the plan. (Member, WorHO)

Other participants also described WBHSP as an important step forward to improve transparency, with one member from the woreda administrative council stating:

[...] improving transparency in planning is foundational if we wish to strengthen open and honest planning. All stakeholders need to be involved and engaged, from the community to the high level officials. Through district based planning, transparency has improved because we are all planning openly and in accordance with the government’s agenda. We are not in a position to do as we please. (Member, Woreda Administrative Council)
Overall, participants held a shared belief regarding the importance of the WBHSP strategy in strengthening the capacity of district health planners at the district-level and in improving planning procedures nationally.

5.2.2. Outcomes Through Implementing WBHSP

In addition to the contextual themes identified as influencing the implementation of WBHSP, a variety of dominant themes also emerged that highlighted both positive and unintended negative outcomes associated with undertaking WBHSP.

5.2.2.1. Positive Outcomes Associated with WBHSP

The following section describes four main sub-themes focused on the positive outcomes. These included: (i) strengthening multistakeholder engagement and collective decision-making; (ii) improved harmonization and alignment of goals and programmatic activities; (iii) improved data usage through the EBPB tool; and (iv) reducing the subjectivity of planning.

I. Strengthened Multi-Stakeholder Engagement and Collective Decision-Making

As previously acknowledged, one of the major themes that emerged from participant interviews was the improvement and importance of multi-stakeholder engagement to district health planning. Through increased harmonization protocols, planning under the WBHSP strategy now required the engagement of multiple stakeholders in the development of the comprehensive annual plan. One member of the WorHO stressed the importance of multi-stakeholder input given that decisions, now through the One Plan Principle, were to include wider stakeholder engagement:

During the WBHSP meeting, all planners—district, zonal and regional—come together with [non-government] partners to discuss health needs of the woreda. This is critical to have all input because decisions affect all parties. By inviting all stakeholders to the meeting, we are enabling everyone to play their role effectively and contribute to the plan. After the prepared draft plan is compiled, all stakeholders will review it. (Member, WorHO)

Another key feature related to stakeholder inclusivity focused on the implementation of the five-day planning meeting as a mechanism for increased multi-stakeholder dialogue and participation.
One member at the level of the administrative council spoke to the increased collaborative nature of the planning process, including members from all levels of government and community:

There is a meeting every two weeks with stakeholders during the review phase of the annual plan. The highest decision maker is the woreda administrative council in all aspects, but all partners come together including the woreda health office, the woreda finance office, and NGO partners when necessary. The approved plan is then sent down to the health post level and communicated with the community for its implementation, to the regional health bureau and all other concerned bodies. (Member, Woreda Administrative Council)

Based on study participant accounts, stakeholders in attendance largely comprised government members and NGO partners. Another member of the district health office highlighted the dynamic and engaging nature of discussions as a result of varied stakeholder perspectives through increased multi-stakeholder engagement of WHBSP. They stated:

The contribution of everyone in attendance was good. All members participated equally and were raising issues important for everyone. For example, the individual from finance office was helping the group in budget code arrangement and in the identification of regular and capital budget items. The person from the woreda council was telling where the major problems of the woreda lie and where attention should be given and would discuss with NGO partners and the budget person on how much money should be allocated for the respective problems. (Member, WorHO)

It therefore appeared that with the onset of WBHSP, and specifically, the five-day planning meeting, greater stakeholder engagement and collective dialogue was encouraged and supported.

II. Improved Harmonization and Alignment of Goals and Programmatic Activities

Although empirical documentation for district health planning prior to WBHSP is limited, participants interviewed did give an overall impression that both the WBHSP strategy and its associated EBPB tool have significantly increased programmatic coordination across all levels of government. As described in section 5.1, the WBHSP strategy had many intentions to improve harmonization across all levels of government and, as a result, reduce duplication of health planning administration. Another emergent positive outcome from WBHSP implementation

61 It should be noted here that although some study participants highlighted the community as a stakeholder in this process, even if peripherally, the scope and degree of the community’s role remains unclear. Additional reflections on the scope of community participation and their pertinence in this district planning process will be further described in Chapter 6, Section 6.1.
focused on the increased alignment between district health goals and national (and international) objectives. This alignment was viewed as important to ensuring all health planning be coordinated and aligned from international and national goals to district health priorities. One WorHO member emphasized the significance of this alignment of plans as a means to improving streamlined planning. They maintained:

Everyone must be on the same page. Some people complain that if the government tells us the priority, then we are not planning for ourselves [at the district level]. This is not the case however. The national government has international goals that every country must meet. We must all work in synergy. That is why we need and have woreda based planning. National health indicators should be reviewed and planned to make sure that all districts are working to meet international MDGs. It is a measure to create efficiency and harmonize national and district health goals. This has been its biggest strength. (Member, WorHO)

These sentiments were echoed by one member of the WorHO who drew attention to comparisons between previous district health planning experiences and procedures:

In the past, all districts aimed to plan in accordance with the government’s HSDP goals. But it was not a standardized procedure. Woreda health offices were doing it their own way and it was hard to track if progress was made and what progress was made. Now with woreda based health planning, we, at the district level, are all working in a targeted way because all districts and regions use the EBPB tool, which identifies the major priorities for the entire country. These health problems such as malaria, HIV, maternal and child health programs and are all a concern for each woreda. (Member, WorHO)

Based on previous health planning procedures, standardization under WBHSP was one of the major positive outcomes identified given that the overall goal of harmonization and alignment was to regulate planning throughout the country. A member of the RHB expressed this opinion:

One of the major benefits of woreda health sector planning is that it is coordinated planning for all districts to work in alignment with the national government’s plan. Imagine this, where each woreda has similar health concerns more or less, but does not know what interventions are effective, what monies are earmarked, etc. Through the [EBPB] tool, district planners know that money and attention have been allocated for these service areas. So we can identify our priority areas accordingly and plan for one comprehensive plan. (Member, RHB)

As identified in the above quote, participants at all levels also spoke to the benefit of the EBPB tool as a mechanism for supporting programmatic alignment, coordination, and evidence-based planning. Another member from the RHB further described the efficient structure of the EBPB
tool to target the focus of health planners:

The evidence-based planning tool helps the districts to identify where to channel their efforts. By identifying the gaps in district health need and in health facilities, the tool guides planners to know where they can make the most impact in their district. For instance, if child mortality is a huge issue for a woreda, this will show in the graphs generated by the tool. Therefore, it helps them channel their efforts according to need. It also assists in the achievement of national and international goals such as the MDGs. We are able to now assess where to make the biggest impact to reach these goals and to also forecast what the impact will be through additional resources. (Member, RHB)

Echoing similar sentiments, a district-level program expert maintained that the EBPB tool has helped guide the district planners on where to allocate resources efficiently in order to fill community health gaps while also meeting international goals. They discussed how:

The planning tool helps us to develop an accurate plan, which is consistent with the direct resources or the input required to undertake the plan such as the number of health workers, and health facilities. It also saves us some time and improves the quality of planning because it is targeted for each district. We are all working under one goal of the government, which is a good thing because we must meet MDG targets. (Program Expert, WorHO)

It was therefore evident from participant accounts that the majority of participants believed that the implementation of WBHSP and the associated EBPB tool fostered greater harmonization and alignment of programmatic goals across all levels, including international, national, and districts.

**III. Improved Data Usage through the EBPB tool**

Another common theme related to positive outcomes of WBHSP that was highlighted by participants revolved around improved data usage harnessed through the EBPB tool. Many participants stressed that since the uptake of the EBPB tool, district level data was more effectively put to use through targeted indicators for planning. One member of the WorHO noted that the uptake of the WBHSP strategy and the EBPB tool, in particular, “enhances the accuracy of our planning because it incorporates district data in a coordinated way that synergizes the national government’s wishes with district need” (Member, WorHO). This view was further supported by another district health office member who reiterated the benefits of the EBPB tool to optimize data utilization. They stated:
Planning without having concrete evidence is wastage. It is difficult to trust the plan if it is not based on reliable evidence. Since the uptake of the EBPB tool, we are using data in a targeted fashion. At the end of the day, the impact of evidence-based planning and budgeting is well known. It helps to accomplish activities according to the plan. Without solid data, you will not end up with a real plan, which in turn leads to failure. [...] Therefore, in order to get a real and achievable plan, concrete evidence is very crucial. For these reasons, the government has been trying to improve data management at the kebele level and now we can use this data in a more effective way for planning through the EBPB tool. (Member, WorHO)

Hence, it was evident from participant accounts that applying data within the tool contributed to a greater sense of credibility of the contents of the plan.

IV. Reduced Subjectivity of Planning

A final positive outcome described by participants focused on reduced subjectivity of planning, as a result of the use of greater evidence under WBHSP. One member from the WorHO summarized this view by describing previous patterns of decision-making that did not directly weigh evidence from the districts.

Prior to WBHSP, planning was based on the interest of individuals who were involved in planning processes. If every kebele said, “we need a hospital,” it will be taken into consideration, but not grounded in evidence. However, currently, the evidence-based planning and budgeting tool completely relies on the baseline data, which improves previous subjective planning. Also, because the gaps are also captured in the tool and the status of every activity, it helps us to bring about significant changes to specific areas. It shows us what is in our hands and helps us fill our gaps. (Member, WorHO)

Such sentiments highlight the subjectivity of planning that was previously in place, which the adoption of the WBHSP strategy has sought to overcome. A member from the RHB also described the favourable outcome of orienting all planners on the same page under WBHSP.

Planning without having concrete evidence is wastage. It is difficult to trust that type of plan. Since the start of the EBPB tool, it is providing guidance from the bottom up and all workers at all levels are now able to talk the same language. (Member, RHB)

Here, a level of trustworthiness in the planning process, highlighted through the use of the EBPB tool, is also viewed as a mechanism towards minimizing the subjectivity of the plan.
5.2.2.2. Unintended Negative Outcomes Associated with WBHSP

While participants detailed many positive outcomes of WBHSP, they also candidly spoke of unintended consequences. The following sub-sections describe three dimensions of this theme in greater depth. It is difficult to know with certainty, however, whether these negative outcomes can be solely attributed to the implementation of WBHSP strategy, or if they are also attributed to other lingering issues in the health system prior to the introduction of this strategy. In many cases, participants did identify frustrations with specific aspects of the WBHSP process and the EBPB tool. This distinction is acknowledged where applicable.

I. Decreased Morale through Fiscal Uncertainty

Through participant interviews, it became increasingly clear that an unintended consequence emerging from the district health planning process was a decreased morale among district health planners and NGO partners. This finding was particularly apparent during interviews with district health planners who incidentally revealed feelings of disempowerment through fiscal uncertainty. Many participants, primarily at the district level, emphasized that having the EBPB tool that generates a budget to meet the needs of their plan creates a certain expectation that these fiscal needs will be met. Since participants revealed a number of challenges associated with receiving these funds (i.e., delayed disbursement or insufficient funds), the unattainable budget appeared to demotivate district health planners during the planning process. One WorHO representative described this decreased morale as rooted in failed attempts to meet these expectations created by the tool:

We have started to use the evidence-planning tool through this process, which has been beneficial to guide our thinking and plan according to the national goals and the needs of the district. It is good to have a very sophisticated tool that can tell how much money we will require to complete our plan. The challenge is when we do not get the funds. We are not motivated and losing faith in this new system. I think this is a problem for most woredas (Member, WorHO)

In relation to this issue, another member from the WorHO highlighted a lessened interest on the part of other stakeholders, such as members from the district finance office, whose primary role is to manage fiscal related issues. They described:
A problem with woreda planning is using this tool that generates a budget and is not attainable. The woreda finance and plan office does not believe in woreda based planning because of this. It tends to manage the planning process by the traditional way of planning—first assessing what the budget is and then allocating to woreda priorities. This [WBHSP] is creating a low commitment of staff to complete this process because they feel it is in vain and many staff are becoming not motivated (Member, WorHO)

This fiscal uncertainty also appeared to influence their planning efforts. A few participants noted scenarios where district health planners tended to set lower targets in the anticipation that the monies needed would not be available. One WorHO member maintained, “[o]ne of the major challenges faced in the planning process are the desire to set lower targets than what is expected to achieve since we are trying to anticipate that we will not receive the monies for the upper levels” (Member, WorHO). Another district health office member further emphasized patterns of under budgeting by outlining, “[w]e have a large budget constraint that leads us to set a plan that can work in accordance with this minimal budget” (Member, WorHO). It was therefore evident that participants did vocalize sentiments of discouragement to plan for too many activities that they were unsure or did not believe would be funded in the long run.

III. Decreased Morale through Navigating a Complex tool

When describing the strengths and weaknesses of the EBPB tool, the majority of participants expressed an overarching sense of frustration when trying to navigate the complexity of the EBPB tool worksheets. This frustration further appeared to be an unintended consequence of implementing a complex tool that required an environment of planners technically able to accommodate it. One WorHO member described such frustration with the tools functionality:

The EBPB tool was not friendly and requires a lot of computer skills that we were not trained with. Some of the conversion rates do not work for all spreadsheets and it was even difficult to understand the terminologies used in the tool. The [central] government needs to invest more in capacity building to strengthen our skills and confidence in using the tool. (Member, WorHO)

Many participants at the district level also focused on aspects of the tool that they believed were not pertinent to them. As a member from the WorHO articulated, “[t]he evidence-based Excel-tool encompasses too many worksheets and information that are not our concern. It is so frustrating and time consuming to figure out the tool and waste our time with service areas that
do not meet our [district] need” (Member, WorHO). This concern was reaffirmed by another WorHO member, who stressed:

The evidence [EBPB] tool planning format does not match with the reporting format we use practically. This becomes so frustrating for us during the planning meeting because we are all struggling to figure out how to align our data and information with the requirements of the tool. (Member, WorHO)

Similarly, many district health planners also described low technical capacity among them, which further contributed to a lessened morale across participants to engage in manipulating the tool. As articulated by one WorHO member:

We have such minimal capacity to undertake woreda planning. This includes limited skills to manipulate the tool, budget shortages for documents and stationary, shortage of budget for transport to collect data from the health centres and posts. This causes so much frustration among us. We feel like we are puppets sometimes and upper levels are controlling us. (Member, WorHO)

Through these expressive quotes, one is able to gather feelings of disempowerment at the district level, particularly if district level participants (who are to be empowered through WBHSP) harbour sentiments that they are at the whim of the central government in undertaking new planning processes whereby they believe they were not optimally capacitated.

IV. Decreased Morale through Planning in Haste

A finale sentiment that was commonly emphasized among participants focused on lessened morale through the frustration of planning in haste as a result of the short duration of the planning meeting. This view was summarized by one district health office member who stressed feelings of frustration and overburden:

There is a shortage of time during our planning meeting and the existence of too many activities to be performed leaves us feeling overwhelmed and frustrated. We are working night and day during these five days to make sure we can complete the evidence [EBPB] tool on time. But we still need more time if it is to be done efficiently. (Member, WorHO)

The need for greater time allocated for planning was further echoed by another WorHO member who emphasized the need for more planning time, as a result of the tool’s complexity.

The training meeting was for a short period and so, we were unable to capture points and ask questions and discuss on it due to shortage of time. People were not familiar with
EBPB tool before planning, so we were facing difficulty to understand it. All participants in attendance were very frustrated and wanted more time. (Member, WorHO)

Ultimately, participants gave an overall impression that given the current duration of time allocated for planning, they were unable to absorb the functionality of the EBPB tool to its fullest extent. As a result, many participants argued for this issue to be taken into great consideration by the central government. One member suggested that even a two-day increase would assist planners at the district level and that greater efforts to accommodate this suggestion (i.e., trainers and workshop facilities) should be taken into consideration.

5.3. Summary of Ethiopian District Health Planning

This Chapter explored and described district health planning and priority setting practices in Ethiopia under the planning strategy of WBHSP. Participant observation and in-depth interviews provided a deep understanding of the various dimensions associated with, and the contextual factors influencing, the implementation of WBHSP. Throughout in-depth qualitative interviews, participants from all three districts described similar contextual factors influencing the implementation of WBHSP as well as overall strengths associated with the strategy. Through these in-depth discussions, it was learned that with the implementation of WBHSP, the central government has aimed, and to varying degrees, implemented in practice, a more standardized process of district health planning throughout the country. Furthermore, it was evident that in both policy and practice, the aim to strengthen participatory dialogue and deliberative measures in planning has been strengthened. These findings were largely observed through enhanced stakeholder inclusivity during the planning meeting, whereby government decision makers and NGO partners were now expected to work more closely under the national harmonization agenda. We also acknowledged improvements in the area of evidence-based and aligned planning, which were both a goal of the strategy and operationalized, to varying degrees, in practice. As well, stakeholders were now expected to review the previous year’s plan, performance, and objectives in preparing for the next annual plan. Participants emphasized that this practice, coupled with the adoption of the EBPB tool, have now minimized the subjectivity of planning.
While the adoption of WBHSP is perceived as improving district health planning, many participants noted a number of structural, organizational, and socio-cultural factors that influence or constrain improvement efforts. Figure 5.4 provides a diagrammatic summary of the three contextual factors that were described in this Chapter (in relation to the WBHSP planning diagram first presented in Figure 5.1). These contextual factors were characterized as: (i) organizational (e.g., limitations to managerial capacity, organizational empowerment, and leadership; limitations to technical capacity to manage the tool; a shared belief in multistakeholder engagement as a means to improve health planning; and insufficient time allocated to complete the plan); (ii) infrastructural (e.g., the presence of required material resources; timely and complete data, and an adequate budget); and (iii) socio-cultural (e.g., milieu that is supportive of multistakeholder engagement and stakeholder inclusivity).

In addition to illustrating dominant contextual features, Figure 5.4 further highlights thematic outcomes (positive and negative) related to WBHSP implementation that participants also detailed. Many of the strengths described were procedural, as participants’ highlighted strengths that included: improvements to multi-stakeholder engagement and overall participation; improved data usage through the EBPB tool; improved harmonized planning standardized throughout the country; and, as a consequence, reduced planning subjectivity. On the other hand, the unintended negative outcomes focused on the aura of planning; whereby components of the WBHSP strategy had frustrated participants to engage in planning and driven feelings of disempowerment in striving to plan for health goals they believed would not be met as a result of fiscal uncertainty. Upon reflection, these unintended negative outcomes seem to manifest when the aspirations of the strategy and the EBPB tool were at odds with the context in which it was being implemented. Chapter 6 will draw our attention to the findings that emerged through an analysis of the Ethiopian district health planning process, described here, against the two frameworks—Accountability for Reasonableness and the Transformative Systems Change Framework—to assess both the procedural fairness of the planning process and the system-level influences on the planning process.
Figure 5.4. Summary of Contextual Factors influencing the Process and Outcomes of WBHSP

**National policies, guidelines, and rules**

**Infrastructure**
Presence of tangible resources; Limitations to the presence of timely and complete data; Planning under fiscal uncertainty

**WOREDA-BASED HEALTH SECTOR PLANNING WORKSHOP**
Steps 1-14

**Organizational Context**
Limitations to managerial capacity, organizational empowerment, and leadership; Limitations to technical capacity to manage the tool; Insufficient time allocated to complete the plan

**Socio-cultural Context**
Milleu supportive of stakeholder inclusivity; A shared belief in WBHSP as a means to improve health planning

**Outcomes of WBHSP**

**Positive:**
- Strengthening multistakeholder engagement and collective decision-making
- Improved harmonization and alignment of goals and programmatic activities;
- Improved data usage through the EBPP tool;
- Reduced planning subjectivity.

**Unintended negative:**
- Loss of morale and feelings of disempowerment among stakeholders

WBHSP principles
Chapter 6 addresses objective 2 of this study by presenting the findings that emerged from an analysis of district health planning process through the conceptual frameworks, Accountability for Reasonableness (A4R) and the Transformative Systems Change Framework (TSCF). Section 6.1 reports on the analysis of the Ethiopian district health planning through the lens of A4R, describes participant perspectives on fairness and legitimacy as normative concepts, and compares these perspectives with the A4R findings to assess conceptual alignment between A4R principles and the Ethiopian conception of fairness and legitimacy. Section 6.2 reports on the analysis of Ethiopian district health planning using the TSCF, to identify system barriers and facilitators in the context of district health planning (including the structure, organization, and dynamics of the system).

6.1. Assessing the Legitimacy and Fairness of District Health Planning in Ethiopia

This section is divided into three sub-sections. Section 6.1.1 applies the revised conceptual framework of A4R, inclusive of the Daniels and Sabin (1998) and Gibson et al. (2005b) conditions to assess how Ethiopian district health planning upheld principles of procedural fairness. Section 6.1.2 describes how Ethiopian participants conceptualized fair and legitimate planning. And finally, Section 6.1.3 assesses the congruency between the A4R principles and the Ethiopian conceptualizations of fair and legitimate planning.

6.1.1. Assessing Procedural Fairness through the Use of A4R

The following section presents evaluative findings of the legitimacy and fairness of district health planning organized according to the five conditions of A4R: (i) Relevance; (ii) Publicity; (iii) Appeals and Revision; (iv) Empowerment; and (v) Enforcement (Daniels & Sabin, 1998; Gibson et al., 2005b).
6.1.1.1. Relevance

To meet the relevance condition in A4R, decisions must be based on evidence, reasons, and principles that are accepted by stakeholders as “relevant” for meeting health needs fairly (Daniels & Sabin, 1998). Decision-making that upholds these principles is believed to improve the quality and fairness of decisions and enhance overall public confidence (Daniels & Sabin, 1998). To satisfy the relevance condition, priority setting and decision-making are characterized by: explicit decision criteria; the use of evidence in applying the criteria; and multiple stakeholder perspectives to increase the chance that all “relevant reasons” are considered and inform the decision-making process.

I. Explicit Decision Criteria Guiding District Health Planning

Under the top-down approach of the WBHSP strategy, district health planning and priority setting are guided by explicit national health priorities detailed in the Health Sector Development Program (HSDP) policy, which identify population-based priority health issues at the national level that are further aligned with the international Millennium Development Goals (MDGs). Through the WBHSP strategy, the Government has displayed an aspirational commitment to standardizing the district health planning process. Implementing the process was largely directed by the national government through the adoption of the Evidence-Based Planning and Budgeting (EBPB) tool, which provides a list of pre-selected health priorities that align with the HSDP and isolate criteria where decision makers should channel their efforts to address district community health needs. As stated in the WBHSP Training Manual, this strategy has aimed to target planning on:

[… ] selected interventions that are high impact and cost-effective, [with] activities prioritized based on major systems bottleneck identification and analysis. [And] takes into consideration the local realities and context. For every input and cost-incurred during planning, it gives corresponding results-output, outcomes and impact. (FMOHb, 2010, p. 8)
While the establishment of pre-determined criteria by the central government has aimed to align all districts on a similar planning trajectory, many participants revealed challenges encountered in practice, particularly around the tool being too structured and inflexible to modification should other district priorities arise. To gain a deeper understanding of what criteria guided their priority setting, study participants—comprised of health planners at all levels and NGO partners—were asked specifically what criteria were used. This analysis was undertaken in an effort to assess what criteria were dominant in this decision-making process and to capture whether these criteria were directly aligned with or divergent from the pre-determined criteria of the EBPB tool. During qualitative interviews, participants described a series of key criteria that aligned with the pre-determined criteria set-forth in the tool that included: addressing the highest burden of disease; meeting community need; and addressing gaps in health care programming and provision.

(i) Alignment with National Guidelines and Criteria

During in-depth interview discussions, many participants emphasized the strong role of government in shaping the explicit criteria that guided district planning, largely through the HSDP. When asked what criteria guided health planning and priority setting, many participants emphasized the prominence of national policies and guidelines as key criteria. Many participants felt that to undertake district health planning, they must follow national and regional guidelines that have already identified the major priorities of the country. As articulated by one member of the WorHO:

Many factors must be considered during the health planning process for the districts. But firstly, it is critical that the national and regional government policies be integrated into practice. This is the main issue. If the intent of the government is to coordinate planning in a specific manner, it is our job to ensure that we are capacitated to make this happen at the district level. [...] Because the national agenda is starting to strengthen evidence-based planning and trying to improve HMIS [Health Management Information Systems] throughout the country, it is easier for us to buy-in to this process. We believe in targeting

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62 Appendix 5A and B—Table 1 and 2, respectively, present a list of criteria for high impact interventions and indicators that district health planners use to guide their decision-making.
interventions on the diseases of highest burden, so planning is relevant and meaningful to us on the ground where the real issues lie. (Member, WorHO)

In support of this strategy, another WorHO member also stressed the significance of adhering to government guidelines and policies.

Guidelines and procedures outlined by the government and any additional instructions given from higher authorities are used as criteria and followed during the processes of planning. Such rules and regulations are critical factors in ensuring compliance across all districts. It ensures that all districts are planning in accordance to their districts need through the application of high impact interventions that the government has prioritized in its sub-packages. (Member, WorHO)

Through this process, many believed that planning in this manner improved the coordination of planning, as all districts were now engaged in one targeted process. One WorHO member expressed the importance ascribed to standardizing planning on district need in comparison to the previous unstructured mode of health decision-making.

Previous direction for planning was sent from higher officials by indicating details where the woreda should focus, thus creating a problem at the woreda level, as it was unstructured and uncoordinated. This time [through WBHSP], planning is made based on the interest of the HSDP, as the EBPB tool gives us an opportunity to observe and address locally available problems. (WorHO member)

(ii) Addressing the Highest Burden of Disease

When asked what criteria guides health planning and priority setting, the majority of participants also identified targeting the highest burden of disease as a leading criterion. The majority of participants believed that directing interventions towards diseases having the highest burden on the community was essential to relevant planning, and that the EBPB tool was particularly useful in guiding this process. One member of the WorHO succinctly described this as follows:

The criteria we used focuses on the major problems affecting the health of the community, which affect a large amount of people. This type of planning ensures that through our planning efforts we will be addressing the primary needs in the kebele. [...] The evidence-based tool helps us define our health priorities because it focuses our attention on the programs that will target the highest burden of diseases affecting the country. These issues are a problem for all districts. (Member, WorHO)
Another WorHO member described priority setting as grounded in national policy and predetermined.

Most of the time the priorities are predetermined by the health policy and guidelines. We have to work within that context. According to this health policy, communicable diseases, maternal health and child health are given priority. We follow this as well. From communicable diseases, we give priority for epidemic prone ones like meningitis, malaria, measles, and diarrheal disease. Mothers and children are also highly susceptible groups. (Member, WorHO)

Diseases acknowledged as highest priority in the tool included both preventative and curative interventions to address family planning and reproductive health, communicable diseases (i.e. HIV/AIDS, malaria and diarrheal disease), and maternal and child health. Building on the condensed list of priorities first presented in Table 5.1 and 5.2, Appendix 5A: Table 1 provides detailed excerpts from the EBPB tool that outline the criteria and priority intervention areas guiding district planning. An examination of Appendix 5B: Table 2, further reveals that while prevention and control of non-communicable disease is a priority area acknowledged in the tool, no specific interventions or indicators are listed in the tool in order to measure them. Many participants acknowledged infectious disease as an issue of highest priority given the huge burden of HIV/AIDS, malaria, and TB on district communities. One WorHO member described this as follows:

[We] give priority for communicable, and epidemic prone diseases like malaria and diarrheal diseases. They are diseases that affect everyone in the district and make the community vulnerable to poor health; especially mothers and children who are highly susceptible groups. (Member, WorHO)

Participants also focused on the importance of addressing health issues that relate to promoting maternal and child health, as these were also considered of highest burden. This sentiment was emphasized by another WorHO member who maintained:

[…] many of these [issues of maternal and child health] concerns are universal issues among all districts. The plan must ensure the health of the community and target the health problems that are of highest burden. Because maternal and child health are priority issues in every kebele, it is important that we ensure proper attention to these service areas. (Member, WorHO)
Overall, most participants’ felt that the indicators identified in the EBPB tool did capture the highest burden of disease identified by the HSDP priority areas.

(iii) **Meeting Community Needs**

Another key criterion of planning that emerged from participant interviews focused on the importance of setting district health priorities to meet the needs of the community. Many participants, at all levels, emphasized this theme as an important feature to ensure that community health needs would be directly addressed. As described by one member at the RHB, “[w]e must target and prioritize diseases that are communicable and affect the majority of the district population. These must be given first priority, so that we improve the health status of the kebele (Member, RHB).” Some study participants spoke to the flexibility they felt the tool had to accommodate their district concerns. One member from the district health office stated, “[…] even though we are guided by the tool for each program and intervention area, we still have the flexibility to prioritize our district needs in the final plan” (Member, WorHO). Another WorHO member indicated that,

[...] The federal government has mapped out what the health needs are for all communities across the nation. These priorities transcend all communities. If one service area requires more attention in one district, then that district can prioritize accordingly. All parts of the tool must be completed though. This is the challenge for some districts who might have missing data for some health indicators. (Member, WorHO)

While participants at all levels clearly acknowledged the importance of weighing district-level community needs in the planning process, some participants emphasized a discrepancy in practice. Some argued that the programmatic intentions of the government were quite centralized and not as inclusive of capturing district level needs that they felt would be necessary. For instance, some participants articulated sentiments of feeling “bound” by the intentions of the national government through the programmatic parameters set forth by the EBPB tool. One member at the WorHO stressed the dominant influence of the national government in structuring which programmatic activities should be prioritized.

When we do planning we consider the needs of the community, such as if there is a drought, unexpected rains. But, first and foremost, we consider the policy of the government. In this [HSDP] framework, we have been given nine policy items to follow,
such as maternal and child health. We do not go beyond these indicators as they are outlined at the government level. They [national government] give us a list of things to plan on and a strategy to follow. (Member, WorHO)

This sentiment of a strong centralized role in planning was further emphasized by a member the WorHO who stressed a sense of “compliance” with the government and an inability to align their district plans more directly with the needs of their community.

Policy guidelines, principles, procedures and any instructions directly come from the higher authorities and are used as criteria and followed during the processes of planning. Everyone [involved with district health planning] is expected to be compliant [emphasis added] with these norms, even if this deviates from the needs of our district. We must still complete all sections within the tool. (Member, WorHO)

Other participants added to this discussion an overall concern that they did not have the fiscal flexibility to allocate any district resources outside of the priorities documented in the tool. One WorHO member, for instance, highlighted this concern and described it in reference to the overall fiscal constraints experienced. They articulated:

We have some health concerns that are not categorized in the evidence tool. Even though we can include other health issues, like infectious diseases, we know that we will likely not receive the resources to tackle such issues. How can we expect resources for alternate areas when there are not even enough resources sometimes to meet the HSDP objectives. (Member, WorHO)

Another member at the regional level echoed this sentiment:

Each kebele has its own issues and therefore, it is imperative that each plan be tailored to meet such needs. For the most part, the evidence-based tool guides us in this process. However, we also have district specific concerns that we try to include. The problem is that we probably will not have the resources and monies to tackles such considerations. (Member, RHB)

In line with the bottom-up approach, the WBHSP training manual states that WorHOs have flexibility to place emphasis on intervention areas deemed more relevant to their district need (EFMOHb, 2007, p. 49). Yet, the extent to which district health planners are able to prioritize health concerns outside of those items already documented in the EBPB tool remains unclear to them. Based on participant accounts, many participants felt they were able to address health concerns unique to their districts, but that other factors, such as limited finances to address
such concerns, hinder the operationalization of such intentions. Although, one WorHO member stated that,

If an emergency situation arises where we need to address an emergency in the community, then we will act to address it. This means, we will request funds to increase the number of ORS if there is an outbreak of diarrhea, for example. It always comes down to a finance issue (Member, WorHO).

(iv) **Addressing Previous Gaps in Health Programming**

Participants also emphasized that addressing the gaps in health programming from the previous year was another implicit planning criterion. During initial planning meetings, many participants described the importance of their baseline assessment to capture programmatic initiatives whose goals had not been fulfilled. One member of the Woreda Administrative Council, described that “[d]uring woreda planning, it is important to ensure that we address gaps that we missed from the previous year. If we had goals that were unable to be met, then it is important to address these or the progress will be difficult to reach” (Member, Woreda Administrative Council). Another WorHO member further emphasized that by acknowledging previous gaps in programming, one is able to support the planning activities in the current plan.

In setting this year’s annual plan, it is essential that we review the past plan. This identifies which indicators to maintain and which to improve from the previous year performance. If there are areas of concern, such as we did not have enough medicines or health personnel, then we need this to be addressed for the upcoming year. Recurring gaps will not disappear until to give them attention. (Member, WorHO)

In practice, the planning process under WBHSP appears to operationalize these beliefs. The EBPB tool, for instance, allows district health planners to clearly identify gaps in performance and programmatic activity (EFMOHb, 2007, pp. 53-63).

II. **Evidence Guiding District Health Planning**

In addition to a variety of criteria guiding priority setting and in order to further support relevance in planning, the HSDP provides guidance on the key health areas that speak to overarching population health needs. To guide this process, the HSDP acknowledges the importance of strengthening the “existing HMIS [Health Information Management Systems] at the federal, regional, woreda, health facility, and community levels to produce timely information
for planning, management, and efficient decision-making” (FMOH, 2010, p. 28). The HSDP-III document further acknowledges “challenges faced in relation to HMIS [involve a] lack of coordinated effort and leadership, lack of strategy and policy, shortage of skilled human resource and lack of guideline. The timeliness and completeness of HMIS reporting remains poor, and such delays contribute to the failure (at all levels) to use data as the basis for informed decision-making in planning and management” (FMOH, 2010, p. 28). Consequently, the government has made a concerted effort within the HSDP-IV, to improve the collection and management of data. Under WBHSP (described in the HSDP-IV), the adoption of the EBPB tool, in particular, has aimed to organize planning in order to incorporate district data in a structured format that is standardized throughout the entire country and also able to include unique district needs when they arise. This attention to district-level considerations resonated well with stakeholders during planning, as many participants commented on improvements in data usage since the adoption of the EBPB tool under WBHSP. As previously described by one district health planner:

Planning without having concrete evidence is wastage. It is difficult to trust the plan if it is not based on reliable evidence. Since the uptake of the EBPB tool, we are using data in a targeted fashion. At the end of the day, the impact of evidence-based planning and budgeting is well known. It helps to accomplish activities according to the plan. Without solid data, you will not end up with a real plan, which in turn leads to failure. […] Therefore, in order to get a real and achievable plan, concrete evidence is very crucial. For these reasons, the government has been trying to improve data management at the kebele level and now we can use this data in a more effective way for planning through the EBPB tool. (Member, WorHO)

As further highlighted in Section 5.1.1, one of the central principles of the WBHSP strategy was the evidence-based planning principle, which places emphasis on the use of reliable evidence to guide decision-making. Described in the WBHSP Training Manual (EFMOHb, 2007, p. 8):

Planning in the health sector should be conducted with the help of concrete and reliable evidence. Based on the evidences root caused of health problems of the society should be identified and tackled using proven high impact interventions. The […] process of both strategic and annual plan preparation should use complete, reliable and timely information for decision-making at all level[s] of the health sector. Furthermore a logical and systematic approach should be used to define goals, objectives and targets (EFMOHb, 2007, p. 8).
The EBPB tool facilitates this process, as it requires the completion of the Marginal Budgeting for Bottlenecks (MBB) analysis; described in greater detail in Section 5.1.1. The MBB analysis incorporates district acquired epidemiologic data and identifies what evidence-based interventions, with known effectiveness, should be prioritized. Data comprised of community health related information, morbidity and mortality statistics, and health facility and human resource requirements are used as relevant evidence in this process. This includes information capturing population statistics, such as number of children under 1 year and 5 years, women of reproductive age, pregnant women, those residing in urban and rural kebeles, and the total number of health personnel required and available, as well as the number of health facilities functional and under construction. Data captured is used during the first phase of the WBHSP process to guide district profiling of demographic information, statistics, and health infrastructure. Establishing this baseline was viewed as critical to facilitate decision makers’ understanding of “what the woreda health system looks like” (Program Officer, WorHO); capturing not only the major health problems of the district (i.e., major diseases affecting the community), but also previous interventions implemented, challenges encountered, and major achievements.

In addition, many participants also detailed relevant data as including district information that captured achievements from the previous year, and overall district capacity. One member at the regional level detailed the importance of ensuring adequate capacity to meet such needs, and how a lack of consideration to district capability considerations can limit planning relevance in meeting these needs.

It is essential that we ensure that we have the adequate health infrastructures, facilities, and health personnel and medicines to address this. Planning must be all-inclusive to ensure that once you define need, you can actually meet the need. That is also a major difference with woreda based health sector planning […] that we are able to and place more weight on looking at infrastructures and what materials and manpower is needed to address said priorities. (Member, RHB)

In reflecting on capacity considerations, district health planners also regarded effective evidence-based planning as a process that must consider the achievements of the previous year as indicative of capability. Relevance in this sense is viewed as what is achievable and in line with national and regional guidelines and actual capacity. The planning process not only considers
district data to outline priority areas requiring intervention, but also factors in the previous year performance to a establish a baseline of what has been and can be achieved. One WorHO member stressed the importance of capacity in this sense as a means of understanding what is programatically achievable.

So as to the plan, first you have to have a starting point baseline. For examples, to plan for this year, we have the previous year’s performance, what was accomplished and what is outstanding, achieved, not achieved. We must give priorities to urgent and prevailing problems of the woreda and also complete unfinished projects from the previous fiscal year. We consider reliable evidence to guide almost all decision-making. Evidence is key and it should also follow rules and guides of the sector and baseline data collected at the woreda level. (Member, WorHO)

This mode of reflection was further described by another WorHO member who stressed the importance of factoring in the capacity considerations when developing their plan.

