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Strengthening Fairness, Transparency and Accountability in Health Care Priority Setting at District Level in Tanzania

Opportunities, challenges and the way forward

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“...there is no technological fix, scientific method, or method of philosophic inquiry for determining priorities. Of course, the three Es-economists, ethicists, and epidemiologists – all have valuable insights to contribute to the debate about resource allocation and rationing, though none of them can resolve our dilemmas for us”

(Rudolf Klein, 1993:311).

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Abbreviations and acronyms

A4R	Accountability for Reasonableness
ART	Action Research Team
BOD	Burden of Disease
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CHSB	Council Health Service Board
DALYs	Disability Adjusted Life Years
DED	District Executive Director
DMO	District Medical Officer
DPLO	District Planning Officer
EBM	Evidence-Based Medicine
EHP	Essential Health Package
EU	European Union
FBOs	Faith Based Organisations
HSBF	Health Sector Basket Fund
HSRs	Health Sector Reforms
LGAs	Local Government Authorities
LGRP	Local Government Reform Programme
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NGOs	Nongovernmental organisations
PHC	Primary Health Care
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
REACT	Response to Accountable Priority Setting for Trust in Health Systems
SWAP	Sector Wide Approach
URT	United Republic of Tanzania
WHO	World Health Organization

Original papers

This thesis is based upon the following publications:

- I** Maluka S., Hurtig AK., San Sebastián M., Byskov J., Shayo E., & Kamuzora P (2010). Decentralization and health care prioritization process in Tanzania: From national rhetoric to local reality. *International Journal of Health Planning and Management*. PMID: 20603818 (Epub ahead of print)
- II** Maluka S., Kamuzora P., San Sebastián M., Byskov J., Ndawi B., Shayo E., Olsen ØE. & Hurtig AK. (2010). Decentralized Health Care Priority Setting in Tanzania: Evaluating against Accountability for Reasonableness Framework. *Social Science and Medicine*, 71 (4): 751-759.
- III** Maluka S., Kamuzora P., San Sebastián M., Byskov J., Ndawi B., & Hurtig AK. (2010). Improving district level health planning and priority setting in Tanzania through implementing accountability for reasonableness framework: Perceptions of stakeholders. *BMC Health Services Research*, 10:322.
- IV** Maluka S., Kamuzora P., San Sebastián M., Byskov J., Ndawi B., Olsen ØE. & Hurtig AK. (2011). Implementing accountability for reasonableness framework at district level in Tanzania: A realist evaluation. *Implementation Science*, 6:11.

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Abstract

Background

During the 1990s, Tanzania, like many other developing countries, adopted health sector reforms. The most common policy change under health sector reforms has been decentralisation, which involves the transfer of power and authority from the central levels to the local governments. However, while decentralisation of health care planning and priority-setting in Tanzania gained currency in the last decade, its performance has, so far, been less than satisfactory. In a five-year EU-supported project, which started in 2006, ways of strengthening fairness and accountability in priority-setting in district health management were studied through action research. As part of this overall project, this doctoral thesis aims to analyse the existing health care organisation and management systems, and explore the potential and challenges of implementing Accountability for Reasonableness approach to priority setting in Tanzania.

Methods

A qualitative case study in Mbarali district formed the basis of exploring the socio-political and institutional contexts within which health care decision-making takes place. The thesis also explores how the Accountability for Reasonableness intervention was shaped, enabled and constrained by the interaction between the contexts and mechanisms. Key informant interviews were conducted with the Council Health Management Team, local government officials, and other stakeholders, using a semi-structured interview guide. Relevant documents were also gathered and group priority-setting processes in the district were observed.

Main findings

The study revealed that, despite the obvious national rhetoric on decentralisation, actual practice in the district involved little community participation. The findings showed that decentralisation, in whatever form, does not automatically provide space for community engagement. The assumption that devolution to local government promotes transparency, accountability and community participation, is far from reality. In addition, the thesis found that while the Accountability for Reasonableness approach to priority setting was perceived to be helpful in strengthening transparency, accountability, stakeholder engagement and fairness, integrating the innovation into the current district health system was challenging.

Conclusion

This thesis underscores the idea that greater involvement and accountability among local actors may increase the legitimacy and fairness of priority-setting decisions. A broader and more detailed analysis of health system elements, and socio-cultural context, can lead to better prediction of the effects of the innovation, pinpoint stakeholders' concerns, and thereby illuminate areas requiring special attention in fostering sustainability. Additionally, the thesis stresses the need to recognise and deal with power asymmetries among various actors in priority-setting contexts.

1. Introduction

Attempts to strengthen district-level planning and priority setting in Tanzania mainly based on burden of disease measures, cost-effectiveness and related planning tools, have not achieved adequate and sustainable improvements (Makundi, Mboera, Malebo, & Kitua, 2007; Mshana et al., 2007). National health policies and guidelines promote more inclusive planning processes, but concrete involvement of stakeholders in the actual planning and priority-setting process is still limited. This thesis seeks to analyse the existing health care organisation and management systems in Tanzania and explore potential and challenges of implementing the Accountability for Reasonableness (A4R) framework to priority setting in the context of resource poor settings, relatively weak organisations and fragile democratic institutions.

1.1 Background to the study

Health care systems are faced with the challenge of resource scarcity and have insufficient resources to respond to all health problems and target groups simultaneously. Health care competes for resources, along with other services, such as education, water, food, just to mention a few. Hence, priority setting is an inevitable aspect of every health system (Goold, 1996) - a phenomenon which has more significant consequences in developing countries where there are relatively limited resources and unmet basic needs (Kapiriri & Martin, 2007).

Priority setting, sometimes called rationing or resource allocation, has been defined as the distribution of resources (e.g. money, clinicians' time, beds, drugs) among competing interests such as institutions, programs, people/patients, services, diseases (Gibson, 2005; McKneally, Dickens, Meslin, & Singer, 1997), and is arguably one of the most important health policy issues of our time (Martin, 2007; Ham & Coulter, 2003; Klein & Williams, 2000). Loughlin (1996) defined priority setting as the process by which decisions are made as to how to allocate health service resources ethically. In this thesis, priority setting is defined as a process of formulating systematic rules to decide on the distribution of limited health care resources among competing programmes or patients.

Priority setting occurs simultaneously at the macro (health system), meso (institutional) and micro (bedside) policy-making levels (Martin, 2007; Martin, Walton, & Singer, 2003). At the highest level, governments make decisions regarding prioritising health services in their annual budgets and at the lowest level, clinicians and other professionals set priorities regarding which patient get services first (Obermann & Tolley, 1997). Therefore, when one talks about health care priority setting, one is in fact discussing the complex interaction of multiple

decisions, taken at various levels, about allocating scarce resources. Scarcity raises questions of justice and efficiency: how should limited health care resources be allocated? What health services should be publicly funded? How should indications for particular interventions be defined? (Sabik & Lie, 2008; Fleck, 2001; Emanuel, 2000; Rawls, 1999).

The challenge of priority setting is relevant in both developing and developed countries. Developed countries’ challenges are mainly caused by ageing populations, expensive medical equipment, and increasing public demand (Norheim, 2003). However, developing countries’ challenges are due to many factors, such as the growing gap between basic health needs and available resources to satisfy them, the lack of reliable information, few systematic and formal processes for decision making, multiple obstacles to implementation such as inadequately developed social sectors, weak institutions and marked social inequalities (Kapiriri & Martin, 2007; Bryant, 2000; Klein & Williams, 2000).

Insufficiency of resources is one of the problems of the Tanzanian health system too and, as will be shown later, the Ministry of Health and Social Warfare has become aware of the necessity of priority setting for this reason. Priority-setting in Tanzania occurs implicitly, according to policy makers’ and clinicians’ judgments, but it is neither efficient nor ethically acceptable. Hence, one could argue that taking steps toward explicit approaches to priority setting is a way towards strengthening health systems. Having a clear understanding of the current state of priority setting is a prerequisite for developing any explicit initiative towards evidence-based priority setting.

1.2 Theoretical debates on priority setting

A number of approaches to priority setting that are grounded in many disciplines have been suggested to support actual priority setting (see Table 1). Each approach presents an alternative idea of what a good and successful priority-setting process should consider and/or what a successful outcome would look like.