We considered budget conditions, what potential sources we could use, and what community support could be achieved from kebele stakeholders and NGO partners. […] Another thing we consider during planning is the number of trained resources, such that will the number of human resources we currently have serve efficiently. (Member, WorHO)

With respect to data management, some participants further highlighted that since the implementation of the Health Management Information Systems (HMIS) strategy in 2007, improvements had been made in the collection and documentation of health information. One WorHO member summarized some of the strengths of HMIS by noting, “[s]ince the adoption of HMISs, we are improving our data collection and monitoring and evaluation systems. There has been improvement in data management as well” (Member, WorHO). The majority of participants, however, still felt that ongoing weaknesses in the availability and quality of data infringed on the process towards planning in alignment with community need, and highlighted a variety of data management issues that still posed significant limitations to planning in accordance with district need. For instance, many participants spoke of incomplete data as a concrete issue at the district level impacting the quality of decisions. One member from the district health office described:

From what I have seen, one of the major challenges we face is the lack of data and the poor handling of records and reports, even by responsible people and this is impacting the quality of our decisions. This is mainly the result of capacity limitations for health
workers to collect the data according to our needs and district personnel to manage the data accordingly. (Member, WorHO)

As a result of planning with incomplete data, many participants articulated a concern that decision-making would be under-representing the needs of the woreda. Some participants spoke of scenarios where regional, zonal, or national estimates would be used in lieu of scant district level data, which would affect the authenticity of actual need. One member from the district health office maintained,

If there is no data about a specific health indicator at the woreda level, then we will use data from the zone or the region to fill this gap. The problem is that by using this strategy, the decisions we make become less authentic with meeting the actual needs of the districts. This should not be the solution. We need better data that meets the needs of the districts. (Member, WorHO)

Another NGO representative also highlighted the concern around the use of “old data;” further emphasizing that by simply using last year’s district figures would “skew” the perception of what needs to be prioritized in the woreda. It was apparent during participant observation that decision makers were clearly restricted by the availability of their data, as many delays were visible during the importation of data into the EBPB tool.

III. Multiple Stakeholder Perspectives

To also satisfy the relevance condition, the presence of multiple stakeholder engagement is important to the priority setting process so as to increase the chance that all the “relevant reasons” will be identified and will inform the decision-making process. In both policy and practice, the adoption of WBHSP has instituted fairly clear procedures to enhance stakeholder inclusivity in decision-making. This was primarily witnessed during the five-day planning meeting where multiple stakeholders were invited to attend. These included regional planning and programming departments, zonal health planners (where applicable) to guide district health planners, and WorHO officials (in order to complete various components of the tool, including, maternal and child health, malaria, HIV/AIDS, etc.). In addition, members from the Woreda Administrative Council and Woreda Finance and Economic Development (WoFED) were invited to attend in order to provide additional guidance regarding alignment with other sectoral areas,
and to discuss budget considerations, respectively. Lastly, non-governmental partners were also invited to attend the meeting in order to assist in the identification of programmatic alignment. Despite these efforts, delays in the invitation process did appear to pose a constraint to their attendance, yet not everyone was impacted.

This inclusive approach of WBHSP speaks to the government’s commitment to strengthen multistakeholder engagement and democratic decision-making, as noted in both policy and through participant accounts. In policy, the HSDP-III acknowledges the government’s aspirational commitment to support multistakeholder inclusivity as an epistemic mechanism to “capitalize on the experience and preparedness of the other stakeholders (mainly NGOs and the private sector) [and …] complement the public sector’s capacity in tackling public health problems” (FMOH, 2010, p.88). Through the harmonization agenda, the “one plan principle,” in particular, “means that all stakeholders (government, donor NGOs and the community) agree to be part of a broader sectoral plan” (EFMOHb, 2007, p.7). Similarly, as further outlined in the harmonization manual, “developing annual plans involves consultation with major stakeholders, including relevant government institutions, donors, NGOs and the community at each level (EFMOHa, 2007, p.28).” This statement speaks to the importance of ensuring multistakeholder presence in the planning and design of health initiatives and programs.

In practice, there was overall consensus among participants that increasing stakeholder inclusivity did enhance the quality of decision-making by cultivating a forum for open and deliberative dialogue. As described by one district office member:

During the WBHSP meeting, all planners—district, zonal and regional—come together with [non-government] partners to discuss health needs of the woreda, which is critical to have all input because decisions affect all parties. By inviting all stakeholders to the meeting, we are enabling everyone to play their role effectively and contribute to the plan. After the prepared draft plan is compiled, all stakeholders will review it. (Member, WorHO)

During the initial phase of the meeting focused on the district profile, participant observation further revealed the deliberative nature of planning, as stakeholders debated on diseases of highest prevalence, identified what they believed were the major achievements of the previous year, and discussed the programmatic challenges to be circumvented. Upon the completion of the
draft annual plan, the establishment of the review board at the level of the Woreda Administrative Council provided a structured forum for all stakeholders—including community leaders—to consult on the draft plan and discuss the priorities identified and evidence emergent from the districts.

Ensuring the attendance of stakeholders, however, did emerge as an area requiring improvement. At the time of this study, the RHB and, in some cases, the ZHDs, were responsible for inviting district health planners and NGO partners to participate in WBHSP meeting. As first detailed in Chapter 5, absenteeism was described by many district participants as common occurrence resulting from meeting conflicts that district health planners or non-governmental partners may be required to attend in lieu of the WBHSP meeting. Many participants spoke of delays in the submission of invitation letters for stakeholders. It was therefore apparent that increased efforts were required to enhance the inclusive nature of stakeholders in the planning process. While attendance alone does not necessarily equate to active participation in the decision making process, participants still viewed attendance of all members as a precursory step in deliberative decision-making. One member at the WorHO maintained,

If we do not have all members in attendance at various stages of the planning process, this impacts who gets to say what and the weight of different views considered. It is important for the upper levels to ensure that all members attend, so they can incorporate their data and contribute to the plan development accordingly (Member, WorHO).

Furthermore, while community leaders were invited to participate at the Woreda Administrative Council meeting, community members appeared to be clearly missing from this forum of engagement; thus indicating that community perspectives are not directly included among the range of “relevant reasons” that informed the health priorities decided at the district level.

IV. Relevance Condition Satisfied?

In analyzing the relevance condition, the study findings demonstrate that the process of district health planning did, to varying degrees, accord with the principles underscoring this condition. Through the conceptualization of WBHSP, the government has aspired to strengthen mechanisms that: (i) facilitate targeted planning based on criteria that aligns with the highest
burden of disease; (ii) are guided by district-level epidemiologic data and evidence; and (iii) create a deliberative environment for multiple stakeholders to ensure relevance in the aforementioned. In practice, there was a strong commitment among participants to uphold this vision. There has clearly been an increased effort by the national government to provide explicit criteria to help guide district health planning among all districts. Many district planners believed that the national priorities isolated in the EBPB tool did capture many of the indicators that addressed the highest burden of disease experienced at the district level. Furthermore, participants did value this standardized process as they recognized the importance of ensuring that national needs were also meeting international goals set-forth by the MDGs. Some described an inflexibility of the tool to incorporate district needs (such as non-communicable/chronic diseases) and expressed concern that health issues prioritized outside of the EBPB tool would not receive any monies required to programmatically undertake them. In addition, through the implementation of WBHSP, there has now been a growing commitment to ground decisions on evidence captured at the district level, and focus health activities on high impact interventions. Participants expressed that the HMISs strategy has been useful in strengthening the collection and management of data overall. Many participants, however, also felt that ongoing capacity limitations to collect and manage data had implications on the ability to uphold effective data acquisition and utilization. Similarly, participants spoke of alignment issues between data captured at the district level and data required in the EBPB tool.

Lastly, the implementation of WBHSP has also instituted clearer procedures for increased multi-stakeholder engagement and deliberation. Participants are now in a position to dialogue in a structured format during the planning meeting and at the Woreda Administrative Council meeting (where plans from all sectors, including health, were presented and debated). Participants’ further emphasized that measures should be taken to ensure the presence of all pertinent stakeholders during the planning meeting; particularly NGO partners, as their absence and the absence of other key members limited the inclusion of multiple values in the decision making process. Table 6.1 provides a summary of the aspects of WBHSP that accord with the relevance condition of A4R.
Table 6.1. Aspects of WBHSP that Accord with the A4R Relevance Condition

<table>
<thead>
<tr>
<th>Aspect</th>
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<tbody>
<tr>
<td>• Presence of explicit criteria through HSDP to guide planning.</td>
</tr>
<tr>
<td>• Mechanisms to capture highest burden of disease through EBPB tool.</td>
</tr>
<tr>
<td>• Evidence-based decision making that applies district epidemiologic data.</td>
</tr>
<tr>
<td>• Planning processes that encourage multi-stakeholder engagement.</td>
</tr>
<tr>
<td>• Enhanced mechanisms for deliberative planning and varied stakeholder perspectives.</td>
</tr>
</tbody>
</table>

To further satisfy the relevance condition, some opportunities for improvement would include:

(i) Enhancing the flexibility of the EBPB tool to capture district level priorities and reserving monies for the potential likelihood that district plans may deviate slightly from those priorities outlined at the national level.

(ii) Ensuring that data collection methods align with the indicators described in the tool, so as to limit district health planners from utilizing data that may underrepresent their district needs.

(iii) Further support the increased participation of stakeholders during the planning meeting by encouraging attendance and providing stakeholders with enough time to accommodate the meeting their schedules.

6.1.1.2. Publicity

To meet the publicity condition of A4R, decisions and their rationales must be made publicly available to stakeholder groups, so as to promote public disclosure (Daniels & Sabin, 1998). Publicity is ultimately concerned with both internal and external transparency of goals and objectives; of priority setting criteria; of who is involved in the process; and of how decisions will be and are made. Internal transparency involves transparency among stakeholders intimately connected to the planning and priority setting process. In contrast, external transparency is classified as openness with stakeholders considered more peripheral to the planning process, such as community members. Ensuring publicity allows stakeholders, including the community, to assess the relevance and values underscoring the decision-making process, which in the long run, can facilitate the fair management of health planning (Daniels & Sabin, 1998). The publicity
condition is satisfied if mechanisms to promote transparency, and to communicate decisions and their rationales to internal and external stakeholders are present.

In Ethiopian health planning, it is apparent that the government has increasingly aspired to promote openness of decision-making to stakeholders at all levels of government. For instance, the HSDP-IV specifically acknowledges the concept of transparency as a key component of its “strategic theme 2: excellence in leadership and governance” (FMOH, 2010, p. 38), as it is believed that measures to support openness in planning among stakeholders underscores good governance (FMOH, 2010, p. 35). As mentioned in Chapter 3, the government categorizes stakeholders involved in health planning into two groups - internal and external. Internal stakeholders hold the primary responsibility of planning, implementing, monitoring and evaluating, and include members of the FMOH, RHBs, ZHDs, and WorHOs. External stakeholders, play a more peripheral role in health planning, and include the community at large, MOFED, Council Administrations, professional associations and various other ministries with a stake in health-related programming. As we reflect on the publicity condition, the implementation of WBHSP has established clearer mechanisms to support the dissemination of the draft annual plan. However, such mechanisms also appear to be stronger in practice among internal stakeholders than external stakeholders, such as members of the community.

I. Disclosure of Decisions and their Rationales among Internal Stakeholders

Among internal stakeholders central to the decision-making process, clearer processes of plan development and overall disclosure of decisions has paved the way for enhanced transparency of district health decisions. Upon the completion of the draft annual plan, which includes a summary of all district health priorities, the establishment of the Woreda Joint Steering Committee (WJSC) under the Woreda Administrative Council Review Board, facilitates a structured forum for internal (and some external) stakeholders to consult on the draft plan and discuss the priorities identified. Each woreda is to have a WJSC, which reviews the annual plans and then later presents it to the Woreda Administrative Council Review Board (FMOH, 2010, p. 71). As outlined in Figure 6.1, the HSDP-IV describes suggested membership for the WJSC that
reveals both internal and external stakeholders who are encouraged to attend this forum for dissemination. As described by one member at the WorHO:

The woreda health office, together with health centre directors and the head of health posts discuss on the plan—build, adjust and agree on it. The developed draft plan is submitted to the woreda finance and development planning office. The plan is further seen by the woreda council and comments are incorporated. (Member, WorHO)

**Figure 6.1.** Structure of the Woreda Administrative Council Review Board and Suggested Membership of the WJSC (partly excerpted from FMOH, 2010, p. 71)

Another member at the district health office reinforced this process by highlighting the different dissemination strategies to stakeholders at various levels:

We use different methods of information dissemination that may be through discussion in meetings or through a copy of the document. Copies [of the drafted plan] are given to the woreda council, zonal planning and monitoring team, regional health bureaus, woreda finance, NGOs in the woreda, health centres and health extension workers. Public meetings are used to communicate issues with the general community. (Member, WorHO)

Once the draft annual plan is finalized, participants described some dissemination strategies involving a variety of stakeholders (previously mentioned) who are presented with the plan and can comment accordingly. At the Woreda Administrative Council Review Board meeting,
district health representatives, typically the head manager at the WorHO, present the plan. This process of dissemination was described by another WorHO member as follows:

During our plan dissemination review, the woreda office head discusses the plan, if they are available, and this discussion includes who came together to help make the plan, what are the health priorities and mostly the challenges from the previous year of planning. […] Many bottlenecks and gaps are identified from the previous year and so, much of the discussion focuses on the resources needed to make the plan a reality. (Member, WorHO)

Through this process, it is evident that the WBHSP has sought to create a forum for discussion of the annual plan among all pertinent internal stakeholders to the process. However, within the WJSC, structured mechanisms to disclose the rationale underpinning decisions appeared to be less explicit. At this review meeting, based on participant accounts, stakeholders appeared to place a stronger emphasis on discussing how to financially meet the needs of the plan, beyond solely focusing on health priorities identified and their rationales. In addition, it also became increasingly apparent through participant accounts that given the heavy weight of district-level data now captured in the EBPB tool, the rationales underscoring decisions were built into evidence captured at the district-level. As emphasized by one head manager, for instance, the evidence-based tool has now grounded priority setting in the “evidence emerging from the districts,” resulting in decisions and plans that are grounded in evidence. Most stakeholders in attendance, therefore, appeared to trust that the decisions presented in the annual plan are based upon the data directly captured from the districts through the EBPB tool.

What we are presenting here [at the Woreda Administrative Council meeting] is known to be based on highest burden of disease in the woreda. […] Decisions are accepted primarily because they are grounded in evidence and the consolidated plan showcases this because the planning process is grounded in evidence through the use of the tool. (Member, WorHO)

Another member at the RHB emphasized this thinking by highlighting:

[…] the plan includes a lot of information that is important in reviewing the woreda’s priorities. We receive profiles of the woreda that incorporates the partners working at the district level, the health and disease profile, demographic data and the health facility requirements. Therefore, it is a comprehensive annual plan. So it is reviewed and accepted on many levels. (Member, RHB)
During interviews, no study participants highlighted any scenarios that specifically spoke to the dissemination of rationales beyond that of the decisions identified in the plan. As previously described, perhaps this outcome may have been the result of the annual plan being inclusive of statistical data and graphic representations drawn from the EBPB tool that grounded the priorities in the evidence of the woreda; similar to what was described by the head managers of the WorHO above. One member from the Woreda Administrative Council further articulated this view and the process of review as follows:

[…] opportunity to come together with all important members in the sectors. During this time we discuss the content of the intended plans and if everyone agrees they are justified and grounded in evidence, then we give it our approval and send it to the regions [RHB] (Member, Woreda Administrative Council).

II. Disclosure of Decisions and their Rationales Among External Stakeholders

The disclosure of decisions and their rationales were less clear across stakeholders viewed as external to the decision-making process. Within the HSDP, the engagement of NGO members and community leaders at the level of the Woreda Administrative Council has been a measure to enhance the transparency and public accessibility of decisions and their rationales to external stakeholders. The inclusion of NGO counterparts, for instance, is described clearly in the HSDP-IV.63 Here, NGO members are encouraged to have a shared role with the WorHO in planning and “reviewing” district activities. However, the degree to which NGOs are included, or wish to be included in the dissemination and review process of district priorities remains unclear. In practice, many NGO counterparts attested to their limited inclusion in this process. As described by one NGO representative, “[o]nce the plan is finalized at the level of the regional health bureau and national government, then we are informed” (NGO representative). The underlying reasoning as to why NGO partners appear removed from the review process also remains unclear, as such reasoning did not explicitly emerge from participant interviews. The question remains as to

63 As stated in the HSDP-IV, “NGOs should be represented by their focal persons working at woreda level. It is important that WorHOs and NGOs closely collaborate and work together. NGOs should share their plans, budgets and activities with WorHOs; WorHOs should include NGOs in their main planning and review mechanisms.”
whether such a phenomenon (i.e., regarding the inclusion of NGOs counterparts in the dissemination and review of the plan) is exclusive to each district, or whether there are some WorHO and Woreda Administrative Councils more committed to ensuring the participation of NGO counterparts than others, or are NGO partners consistently withdrawn for their own reasons (i.e. working across multiple districts, meeting conflicts, etc.).

When reflecting on measures to strengthen the delivery of decisions to the community, the WBHSP Training Manual explicitly emphasizes a clear intent to strengthen information delivery to communities once decisions have been made; thus supporting a process of community accessibility to community members and transparency of decisions.

The process starts from continuous policy analysis and **ends by delivering information for customers** [emphasis added]. Both the strategic and annual plans fall into this core process. […] Customers’ benefit from proper decision making that ensures aligned planning for efficient, effective and equitable health service delivery (EFMOHb, 2007, p. 5).

Although participants reaffirmed the importance of including the community at various points in the decision-making process (i.e., formulation, development, review), study participant accounts lacked consistency in how and to what degree the community was aware of how decisions were made and what specifically was included in the plan. Some participants felt that disclosure of the plan to the community was strong, as mechanisms were in place for community leaders and health extension workers to relay decisions back to the community and to communicate the plans devised by decision makers. For instance, one member at the WorHO articulated, “[i]t was quite a fair planning process compared to the previous years since […] [d]uring the dissemination of the plan, the kebele leaders come to the woreda council meetings to discuss on the current plan and are the eyes and voice of the community” (Member, WorHO). Another district health office member described community engagement in this process as follows:

The community is consulted through the health centres, health extension works and the woreda political leaders who have a place at the woreda administrative council. Through this process they [the community] are asked the major health problems they face and any inconveniences that they come across is accessing health services. If there is no health facility near by and they bring this information forward to the planning team at the woreda health office. We then add their comments. (Member, WorHO)
In contrast, other participants felt that strategies to engage the community were still weak. One WorHO member felt that there was a minimal role for the community in the review process and this lack of role clarity was largely the source of their limited engagement.

We have no major role for the community themselves to review the plan. If the community leaders are keen, they will communicate the intentions. But there is not standard process of communication with the public. […] This is maybe because the plan is developed by experts and based on the evidence emerging from the woredas. Therefore, the plan is made in the community’s best interest. (Member, WorHO)

Although the role of community engagement appeared rather unclear, some participants described scenarios where decisions were posted on the gate of the WorHO in order to share the findings of the decisions of the plan with the community. This list conveyed what health issues had been prioritized and what plans had been made regarding the number of health facilities and human resources. This process of passive dissemination was also noted to lack disclosure of rationales in support of what was planned, and any explicit descriptions of who was in attendance during this process. But here, this form of disclosure to the community was viewed as a form of transparency.

III. Publicity Condition Satisfied?

In analyzing the publicity condition, the findings demonstrate that while there have been some efforts to strengthen disclosure of decisions to internal and external stakeholders, dissemination of the rationales underpinning decisions has been weak in both vision and practice. Although national values in support of transparency and disclosure have now fostered an environment of increased internal stakeholder consultation and deliberation—largely evident through the presence of the Woreda Administrative Council review board—mechanisms to disclose rationales and increase member involvement remained limited. Similarly, standardized procedures to engage the community and other external members, such as NGO partners, and to disseminate decisions and their rationales to these groups also remained limited. This finding was further evidenced by passive mechanisms to disclose information to the district communities, such as through the posting of decisions on the WorHO gate wall. Table 6.2 provides a summary of the aspects of WBHSP that aligned with the publicity condition of A4R.
Table 6.2. Aspects of WBHSP that Accord with the A4R Publicity Condition

<table>
<thead>
<tr>
<th>Aspect</th>
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<tbody>
<tr>
<td>• National values in support of transparency documented in policy.</td>
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<tr>
<td>• Development of a review board at the level of Woreda Administrative Council support a forum of review and deliberation.</td>
</tr>
<tr>
<td>• Internal stakeholders more strongly engaged in the review and deliberative process.</td>
</tr>
<tr>
<td>• Presence of community leaders on the review board encourages involvement of external stakeholders in the deliberative process of review.</td>
</tr>
</tbody>
</table>

To further satisfy the publicity condition, some opportunities for improvement may include:

(i) Emphasizing clearer mechanisms in policy and practice to ensure effective dissemination of decision rationales, particularly at the level of the review board at the Woreda Administrative Council.

(ii) Cultivating stronger strategies to communicate decisions and their rationales actively to external stakeholders, such as NGO partners and community members.

(iii) Formalizing the role of community leaders as mediator to encourage active discourse in health plan priorities and their rationales.

6.1.1.3. Revision and Appeals

To meet the revision and appeals condition in A4R, there must be mechanisms present for stakeholders and decision-makers to challenge and revise decisions in light of new evidence (once the decisions have been made) and mechanisms present to assist in resolving disputes (Daniels & Sabin, 1998). This feature would provide stakeholders with an opportunity—via a meeting, event, or other communicative forum—to voice their opinions and, subsequently, enhance democratic planning. Decision-making that upholds these principles is believed to improve the quality and fairness of decisions, and enhance overall public confidence (Daniels & Sabin, 1998). To satisfy this condition, the priority setting and decision-making process should include opportunities for the iterative review of the final plan and revision should any issues arise with the decisions made.
I. **Opportunities for Iterative Review of Decisions**

Through the implementation of WBHSP, the government has increased its aspirational commitment to strengthen opportunities for stakeholders to engage in deliberative processes of review during district-based planning as well as offer the possibility for revisions in the district plan, should they arise. As previously described under the publicity condition, the establishment of the review board at the level of the Woreda Administrative Council facilitates a structured forum for stakeholders to consult on the draft plan and to discuss the priorities identified. During interviews, participants spoke to the increased consultative nature of district planning since the implementation of WBHSP. One district health office member described this process as follows:

Once the annual plan is finalized, it is reviewed at the level of the Woreda Administrative Council. During this meeting, stakeholders from all sectors convene to discuss their plans for the woreda. Agriculture, education, and health – we all come together to share what is the priority of the districts. If at this time, there is a concern raised by anyone there, then we openly discuss and share our thoughts. Then, once this process is finalized, the plan is completed and shared with the higher levels of government. (Member, WorHO)

This sentiment of consultation and the potential for revision was echoed by a WorHO member who further spoke to the inclusivity of planning under WBHSP; which now created a process of high consultative review of decisions post the completion of the district annual plan.

What is important to know is that we now have many stakeholders coming together during the planning meeting to plan. When the plan reaches the woreda administrative council, the members who are part of this review process know that we have a very consultative process guided now by the evidence-based tool. So, in practice, most feel confident that planning is grounded in evidence and accountable. (Member, WorHO)

The majority of participant accounts spoke to the establishment of greater consultation under the WBHSP strategy to convene stakeholders, in both discussing and reviewing the decisions made. Another district health office member spoke further to the opportunity for external stakeholders to also participate in reviewing and contributing to plan modification.

Since the hard copy is going to be given to each institution, they will discuss on it. For example, health extension workers will discuss the plan with the community. Staff of the health center, health extension workers and kebele council will also comment on it. If there is something to be modified—it is open, it is flexible. The feedback is then sent to the zone after the comment of the commentators is included in the document. (Member, WorHO)
As highlighted in section 5.1.1, a central value of WBHSP was the “Flexibility Principle,” which explicitly places emphasis on the importance of a revision should stakeholders disagree on any aspect of the developed plan. As stated in the WBHSP Training Manual:

Plans should have some degree of flexibility in a way that important revision is possible. Planning engages estimation and forecasting. However, there is an error gap since the existence of forecasting with 100% level of confidence is rare. Therefore, plan should be revised as needed. The new planning process recognized this fact and considered flexibility as [a] principle of planning in the health sector. (EFMOHb, 2007, p. 9)

In practice, participants valued the flexibility principle as a critical component of deliberative planning. One member of the regional health bureau had emphasized, “because there is some flexibility in the plan, participants are able to dialogue more freely and if anyone feels that something needs to be added or taken away, then we can revise accordingly” (Member, RHB). Similarly, another member at the WorHO maintained, “[w]oreda planning now allows us to revise our plans if necessary. Planning is now more accommodating if anyone has an issue with what has been decided. […] This revision rarely occurs, but at least it is recognized under woreda planning” (Member, WorHO). As evident in the aforementioned quote, while stakeholders spoke to the openness of the plan for revision, many planners highlighted that it rarely reaches that state. This outcome plan was viewed as the result of a strong process for evidence-based planning, which stakeholders believed fostered an environment of robust decision-making and thus, disagreements and amendments were rarely encountered. As conveyed by one member of the WorHO, “[g]enerally major disagreements do not occur because the planning process is participatory and is grounded in district evidence” (Member, WorHO). Another member at the WorHO maintained:

Up until now, there has been no significant opposition. Because the planning process involves all concerned members and is communicated at all stages, we did not encounter major disagreements. […] The decisions are also made in favour of the community because it is based on community data that identifies highest burden of disease. Because of this, there is no significant change required. (Member, WorHO)

If revision and appeals were to take place, there was evidence of formality at the administrative review phase through participant accounts. Some participants emphasized that the Woreda Administrative Council review meeting would offer an ideal forum for review and
deliberation. The majority of participants revealed that the nature of revision is highly dependent on what stage of the planning process the conflict arises. Many participants conveyed that any disagreements are more likely to arise during the five-day planning meeting, as the process to dispute the plan’s contents and amend the plan are more challenging once it has undergone review at the level of the woreda administrative council. One member of the woreda council reinforced this process as follows:

The ability to amend the annual plan is there. It requires evidence to support the dispute and majority consensus by all parties involved in the decision-making. Most often this amendment takes place at the level of the planning meeting, when they are inputting data into the tool and generating their priorities. Once it has undergone review at each level and it comes to the woreda council meeting, it is less likely that decisions would be as easily amendable. Most planners at this point have reviewed and agreed with the plan. (Member, Woreda Administrative Council)

Should disagreements in the plan or revisions be required at the review stage of the planning process, majority vote, multistakeholder discussion, and data from the community were features widely acknowledged as mandatory for revision. One district member emphasized majority consensus as a primary criterion for amendment, otherwise the decision will not be altered.

Most of the time we do not encounter disagreements during the planning process. If there is a different idea raised, we discuss and reach consensus. This issue mostly arises during the planning meeting. If in few cases any one disagrees with the decision reached and it was decided by most of the participants, it will not be amended. However, if a decision is made by a mistake and somebody complains of it, we come together and review our plan. The data from the district is our main guide in this process. (Member, WorHO)

Another WorHO member echoed similar sentiments of majority consensus by describing:

When conflicts may arise, majority consensus would guide the amendment, because the planning process involves all concerned ones and is communicated at all stages of the hierarchy. But major disagreement was not encountered. If there is a different idea raised, we discuss and reach consensus. Majority vote will result in an amendment should it be justified. (Member, WorHO)

Similarly, another district program advisor spoke to the deliberative nature of this process and the importance of weighing evidence in support of the amendment.

If someone disagrees, he will be asked to present justifications and then there will be hot debate. Generally, major disagreements do not occur, especially at the lower, community
level, because the planning process is participatory and everyone is part of the process from the beginning. But sometimes, either under planning for a certain area or demand for other priority areas that might become an emergency may cause us to revisit the plan. In a situation where this occurs, we need the evidence to prove the change is needed. We reevaluate it and a majority vote is then done among WorHO members and administrative council members with input from select other stakeholders’ … regional … national. (Member, WorHO)

An unexpected observation emerged when many participants described that most revisions to the plan tended to result when the WorHO did not receive the finances necessary to undertake it. During this scenario, many participants highlighted that discussion would take place among district counterparts at a later stage. These counterparts would include WorHO members, donor partners, and members of the woreda administrative council and finance office. Participants who spoke of this scenario described it as a form of “re-prioritization.” Insight into this process was gleaned by further probing where it was asked: “In a situation where you do not receive the monies that the EBPB tool forecasts, how do you re-prioritize where to allocate this lesser amount?” The majority of participants stressed that it was at this point where the plan may be revised in light of funding shortages. One member at the WorHO identified some of the features of this process that focused on multi-stakeholder consultation, inclusive of NGO partners and members of the community.

If the intended budget is not allowed, we will see the list of problems of the community and reprioritize according to priority need. This can be difficult because every issue already included is a priority. This is where we work closely with donor partners to see where we can fill the gap. […] Community consultation is also sought to help solve the budget problems to some extent since the community might be able to raise funds or give free labour to help with the construction of health facilities. (Member, WorHO)

Another member at the WorHO emphasized the need for reliable information during this re-prioritization phase given the challenge of altering already established decisions.

In revising the plan because of fewer monies, we give attention to prevention of diseases because district health needs like maternal and child health, and prevention of communicable diseases such as HIV/AIDS, TB, and malaria take priority. It is hard to reselect over priority areas we’ve planned for. In such cases, we look to district data that reveals the most need. What is the most mortality and morbidity? In our woreda, TB is more of an issue than malaria, so if no donor can assist with meeting our minimal malaria targets, then we push it aside for the time being. (Member, WorHO)
Ultimately with respect to revision and appeals during any part of the health-planning process, the presence of a formal decision-review process based on explicit decision-review criteria was not apparent. During the Woreda Administrative Council review meeting, district health planners did have the opportunity debate on decisions and potentially revise, should this be warranted. Yet, no explicit decision-review criteria was instituted or informally followed by stakeholders. The existing review process was described by one Woreda Administrative Council member who stressed:

Our review process proceeds in a manner that is open and debated. Once the plan is presented, it is open for discussion and members can flag any issue of concern. There is no formal process for this. If there is an issue that members feel needs to be addressed and is not accounted for, then it is raised by the member interested to raise it. (Member, Woreda Administrative Council)

II. Revision and Appeals Condition Satisfied?

In analyzing the revision and appeals condition, the findings demonstrate that while the principles in support of appeals and revisions are present in policy and through stakeholder perceptions, the degree to which appeals are made in practice are less clear. Through the “flexibility principle” of WBHSP, the government has acknowledged the salience of appealing decisions and potentially revising them as part of supporting democratic planning procedures. The presence of the review board of the Woreda Administrative Council acts as an ideal platform for encouraging deliberation and plan review. During this meeting in particular, stakeholders may convene and debate on the contents of the plan once it is formally presented. Through this process, district and regional planners emphasized that if a discrepancy arises—which was described as relatively rare—decisions would be amended based on a majority consensus and evidence in support of the amendment. Participants further revealed that if decisions were to be appealed, the woreda-based planning five-day meeting is the forum under which any amendments would likely arise. In addition, participants described that revisions were often common when the financial resources projected by the plan were not provided and, hence, a form of “re-prioritization” of health priorities had to be undertaken. One of the primary challenges in satisfying this condition was the apparent lack of formal decision-review processes that are based on explicit review criteria. No formal policy or criteria currently guides decision makers in
appealing or revising their plans, or in operationalizing the “flexibility principle.” Table 6.3 provides a summary of the aspects of WBHSP that accord with the revision and appeals condition of A4R.

**Table 6.3. Aspects of WBHSP that Accord with the A4R Revision and Appeals Condition**

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>In policy, the “flexibility principle”</td>
<td>represents an acknowledgement of the salience in plan amendment in support of democratic planning.</td>
</tr>
<tr>
<td>Review board of the Woreda Administrative Council</td>
<td>acts as platform for encouraging deliberation and potential revision.</td>
</tr>
<tr>
<td>Majority consensus, multi-stakeholder review, and evidence</td>
<td>are key criteria during any process of appeals and revision.</td>
</tr>
<tr>
<td>Revision and re-prioritization of the plan</td>
<td>is reliant upon the aforementioned criteria.</td>
</tr>
</tbody>
</table>

To further satisfy the publicity condition, some opportunities for improvement should include:

(i) Developing clearer formalized decision-review process to guide any appeals procedures that may arise throughout the entire planning process (i.e., including who should participate in this process, what criteria should be explicitly followed, etc.).

### 6.1.1.4. Empowerment

To meet the empowerment condition proposed by Gibson et al. (2005b), the priority-setting process should have procedures in place that minimize power differentials across stakeholders at the decision-making table and optimize strategies for effective stakeholder participation. To satisfy this condition, the decision-making milieu should be characterized by a process and set of procedures that encourage stakeholder inclusivity and their active participation.

**I. Cultivating a Planning Milieu for Stakeholder Inclusivity**

In various policies and strategies (such as the Ethiopian Constitution, the HSDP, and the WBHSP strategy), the Ethiopian government has conveyed an aspirational commitment to strengthening democratic decision-making through improved stakeholder inclusivity and
community engagement. Prior to the implementation of WBHSP, the Civil Service Reform Program required all public bodies in Ethiopia to plan using the Strategic Planning and Management (SPM) approach, which acted as the foundation to the development of the HSDP. Here, the SPM approach emphasized the importance of “[…] shared goals and objectives among as many partners as possible, from the federal level to the level of the institution. [Further] the SPM approach encouraged the participation of stakeholders and developing consensus during the various stages of the planning process” (EFMOHa, 2007, p. 25). Under HSDP-IV, the government continued to emphasize the importance of “ensuring full community participation in the planning, implementation, monitoring and evaluation of health care” (FMOH, 2010, p. 3). However, neither the HSDP nor the WBHSP training manual detail explicit procedures to actively engage stakeholders in an organized or explicit manner during the health planning process. Similarly, while the term “empowerment” is a consistent theme throughout the HSDP-IV and, in relation to governance, centers on “empowering employees at every level” (FMOH, 2010, p. 46), specific guidance for health planners to “empower” stakeholders is not detailed. It is apparent through participant interviews and through participant observation that different mechanisms exist to engage and empower internal stakeholders during the decision-making process versus external stakeholders (i.e., NGO partners and community members).

(i) **Active Participation among Internal Stakeholders**

During in-depth interviews, district and regional participants described the five-day planning meeting as a platform where decision makers internal to the process naturally felt as though it was an open forum for dialogue. One member at the WorHO, for instance, stressed how the process engaged all participants in contributing to the plan development.

Everybody in attendance was participating in terms of their role and profession and performed all that was expected from them. For example, new ideas, suggestions, and comments were

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64 Strategic Planning and Management (SPM) was an initiative being introduced under HSDP-III into the public services at all levels under the leadership of the Ministry of Capacity Building. Prior to the adoption of WBHSP, the SPM approach was a participatory bottom-up approach to planning based on assessment of the local situation and identification of strategic issues that need to be addressed (HSDP-III, p. 44).
raised by different people when something should be included and was overlooked. Everyone felt like they could contribute and the Woreda Health Office head made sure to include everyone. (Member, WorHO)

Another WorHO member also identified the EBPB tool as a mechanism that facilitated the participation of stakeholders present in the meeting; particularly given the various service areas and indicators required to be completed in the tool (to be informed by each pertinent WorHO representative). When reflecting on those participants who felt stakeholders could actively contribute in planning, no participant made specific mention of anyone feeling particularly disempowered to advocate for their interests during the planning process.

Each participant had their own contribution. […] Participants were contributing equally because their participation is a must to complete the plan. Plan development, through the EBPB tool, requires full stakeholder input to finalize the plan. Woreda-based planning has improved the level of collective decision-making since the EBPB tool requires a variety of multistakeholder input. (Member, WorHO)

If there was any disparity noted across stakeholder participation in the planning meeting, it was described to be a by-product of the process whereby different levels of expertise were required from different decision makers. One WorHO member aptly described this experience as follows:

Everybody has their roles and responsibilities. The magnitude of their contribution was not equal, but not in a bad way. Different people in attendance have different requirements. For example, the contribution of individuals from the health sector was vast. Yet, even among them, their contribution was different. Representatives from each division of the Woreda Health Office were contributing when issues related to their service area arose. What is good now with woreda health planning is that other members are involved. For instance, a representative from finance was responsible for all budget related questions. The reason why he was involved was to make him aware about health related activities—to enhance his awareness and participation. Discussing the budget code arrangement was also his duty since he knows the amount of budget from government and NGO bodies. At the end of the day, a representative from woreda council was the final decision maker, so it is important that he attends the meeting as well. (Member, WorHO)

As a result, some discussion emerged among participants that focused on the challenges associated with ensuring the equal participation across all members in attendance in the planning meeting. One WorHO member articulated that while everyone’s presence was essential, some decision makers at the meeting lacked confidence given a limited awareness as to the scope of their role in the planning process. This lack of confidence was typically more apparent among
stakeholders outside of the WorHO, such as members from the WoFED and the Woreda Administrative Council.

Everybody had their own roles and responsibilities, although some did not know what was expected of them to the full extent. Therefore, the magnitude of their contribution was not equal. For example the contribution of individuals from the health sector was vast. But even among them their contribution was different. Some felt like they were just sitting there and not as engaged. Their lack of engagement was mostly common among the members from the administrative council. Also, non-government partners may feel left out during most of this process. It [the process] can be very technical and until we need them for a specific service area, they can feel distant to this process. (Member, WorHO)

Another WorHO member spoke to the demotivation among stakeholders should other pertinent stakeholders be missing from the meeting. “We started woreda based planning last year and during that time, some responsible bodies were not included in the process. Because of that, many staffs became demotivated and they were not as engaged in the process” (Member, WorHO). This experience illustrates some of the sentiments conveyed by participants that highlighted empowerment as partly stemming from collegiality among decision makers; in that, stakeholders may be more inclined to actively participate in planning when they all other pertinent stakeholders are present at the woreda-planning meeting.

(ii) Active Participation of External Stakeholders

Among external stakeholders—including NGO partners and community members—all participants spoke of weak structures in place to meaningfully engage these stakeholder groups. As previously alluded in Section 5.2.1, the level of NGO engagement in district health planning was still considered inconsistent by participants. Based on informal discussions with training facilitators during the planning meeting, it was described that NGO partners played an important role in the process and would be invited to the planning meeting to partake in the completion of the EBPB tool (i.e., to inform the WorHO how it could assist in meeting the district’s goals for that upcoming year). District health planners further acknowledged these sentiments during participant interviews by describing the importance of NGO participation in woreda planning.

For instance, one member from the WorHO emphasized the importance of engaging all
stakeholders in district health planning, paying particular attention to the salient role NGO partners play in aligning district health activities.

All government planners and NGO partners are important to woreda planning. We must plan together and encourage collective planning under woreda planning. Even our NGO partners need to be brought into this process and encouraged to work in alignment with the Woreda Health Office. It is about leveraging resources and working together. (Member, WorHO)

Here, empowerment was partly conceptualized as “being brought into [the] process” of planning. As described by one WorHO member, this inclusion was viewed as “the first step to empowering stakeholders. Everyone, even the NGOs, need to be engaged and encouraged to participate. It is important that we ensure that all important members are invited and attend.” Similar sentiments were expressed by another NGO representative who spoke to the importance for a decision-making milieu to be cultivated that encourages stakeholders, particularly NGO partners, to feel open in disclosing their concerns and views.