Table 1: Discipline-specific approaches to priority setting and their key values, (modified from Sibbald, Singer, Upshur & Martin, 2009)

Discipline	Key values
Evidence-based medicine	Effectiveness
Health economics	Efficiency and Equity
Philosophical approaches	Justice
Political science approaches	Democracy
Legal approaches	Reasonableness

1.2.1 Evidence-based medicine

EBM is often used by health care professionals in priority setting, and is predominantly concerned with the use of interventions with established effectiveness. Sackett et al. (1996) defined EBM as the conscientious and judicious use of current best medicine from clinical care research, in the management of individual patients. Rosenberg & Donald (1995) defined EBM as the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. *Individual clinical expertise* refers to the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). EBM dates back to the beginning of the 1970s (see for example, Cochrane, 1989) but was institutionalised by the foundation of the Cochrane Collaboration in 1993. The Cochrane Collaboration produces and disseminates systematic reviews of health care interventions and promotes the search for evidence in the form of clinical trials and other studies. EBM does not, however, consider contextual factors and different values that play into, and are an essential part of, achieving successful priority setting (Sibbald, Singer, Upshur, & Martin, 2009).

1.2.2 Health economics

Because of steep increases in health intervention costs in Western countries in the 1980s, economists proposed the use of cost-effectiveness analysis. The underlying notion is that interventions should not only have established effectiveness, but should also be worth the cost (Drummond & McGuire, 1997). Population health should then be maximised by choosing interventions that give the best value for money (most cost-effective). The World Bank promoted the concept in developing countries in 1993 (World Bank, 1993) and, more recently, the World Health Organization has made such information available at the regional level through the WHO-CHOICE project, e.g. on tuberculosis and HIV/AIDS control (Baltussen, Floyd, & Dye, 2005; Hogan, Baltussen, Hayashi, Lauer, & Salomon, 2005). Efforts have also been made to apply these cost-effectiveness measures at the country level. According to an economic approach, achieving successful priority setting would focus on efficiency as the key value in decision-making. However, economic approaches to priority setting do not take into account the nature of the wider context within which decisions on priority setting actually take place. Politicians, health care professionals, and local people may attach importance to other factors besides efficiency.

Also in the early 1990s, the World Bank expanded epidemiological mortality measures to Burden of Disease (BOD) analysis (Murray & Lopez, 1996). Burden of disease analysis measures ill-health in terms of morbidity and mortality to indicate the most important disease areas in a country. Its proponents consider BOD analysis as an important aid to priority setting, as they believe it guides policy makers in targeting their interventions at the most important disease areas. Burden of disease analysis has been applied in many developed and developing countries, including Eritrea, Ethiopia, Kenya, Uganda, and Tanzania in East Africa; Algeria, Morocco and Tunis in Northern Africa, and India (Kapiriri, Norheim, & Heggenhougen, 2003; Bobadilla, Cowley, Musgrove, & Saxenian, 1994). However, despite its intended usage as a supportive and functional tool, studies in developing countries have shown that decision makers find the WHO-CHOICE approach to be too opaque, requiring unavailable expertise, and in conflict with local values (Kapiriri & Bondy, 2006; Kapiriri, Arnesen, & Norheim, 2004). Other authors have argued strongly against the use of the BOD concept in priority setting in health care (see for example, Mooney & Wiseman, 2000). According to these authors, using BOD calculations in setting priorities is likely to lead to inefficient and inequitable resource use.

1.2.3 Philosophical approaches

Philosophical approaches to priority setting focus on meeting health needs justly within limited resources (Beauchamp & Childress, 1994). However, disagreement occurs because there is no consensus on what setting priorities ‘justly’ should mean on the ground. Different philosophical theories argue for different distributive principles for the allocation of health care resources. For example, utilitarian writers tend to focus on the greatest good for the greatest number, and egalitarian theories emphasise need and equality of opportunity (Daniels, 1985). Libertarian theories focus on individual choice (liberty or autonomy) and emphasise the process by which resource allocation decisions are made (Englehardt, 1996).

1.2.4 Political science approaches

Political science approaches to priority-setting focus on the political forces that interact to produce negotiated policy. According to Klein, priority setting is a political process that involves pluralistic bargaining between different lobbies, modified by shifting political judgements made in the light of changing pressures (Klein, 1993). According to this approach, achieving success in priority setting would focus profoundly on process and structure of decision-making. The process should promote reasoned, informed, and open argument, draw on a variety of perspectives, and involve a plurality of interests. Priority setting is a form of

policy making; policies in health care ultimately affect front-line practices and priority-setting decisions (Berry, Hubay, Soibelman, & Martin, 2007). Goddard et al., (2006) argued that the context of policy making, and potential influences of normative theories of public policy making, are relevant to understanding successful priority setting. They argue that there can be value in exploring and analysing priority setting using models of political economy to understand what constitutes rational behaviour when decision makers operate within political and institutional constraints.

1.2.5 Legal approaches

In some countries, the law sets a minimum standard for the ethical practise of medicine. The law holds that a physician's duty is to their patients, and physicians are expected to meet a reasonable standard of care (Sibbald, et al., 2009). Similarly, hospitals or regions must act in the best interest of the community being served. For example, in Norway, the Norwegian Patients' Rights Act guarantees the population equal access to necessary specialised care (Kapiriri, Norheim, & Martin, 2007). Additionally, international human rights documents have established the right to the highest attainable standards of mental and physical health (The Commission on Human Rights, 2002). There remain, however, questions as to what this entails in practice-what it requires in terms of the allocation of health care resources, particularly in resource constrained settings. Successful priority setting, according to a legal approach, would involve meeting minimum requirements as set by relevant legislation. However, using solely a legal approach would not be helpful in achieving successful priority setting, since it would only provide a minimum standard (Sibbald, et al., 2009).

1.3 Empirical experience with priority setting in developed countries

Early priority-setting efforts focused on the idea that it is possible to devise a rational priority-setting system to produce legitimate decisions, and assumed that using the 'right' system would yield the 'right' results (Holm, 1998). Parallel to this paradigm since the late 1980s, many governments have instituted transparent and explicit discussions about priorities for health care (Ham, 1997). One can draw on the experiences of three developed countries (Norway, the Netherlands, and Sweden) that have explicitly addressed the question of health care priorities.

Norway was the first country to attempt the principlist/values-based approach (Norheim, 2000). In the context of increased demand for health care resources, and the question of how to prioritise their use, the Norwegian government convened the Lønning Commission in 1985-the first body to set forth principles for

prioritisation and discuss their implementation (Norheim, 2003; Calltorp, 1999). The commission was composed of health care experts as well as members of the public, but no politicians were included. The commission decided to use severity of disease as its guiding principle for prioritisation. Ten years later, Norway convened a second commission. This second commission acknowledged the need to take into account potential effect and cost-effectiveness as secondary principles to be balanced with severity and introduced four priority groups: core or fundamental services, supplementary services, low-priority services, and services with no priority (Sabik & Lie, 2008).

In 1990, the Netherlands established the Committee on Choices in Health Care (Dunning Committee), to discuss methods and principles for setting priorities. The Dunning Committee outlined a framework intended to assist policy makers to decide which services should be included in the basic health care package. Underpinning the Dutch approach was a belief that explicit priority setting, such as the exclusion of certain services, was necessary if access to essential care was to be guaranteed to all (Ham, 1997). The committee established four principles for assessing competing claims on resources: necessity (is intervention necessary to allow individuals to function in society?), effectiveness, efficiency, and individual responsibility (could it be considered a matter of individual responsibility?). These four criteria were to be used to determine which non-essential services should be excluded from the national health services package. The individual responsibility principle was meant to exclude services that could be easily paid for by the individuals themselves, such as routine adult dental care. There was also a strong focus on solidarity and an emphasis on approaching macro-level decisions from the community's point of view (Sabik & Lie, 2008).

In 1992, Sweden convened the Parliamentary Priorities Commission, which was comprised of seven members of Parliament (representing the main political parties) and nine expert advisors from areas such as clinical medicine, health economics, health services management, law, and ethics (Calltorp, 1999). A discussion document was published in 1993, and a final report was issued in 1995 taking into account comments made on the discussion document. The commission proposed an ethical template as a basis of priority setting. Sweden placed human dignity as the highest value (which emphasises that all people have the same rights irrespective of their personal characteristics), followed by need (which emphasises that resources should be devoted to those in greatest need) and solidarity (which emphasises that the most vulnerable groups should be given special consideration), and then efficiency. Through this, the commission defined five priority groups. This approach offered a way of thinking about priority setting that could assist in decision-making, but many of the substantive issues were

left to the health authorities. It did not provide concrete recommendations for change (Ham & Coulter, 2000), nor did it include a role for the public (Sabik & Lie, 2008). In 2001, Sweden created a National Centre for Priority Setting in Health Care, which acts as a countrywide resource with both national and international interfaces. It provides education, support, knowledge exchange, and consultation services for the country's county councils (Waldau, 2010).

1.4 Priority-setting experience in Africa

International experience with priority setting at the macro level in low and middle-income countries is an area of growing research, and there has been a recent increase in empirical studies describing priority setting in this context. In the following section, the study draws on experiences from Uganda and Zambia.

In 1999, the Ugandan government developed the National Essential Health Care Package (UNEHP). The Health Sector Strategic Plan (HSSP) outlines the Minimum Health Care Package and how it will be delivered at the different levels of each health care system (Kapiriri, Norheim & Martin, 2007). The minimum package comprises of interventions that address the major causes of the burden of disease and is the key determinant of how public funds and other essential inputs are allocated (Ibid.). Districts and hospitals are required to set priorities within this framework in collaboration with the ministry officials, as well as national and international development partners. The key priority areas in the package are: communicable disease control; integrated management of childhood illness; sexual and reproductive health rights; other public health interventions; and essential clinical care, including non-communicable diseases (Government of Uganda, 1999). Burden of disease and cost-effectiveness were the key values considered in the development of the UNEHP (Kapiriri, Norheim & Martin, 2007).

Since 1992, Zambia, like other developing countries, has embarked on a health sector reform programme (Ministry of Health, 1992), in which decentralised management of health services and financing reforms were introduced as a way to ensure equity and accountability. Guided by the three pillars: accountability, leadership, and partnership at all levels, the government introduced a bottom-up approach for the priority setting of primary health care service provision (Ngulube, Mdhluli & Gondwe, 2005). To facilitate priority setting, the Ministry of Health (in 1992) adopted an essential health care package of cost-effective interventions at the frontline level, i.e., at the health centres, health posts and local communities. Using these guidelines, priority setting with plans and budgets are made for each district in Zambia annually, guided by the Ministry of Health's national health strategic plan (Ngulube, Mdhluli & Gondwe, 2005).

1.5 Unsolved priority-setting challenges

As pointed out earlier (section 1.3), much of the early debate on priority setting was focused on government as an allocator of scarce health care resources, involving the selection of health services, programmes or actions that would be provided first, with the purpose of improving health and the distribution of health resources. Ideally, priority setting was perceived as a technical process, requiring the quantitative analysis of: the burden of diseases, premature mortality and disability losses, and the analysis of the cost-effectiveness of alternative interventions to control the diseases that cause the largest health losses; plus the selection of a package or list of interventions that can be delivered within the available budget through the current health system (Ham, 1996; Bobadilla, 1996). In reality, priority setting is complex and difficult because the process is frequently influenced by political, institutional and managerial factors that are not considered by priority setting tools, such as burden of disease, cost-effectiveness or Disability Adjusted Life Years (DALYS).

At its core, priority setting involves choices among the full range of competing values. However, values often conflict and people disagree about which values to include and how to balance them (Klein, 1993). Daniels (1994) identified four key problems that face decision makers in the context of scarce resources:

1. The fairness/best outcome problem: should one give all people a fair chance at some benefit, or should one favour producing the best outcome with limited resources?
2. The priorities problem: how much priority should one give to the most vulnerable or worst-off individuals or groups?
3. The aggregation problem: when should one allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people?
4. The democracy problem: when must we rely on a fair democratic process as the only way to determine what constitutes a fair priority-setting outcome?

It is evident that priority-setting decisions are not cut and dried; they often go beyond weighing options of varying efficiency, effectiveness and other factors that may be demonstrated through research. These decisions sometimes involve trade-offs for which there is no research base, and may lead to different outcomes for different populations. Discipline-specific approaches, which focus on a single value, are inadequate to resolve disagreements about how to decide among competing values in setting priorities.

1.6 Combining principles and fair decision-making processes

In the absence of agreement about which values should ground priority-setting decisions, there has been a shift in focus away from principles, towards the process of priority setting (Daniels & Sabin, 2002; Klein & Williams, 2000; Martin & Singer, 2000; Daniels & Sabin, 1998, 1997; Goold, 1996; Klein, 1993). Klein and Williams (2000), for example, stressed the importance of getting the institutional setting for the debate right, suggesting that the right process will produce socially acceptable answers, and this is the best that can be hoped for. Daniels & Sabin (2002, 1998, and 1997) have argued that since it is not possible to agree on the correct approach to priority setting, or what constitutes the best priority-setting outcomes, an appropriate approach to priority setting should focus on legitimacy and fairness.

Legitimacy refers to the moral authority of institutional actors to make priority-setting decisions. The legitimacy problem concerns not only who can set priorities, but also under what conditions the resolution becomes legitimate (Daniels, 2008). Legitimate decision-makers may act fairly or unfairly (Daniels & Sabin, 2002; Rawls, 1999), but legitimacy can be achieved through a fair process (Daniels & Sabin, 2002; Singer, Martin, Giacomini et al., 2000; Rawls, 1999). *Fairness* refers to the moral acceptability of the priority-setting process. That is, fair priority-setting decisions are made through a process that is, and is perceived to be, morally acceptable, irrespective of outcome (Martin, 2007).

1.7 Accountability for Reasonableness: a framework for improving fairness and legitimacy

Recognising both the difficulty that democratic societies have in achieving consensus on distributive principles for health care, and the need for legitimacy of allocation decisions, Norman Daniels and James Sabin (2002) proposed a framework for institutional decision-making, which they call “Accountability for Reasonableness.” Central to the theory is the acceptance that people may justifiably disagree on what reasons are relevant to consider when priorities are set. In order to narrow the scope of controversy, Accountability for Reasonableness relies on “fair deliberative procedures that yield a range of acceptable answers” and consists of four conditions: relevance, publicity, appeals/revision, and enforcement (see Box 1).

Box 1: Four conditions of the A4R (modified from Daniels & Sabin, 2002; Daniels, 2008)

1. Relevance	The rationales for priority-setting decisions must 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.
2. Publicity	Priority-setting decisions, and the grounds for making them, must be publicly accessible through various forms of active communication outreach. Transparency should open decisions and their rationales to scrutiny by all those affected by them, not just the members of the decision-making group.
3. Appeals & revision	There must be a mechanism for challenge, including the processes for revising decisions and policies in response to new evidence, individual considerations, and as lessons are learnt from experience.
4. Enforcement/leadership & public regulation	Local systems and leaders must ensure that the above three conditions are met.

Daniels and Sabin recognise that having a fair process does not eliminate all controversy about priority-setting decisions. It does, however, narrow the scope of controversy and provides the grounds on which disputes can be adjudicated.

The Accountability for Reasonableness framework specifies a number of requirements for the organisational structures of decision-making health care institutions, and provides limited guidance on the ways in which the conditions of Accountability for Reasonableness should be implemented so as to achieve fair and legitimate priority setting. Other scholars have recently questioned whether the Accountability for Reasonableness framework’s four conditions are adequate to set the necessary ground rules for a procedure that would ensure that priority-setting decisions are reasonable, fair and legitimate (Rid, 2009; Lauridsen & Lippert-Rasmussen, 2009; Friedman, 2008; Hasman & Holm, 2005). The framework recognises that different tools, such as cost-effectiveness analyses and disease burden measurements, are useful in the process but does not prescribe when or how to use them. According to the Accountability for Reasonableness framework, acting fairly towards all members of society is rational, not because it is the most efficient and effective means of achieving health outcomes, but because fairness in decision-making is itself a goal that it is rational to pursue in priority setting (Daniels, 2008). However, it is clear that decision-makers consider both process and outcome indicators as important measures of successful priority setting (Sibbald, Singer, Upshur & Martin, 2009; Kapiriri & Martin, 2009).