Active participation is the key [of all members]. We must be comfortable to openly discuss because engagement of all important stakeholders is crucial for legitimate planning. Everyone must be on the same page to accept the decisions for the upcoming years. (NGO representative)

Yet while the participation of NGO partners was acknowledged as important to achieving the goals of alignment, many NGO partners conveyed feeling withdrawn from the process. These feelings of withdrawal appeared rooted in either not being actively invited to participate in the WBHSP process, or for those partners who were invited, feeling that their organizational goals would be absorbed into the district’s agenda. As described by one NGO representative,

Our agendas are to fit within the government’s agenda through harmonization, and woreda planning. Through this revised process, we are encouraged to come and participate, which is an important step. The challenge is making sure that we can advocate for our programmatic goals as well. It’s an accountability issue that can become challenging for us. (NGO representative)

The active participation of some NGO partners, therefore, appeared somewhat limited by the lack of clarity regarding alignment between their organizational goals and those goals of the WorHO. As articulated by another NGO representative,
We come to the woreda-based planning meeting to assess how we can align our program agenda with the government’s plan, but this process is complicated too. Mostly because we have our own agenda and reporting and need to meet our [organizational] needs. It is a balancing act and this limits our willingness to partake in the planning. (NGO representative)

Of those NGO partners who did attend and participate in the planning meeting, there was a lack of clarity as to whether they felt encouraged and supported by their district counterparts to actively engage; perhaps influenced by the degree to which NGO partners felt they could contribute. Many NGO partners interviewed also conveyed feeling “disconnected” and “removed” from the process. One partner emphasized their limited knowledge of the EBPB tool as an underlying component to feeling disconnected.

One of the major challenges of this planning process is that I do not know how to use the evidence tool and because of this, I do not feel like I am a real part of the process. The district health officials are using it alone, but they too, struggle to understand it. So, how can I be expected to engage in the planning process? We all sit around talking and this is how the delays in completion arise. (NGO partner)

Based on participant discussions, it did not appear that there was any form of active engagement to empower NGO partners through training. Partners appeared to be invited simply to contribute to discussions, which leaves their level of empowerment to actively participate questionable. In addition to the lack of clarity surrounding the engagement of NGO partners and their role in this process, less clear has been the role of community members in district health planning and priority setting. Acknowledged in the HSDP-III, health planning and program implementation must, “[…] aim at enhancing community involvement [emphasis added] in the management of health facilities and public health interventions” (FMOH, 2010 p. xvi). Similarly, it further describes that in order to achieve the health goals and objectives set-forth, one of the major strategies should be to “[…] ensure full community participation [emphasis added] in the planning […] of health care” (FMOH, 2010, p. xvii). In addition, it was believed that through the improvement of health management information systems, community access to timely information would also increase and facilitate community engagement (FMOH, 2010, p. 28).

While engaging community members has been clearly acknowledged in the health policy as an important component to achieving the health goals of the district, many participants felt that
the community was disengaged from the process. For one, members of the community-at-large were not present during the five-day planning meeting. While interviewing community members was not a part of the scope of this study, government health planners and NGO partners interviewed maintained that empowering the community to actively participate was weak. As succinctly noted by one WorHO member:

> There was no involvement of community representatives during woreda-based planning. We need to involve communities because the community themselves should devise solutions for their own real problems. As a result, we need a stronger system of planning that acknowledges the importance of their role and is able to collectively engage members and ensure their active participation in the planning and review of our comprehensive plan. (Member, WorHO)

Participants also emphasized that many of the limitations to actively engage the community in the decision-making process was not only rooted in whether the community should be involved, but in uncovering meaningful and effective ways to harness and incorporate their input and participation. As one member at the WorHO described:

> The need to involve communities is interesting because the community themselves should devise solutions for their own real problems, but it is another capacity issue. Accessing communities and individual members in a coordinated and meaningful way is the ongoing challenge. (Member, WorHO)

When reflecting on the empowerment condition, a key consideration lies in understanding how well the current process is enabling communities to devise solutions for their own problems. While policy and the views of participants acknowledge the important role of the community in highlighting and advocating for their health needs, current planning processes leave these members peripheral in the process. Some participants interviewed, such as regional and district health planners, explained this minimal community engagement as likely the result of the heightened technicality of the meeting and, therefore, felt that community contribution would not be ideal at this planning stage. To overcome this challenge, it became clear that community members did have some representation during the Woreda Administrative Council review meeting via the participation of selected community leaders. During this meeting, participants described that selected community leaders would act on the behalf of the community to verify
“kebele” (community) needs prioritized through the plan. A few participants described this activity as one mode of community engagement. As described by one WorHO member,

We have representation of community leaders and they act on behalf of the kebeles. They return to the community to discuss what the plan includes. This is indirectly including the communities since they have no direct involvement. But it is a way for them to be informed. (Member, WorHO)

However, it was unclear the level to which community leaders were encouraged to actively engage in discussions and comment on the plan during the Woreda Administrative Council meeting. A few participants described the role of community leaders as important in relaying information back to the communities, but were more peripheral at the review meeting. One member of the Woreda Administrative Council emphasized, “community leaders are present to represent their kebeles and to learn of the intentions of health plan. They are the voice of the community. If there is any issue that they feel is not acknowledged in the plan, they are welcome to discuss with everyone present” (Member, WAC). Engaging the community leaders was therefore believed to cultivate a forum of shared decision-making where external stakeholders are empowered to feel they do have a role in health planning (even if more distal to the process).

However, this view was only documented at the level of the Woreda Administrative Council review meeting. Community leaders were not invited to attend the WBHSP meeting. Thus, while attempts were made to include the community through the presence of selected community leaders, their level of active engagement was hindered by their limited exposure during the plan’s actual formulation.

II. Empowerment Condition Satisfied?

In analyzing the empowerment condition, the findings demonstrate that mechanisms to actively engage internal stakeholders are stronger than in comparison to external stakeholders. Although policy documents at the national level do speak to an aspirational commitment to improve multi-stakeholder and community engagement as well as the overall empowerment of all stakeholders, it is clear that internal stakeholders have a stronger presence at the decision-making table given their intimate connection in the development and review of the plan. Some participants conveyed sentiments that the technical expertise possessed by district health planners
cultivated a decision-making milieu where they [district health planners] were more confident to complete the EBPB tool. However, this view was countered with other participant responses that conveyed sentiments that active modes to participate did not exist for all stakeholders at the planning meeting; with some feeling left unengaged and voiceless, such as members of WoFED and the Woreda Administrative Council.

On the other hand, the empowerment and active engagement of external stakeholders—NGO partners and the community—was much weaker. While NGO partners were encouraged by the government to attend the planning meeting, some participants articulated feelings of withdrawal from the process for a lack of technical skills required to understand and manage the tool. Here, a lack of understanding the intricacies of the EBPB tool appeared to foster a decision-making milieu that NGO partners felt was disengaging for them. In addition to these external counterparts, the active engagement of the community also remained rather weak given the nebulous scope of their role. While bringing community leaders into this process was an indirect mechanism to engaging the community, their level of active participation in the development of the district plan was limited; although their presence in the plan review was present. Table 6.4 provides a summary of the aspects of WBHSP that accord with the empowerment condition of A4R.

<table>
<thead>
<tr>
<th>Table 6.4. Aspects of WBHSP that Accord with the A4R Empowerment Condition</th>
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- Government documents acknowledge an aspirational commitment to strengthening multi-stakeholder and community engagement in decision-making. However, no formalized or institutionalized structures in place to promote active participation.

- Intrinsic mechanisms in place, such as completion of the EBPB tool, to encourage active participation of internal stakeholders directly involved in planning.

- External stakeholders, such as NGO partners and community leaders, are invited to participate in the development and review of the plan; although extent to which they are actively engaged remains unclear.
To further satisfy the empowerment condition, some opportunities for improvement should include:

(i) Explicitly outlining mechanisms in government policy that articulate the scope of each internal and external stakeholder’s participation and their role in the planning process.

(ii) Mechanisms to strengthen the voice of the community can be augmented through the participation of community leaders in the planning meeting.

(iii) Incorporating explicit strategies for staff empowerment into all leadership development activities (i.e., ensuring that the chair of any planning or review of the annual plan meeting has explicit criteria for ensuring all stakeholders present have an active voice).

6.1.1.5. Enforcement

To meet the enforcement condition in A4R, there must be public, voluntary, or institutional regulations established to support the previously described conditions (Daniels & Sabin, 1998). Decision-making that is supported by these regulations is believed to establish accountability structures that enable fair and legitimate planning to be upheld (Daniels & Sabin, 1998). To satisfy the enforcement condition, the priority-setting process should be characterized by regulative procedures that enact, monitor, and strengthen the manifestation of each condition.

I. Regulative Procedures to Enact the Aforementioned Conditions

Since 2002, the government has sought to decentralize health governance to the district-level; thus providing district health planners with greater organizational guidance to develop and implement their annual plans in accordance with their district needs. In particular, two strategies extending from the HSDP—namely, the HMM and WBHSP—have sought to detail how district planning should unfold, who is to be involved in the process, and in what capacity they should be involved. The HSDP policy, for one, “act[s] as a comprehensive national plan and guiding framework for regional and woreda detailed planning” (FMOH, 2010, p. xii). Moreover, it sets in motion a framework for planning that outlines the national government’s vision for establishing which health areas should be prioritized, and which structural and human resource considerations need to be made. In addition, it underlines a set of core values that aim to guide the
operationalization of the government’s health sector agenda. These include: placing the needs of the community at the fore; collaborating with multiple stakeholders in the realization of their vision; staying committed and open to change and reform; and ensuring trust and integrity among all stakeholders (FMOH, 2010, p. 199). Figure 6.2 provides a map of the health sector’s strategic goals underlying the core values that support evidence-based planning, stakeholder participation, community empowerment, and harmonization and alignment.

**Figure 6.2.** Ethiopian Government Health Sector Strategy Map (taken from FMOH, 2010, p. 42; boxes highlight areas of alignment with A4R conditions)
Thus, through the adoption of the HHM, HSDP and the WBHSP strategy, the national government has instituted regulative structures that have facilitated in the operationalization of each condition to varying degrees. For one, the HSDP-IV is organized around a set of strategic targets that speak to aspects of each condition previously discussed. Table 6.5 lists these strategic objectives and targets, and places an asterisk beside those that align with and underscore the A4R conditions.

**Table 6.5. Strategic Objectives and Targets of the HSDP-IV**
(consolidated from FMOH, 2010, pp. 42-56)

<table>
<thead>
<tr>
<th>Strategic Objective 1</th>
<th>Improve health *</th>
</tr>
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<tbody>
<tr>
<td>Strategic Objective 2</td>
<td>Improve access *</td>
</tr>
<tr>
<td>Strategic Objective 3</td>
<td>Improve community ownership *</td>
</tr>
<tr>
<td>Strategic Objective 4</td>
<td>Maximize resource utilization</td>
</tr>
<tr>
<td>Strategic Objective 5</td>
<td>Improve delivery of quality health services</td>
</tr>
<tr>
<td>Strategic Objective 6</td>
<td>Enhance harmonization and alignment *</td>
</tr>
<tr>
<td>Strategic Objective 8</td>
<td>Improve emergency preparedness and responses</td>
</tr>
<tr>
<td>Strategic Objective 9</td>
<td>Improve evidence-based decision making*</td>
</tr>
<tr>
<td>Strategic Objective 10</td>
<td>Improve health infrastructure</td>
</tr>
<tr>
<td>Strategic Objective 11</td>
<td>Improve resource mobilization</td>
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<tr>
<td>Strategic Objective 12</td>
<td>Improve human capital and leadership *</td>
</tr>
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</table>

(i)  **Regulative Structures Upholding Relevance**

As previously described, to satisfy the relevance condition, decision-making must be characterized by the presence of explicit decision criteria, the use of evidence in applying the criteria, and the presence of multiple stakeholder perspectives to increase the chance that all the relevant reasons will be identified and inform decision-making. To uphold the relevance condition, a variety of strategic policy directives have been instituted since the adoption of the HSDP strategy, and most recently, through the implementation of the HHM and WBHSP.
strategies. Through these strategies, district health planning now provides decision makers with explicit criteria that focus their attention on pertinent evidence deemed relevant for setting health priorities at the district level. For instance, under *strategic objective 1: improve health*, the HSDP-IV outlines the relevant health issues identified by the government as priority criteria. These include a focus on improving the health of mothers, neonates, children, adolescents and youth; improving the nutrition status, hygiene, and environmental health of individuals; and reducing the incidence and prevalence of HIV/AIDS, TB, and other communicable and non-communicable diseases to meet the MDGs (HSDP-IV, p. 43).

With the emergence of the WBHSP strategy, the EBPB tool has been a recent regulative measure that facilitates relevance in planning. In particular, the tool structures district health priority setting around the criteria described in the HSDP; focusing their attention on which targets to prioritize, and the degree to which they should be achieved. For instance, given that malaria is a key health priority at the national level, the EBPB tool incorporates this service area within the EBPB tool by requiring district health planners to document the proportion of children under five sleeping under insecticide treated bednets. Therefore, such a regulative tool now creates a planning process whereby relevant criteria prioritized at the national level are systematically applied and used at the district-level for setting district health priorities. Further, *strategic objective 9: improve evidence-based decision-making*, also supports the operationalization of the relevance condition, as the government explicitly highlights the relevant evidence that should be captured and used in the EBPB tool to guide decision-making. This evidence includes data and research captured from the specific district communities, which identify critical health priorities requiring attention within the annual plan (FMOH, 2010, p. 54).

Another important feature of relevance in fair and legitimate planning involves the presence of multiple stakeholder inclusivity to enhance the potential for all relevant stakeholder views to be weighed and considered in decision-making. The concept of “governance” is an important feature consistently described throughout the HSDP-IV policy. Here, it is defined as “how the development and implementation of the plan is organized, managed, and communicated—the responsibilities of the different organizations involved, the mechanisms for
policy-making, planning, monitoring and evaluation and co-ordination among them” (p. 68).” The HSDP also acknowledges the importance of all stakeholders in the process, including that of citizens, NGOs, donors, “who all have a relevant role to play” (p. 68). To encourage multistakeholder engagement, the HSDP, HHM, and WBHSP do acknowledge its importance as a mechanism to facilitate inter-sectoral collaboration in district health planning. In particular, strategic objective 6: enhance harmonization and alignment acknowledges the importance of enhancing partnerships and inter-sectoral collaboration in order to achieve goals of the health policy. The HHM and the WBHSP strategies have established a structure of decision-making through the one plan principle that cultivates a planning milieu supportive of collective decision-making; as the one plan principle inherently requires the participation and consultation of multiple stakeholders in coordinating their plans and advocating for their programmatic interests.

Under objective 6, district health planners are also encouraged to engage partners. The relevance of this procedure is documented in the HSDP-IV via tracking the percentage of partners implementing the “one plan.” (i.e., to increase from X% to 75%). This activity establishes a structure of planning that encourages the weighing of different stakeholder views and has instituted a measure of tracking it. To further support collaboration in health decision-making environment, the government provides explicit detail in the HSDP-IV on which stakeholders should attend the Woreda Joint Steering Committee meeting; which, to reiterate, holds the role of reviewing and monitoring the implementation of the district annual plan (FMOH, 2010, p. 71). Therefore, through government policy and the adoption of recent tools and procedures (extending from the call for increased harmonization and alignment and WBHSP), it is apparent that there exist a number of regulative measures in place that enforce the relevance in planning, as viewed through the lens of the A4R.

(ii) Regulative Structures Upholding Publicity

To satisfy the publicity condition of A4R, decisions and their rationales must be made publicly available to stakeholder groups, so as to promote public disclosure. As previously described, publicity is heavily concerned with both internal and external transparency of goals and objectives; of priority setting criteria; of who is involved in the process; and in how decisions
will be and are made. While a number of regulative structures to encourage openness and public disclosure are documented in the HSDP-IV and via the WBHSP strategy, no frameworks or tools are explicitly provided to facilitate or monitor such activity. Under *strategic objective 2: improve access*, for instance, the main objective is to ensure that the “community has increased awareness on health matters (FMOH, 2010, p. 48). Yet, there are no explicit measures described that attempt to facilitate the disclosure of district health plans, or the procedures or rationales to the external stakeholders, such as the community.

To encourage transparent decision-making, the establishment of the Woreda Administrative Council Review meeting, as described under relevance, has been one forum of significance that has instituted a process of plan dissemination. In the HSDP-IV policy, these stakeholders include: district health personnel, heads of health centres in the district, the medical director of the district hospital, WoFED representatives, RHB representatives, and NGO partners. Thus, the policy clearly acknowledges who is to participate, including both internal and external stakeholders. In addition, the HSDP-IV explicitly states that stakeholders meet quarterly to review the contents and monitor the progress of the annual plan. During this meeting, some participants spoke to the presence of a clear reporting structure or agenda to guide participants during the meeting. As described by one member from the Woreda Administrative Council:

*We have a procedure in place, whereby everyone, including members from the woreda health office, woreda finance, local partners, regional representatives and community leaders, all meet to review the contents of the plan. First there is an introduction and then members from the woreda council go through the agenda of the meeting with each sector.* (Member, Woreda Administrative Council)

Through the detailed structure of this meeting, it is evident that efforts to promote internal transparency have been instituted by the government to guide planners in accessing pertinent information through discussion. Therefore, the HSDP-IV does institute a practice of collective gathering among stakeholders that encourages discussion of the plan. However, it does not provide clarity on the level of detail and the specific content to be disclosed, nor did any participants reveal the extent to which public disclosure should manifest, how and to whom.
(iii) **Regulative Structures Upholding Revisions and Appeals**

To satisfy the revision and appeals condition, there must be mechanisms present for stakeholders and decision-makers to challenge and revise decisions in light of new evidence, and resolve disputes in this process of revision. As previously described, this process would provide stakeholders with an opportunity—via a meeting, meeting, event, or other communicative forum—to voice their opinions and, subsequently, to enhance democratic planning. Explicitly detailed in the WBHSP strategy, the government acknowledges the importance of revision via the flexibility principle; one of the seven principles underpinning the WBHSP strategy. Through this principle, the government has recognized the salience of having level of flexibility in the planning process that facilitates important revision, when necessary (EFMOHb, 2007, p. 9). Yet, as described in section 6.1.1.3, no explicit guidance from the government—whether through the HSDP, WBHSP strategy, or other-related documents—are provided to encourage such review processes in a structured format, or to monitor how these procedures may transpire in practice and/or their frequency of occurrence. Thus, while the government has acknowledged “flexibility” as a critical component of planning, no detailed or explicit frameworks are provided to guide decision-makers in the revision process, should it arise.

(iii) **Regulative Structures Upholding Empowerment**

To satisfy the empowerment condition, the decision-making process should have procedures or mechanisms in place that encourage stakeholder inclusivity and their active participation. The implementation of WBHSP, in and of itself, has been one of the primary strategies implemented by the government with the aspiration to strengthen the leadership capacity of managers and planners at all levels of the health system (EFMOHb, 2007, p. VII). Through the strategic initiative of WBHSP, the government has implicitly sought to empower district health planners via the adoption of a more standardized mode of district health planning that will provide them greater authority over the decisions made. However, very little policy directives have been provided by the government that identify key strategies to strengthen the role and empowerment of district level planners. While the Woreda Joint Steering Committee,
described under relevance and publicity, has been a core forum of engagement instituted by the government to encourage stakeholder inclusivity in decision-making, explicit directives to encourage the active participation of all participating stakeholders, particularly district health planners, remains limited. Although the HSDP-IV makes a strong case for stakeholder inclusivity and collective stakeholder participation, it does not provide an explicit framework for ensuring that all stakeholders in attendance will feel encouraged to actively participate.

In addition to the empowerment of internal stakeholders, the government describes the importance of encouraging the inclusion and empowerment of external stakeholders. In particular, *strategic objective 3: improve community ownership*, is one of the key strategic objectives described in the HSDP-IV that has sought to “create awareness and change behaviour of the community in order to ensure that their full participation in: policy formulation, planning and implementation; monitoring and evaluation; and regulation are met” (FMOH, 2010, p. 48). To achieve this process, the HSDP-IV explicitly acknowledges the outcome goal to “empower communities that ensure sustainability of health programs and get involved in the administration and regulation of their respective local facilities” (p. 48). However, there does not appear to be specific measures outlined to capture the degree of community engagement or empowerment, nor to institutionalize such strategies in practice. While some participants did acknowledge the presence of community leaders at this meeting—as representative bodies of the community—explicit mention of their participation was not identified by participants, nor explicitly described in the HSDP-IV. As a result, the extent to which community engagement has been institutionalized to participate and inform of decision-making processes remains limited.

**II. Enforcement Condition Satisfied?**

In analyzing the enforcement condition, the findings demonstrate that a variety of policy directives and regulations documented in the HSDP, HHM, and WBHSP have institutionalized various elements of each A4R condition. In particular, the strategic objectives outlined in the HSDP reveal a variety of key government-led goals that enforce the operationalization of each condition. In upholding relevance, for instance, the strategic objective 1 (*improve health*)
provides a selection of priority health criteria for district health planners to focus their health planning efforts at the district level. Through the isolation of health criteria at the national level, district health planners are now focused to prioritize their health plans within the national goals and objectives. This action has been further operationalized through the implementation of the EBPB tool that now “enforces” district health planners to use these criteria laid out in the HSDP in the Excel tool. Similarly, through strategic objective 9 in the HSDP (improve evidence-based decision-making), the government has now oriented district health planners to prioritize their plans around key health evidence deemed important at the national and international level (i.e., MDGs). Moreover, the WBHSP strategy has provided further regulative structure to operationalize this process of evidence-based planning via the EBPB tool. Through each of the aforementioned policies, there is not only an aspirational commitment for planning using relevant criteria and evidence, but also a commitment manifesting in practice through the adoption of the EBPB tool.

Also documented in the HSDP-IV, the government has further sought to institutionalize processes for increased multi-stakeholder engagement in health planning. The development of the Woreda Joint Steering Committee has been an example described in the HSDP-IV that details the purpose of increased stakeholder engagement, who is to attend, and how often. The aspirational commitment to this process of increased collective decision-making and the government’s efforts to institutionalize it into practice bear implications on upholding conditions of relevance and publicity. Only through forums of increased dialogue can the relevance of what is prioritized in the plan be optimized (i.e., through the incorporation of varied perspectives and values). The practice of the woreda five-day planning session is an additional forum of collective decision-making where stakeholders convene and openly discuss district health priorities.

When reflecting on the enforcement of publicity, both the development of the Woreda Joint Steering committee and the Woreda Administrative Council meetings have been mechanisms outlined in policy with the goal to “enforce” such practices of plan dissemination and review. In particular, objective 2 (improve access), objective 3 (improve community ownership), objective 6 (enhance harmonization and alignment) emphasize the importance of
enhancing community participation, awareness, and inter-sectoral collaboration. However, there still lacks explicit measures acknowledged in the policy to regulate how different stakeholders are engaged in the dissemination of the plan and made aware of the rationales underpinning the priorities set.

With respect to upholding revision and appeals, although the government acknowledges the importance of flexibility in the planning process (to facilitate revision if necessary), there were no clear institutional regulations in place to formally guide this process of review (outside of the list of stakeholders who should be in attendance at the level of the Woreda Administrative Council review meeting). Moreover, to enforce principles underscoring the empowerment condition, strategic objective 12 (strengthen leadership), outlines measures in policy to support the empowerment and capacity of all planners throughout the health system; with an emphasis on both internal and external stakeholders. Yet, while measures to encourage the inclusion of the community in the decision-making process are present in policy, no clear mechanisms are described to operationalize these aspirations.

Overall, it can be argued that while the government supports many of the principles defined in A4R through its policies and guidelines, there is often a lack of standardized mechanisms and procedures to explicitly guide planners in the operationalization of these principles; particularly around community engagement and public disclosure, and revisions associated with the plan. Table 6.6 provides a summary of the aspects of WBHSP that accord with the enforcement condition of A4R.
Table 6.6. Aspects of WBHSP that Accord with the A4R Enforcement Condition

- Presence of HSDP strategic objectives 1 and 9, which align in policy and practice with supporting the operationalization of the relevance condition—to explicitly guide decision makers on which health priorities to focus, and how to measure improvements in health status through the EBPB tool.

- Presence of HSDP strategic objectives 2, 3, and 6 that align in policy with supporting the operationalization of publicity.

- Presence of WBHSP flexibility principle, which align in policy with supporting the operationalization of revision and appeals.

- Presence of HSDP strategic objectives 3 and 6, which align in policy with supporting the operationalization of empowerment; although not entirely explicit.

- Presence of active evaluation of procedures to monitor, evaluate, and strengthen governance activities under WBHSP.

To further satisfy the enforcement condition, some opportunities for improvement should include:

(i) Developing explicit mechanisms (i.e. feasible and sustainable strategies that are culturally appropriate), to provide further institutional regulations for operationalizing inter-sectoral collaboration, community participation and empowerment.

(ii) Developing explicit mechanisms to provide further institutional regulation for enhancing public disclosure of decisions and their rationales.

(iii) Developing explicit mechanisms and/or frameworks to guide the review, revision, and appeals process, if they should arise.
6.1.2. Participant Conceptualizations of Fairness and Legitimacy

Daniels and Sabin (2008) maintain that when we lack consensus on the principles that tell us what is fair, but are burdened by reasonable disagreements on how they apply, we may opt for a procedure that most who are affected would accept as fair (p. 4). Through this lens, a fair process largely determines what is considered as a fair outcome decision. As a result, legitimacy and fairness are central features of decision-making process; legitimacy being concerned with how authority manifests and who is given this authority, and fairness concerned with appropriate standards that all involved agree with when reflecting on resource distribution (Daniels & Sabin, 1998). Over the past decade, the conditions of A4R have become a prominent conceptual guide defining the features that characterize fair and legitimate health decision-making. The conditions, however, emerged from Western conceptualizations of what constitute fairness in “limit-setting;” thus placing transparency, public engagement, and principles of democratic deliberation at the fore.

To date, there is a paucity of literature that captures how decision makers outside of the West, particularly from the “Global South,” conceptualize fair and legitimate health planning and whether concepts of transparency, public engagement, and democratic deliberation naturally emerge as prominent features in such contexts. I sought to contribute to the ethics literature by examining how Ethiopian decision makers conceptualize fair and legitimate health planning and, further, analyze the degree of alignment between these conceptualizations and the principles espoused in A4R. As researchers aim to strengthen the sustainability of democratic procedures in contexts of the Global South, it is imperative that we gain a deeper understanding of the Ethiopian values and perspectives that shape how decision makers convene and engage in health planning. Such an understanding will cultivate a deeper understanding for the application of the A4R framework and, henceforth, the sustainability of its principles.

To gather these insights, questions were asked that sought to explore the characteristics that stakeholders attributed to a “fair” decision-making process, if they believed there was fairness in their planning process, whether they believed that changes should be made to improve planning fairness, and if so, how specifically. With respect to the concept of “legitimacy”, the
same questions were posed, however, the term “fairness” was substituted with term “legitimate.” In the following sections, the key themes in association with the concepts of fairness and legitimacy that emerged from participant accounts are described. In a few cases, findings indicated that participants used the terms “legitimacy” and “fairness” interchangeably. This synonymous usage does not necessarily mean that the concepts are the same, but simply that participants conceptualized certain features of planning, such as evidence-based planning, as both a feature that promotes fairness and supports legitimacy. Each theme described in the following sections highlights the dominant views that participants felt encapsulated each concept. This section ends with a summation of two critical questions in Section 6.1.3; namely: (i) what features, from participant perspectives, give moral authority to priority setting decisions?; and (ii) on what basis are these priority setting decisions justified as being “fair” by participants? In section 6.1.4, the degree of alignment between the Ethiopian conceptualization of fairness and legitimacy is discussed in relation to the conditions of A4R.

6.1.2.1. Fairness and Legitimacy Conferred through Evidence-Based Planning and Criteria Grounded in Community Need

Evidence-based decision-making alongside criteria grounded in capturing community need were dominant characteristics of both fair and legitimate planning that emerged among participants at all levels of government. When asked what are the characteristics of fair decision-making, the majority of participants conceptualized fairness as being upheld if criteria used to guide decision-making “incorporated baseline data” and “prioritized the highest burden of disease.” Many participants articulated that planning in accordance with such rationales conferred both fairness (in meeting the direct needs of the community) and legitimacy (through using criteria rooted in the national government’s HSDP plan). One WorHO member stressed the importance of addressing community need and severity of illness as a measure of supporting a fair health planning process. “A fair process must give priority to the major health problems of the community and include the magnitude, feasibility, and severity of illness within the community and support the community’s concern, which it did” (Member, WorHO). Another WorHO member further described a more explicit process with defined criteria as characterizing
fairness in planning, as it removed the subjective nature of ad hoc planning from the past, and now, through WBHSP, was able to explicitly select interventions with proven efficacy.

Fairness is present in planning when decisions are based on baseline data and is therefore no longer subjective. The planning method [under WBHSP] used evidence-based data and interventions that have shown proven success in addressing these major health issues. These interventions have been approved by the Lancet and the British Medical Journal and so, it is fair when it is based on what works. (Member, WorHO)

Fair planning was therefore conceptualized by many participants as planning in alignment with criteria that captures the “burden” and “needs” of the district communities. Similarly, many participants also stressed that basing such decisions on concrete evidence that captures this burden and need, also confers a sense of fairness in planning. One member at the district level maintained, “[p]lanning is fair if decisions are based on concrete data and evidence that capture the needs of the community” (Member, WorHO). Another district health office member further emphasized that in comparison to previous years, fairness in planning has been strengthened through improved efforts to enhance concrete data and evidence. “Our planning is quite fair in comparison to years past because it is now based on concrete data and evidence from the community that is aligned with capturing the highest burden of disease in the evidence-based tool” (Member, WorHO). When asked if they felt fairness was present during their decision-making process, many felt that while efforts to improve evidence-based planning strengthened fair resource allocation, improvements in strengthening the capacity of health planners were needed. One WorHO member emphasized the need for improvements to fairness to focus on capacitating health planners as well as increasing personnel on the ground.

Yes, anyone can say it was fair. If we considered our last year’s achievement, it was about 80% in terms of fairness. When we plan this year’s activity, we use [last year’s report] as baseline information in addition to the EBPB tool. But still our planning is not 100% fair. For instance, we have a shortage of manpower and this has its own implications in the planning process; even in understanding things. So to be fair, well-trained individuals should be assigned in planning department team. (Member, WorHO)

Similarly, this view was further reinforced by a WorHO member who also maintained that improvements to fairness in planning be achieved by enhancing the capacity of planners through the provision of trainings and infrastructural measures. “To improve fairness, it is better to […] improve the availability of computers to district health offices and enhance the skill required.
Also, it is important that enough planning manuals and guidelines be supplied” (Member, WorHO).

When asked to describe the characteristics of legitimate decision-making, the majority of participants also highlighted features that included planning in accordance with district health needs, and through the use of concrete evidence that captures these needs. One WorHO member, for instance, emphasized that legitimacy relies upon procedures that prioritize community need. “We say legitimate when first of all, the decisions are based on priority health problems in the community” (Member, WorHO). One member of the RHB reaffirmed this view and, also stressed the salience of evidence in grounding decisions that are based on community need.

[...] The criteria that we use to guide our decision-making captures the needs of the community and the highest burden of disease. At the basic level the community should feel our decisions are legitimate because they are grounded in real evidence from the kebele that reveals their needs and that this evidence is prioritized from the national level. The evidence tool that we use structures our planning is this way (Member, RHB).

In addition to planning in alignment with district needs, many participants further emphasized the notion of planning with robust and concrete data as conferring legitimacy. One zonal program officer for instance, conceptualized legitimacy in health planning as being as based on “quality” data. “Legitimacy decisions come from using legitimate data that is of quality” (Member, ZHD). Quality of decisions in this sense confers both legitimacy and authority. He went on to further describe:

Deriving decisions from what the evidence suggests is how we build legitimate planning processes. Because decisions are then made on the data obtained from the needs of the community. This is why it is important that we strengthen the capacity of health professionals to take woreda information accordingly and accurately—to build legitimacy. (Member, ZHD)

Furthermore, a technical officer from the WorHO maintained that through concrete data, planners are able to capture the real evidence that speaks to the needs of the district communities who they are trying to assist.

Planning is fair if decisions are based on concrete data and evidence that capture the needs of the community. Planning in this way legitimizes our decisions because the evidence indicates that maternal health services are of great concern, for instance. All
decisions need to be based on such concrete evidence to be considered both fair and legitimate. (Member, WorHO)

This view also appeared to reinforce notions of accountability among some participants. Another district health officer, for instance, spoke to the increased accountability that arises when decisions are based on evidence and data from the district. “Legitimate planning leads to more accountable planning. By doing evidence-based planning, it establishes accountability and legitimacy because decision-making is based on data from the ground [community level]” (Member, WorHO).

Reflection on Ethiopian Conceptualization of Fairness and Legitimacy

Ethiopian health planners conceptualize fair and legitimate health planning as decisions based on concrete evidence that captures the health needs and disease burden of the community. This reveals an outcome-based conception of fairness that focuses on the concept of “need” as a distributive norm. Further, the concept of “quality” and “concrete” data also confers a level of authority in decision-making and as a result, what is conceptualized as legitimate.

6.1.2.2. Fairness and Legitimacy Conferred through Multistakeholder Engagement and Deliberation

Multi-stakeholder engagement and deliberative dialogue between government officials, NGO partners, and the community also emerged as locally conceptualized characteristics of a fair and legitimate decision-making process. The majority of participants framed these characteristics around the deliberative nature of decision-making, the importance of active participation and dialogue among all stakeholders during this process, and the importance of ensuring that avenues to include external stakeholders, such as the community and NGO partners, also be nurtured. By upholding these characteristics, it was believed the plan also upheld a level of “authority” given the multiple views engaged in its development. When asked what features characterize fair decision-making, the majority of participants, at all levels of government, acknowledged multiple stakeholder input as connoting fairness; largely through the weighing of varied and multiple
stakeholder views. One WorHO member described a fair process as one that includes all stakeholders in the review process, thus validating the importance of peer review and stakeholder deliberation. They stated, “[t]o make it [the planning process] fair, there is a meeting at the woreda-level quarterly and annually. By inviting all stakeholders, the plan will be criticized accordingly and considered fair as a result” (Member, WorHO). Further to this view, another WorHO member went on to conceptualize fairness of multistakeholder engagement as a means to encouraging varied perspectives when prioritizing health services and developing the plan.

Our planning is fair because we have many viewpoints that are being considered in the decision making process. By considering everyone’s view means that no one decision is taking precedence over another. Each decision is judged by multiple stakeholders at the table. (Member, WorHO)

Many participants also identified engaging the community in planning as an indicator of fairness. One member at the RHB emphasized, “[…] The community is the most important stakeholder and should be involved at all stages because they are impacted by these decisions. If there is a priority to engage the community in decision-making, then we can say it is fair” (Member, RHB). Fairness, in this sense, was conceptualized as including members of the public in the decision-making process, who would ultimately be impacted by the decisions made. Participants also described the importance of engaging with the community to increase awareness and enhance transparency and community ownership. For instance, one WorHO member described: “For me, fairness of health planning includes many components […] Being transparent with the community is important for fairness in planning and to facilitate in building community ownership” (Member, WorHO).

When asked what features characterize legitimate planning, the majority of participants also emphasized multistakeholder engagement and collective decision-making as conferring legitimacy in planning. One member of the woreda administrative council articulated that the “[…] planning process is legitimate because if somebody is dissatisfied by the decision, they can have the chance to complain or discuss with other decision makers” (Member, Woreda Administrative Council). Many participants also felt the presence of different forums to engage and deliberate, such as through the planning meeting and at the level of the Woreda
Administrative Council review meeting, also conferred a sense of authority in decision-making; thus further legitimizing decisions. One WorHO member emphasized,

Under WBHSP we have a more structured form of decision-making that brings planners and non-government partners together at different forums, such as the planning meeting and the woreda council meeting. Through these meetings, we can deliberate and reach consensus about what to plan, which makes our decisions legitimate because everyone is contributing and agreeing on the final priority (Technical Officer, WorHO).

Similar to conceptualizations of fairness, many participants also conceptualized legitimate planning as being characterized by “active participation” and including the equal involvement of all stakeholders. As described by one member at the Federal Ministry of Health, “[…] active participation in planning is essential for legitimate decision-making because it ensures everyone is in agreement with the plan and aware and accepting of the data used.” One member at the regional health bureau further maintained, “equal involvement of all stakeholders at each level is crucial to build a legitimate planning process” (Member, RHB). A member from the ZHD further commented on the legitimacy of planning being enhanced if stakeholders from all sectors are involved in open and participatory dialogue.

Relevant stakeholders from sector offices, administration bodies, partners and resource persons are involved in the planning process. Contract agreements are signed between the Federal Ministry of Health and Regional Health Bureaus and between Regional Health Bureaus and Zonal Health Departments to accomplish the planning activities. It is because there are many parties involved and open dialogue that is can be considered legitimate (Member, ZHD).

Another NGO partner reinforced this view by stressing the importance for a decision-making milieu to be cultivated that encourages stakeholders to be comfortable in disclosing their concerns and views. “Active participation is the key. Stakeholders must be comfortable to openly discuss because engagement of all stakeholders is crucial for legitimate planning. Everyone must be on the same page to accept the decisions for the upcoming years” (NGO representative). Some participants also conceptualized community engagement as conferring legitimacy in health planning given the importance of ensuring that decisions made also align with the needs conveyed by the community. One member at the RHB referred to stronger modes of community
engagement a major underlying reason as to why the planning process has increased legitimacy. They maintained:

Yes, I can say that the planning process is more legitimate now. Previously however, I can say the planning process was not legitimate because it was not participatory, to the community especially. [Previously,] the plan was prepared at the woreda level and then transferred to the community for implementation and the community was considering, as the plan was someone else’s plan. (Member, RHB)

While participants at all levels viewed community engagement as an important characteristic of fair and legitimate planning, in practice participant accounts revealed that engaging the community meaningfully is still a work in progress. As noted by one member of the Woreda Administrative Council, “[f]airness is upheld if it allows for the participation of the public and allows for multiple stakeholder participation. In this case, stakeholders were invited during the planning process, but the community was not invited” (Member, Woreda Administrative Council). Another WorHO member further maintained that while efforts to include the community are weak, they are improving. “Legitimacy requires multistakeholder engagement that includes the community to appeal to the interests of the majority. However, we lack mechanisms to adequately engage them in this process. Our intent is there and it is getting better” (Member, WorHO). Some participants did shed light on improvements in community engagement in comparison to previous planning procedures. As described by a WorHO member, “[f]airness was present in our planning process because of many factors. […] One in particular is increasing ways that the community can participate through their kebele leaders” (Member, WorHO). Such a view was further reinforced by another program officer at the WorHO who stressed, “[p]lanning does unfold legitimately, but, if we [can] improve community participation and increase the equal involvement of stakeholders, then it will be strengthened. Right now, each member is not fully empowered” (Member, WorHO).
Reflection on Ethiopian Conceptualization of Fairness and Legitimacy

Ethiopian health planners conceptualized fair and legitimate health planning as a process that includes multiple stakeholder engagement and the active participation of all members in attendance, so as to encourage a process of deliberative dialogue. This reveals a *process-based conception of fairness* that values deliberative dialogue and inclusive planning. Through such deliberation, both the plan and the decisions within it are viewed as conferring authority and legitimacy based upon the weighing of different stakeholder views (both internal and external stakeholders).