The Accountability for Reasonableness framework is only meant to set the ground rules of the actual process of identifying priorities, but is not a formula for identifying particular priorities (Gruskin & Daniels, 2008). Nevertheless, the

Accountability for Reasonableness framework could be used as a tool to evaluate present priority-setting practices, determine where they fall short, and design and implement improvement strategies. Furthermore, Accountability for Reasonableness is not a complex management or technical framework to be practised only by experts, and could be a relevant tool for ensuring that priority-setting decisions are made transparently so that stakeholders, including the public, can discuss and influence the process. Accountability for Reasonableness has, in its simplicity, potentially much to offer in the current efforts to revitalise Primary Health Care (PHC) based on the values expressed in the Alma Ata declaration (WHO, 2008; 1978). The PHC concept rests on the principles of equity and community participation, with a focus on prevention, intersectoral collaboration, and appropriate technology. PHC does not see specific outcomes in isolation but, like Accountability for Reasonableness, tries to harness processes that can lead to improvements in a range of them.

Based on experiences of power differences that influence participatory priority-setting, Gibson, Martin and Singer (2005) propose a fifth condition of empowerment; the condition states that “...there should be efforts to minimise power differences in the decision-making context and to optimise effective opportunities for participation in priority setting” (Gibson, Martin & Singer, 2005). However, as will be argued later in this thesis, while the empowerment aspect has not been added to the Accountability for Reasonableness framework, there are reasons to recognise and deal with unequal power asymmetries among the various actors in various priority-setting contexts.

1.7.1 Accountability for Reasonableness framework in developed countries

Accountability for Reasonableness was originally developed by examining the decision-making process in the decentralised and private U.S. medical insurance context. The field studies that informed the Accountability for Reasonableness framework were done in settings with individual patients who were part of a larger population for which there was a total health care budget: not-for-profit Health Maintenance Organisations (HMOs); Medicaid programmes; and the U.S. Department of Veterans Affairs (VA) (Sabin, 2007). In the ten years since Daniels and Sabin did the major fieldwork, however, the U.S. criticism against managed care has led to fewer budgeted care systems (Ibid.). As a result, the framework has had much more application outside of the U.S.-in countries like Canada, England, New Zealand, Norway, and Sweden, where the principle of solidarity is stronger, the entire population is insured, and the health system has an overall budget (see for example, Lindstrom & Waldau, 2008; Walton, Martin, Peter,

Pingle & Singer, 2007; Jansson, 2007; Martin, Reeleder, Keresztes & Singer, 2005; Rawlins, 2005; Gibson, Martin & Singer, 2004; Martin and Singer, 2004; Martin, Giacomini & Singer, 2002).

1.7.2 Accountability for Reasonableness in low and middle-income countries

A few empirical studies have used Accountability for Reasonableness as a conceptual framework to evaluate priority-setting and decision-making processes in such settings, and they have shown that Accountability for Reasonableness can provide useful guidance (see for example, Kapiriri & Martin, 2007; Kapiriri, Norheim & Martin, 2007; Kapiriri & Martin, 2006; WHO, 2006). In 2006, WHO used Accountability for Reasonableness in a case study evaluating the decision-making process used in Tanzania to develop a plan for scaling up ARTs. Decision-makers considered the approach to be a plausible way of addressing important resource allocation problems (WHO, 2006).

In 2003, Mexico embarked on a structural reform to improve health system performance, by establishing the System of Social Protection in Health (SSPH), which introduced new financial rules and incentives. The main innovation of the reform has been the Seguro Popular (Popular Health Insurance), the insurance-based component of the SSPH, aimed at funding health care for all those families, most of them poor, who had been previously excluded from social health insurance (Frenk, González-Pier, Gómez-Dantés, et al., 2006).

In addition to cost-effectiveness, decision-makers must (by law) take into account the ethical and social acceptability of their decisions. Thus, decisions to include new interventions through a more democratic and participatory process have required an exercise in priority setting that is not only evidence-based but also equitable, transparent, and contestable (González-Pier, et al., 2006). A process was constructed that involves considering inputs from clinical, economic, ethical, and social working groups, with full disclosure of the rationale behind decisions. One unsolved difficulty was the problem posed by including stakeholders with vested interests who act as lobbyists and who are not willing to look for mutually justifiable decisions (Daniels, 2008). In a political culture with little history of transparency, the selection of stakeholders to participate poses particular difficulties (Ibid.).

In 2006, researchers from many institutions (the Primary Health Care Institute, the Institute of Development Studies, the University of Dar es Salaam, and the National Institute for Medical Research in Tanzania, in collaboration with research institutions from Europe) asked whether Accountability for Reasonableness, with its emphasis on openness, democratic process, and deliberation,

could be relevant in Tanzania with its different cultural traditions and limited resources. These researchers teamed with decision-makers in Mbarali District and launched a five-year project: Response to Accountable Priority Setting for Trust in Health Systems (REACT). The REACT project aimed at improving priority setting in health care institutions through implementing the Accountability for Reasonableness framework in Mbarali District in Tanzania, Malindi District in Kenya, and Kapiri Mposhi District in Zambia (Byskov et al., 2009).

1.8 The research problem which motivated this thesis

To my knowledge, in 2008, when I began my PhD studies, there had been little research on how decision-making bodies in Tanzania deliberate upon and make actual priority-setting decisions in the health sector. In other words, little attention had been paid to examining the institutional conditions within which priority-setting decisions are made, i.e., what are the formal and informal rules governing priority-setting decisions at the district level in the health sector in Tanzania? Which stakeholders have been included or excluded in the priority setting process at the district level in the context of decentralisation? What interests are they representing? What is the nature of relationship between stakeholders and policy makers? What are the power asymmetries between all actors? Are these asymmetries reduced or exacerbated by the institutional practices and the rules of the game? What strategies can be used to reduce power asymmetries and improve priority-setting practices?

Equally important, while the Accountability for Reasonableness framework has surfaced as a guide to achieving a fair, ethical, and legitimate priority-setting process, understanding of the processes and mechanisms underlying its impact on trust, quality, equity and fairness has largely been theoretical. As a result, the ability to draw scientifically-sound lessons from the framework has been limited. Could this approach to priority setting apply in low-income countries with the most dramatic resource allocation problems, relatively weak organisations and democratic institutions? What are the contextual factors that could facilitate and constrain the implementation of the framework? Given the growing popularity of the Accountability for Reasonableness framework to priority setting, it is imperative that one understands what works, what does not work and why, and under what circumstances. One must understand not just the outcome, but also the mechanisms that trigger changes as well as the contextual factors that facilitate or constrain the implementation of the framework. This thesis attempts to shed light upon all of these important issues.

2. Aims

2.1 General aim

The main aim of this thesis is to analyse the existing health care organisation and management systems, and to explore the potential and challenges of implementing the Accountability for Reasonableness framework to improve priority-setting in the context of resource-poor settings, weak organisations and fragile democratic institutions.

2. 2 Specific objectives

The specific objectives are:

- (i) To examine the socio-political contexts which shape the priority-setting process in Mbarali district, Tanzania (**Paper I**).
- (ii) To assess the actual priority-setting process in Mbarali District, and evaluate it against the Accountability for Reasonableness framework (**Paper II**).
- (iii) To explore the acceptability and feasibility of the Accountability for Reasonableness framework from the perspectives of district health managers, local government officials, the health workforce, and members of the user boards and committees (**Paper III**).
- (iv) To assess individual, organisational, and wider contextual factors influencing the adoption and implementation of the Accountability for Reasonableness approach to priority-setting in Mbarali district, Tanzania (**Paper IV**).

2.3 Broad research questions

Six broad research questions arose from the research objectives, and were as follows:

- What are the socio-political factors that shape the decentralised health care priority-setting process?
- What is the actual priority-setting process in Mbarali district through which priorities are identified, negotiated, and included in the district plans?
- What are the power relations between stakeholders and decision makers in Mbarali district?
- What are the perceptions of stakeholders in Mbarali District regarding the relevance and feasibility of the Accountability for Reasonableness framework in improving the district level priority-setting process?

- What are the contextual factors that influence the adoption and implementation of the Accountability for Reasonableness intervention?
- What lessons, if any, can be learned from the experiences of Mbarali District to create and implement an appropriate, fair, and transparent priority-setting framework?

3. Context, study design and methods

3.1 The study setting

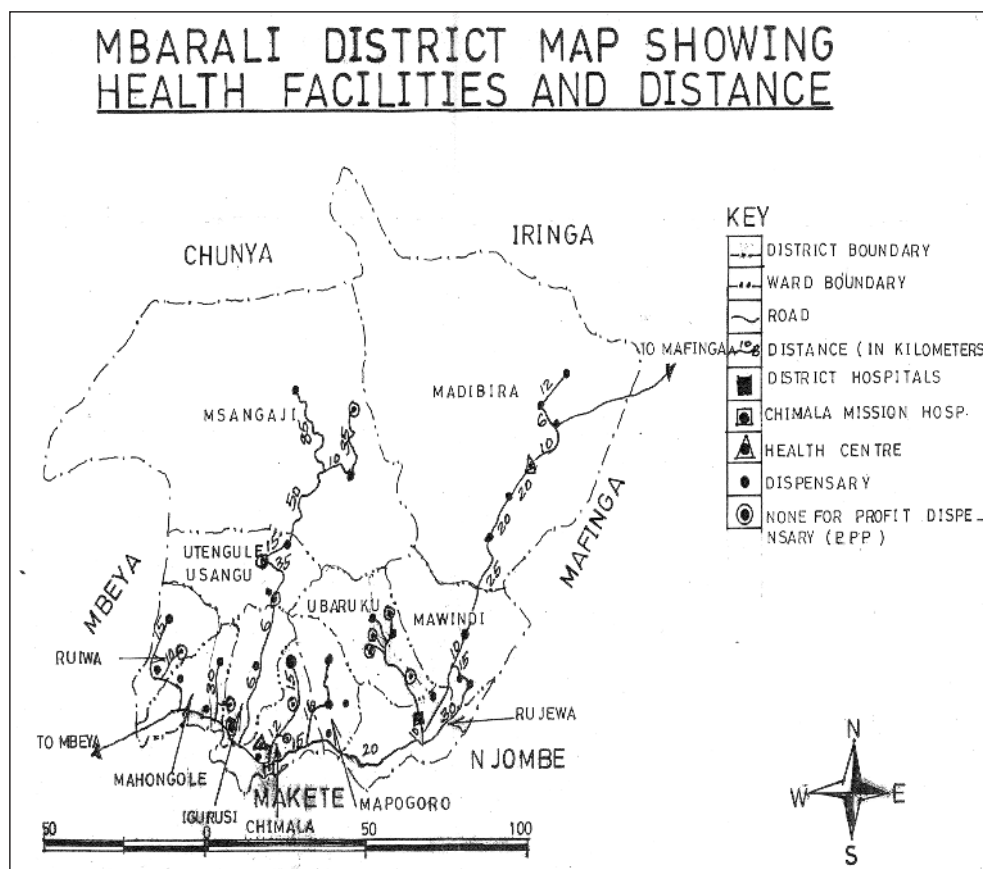
The study was conducted in Mbarali district in the Mbeya region, Tanzania. Mbarali district was selected by the REACT project because it was a ‘typical’ rural district in Tanzania. Mbarali district has two divisions with 11 wards, 98 registered villages, 652 hamlets and 55,374 households. Based on the 2002 National Population Census, the district had 234,101 people, of which 114,738 were males and 119,363 were females, with an annual growth rate of 2.8 per cent (see table 2).

Table 2: Important demographic and health indicators

	Indicators	National	Mbarali district
1	Total population	33,461,849	234,101
2	Growth rate	2.9%	2.8%
3	Fertility rates	4.6	4
4	Children <1 year	4.0%	4%
5	Children <5 years	21%	20%
6	Women: 15 – 49	18%	20%
7	Maternal mortality	578/100,000	247/100,000
8	Under-five mortality	112/1,000	104/1,000

Source: Tanzania Census report, 2002 & Demographic and Health Survey, 2004

The health care system in Mbarali district is based around government provision of services, although there is also a growing private sector and non-governmental organisation (NGO) providers. Public health care services are organised into a variety of primary-level services, feeding into district level hospital. There are 37 dispensaries, 28 of which belong to the government and nine belong to private/parastatal owners. There is one health centre and two hospitals, one of which belongs to the government and the other to a religious institution (See Map 1).



Map 1: Mbarali District (Source: Mbarali Comprehensive Council Health Plan, 2010/2011)

3.2 The context of priority setting in Tanzania

The United Republic of Tanzania is a union between Tanganyika and Zanzibar, which was formed in April 1964. It is the largest country in East Africa, occupying an area of about 945,087 sq. km, and it has a common border with eight neighbouring countries (see Map 2). Tanzania is classified by the UN as one of the least developed countries in the world. The average national income (GNI) per person was US\$350 in 2006. About 25 per cent of Tanzanians were living below the poverty line in 2007 (Household and Budget Survey, 2007).

Mainland Tanzania is divided into 21 administrative regions and 113 districts with 133 Councils. In Tanzania, most people live in hamlets or villages. For administrative purposes, these are grouped together as 'wards', each with a population of 8-12,000 people. In urban areas these communities can be continuous, with the boundary being just a line on a map. Rural communities are more spread

out and, in places, even the different villages that make up a ward can be many hours walk from each other.

Primary health care (PHC) services form the base of the pyramidal structure of health care services with a number of dispensaries, health centres, and one district hospital, at the district level. People’s health care needs in a ward are usually served by a village dispensary. Four or five wards, together, will form a division. This population of 40-60,000 people will be served by a health centre. Health centres have in-patient facilities, larger outpatient departments, very basic laboratory facilities and more senior medical staff. Four or five divisions form a district with a district hospital, whilst four or five districts make up a region. The first time one would usually meet a graduate doctor in the Tanzanian system is in a district hospital. Even at this level, there is often only one doctor who may double up as the District Medical Officer (with a variety of administrative and planning functions). Primary Health Care was adopted as a guiding framework in the late 1970s, and is still a point of reference in the health sector as also seen in the names of organisations and committees.



Map 2: Tanzania (Source: the CIA World Fact book 2011)

3.3 Local government and health sector reforms in Tanzania

The health sector is guided by national policy. The National Strategy for Growth and Reduction of Poverty (NSGRP), known in Kiswahili as *Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania* (MKUKUTA) provides the overall direction for the achievement of the Millennium Development Goals (MDGs). The 1982 Local Government Authorities Act (revised in 2000), provided by article 146 (1) of the Constitution of the United Republic of Tanzania, was created to transfer authority and resources to people at the lower level of government to give them wider opportunities to participate in the planning, implementation and evaluation of development projects within their respective areas (URT, 2005). Implementation of these reforms is guided by the Local Government Reform Programme (LGRP), which started in 1996 to speed up, among other things, political, financial, and administrative accountability at district level. The programme also sought to improve transparency in local government transactions, and bring public services to the grassroots level (URT, 1998).

Responding to these general reforms, the Ministry of Health (MoH), supported by major development partners, adopted health sector reforms (HSRs) in the early 1990s. Health reforms are defined as institutionalised changes in the way health services (curative, preventive, promotive and rehabilitative) are produced and financed. These reforms represent significant organisational, managerial, and financial changes to health care planning and service delivery. The most common institutional change under HSRs has been decentralisation, which involves the transfer of resources, decision-making, planning and management of health services from the central Ministry of Health to regional and local authorities. This reallocation of authority and resources is a major political issue affecting the internal power relationships within the public sector, and increasing the access of social groups to the decision-making process. Donor communities in particular have often insisted on decentralisation of health care systems as a mechanism to encourage quality and sustainability of health services, as well as the availability of timely resources at local levels by reducing bureaucracy.

As part of the reform programmes, the Ministry of Health (currently the Ministry of Health and Social Welfare MoHSW) developed guidelines for district level planning and budgeting. The planning guidelines called for partnership in the process of setting priorities. The partners who were identified as relevant were the Council Health Management Team (CHMT)¹, the local government authority,

¹ The CHMT consists of: the District Medical Officer (chairperson), District Nursing Officer, District Laboratory Technician, District Health Officer, District Pharmacist, District Dental Officer and District Health Secretary (secretary to the team). Others co-opted members of the CHMT may include: Reproductive and Child Health Coordinator, Tuberculosis and Leprosy Coordinator, Malaria Focal Person, Aids Coordinator, and Cold Chain Operator who are invited in the CHMT meetings as the need arise.

health facility managers, health facility committees and boards, NGOs, private service providers, and the communities. Partnership was also to be promoted and strengthened with non-health-sector partners or actors who might have had a role to play in health issues. By bringing the decision-making processes closer to the people at the grassroots level, decentralised planning and priority setting was thought to facilitate sensitivity to local priorities, provide space for public involvement, and improve the flexibility, efficiency and accountability of resource use (Ministry of Health, 1998; 1996). It was assumed that local governments were better positioned to respond to the people's needs, and that district health priorities could reflect real community priorities.