6.1.2.3. Fairness and legitimacy Conferred through Planning in Accordance with International and National Priorities

Planning in accordance with national and international policies was conceptualized as a characteristic of both fair and legitimate health planning among participants. The majority of participants conveyed the notion that if decision-making “aligned with government policies” and “international guidelines,” then the plan and its decisions were both fair (by aligning with national and international criteria) and legitimate (guided by responsible planners upholding government mandates). Participants who predominantly emphasized these characteristics were district-level decision makers who stressed that the decisions had authority if they complied with national programmatic goals and objectives. When asked specifically what features characterized fair decision-making, the majority of participants emphasized the importance of planning in alignment with national and international mandates. This belief further augmented the conception of fairness that emerged in section 6.1.2.1, which emphasized the value among participants to plan in accordance with the criteria represented in the HSDP policy. As further described by one WorHO member:

Fair planning is characterized by the existence of predetermined criteria and direction set out by the government. We can then say a decision-making process is said to be fair if it follows […] the] rules and laws developed [by the upper level government] to improve the planning process. […] We trust the government to develop planning priorities that are important for all woredas and that meet the requirements at the international as well through the MDGs. (Member, WorHO)
An emphasis on trust that also emerged among participants appeared quite closely linked with legitimacy and authority. Many participants emphasized the concept of entrusting “responsible bodies” with decision-making authority, as represented through policy and guidelines. This concept of responsible planners further supported legitimacy and “trust” in the national government as an “overseer” of planning. One district member at the WorHO described, for instance, that district planning must align with the national mandates and objectives cultivated by “responsible bodies.”

What I think is that when a decision […] follows the policies, rules and regulations established by responsible bodies, then the process is seen to be fair. It [the planning process] complies now with the government policy to strengthen woreda planning through the harmonization initiative. (Member, WorHO)

Prior to the implementation of WBHSP, participants described scenarios where they felt that the previous non-standardized and subjective mode of decision-making deviated from one where “responsible bodies” (i.e., the government) were legitimized to plan in accordance with need. One member at the WorHO compared prior planning processes to the current one, emphasizing the strengthened fairness and legitimacy that has emerged through the dominance of “responsible bodies” and government objectives.

I do not say it is 100% perfect because sometimes some people informally discuss and put their own ideas in the plan without discussing with responsible bodies. Previous to woreda-based health sector planning, a single individual would make the woreda sectoral plan and send it to all responsible bodies, as if it was put together by a committee. But, nowadays, this is becoming improved. People in the management committee come together and make a plan together according to the objectives and guidance of the Ministry of Health and based on district need. […] Through this [process] the plan is fair and more legitimate. (Member, WorHO)

When asked specifically what features characterized legitimate decision-making, the majority of participants reinforced this notion of legitimate decision-making conferred if it incorporated the policies and procedures set out by the national government. One member from the RHB emphasized,

We are following guidelines of the federal ministry through the HSDP and now working with all concerned bodies, so that this certifies that we are making decisions in a legitimate way. Since our decision-making process follows in an evidence-based manner
and also takes into account the criteria prioritized by the government and the bureau, it can be seen as legitimate. (Member, RHB)

In addition to national mandates, many participants also emphasized the importance of planning in accordance with international priorities as further supporting legitimate planning. One WorHO member, for instance, described legitimacy as characterized by planning in accordance with international priorities established by the Millennium Development Goals (MDGs).

If decisions are decided with respect to national and international policies, then it can be considered legitimate because it follows the protocol set forth by the government. Stakeholders should be aware of the policies and procedures and planning should unfold in this manner. Taking the MDG targets into consideration while planning is also important because we are working towards one overall goal. (Member, WorHO)

Furthermore, when commenting on characteristics of legitimacy, many participants also described the importance of following existing national and international mandates and policies as a measure of legitimate planning. One member at the RHB defined legitimate planning as one inclusive of multiple stakeholders who follow the guidelines and goals of the FMoH.

**Reflection on Ethiopian Conceptualization of Fairness and Legitimacy**

Ethiopian health planners conceptualize fair and legitimate health planning as decisions that are based on national and international policies and rules that confer authority and trust. Government and international bodies are viewed as “responsible” for identifying population needs, and are therefore “trusted” by planners to guide district planning in a manner that accords with meeting these needs. This also reveals an outcome-based conception of fairness that focuses on the concepts of “need” and “responsibility” as a distributive norm.

**6.1.2.4. Fairness Conferred through Transparent Planning**

Transparency in planning was also conceptualized by participants as a characteristic of fair decision-making. Many participants conveyed the notion that if the process of decision-making was “transparent,” then it was fair as a result of cultivating an environment of “openness,” “dialogue,” and “inclusivity.” During participant interviews, participants described transparency as related to both internal and external transparency—internal transparency,
referring to those intimately connected to the planning and priority setting process (government bodies), and external transparency, referring to those considered more peripheral to the planning process (non-governmental partners and the community). Through participant accounts, transparency was largely viewed as “making it clear how, when, and where decisions were reached (NGO expert),” so as to encourage plan disclosure and deliberation.

When asked what features characterized fair decision-making, many participants conveyed that since the emergence of WBHSP, increased transparency of the process has strengthened the fairness of their decision-making. One member from the RHB, for instance, compared current planning structures to the past, and described how procedures of open communication and stakeholder inclusivity have improved both the transparency and consequently, the fairness of planning.

[...] transparency, among decision makers, is an important concept in fair planning. The process is now more transparent in how decisions are made, in who is supposed to join in the planning, in what information is used and in how people [decision makers] are to communicate. [...] In the past, many of us were left in the dark with how decisions were made. Now, we know what to expect from each other more or less. (Member, RHB)

Another member from the WorHO further emphasized that since the onset of WBHSP, “transparency among government counterparts has increased and therefore, improved the fairness of planning because everyone is aware of what is going on now, for the most part. We all come together at the meeting to discuss on the action points and then submit the final plan for review at the woreda council and regional level, which is fairness because there is openness and dialogue” (Member, WorHO).

In addition, participants also identified that increased measures to strengthen transparency and openness with “external stakeholders” (such as non-governmental partners and the community) has further increased the fairness of decision-making. As stated by one WorHO member:

[the] woreda planning process was fair because it involved all stakeholders in some capacity. Our non-government partners are more involved now and aware of what the government’s agenda is, which facilitates transparency throughout the process and supports a fair planning process (Member, WorHO).
Another member from the FMOH reinforced the importance of increased stakeholder inclusivity as a mechanism for transparency by also reflecting on the increased role of the community.

The decision-making process is said to be fair if it follows a transparent procedure and is open with all stakeholders involved and the community. […] Because WBHSP has strengthened the transparency of our planning process with the community, it is fair. We do need to consider different ways to encourage more participation from them [the community] (Member, FMOH).

**Reflection on Ethiopian Conceptualization of Fairness**

Ethiopian health planners conceptualize fair health planning as a transparent process that cultivates procedural “openness” and inclusivity with both internal and external counterparts. This reveals a *process-based conception of fairness* that values transparency of decisions and decision-making in health planning reform.

6.1.2.5. *Fairness Conferred through Fiscal Predictability and Decisions that Acknowledge District Capacity*

Many participants also characterized a fair decision-making process as one that provides a level of fiscal predictability to district planners and also acknowledges district-level capacity while setting priorities. In this instance, fairness was conceptualized as an issue of meeting the needs and resources in order to optimize the performance of the plan (to achieve its objectives) and of health planners (to assist them in meeting their programmatic goals). When asked what features characterized a fair decision-making process, many participants described fiscal predictability by district health planners as an element of fair planning; in that, it was viewed as either unfair (primarily to district participants) to be unaware of the funding reserved for their plan, or to not receive the monies (in a timely fashion, or in full), as projected by the EBPB tool. One member from the ZHD, for instance, voiced that the planning process, while fair because it was now evidence-based, was still viewed as “unfair” given the lack of budget that was ultimately allocated to meet the requirements of their plan. “There is fairness in the planning process because it is evidence-based, but it is unfair when the budget is not released in time and did not match the projected budget generated in the tool” (Member, ZHD).
In addition to this view, another WorHO member stressed that if setting priorities focuses their attention on a few key areas of need, “fair planning” would provide the funding required to address these identified priority areas. Here, fairness was also conceptualized as an “equity” issue—that by not receiving the monies required to tackle the health priorities of the district, limited the fulfillment of equitable planning and service provision.

The budget allocated for a specific activity should be allocated to that activity. There is no fairness in planning if there is a shifting of earmarked resources. There has to be equity in planning for us to fulfill the goals of the plan. (Member, WorHO)

Another WorHO member reinforced, “[f]air planning must include an understanding of the current manpower and resources capacity available. It must also include awareness of what finances will be available for us to plan. It is not fair to plan in such an environment of unawareness” (Member, WorHO). This experience also reveals a frustration among district health planners who plan in accordance with the needs of their districts, but may not receive the monies required to address these issues.

In addition, many participants also referred to district resource capacity to undertake the plan as a characteristic of fair decision-making. Fair planning in this sense was conferred if decision-making “was based on realistic capacity considerations of the woreda” was “achievable and realistic.” Reflecting on the six principles of WBSHP, this conceptualization of fairness appeared to align with both the resource-constraint principle (which emphasizes that the capacity of resources available influences the capacity of what can actually be implemented) and the results-oriented budgeting principle (which aims to link resources available with the desired outputs of the plan to determine what is achievable). In both cases, capacity and resources available are central to their conceptualization of fairness. As described by one member of the WorHO:

Yes, planning should include the evidence of what the community needs since this helps to make the budget decisions. But, fairness in planning also includes having the available resources. It is not fair to have a process of planning that fails to consider what the resource capacity of the government or woreda is. (Member, WorHO)

Many believed that under WBHSP, fairness had improved as a result of these considerations through the existing bottleneck analysis. One member from the district health office articulated,
Since the onset of WBHSP, fairness in our planning has improved because we are also including the woreda’s capacity considerations in our tool. The bottleneck analysis allows us to view what the resource needs and capacity of the woreda is. And through this, what is and can be achievable. This consideration makes planning more fair. There is no sense in planning for objectives that are unrealistic and unattainable (Member, WorHO).

Some participants also viewed the adoption of the EBPB tool as a mechanism to enhance fairness given its attention to “understanding woreda capacity and filling bottlenecks identified through the data” (Member, WorHO).

In addition, many participants emphasized the notion that that fairness in decision-making would be present if decisions were based on achievable and realistic goals. Another WorHO member emphasized, “To achieve fairness in health decision-making, decisions should be achievable and realistic. There is no sense to plan big and not reach our goals. It becomes discouraging” (member, WorHO). These sentiments were further reinforced by member of the RHB who felt that fair planning must include the provision of resources to meet the defined objectives.

Health planning must be realistic and achievable. It must take into consideration the woreda context, existing available resources and also, the financial resources that will be available to achieve the plan. If we do not receive the monies to meet these goals, then it cannot be considered fair planning. (Member, RHB)

Some also framed ongoing resource and capacity constraints as a lack of fairness present in planning. Another member from the RHB highlighted that although planning has increased in fairness as a result of policy alignment and evidence-based planning, lack of resources continue to strain fairer processes of health decision-making.

Currently, our process of planning is fair. It is based on the criteria of the HSDP that aligns with international priorities and the evidence-based tool allows us to plan in accordance with the needs of the woreda. However, we lack health infrastructure and resources in the woreda. It is not fair to plan without such resources and therefore, fairness will improve once there is an alignment between our needs and the capacity to meet those needs. (Member, RHB)
Reflection on Ethiopian conceptualization of fairness

Ethiopian health planners conceptualize fair health planning as one that weighs the needs and capacity of the districts. This reveals both a *process-oriented conception of fairness* (in that fairness of decision-making is conferred if there is a level of openness during the planning process that reveals the resources available to meet district objectives) and an *outcome-based conception of fairness* (that values an outcome decision as fair if it is realistic with respect to the district’s capacity to achieve it).

6.1.3. Alignment Between Ethiopian Conceptualization of Fairness and Legitimacy and the Conditions of A4R

Throughout section 6.1.2, characteristics of fair and legitimate health planning were presented, as conceptualized by Ethiopian participants. During in-depth qualitative interviews, participants were candid in discussing such concepts and, overall, believed that the existing planning procedures under WBHSP were fair and legitimate. When reflecting on the aforementioned themes, dominant trends emerge in how Ethiopians conceptualized authority of health priority setting and fairness in priority setting. Moral authority in decision-making (i.e. legitimacy) appeared to be largely conferred through compliance with international and national authority, and through a democratization of the priority setting process. The former formulation is aptly captured in a quote provided by a WorHO member in Section 6.1.2.3:

[…] we say a decision-making process is said to be fair if it follows […] the] rules and laws developed [by the upper level government] to improve the planning process. […] We trust the government to develop planning priorities that are important for all woredas and that meet the requirements at the international as well through the MDGs. (Member, WorHO)

Although the participant describes this assertion as an aspect of “fair” planning, this quote is primarily centered on describing who has the moral authority in relation to priority setting decisions (i.e. the government and international bodies). This conceptualization of legitimacy was further echoed by a WorHO member in Section 6.1.2.3, who described authority for decision-
making as being conferred by following the policies and protocols of the national government that are ultimately in line with an international common goal.

If decisions are decided with respect to national and international policies, then it can be considered legitimate because it follows the protocol set forth by the government. Stakeholders should be aware of the policies and procedures and planning should unfold in this manner. Taking the MDG targets into consideration while planning is also important because we are working towards one overall goal. (Member, WorHO)

The second formulation of moral authority focused on democratization. Throughout participant interviews, it was believed that the presence of different forums to engage and deliberate, such as through the planning meeting and at the level of the Woreda Administrative Council review meeting, also conferred a sense of authority in and legitimacy to decision-making. These sentiments were succinctly captured by a WorHO member in Section 6.1.2.2:

Under WBHSP, we have a more structured form of decision-making that brings planners and non-government partners together at different forums, such as the planning meeting and the Woreda council meeting. Through these meetings, we can deliberate and reach consensus about what to plan. This makes our decisions legitimate because everyone is contributing and agreeing on the final priority (Member, WorHO).

In terms of the fairness of the priority setting decisions, there were both substantive elements (e.g., explicit criteria, such as burden of disease as an important consideration) and procedural elements (e.g., decisions should be made openly and be informed by multiple perspectives) that emerged through participant discussions. Firstly, there seems to be reasonable (and possibly uncontroversial) “agreement” among the participants that the aim of priority setting should be to prioritize the high burden of disease since they “affect everyone in the district and make the community vulnerable to poor health” (Member, WorHO). This substantive commitment to addressing BOD guides the priority setting process and defines what would make it successful (and fair), such that if the priority setting process failed to allocate resources to address BOD, it would be seen to be unfair. This view suggests a particular population health/utilitarian conception of fairness, about which there is wide agreement.

In addition to substantive criteria guiding “fairness” in priority setting, participants also emphasized procedural elements in their conception of fairness, which predominantly focused on multiple stakeholder inclusivity and transparent decision-making. As described by one member
of the WorHO in Section 6.1.2.2, “[o]ur planning is fair because we have many viewpoints that are being considered in the decision making process. This inclusiveness means that no one decision may take precedence over another. Each decision is judged by multiple stakeholders” (Member, WorHO). Fairness, in this sense, was viewed as largely maintained through the presence of many viewpoints to deliberate and decide on what health priorities exist at the community-level. In this sense, a failure to incorporate such varied perspectives would deviate from what Ethiopian stakeholders conceptualize as fair planning and priority setting. Similarly, transparency in planning was also emphasized as an important dimension of fairness. Participants conveyed the notion that if the process of decision-making was “transparent,” then it was fair as a result of cultivating an environment of “openness,” “dialogue,” and “inclusivity.” The essence of this conception was succinctly noted by one member from the RHB, as previously mentioned in Section 6.1.2.4:

[…] transparency, among decision makers, is an important concept in fair planning. The process is now more transparent in how decisions are made, in who is supposed to join in the planning, in what information is used and in how people [decision makers] are to communicate. […] In the past, many of us were left in the dark with how decisions were made. Now, we know what to expect from each other more or less. (Member, RHB)

Here, fairness was intimately linked with transparency, in that decision makers viewed the planning process as much fairer given the presence of a planning milieu where each felt more aware of what decisions were made, how they were made (i.e., via the completion of the EBPB tool), and who was to be involved in planning process. Hence, through the conceptual formulations detailed by participants, it appears that fairness of priority setting in Ethiopia rests on the presence of both on this substantive consideration (fair outcomes) as well as on procedural considerations (fair processes).

Throughout this analysis, it is apparent that commonalities exist between the principles embedded in the A4R framework and the conceptualizations emergent from Ethiopian participants. Through A4R, fairness and legitimacy are conferred through procedural elements that promote multistakeholder engagement, deliberative dialogue, transparency, and relevance. In Ethiopia, fairness in health planning also aligns with these procedural components. Further to these procedural elements, however, Ethiopians also construct legitimate planning and moral
authority around the notion of compliance with national and international policies and through a process of democratization; features that are not acknowledged in the procedurally driven conception A4R framework. As a result, it is apparent that in addition to valuing procedural elements in fair and legitimate priority setting, Ethiopians also value substantive elements in the decision-making process. Table 6.7 presents a summary of the conceptual alignment between Ethiopian accounts and the five conditions of the revised model of A4R. Quotes are provided that support the Ethiopian conceptualization, and act as a conceptual “bridge” with each condition of A4R.
### Table 6.7. Conceptual Alignment Between Ethiopian Procedural Fairness and A4R

<table>
<thead>
<tr>
<th>A4R (Daniels and Sabin, 1998; Gibson et al, 2005b)</th>
<th>Direct quote from Ethiopian participants</th>
<th>Key characteristics of the participant conceptualizations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relevance</strong></td>
<td>One of the main characteristics of legitimate planning is that resources are allocated based on reliable data and evidence of need. Legitimate decisions come from using legitimate data that is of quality. Quality data is found if collected by experienced health professionals at all level. [...] Deriving decisions from what the evidence suggests is how we build legitimate planning processes. Because decisions are then made on the data obtained from the needs of the community. This is why it is important that we strengthen the capacity of health professionals to take woreda information accordingly and accurately—to build legitimacy. (Program Officer, ZHD)</td>
<td>Decisions based on concrete evidence that captures the health needs and disease burden of the community</td>
</tr>
<tr>
<td></td>
<td>Relevant stakeholders from sector offices, administration bodies, partners and resource persons are involved in the planning process. Contract agreements are signed between the Federal Ministry of Health and Regional Health Bureaus and between Regional Health Bureaus and Zonal Health Departments to accomplish the planning activities. It is because there are many parties involved and open dialogue that is can be considered legitimate. (Manager, ZHD)</td>
<td>A process that includes multiple stakeholder engagement with both internal and external counterparts</td>
</tr>
<tr>
<td></td>
<td>In order to make decisions fair, it should be presented in a forum, so that every member will contribute his or her share in the meeting. If the decision-making process is participatory […] and based on discussions from all responsible participants, then it can be said to be fair. By doing this, fairness will be ensured. We must avoid individual-based decision-making by seeing the issue as a team. (Program Planner, RHB)</td>
<td>A process that encourages the weighing of multiple viewpoints and deliberative dialogue</td>
</tr>
<tr>
<td><strong>Previous to woreda-based health sector planning, a single individual would make the woreda sectoral plan and send it to all responsible bodies, as if it was put together by a committee. But, nowadays, this is becoming improved. People in the management committee come together and make a plan together according to the objectives and guidance of the Ministry of Health and based on district need. […] Through this [process] the plan is fair and more legitimate. (Program Officer, WorHO)</strong></td>
<td>A process that is guided by responsible planners</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Publicity</strong></td>
<td>[…] transparency, among decision makers, is an important concept in fair planning. The process is now more transparent in how decisions are made, in who is supposed to join in the planning, in what information is used and in how people [decision makers] are to communicate. […] In the past, many of us were left in the dark with how decisions were made. Now, we know what to expect from each other more or less. (Program Officer, RHB)</td>
<td>A planning process that is transparent that cultivates procedural “openness” and inclusivity with both internal and external counterparts</td>
</tr>
<tr>
<td><strong>Appeals</strong></td>
<td>The Flexibility Principle acknowledged in the WBHSP Training Manual (EFMOHb, 2007)</td>
<td></td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td>Active participation is the key. Stakeholders must be comfortable to openly discuss because engagement of all important stakeholders is crucial for legitimate planning. Everyone must be on the same page to accept the decisions for the upcoming years.” (NGO partner)</td>
<td>A process that encourages the active participation of all members in attendance. so as to encourage a process of deliberative dialogue</td>
</tr>
<tr>
<td>Enforcement</td>
<td>We are following guidelines of the federal ministry through the HSDP and now working with all concerned bodies, so that this certifies that we are making decisions in a legitimate way. Since our decision-making process follows in an evidence-based manner and also takes into account the criteria prioritized by the government and the bureau, it can be seen as legitimate. (Program Officer, RHB)</td>
<td>Decisions that are in alignment with national and international policies and strategies, conferring authority and legitimacy</td>
</tr>
</tbody>
</table>

| Other factors characterizing fairness and/or legitimacy | There is fairness in the planning process because it is evidence-based, but it is unfair when the budget is not released in time and did not match the projected budget generated in the tool (Program Planner, ZHD) | A process that discloses fiscal resources available to operationalize the plan |

| | Yes, planning should include the evidence of what the community needs since this helps to make the budget decisions. But, fairness in planning also includes having the available resources. It is not fair to have a process of planning that fails to consider what the resource capacity of the government or woreda is. (Program Officer, WorHO) | Decisions are fair if they are realistic and in alignment with the district’s technical and resource capacity |
6.2. Assessing the Systemic Factors Influencing District Health Planning in Ethiopia

To address objective 2 of this dissertation, Section 6.2 advances knowledge on the system factors influencing district health planning and priority setting through the application of the Transformative Systems Change Framework (TSCF). The application this framework aims to address the lack of extensive consideration of context in district health planning and priority setting that was previously identified in Chapters 1 and 2. In this section, the TSCF was used to uncover key system parts and interactions that may explain system behaviour (Foster-Fishman et al., 2007). Foster-Fishman et al. (2007) describe four stages within the framework that assist in the identification of the system’s boundaries, structure, interactions, and potential areas (“levers”) for change. To guide the analysis of system barriers of and facilitators to Ethiopian district health planning, this section is divided into three sub-sections that correspond with each stage. Section 6.2.1 will apply the TSCF to bind the system. Section 6.2.2 will describe components of the system’s structure. Section 6.2.3 will assess interaction dynamics within the system by presenting a series of system dynamics models. And Section 6.2.4 will suggest potential levers for change in light of challenges described by participants. This entire section will ultimately assist in identifying barriers and facilitators of the district health planning process. Chapter 7 will then explore the implications of these barriers and facilitators to procedural fairness.

6.2.1. Stage 1: Binding the System through the TSCF

Primary to any systems analysis, Foster-Fishman et al. (2007) emphasize the importance of setting boundaries to the system in order to draw conceptual parameters around the issue under investigation and identify the key stakeholders, levels, niches, and organizations involved. Given that one may approach this topic from as broadly as the international policies that inform its practice, to as local as the community groups involved in decision-making, it was imperative that boundaries be set to focus this analysis.

6.2.1.1. Defining the Problem Situation

As described by Foster-Fishman et al. (2007), binding the system takes place in two steps: Step 1 will identify the problem that should be targeted for assessment and intervention and, Step
2 will define who and what is contained within the system given the targeted problem. To identify the Problem Situation, Foster-Fishman et al. (2007) call for a dialogic process of inquiry (such as focus group discussions) that may elicit multiple stakeholder perspectives. For the purpose of this study, however, focus group discussions were viewed as an inappropriate method due to the sensitivity associated with openly discussing government policy implementation and governance. Data from Phase 1 key informant interviews was, instead, used to draw inferences from questions capturing participant experiences with the WBHSP strategy. During this process, early experiences with WBHSP had revealed both strengths (successes) and challenges with WBHSP implementation. In defining the Problem Situation, focusing solely on the challenges at the outset, as suggested by the TCSF, would narrow the scope of analysis of the system. The Problem Situation was therefore framed as the change initiative itself (i.e., the implementation of WBHSP).

6.2.1.2. Defining the System Levels, Organizations, Niches, and Actors

To finalize binding of the system, Step 2 drew from document analysis and participant interviews to further establish which actors, levels, and organizations were key in this process. Informed by participant interviews and document analysis of the HSDP, the HHM strategy, and the WBHSP manual, Table 6.8 provides a breakdown of the different actors, levels, niches, and organizations. The significance in identifying these levels serves to ensure that no key stakeholders were missed in setting this system boundary.

To guide our understanding of which actors and what levels, niches, and organizations are influencing WBHSP implementation, participants were asked in Question 2, Phase 1: who is involved in this planning process? Participants identified all levels of government as relevant to understanding the Problem Situation (WBHSP implementation). System niches are described as settings (e.g., programs and/or activities) within the system that promote unique behaviour connected to the Problem Situation. These features included the five-day planning meeting and Woreda Administrative Council meetings, which both collectively unite stakeholders under the WBHSP strategy and serve as a platform for developing, reviewing, and finalizing the plan. Organizations relevant to the Problem Situation included NGOs, administrative groups, and
different health offices at each level of government. Finally, the majority of participants identified a variety of actors involved in the district health planning process. Stakeholders consistently cited by participants as key members of this process were positioned at all levels of the government—national, regional, zonal, and district. Non-governmental partners were also cited as key stakeholders in this process, as well as members of the Woreda Administrative Council and Woreda Finance and Economic Development (WoFED).

Table 6.8. Ethiopian Levels, Organizations, Niches, and Actors

<table>
<thead>
<tr>
<th>System Surrounding the Problem Situation</th>
<th>Features (Foster-Fishman et al., 2007)</th>
<th>Ethiopian Levels, Organizations, Niches, and Actors</th>
</tr>
</thead>
</table>
| **System Levels**                      | Relevant, nested ecological layers relevant to the targeted problem | • National level  
• Regional level  
• Zonal level (in most cases)  
• District Level  
• Kebeles (neighbourhoods) |
| **Organizations**                      | Organizations and Administrative Groups relevant to the targeted problem within the system | • NGO partners  
• Administrative groups  
• Federal Ministry of Health  
• Regional Health Bureaus  
• Zonal Health Department  
• Woreda Health Office |
| **Niches**                             | Settings (i.e., programs and activities) within system levels that promote unique behaviour | • Woreda Administrative Council meeting  
• Woreda five-day planning meeting |
| **Actors**                             | Individuals that are relevant to, vested in or affected by the targeted problem | • Federal Ministry of Health  
• Woreda Administrative Council  
• NGO counterparts  
• WorHO officials  
• WoFED officials  
• RHB officials  
• ZHD officials |

During interviews, some participants also alluded to the role of both the community and health extension workers (HEWs) in this process. The scope of their role, however, remained unclear and inconsistent across participant accounts. In Phase 2, when asked who has been
missing from the decision-making process, some participants identified the exclusion of community members from the decision-making process. A few participants stressed the importance of both community members and community groups as essential to ensuring that the decisions made align with the needs of the district communities. As stressed by one WorHO health planner:

A group actively missing from the decision-making process is the community. Community members presently do not have a voice in actual district health planning. It would be important to somehow find a way to bring them into this process because they know the real needs of their community. (Member, WorHO)

One WorHO member also stressed the importance of political leaders in mobilizing community participation, but also acknowledged the nebulous role of the community in the planning process.

It may not solely be an issue of getting the community members to participate, but once they are, what is their role? They may not have a capacity to attend these highly technical meetings. Therefore, it is important to capacitate the community leaders who attend the Woreda Council meetings. (Member, WorHO)

In addition to highlighting community members as a stakeholder in district health planning, a few participants also emphasized the role of HEWs in relation to issues with data collection. One member from the WorHO stated:

All stakeholders and levels included are appropriate. But since we are challenged in the collection of adequate data, we must include health extension workers when we are considering all levels of people impacting woreda-based planning. They are important in this process because they collect the data we use. Therefore, it is important to factor them into this process (Member, WorHO).

Although both the community and HEWs were identified as actors in WBHSP implementation, their relevance to the Problem Situation was not deemed as directly significant, as the identified Problem Situation focused largely on those internal stakeholders engaged in using data and manipulating the EBPB tool; whereas HEWs and the community would be classified in this study as external stakeholder. In Table 6.9, those groups and stakeholders marked with an asterisk signify those stakeholders not consulted for an interview.
6.2.2. Stage 2: Understanding the System Structure

The identification of the problem situation, including the associated levels, niches, organizations, and actors involved, assisted in isolating the parameters by which the system structure could be explored. In Stage 2 of the TSCF, the aim is to understand the system structure by identifying fundamental system parts as potential root causes of the identified Problem Situation (i.e., issues related to WBHSP implementation). Foster-Fishman et al. (2007) identify four components (or parts) of a system’s structure that are important to this analysis. These include the system norms (Section 6.2.2.1), system operations (Section 6.2.2.2), system regulations (Section 6.2.2.3), and system resources (Section 6.2.2.4). The subsequent sections explore each of these four components of the Ethiopian “system,” and reflect on the actors, levels, and organizations identified in Stage 1.

6.2.2.1. System Norms: Attitudes, Values, and Beliefs

System norms encompass the dominant values and attitudes that cultivate social and cultural belief systems, and create a “dominant normative context that determines the practices and functions of the system” (Foster-Fishman et al., 2007). To uncover system norms, the TSCF offers a series of questions that were adapted for this study. These questions included: what values guide district health planning efforts; what assumptions support the systems change effort (i.e., the implementation of WBHSP); and what beliefs may impede the success of WBHSP implementation? Ultimately, the social and cultural norms that influence the WBHSP implementation would shape the scope, frequency, and degree to which stakeholders interact; including how they view and value each other’s role in the health planning process, capacitate one another, and communicate across different levels of the health system. The following two sub-sections (I) explore dominant Ethiopian values in alignment with the principles of WBHSP and (II) situate these values within the dominant Ethiopian political culture.

I. Ethiopian Values in Alignment with the Principles of WBHSP

Foster-Fishman et al. (2007) suggest that an alignment of policy values with a system’s norms would facilitate policy implementation. To therefore support the implementation of the
WBHSP strategy, there would need to be congruency between the principles of WBHSP and the Ethiopian values and social norms that would permit these principles to manifest in practice, both at an individual and organizational level. When analyzing social norms, the key focus was whether Ethiopian values would support the adoption of the new district planning strategy. Although WBHSP partly emerged from an international vision of harmonization and alignment, it was largely a policy directive arising from the Ethiopian Ministry of Health, with technical assistance offered by the World Bank, UNICEF, and Tulane University. As a result, the principles underscoring WBHSP were predicated on Ethiopian values in support of strengthening evidence-based practice, efficiency, transparency, and participatory dialogue—as previously documented in the HSDP policy. While it may be difficult to cast-overarching generalizations of representative Ethiopian values (as a result of cultural diversity described by Vaughan and Tronvoll, 2003), congruency between the principles of WBHSP and participant values were apparent. Three key values emerged from both participant interviews and policy documents that have facilitated the implementation of the WBHSP strategy. These values have included: (i) values in support of harmonization and efficiency and the establishment of the “One Plan, One Budget, One Report” strategy; (ii) values in support of evidence-based planning and transparency upheld through the implementation of the EBPB tool; and (iii) values in support of multistakeholder engagement and participatory planning upheld through the implementation of the WBHSP planning meeting.

(i) **Values in Support of Harmonization and Efficiency in Planning**

As previously detailed in Section 5.1.1, the WBHSP strategy has aimed to minimize duplication of reporting and standardize health planning throughout the country; by ensuring that government members, donor partners, and district communities agree on one overall health sector plan. Values in support of improved harmonization were clear among participant accounts documented in Chapter 5 (Section 5.2.2.1, II). Many participants described the importance of “harmonized” and “coordinated” planning in an effort to strengthen “efficiency” in health planning by ensuring that all stakeholders operate within a “shared vision” and towards a common goal. When asked to describe successes of WBHSP, many participants described that
planning had become “more efficient because of the harmonization efforts of the government” (Member, WorHO). This district health planner went on to further articulate the importance of more streamlined processes of decision-making that were desired by participants.

We have always needed a more streamlined process of planning because of the varied levels and players in the health system and a major success with woreda based health sector planning is that we have established mechanisms to support this streamlined practice. (Member, WorHO)

During interviews, participants were in support of these alterations to planning; which highlight a level of congruency between values that support more efficient modes of planning towards the vision of harmonization. As described by one member from the RHB:

We have needed the one budget, one report plan to make our process of planning more streamlined and efficient. We did not have such kind of procedures in the past. That is why the woreda planning strategy is so important. (Member, RHB)

Similarly, a district health planner conveyed, “we believe in planning that is timely and efficient. Duplication of effort has always been an issue” (Member, WorHO). Within the WBHSP strategy, the development of the Annual Plan is now based on national priorities that include district-level data that are consolidated and channeled up to the federal level once it has gone through the RHB review. Hence, that the principles of WBHSP that focus on “One Plan,” “One Budget,” and “One Report” appear to align with Ethiopian values in support of greater health sector harmonization in this planning process.

(ii) Values in Support of Evidence-Based Planning and Transparency in Planning

Values in support of evidence-guided practice and greater transparency were also evident in both policy documents and through participant accounts. Explicitly documented in the (Health Sector Development Programme (HSDP)-IV, values of “transparency” are highlighted as one of the attributes of the health sector’s vision. Excellence in Leadership and Governance” are further described here as being facilitated by “collaborative, accountable, and transparent [emphasis added] institutions. Decision making in the sector is based on research evidence [emphasis added], which ensures the equitable and effective allocation and/or application of health resources” (FMOH, 2010, p. 37).
In support of this vision, participant accounts documented in Chapter 5 (Section 5.2.2.1, IV) reveal consistent values in support of greater “evidence-based health decision-making” and “transparency” in health planning. With the implementation of WBHSP, the adoption of the EBPB tool has been a key alteration in the district health planning process that as operated in alignment with these values. Through the implementation of the EBPB tool, health planning was to be guided by complete and reliable evidence from the district-level. Such a policy directive was viewed as strengthening the use of district-level data and, further, enhancing the transparency of decision-making given the explicitness associated with completion of the tool.

Similarly, during Phase 2 interviews, when asked to describe successes of the WBHSP process, participants spoke to greater evidence-based practice and transparency as not only successful outcomes of WBHSP, but also as an important value to strive for in health planning. Described by one RHB member, “one of the most important features of any health planning is that it must be grounded in evidence. To plan based on evidence ensures that planning is consistent with the needs of the community” (Member, RHB). A member of the WorHO further echoed these sentiments of planning with community-level evidence that is not based on assumptions:

Evidence based planning is a must in health planning. We cannot plan for health services based on assumptions. Each woreda is unique. It is a good move to have the EBPB tool to assist us in this planning evolution towards evidence and more transparency of planning.
(Member, WorHO)

Such views suggest that the desire for both evidence-based practice and transparency are strong values envisioned for health planning, and that through the implementation of WBHSP, participants believed that they would be operationalized. One district health planner aptly articulated, “[e]vidence should always be the currency of health planning, especially when you are trying to target the needs of the community and be transparent with where the money is going” (Member, WorHO).

Based on participant accounts, the EBPB tool appeared to afford planners with the ability to forecast the desired amount of fiscal resources required to complete the objectives of the annual plan as well as the ability to directly link the government budget to anticipated results. The establishment of such procedures appeared to further align with values in support of greater transparency in planning. As observed by one regional planner in Phase 2, “with the
implementation of the tool, all planners are aware of the budget and resource needs to reach the goals of the plan. The tool has set us on an important path of transparent health planning” (Member, RHB). There is evidence, then, of alignment between Ethiopian values (in support of evidence-based practice and transparency) and the implementation of the EBPB tool of WBHSP. In addition to the evidence-based principle, the EBPB tool also operationalized aspects of the resource constraint principle and the results-oriented budgeting principle by enhancing mechanisms for planning in accordance with desired health outcomes and fiscal resource requirements.

(iii) **Values in Support of Multi-Stakeholder Engagement and Democratic Planning**

Intrinsic to WBHSP implementation was the requirement for increased multi-stakeholder engagement and deliberative planning, as various procedures within this change initiative required these characteristics. Based on analysis of both policy documents (e.g., HSDP, the HHM, and WBHSP) and participant interviews, cultural values in support of multi-stakeholder engagement and participation in health planning were evident. In both the HSDP and the HHM strategy, for instance, values in support of multi-stakeholder engagement and democratic planning were described. Outlined in the HSDP policy, the mission is:

[…] to reduce morbidity, mortality and disability and improve the health status of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, basic curative and rehabilitative health services via a decentralized and democratized health system in collaboration with stakeholders [emphasis added]” (FMOH, 2010, p.33).

Similarly in the HHM strategy, values in support of multistakeholder engagement and participatory dialogue were clearly evident.

This is not just about government officials—citizens, NGOs, and development partners all have a relevant role to play in the governance of HSDP. […] The governance structure should encourage: […] inclusiveness (taking different groups’ needs into consideration) and […] participation (involving appropriate stakeholders). (EFMOHa, 2007, p. 61)

Here, it was clearly evident in policy that there was both an aspirational commitment to stakeholder inclusivity and values in support of this effort by encouraging full participation. Such values were also apparent from participant interviews in both Phase 1 and 2, whereby values in
support of multi-stakeholder engagement and a more democratic process of planning were identified as important features of the health planning process.

In Chapter 5 (Section 5.2.1.3, I) participants described the importance of increased stakeholder inclusivity as a mechanism to enhance democratic deliberation of the health planning process. One district health planner, for instance, described the success of WBHSP as attributable to increased collective dialogue among stakeholders. “Woreda based health planning has been a success because of everyone coming together—woreda planners, regional planners, development partners, the federal level, finance, members from the community. Health planning must be democratic and weigh all stakeholder views” (Member, WorHO). In addition, a member from the RHB emphasized the importance of stakeholder engagement in health planning as a mechanism for ensuring that all pertinent stakeholders are aware of community needs and in agreement with the plan to address these needs.

We have a long history of centralized decision-making where in the past, the regions, districts, and NGO members did have a big role in planning. But all members at all levels are important and must have a voice in planning because we plan on behalf of the communities that we serve and are each aware of the specific needs that need to be addressed. (Member, RHB)

Such values appeared to therefore act as facilitators for WBHSP implementation, as they supported collective decision-making during the five-day meeting and, through the flexibility principle, increased stakeholder dialogue (should revisions arise during the annual plan review).

II. Ethiopian Political Culture and the Respect for Federal Authority

While many district health planners constructively critiqued the WBHSP process (i.e., identifying gaps in technical capacity and ongoing challenges), not only was there an acceptance of the government’s efforts to strengthen coordination of health planning throughout the health system, but an overarching respect for national authority to act on behalf of its citizens. Such views of “acceptance” and “respect” were quite evident whether through formal participant interviews or informal discussions with stakeholders. As conveyed by one member at the WorHO:
It is important that we support the woreda based planning approach because the central government is behind it. We trust that they will work to support what is best for the health of the country and to help us at the district level make more evidence-based decisions with the [EBPB] tool. (Member, WorHO)

This sentiment of respecting government authority was further echoed by a member from the WorHO who stressed the importance of respecting the government’s policy intentions because of their leadership position, and overall good intention for the entire country.

The government knows what is best because they are a high authority. They are working in alignment with the international goals that are being prioritized such as the MDGs. Therefore they are at the top of understanding what we need at the national policy level and at the kebele level. We are especially working in support of the HSDP and must respect the government’s intentions to meet the goals in the HSDP because they are our leaders in tena [health] planning. (Member, WorHO)

While many participants emphasized the importance of “respecting” the judgment of the federal government (for the belief that they were working in line with the interest of the people), a few participants articulated the need for a greater voice of district-level counterparts. These participants maintained that greater attempts to include district counterparts in the development of various components of the WBHSP strategy would operationalize a political vision of stakeholder and community engagement, as outlined in policy documents (such as the HSDP and the WBHSP strategy) (See Section 6.1.1.4). As stated by one district health planner from the WorHO:

At the district level we are planning in accordance with the policies of the government. We are agreement that greater coordination is needed and so, there is a need for woreda-based planning. District and regional players needed to have a greater voice in the development of the tool and in the feasibility if this [strategy] is possible for the long-term. We need a tool that is formatted to the meet district needs. If we were included in the development phase, then we could also discuss the reality of what is visualized by the government. (Member, WorHO)

Another WorHO member further supported these views by highlighting the need for greater attempts to strengthen the authority of the WorHO in light of existing structures supporting more centralized authority.

The government needs to encourage a greater voice from us. Even though the vision of the government is to give more control for planning to the districts, it is not happening that way. There is a long tradition of centralized control that is slow to change. (Member, WorHO)
While the cultural and social values captured above highlight facilitators to implementing WBHSP, a high regard for federal authority in district health planning and a reliance on the central government for guidance in coordinating and managing various aspects of WBHSP may inadvertently minimize district authority (and, consequently, capacity) for district health planning.

III. System Norms: Summary of Key Points

As documented in both policy and through participant accounts, Ethiopian values in support of planning efficiency, increased harmonization, evidence-based practice, transparency, multistakeholder engagement, and participatory dialogue are all congruent with the principles and procedures of the WBHSP strategy and, thus, act as facilitators to its implementation. On the other hand, the dominance of central authority and respect for social hierarchy in decision-making may act as potential barriers in the implementation of WBHSP by limiting the scope of autonomy among district health planners.

6.2.2.2. System Operations: Power and Authority

System operations is a dimension of a systems structure acknowledged in the TSCF that recognizes the importance of power dynamics and authority in the system change effort. As emphasized by Foster-Fishman et al. (2007), “systems require multiple operations to enact their purpose, including processes for moving […] people through a system, for communicating information across system members, and for making decisions and determining where power is held” (p. 209). Foster-Fishman et al. (2007) describe two dimensions of power and authority, which are salient to capturing a holistic view of this systems component. The first dimension focuses on formal authority given to individuals or groups through policies and procedures. Applied to WBHSP, it was important to reflect on who was granted formal authority for health planning, as documented in official policy documents (i.e., in the HSDP, the HHM, and the WBHSP strategy). The second dimension of authority focuses on discrete aspects of power that may be captured by understanding the reputation of different actors within a system, their ability to control information or other resources, their relationship with others in the system, and their
ability to sanction or reward others. Ultimately, such an examination focuses on the concept of influence, and in trying to establish who influences who and what in the health decision-making process.

I. **Formal Authority for Health Planning**

Since the onset of decentralization in the 1990s, authority in health planning has been slowly devolved to the regions and districts, and is explicitly captured in both the HSDP policy and the HHM strategy. As indicated in the HSDP-IV, “the core elements of the health policy are [...] decentralization of the health care system” (FMOH, 2010, p. 5). Through this process, decentralization of powers and duties to the lower levels of government, including the regions and districts, has aimed to improve accountability, responsibility, and flexibility in health service delivery, as well as increase district participation in decision-making on district health issues (FMOH, 2010). In these documents as well, other actors in the health system are ascribed important roles in health planning. For example, the HSDP-IV states that it: “[...] cannot be implemented by the public sector alone, but must involve the concerted effort of development partners, the private sector, NGOs, and the community” (FMOH, 2010, p. 5). Through this decentralized structure, the governance of HSDP is comprised of a number of key stakeholders, committees at all levels of government, and consultative forums.

As summarized in Table 6.9, the presence of the regional and woreda steering committees formalized decision-making structures at the regional and district levels of government, and institutionalized greater responsibility among regional and district counterparts for health planning and prioritizing. In particular, the development of the Woreda Joint Steering Committee (WJSC) and the Regional Joint Steering Committee (RJSC) are representative of a greater commitment to coordinated planning at these levels. It is also evident, however, that although regional, district, and kebele committees have a greater prominence in the health planning process, formal authority for health planning is still centrally monitored and coordinated. The HSDP explicitly specifies the dominant role of the Central Joint Steering Committee, the Joint Core Coordinating Committee, and the FMOH-RHB Joint Steering Committee in “deciding”, “guiding,” and “overseeing” the implementation of the HSDP (FMOH, 2010, p. 68). As further
described in the HSDP, “collaboration with and between stakeholders” (across all levels of government) is still highly regarded as a necessity in the fulfillment of decentralization (p. 33).

This collaborative structure of planning is also documented in the WBHSP strategy, whereby the “top-down” and “bottom-up” planning process of WBHSP is described as necessary to harmonize planning towards “one plan” and “one report” (EFMOHb, 2010, p. 6).

Table 6.9. The Role of each Government Health Planning Committee at all levels of the Health System (Drawn from FMOH, 2010, pp. 68-72)

<table>
<thead>
<tr>
<th>Level of government</th>
<th>Committee name</th>
<th>Roles and responsibilities related to health planning within the health system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal policy and planning</strong></td>
<td><strong>Central Joint Steering Committee (CJSC)</strong></td>
<td>• Highest governance body who “decides, guides, oversees and facilitates the implementation of the HSDP” (p. 68).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The CJSC is chaired by the Minister of Health and plays a leading role in coordinating dialogue of health policy and planning between government, development partners, and other stakeholders.</td>
</tr>
<tr>
<td><strong>Federal</strong></td>
<td><strong>The Joint Core Coordinating Committee (JCCC)</strong></td>
<td>• Serves as a technical arm of the CJSC and the FMOH-HPN Consultative Forum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assists and works closely with the Secretariat of the HSDP in following up the implementation of the decisions of the CJSC and the Joint Consultative Forum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Membership includes staff from the Policy, Planning, and Financing Directorate Department of the FMOH, and donor groups.</td>
</tr>
<tr>
<td><strong>Federal and Regional</strong></td>
<td><strong>FMOH-RHBs Joint Steering Committee</strong></td>
<td>• Chaired by the Minister of Health, RHB Heads and directors of the FMOH and RHBs, this steering committee brings together members from the FMOH and RHBs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facilitates the effective and smooth implementation of HSDP priority issues by seeking to “bridg[e] communication gaps,” “improve[e] internal harmonization and co-ordination,” and monitor “progress and problems at the operational level” (p. 69).</td>
</tr>
<tr>
<td><strong>Regional policy and planning</strong></td>
<td><strong>Regional Joint Steering Committee (RJSC)</strong></td>
<td>• The RJSC serves as a key governance structure in the nine regional states, and the Addis Ababa and Dire Dawa City Administrations.</td>
</tr>
</tbody>
</table>
|                             |                                                    | • The RJSC functions similar to the CJSC at the
central level and convenes to review regional plans consolidated from all districts.

- Chaired by the Head of the RHB, membership includes: heads of Regional Bureau of Finance and Economic Development, Regional Bureau of Capacity Building, two Woreda Health Bureaus and representatives of donors and NGO partners.

| Woreda       | Woreda Joint Steering Committee (WJSC) (Planning/Execution/Monitoring) | • Each woreda has a WJSC that discusses issues related to the strategic and annual woreda health plan and reviews progress regularly.
  |               |                                                                         | • Membership on the WJSC includes: Woreda administrative chair, Head of the WorHO, Heads of the health centre in the woreda, Medical director of the district hospital, WoFED representatives, RHB representatives, NGO representatives, and other pertinent woreda-level associations and organizations.

| Kebele      | Kebele HIV and Health Committee (Planning/Execution/Monitoring – community participation) | • Each kebele has one HIV and Health Committee that unites different sectors at the kebele-level and acts as a link between the health system and the community.
  |             |                                                                         | • From a planning standpoint, the committee should be consulted about the strategic and annual health plans.

Similar to the committees described in Table 6.9, Table 6.10 highlights the various consultative forums at each level of government, which serve as formal authoritative gatherings “to promote dialogue and regular exchange of information, enhance the spirit of partnership between the government, donors and other stakeholders, and facilitate the implementation, monitoring and evaluation of HSDP” (pp. 68-69). While such committees do not guarantee power sharing across stakeholders, they do support prescriptive measures to institutionalize multi-stakeholder inclusivity and authority in decision-making. For instance, each level of government (i.e., federal, regional, district, and kebele) must ensure that these biannual meetings take place and that all appropriate stakeholders convene when necessary. For instance, as drawn from the HSDP-IV, the FMOH-Joint Consultative meeting, the CJSC, the Minister of Health and their associated members must ensure that all applicable parties are invited to this meeting. Similarly, at the regional level, the RHB must ensure that all pertinent stakeholders (as detailed in
Table 6.11) are invited to attend this biannual meeting. With regards to NGOs and development partners, while their participation is acknowledged in both Tables 6.10 and 6.11, the scope of their role is not stated explicitly in these documents, and as described in Chapter 5 (Section 5.2.2.1, I), remained unclear among participants.

**Table 6.10. Consultative Meeting at Federal, Regional, and District Levels**
(Drawn from FMOH, 2010, pp. 68-72)

<table>
<thead>
<tr>
<th>Consultative Meeting at Federal, Regional, and District Levels</th>
<th>Attendance in and Goals of the Meetings</th>
</tr>
</thead>
</table>
| FMOH – Donors Joint Consultative Meeting                      | • A consultative forum that functions under the auspices of the CJSC and is chaired by the Minister of Health.  
• Attendance includes: directors of the FMOH and agencies, members of the HPN Donors Working Group, NGO representatives, head of the Oromia RHB, and head of the Addis Ababa City Administration Health Bureau. |
| Annual Review Meeting (ARM)                                   | • Unites federal and regional government agencies, selected WorHOs, health workers, donor partners, NGO partners, members from professional associations, universities, the private sector, and Ethiopian and international consultants.  
• Reviews progress of the year towards the completion of annual HSDP objectives. |
| Regional Review Meetings                                      | • RHB staff initiate meeting held twice a year to review annual plans and progress.  
• Issues discussed include: timeliness of plan preparation, compatibility between plans and budgets at the woreda and regional levels.  
• Stakeholders in participation include: RHB staff, WorHOs, staff of health centres, donors, major private providers. |
still required a prominent role of the central government in health planning initiatives. As described by many participants, although WBHSP aimed to strengthen decision-making authority at the woreda-level, it still required a heavy investment of federal and regional capacity in the organization and facilitation of meetings, in the development and refinement of the EBPB tool, and in the guidance of EBPB tool completion among district health planners.

II. **Discrete Aspects of Power: Authority, Relationships, and Communication**

A second dimension of system operations focuses on discrete aspects of power that may be captured by understanding authority, reputation, and communication among stakeholders in practice. As asserted by Foster-Fishman et al. (2007), an examination of power ultimately focuses on the concept of “influence” (i.e., who influences how health resources will be and are distributed [p. 209]). They describe that systems require multiple operations to enact their purpose that include: (i) processes for making decisions and determining how and where power is held; and (ii) processes for communicating information across system members. To uncover these operations, questions posed to participants in Phase 2 focused on how WBHSP has altered decision-making structures and power dynamics across stakeholders; what types of information and resources are most important and who controls access; how health planners communicate; if anyone was described as missing from the decision-making process; and, if participants felt equal participation was present.

(i) **The Prominence of Centralized Authority in Decision-making**

As previously detailed in Section 6.2.2.1, many district level participants spoke to the federal government’s prominent role in planning, and the overarching acceptance of this increased role as rooted in the belief that the government was acting in their best interest. During Phase 2, one district health planner described one of the strengths of WBHSP was working in accordance with the government’s agenda, as it was believed that this alignment facilitated greater collective and guided decision-making. They stated:

One of the biggest strengths since implementing woreda based planning has been that we [stakeholders at all levels of government] are all following the same plan. We know each activity, which has been the biggest strength since we can work in accordance with the
It is evident from similar sentiments echoed by participants that the majority of district health planners value the government's authority in guiding participants through the process. As noted previously, the respect for central authority was partly due to Ethiopian belief that the upper government was ensuring the best interests of the country (Section 6.2.2.1). Although many participants from the district level spoke to the importance of the central coordinating role, many participants also highlighted its implications for exercising district authority. Participants from the district level described that while WBHSP was implemented to enhance district capacity for planning, they still felt at the whim of the upper government for guidance and capacity building to operate the tool and develop their overall plan. While centralized guidance was thought by many participants to have its benefits in providing direction to district health planners, it tended to constrain their ability to plan for district needs.

Because we have traditionally had a planning process guided by the government, we continue to work under the same centralized umbrella of planning. It is a good thing because it guides us in one way. But in another way, it limits how much freedom we have as district planners. (Member, WorHO)

Planning constraints were further exacerbated by time constraints of the 5-day planning meeting (e.g., for training) and in the inadequacy of available data, which had as a consequence that district health planners relied heavily on regional and federal officials for capacity to guide planning decisions. As described by one WorHO representative:

Firstly, the time of the meeting is not enough for us to learn the tool and finalize our plan. When we return to the woredas, we are struggling to finalize our annual plans due to the constraints of data and the tool. Secondly, because of this issue, we are at the whim of the government—feeling like we are begging for more assistance. (Member, WorHO)

Participants described a lack of clarity regarding the scope of authority at different levels of government as another limitation to district level management capacity. They were unclear as to who was organizing what parts of the process, which appeared to be shared across the federal, regional, and zonal levels. One district health planner explained:

We wait to hear from the upper government levels, such as the Federal Ministry or the Regions [RHB]. Usually they are the ones in charge of bringing everyone together. But sometimes it differs. So we do not know who is specifically in charge of this process of setting the meetings (Member, WorHO).
Through participant observation, federal and regional government officials played active roles in convening, organizing and facilitating the 5-day planning meetings (see also Section 5.2.1.1). Participant accounts, however, suggest that federal and regional governments were seeking a more limited role in convening meetings. A RHB representative noted: “[e]ach year we are trying to capacitate the woreda to organize the planning meeting themselves and invite the partners, and book the meetings, etc. They [district health planners] still require some assistance. But we are guiding them and trying to facilitate this process” (Member, RHB). Nevertheless, there did not appear to be any major mechanisms established to facilitate this type of “hand-over” to the district levels beyond statements of authoritative handover.

Another critical element of system operations is the technical and data management capacity in support of WBHSP. As noted previously in Section 6.2.1, these presented unique challenges for district health planners. (While the WBHSP strategy, which included the EBPB tool and country-level data, has aimed to strengthen the technical aspects of health planning at the woreda level, the majority of participants felt that greater investment in woreda-level technical capacity would facilitate a hand-over of “true authority” to the woredas. As articulated by one district health planner:

We are still unclear how to complete the tool by ourselves and how to organize the meeting and the facilitators, who will they be? We would still need them, no? We know who should be here [at the planning meeting], but the capacity to make sure it all happens is difficult. We are already managing too much (Member, WorHO).

Despite such constraints, during the completion of the tool, district health planning and priority setting appeared to be quite a collegial process. Based upon participant observation, actors convening at this meeting —including WorHO members, Woreda Administrative Council members, Woreda Finance members, NGO partners—all appeared to have equal opportunity to contribute, as all in attendance could speak up should the need arise. Such participatory dialogue was also described in Chapter 5 (Section 5.2.1.3, I) where the equal participation of key stakeholders was detailed. Everyone at the decision-making table (i.e., during the WBHSP planning meeting) appeared to have some level of influence in decision-making. Although, many district level participants did view the WorHO as having more authority in ensuring the completion of the tool. It was evident that participants felt that the head manager of the WorHO
had the most authority in the district health planning and the related meeting. One WorHO administrative council member indicated:

At the district level, the woreda planning is primarily lead by the woreda health office. The manager must take a lead role to ensure that the data collected in the kebeles is accurate and managed accordingly. During the planning meeting they [the manager] take a lead role to ensure that planning is done accordingly—that the tool is completed and all the steps of the process are achieved (Member, Woreda Administrative Council).

A member from the WorHO also echoed similar views: “Within the district we know the woreda health office has a key role to manage and coordinate the annual plan” (Member, WorHO). Hence, primary accountability for WBHSP was understood by fall to the WorHO with added support from members of the Woreda Administrative council, Woreda Finance office, and NGO partners.

Through a top-down, bottom-up approach of WBHSP, it is apparent that the central government has continued to have prominent authority in a variety of areas related to the district health planning process—from coordination of the meeting, to inviting stakeholders, to training of district health planners. At the district level itself, however, participants maintained a prominent authoritative role of the district health office in coordinating data management and in the consolidation of the plan for the district level. Hence, notwithstanding the decentralization effort, the historically prominent role of the federal and regional governments in health decision-making was sustained during the implementation of WBHSP.

(ii) **Processes for Communicating Information Across System Members**

Foster-Fishman et al. (2007) emphasize that systems require processes for communicating information across system members; both across levels and within each level. As described in the previous section, and in Chapter 5, the federal government held a prominent role in the communication and dissemination of information across all levels of government in support of WBHSP. Training manuals were prepared and communicated to the district levels. Training of trainer (TOT) meeting were organized by the FMoH to convene all regional counterparts in preparing for the WBHSP 5-day meeting. At this time, facilitators from the regional and zonal levels were trained to guide district health planners. In addition, invitations to NGO partners and
each WorHO were disseminated to support stakeholder inclusivity. It is unclear through participant account, however, who held complete responsibility for this action, as some participants described the FMoH, others the RHB, and others the ZHD. No documentation related to this activity was noted in policy or strategy. Yet, asking participants from the FMoH, they indicated that it was a shared effort between the RHBs and ZHDs.

In addition to the above, what was also particularly evident through participant accounts was the missing voice of NGO partners during the district-planning meeting. Although underlying reasons for this absence varied across participant accounts, many participants, including NGO partners, contended that efforts to include NGO partners in the meeting could be improved given limited communication from upper level governments. Such sentiments were clearly expressed in Chapter 5 (Section 5.2.1.3, I) and further described in Phase 2. As stated by one WorHO member:

Communication is weak to include our partners. Some [NGO partners] say they did not receive the invitation letter, while others say the invitation was late and they could not plan ahead to attend the meeting. This miscommunication needs to be better coordinated and we need a clearer understanding of who is responsible for communicating this information (Member, WorHO).

While many participants spoke of a lack of communication to include the partners as an underlying reason, a few participants also suggested a lack of initiative on the part of NGO partners to attend. Described by one member from the Regional Health Bureau in Phase 2, NGO members appeared to show disinterest in attending.

This year we have missed the partners. They have not been keen to show interest. Overall, their support is poor since they do not want to participate actively. Typically they communicate with their headquarters in order to obtain direction on their work plans. To rectify their lack of participation, we are planning a partner forum that will bring all partners together to discuss their plans and intentions for the upcoming planning year (Member, RHB)

Potential reasons described by participants included the fact that “NGOs have their own plans and their willingness to work with the woredas [WorHO] has been slow” (Member, WorHO). While the vision has strived to be more inclusive and democratic, authority to ensure this takes place appeared less clear.
To promote communication within each level across stakeholders, consultative meetings were in place. It was unclear as to the extent that participants would fully communicate concerns and opinions beyond the 5-day planning meeting, as participant observation only occurred at stage. During this meeting, stakeholders were in a position to discuss planning related matters for the annual plan. One zonal health planner detailed other relevant consultative meetings that complement the planning meeting. “After we attend the meeting, we then continue our discussions within our WorHO and at the various other meetings like the Woreda Administrative Council” (Member, ZHD). It did appear, however, that mechanisms to support district dialogue with federal counterparts were weak. One reason cited by a WorHO planner focused on structural challenges in not being able to reach counterparts at the national level. “We try to talk to the federal ministry, but our discussions are minimal. Most of the time we cannot reach people” (Member, WorHO). Another district health planner went on to further assert communication challenges upon the cessation of the planning meeting. Here, they focused on a need to enhance channels for communication once the meeting is complete, as the annual meetings are not enough for routine discussion in this district planning process.

III. System Operations: Summary of Key Points

Overall, it is evident that in the HSDP policy and in the HHM strategy, directives have been established to guide stakeholder inclusivity at all levels of government and ensure that consultations (at all levels) take place within the decentralized health system, so as to support the vision of democratized health planning. To support WBHSP implementation, clarity of roles and responsibilities in policy would act as facilitators in this process. Similarly, the presence of consultative forums at each level of government would facilitate in the implementation WBHSP harmonization (one plan, one budget, one report principles), given the pre-established policy directives on when stakeholders should meet, who should attend, and what topics may be discussed. While greater efforts to strengthen decentralized decision-making capacity and accountability among woreda health planners has been the aim of WBHSP, authority in planning is still largely influenced by the goals of the central government and the HSDP policy built into the EBPB tool (a prominent component of WBHSP). The implementation of WBHSP has aimed
to standardize decision-making structures throughout the country and capacitate district-level decision makers in the process. It has therefore required a greater shift in power and authority to district health planners. Participants at the district level, however, maintained that full autonomy to plan does not exist at the district-level, as planning is still controlled by the upper level government to a certain extent (i.e., who is in charge of convening participants, training health planners, and overseeing and approving plans). Although, many participants did convey a lack of overall clarity in who is ultimately responsible for organizing and overseeing all aspects of the planning process. Similarly, a lack of clarity on the role of development partners in the WBHSP process left many participants (namely district health planners) unsure on how to actively engage this group, given the importance of their presence in deciding in district-related health activities.

6.2.2.3. **System Regulations: Policies, Procedures, and Routines**

System regulations are another component of the TSCF system structure that focuses on the policies, procedures, and routines that would be required to support the implementation of WBHSP. For a system to function in light of a new strategy, it requires its members to function in a coordinated manner to align with the overall goal of the initiative. As argued by Foster-Fishman et al., (2007) “developing broad support for specific policy changes and aligning system resources to support adopted policies is critical to the institutionalization of a desired change (p. 209).” Under system regulations, it is important to capture the policies and procedures within the health system that would foster a receptive environment for WBHSP to manifest. This analysis therefore warrants a deeper investigation of what policies and procedures existed prior to the implementation of WBHSP. This reflective step is essential to achieving a greater understanding of the congruency between WBHSP with the existing structures of the health system.

The analysis for this section is undertaken in two parts. First, it reflects on the policy milieu prior to and during the implementation of the WBHSP strategy to provide a basis for understanding the regulative policies that would influence the WBHSP planning process. Second, it draws out previous and existing procedures and routines that would similarly influence WBHSP implementation. To offer insights into the process of decision-making prior to WBHSP, this section is organized around as series of questions posed by Foster-Fishman et al. (2007) that
include the presence of any major inconsistencies between existing policies in practice and the principles of WBHSP, current procedures that may impede successful implementation of WBHSP, and practices that may need to be implemented to facilitate the goals of WBHSP. Given that this study commenced at the time of WBHSP implementation, an empirical analysis of previous decision-making processes was not within the scope of this investigation. To guide this analysis, a literature review was undertaken to draw from gray and scholarly research that analyzed health planning processes and structures before 2007. Where applicable, participant accounts also provided a basis for furthering our understanding of the procedures and routines in support of WBHSP.

I. Policy, Procedures, and Routines Shaping the Health System Prior to WBHSP

As described in Chapters 3 and 5, the WBHSP strategy emerged from the recognition among Ethiopian government officials that health planning needed to become more streamlined throughout the entire country and guided by a standardized system of evidence-based practice. Prior to the implementation of WBHSP, five major health-related policies played a key role in shaping the health system by providing a series of directives on how health planning and priority setting should transpire. These policies included the Health Policy (1993), the HSDP (1997-2015), the District Level Decentralization Program (DLDP) (2002), the HHM strategy (2007) and the Health Management and Information System (HMIS) (2007) strategy. Detailed explicitly in Chapter 3 (Section 3.3), each policy contributed broadly to establishing who should have responsibility in health planning, what health priorities are to be planned and prioritized at the national and district levels, how decision making procedures are to take place, and how health-related information should be collected, managed, and analyzed.

To briefly reiterate, the Ethiopian Health Policy (1993) emphasized principles of “democratization and decentralization of the health service system (FMOH, 1993, p. 3)” It described a health planning environment to be built upon principles of stakeholder inclusivity, the establishment of health committees, and community—as the government works toward health planning, implementing, and monitoring and evaluating health activities (p. 5). To operationalize this vision of democratic and decentralized planning, the HSDP and the DLDP emerged in the
late 1990s/early 2000s to guide all levels of government on this process. In 1997, the HSDP crystallized policy discussions focused on national priorities that would guide health priority setting throughout the country, at all levels of government. In addition to the HSDP, more formalized structures for devolving decision-making power to the regional level emerged through the government’s decentralization effort. As also previously outlined in Chapter 3, the government sought to decentralize health planning and implementing power to the regions early 1990s. This effort was to dissociate from the overall record of centralized control in health planning, and, subsequently, establish greater alignment between resource allocation practices and regional/district need. Such a transfer of power to the lower government levels was believed to facilitate greater political stability and contribute to democratic governance, while simultaneously cultivating an environment of harmonized planning across different ethnic groups and district self-rule (Assefa & Gebre-Egziabher, 2007, p. 1).

Decentralization emerged in two phases, whereby the first phase (1991-2001) devolved administrative authority to the National/Regional governments and was termed as “mid-level decentralization” (Assefa & Gebre-Egziabher, 2007, p. 1). During this phase, the national/regional governments were entrusted with legislative, executive, fiscal, and judicial power, with the exception of key national matters under the jurisdiction of the Federal Government (i.e., defense, foreign affairs, etc.). Fiscal decentralization was also introduced and intended to assist regional governments in strengthening their capacity to narrow gaps in economic growth and development across the regions. Yet, while significant achievements were noted with respect to strengthening district governance, self-rule at the district level was still considered weak.

A second phase of decentralization emerged in 2001, which further devolved authority to the WorHO. The DLDP was launched in 2002 with the objectives to further devolve decision-making power, enhance good governance, and improve service delivery at the woreda-level. From a health-planning standpoint, Garcia and Rajkumar (eds) (2008) describe this phase of decentralization as a mission to “improve democratic local governance” (p. 8). In support of this process towards greater democratic governance, the HSDP laid out clear plans to encourage multi-stakeholder dialogue through the development of health committees and consultative
meetings at each level of government that would include government officials, development partners, and international donors (at the federal level) (See Tables 6.10 and 6.11 under Systems Operations). Prior to the implementation of WBHSP, many administrative constraints to decentralized decision-making were documented in the literature (Assefa & Gebre-Egziabher, 2007; Garcia & Rajkumar (eds), 2008). These constraints focused on five key areas that included: (I) inadequate resources channeled to the woreda-level; (II) difficulty in health planning due to inadequate information; (III) lack of clarity around roles and responsibilities; (IV) limited woreda-level administrative capacity; and (V) minimal accountability and performance tracking.

With international attention progressing towards increased aid effectiveness in 2005 (See Chapter 3, Section 3.3.2), principles in support of increased alignment and harmonization of health priorities emerged as a key policy initiative. The development and implementation of the HSDP Harmonization Manual in 2007 served as a step towards systematizing planning throughout the decentralized health system to ensure stronger alignment between the national HSDP, NGO partner plans, and district health plans. The HHM strategy was largely in support of the “One Plan, One Budget, One Report” vision for the health system, whereby all planning was to be streamlined into one overall plan to improve efficiency, accountability, and effectiveness of health planning.

In 2007, greater attention was placed on strengthening HMIS within the health system. This discussion emerged from the recognition that to improve performance and remove “bottlenecks” in the health system required improvements in monitoring and evaluation (M&E) and health data management. Hence, four strategic areas were outlined that sought to: (i) improve clarity on health indicators definitions; (ii) refine disease classifications and case definitions; (iii) improve HMIS data recording and reporting procedures; and (iv) strengthen HMIS and M&E information use guidelines. Ultimately, the purpose of HMIS was to routinely generate quality health information that provides specific information support to the decision-making process at each level of the health system for improving the performance of the health system and thereby the health status of the population. Similarly, there is a pivotal role for HMIS within the Health Sector’s Monitoring and Evaluation (M&E) system and within the HSDP agenda. Under the harmonization “one plan, one report, and one budget” initiative, HMIS provides the core
indicators to guide this process. Three overarching principles—standardization, integration, and simplification—have guided the redesign of these aforementioned strategic areas of HMIS and support the implementation of an effective HMIS/M&E system. Table 6.11 describes each principle in greater detail.

**Table 6.11. HMIS Core Principles (taken from FMOH [2007])**

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardization</td>
<td>Common definitions of indicators, data collection instrument, and data processing and analysis procedures form the foundation for effective HMIS/M&amp;E. Without consistent principles and definition performance cannot be systematically measured and improved across locations or over time.</td>
</tr>
<tr>
<td>Integration</td>
<td>A single HMIS/M&amp;E plan, shared by all partners, is a cornerstone of HSDP. Implementation of this principle requires integrating data from different programs into an integrated channel from which all derive their information.</td>
</tr>
<tr>
<td>Simplification</td>
<td>Collecting, analyzing, and interpreting only the information that is immediately relevant to performance improvement makes best use of scarce resources, especially human resources.</td>
</tr>
</tbody>
</table>

In light of the above principles, it is evident that greater emphasis has been placed on strengthening coordination of data collection and management at all levels, including HEWs, working at the community level. Figure 6.3 outlines the “bottom-up” structure of data management under the HMIS, whereby data is to be collected, checked for quality, compiled and sent to the upper levels of government (namely the WorHO, the RHB, and then the FMOH). Further, the HMIS strategy further acknowledges the important role of implementing partners in providing capacity and resources in this management process. It is therefore evident that prior to the introduction to WBHSP, various policy directives had been instituted to support multi-stakeholder engagement in planning; greater awareness on roles and responsibilities of stakeholder in the health system; improvements in strategies for data collection and management (in alignment with health priorities defined by the HSDP); more efficient procedures for aligning health planning objectives across all levels of government; and greater attempts to strengthen regional and district-level authority through decentralization policies.
II. **Barriers to and Facilitators of WBHSP Implementation**

Described by Foster-Fishman et al. (2007), regulative directives within a system guide the establishment of procedures and routines that influence how the implementation of WBHSP would align with the system. Through this lens, governmental and organizational policies have the most substantial impact since they clarify what procedures and routines are normative and expected. “These regulations are so important to system functioning that the success of a systems change endeavour [i.e., WBHSP implementation] rests on the extent to which the routines, protocols, and procedures [already established within the Ethiopian health system] are or become compatible with the targeted change (p. 209).”

This section is organized around a series of questions adapted from the TSCF framework, which guided analysis on the regulative facilitators of and barriers to WBHSP implementation. These adapted questions included: have there been any major inconsistencies with what is written...
in the WBHSP document and what can actually be implemented; are there any other current policies or practices that would impede successful implementation of WBHSP; and, what practices are not in place, but are potentially required to fully support the goals of the WBHSP implementation.

(i) Implementation of the WBHSP Meeting and the Adoption of the EBPB tool

With the implementation of WBHSP, two significant changes to routines and procedures were involved that included: (a) the development of the WBHSP 5-day planning meeting, and (b) the implementation of the EBPB tool. The introduction of these two features served a very explicit purpose of routinizing some key policy directions, such as harmonization across the country and improving the evidence-base of decisions.

a) Development of the WBHSP Planning Meeting

Overall, the policy and decision-making environment was receptive to the introduction of the novel WBHSP process. As described above (Section 6.2.2.1), many of the principles of WBHSP were in alignment with principles, procedures, and practices already in operation within the health system. For instance, the HSDP consultative (Table 6.11) had established mechanisms conducive to additional stakeholder gatherings under WBHSP (i.e., during the 5-day planning meeting). In addition, decentralization of health governance had established a structure for health planning in support of a more prominent role for district health planners. Further, the implementation of the harmonization and alignment agenda fostered a district health-planning milieu in support of greater alignment in health priority setting and cross-collaboration between different levels of government—features salient to the implementation of WBHSP. And finally, since the implementation of HMISs in 2004, greater attention had been placed on data management systems at all levels of government, and on the clarification of data indicators and classifications; issues important to the implementation of the EBPB tool.

During interviews, participants underscored the importance of the 5-day planning meeting to the new WBHSP process. A RHB member, for instance, described how the presence of other consultative meetings had created an environment for stakeholders to embrace similar practices.
under WBHSP.

Since woreda based health sector planning, we meet to discuss the plan’s development during the planning meeting for the tool. This is a new meeting for us, but we are used to gathering for such kind of meetings. It is important to ensure all views are weighed in the process. (Member, RHB)

Further, in pursuit of collective decision-making, another WorHO member spoke to the benefit of the planning meeting as a mechanism for cultivating greater dialogue among stakeholders at all levels.

One major benefit of woreda based planning is the presence of more discussion among us [stakeholders]. The woreda planning meeting, for example, did not exist before this new strategy. This meeting is important because it guides us to complete the tool and many of us are open to join because we need to ensure the discussions continue across all levels. (Member, WorHO).

Another zonal health planner further detailed other relevant consultative meetings that compliment the planning meeting. “After we attend the meeting, we then continue our discussions within our WorHO and at the various other meetings like the Woreda Administrative Council” (Member, ZHD).

While many participants valued this forum as a mechanism for collective discussion, its implementation was constrained by logistical issues related to a lack of clarity around meeting logistics and absenteeism. As described above (section 6.2.2.2), a lack of clarity about which government body or level had regulative authority to convene stakeholders in the planning meeting resulted in absenteeism (as a result of delayed letters and blurred responsibility). Limitations associated with convening stakeholders for related meetings, however, appeared to be inexistence prior to the implementation of WBHSP. One regional member described some challenges experienced in the past of bringing stakeholders together.

Bringing everyone together for the woreda planning is particularly difficult sometimes. We send out the invitations to the woredas, but many do not show up, sometimes for reasons unknown. But this issue [of absenteeism] happens all the time, in different meetings. Sometimes you try to bring them together, but they have other meetings, or they do not have transport. Such challenges always exist. (Member, RHB)

It was evident from participant accounts that during the meeting, the 5-day planning meetings as a mechanism for inclusive decision-making do not appear to have been successful in addressing
the recurring problem of insufficient NGO participation in health planning.

b) The Implementation of the EBPB Tool

Since the adoption of the WBHSP strategy, the major system change effort has revolved around the introduction of the EBPB tool. When reflecting on the completion of the tool, a number of regulative factors also act as facilitators of or barriers to its overall implementation. In particular, previous structures described above, concerning the participation of pertinent stakeholders, play a large role in the completion of the tool. As stated by one district planner, “we come together during this meeting to complete the tool. If we did not have this meeting, we would struggle to complete it and finalize our annual plan (Member, WorHO).” From Phase 2, another district health planner from the WorHO further emphasized the importance of the planning meeting as a facilitator in completing the tool.

Everyone’s participation in the woreda-planning meeting is essential. We all bring specific skills to meeting to complete the tool together. If one is not there, it delays the process [of completing the tool]. We have to make phone calls, etc. Therefore, we all must try to be there. But this is not always possible. It is a challenge (Member, WorHO)

Mentioned in Chapter 5 (Section 5.2.1.3, I), it is evident that a plethora of skills and expertise from multiple stakeholders are needed to contribute to the importation of pertinent data, as well as for the engagement of discussion in this process. As described above, however, the lack of clarity around who held responsibility to convene counterparts in this process acted as a barrier to the EBPB tools completion. In addition to the role of the planning meeting in facilitating the completion of the tool, regulative structures influencing HMISs also emerge as an important consideration for the effective implementation of the EBPB tool. Prior to the introduction of WBHSP and the adoption of the tool, the government had commenced the HMISs initiative throughout the country. As detailed above (section 6.2.2.3, I), efforts had been taken to improve data collection strategies at all levels, from routine data collection at the kebele level, to the consolidation, management, and reporting at the district, zonal, regional, and national levels. Previous attempts to standardize data classifications and strengthen methods to collect community-level data inherently fed into the evidence-based planning principle. It was evident through participant accounts that great strides had been taken to improve evidence-based
planning through HMISs. As stated by one member from the RHB, “[e]vidence-based planning is about having quality data. We have been working to improve this under the HMIS strategy” (Member, RHB). District health planners from the WorHO further described similar sentiments. One WorHO member described how “the collection of data is improving now. We have started to see improvements in the amount of data and in the surveys to collect the data. This process is being improved in all woredas” (Member, WorHO). Another WorHO member echoed, “HMISs has been important for towards the evidence based planning principle [of the WBHSP strategy]. Therefore, the EBPB tool was viewed by participants has having potential to improve the application of HMIS-derived data and, hence, to improve the evidence-base of health planning decisions as well as their consistency between woredas.