In order to ensure that the district health plans are in line with the national strategies in health, in 2000 the MoH developed the National Package of Essential Health Interventions as a way of ensuring that the highest priority services are fully supported. Burden of disease, efficiency, effectiveness, and equity were the main principles guiding the selection of the priority areas. Based on these principles, six broad priority areas were identified: reproductive and child health, communicable disease control, non-communicable disease control, treatment of other common disease of local priorities within the district, community health promotion and disease prevention, and management support (MoH, 2000). Table 3 illustrates six broad priority areas included in the National Package of Essential Health Interventions.

Table 3: Priority areas contained in the National Package of Essential Health Interventions

	Priority Area	Disease control and other activities to be implemented
1	Reproductive and child health	- Antenatal care, obstetric care, post natal care, family planning, integrated management of childhood illness, immunisation, post abortion care, nutritional deficiencies
2	Communicable diseases control	- Malaria, TB/leprosy, HIV/AIDS, epidemics (cholera, meningitis, yellow fever, measles, polio)
3	Non-communicable disease control	- Acute, chronic respiratory, cardiovascular disease, neoplasm/cancer, injuries/trauma, mental health, drug abuse, anaemia and nutritional deficiencies
4	Treatment of other common disease of local priorities within the district	- Eye disease, oral condition, skin disease, schistosomiasis, plague, relapsing fever
5	Community health promotion	- Health communication for behaviour change; water, hygiene & sanitation; school health promotion, food control & hygiene, occupational health & safety, enforcement of by-laws and regulations related to health.
6	Strengthen organisational structures and institutional capacities at all levels	- Council Health Service Board and Health Facility Governing Committees functions, utilities management, health management information system, capacity development for human resources, public and private collaboration and supportive supervision and inspection.

The National Package of Essential Health Interventions is meant to facilitate a co-ordinated and integrated approach to planning in the district. In addition, at least theoretically, the framework means a move towards a tighter planning approach, ensuring scientific and epidemiological evidence are translated into action at the community level.

Based on this national framework, all districts produce an annual Comprehensive Council Health Plan (CCHP), which incorporates all activities of the District Health Services, and all sources of funding at the council level (government funds, locally-generated funds, local donor funds, etc.). It is, however, imperative to note that the national framework does not completely deprive the districts, health facilities, and the communities of the authority to set priorities, but it provides them with a framework within which to set their priorities.

The CCHP is produced by the CHMT with input, at least theoretically, from the health facilities, non-state actors and other co-opted members. It is approved by the Council Health Services Board (CHSB), which consists of community representatives, officers from other departments, and representatives from the private sector. The final plan is approved at the Full Council Meeting. The Regional Secretariat (Regional Health Management Team) approves the CCHP and forwards it to national level. The PMO-RALG, together with the MOHSW, assesses the CCHPs and must give its final approval before funds can be disbursed to the LGAs.

Further, in the 2009-2010 planning cycle, the Ministry of Health and Social Welfare further devolved decision-making to the facility level (e.g. health centres and dispensaries) by requiring that planning and budgeting should be done at each individual facility with the active involvement of the community. In the future, further decentralisation will give more responsibilities to the health facilities to plan and manage health activities, in collaboration with communities and village governments.

3.4 District health care financing systems in Tanzania

The per capita expenditure on health in Tanzania was US\$ 9 in 2007. The health sector receives about 11 percent of total government spending. However, the share of health sector budget that goes to the district authorities is usually less than 40 percent (URT, 2008). This implies that financial decentralisation as a measure to ensure sufficient budget for district authorities and implementation of decentralisation by devolution is yet to be adequately implemented in the health sector.

The funding of health services at district level in Tanzania is fragmented and unpredictable (see Table 4). There are at least five different sources. Health block grant and health basket funding from central government which are the major source of health financing at district level, followed by cost sharing, Council's own funds, and other sources (URT, 2008). **The health block grant consists nearly exclusively of personal emoluments, leaving small amounts for other charges (OC).** The Health Basket Fund, Council funds and locally generated funds (Community Health Fund (CHF), National Health Insurance Fund (NHIF), cost sharing) are the major sources of funding for other charges.

Other sources of funds are vertical programme or NGO allocations support for the running of health services, but CHMTs do not have a full insight into funds that can be expected from all different sources, and may not utilise available options for resource mobilisation, e.g. from local government authorities (Koot & Kilima, 2009).

Payment for health services (cost sharing) has existed for about 15 years. District councils may determine the level of the fees, and village governments may grant waivers for the poor, but should reimburse health facilities for services rendered. In addition, many waivers of payment are determined nationally, e.g. treatment for children under five, vaccinations, ANC, deliveries, TB treatment, services for the elderly. The Community Health Fund was created to offer patients free access to health care. The enrolment is less than five percent of the district population, and members often do not subscribe for longer than a year, because they do not experience any real benefit from it, mostly because medicines are often not available (Koot & Kilima, 2009). A recent study in Tanzania has shown that

success or failure of the CHF is largely dependent on commitment from district and health facility managers for proper management of the scheme (Kamuzora & Gilson, 2007).

Table 4: Sources of funds for Comprehensive Council Health Plans

Financial Year	Source of Fund	Amount (TShs)	%
2009/2010	Block grant	1,734,399,380	61.1
	Basket Fund	481,997,000	16.9
	Received in kind	199,345,805	7.0
	Vertical Programmes	25,168,416	0.8
	Health Sector Development Grant	243,000,000	8.5
	Cost Sharing	51,274,052	1.8
	Walter Reed (NGO)	56,000,000	1.9
	National Aids Control Programme	50,000,000	1.7
	Tanzania Food Drug Association	0	0.0
	Community Health Fund	1,190,000	0.4
	National Health Insurance Fund	27,024,028	0.9
	Council Own Sources	20,000,000	0.7
	Total	2,838,124,629	100
2010/2011	Block grant	1, 472,940,640	48.3
	Basket Fund	495,263,100	16.2
	Received in kind	246,000,000	8.0
	Vertical Programmes	371,268,161	12.1
	Health Sector Development Grant	223,647,000	7.3
	Cost Sharing	60,000,000	1.9
	Walter Reed (NGO)	63,000,000	2.0
	National Aids Control Programme	50,000,000	1.6
	Tanzania Food Drug Association	8,000,000	0.2
	Community Health Fund	2,500,000	0.1
	National Health Insurance Fund	37,000,000	1.2
	Council Own Sources	18,000,000	0.5
	Total	3,047,618,901	100

Source: Mbarali Comprehensive Council Health Plan-2009/2010 & 2010/2011

3.5 The REACT project in Tanzania

REACT is a five-year European Union-funded project aimed at testing the application and effects of the Accountability for Reasonableness framework in Mbarali District, Tanzania. The REACT research process set out to implement an intervention, the Accountability for Reasonableness, and is a scientific assessment of the intervention process as well as an evaluation of the applicability of its conditions to priority setting and its subsequent effects on health systems (Byskov et al., 2009). A preliminary phase of the implementation of the Accountability for Reasonableness framework in the district began in 2006, involving gathering baseline data, consultation and planning. The full application of Accountability for Reasonableness began in 2008, and the project ended in December 2010. However, the actual implementation of the Accountability for Reasonableness intervention fell short of the initial plan. A delay in funding disbursements delayed part of the implementation process. With time, and as circumstances dictated, the plan to monitor and evaluate service domains such as malaria, HIV/AIDS, emergency obstetric care, and generalised care were dropped, and the focus remained merely on monitoring the priority-setting process and management changes within the CHMT and at the district hospital.

3.6 The causal theories in the Accountability for Reasonableness intervention

The implementation of Accountability for Reasonableness conditions is expected to lead to increased fairness in priority setting. Stakeholder engagement and publicity is supposed to offer staff and members of the community better access to information on decisions that pertain to them, and better opportunities to express their consent or opposition; this should lead to more responsive and fair management. The assumed *mechanism* that connects fair priority setting (the output) to increased organisational trust, quality, and equity (the outcome) is increased *perceived* fairness (see Figure 1). Engaging stakeholders should also lead to improved public trust and confidence in the healthcare system. In addition, transparency and appeals may lead to more widely shared and supported decisions which, in turn, should lead to higher ownership. The end result should be more attention paid to ensuring correct implementation of decisions through adequate budget allocations, working conditions, training, etc.