While HMIS was recognized among participants as an important strategy towards enhancing evidence-based practice, there were significant recurring challenges associated with aligning HMIS data with the indicators present in the tool (see Section 5.2.2.2, I, iii). The need to improve alignment was underscored by many participants, including this ZHD member:

What is needed is a greater attempt to bring stakeholders together who are both involved with the HMIS and the woreda based planning tool. There is a mismatch and this needs to be addressed at the upper level. The surveys used at the woreda level need to be formatted in such a way so as to be aligned more directly with the data indicators in the tools. In doing this, planners will not be struggling to import accurate data and will use actual data and not regional or national estimates as a default for missing information (Member, ZHD).

III. System Regulations: Summary of Key Points

The WBHSP strategy was an important initiative in the area of district health planning since it aimed to standardize practice throughout the country and capacitate district health planners to harmonize planning throughout the health system. While a number of policies, such as the DLDP, HMIS, HHM, and HSDP, have all held paralleled agendas to that of WBHSP, the capacity to absorb the procedures and routines required of WBHSP (i.e., such as the 5-day planning meeting and the EBPB tool) have been limited. The EBPB tool, in particular, is one of the key components of change instituted through WBHSP that has required shifts in procedures to convene key stakeholders to complete it, shifts in data collection and management to run
various analyses, and an overall structural and technical capacity for district health planners to work with the tool. Therefore, while the adoption of the WBHSP strategy is in alignment with the decentralization and harmonization agenda, to strengthen its implementation, clearer policy directives may be required on the roles and responsibilities for each level of government (in terms of who is to participate and in what capacity) as well as technical intervention with support from different levels of government. Similarly, greater regulative clarity is required on procedural elements that regulate training structures at the district level and to ensure that both the structural capacity (i.e., laptops and computers) and data management procedures are in sync with the new strategy.

6.2.2.4. System Resources: Human, Social, and Economic

To uncover system resources, Foster-Fishman et al. (2007) focus on three dimensions of resources in the TSCF: (I) human; (II) social; and (III) economic—that would be required to sustain the system change effort. The following section describes these three dimensions in greater detail to capture a holistic understanding of the resources required to support the WBHSP strategy. This analysis is focused around a series of questions posed in the TSCF and will be outlined in each of the following sections.

I. Human Resources: Roles, Responsibilities, and Skills

In order to adapt and incorporate changes from a new initiative, the TSCF recognizes the importance of human resources within a system. The human resources domain of the TSCF refers to the knowledge, skills, and abilities of key actors that exist within a system. Although system actors may hold beliefs and values that are congruent with an initiative, they may not possess the knowledge, skills, or abilities needed (both in the short- and long-run) to fully implement the system changes (Foster-Fishman et al., 2007). To reflect on the human resource requirements necessary for the implementation of the WBHSP strategy, my analysis focused on understanding knowledge, capacity and the technical skills required for all actors involved in the process. Analysis was guided by a series of questions posed in the TSCF and presented in Table 4.4. Briefly, questions focused on the expectations for each health planner since the emergence of
WBHSP; what skills are required of planners now; and whether any champions been identified to
guide implementation.

Although no champions have been explicitly declared as such with the implementation of
the WBHSP strategy, the WorHO has a prominent role in the completion of the EBPB tool.
Policy directives stemming from the HHM strategy emphasize that the WorHO has the primary
responsibility to complete the tool with other WorHO technical representatives, post the 5-day
meeting and assemble the final annual plan report for review at the RHB. In addition, many
participants further described the strong role the regional government has played in ensuring the
adequate level of trainers would be deployed.

(i) **Technical Capacity and Skills Required for WBHSP**

As previously described under system regulations, two key changes of the district health
planning process took place since the onset of WBHSP. These included the emergence of the 5-
day planning meeting and the adoption of the EBPB tool, which collectively warranted greater
capacity and involvement of stakeholders, at all levels. To accommodate the introduction of the
5-day meetings, programmatic shifts would be required to ensure that one government body
would be leading the organization of the meeting. Further, there would be a requirement to
ensure that trained facilitators would be present to both lead the meeting and mentor district
health planners on the functionality of the tool, as well as a commitment to ensuring an
appropriate mix of expertise to guide completion of the tool and priority setting.

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ensure that trained facilitators would be present to both lead the meeting and mentor district
health planners on the functionality of the tool, as well as a commitment to ensuring an appropriate mix of expertise to guide completion of the tool and priority setting.

Table 6.12. Previous Table 5.1: Key Responsibilities of Major Stakeholders involved in Development of the Annual Plan (modified from the EFMoHa, 2007, p. 27)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Activities for which they are responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Ministry of Health</td>
<td>Develop the HSDP</td>
</tr>
<tr>
<td></td>
<td>Secure approval of the plan by the Central Joint Steering Committee</td>
</tr>
<tr>
<td></td>
<td>Share the plan with RHBs</td>
</tr>
<tr>
<td></td>
<td><strong>Support the RHBs in the development of their strategic and annual plans</strong></td>
</tr>
<tr>
<td></td>
<td>Ensure that regional plans are consistent with national priorities.</td>
</tr>
<tr>
<td></td>
<td>Ensure all RHBs and senior Federal managers have copies of all pertinent national documents related to planning.</td>
</tr>
<tr>
<td>Regional Health Bureaus</td>
<td>Develop and implement the Strategic Plan</td>
</tr>
<tr>
<td></td>
<td>Secure approval of the plan by regional government</td>
</tr>
<tr>
<td></td>
<td>Share plan with the FMOH and WorHOs</td>
</tr>
<tr>
<td></td>
<td><strong>Support WorHOs in the development of their strategic and annual plans</strong></td>
</tr>
<tr>
<td></td>
<td>Ensure all WorHOs and senior RHB managers have copies of pertinent health planning documents.</td>
</tr>
<tr>
<td>Woreda Health Office</td>
<td>Develop and implement Annual Plan with involvement of community and partners</td>
</tr>
<tr>
<td></td>
<td>Secure approval of strategic plans by the woreda government</td>
</tr>
<tr>
<td></td>
<td>Share plan with the Regional Health Bureaus (or ZHD)</td>
</tr>
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</table>

In both Phase 1 and 2 of this study, limited technical capacity of district health planners was cited as an ongoing issue among participants. Throughout Chapters 5 and 6, participants consistently described a lack of technical skills to meet the technical requirements of EBPB tool. In Phase 2, district health planners further reinforced that they keenly felt a lack of skills to manage the functionality of the tool or to manage data entry into the tool. Participants did convey that they felt WBHSP was implemented without recognition of district level workflows or capacity. Chapter 5, Section 5.2.1.1 (II), for instance, introduced a number of these constraints identified by participants. These constraints included limited capacity at the regional and zonal levels for deploying adequately trained facilitators for the planning process. For instance, one ZHD representative focused on limited capacity for mentoring during the meeting as a by-
product of being overburdened: “The number of mentors per woreda, with existing conditions was not balanced. There might be quality compromising as a result of over-burdening. One mentor for five woredas is very difficult” (Member, ZHD).

Another example of constraints that reveals the limited absorptive capacity of the system focused on a misalignment between the needs of the tool and the data available at the district level. Further to technical capacity to manage the tool, many participants indicated that the tool was introduced into a decision-making environment that was not formatted to the data collected from the woreda level. One district health planner focused on the limited data itself and a sophisticated tool that could not be populated fully. “[…This] is an elaborate tool that requires data that is incomplete because the information system is still weak. How is this building the capacity of the woreda to plan?” (Member, WorHO). Another WorHO representative echoed:

We are given this elaborate and technically advanced tool to use in district planning, but I don’t think this tool was developed with our capacity in mind. It requires a lot of data that we have in some way, but the formatting is different. It makes it time intensive and demanding in too many ways (Member, WorHO).

Reflecting on issues with data alignment, another WorHO representative highlighted inefficiencies at the kebele level related to human resource capacity and gaps in data acquisition by health extension workers. Such sentiments continue to highlight the demands of the system that were likely not considered prior to the implementation of the tool.

Technical capacity is still a problem. We have a shortage of budget and a shortage of human resources that affects our ability to plan. One of the major issues at the bottom level is a shortage of health extension workers in the health posts and health centres, which makes data collection difficult. Also, we have a shortage of bikes that the health extension workers are unable to travel freely into the kebeles to collect the data. Data is an issue because of this. (Member, WorHO).

Described in Chapter 5, a consequence of this lack of alignment with the tool has been the use of regional and national estimates, which further skews analysis of district needs at the completion of the annual plan.

In addition to capacity constraints during the meeting, another WorHO member spoke to the lack of support upon the completion of the five-day meeting. “Once the planning meeting is completed, there is no support outside of this meeting. No materials, or additional training
meeting are provided and, so, maintenance and retention are difficult” (Member, WorHO). Based upon these sentiments, it is evident that in reference to technical skills, the Ethiopian system was not ready to acknowledge and address the capacity requirements for undertaking WBHSP; although there was a strong aspirational commitment to adopt this policy. Such a claim is validated by a number of additional sentiments from participants in Phase 2 who spoke to the myriad of capacity constraints they were confronted with. Many participants contended that the EBPB tool was implemented within an environment where district health planners were not fully equipped to technically manage the EBPB tool. One district health planner spoke to this lack of acknowledgment by stating:

The evidence-based tool has been implemented without proper attention to our capacity at the district level. We need proper training and when we have the five-day meeting, there are not enough facilitators present. And sometimes they need more training as well. (Member, WorHO)

The TSCF also recognizes that while significant differences in human resources are present in most systems, it is how the system recognizes and integrates these differences that determines how the system adapts. The lack of available human capital can often constrain the successful pursuit of a systems change effort. While it was evident that the FMoH had taken steps to strengthen training of regional and district health staff (through Training of Trainer workshops and meetings), it was unclear where additional hiring of staff had taken place under WBHSP.

In light of the aforementioned challenges, when reflecting on solutions moving forward, many participants offered their views on how to strengthen capacity at the district level. One member reaffirmed, “while capacity is still weak, district planners recognize the importance of WBHSP and desire to be trained” (Member, WorHO). They went on to further suggest, “[t]he government needs to bring more facilitators and increase the frequency of training. We plan for 5-day and then wait for another year. We require ongoing refresher trainings” (Member, WorHO). Human resource gaps were also described by a RHB representative who stated, “we are training facilitators from the regions [RHB] and zones [ZHD], but it can become challenging because many may leave during the next planning cycle. New jobs arise and people leave for more opportunity” (Member, RHB). Such issues of staff turnover were further described as
limiting technical capacity. One WorHO representative, for instance, focused on the consequence of losing technical skills as a result of staff turnover.

What becomes the challenge is that we are trained this year to use the tool. We maybe understand 75% of it. But then for the next year, some [district health planners] leave. Maybe they are limited by their knowledge. And they move to other work with higher pay too. As a result, staff turnover is an issue” (Member, WorHO).

Some participants honed in on ensuring training materials should be less dense and easier for untrained district health planners to digest.

Some terms in the training manual are not easily understood like BSC, the materials are huge and were beyond the capacity of the woreda, and therefore a more simplified training manual for the woreda needs to be prepared (Member, WorHO).

The implementation of the EBPB tool was therefore a resource-intensive component of the WBHSP strategy. It required a level of technical capability among district health planners, and an aligned and strong database of district data in order for it to be finalized. Findings reveal that in light of these requirements, optimally trained facilitators has been suboptimal and, consequently, training district health planners has been challenged. Further, existing infrastructure and capacity for collecting and managing data has not been aligned with the indicators required in the tool. One WorHO representative further suggested that the tool be “tested to detect any defects and to assess its application in the districts” (WorHO representative). Therefore, findings reveal that efforts in support of any of the above challenges could yield significant improvements to technical capacity to manage this new component (i.e., the EBPB tool) to the district health planning process.

II. Social Resources: Successes, Relationships, and Social Interactions

Also acknowledged within the TSCF are the social resources that would influence the implementation of WBHSP, which include the interactions that occur between different levels of government that would either hinder or facilitate WBHSP. When the focus of a change effort is a social system (i.e. an organization or a community), attention to the presence, absence, and nature of social relationships among system members is particularly critical to understanding system functioning (Foster-Fishman et al., 2007). In reflecting upon the social relationships important to
the success of WBHSP implementation, the TSCF offers a series of key questions that were formatted for application to this study. These questions include reflections on social interactions between stakeholders, how relationships among stakeholders have been altered in light of WBHSP implementation, and how have these interactions impacted implementation.

(i) **Relationships and Social Interactions: Changes in Stakeholder Dialogue**

In Chapter 5, participants detailed a variety of successes of WBHSP planning that focused on improvements to: strengthening multi-stakeholder engagement and collective decision-making; harmonization and alignment of goals and programmatic activities; strengthening data usage through the EBPB tool; and minimizing the subjectivity of planning (as had been noted prior to WBHSP implementation). It was noted by many of the participants that the success of WBHSP has largely hinged upon the ability of stakeholders to work in synergy with each other, to communicate regularly throughout the planning process, and to collaborate across different levels of the government. One major factor that has played a significant role in supporting these structures has been the planning reform that emerged in 2006/7 through the implementation of the HSDP Harmonization (HHM) Strategy. As described in Chapter 3, this policy set the Ethiopian political milieu on a course towards increased harmonization and alignment at all levels of government and detailed a set of policy directives for increased collaborative engagement across stakeholders through the one plan and one report principles. Chapter 5 presents Figure 5.2* (re-presented below for convenience), which outlines various communicative structures across different levels of government that have been required during the implementation of WBHSP. Based upon this diagram, it is evident that all levels are connected and in a position to interact with each other given the processes and procedures outlined in the WBHSP strategy.

Although the precise channels of communication were not explicitly explored within this study, policy documents and participant accounts reveal a series of formal mechanisms for stakeholder engagement that had already been present prior to WBHSP. As previously outlined in Tables 6.10 and 6.11, the presence of different committees and consultative forums for engagement suggest the existence of pre-existing interactions that served as a mechanism for
enhanced stakeholder engagement under WBHSP. Such mechanisms were identified and discussed under system operations and appeared to play a facilitative role in supporting communication under WBHSP. As previously described in Chapter 5, some participants spoke to the presence of stronger communication structures and, consequently, greater transparency across all stakeholders and levels of government.

**Figure 5.2.** Annual Planning Cycle (Modified from the EFMOHb, 2007, p.10)

Under WBHSP, there has been a clear need for greater communication throughout the health system in light of the “One Plan, One Budget, One Report” principle. Since the implementation of WBHSP, the planning meeting has been one of the primary vehicles for increased stakeholder engagement and communication among planners at all levels of government. All key stakeholders at the woreda level (i.e., WorHO representatives, Woreda Administrative Council representatives, and NGO partners) are to convene and communicate the needs and intentions of the woreda during this time. In Phase 2, many participants spoke to the added value of the meeting in convening stakeholders to plan in a more open, efficient, and collegial manner. This view was succinctly summarized by one district health planner from Phase 2 who stated:
Woreda planning and the planning meeting, in particular, are helping us communicate more. Before we were fairly in touch with the regional level and the zonal level, but that was only at the review phase. Now we see them all, which is great. We can troubleshoot and discuss together. (Member, WorHO)

A few participants, however, also noted gaps in communication. Some district health planners spoke of gaps in communication between the government (mainly the regions and zones) and external stakeholders, such as NGO partners and the wider community. This disconnect was largely emphasized as occurring prior to the meeting when communication to invite partners was delayed. One WorHO representative summarized such an issue in the following statement:

Communication is weak to include our partners. I do not know why there is this gap. There is delay in invitation sometimes and sometimes we don’t know. Maybe they go to another woreda for the planning meeting. There should be greater transparency of who can and cannot attend and why. (Member, WorHO).

Although this issue of minimal partner engagement and weak communication to external members emerged consistently, additional analysis is required to understand the underlying reasons for such systemic behaviour.

### III. Economic Resources: Fiscal, Programmatic, and Organizational Resources

Finally, economic resources are also reflected upon within the TSCF. Here, economic and opportunity capital refers to the configuration and distribution of financial, programmatic, and organizational resources in order to accommodate the needs of WBHSP. Thus, one task in understanding if the resource context is compatible with a systems change pursuit is to examine the extent to which current resource distributions (such as service funds) and opportunity configurations (such as program and job locations) reflect and support the desired goals or outcomes of a systems change effort. Although attempts were made to access fiscal records related to WBHSP distribution, descriptive costing information was not obtainable based upon challenges encountered in accessing the data. Inferences related to WBHSP allocation below are therefore based upon participant interviews and document analysis (i.e., FMOH evaluation of WBHSP [2010] and a WBHSP PowerPoint presentation) where some discussion of funding available for WBHSP was discussed.
(i) **Financial Resource Distributions**

While many participants acknowledged the fiscal requirements needed to meet WBSHP, the exact amount of financial expenses required was not divulged to me. In a 2010 PowerPoint presentation on the WBHSP strategy given by the Regional Administration in SNNPR (permission granted by the SNNPR RHB to share this information), funds released to undertake WBHSP from the FMOH and RHB totaled 2,210,000ETB (124,681.41CDN), with added support from an international NGO partner in the amount of 200,000ETB (11,279.89CDN). Participant accounts did convey that to meet the needs of implementing WBHSP, greater resource distributions would be required at the district level. For instance, a need for greater funding was emphasized to support the 5-day planning meeting and other resource materials required, such as training materials and laptops, etc. Increased funding was also voiced as a necessity to support travel costs associated with national, regional, zonal, and district health planners attending the meeting. In support of these needs, some participants in Phase 2 spoke to the importance of ensuring that adequate financial resources would be available. One RHB member, for instance, described that while resources have been available to meet the needs of organizing the planning meeting, other costs associated with additional training materials and infrastructure have been minimal. “We have had the support to coordinate our planning meetings, but we have lacked the funds to ensure that training materials are provided to all and that laptops are available” (Member, RHB).

Similar to the aforementioned statement, many participants further echoed challenges experienced in budget allocations to meet the needs of the district planning process itself. As aptly summarized by one participant from the FMOH:

> Planning appears to be working well with the adoption of woreda based planning, except that budgeting gets very difficult. There are a lot of resources that we have been struggling to provide at the district level. Training materials could be more and we need more trainers and laptops (Member, FMOH).

This sentiment was further reinforced by a member from the WorHO who argued that “[t]his redesigned strategy requires a budget and hence, health planners need to convince the government and lobby for resources if we are to be given proper capacity” (Member, WorHO).
Another district health planner went on to emphasize that not enough engagement with the donor community has been undertaken and that to improve budget allocations for the implementation of this new strategy, that the “government must work closely with donors mobilize adequate resources” (WorHO, Technical Officer).

(ii) **Opportunity Configurations: Programmatic and Organizational Resources**

In addition to fiscal considerations, the implementation of WBHSP has required the participation of a number of different stakeholders within the health system. The central and regional coordinating role of the government has played a significant role in the configuration and distribution of the resources required for undertaking the process. Although details of fiscal distribution are uncertain at this stage, it was clear from district health planner interviews that a clear commitment from the upper level government (i.e., central and regional) to ensure adequate programmatic resources. One district health planner from Phase 2, for instance, drew our attention to the “strong effort of the regional government to ensure adequate trainers and facilitators” (Member, WorHO). Another WorHO representative, from Phase 2, acknowledged attempts by the federal government to strengthen the availability of structural resources at the district level. They maintained:

> It is important to recognize the effort of the Federal Ministry to improve our resources as well. It is not as comprehensive as it could be, but since woreda planning started, I see the difference. They are providing trainers and more programmatic direction. Also, we need more laptops, but they are helping us with some material resources like computers (Member, WorHO).

Although some participants acknowledged a resource commitment by the upper government levels, a few other participants expressed sentiments that the resource commitment has not matched the entirety of WBHSP programmatic needs. One member from the WoFED approached this sentiment from a fiscal perspective and stressed, “[w]ith such a strong effort by the Ministry of Health to push woreda planning, it would be ideal to have the resources to match the vision” (Member, WoFED). Additionally, other participants focused on human resource requirements to facilitate in the planning. While many focused on fiscal resources as a source of capacity limitation, many also further attributed weaknesses in the planning process as partly the
result of high staff turnover and limited personnel on the ground. As succinctly noted by one ZHD representative:

"We are in a constant state of influx and efflux. Some [health planners] come and some go. This is the cycle of employment. But we need people that will commit to staying and working on health planning. Otherwise, capacity can never be strengthened. Who will be the facilitators if we need to keep training them" (Member, ZHD).

Such an issue bears implications on the number of facilitators and the quality of their training. Given the technical requirements of the EBPB tool since WBHSP, a greater number of trainers has been essential at the district level. As further echoed in Phase 2, however, district health planners maintain that greater efforts are required to ensure that trained point persons from the national, regional, and/or zonal levels are available to provide such technical assistance. Such a resource commitment has been challenging in light of issues of staff retention. Furthermore, from a more structural perspective, the implementation of WBHSP has required a commitment to other materials, such as training manuals, and infrastructure under which the planning meeting can take place. However, resources such as laptops and infrastructure were described as lacking for adequate WBHSP. One RHB representative argued, "[t]he new woreda planning has been a good progress for the health system, but practically, it still requires more resources and manpower" (Member, RHB).

IV.   **System Resources: Summary of Key Points**

Prior to the implementation of WBHSP, a number of resource facilitators were in existence. Related to human resources, facilitators were trained to guide district health planners on the completion of the tool during the health-planning meeting. There was also effort to ensure that an appropriate mix of skills and relevant expertise were present at the decision-making table, so as to strengthen the comprehensiveness of planning. In addition, social resources were present to facilitate the process largely through the presence of formalized committees and consultative meetings that utilized pre-existing stakeholder interactions. While somewhat less clear was the exact amount of fiscal resources earmarked for implementing WBHSP, there was evidence of a commitment of financial resources both on the part of the government and the donor community.
The central and regional coordinating role of the government also acted as a key facilitator in the configuration and distribution of the resources required for undertaking the process.

Although re-shifting and influx of additional resources was apparent across the human, social, and economic realm, barriers to leveraging existing structures and building capacity as a result of limited resources was resoundingly articulated by participants. Staff turnover, for one, was cited as an underlying issue limiting the presence of skills at the district level for planning and for training district health planners. Further, limited resources available to strengthen infrastructure and material resources limited stakeholder communication patterns and the completion of planning during the meeting.

6.2.2.5. System Structure Summary

When reflecting on the system boundaries conceptualized by participants, my findings suggest that the social norms and political culture of the Ethiopian system influence the power dynamics and communication patterns across stakeholders, which further influence the policies that emerge and that practice that manifest. Regulations extend from this social fabric of politics, norms, and culture to create a normative context for district health planning that seeks to operationalize principles of evidence-based planning, harmonization, efficiency, transparency, and multistakeholder engagement in planning. However, the hidden dynamics of politics that were superficially captured here support the necessity of analyzing such variables in the process of planning, as they have significant bearing on authority in planning and inclusivity and engagement, overall. Findings also revealed that the three dimensions of resources—human, social, and economic—have significant bearing on the resource availability for supporting district health planning, from both a social and fiscal perspective.

6.2.3. Stage 3: Assessing System Dynamics and Interactions

In Stage 3 of the TSCF, an examination of system dynamics is undertaken to gain a better understanding of the interactions among system parts identified above. In Stage 4, levers of change are identified to provide greater insight to areas of the system where systems parts may be leveraged or efforts channeled to alter the system’s behaviour. As described by Foster-Fishman et
all systems, no matter how complex, are comprised of two patterns of interactions that include: balancing and reinforcing loops. Reinforcing loops interact with one another in a manner that leads to an escalation of a given outcome; therefore creating either a virtuous or vicious cycle. Balancing loops, on the other hand, are patterns of interaction, whereby system parts serve to stabilize the influence of one another, creating stability or stagnation in the system (Foster-Fishman et al., 2007, p. 210). Through an analysis of balancing and reinforcing interactions, patterns of a system’s behaviour emerge to shed light on areas where efforts may be channeled to balance potentially virtuous reinforcing behaviour.

The Problem Situation first identified in the binding of the system focused on the implementation of the change initiative itself (i.e., the implementation of the WBHSP strategy). This binding facilitated an investigation of the system structure that revealed two key technical issues related to implementation—limited technical capacity to manage the EBPB tool and limited capacity for data management and use—that will be the focus of the system dynamics models. Related to the development of the models, Foster-Fishman et al. (2007) state that system change involves an integration of elements emergent from the analysis of system structure. The following system dynamics models, therefore, offer qualitative conceptualizations of the system interactions associated with each of the two issues identified through the implementation of WBHSP; namely, limited technical capacity and limited capacity to manage and apply the data needed to facilitate district health planning. Data was extracted from each of the system parts described above to conceptualize the dynamics that facilitate, moderate, or impede aspects of the change initiative (i.e., the implementation of WBHSP). Section 6.2.3.1 explores a series of system conceptualizations that detail interactions and interdependencies associated with issues around limited technical capacity highlighted by participants. Section 6.2.3.2 explores a series of system conceptualizations that detail interactions associated with limited capacity to manage and apply the data needed to facilitate district health planning. And lastly, Section 6.2.3.3 links the two models together to provide a more holistic understanding of the system dynamics in effect, in relation to each other.
6.2.3.1. System Dynamics Associated with Limited Technical Capacity

As gathered from participant accounts, the presence of limited technical capacity was influenced by a number of reinforcing and balancing interactions within the system. As highlighted in Figure 6.4, participants detailed a variety of reasons for the limited technical capacity experienced by district health planners. In Chapters 5 and 6, these reasons were thematically categorized into the following themes: (i) inconsistency in training from upper levels of government needed to guide district health planners; (ii) insufficient time allocated to meet the training needs of district planners; (iii) limited training of district health planners on the functionality of the EBPB tool; and (iv) high staff turnover leading to a limited number of capacitated trainers. Described by participants at all levels, limited capacity to undertake technical aspects of the planning process, such as to complete the EBPB tool, led to a loss of morale among district health planners, as was noted in Chapter 5 (Section 5.2.2.2, I). The study findings reveal that the majority of participants conveyed that limited technical capacity fostered a sense of disengagement as a result of manipulating the sophisticated tool for which they believed they lacked adequate technical capacity. Such disengagement appeared to partly contribute to staff turnover, resulting in the limited training capacity of incoming staff for such technical tasks as managing and completing the EBPB tool, and in undertaking other project-related technical tasks (i.e., management of health portfolios).

**Figure 6.4. Summary of Participant Reasons Underpinning Limited Technical Capacity**

- Inconsistent training from upper levels of government needed to guide district health planners
- Insufficient time allocated to meet training needs of district planners
- Limited training of district health planners on the functionality of the EBPB tool
- High staff turnover leading to a limited number of capacitated trainers
In light of these challenges, participants provided suggestions that district health planners should be empowered or “capacitated” in their technical capacity. Such efforts would facilitate change in the “opposite” direction and increase the sense of ownership in the planning process, thus enhancing overall engagement. This focus on enhancing the morale of planners would then interact in the “same” direction to work towards increasing staff retention, which would then have an “opposite” interaction in the balancing loop. Figure 6.5 provides a qualitative conceptual model drawn from participant accounts that illustrates various balancing and reinforcing loop interactions associated with limited technical capacity. A reinforcing loop is presented here that highlights some of the reasons underscoring limited technical capacity. As noted through participant interviews, one of the primary sources of this phenomenon focused on issues related to staff turnover and an influx of staff with minimal training and capacity. Other structural constraints, such as the short duration allocated to planning also appeared to partly contribute to such a phenomenon. As a result, district health planners felt disengaged from the planning process and, were thus, more likely to shift to another position (as acknowledged in bold). As participants were asked what strategies could strengthen their capacity, many touched upon strategies to strengthen overall empowerment and ownership of the planning process. This strategy could facilitate in greater engagement of district planners, thus lead to potential increases in overall staff retention. The “S” designation signifies a system behaviour that is perpetuating, or existing in the “same” direction. The “O” designation, on the other hand, signifies a system behaviour that is limiting (i.e., may change the direction of the system’s behaviour in the opposite direction.
6.2.3.2. System Dynamics Associated with Challenges in Harnessing and Managing Data

In addition to the complex system interactions influencing limited technical capacity, a variety of system dynamics also appeared to be perpetuating challenges in harnessing and managing data needed for district level planning. Figure 6.6 provides a summary of the participant reasons underpinning weak data collection, management, and use. Particularly, participants focused on three challenges that included: (i) misalignment between the data captured from the districts and that required for the tool; (ii) weak implementation of HMISs to collect and manage data overall; and (iii) issues with HEW ability to collect data from the communities.
Figure 6.6. Summary of Participant Reasons Underpinning Limited Data Management Capacity

![Diagram showing data collection, management, and use concerns in district health planning]

Figure 6.7 presents a conceptual systems dynamics model that identifies some of these interacting features within this system. From the reinforcing loop modeled, it is evident that weaknesses experienced in harnessing and managing data have contributed to minimizing accurate and aligned data entry. Participants described causes related to a misalignment between the health indicators of the EBPB tool and the data collected in HMIS surveys. As detailed in Chapter 5 and 6, such issues of misaligned data contribute to delays in completion of the tool, which similar in Figure 6.6, highlights increased frustration among planners, leading to a sense of disengagement, and, thus, the likelihood for greater staff turnover. The implications of staff turnover in this model focus on the impacts to institutional memory that may result, and therefore, may further bear implications on data management. To balance this reinforcing loop, participants highlighted the importance of strengthening the collection and management of data; particularly focused on the district-level data required for the tool. Such a feature would lead to further impacts, including facilitating the completion of the tool in a more timely and efficient fashion, which would ultimately facilitate in strengthening evidence-based practice associated with WBHSP. In addition to facilitating the completion of the tool, attempts to strengthen strategies and methods for data collection would lead to overarching improvements to HMIS as well, which would likely have cascading impacts on strengthening the capacity of HEWs, which would further facilitate to the overall implementation of WBHSP.
In reflecting on the system as an entirety, Figure 6.8 presents a systems dynamics model that links both scenarios of challenges articulated by participants. In particular, the upper model focuses on data management challenges, it was noted in participant interviews that delays in completing the tool further feeds into the loss of morale among participants, as noted in the dynamics model at the bottom. Further, limited technical capacity in managing the tool would also contribute to challenges with data that may not be accurately entered or interpreted. Thus, focused around the two challenges isolated by participants in the problem situation, it is visible that a number of reinforcing loops keep the system functioning in a manner that contributes to perpetuating the challenges. And, thus, to “balance” the system, interventions would be required that would alter system behaviour in the “opposite” direction; thus creating a situation where
participants would feel capacitated, empowered, and engaged in the district health planning process.

**Figure 6.8.** Systems Dynamics Model Identifying Linkages Between Challenges of Technical Capacity and Limitations to Data Collection and Management
6.2.4. **Stage 4: Identification of Levers for Change**

Section 6.2.4 identifies levers for change in systems patterns and interactions. As described by Foster-Fishman et al. (2007), “patterns and interactions within systems can also serve as powerful levers for change, particularly when they are adjusted—or created—to foster learning and self-improvement within a system (Olson & Eoyang 2001) in Foster-Fishman et al. (2007), p. 212). To guide this analysis, Foster-Fishman et al. (2007) propose a set of key questions for reflection. These include: What differences within the system could serve as leverage points for change? What enduring patterns within the system will likely impede change or the targeted systems change goals? and What linkages between system parts could be created or altered to align system functioning with the system change goal?

Based upon the model presented in Figure 6.8, three potential levers for change are suggested that emerged from participant accounts, which may yield positive shifts in the systems behaviour. First, as noted in the bottom right corner of Figure 6.9, increasing the number of regional and zonal facilitators may yield a change in the systems behaviour that would increase the capacity of district planners. Second, and on a similar note, increasing the duration and frequency of training would synergistically align with the former to create a district health-planning environment that would offer district health planners more capacitive support as they manipulate the tool, and seek to understand various aspects of the newly implemented system of planning. And third, it is evident from study findings that a greater emphasis needs to be placed on strengthening HMISs and the newly implemented tool. Participants appeared to struggle not only with the sophistication of the tool’s functionality, but also highlighted technical challenges experienced between the data required by the tool and the data collected through routine data collection. Strengthening the alignment between HMIS survey instruments and that data needed within the tool, for instance, could also enhance the capacity of HEWs to recognize the importance of key data needed under the WBHSP process.
Figure 6.9. A Systems Dynamics Model Highlighting Levers for Change

- **B** Balancing Loop
- **R** Reinforcing Loop
- **S** Same Direction
- **O** Opposite Direction
6.3. **Chapter Summary**

Chapter 6 provides an analysis of Ethiopian district health planning through two conceptual frameworks—A4R and the TSCF—to offer insights to procedural fairness and system level factors influencing the process, respectively. Through an application of A4R, findings reveal that overall, Ethiopian district health planning satisfies, to varying degrees, each of the five conditions of fairness and legitimacy. On the one hand, there is a clear commitment to the use of a criteria-based evidence-based planning tool and HMIS data in planning (relevance), greater multistakeholder engagement (relevance and publicity), increased transparency (publicity), increased opportunities for review and possible revision (revision and appeals), increased participation and stakeholder inclusivity (empowerment), and fairly clear regulative mechanisms to ensure the latter are operationalized (enforcement). Opportunities for improved fairness and legitimacy emerged largely as a result of contextual factors, whereby the operationalization of policy was limited as a result of contextual constraints. In addition to the A4R-based analysis, a sub-analysis of Ethiopian conceptualizations of fairness was conducted and revealed a congruency between the principles of fairness and legitimacy espoused in A4R and those views held by Ethiopians. However, fairness of the priority setting decision in Ethiopia is not only based upon procedural considerations (such as transparent and inclusive decision-making), but also on substantive considerations (such as impact on burden of disease criteria), which make their conception of a fair decision also outcomes-based. Further, moral authority and the justification of decisions as fair were largely conferred through government authority, international standards, and formal democratic engagement. Such conceptualizations lie in contrast to the principles of A4R, whereby it is the fairness of the process that confers authority, fairness, and legitimacy (i.e., a process that promotes multistakeholder engagement, transparency, and relevance).

The application of the TSCF revealed a number of system-level facilitators and barriers to the Ethiopian district health planning process. For one, the application of the four components of the system’s structure facilitated a greater understanding of the parts of the system that have a significant bearing on understanding system-levels influences. The study findings reveal that social norms play a particularly important role in shaping policy (system regulations) and
practice (system operations). A series of facilitators were identified that were focused largely on strong values in support of increased evidence-based practice, harmonization, efficiency, and transparency in planning. Further, various authoritative structures, as noted through policy and established procedures, further acted as facilitators in the uptake and operationalization of WBHSP. The study findings also reveal, however, that a lack of explicitness in policy, and limited clarity around stakeholder responsibilities, contributed to limitations in communicative structures across stakeholders. Additional barriers across human and economic resources were also noted as contributing factors to limited technical expertise and structural requirements for undertaking WBHSP. Stage 3 and 4 reflected on the qualitative exploration of the system’s structure to conceptualize a series of systems dynamic models focused around the problem issues first identified by participants as limiting WBHSP implementation. These conceptualizations reveal a series of reinforcing and balancing loops that describe the system’s behaviour around limited technical capacity and weaknesses in data management and use. Through these conceptualizations, a series of levers are identified (such as, strengthening HMISs to align with the tool and increasing the duration of time for the meeting) that could act in positively reinforcing ways to alter the system’s behaviour and, ultimately, facilitate in the implementation of WBHSP.

As detailed in Chapter 2, a weakness in the priority setting discourse focuses on a paucity of scholarly work that can facilitate our understanding of system-levels factors that may be impacting priority-setting practice and the operationalization of procedural fairness. Chapter 7 aims to advance methods for priority setting through a conceptual synthesis of the findings that emerged through an analysis of Ethiopian priority setting through the two heuristics described herein.
No longer is the search for a rational set of decision making rules thought adequate: the process is seen to be more complex.

(Holm, 1998)

In his justification of the move towards a second phase of priority setting, Soren Holm (1998), in the above quote, acknowledged the complexity of the process. Chapter 1 drew our attention to priority setting complexity in low-income countries and the need for additional case studies to advance learning that strengthens healthcare rationing under resource scarcity. Chapter 1 also drew our attention to the first two phases of the priority setting discourse described by Holm (1998); whereby phase one was described as focusing on the establishment of technocratic approaches and tools to guide priority setting and, phase two, on strengthening the process of priority setting and procedural fairness. While researchers and practitioners have turned to the fields of economics, evidence-based medicine, political science, and ethics to resolve challenges encountered in priority setting practice, literature over the past 10 years has increasingly identified a variety of contextual factors (socio-cultural, organizational, political, and economic) that facilitate or impede the practice and process of priority setting. In this dissertation, I have argued that the priority setting discourse has now entered a third phase focused on the necessity to understand the system within which priority setting unfolds. To pragmatically and conceptually advance this third phase, and augment the database of research from low-income countries, this dissertation had two key aims:

**Aim 1:** To advance knowledge of district health planning and priority setting in low-income contexts through a case study investigation of Ethiopian district health planning under the health policy regime of Woreda-Based Health Sector Planning (WBHSP).

**Aim 2:** To advance methods for priority setting by examining the potential contribution of the TSCF to understand the influence of system factors on health priority setting in practice.
Chapter 7 is organized around these two aims. Section 7.1 aligns with Aim 1, and discusses key lessons generated from the case study investigation of Ethiopian district health planning and priority setting. Section 7.2 aligns with Aim 2, and discusses key lessons emergent from the application of the TSCF to the district health planning and priority setting process. Section 7.3 discusses the practical implications of these findings on priority setting practice and procedural fairness, with a wider reflection on such practices in low-income countries. Section 7.4 outlines limitations to this study and identifies areas for future research. Section 7.5 highlights the study strengths, and discusses the salience and pertinence of a third phase in priority setting practice. Finally, in Section 7.6, a series of conclusions for the field of priority setting are described.

7.1. Aim 1: Priority Setting in Low-income Countries—Lessons from an Ethiopian Case Study of District Health Planning

Chapter 5 presented a description of Ethiopian district health planning and priority setting as initially envisioned, and as it unfolded in practice through the views of study participants. Prior to the implementation of WBHSP in 2007, Ethiopian district health planning, while decentralized, followed implicit patterns of rationing. Study participants described this era of priority setting as opaque, behind closed doors, reflective primarily of government policymaker perspectives, and variable across the country. One Regional Health Bureau (RHB) representative described planning before woreda based planning as “highly fragmented” (Member, RHB). This fragmentation translated into a need for policy reform in the health planning system that would standardize health-planning processes at the district level, so as to enhance alignment across all levels of government and ensure stronger mechanisms for monitoring and transparency. The emergence of the WBHSP strategy was a national policy effort to reform health planning structures and procedures in efforts to address these issues. This policy directive was established upon seven principles—one plan principle, one budget principle, one report principle, resource constraint principle, results-orient budgeting principle, the evidence-based principle, and the flexibility principle—which collectively emphasized values in support of efficiency (i.e., it removes duplication, is targeted, and aligned at all levels), evidence-based planning (i.e., it applies data systematically through the use of decision tools), and stakeholder deliberation (i.e., encourages and seeks input from a range of stakeholders to inform decisions).
This case study of Ethiopian district health planning and priority setting adds to a small, but growing number of case studies of district health planning from African countries, including Tanzania, Zambia, and Kenya (de Savigny et al., 2004; Maluka et al., 2011; Bukachi et al., 2013; Zulu et al., 2014). Documented previously in these case studies, the importance of technical approaches (such as burden of disease and cost-effectiveness analysis) as well as multi-stakeholder engagement in the priority setting process have been underscored. In this Ethiopian case study, both approaches were exemplified through the criteria-based Evidence-Based Planning and Budgeting (EBPB) tool and five-day planning meeting. First, the EBPB tool reflects insights derived from the first phase of priority setting (Holm 1998), whereby a robust evidence base, and a more rational and explicit approach to priority setting was established. Study participants described the EBPB tool as being helpful in standardizing priority setting thinking and practice throughout the country in a way that aligned district health priorities with both national and international health priorities and, which drew from relevant district and population data. In contrast to previous health planning and priority setting approaches in Ethiopia, this standardized technical approach ensured that all health planners undertook similar procedures of health priority setting throughout the country, while also accommodating health needs specific to a district.

Second, the establishment of the five-day planning meeting, which brought together diverse district and regional stakeholders to set district health priorities, reflects insights derived from the second phase of priority setting (Holm 1998). This planning meeting emphasized salient features of a legitimate and fair priority setting process that included mechanisms for increased stakeholder engagement and transparency in decision-making. Study participants emphasized that the meeting provided stakeholders with the opportunity to collectively learn and discuss district health priorities in an open and constructive fashion. For those stakeholders in attendance, this forum cultivated a collective learning environment to convene, discuss, strategize, and prioritize health services with other pertinent stakeholders. As a result, participants were in a better position to communicate and explain the rationale for district health priorities to their various constituencies.
Both features of the Ethiopian district health planning and priority setting process—the EBPB tool and the multi-stakeholder planning meetings—therefore highlight the contribution and significance of the first 2 phases of priority setting discourse; which included efforts to strengthen technical and evidence-based approaches guided by burden of disease criteria and cost-effectiveness analysis (first phase) and to strengthen the process of decision making through active stakeholder engagement in the priority setting process (second phase). While the majority of study participants held positive views towards WBHSP implementation, their sentiments also spoke to a number of contextual factors that influenced the implementation of the district health planning and priority setting process. Figure 5.4 (re-presented below in Figure 7.1) summarized three types of contextual factors that emerged from findings of this case study. These contextual factors were categorized as: Organizational (including factors related to limitations to managerial capacity, organizational empowerment, and leadership; and technical capacity to manage the tool; and insufficient time allocated to complete the plan); Infrastructural (including factors related to the presence of required material resources; timely and complete data; and an adequate budget to support planning activities); and Socio-cultural (including factors related to the decision-making milieu supportive and inclusive of multi-stakeholder engagement and stakeholder inclusivity).

The influence of context detailed in this Ethiopian case study augments previous findings in the priority setting literature that highlight organizational and socio-cultural factors affecting the successful implementation of priority setting processes (Mitton & Prout, 2004; Teng et al., 2007; Maluka et al., 2010). For example, Mitton and Donaldson (2003) argued, “understanding of the context in which the application of […] any explicit, evidence-based decision-making framework takes places is required in order for the exercise to have a chance at being successful” (pp. 335-348). In their research on priority setting in low and middle income countries, Kapiriri and Martin (2007b) identified: (i) the capacity and credibility of institutions; and (ii) the political, economic and social/cultural contexts in which priority setting takes place as important contextual influencers. Further, they argued that an understanding of these contextual influencers is necessary in order to improve priority setting in practice (i.e. “context sensitive improvement strategies”) (p. 145). A unique contribution of this case study of Ethiopian district health
planning reveals the critical significance of contextual factors focused on infrastructure, which have scarcely emphasized in these previous discussions.

**Figure 7.1.** Figure 5.4: Summary of Contextual Factors influencing the Process and Outcomes of WBHSP

This attention to context further relates to the ongoing debate initiated by Williams and Klein (2000) regarding the limits of rationality and the effectiveness of priority setting. In 2000, Williams took the stance that the inadequacy of information regarding costs and outcomes has limited decision makers from achieving effective and rational priority setting. In contrast to this stance, Klein argued that successful priority setting was reliant instead on getting the institutional conditions “right” to produce more socially acceptable answers (Klein & Williams, 2000). Klein acknowledged that although data and information are important in the priority setting process, an emphasis on these components alone is insufficient to tackle the varied interests of stakeholders and other important procedural considerations. Findings from this Ethiopian case study reinforce Klein’s claim that strengthening institutional capacity to analyze evidence, communicate priority
setting choices, and promote informed debate are profoundly important in the success of a priority setting process.

This dissertation therefore advances knowledge of district health planning and priority setting for low-income countries by outlining novel priority setting approaches in Ethiopia that are both principle-based (phase one) and procedural-based (phase 2). From this case study, we observe the significance of context in influencing the success of priority setting. Key contextual factors appeared to influence how the EBPB tool was used, and how and when stakeholders were able to convene and discuss. These contextual factors were categorized into three dominant themes that speak to the types of issues at play within this Ethiopian experience of district health planning. Such findings align with the two dimensions of contextual influencers impacting successful priority setting as previously outlined by Kapiriri and Martin (2007b). Here, Kapiriri and Martin claim the following two dimensions of context as important to priority setting success—namely, (i) the capacity and credibility of institutions; and (ii) the political, economic and social/cultural contexts in which priority setting takes place. They argue that to strive for successful priority setting, we must understand the contextual dynamics that may influence priority setting and “facilitate development of context sensitive improvement strategies” (p. 145). The emphasized significance of context captured in the literature and through this empirical investigation reaffirms the need for a nuanced approach that may practically and conceptually acknowledge contextual influencers in a more meaningful way to better inform implementation of priority setting procedures and processes.

7.2. **Aim 2: Advancing Priority Setting Methods through Systems Theory**

To advance methods for priority setting, this dissertation sought to understand the influence of contextual factors on priority setting using TSCF as an analytic lens and to explore how this analysis contributes to understanding the implementation of fair priority setting processes as defined by the principles of A4R. Figure 7.2 provides a summary of the analytical steps included in this synthesis. Objective 3 sought to advance methods for priority setting through pragmatic and conceptual considerations of district health planning, procedural fairness, and systems theory. To present these findings, Section 7.2.1 describes lessons that emerged from
the application of the TSCF on district health planning and priority setting in Ethiopia. Section 7.2.2 focuses on the lessons that emerged from the application of A4R on Ethiopian district health planning and includes a wider reflection on systemic insights that support procedural fairness. And Section 7.2.3 proposes the relevance of a third phase of priority setting thinking, with attention to methods that incorporate a more nuanced analysis of the system under which priority setting practice and procedures unfold.

**Figure 7.2.** Summary Diagram of the Analytical Steps in this Synthesis

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7.2.1. **District Health Priority Setting through the lens of the Transformative Systems Change Framework**

To date, no application of the TSCF has been reported in the literature with a particular focus on understanding system influences on district health planning and priority setting. In this study, the TSCF was used as a conceptual framework to understand the dimensions of system-level factors that may influence the Ethiopian district health planning and priority setting process. Through an examination of system norms in the TSCF, Ethiopian social values and cultural beliefs appeared to have a significant role on how priority setting transpired. In particular, my findings revealed that priority setting was facilitated through the alignment of system norms with the implementation of WBHSP. The presence of stakeholder values in support of multi-stakeholder engagement and evidence-based planning, as captured through participant views and in the HSDP and the HHM strategy, appeared essential to cultivating patterns of behaviour.
among stakeholders that facilitated these features in the planning process. It was evident from participant accounts that strong values in support of increased harmonization, evidence-based practice, participatory dialogue and greater transparency in health planning fostered a facilitating environment for the implementation of WBHSP. Stamper, Liu, Hafkamp, and Ades (2000) maintain that understanding social norms creates a conduit to understanding organizational change and how actors within the system operate and interact with each other. Further, when the principles of a policy align with the social and cultural values of the members within a health system, effective implementation is more likely to occur (Municipal Research and Services Center, 1999, p. 4).

Conversely, study findings revealed that health planning and priority setting were impeded when system norms were at odds with the goals of WBHSP. Although decentralization sought to encourage greater authority for planning at the district-level, the historical hierarchical political structure appeared to have significance in limiting district health planner empowerment to fully lead the planning process and raise relevant issues at the district level. Vaughan and Tronvoll’s (2003) review of Ethiopian social norms in relation to governance support this assertion. In their report, The Culture of Power in Contemporary Ethiopian Political Life, they argue that from a young age, Ethiopians are socialized into a system that acknowledges (and, to a high degree, abides by) rigid hierarchical structures, segmentation across social groups, and non-egalitarian distributions of power.

[A] child receives his/her first impression of political behaviour [...] through observations, experiences, teaching and sanction at home, based on the interaction among family members and between family members and the outside world. [...] The elaborate set of rules guiding social conduct between family members, and within the community at large, ensures that everyone, from an early age, knows their place in the hierarchy with respect to one another and is expected to show the appropriate degree of deference. Thus, for instance, interaction continually reaffirms how men are superior to women, and elders to those younger. Moreover, religious or political office gives added authority, whereas members of certain despised groups (craftsmen, potters, tanners, hunters) are classified as inferior. A system of social classification along these lines continues to be widely reproduced, imbuing new generations with cultural notions that people are not equal and the world is not egalitarian. Individuals are ranked according to a set of criteria, which invests some people with greater ‘value’ than others—both in social and political terms—and determines, moreover, that one should always be
subservient to any individual regarded as superior to oneself (Vaughan & Tronvoll, 2003, p. 33).

The dominant political and social values observed by study participants align closely with this description. With respect to matters of governance and district health planning, Ethiopians appear to have a profound respect for the hierarchical structure of authority; this is a socio-cultural norm that is sustained through the socialization process. These social norms were clearly articulated by study participants when they were asked who leads district health planning and in what capacity. Study participants described the role of the central government as a dominant authoritative and coordinating one in the implementation of WBHSP. Such assertions are also consistent with the broader policy literature. Garcia & Rajkumar (2008) argue that this pattern of behaviour in political social structure is quite common, where the central or state government tends to play a primarily oversight function in overall policy-making, setting standards, and auditing, while district governments tend to be more engaged in the provision of health services directly. These findings further align with those described by Ford (2007), in which the construction of organizational “hierarchy” among upper level management hindered authority in the workplace among lower level staff.

What these findings suggest is that the degree of alignment between system norms and the change effort plays an important role in the implementation and effectiveness of a systems change intervention. In Chapter 2, I referenced Ford (2007), who referred to this systemic element as the “below the surface organization,” emphasizing the importance of social norms and hidden system politics that shape how organizational processes transpire. This phenomenon was observed in my study, whereby power and authority played a role in shaping whether and how stakeholders convened, communicated, and interacted. Vaughan and Tronvoll (2003) describe power as a “function of the whole social system […] and] the interaction of the collectivity of individuals, who are themselves also all positioned in, and constitutive of, the structure” (p. 30). In regards to Ethiopia, they apply an understanding of power that captures the positions of individuals and groups of actors by means of their relations with others. Through such an analytical lens, they argue, “state power [in Ethiopia] is not an attribute of the state machinery as such, but a product of the interaction between the state’s ruling elite and all of its citizens. The
state “influence[s] the structure of power in so far as it is influential in dictating the social distribution of knowledge” (p. 31). This assertion acknowledges the dominance of central authority and, from a systems perspective, underscores the importance of understanding how power and authority across different stakeholders may influence patterns of communication and information flow prior to, and during the planning process. The analysis of system operations in the TSCF captures these dimensions well. For instance, although policy (i.e., formal authority) outlines the role of NGOs and development partners in this planning process, their absence from the planning meeting (whether through delayed invitation or by their choice) suggests that, in practice, the role of “external” stakeholders in the matters of national governance is unclear and requires greater reflection as to the structures and mechanisms needed to strengthen their participation. This finding reveals the salience of the systems regulation component of the TSCF. Policy directives, guided by the HSDP and HHM policies, supported the implementation of the WBHSP process through a delineation of authoritative roles and responsibilities; in particular, they played a regulative role in shaping how processes should transpire and how stakeholders should interact. Findings described in Section 6.2.2.3 outline key policies (such as the HSDP and the District Level Decentralization Program [DLDP]) that cultivated a system conducive for the implementation of the district health planning under WBHSP. The presence of the DLDP, for one, was intended to strengthen the decentralization of health decision-making to district health planners. These regulative efforts to strengthen district governance forged a political climate where the roles and responsibilities of decision makers had already become relatively clearer through the HSDP policy. Similarly, the HHM strategy fostered regulative structures to commence the process of harmonization and alignment—two concepts foundational to the core of the “One Plan, One Budget, One Report” within the WBHSP strategy.

Further, from a regulative standpoint, the documentation of consultative meetings explicitly outlining who “should” attend various meeting forums provided some level of guidance regarding which actors in the health system had a role and were accountable in the decision-making process. Although pertinent stakeholders were identified in policy, study participants spoke to a lack of clear directives on the scope of their roles and accountability structures for each stakeholder. Such regulative facilitators have also been captured in the literature. For
instance, in support of system change, Neville et al. (2005) highlights the importance of clarity of stakeholder roles, authority, and accountability as facilitators in the regionalization of health services in Newfoundland, Canada. This acknowledgement points to the importance of clarity for scope of role and practice, particularly in light of organizational expectations of stakeholders and transitioning.

Finally, through an analysis of system resources, it was apparent that the presence of human resources, technical capacity and skills to uptake new procedures, and fiscal resources to support a variety of organizational requirements for health planning, were structurally imperative to facilitate district health planning and priority setting under WBHSP. For instance, having the right mix of expertise was noted as a key facilitator of priority setting. This expertise included pertinent stakeholders from all levels of the health system who were required to complete the technical components of the EBPB tool. It appeared however that the district health planners, to whom this authority was being ceded, were not adequately equipped with the skills to engage in priority setting through the use of the EBPB tool. Many study participants spoke to their lack of technical capacity and skill to manipulate the sophisticated tool. Further to this, the impact of system resource limitations on organizational capacity has been acknowledged in the wider literature. Lemieux-Charles et al. (2002) noted the significance of the existing interorganizational resource commitments, as well as knowledge and capacity in order to successfully internalize new knowledge associated with the implementation of a new organizational initiative.

The TSCF therefore served as a useful conceptual framework to identify components of a systems structure—norms, operations, regulations, and resources—that impact how the planning process unfolded. Analyzed through each of the four system components of the TSCF, Figure 7.3 provides a summary of system-level facilitators and barriers to WBHSP implementation. In this figure, system norms act as a social backdrop for the manifestation of system operations (i.e., social hierarchies and power dynamics), system regulations (i.e., policies, procedures, and routines), and system resources (i.e., human, social, and economic). In light of my analysis of each system component (Chapter 6, Section 6.2), it does not appear that each component exerts an equal influence on priority setting process, nor are these effects linear. Instead, components are nested, as shown in Figure 7.2, and are highly interdependent—where a change in one
dimension of a system component may facilitate change in another component. These influences are characteristic of complex systems (Edwards et al., 2007; Foster-Fishman & Behrens, 2007). To approach any change within a system therefore requires a holistic understanding of how each system component (i.e., norms, operations, regulations, resources) interacts with all other system components. For instance, stakeholder relationships identified by system operations may play a facilitating and/or constraining role in a system by: providing a vehicle for information and resources to diffuse through the system (Bailey & Koney, 2000; Frank & Zhao, 2004), supporting the development and transfer of norms, values, beliefs, and attitudes (Coleman, 1988; Putnam, 2000); and by providing a mechanism for system members to access opportunities for engagement or participation (Burt, 2000). From this analysis of system structure applying the TSCF, the following lessons have been derived:

- **Lesson 1:** Each system feature identified by the TSCF acts in both facilitating and impeding ways to the district health planning process.
- **Lesson 2:** Not all systemic facilitators and barriers are equal. Some system features, such as norms and operations, operate at a level that is deeply engrained within the social fabric of society, such that if they are in strong opposition to the change initiative, it may be constrained by another system feature.
- **Lesson 3:** To improve processes and work towards transformative change, system dynamic models provide a qualitative conceptual vehicle for analyzing overarching problems that require attention.
- **Lesson 4:** System factors are embedded within each other offering a complex layer of interaction that suggests that to approach any changes requires a more holistic understanding of how each system feature interacts with each other.
- **Lesson 5:** Stakeholders at all levels must engage and cultivate continuous modes of communication.
- **Lesson 6:** Clear roles and responsibilities should be communicated and understood by all system members.
- **Lesson 7:** The new strategy for planning and priority setting must align with existing system norms and regulations. If it does not, greater effort at the outset must focus on generating dialogue to support the priority setting method.
- **Lesson 8:** System resources must be ready to absorb the resource demands of district health planning.
- **Lesson 9:** Sustainable change requires flexibility to learn and patience to adapt across all system components.
In addition to an analysis of system structure, Stage 3 of the TSCF provides a useful vehicle to identify interactions between system components through the conceptualization of system dynamics models. During this conceptualization process, Foster-Fishman et al. (2007) emphasize that in order to improve processes, and work towards transformative change, we must build on sources of data that emerge from an analysis of the system’s structure, and identify overarching problems that require attention. While the qualitative conceptualizations of system dynamic models presented in Section 6.3 provide insights into the reasons for limited technical capacity and poor capacity to manage data, they are, as Hirsch et al. (2007) maintains, only as insightful as the assumptions that underlie them. It is also important to recognize that they are only a scenario captured at one point in time and not an absolute predication. Further, Hirsch et al. (2007) emphasize that while system dynamic models may produce a relatively accurate portrayal of one dimension of the problem, they may never capture the entire picture of complexity.
Figure 7.3. Summary of System Component Facilitators and Barriers to WBHSP Implementation
7.2.2. District Health Priority Setting through the lens of Accountability for Reasonableeness

In phase two of the priority setting discourse, an emphasis on strengthening the process of priority setting emerged, with a focus on strengthening procedural fairness. A dominant framework used to guide procedural fairness has been the ethical framework, A4R, which has been widely tested in a number of contexts and at different levels of the health system (macro-, meso, and micro-). Given its limited application in the Ethiopian context, A4R was applied in this case study to advance our understanding of fairness and legitimacy in Ethiopian district health priority setting. Through the analysis of applying A4R, it was evident that the WBHSP strategy had facilitated the establishment of a few key organizational structures and processes that supported opportunities for meeting the relevance, publicity, appeals and revision, and empowerment conditions, albeit to varying degrees. For one, the provision of different forums for stakeholder engagement facilitated the gathering of pertinent stakeholders, and increased opportunities for their input in the planning and priority setting process. The establishment of the five-day planning meeting and the Woreda Administrative Council Review Board appeared to act as effective forums to promote collective discussions and the gathering of various stakeholder views in the decision-making process. Similarly, the adoption of the EBPB tool further increased stakeholder dialogue to complete it and ensured that decisions were consistently based on relevant data and criteria. These features of WBHSP supported mechanisms toward strengthening the reasonableness of district health plans and priorities in keeping with the Relevance Condition of A4R.

Related to the Publicity Condition, the presence of the Woreda Administrative Council Review Board also acted as a procedural forum for stakeholders to review, appraise, and disseminate the plan. Although it was unclear the degree to which rationales underpinning decisions were communicated—since participant observation methods were not conducted at the level of the Woreda Administrative Council Review meeting—participant accounts did suggest that the use of the evidence-based tool permitted the rationales underpinning decisions to be more firmly grounded in evidence; thus serving as an appropriate and acknowledged rationale among decision makers. Further, with respect to meeting the Revision and Appeals Condition, the flexibility principle documented as a principle of the WBHSP strategy served as an important
policy step to recognize the importance of flexibility and the need for amendment in health planning and priority setting, should revisions be required. Although the presence of an aspirational commitment to an appeals process was noted, there did not appear to be any formal appeal procedures in place to resolve disagreements, should they arise. Had disagreements arisen, the extent to which appeals were made during the review process remains unclear. Many participants did highlight that in some cases, as a result of fiscal constraints, a re-prioritization of the plan would occur, and that during this process, the WorHO planners would consider criteria that included: multiple stakeholder views, majority consensus, and evidence in support of highest burden of disease or urgent health priorities of the community.

In addition, this case study of Ethiopian district health planning further validates the importance of the fifth condition, Empowerment, to acknowledge the significance of power differentials across stakeholders during the priority setting process (Gibson et al., 2005b). While encouraging multi-stakeholder engagement was visible in policy, mechanisms to ensure active participation across all participants were less apparent in practice. This phenomenon speaks to the importance of an A4R condition that acknowledges the presence of mechanisms or directives that encourage active stakeholder participation. Although attendance is essential, it is only the first step on the path towards participatory planning. An explicit strategy for inclusion in planning is therefore required to facilitate active participation by ensuring the presence of structural mechanisms that may promote engagement of all decision makers at the priority setting discussion.

Related to the enforcement condition, my study findings also demonstrated that a variety of policy directives and regulations documented in the HSDP, HHM, and WBHSP had institutionalized various elements of each A4R condition. In particular, the strategic objectives outlined in the HSDP revealed the presence of an aspirational commitment towards strengthening clarity around evidence-based planning and criteria for setting health priorities. Similarly, the strategic objectives and the establishment of forums for stakeholder engagement (i.e., the five-day planning meeting and the Woreda Administrative Council meeting) further sought to institutionalize processes for increased multi-stakeholder engagement in the health planning process. The acknowledgment of such mechanisms for priority setting were an essential underlying feature to the fulfillment of enforcement mechanisms in support of procedural fairness. To
strengthen priority-setting measures in support of enforcement, opportunities for improvement should focus on enhancing explicit directives to regulate, for instance, the roles and responsibilities of stakeholders within the planning process, and the processes for disseminating the plan and the rationales underpinning the decisions made.

What was particularly noteworthy is that while a commitment in policy (HSDP, HHM, WBSHP) was apparent in support of the principles underpinning each condition (i.e., evidence-based planning, multi-stakeholder engagement, increased transparency, and flexibility in planning) contextual factors appeared to limit the degree to which these commitments could be realized. For instance, there did not appear to be standardized directives to guide stakeholders on how to engage in reviewing and disseminating decisions and their rationales, and to which cohort of stakeholders. The degree to which the community was engaged also appeared to be ill defined, as study participants spoke of sign postings on the gate of the WorHO. Moreover, while flexibility in planning was valued in policy, there lacked clear and standardized mechanisms for challenging and revising decisions. Although pre-existing procedures and those established by WBHSP supported relevance in planning (e.g., the presence of explicit criteria guided by the HSDP, mechanisms to capture the highest burden of disease through the EBPB tool, and increased opportunities for multi-stakeholder engagement), previous data collection methods under the Health Management Information System (HMIS) did not align with the data needs of the EBPB tool. Also, while the convening of multiple stakeholders was noted in the HSDP and the HHM as significant to improving transparency and engagement, structural delays in sending invitations and conflicting schedules of stakeholders hindered their full participation. Although slightly different in scope, my findings confirmed those assertions documented by Maluka et al. (2011): that context plays a significant role in the implementation of procedural fairness in practice.

Reflecting on phase two of the priority setting discourse, we can appreciate a strong emphasis on strengthening multi-stakeholder engagement and collective decision making through the change initiative of WBHSP. Through the application of A4R in understanding procedural fairness, the Ethiopian case study reveals that fairness in planning is not an “all or nothing” phenomenon. The implementation of WBHSP reveals a path towards strengthening procedural elements that accord with fairer and more legitimate processes of decision-making. These
procedural elements included increased organizational procedures to convene stakeholders in the priority setting process, and improve evidence-based planning and transparency through the adoption of the EBPB tool. From this analysis of procedural fairness using A4R against Ethiopian district health planning, the following lessons have been derived:

- **Lesson 1:** Under WBHSP, the five-day planning meeting, and Woreda Administrative Council Review Board meeting offered an important platform for collective multi-stakeholders gathering for priority setting and review of decisions made.
- **Lesson 2:** Under WBHSP, the criteria-based EBPB tool acts as an effective guide to evidence-based planning and to ensuring priority setting decisions are based on relevant factors in the circumstances.
- **Lesson 3:** The inclusion of the Empowerment condition within the parameters of A4R holds great significance in acknowledging power differentials in the priority setting process.
- **Lesson 4:** Fairness in health planning is not an “all or nothing” phenomenon. There is evidence of a path towards strengthening procedural elements of fairness and legitimacy that was illustrated by procedures instituted through the implementation of the WBHSP.
- **Lesson 5:** The context in which the priority setting process unfolds plays a significant role in the implementation of fair priority setting procedures. Therefore, as district health planners strive to improve the fairness and transparency of their health priority setting processes, a deeper understanding of the context is crucial for the implementation and long-term sustainability of such efforts.

### 7.2.3. Introducing a Third Phase in the Priority Setting Discourse: Advancing Methods for Priority Setting through Greater attention to the System

In this dissertation I have proposed that the increasing recognition of contextual significance on the priority setting process heralds a third phase in the priority setting discourse. This third phase emphasizes the need for methods and approaches to priority setting that are inclusive of contextual considerations. For instance, in regards to priority setting practice, Mitton and Donaldson (2003) and Mitton and Prout (2004) have each recognized the significance of contextual barriers and facilitators at the organizational level of the priority setting process. Others refer to the significance of organizational context and power structures in influencing procedural fairness and the conditions of A4R (Gibson et al., 2005b; Kapiriri & Martin, 2007b; Maluka et al. 2011). As outlined by Maluka et al. (2011), “context matters because the adoption and integration
of a health intervention in a health system, and its sustainability, largely depends on a number of contextual factors” (p. 5). Ultimately, context influences how tools and guidelines are used in priority setting, how stakeholders convene and discuss priority-setting decisions, and how fair and legitimate processes may transpire.

Specifically, in this dissertation, I have proposed that systems theory may act as a useful conceptual lens for capturing the underlying systemic dynamics that may meaningfully inform priority-setting practice. In Chapter 2, it was emphasized how Foster-Fishman and Behrens (2007) oppose the synonymous usage of context and system, suggesting that the term system “better captures the ecological and social change emphasis of [the] field than the more often used term context” (p. 191). Through my application of the TSCF to Ethiopian district health priority setting, we learn that each of the four system components provided an effective analytical guide to uncover the ‘how’ and ‘why’ of specific contextual elements and mechanisms guiding priority setting practice. When reflecting on strengthening procedural fairness through the lens of A4R, the TSCF provides a descriptive understanding of the system elements that would be required to support the manifestation of each condition. An analysis of system norms provides a window into the potential complementarity of the TSCF with that of A4R. Both A4R and the TSCF are attuned to norms operating in the health-planning context. A4R is an inherently normative ethical framework and the TSCF offers a descriptive analysis regarding how norms operate to influence change in a given context. My analysis of district health planning using the TSCF provides a richer understanding of the normative dimensions of Ethiopian health planning by identifying additional norms operating in this particular context; such that respect for authority, and substantive outcome considerations to fairness were identified as other norms.

Similarly, there is complementarity afforded by applying both A4R and the TSCF to the analysis of system operations. This component of the system augments our understanding of how stakeholders organize, convene, interact, communicate, and collectively make decisions. In particular, it provides an important descriptive framework to explore how amenable a system is to supporting the principles and operational needs of specific priority setting procedures and, in the case of A4R, the needs to meet fairer, more inclusive, and transparent processes for priority setting
practice. Such an in-depth understanding is important in order to capture existing procedures that convene stakeholders, explain patterns of communication (across stakeholders and at different levels), and to reflect upon who is selected for inclusion in these discussions and in the dissemination. For instance, through the empirical examination of Ethiopian district health planning under WBHSP, an analysis of system operations revealed that while directives in the HSDP and HHM outline which stakeholders are to attend the various meetings and forums, there was a lack of clarity around the scope of stakeholder roles and engagement. The implication of this finding on strengthening a fairer priority setting process is that the lack of clarity around authority in decision-making may influence stakeholder dynamics during the district health priority setting process. Hence, a priori in-depth analysis of the system operations would serve to anticipate the underlying directives and mechanisms that shape which stakeholders are invited and why, and which of them attend and why. These insights, I argue, would inform the implementation requirements for more successful district health planning and priority setting.

In addition to the above, there is also a complementarity between A4R and the TSCF through the enforcement condition. A4R recognizes the significance of regulative measures to support procedural fairness. The presence of the enforcement condition, similar to system regulations in the TSCF, emphasizes the need for an analysis of regulations and accountability structures that enable fairness and legitimacy to be upheld. To satisfy the enforcement condition, the priority setting process should be characterized by regulative procedures that enact, monitor, and strengthen the manifestation of each condition. Similarly, an analysis of system regulations focuses on the policies, procedures, and routines that are established within the system to guide practice. The significance of this complementarity emphasizes the importance of regulation in the priority setting process and ensures measures are in place for strengthening the mechanisms needed to support procedural fairness. Therefore, the complementarity between the TSCF and A4R that is identified above illustrates important areas of overlap between these two frameworks that supports why, and how, they may be used synergistically to guide priority setting in a manner that neither framework in isolation can achieve towards more contextually sensitive priority setting.

In Chapter 6, Section 6.1, it was evident that contextual factors influenced the procedural fairness of WBHSP. TSCF instructs us that an analysis of system resources provides an important
understanding of resource constraints or facilitators that underlie how priority setting procedures and processes would manifest. The TSCF emphasizes the criticality of resource commitment from three angles of analysis—human, social, and economic—that were important to the operationalization of WBHSP. For instance, findings from my analysis using the TSCF reveal that the presence of human capacity for implementing new priority setting processes played a significant role in the uptake and implementation of the process (i.e., through the identification of structures and capacity to facilitate additional meetings and to support stakeholder trainings, gatherings, and other needs of the priority setting process). Further, in seeking to support greater procedural fairness (through a lens of A4R), a description of system resources would offer critical reflection as to the resource needs required to maintain and support more procedurally fair priority setting practices.

As district health planners and researchers strive to improve the procedural fairness of their health priority setting, and design more procedurally fair processes, a deeper understanding of the system is therefore critical. The TSCF complements the A4R framework, and helps us to understand the key system factors that may facilitate and/or constrain the implementation of fair processes predicated on the A4R principles. The TCSF also guides us in understanding how and why other priority setting processes unfold in the ways that they did in the Ethiopian context, and the critical role that the system may play in influencing district planning and priority setting efforts in other low-income countries. Systems thinking therefore contributes to the priority setting discourse by leading one to reflect on the influence of systems norms, regulations, operations, and resources when contemplating a change to the system. To engage in any efforts to strengthen priority setting in isolation of this precursory analysis sets researchers and practitioners up for a “business as usual” model of priority setting practice that may not lead to the desired outcomes sought. To consolidate this thinking, Figure 7.4 extends the arguments made by Holm (1998, p. 1001). Here, I make the addition of Phase 3 and argue that a fair and legitimate priority setting process is “influenced by a system” that “values” transparency and accountability. And, that the “system,” described here, is one that is characterized by norms, operations, regulations, and resources that will influence priority setting procedures and processes.
**Figure 7.4.** Arguments informing the Debate on Priority Setting: Proposing Phase 3 (modified from Holm, 1998, p. 1000)

*Signifies my conceptual addition to the priority setting debate proposed by Holm (1998)*

**Phase 1**
There is a principled way of making priority decisions, and it is possible to devise a rational priority setting system.
Decisions made by applying the appropriate tools to priority setting are thereby legitimate.

**Phase 2**
There is reasonable disagreement about what priorities should be set, so it is not possible to devise a rational priority setting system based on technocratic considerations alone.
Decisions made through a fair priority setting process are thereby legitimate.
The fair priority setting process is characterized by transparency and accountability—this seems to limited a definition of such a process.

**Phase 3***
A fair and legitimate priority setting process is influenced by a system that values transparency and accountability and supports their attainment.
A system is characterized by four key components—norms, regulations, operations, and resources—that will uncover system patterns and dynamics influencing priority setting practice.

7.3. **Practical Implications**

In this third phase of the priority setting discourse, I propose that researchers and practitioners adopt a systems approach to priority setting. Such an approach would provide a more comprehensive understanding of the implementation considerations that are significant in the application of technical procedures in priority setting practice as well as in the establishment of fairer and more transparent processes. The implications of my empirical findings provide an important conceptual and practical advancement in the way in which we approach district health planning and priority setting, particularly—but not exclusively—with respect to establishing fair processes for resource allocation. This advancement would be important for priority setting practices in both low-income countries as well as in high-income contexts. Although, attention to system resources in the TSCF does emphasize the importance of capturing aspects of technical,
structural, and fiscal capacity, which may hold particular significance in settings compounded by resource scarcity.

In moving forward, it is particularly important that researchers and practitioners acknowledge: 1) the system in which priority setting methods are being applied, and 2) the specific features/components of that system, which may have a facilitative or impeding role in the manifestation of patterns of interaction between system components and/or members. An analysis of each system component is necessary to determine how the system may support the adoption of a particular priority setting method or procedure. My study findings reveal that practically, each system component may influence the priority setting process to different degrees and in different ways, and that each system component is nested in such a way that a perturbation in one component will likely effect change in another. This thinking suggests that all components of a system are not equal in their influence, establishment, and/or sustainability during the implementation of priority setting processes, nor are they all or none phenomena. System components interact in ways that may permit some system parts to dominate more at one point in time than others, during the implementation of priority setting methods to improve practice. For instance, this empirical examination of Ethiopian district health planning revealed that the principles underpinning the implementation of WBHSP aligned with previous system values in support of greater multi-stakeholder engagement, collective decision-making, and evidence practice, as captured from participant interviews and document analysis of policies and strategies. The presence of normative alignment between the change initiative and those norms already active within a system appeared to be facilitative in the implementation of the WBHSP strategy. Hence, from a systems perspective, practitioners in this scenario may focus their efforts on strengthening other parts of the system that require greater attention to facilitate WBHSP implementation, such as strengthening the system operations and regulations (i.e., to improve channels for communication across system members, and greater clarity around directives on stakeholder roles, responsibilities, and accountability) and system resources (i.e., to strengthen the technical capacity of decision makers). Ultimately, system factors are interdependent—offering a complex layered interaction such that approaching any change requires a holistic appraisal of system variables and dynamics.
To conceptually and practically guide the design and implementation of priority setting initiatives, Figure 7.5 summarizes the systemic considerations that might be associated with the implementation of a change initiative to alter priority setting procedures and/or processes. A series of guiding questions, organized around each of the four system components, are provided that were derived from the analysis of the TSCF on Ethiopian district health planning, and should be considered in the design and implementation of a priority setting method or process. These reflective questions can be used as a prospective tool (to guide planners in the identification of key system components prior to the implementation of a priority setting procedure or process) or a retrospective tool (to reflect on the key system components to identify barriers to and facilitators of implementation). Decision makers and researchers may also view this analytical process iteratively, whereby prospective and retrospective application of these questions may guide a series of ongoing systemic learning that can contribute to more effective implementation and system change.
Figure 7.5. Pertinent System Considerations to Guide the Implementation of Priority Setting Procedures and Processes

| Systems Norms                  | • Do the principles of the priority setting initiative align with the goals and values of the system and its members?  
| Alignment between system norms and the principles of the priority setting initiative are facilitative | • Are there any system values or cultural views that may impede the implementation of new priority setting practices or procedures? |
| Systems Operations            | • What are existing patterns of interaction for system members?  
| Clear directives on the roles and responsibilities of system members and clear pathways for communication are facilitative | • Who in the system will need to have ongoing interaction in light of changes to priority setting procedures or practice? |
| Systems Regulations           | • Do system members have a clear understanding of their roles and the roles of other system members?  
| Alignment of the new priority setting process with existing policies and procedures of the system are facilitative | • What changes in the patterns of communication are required to facilitate priority setting practice? |
| Systems Resources             | • Who are the key system members assigned with responsibility for priority setting?  
| The presence of human capacity, social structures for convening system members, and financial resources are facilitative to successful priority setting practice | • Do existing directives exist that outline how processes and procedures are to transpire?  
| | • What are the existing procedures that may align or conflict with the priority procedures or processes? |

- System components interact in ways that allow some system parts to dominate more than others during the course of the priority setting process.
- Systemic factors are deeply rooted within each other, offering a complex layer of interaction that suggests that to approach any priority setting process requires a more holistic understanding of how each system feature (i.e., norms, operations, regulations, resources) interacts with each other.
- An analysis of system components provides an essential analytical platform for uncovering how the principles of fairness and legitimacy in the priority setting process will align conceptually and practically.
7.4. Study Limitations and Areas for Future Research

When reflecting on study limitations, I note three main conceptual and methodological weaknesses. A first limitation involves the districts that were selected for inclusion. While I sought to include districts that would have provided a broad range of characteristics (i.e., geographic, population density, etc.), ultimately the Regional Health Bureaus had final authority over district selection and approval for inclusion in this study. Hence, district variability may have been limited as a result of the districts selected that may have been classified as more “successful” (by government standards) in undertaking WBHSP. As a result, remote districts were not included in this study, which may have limited the inclusion of other contextual challenges or successes experienced under different geographical settings. For example, some districts in the South are home to nomadic populations that may be guided by unique social norms and require distinct health needs that further challenge the process of planning.