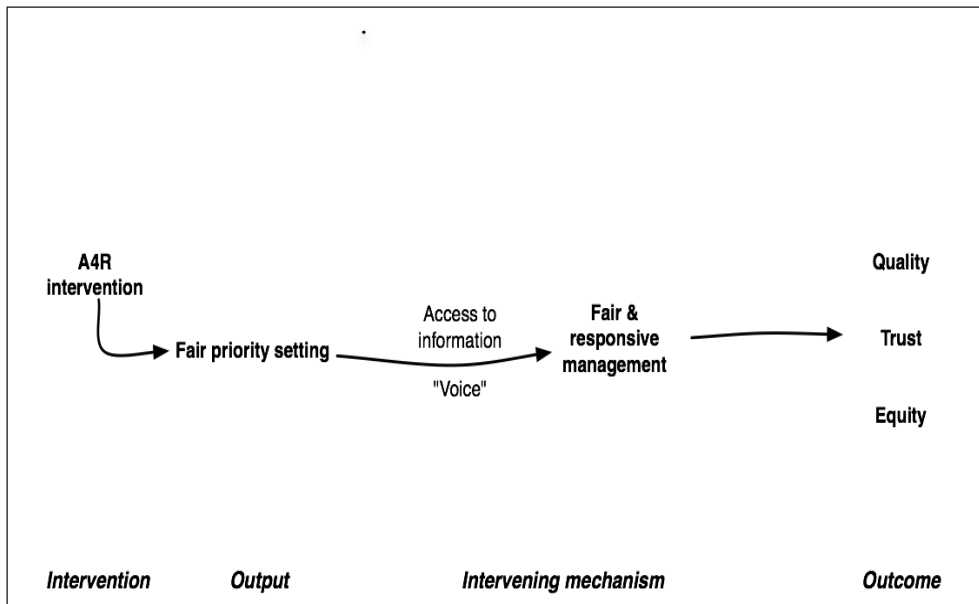


Figure 1: Linking intervention, output, mechanisms and outcome within REACT (adopted from Marchal, 2007)

3.7 The overall research process and strategy

The project applied Accountability for Reasonableness through participatory and interdisciplinary action research design. *Action research* is research conducted in partnership with members of the community with the specific purpose of bringing about structural change. Action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously (Robson, 2002). The application of Accountability for Reasonableness includes: describing existing priority-setting practices in the district, evaluating the description using Accountability for Reasonableness, and implementing improvement strategies in a continuous process to address gaps in Accountability for Reasonableness conditions (Martin, et al., 2003).

Before engaging in the change process, it was indispensable for the researchers to understand the organisation and its priority-setting practices. This involved capturing current priority-setting contexts, the people involved, existing external influences, the tools used, the values, evidence that guides the decisions, and the overall priority-setting process. The researchers generated the knowledge necessary to transform priority-setting practices and incorporate the resulting Accountability for Reasonableness conditions into practice. The second step involved identifying the good practices and opportunities for improvement in current practices and the facilitation of Accountability for Reasonableness in

the priority-setting process through enhancing the knowledge and capacity of context-specific leaders to implement fair processes.

To meet its goals, the REACT intervention employed three overlapping strategies: (i) active collaboration with district health decision-makers, (ii) sensitisation workshops with stakeholders, and (iii) the presence of a project focal person in the district to facilitate the implementation process.

First, the process of change in the district was carried out by the CHMT with support from an Action Research Team (ART). The role of the CHMT was to introduce the application of Accountability for Reasonableness conditions during the annual planning and priority setting at the district level, and in day-to-day decision-making processes that concern prioritisation within tight resource limits. The ART comprised four members of the CHMT and two researchers from research and academic institutions. The two researchers were from the Primary Health Care Institute (PHCI) in Iringa and the Institute of Development Studies, University of Dar es Salaam. The ART, with the support from the rest of the research team members, carried out action research. The relevant results from the baseline and monitoring were communicated to the CHMT through the ART. The ART team conducted meetings once every two months to discuss and review the implementation of Accountability for Reasonableness in the district. Additionally, the researchers held meetings with the CHMT every six months to discuss and review the application of Accountability for Reasonableness conditions in the district. Furthermore, all collaborating research institutions held annual workshops to review and discuss the experiences of implementing the intervention in the study districts.

Second, throughout the project period, there was close collaboration between ART members and other actors to ensure effective implementation of the Accountability for Reasonableness approach. To get the project underway, ART members organised sensitisation workshops at the district level to generate enthusiasm not only for the Accountability for Reasonableness framework but also for the concept of decentralised health care planning and priority setting. Stakeholders who have been sensitised about Accountability for Reasonableness conditions include: the Regional Health Management Team (RHMT), the Regional Secretariat, the District Health Forum (heads of health facilities), councillors (political leaders), the Chairperson of Health Facility Governing Committees, non-governmental organisations (NGOs), faith-based organisations (FBOs), community-based organisations (CBOs), heads of department, and the media. However, while different stakeholders in the district had been sensitised to Accountability for Reasonableness conditions, the initial focuses for the application of the framework were the CHMTs and their main collaborators, with the aim of increasingly including health facilities, communities and other stakeholders.

Third, based on the request of district health managers to have a person stationed in the district, in November 2008 the REACT project recruited a full-time focal person based in the district to observe and facilitate the implementation of Accountability for Reasonableness. The role of the focal person included documenting events related to the implementation of Accountability for Reasonableness in the district, attending CHMT management meetings to observe the actual application of Accountability for Reasonableness in day-to-day decision-making processes, and coaching CHMT members in the Accountability for Reasonableness concepts and their application. It was also necessary for them to capture the reactions of different stakeholders to the implementation of the Accountability for Reasonableness framework in the district. Figure 2 illustrates the structures and relationships between the key actors in the implementation of Accountability for Reasonableness in Mbarali district.

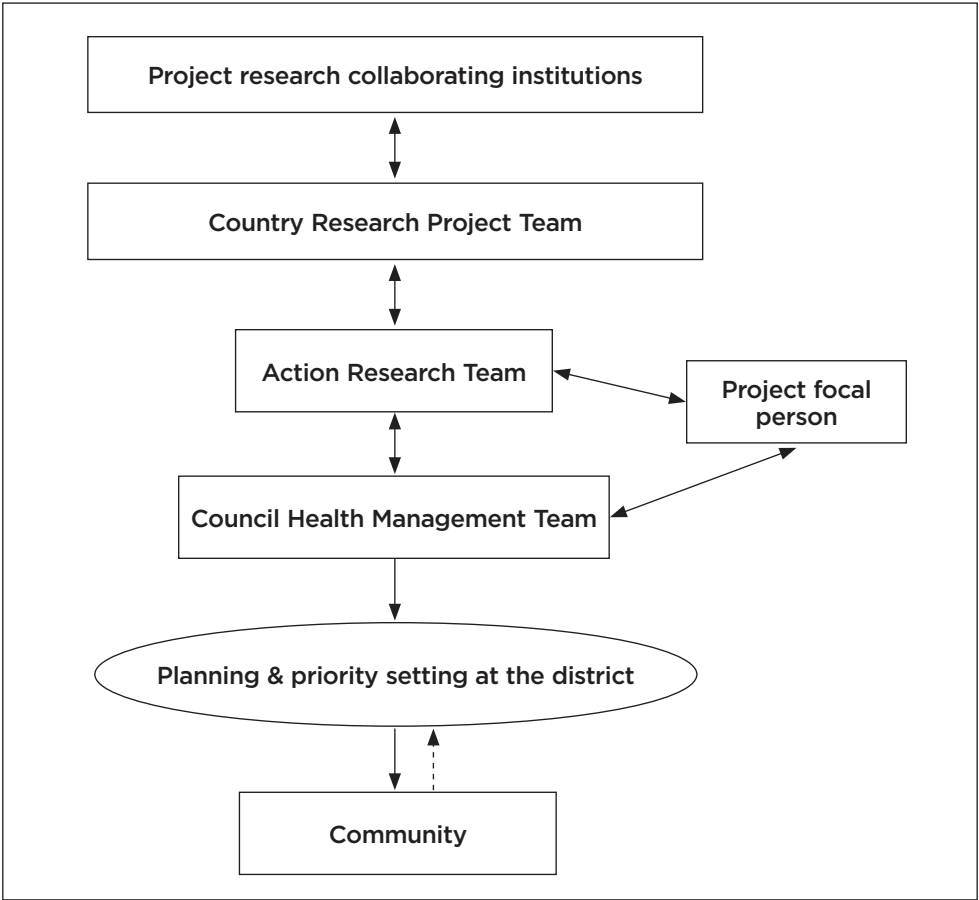


Figure 2: Diagrammatic presentation of relationships between key actors in the implementation of Accountability for Reasonableness in Tanzania

3.8 My role in the implementation of the A4R intervention in Tanzania

When I joined the Institute of Development Studies, University of Dar es Salaam, in 2007, I became aware of the REACT project, which by then was in its first year of implementation. The Institute of Development Studies was one of the research institutions in Tanzania with the mandate of implementing the Accountability for Reasonableness approach to priority setting in Mbarali district. Having interests in health policy and implementation research, I joined the REACT project as an associated PhD research student. I became an independent researcher during the entire period of the project implementation while maintaining a close link with the Action Research Team and other institutions participating in the implementation of the project (see Box 2 for a list of participating institutions).