A second limitation focuses on the small number of NGO partners interviewed, as a result of challenges to secure interviews with those partners working in the districts selected. In many cases, partners did not respond to emails, or answer phone calls when being contacted for inclusion. The implication of this result is that some additional unique perspectives may have emerged. Future research employing a systems perspective may broaden the scope of stakeholders external to the process of district health planning (such as community members and a greater number of NGO partners). While attempts were made to interview NGO partners from the districts selected, it may also be advisable to interview NGO partners working in any district, so as to broaden the scope of opinions expressed from this specific cohort. Furthermore, the presence of community leaders at the level of the Woreda Administrative Council meeting reveals a particularly strategic entry point for engaging the community in district health planning procedures. An assessment of structures to encourage active dissemination of meeting contents to communities may be considered for future research to investigate how communities “learn” in the policy process and engage in decision-making constructively.

Thirdly, although capturing power dynamics and differentials is an important component of both A4R and the TSCF, capturing accurate and intricate portrayals of power can be challenging
for any cross-cultural (external) researcher. While methodological attempts were made to derive claims from the participant accounts themselves, I am not Ethiopian, nor have lived in the setting for a significant period of time. Governance and power dynamics are complex and inherently embedded within a nexus of political history, ethnic federalism, and power relations. Consequently, inferences may not be as comprehensive in light of the aforementioned limitations.

In addition, potential areas for further study are suggested by my findings. For instance, although system dynamics models were conceptualized and levers for change identified, presenting these models and solutions back to Ethiopian district health planners for learning, adaptation, and impact was not a component of this research. It is suggested that following the completion of this dissertation, a dialogic component be included to discuss inferences and strategize with the Ethiopian team.

7.5. Study Strengths and Contributions

This study has several strengths in its conceptualization and methodology. First, the consistent engagement of Ethiopian counterparts ensured that there was stakeholder buy-in and support of this study to facilitate data collection. Second, perspectives were sought from health planners at all levels of government to provide a holistic perspective of the experience of district health planning. In addition, this dissertation emerges from the paucity of scholarly research that advances this third phase of the priority setting thinking. Further, it advances our empirical understanding of priority setting in a low-income country as exemplified by Ethiopia, and approaches that have been undertaken to strengthen district health planning and priority setting in practice.

7.5.1. Contributions to Advancing Knowledge of Priority Setting Practice in Low-Income Countries

Chapter 2 acknowledges a research gap related to the paucity of empirical work that describes health planning in low-income countries and in Ethiopia, as well as the application of A4R in understanding procedural fairness within this context. This dissertation fills this gap by providing a detailed empirical account of district health priority setting and planning under the WBHSP regime and analyzes this process under the conditions of A4R to contribute to the
growing body of empirical analysis of A4R applied within a low-income country context. Furthermore, this dissertation practically informs our understanding of the conception of fairness and legitimacy in the Ethiopian experience. To guide this analysis, Ethiopian participants were asked to describe characteristics of both “fair” and “legitimate” health planning and priority setting. Legitimacy, here, is concerned with the concept of “moral authority,” whereas fairness is concerned with the defensibility of a particular distribution of resources (i.e., what largely constitutes the fairness of a decision). Section 6.1.2 described participant views and reflections, and concluded with two main findings: (1) Fairness of the priority setting decision in Ethiopia is not only based upon procedural considerations (such as transparent and inclusive decision-making), but also on substantive considerations (such as burden of disease criteria), which make their conception of a fair decision also outcome-based; and (2) Moral authority and the justification of decisions as fair in Ethiopia are conferred through government authority, international standards, and formal democratic engagement. The Ethiopian conception of fairness in planning, while consistent with A4R, goes beyond a procedural conception to include outcome considerations. Researchers and practitioners who work within this context must therefore be sensitive to frame fairness in planning as both an issue process and outcomes.

7.5.2. Contribution to Advancing Methods for Priority Setting

This dissertation also advances methods for priority setting by demonstrating the value of an integrative approach that considers both procedural fairness and the profound influence of system-contextual factors. Through this analysis, this dissertation advances priority setting thinking and practice through an acknowledgment of the systemic factors that cultivate and sustain existing practice. The emergent lessons from this study provide an empirical conduit into the significance of a systems analysis on strengthening priority setting practice and procedural measures to enhance fairness and legitimacy of priority setting. To date, outside of the application of the TSCF by Foster-Fishman et al. (2007), no literature has been documented that has applied the TSCF to understand the system facilitators and barriers to district health planning implementation. Nor has this framework been applied in a manner to advance priority setting thinking. Through the lens of the TSCF, analysis reveals a number of system barriers and facilitators that impact not only the implementation of district health planning and priority setting
practice in Ethiopia, but also the degree to which elements of procedural fairness are upheld. In light of these findings, a third phase in the priority setting discourse is proposed that emphasizes the need for methods and approaches that are inclusive of system-level considerations. A series of practical questions are offered to guide researchers and practitioners in the design and implementation of their priority setting methods.

7.6. Conclusions

Whether improving the evidence-base through explicit tools and guidelines, or strengthening the fairness and legitimacy of the priority setting process, it is evident that the context in which the process is embedded shapes who is involved, what issues will be prioritized, and how the process will transpire. The third phase in the priority setting discourse, that I propose, must acknowledge this contextual complexity of health priority setting by recognizing that, for one, while we may have a vision of what procedures and processes of priority setting should follow or resemble, the attainment of priority setting improvements are not in isolation of the system.

My study findings reaffirm that district health planning is highly complex, value laden, and influenced by a multiplicity of system-level factors. They provide a nuanced conceptual understanding of applying A4R, a prominent framework to improve priority-setting practice, by reflecting on the systemic influences, through the TSCF. Overall, these findings contribute substantively to our understanding of priority setting in low-income countries through a case study investigation of district health planning in Ethiopia. The experience of health planning reform in Ethiopia offered a unique opportunity to not only advance our understanding of how the district health planning process transpires in practice, but also our conceptual and practical understanding procedural fairness, and the systemic factors that impact both policy implementation and district health planning and priority setting practice.

In the opening prologue of this dissertation, I described the experience of real-world district health planning and priority setting complexity in Ethiopia. This narrative illustrated how the process of district health planning is ultimately influenced by a series of context-related features of the system and the complex interrelationships between the stakeholders engaged in this process.
Through the analysis, and findings presented in this dissertation, we have learned that to improve implementation strategies for strengthened priority-setting practice, system factors must be targeted and addressed—albeit with a level of ongoing learning, persistence, and commitment. As de Savigny and Adam (2009) contend, the application of a systems analysis “does not mean that resolving problems and weaknesses will come easily or naturally or without overcoming inertia of the established way of doing things. But it will identify, with more precision, where some of the true blockages lie” (p. 20). As we enter this third phase of priority setting, where ongoing improvements efforts in priority setting practice are sought, these incremental steps to achieve greater systemic awareness remain as critical as ever.
I enter my hotel room. Electricity is out for the night.

Surprisingly, a candle and a few matches sit high on the windowsill above the desk.

Perhaps a subtle reminder that amidst all challenge, there is a solution, if we look closely enough.
REFERENCES


Cohen WM. and Levinthal DA. (1990). Absorptive Capacity: A New Perspective on Learning and


Kapiriri L, Norheim OF and Martin DK. (2009). Fairness and accountability for reasonableness. Do the views of priority setting decision makers differ across health systems and levels of decision making?


Neville D, Barrowman G, Fitzgerald B and Tomblin S. (2005). Regionalization of health services in Newfoundland and Labrador: perception of the planning, implementation and


http://www.biomedcentral.com/imedia/2614814886790156_article.pdf
Excerpted from the HHM Strategy (EFMOHa, 2007, p. 43), these channels demonstrate the range of possible budget modalities operating in Ethiopia’s fiscal system.

**Channel 1a (unearmarked):** Donor money goes into the government’s account and is disbursed through government procedures. The money is pooled with government money to finance the activities in the government’s plan. A typical example of this channel is direct budget support. In this type of support, the disbursement and accounting functions remain with MOFED, BOFEDs, and WoFED offices. This is the channel that is used by donors providing budget support. However, there are also fund flowing to the health sector, which are highly flexible, such as GAVI Health Systems Strengthening funding and pooled funds managed by the FMOH according to government procedures.

**Channel 1b (earmarked):** can be used by several of the larger multilateral and bilateral donors, such as the World Bank, the African Development Bank, and the British DFID. Donor money goes into the government channel and the money is earmarked for specific use (consistent with government priorities). There are also donors, which require a separate planning document with their own separate format.

**Channel 2:** is used by a number of bilateral and multilateral partners. Sector units at each administrative level expend and account for funds. There are variations on this channel. Some donors centralize disbursement responsibility at the Federal level (so that even regional contractors are paid centrally). Other donors have worked directly with regional and/or woreda administrations.

**Channel 3:** Money is not in a government account and is not disbursed according to government procedures. The money is used to finance activities in the plan, but requires a separate planning document in a different format. Type 3 examples include some funding from UN agencies and some project funding. Most of the UN agencies and some bilateral donors currently use Channel 3. As part of this channel, there is a resource the sector has no control at all. Money is not in a government account and is not known to the government - hence is not included in government plans. Some NGOs have this variant of channel 3 funding.
Interviewer Confidentiality Form

Study Title:
Development of a Framework to Strengthen District-Level Priority Setting for Health Service in Low-Income Countries

Study Coordinators:
Ms. Kadia Petricca (PhD student)
Dr. Whitney Berta (Supervisor)
Dr. Jennifer Gibson (Committee Member)
Dr. Clare Pain (Committee Member)
Mr. Dereje Mamo (Collaborator)

Funding Agency
University of Toronto Fellowship Grant
Canadian Institutes of Health Research
Sir Val Duncan Travel Grant

Dear Potential Data Collector,

We are writing to invite you to participate in a research study affiliated with the University of Toronto in Toronto, Canada. The purpose of this study is to strengthen district priority setting for health services in Ethiopia. The study will be conducted in three districts (Lome, Shebedino, and Hintalo-Wajerat) associated with three separate regions (Oromia, SNNPR, and Tigray respectively). The title of the study is, “District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.”

We are inviting you to act in the capacity of a Data Collector to conduct interviews in the local language and also transcribe any interviews recorded.

Based on your knowledge and experience, you have been identified by the ______________ Regional Health Bureau as an ideal candidate to facilitate in this study.
If you agree to participate as an Interviewer/Translator, you will be asked to meet with Ms. Kadia Petricca to undergo a 30-minute training of the project and questionnaire. You will then be asked to conduct any interview requiring translation of the local language, which may take 30-45 minutes. If the interview participant agrees to have the interview taped, you will be asked to also transcribe each interview into English (which may take 1-2 hours each).

**COMPENSATION**
For your time and participation, you will be paid 1000 ETHbirr per day for a total of 4 days for conducting 7-8 interviews and for transcribing the interviews into English.

**CONFIDENTIALITY**
All information that you are exposed to during the course of the study and while conducting the interviews must be kept confidential. You are not permitted to discuss any of the material that participants may discuss and any breach of confidentiality will result from a removal from this project.

**RISKS**
There are no known risks to you for participating in this study. Benefits from the study will be long-term as the work from this project will seek to strengthen overall capacity for decision makers in their health planning.

Please do acknowledge that taking part in this research study is completely voluntary. If you decide not to participate in this study as an interviewer, you will not be penalized or lose any benefits for which you otherwise qualify.

If you have any further questions about the research study itself, please contact Kadia Petricca, PhD candidate and Primary Investigator at any time.

Thank you very much for your time and consideration. By signing your name below, you are indicating your willingness to undertake the role as interviewer.

Sincerely,

Kadia Petricca  HBSc, MSc, PhD candidate
Primary Investigator

Contact information
Email: k.petricca@utoronto.ca;
Ethiopian mobile: 0912383504
Canadian mobile: 001-416-618-7115
**Interviewer’s Consent**

I have read the above description of this proposed study entitled, “*District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.*”

I have understood the objectives, methods and procedures. I also recognize that there are no direct risks to participating in this study and that benefits will be long-term and contribute to health system strengthening in Ethiopia.

Lastly, I understand my role as an Interviewer and Translator in the study and that all information I am exposed to must be kept confidential.

Region: ______________________ District: ________________________________

Name: ________________________________________________________________

Affiliated Organization: ________________________________________________

Interviewer Signature: _________________________________________________
Dear Potential Data Collector,

We are writing to invite you to participate in a research study affiliated with the University of Toronto in Toronto, Canada. The purpose of this study is to strengthen district priority setting for health services in Ethiopia. The study will be conducted in three districts (Lome, Shebedino, and Hintalo-Wajerat) associated with three separate regions (Oromia, SNNPR, and Tigray respectively). The title of the study is, “District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.”

We are inviting you to act in the capacity of a Translator to assist in the conducting of interviews in the local language and also transcribe any interviews recorded; if required.

If you agree to participate as an Interviewer/Translator, you will be asked to meet with Ms. Kadia Petricca to undergo a 30-minute training of the project and questionnaire. You will then be asked to attend any meetings with Ms. Kadia Petricca to assist in conducting interviews requiring
translation from the local language; which may take 30-45 minutes. If the interview participant agrees to have the interview taped, you will be asked to also transcribe each interview into English (which may take 1-2 hours each).

**COMPENSATION**
For your time and participation, you will be paid 1000 ETHbirr per day for a total of 4 days for conducting 7-8 interviews and for transcribing the interviews into English.

**CONFIDENTIALITY**
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**RISKS**
There are no known risks to you for participating in this study. Benefits from the study will be long-term as the work from this project will seek to strengthen overall capacity for decision makers in their health planning.

Please do acknowledge that taking part in this research study is completely voluntary. If you decide not to participate in this study as an interviewer, you will not be penalized or lose any benefits for which you otherwise qualify.

If you have any further questions about the research study itself, please contact Kadia Petricca, PhD candidate and Primary Investigator at any time. Thank you very much for your time and consideration. By signing your name below, you are indicating your willingness to undertake the role as interviewer.

Sincerely,

Kadia Petricca  HBSc, MSc, PhD candidate  Primary Investigator

*Contact information*
Email: k.petricca@utoronto.ca;  
Ethiopian mobile: 0912383504; Canadian mobile: 001-416-618-7115

**Translator’s Consent**

I have read the above description of this proposed study entitled, “*District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.*”
I have understood the objectives, methods and procedures. I also recognize that there are no direct risks to participating in this study and the benefits will be long-term and contribute to health system strengthening in Ethiopia.

Lastly, I understand my role as an Interviewer and Translator in the study and that all information I am exposed to must be kept confidential.

Name: __________________________________________________________

Affiliated Organization: _________________________________________

Interviewer Signature: ___________________________________________
Letter of Participation and Informed Consent

Study Title:
District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness

Study Coordinators:
Ms. Kadia Petricca (PhD student)
Dr. Whitney Berta (Supervisor)
Dr. Jennifer Gibson (Committee Member)
Dr. Clare Pain (Committee Member)
Mr. Dereje Mamo (Collaborator)

Funding Agency
University of Toronto Fellowship Grant
Canadian Institutes of Health Research
Sir Val Duncan Travel Grant

Dear Participant,

We are writing to invite you to participate in a research study affiliated with the University of Toronto in Toronto, Canada. The title of the study is, “District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.” Overall, the aim of the study is to develop a framework that can strengthen the legitimacy and fairness of district-level priority setting in low-income countries. The study will be conducted in three districts (Lome, Shebedino, and Hintalo-Wajerat) associated with three separate regions (Oromia, SNNPR, and Tigray respectively). All respective planning departments in each Regional Health Bureau have authorized the undertaking of this research.

To facilitate in this process, one of the objectives of this analysis is to understand the planning and priority setting process for the district annual plan for health services in Ethiopia. We are inviting you to be in this study because you play a key role in the priority setting and planning process as a decision maker and your experiences, comments and opinions would be highly valued.

Date: ____________________
Selection of participants is based upon a purposive sampling technique. You have been selected by virtue of your involvement in the planning process for the annual plan or by referral by a fellow colleague who thought you could provide useful experience.

If you agree to participate, we would like to interview you to describe the planning process associated with the annual core plan, weaknesses and strengths and woreda-based health sector planning. Questions asked will include: *How are decisions made for the woreda annual plan?*; *Who is involved in the process?*, *what is considered in the decision-making process?*; *How are decisions disseminated?*, etc.

All information you provide will be kept confidential. Your name will not be associated with any of the information you provide in any published documentation or revealed at any point. Only the primary investigator and any associated local translator will have access to your interview material. When the final report is compiled, you will be classified as health planner, etc. in the results section.

You will be asked if the interview can be tape-recorded. This is completely optional and if you do not wish for the interview to be taped, notes will be taken in its place.

While there are no direct physical or psychological risks associated with participating in this study, there may be a potential social risk associated given the topic of decision-making related to health planning. This will be mitigated by ensuring both confidentiality of all spoken material as well as preserving anonymity in all written material. Please be aware that all data collectors have also been asked to sign confidentiality forms prior to conducting any interview.

Please do acknowledge that taking part in this research study is completely voluntary. If you decide not to participate in this study, or if you stop participating at any time, you will not be penalized or lose any benefits for which you otherwise qualify. In addition, if you do not feel comfortable with answering any particular question or series of questions, you may skip them.

Benefits from the study will be long-term as the work from this project will seek to strengthen overall capacity for decision makers in their health planning.

If you have any further questions about the research study itself, please contact Kadia Petricca, PhD candidate and Primary Investigator, at any time. Additionally, for any ethical concerns please contact: Ms. Rachel Zand (rachel.zand@utoronto.ca) or 001-416 946 3389 at the U of T Office of Research Ethics or Mr. Teshome Shailemariam at 011-156-2155 at the Ministry of Science and Technology.

Thank you very much for your time and consideration. By signing your name below, you are indicating your willingness to participate in this study.

Sincerely,

Kadia Petricca  HBSc, MSc, PhD candidate
Interviewee’s Consent

I have read the above description of this proposed study entitled, “District Health Planning and Priority Setting in Ethiopia: A Systems Change Analysis of Strategy Implementation and Strengthening Procedural Fairness.”

I have understood the objectives, methods and procedures. I also recognize that there are no direct risks to participating in this study and the benefits will be long-term and contribute to health system strengthening in Ethiopia.

Lastly, I understand my role as an Interviewer and Translator in the study and that all information I am exposed to must be kept confidential.

Region: ___________________ District: ____________________________________________

Name: ____________________________

Affiliated Organization: ____________________________

Interviewer Signature: ____________________________
Interview Guide

Date: __________________
Interviewer name: ______________________________
District and Letter Code: _____________________ (A – Oromia, B-SNNPR, C-Tigray)

Interviewee Information
Name: _______________________
Did they participate in the Woreda Annual Plan meeting? Yes No (circle one)
Where do they work: ____________________________
What is their role: ______________________________

Introduction to the Study
Thank you for your participation in this study. Before we start the interview, (sign consent form) I just want to briefly go over the aims and objectives of the study, why you are being interviewed and how your participation and interview will be used in the study.

The purpose of this study is to understand the overall planning process for the woreda annual plan. You will be asked approximately seventeen questions related to this planning process.

Remember, this interview is completely voluntary, so if you would like to stop the interview at any point or avoid specific questions, you have the right to do so.

To ensure that all information is properly captured in this interview, we are requesting that this interview be tape-recorded. If you do not feel comfortable, then notes will be taken.

Tape recorded: Yes or No (please circle one)

Open-ended Questions and Suggested Probes
1) How do you set priorities for the woreda annual plan for health services?
   (Probe: Describe the entire planning process?)
2) **Who is involved in this planning process?** (Probe: Involvement of which stakeholders? - donors, NGOs and community?)

3) **How is participation ensured across all stakeholders involved in the planning process?** (i.e. this question is trying to uncover and power differentials and empowerment of stakeholders)

4a) **Who leads the planning of the Annual Plan? and in what capacity?** (Probe: what is their role? or is it a group effort?)

4b) **How can leadership be strengthened at the district-level?**

5) **What is considered in this decision-making process for the Annual Plan?** (Probe: What guides decision-making? Any tools?; any criteria?; types of information?, etc)
6) **How do you disseminate or publicize these decisions and to who?** (Probe: Are there any groups in particular who you wish to review the decisions?)

7) **What happens when someone or a group disagrees with the decision?** (Probe: Can the decision be changed or revised? If so, how?)

8) **What are some of the challenges you experience during the health planning process for the annual plan?**

   If they answered yes to question 8, ask: What do you think would be necessary to lessen these challenges?

9a) **What are the characteristics of a fair decision-making process?**

9b) **Was there fairness in your planning process or do you feel improvements can be made?** If improvements can be made, how would you improve the fairness of decision-making?
10a) **What are the characteristics of a legitimate decision-making process?** (I.e. making reasonable or “justifiable” decisions)

10b) **Was there legitimacy in your planning process or do you feel improvements can be made?** If improvements can be made, how would you improve the legitimacy of decision-making?

11) **What impact has the Evidence-based Planning and Budgeting tools had on your planning process for the strategic and annual plan?**

12) **Describe the strengths and weaknesses of the EBPB tool and any improvements that can be made to enhance its implementation?**

13) **In a situation where you don’t receive the monies that the EBPB tool forecasts, how do you re-prioritize where to allocate this lesser amount?**

*Thank you for your time!*
**Table 1:** High impact interventions and indicators by service delivery mode selected as priority areas for district health planning (Excerpted from the EBPB tool, 2010)

<table>
<thead>
<tr>
<th>Family oriented community based services</th>
<th>Effective interventions</th>
<th>Example indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family preventative/WASH services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of sanitary latrine</td>
<td>Proportion of households with a latrine; proportion of households utilizing latrines</td>
<td></td>
</tr>
<tr>
<td>Quality of drinking water</td>
<td>Proportion of households using safe drinking water</td>
<td></td>
</tr>
<tr>
<td>Distribution of Insecticide Treated Nets</td>
<td>Proportion of households receiving at least 2 nets.</td>
<td></td>
</tr>
<tr>
<td>Hand washing by mother</td>
<td>Proportion of mothers washing their hands after defecation and before feeding child</td>
<td></td>
</tr>
<tr>
<td>Indoor residual spraying [IRS]</td>
<td>Proportion of villages covered in IRS</td>
<td></td>
</tr>
<tr>
<td>Model household graduated</td>
<td>Proportion of model households graduated</td>
<td></td>
</tr>
<tr>
<td><strong>Family neonatal care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean delivery and cord care</td>
<td>Proportion of deliveries attended by HEWs trained on clean delivery</td>
<td></td>
</tr>
<tr>
<td><strong>Infant and child feeding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early breast feeding and temperature management</td>
<td>Proportion of newborns breastfeed within 1 hour of birth</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding for children 0-5 months</td>
<td>Proportion of children exclusively breastfed for 6 months</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding for children 6-11 months</td>
<td>Proportion of children breastfed for 6-11 months</td>
<td></td>
</tr>
<tr>
<td>Complimentary feeding</td>
<td>% of children 6-9 months receiving complimentary food</td>
<td></td>
</tr>
<tr>
<td>Therapeutic feeding</td>
<td>Proportion of malnourished children receiving therapeutic care</td>
<td></td>
</tr>
<tr>
<td>Care for orphans</td>
<td>Proportion of children who received free education support</td>
<td></td>
</tr>
<tr>
<td>Growth monitoring</td>
<td>Proportion of children under 3 years of age whose weight is monitored.</td>
<td></td>
</tr>
<tr>
<td>Care and support for People Living with HIV/AIDS (PLWA)</td>
<td>Proportion of PLWA who received food support</td>
<td></td>
</tr>
<tr>
<td><strong>Community illness management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Rehydration Therapy</td>
<td>Proportion of children with diarrhea managed with ORS</td>
<td></td>
</tr>
<tr>
<td><strong>Population oriented schedulable services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative care for adolescents and adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td>Contraceptive acceptance rate; contraceptive prevalence rate; proportion of women using modern methods of contraceptives)</td>
<td></td>
</tr>
<tr>
<td>Preventative pregnancy care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal care</td>
<td>Proportion of pregnant women who attended ANC1+ during current pregnancy; proportion of pregnant women who attended ANC3+ during current pregnancy; proportion of pregnant women who attended ANC4+ during current pregnancy</td>
<td></td>
</tr>
<tr>
<td>Health Area</td>
<td>Indicator</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tetanus toxoid</td>
<td>Proportion of women who received TT2+ vaccine</td>
<td></td>
</tr>
<tr>
<td><strong>HIV/AIDS prevention and care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of mother-to-child transmission (PMTCT)</td>
<td>Proportion of pregnant women counseled and tested for PMTCT</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive infant and child care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles immunization</td>
<td>Proportion of surviving infants vaccinated for measles</td>
<td></td>
</tr>
<tr>
<td><strong>Individual oriented clinical services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternal and neonatal care at primary clinical level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal delivery by skilled attendant</td>
<td>Proportion of deliveries attended by skilled birth attendants)</td>
<td></td>
</tr>
<tr>
<td>Antibiotics for under 5 (U5) pneumonia</td>
<td>Proportion of acute respiratory infection cases treated by a health worker trained in IMNCI</td>
<td></td>
</tr>
<tr>
<td>TB detection and treatment</td>
<td>Proportion of smear positive TB cases detected</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: High impact interventions and indicators by *HSDP-III core focus areas* (Excerpted from the EBPB tool, 2010)

<table>
<thead>
<tr>
<th><strong>Objective Description</strong></th>
<th><strong>Indicator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expansion of Primary Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>Increase HP coverage to 100% in all rural kebeles</td>
<td>Proportion of rural kebeles with at least one HP</td>
</tr>
<tr>
<td>Equip newly constructed health posts</td>
<td>Number of fully equipped newly constructed HPs</td>
</tr>
<tr>
<td>Maintain 100% HEW availability in all rural kebeles</td>
<td>Number of HEWs deployed in rural kebeles</td>
</tr>
<tr>
<td>Train and deploy urban HEWs to urban kebeles</td>
<td>Number of HEWs deployed in urban kebeles</td>
</tr>
<tr>
<td>Conduct Integrated refresher Training for HEWs</td>
<td>Proportion of HEWs trained with IRT for 20 days in two years time</td>
</tr>
<tr>
<td>Train and deploy Community Health Workers (CHW)</td>
<td>Number of innovators selected from graduated model HHs and trained as CHW with the standard training guideline</td>
</tr>
<tr>
<td>Graduate model HHs</td>
<td>Proportion of model HHs graduated</td>
</tr>
<tr>
<td>Ensure essential drug availability in health posts</td>
<td>Proportion of months with availability of essential drugs per HP</td>
</tr>
<tr>
<td><strong>Strengthening &amp; Expansion of Health Center Services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase health center coverage as per the standard</td>
<td>Proportion of constructed health centers</td>
</tr>
<tr>
<td>Equip newly constructed health centers</td>
<td>Number of newly constructed health centers fully equipped</td>
</tr>
<tr>
<td>Furnish newly constructed health centers</td>
<td>Number of newly constructed health centers furnished</td>
</tr>
<tr>
<td>Staff health centers with at least one health officer</td>
<td>Proportion of health centers with at least one health officer</td>
</tr>
<tr>
<td>Staff health centers with at least one midwife</td>
<td>Proportion of health centers with at least one midwife</td>
</tr>
<tr>
<td>Ensure essential drug availability in health centers</td>
<td>Proportion of months with availability of essential drugs per HC</td>
</tr>
<tr>
<td>Increase out patient [OPD] attendance per capita</td>
<td>Average number of out patient visit [including first and repeat visits] per person per year</td>
</tr>
<tr>
<td><strong>Promoting Maternal and Adolescent Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase family planning coverage</td>
<td>Contraceptive Acceptance rate</td>
</tr>
<tr>
<td>Increase ANC coverage</td>
<td>Proportion of pregnant women who attended ANC 1+ during the current pregnancy Proportion of pregnant women who attended ANC3+ during the current pregnancy</td>
</tr>
<tr>
<td><strong>Proportion of pregnant women who attended ANC4+ during the current pregnancy</strong></td>
<td>Proportion of pregnant women who received TT2+ vaccine</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Increase TT vaccination coverage for pregnant women</td>
<td>Proportion of non-pregnant women who received TT2+ vaccine</td>
</tr>
<tr>
<td>Increase TT vaccination coverage for non-pregnant women</td>
<td>Proportion of deliveries attended by HEWs/HWs trained on Clean delivery and safe delivery</td>
</tr>
<tr>
<td>Increase Clean and safe delivery service coverage</td>
<td>Proportion of deliveries attended by skilled birth attendants</td>
</tr>
<tr>
<td>Increase delivery service coverage attended by skilled birth attendants</td>
<td>Proportion of women who received care at least once during postpartum (42 days after delivery) from a health professional</td>
</tr>
<tr>
<td>Increase PNC services coverage</td>
<td>Number of safe abortion services provided as far as the law permits</td>
</tr>
<tr>
<td>Increase safe abortion service</td>
<td>Proportion of health centers with B-EmNOC service</td>
</tr>
<tr>
<td>Increase Basic Emergency Obstetric Care service coverage</td>
<td>Proportion of pregnant women counseled &amp; Tested for PMTCT; proportion of HIV+ pregnant women received ARVs for prophylaxis; proportion of deliveries of HIV+ women that receive full course of ARV prophylaxis</td>
</tr>
<tr>
<td>Reduce mother to child transmission of HIV</td>
<td>Proportion of infants who were protected from neonatal tetanus at birth by the immunization of their mothers with tetanus toxoid (TT) before the birth</td>
</tr>
<tr>
<td><strong>Improving Child Health Care</strong></td>
<td>Proportion of live births who received a dose of BCG</td>
</tr>
<tr>
<td>Increase protection at birth against neonatal tetanus</td>
<td>Proportion of surviving infants who received a three dose of OPV vaccine before their 1st Birthday</td>
</tr>
<tr>
<td>Increase BCG Immunization coverage</td>
<td>Proportion of surviving infants vaccinated for Penta-1</td>
</tr>
<tr>
<td>Increase Polio Immunization coverage</td>
<td>Proportion of surviving infants vaccinated for Penta-3</td>
</tr>
<tr>
<td>Increase Penta Immunization coverage</td>
<td>Proportion of surviving infants vaccinated for measles</td>
</tr>
<tr>
<td>Increase Measles Immunization coverage</td>
<td>Proportion of infants fully immunized</td>
</tr>
<tr>
<td>Increase fully immunization coverage</td>
<td>Proportion of children under 5 years with Diarrhea treated with some kind of ORT</td>
</tr>
<tr>
<td>Treat children under 5 years of age with diarrhea</td>
<td>Proportion of children with ARI/pneumonia treated</td>
</tr>
<tr>
<td>Treat Children under 5 years of age with ARI/pneumonia</td>
<td>Proportion of health center Providing IMNCl services according to national guideline</td>
</tr>
<tr>
<td>Expand IMNCl services in Health centers</td>
<td>Proportion of kebeles that implemented community IMNCl</td>
</tr>
<tr>
<td>Expand community IMNCl</td>
<td>Proportion of children 2-5 years of age de wormed Bi-annually</td>
</tr>
<tr>
<td><strong>Promote Nutrition</strong></td>
<td>Proportion of children 6-59 months of age supplemented with Vit A Bi-annually</td>
</tr>
<tr>
<td>Vitamin A supplementation to 6-59 months of age</td>
<td>Proportion of children under 3 years of age whose weight is monitored</td>
</tr>
<tr>
<td>Deworming for 2-5 years of age</td>
<td>Proportion of children under 3 years of age whose weight is monitored</td>
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<tr>
<td>Initiative</td>
<td>Indicator</td>
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<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Increase malnourished children served with therapeutic feeding</td>
<td>Proportion of malnourished children receiving supplementary food</td>
</tr>
<tr>
<td>Iron folate supplementation for pregnant women</td>
<td>Proportion of pregnant mothers supplemented with iron folate</td>
</tr>
<tr>
<td><strong>Strengthen Hygiene and Environmental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Increase latrine coverage</td>
<td>Proportion of HH with latrine</td>
</tr>
<tr>
<td>Increase latrine utilization</td>
<td>Proportion of Households (families) utilizing latrines</td>
</tr>
<tr>
<td>Improve the quality of water supply</td>
<td>Proportion of households (families) using safe drinking water</td>
</tr>
<tr>
<td>Increase number of inspected food and drinking establishment</td>
<td>Proportion of food and drinking establishment inspected at least once every month</td>
</tr>
<tr>
<td>Increase number of Health Facilities with WASH facility</td>
<td>Proportion of health facilities with health facilities (water point, latrine and hand washing facility)</td>
</tr>
<tr>
<td>Increase number of schools with WASH facility</td>
<td>Proportion of schools with WASH facility (water point, latrine and hand washing facility)</td>
</tr>
<tr>
<td><strong>Prevention &amp; Control of HIV/AIDS/STI</strong></td>
<td></td>
</tr>
<tr>
<td>Increase condom distribution</td>
<td>Number of condoms distributed for use in the year</td>
</tr>
<tr>
<td>Increase number of STI cases managed</td>
<td>Proportion of STI cases managed</td>
</tr>
<tr>
<td>Increase number of individuals counselled and tested for HIV [VCT]</td>
<td>Proportion of individuals who received VCT services</td>
</tr>
<tr>
<td>Increase PIHCT Pre-test counselling</td>
<td>Number of individuals who received HIV Pre-test counselling that was initiated by a provider</td>
</tr>
<tr>
<td>Increase PIHCT Testing rate</td>
<td>Proportion of individuals counselled who received HIV testing that was initiated by a provider</td>
</tr>
<tr>
<td>Increase number of People enrolled in HIV Care [Pre-ART]</td>
<td>Cumulative number of People Living With HIV/AIDS (PLWHA) ever enrolled in HIV care</td>
</tr>
<tr>
<td>Increase number of People receiving ART</td>
<td>Cumulative number of People Living With HIV/AIDS (PLWHA) ever started on ART</td>
</tr>
<tr>
<td>Increase number of People receiving ART</td>
<td>Number of PLWHA currently receiving ART</td>
</tr>
<tr>
<td>Increase number of People receiving ART</td>
<td>Proportion of eligible children under 15 years age who can receive ART</td>
</tr>
<tr>
<td>Increase number of People receiving ART</td>
<td>Proportion of eligible HIV+ pregnant women receiving ART</td>
</tr>
<tr>
<td>Increase number of People receiving ART</td>
<td>Proportion of PLWHA currently receiving ART</td>
</tr>
<tr>
<td>Increase TB screening among HIV positive People</td>
<td>Proportion of HIV positive clients screened for TB</td>
</tr>
<tr>
<td>Increase Number of OVC receiving care and Support</td>
<td>Number of OVC who received educational support</td>
</tr>
<tr>
<td></td>
<td>Number of OVC who received food support</td>
</tr>
<tr>
<td></td>
<td>Number of OVC who received shelter support</td>
</tr>
<tr>
<td>Prevention &amp; Control of TB &amp; Leprosy</td>
<td></td>
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<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Increase detection of new sputum smear-positive TB cases</strong></td>
<td>Proportion of Smear Positive TB cases detected</td>
</tr>
<tr>
<td><strong>Increase TB treatment success Rate</strong></td>
<td>Percentage of cohort of new smear Positive TB cases registered in a specific period that successfully completed treatment</td>
</tr>
<tr>
<td><strong>Increase TB Cure rate</strong></td>
<td>Percentage of a cohort of new Smear-positive TB cases registered in specified period that was cured as demonstrated by bacteriologic evidence</td>
</tr>
<tr>
<td><strong>Test newly diagnosed TB patients for HIV</strong></td>
<td>Proportion of newly diagnosed TB patients tested for HIV</td>
</tr>
<tr>
<td><strong>Expand DOTS/MDT service in governmental public health institutions</strong></td>
<td>Proportion of public health facilities providing DOTS/MDT</td>
</tr>
<tr>
<td><strong>Expand DOTS/MDT service in health institutions other than governmental public health institutions</strong></td>
<td>Proportion of private health facilities providing DOTS/MDT</td>
</tr>
<tr>
<td><strong>Increase detection of new leprosy cases</strong></td>
<td>Number of new cases of Multi bacillary leprosy, never treated before and registered during the specified period of time</td>
</tr>
<tr>
<td><strong>Increase leprosy treatment completion rate</strong></td>
<td>Proportion of newly registered multi bacillary cases completed their treatment</td>
</tr>
<tr>
<td>Prevention &amp; Control of Malaria</td>
<td></td>
</tr>
<tr>
<td><strong>To apply timely and targeted IRS in malaria epidemic prone villages</strong></td>
<td>Proportion of household in epidemic prone villages covered with IRS (% household sprayed)</td>
</tr>
<tr>
<td><strong>Maintain 100% distribution coverage of LLNs to households in targeted localities with at least 2 LLNs per household</strong></td>
<td>Proportion of HHs in targeted village received at least 2 LLNs</td>
</tr>
<tr>
<td><strong>Malaria cases treated based on test (RDT &amp; Lab.) result</strong></td>
<td>Proportion of treated positive malaria cases based on RDT &amp; Lab. results</td>
</tr>
<tr>
<td><strong>Treat severe malaria cases</strong></td>
<td>Proportion of patients with sever malaria treated</td>
</tr>
<tr>
<td>Prevention &amp; Control of Other Communicable Diseases</td>
<td></td>
</tr>
<tr>
<td><strong>Reduce epidemic occurrence</strong></td>
<td>Number of epidemics (malaria, meningitis, AWD and measles) occurred</td>
</tr>
<tr>
<td><strong>Increase epidemic response &amp; report</strong></td>
<td>Proportion epidemics that have been responded with in 24 hours Proportion of epidemics that have been responded with in 48 hours</td>
</tr>
</tbody>
</table>
**Prevention and Control of Non Communicable Diseases**

*LEFT BLANK IN THE EBPB TOOL FOR DISTRICT PLANNERS TO COMPLETE*

<table>
<thead>
<tr>
<th><strong>Strengthening Monitoring &amp; Evaluation and Operational Research</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase number of supportive supervision conducted</td>
<td>Number of supportive supervision visits reported by respective health institutions</td>
</tr>
<tr>
<td>Improve performance monitoring</td>
<td>Number of performance monitoring and participatory review meetings held by respective health institutions</td>
</tr>
<tr>
<td>Ensure completeness of routine health and administrative reports</td>
<td>Number of routine health and administrative reports received from respective health institutions</td>
</tr>
<tr>
<td>Ensure timeliness of routine health and administrative reports</td>
<td>Number of routine health and administrative reports timely received from respective health institutions</td>
</tr>
<tr>
<td>Ensure routine data quality</td>
<td>Proportion of correspondence between data reported and data recorded in registers and patient/client records, as measured by a Lot Quality Assurance Sample [LQAS]</td>
</tr>
</tbody>
</table>
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Appendix 5A: Table 1: High impact interventions and indicators by service delivery mode selected as priority areas for district health planning
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Appendix 5B: Table 2: High impact interventions and indicators by HSDP-III core focus areas
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