I participated in all country and international meetings related to the implementation of the project as a way of generating more insight, providing feedback of my research findings to facilitate the implementation and integration of the intervention. I provided formative feedback to the project implementation group both formally and through informal discussions. Once a year I presented my findings during annual workshops. In addition to the baseline and project implementation data, I gathered other data relevant to my research questions (see table 5 below). Therefore, this thesis partly consists of investigation of its own, with the aim of examining existing organisational and health care management systems at the district level.

Box 2: REACT project participating institutions

	Institution	Country
1	DBL-Centre for Health Research and Development	Denmark
2	Centre for International Health (CIH), University of Bergen	Norway
3	Umea International School of Public Health (UISPH)	Sweden
4	Institute of Tropical Medicine (ITM)	Belgium
5	Institute of Development Studies at the University of Dar es Salaam (IDS)	Tanzania
6	National Institute for Medical Research (NIMR)	Tanzania
7	Primary Health Care Institute (PHCI), Iringa	Tanzania
8	Centre for Public Health Research (CPHR) of Kenya Medical Research Institute	Kenya
9	Institute of Anthropology, Gender and African Studies (IAGAS)	Kenya
10	Department of Community Medicine (DCM), University of Zambia	Zambia
11	Institute of Economic and Social Research (INESOR)	Zambia

3.9 The overall study design

The thesis adopted a qualitative case study methodology, i.e., an empirical inquiry that investigates a contemporary phenomenon within its real-life context (Yin, 2003; 1994). Case studies are structured, yet flexible approaches are used to describe institutions and their actions. This approach was considered appropriate for this study because priority setting in healthcare institutions is complex, context dependent, and involves social processes. The use of this approach also made it possible to understand the social settings of health priority-setting. Table 5 summarises the overall study design.

To achieve the objectives of this thesis, the study was designed and implemented in two phases: the baseline study and the project implementation study. The first phase aimed to document the actual priority-setting practices in Mbarali district. The second phase aimed to document the experiences of implementing the Accountability for Reasonableness approach in Mbarali district, Tanzania.

Table 5: Qualitative case study approach and data sources

Study	Objective	Data from the REACT project	My own data set	Total
Phase one	Examine the socio-political contexts which shape priority-setting process in Mbarali district (Paper I)	- 16 interviews - One FGD with CHMT	- 15 interviews - Document analysis	- 31 interviews - One FGD - Two reports
	Describe the actual priority setting practices in Mbarali district (Paper II)	-Two observation reports		- Document analysis
Phase two	Assess perceptions of stakeholders on A4R approach to priority setting in Mbarali district (Paper III)	- Observation reports - Minutes of CHMT and ART meetings	- 20 interviews - Document analysis	- 20 interviews - Observation reports - Minutes
	Explore contextual factors influencing adoption and implementation of A4R intervention in Mbarali district (Paper IV)			- Document analysis

3.10 Framework for analysing priority setting (Phase I)

In the analysis of priority setting, the understating of the term policy is essential. Hogwood and Gunn (1984) define policy as a set of interrelated decisions taken by political actors or groups of actors concerning social goals and the means of achieving them. Thus institutions, their ideas and interests explain why policies change or remain the same. Hogwood and Gunn (1984) have pointed out that,

through policy analysis, one seeks to find out how policies are made, who the actors are, whether a policy has achieved its objectives, and if it should be maintained or replaced. Thus the analysis of the priority-setting process has a great importance in understanding how the policy makers set objectives and make decisions on different health priorities, and how actions are taken to implement the priorities.

Thus, to guide the baseline study, the thesis adopted Walt and Gilson’s (1994) policy analysis framework. The Walt and Gilson framework recognises that the health policy process involves four elements: the content of policy and/or programme, the actors involved, the processes contingent on developing sector priorities and implementing programmes, as well as the context within which the priorities or programmes are developed (Walt & Gilson, 1994) (seeFigure 3).

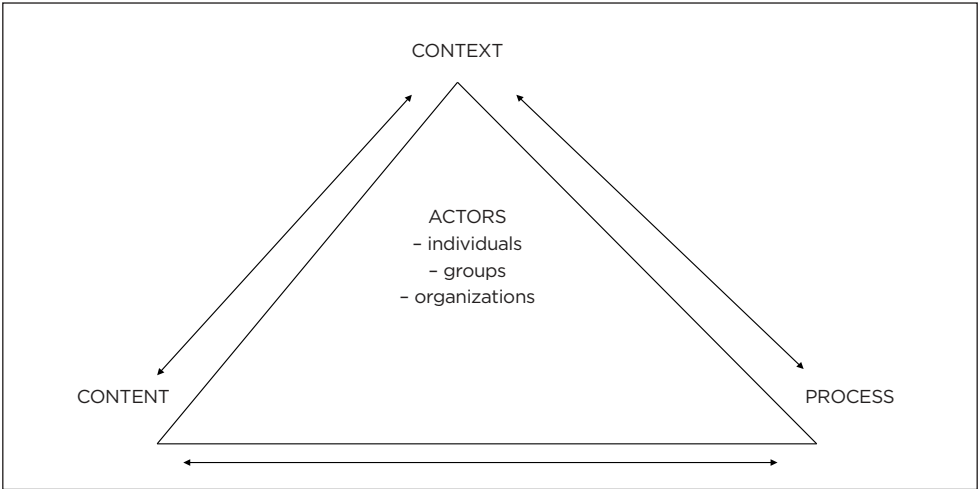


Figure 3: Policy analysis framework (adopted from Walt & Gilson, 1994)

This framework was used not as a methodological tool, but as a conceptual list to identify and organise possible analytical issues (content, process, contexts and actors) affecting policy implementation and the interrelations between these factors (Buse, 2007; Lee, Buse & Fustukian, 2002). Using this framework, the content of district health plans was reviewed. The priority-setting context was assessed and the actors involved in district level priority setting were identified. The process of policy formulation and implementation was then examined, focusing on priority-setting procedures and power relations exercised during the process.

The study was guided by the assumption that actors such as the district health management team directly influence the form that any policy implementation takes within the routine practices of health care delivery through their actions (Gilson & Erasmus, 2008). Actors’ views and behaviours are, in turn, influenced

by the institutional contexts and informal norms and values in which they work. Values conflict and there is no consensus on their application. They do not only include those medically and otherwise technically-defined such as burden of disease or cost-effectiveness but also include the values of local people and institutions involved in priority setting (Kapiriri & Martin, 2007). The different weighting given to the values of quality and equity, which differs between actors, is just one example.

However, the degree to which actors are able to influence priority-setting depends on, amongst other things, their perceived or actual power (Buse, Mays & Walt, 2005). Power differences exist when some actors are better positioned than others to influence priority-setting decisions, and may have the effect of pre-determining the considerations that inform the priority setting and hence undermine the overall legitimacy and fairness of the process (Gibson, Martin & Singer, 2005). Power differences in priority setting may be characterised by a mixture of individual wealth, professional status, access to knowledge, authority, or sex, but it is strongly tied up with the organisation and structure within which the individual actors work and live (Buse, et al, op.cit., 2005). Priority setting is also influenced by institutional contexts. Institutional contexts increase the predictability of the decision-making process by setting rules that govern the actors, allowable actions and strategies, authorised results and linkages among decisions (Heywood, 2000).

3.10 Analytical framework for evaluating the implementation of the A4R intervention (Phase II)

The second phase of the study was guided by the idea that innovations in health care are often characterised by complexity and unclear boundaries, pertaining both to the elements of the innovation and the organisational structure required for full implementation. The Accountability for Reasonableness framework typically aims to positively influence priority-setting practices that, in turn, are determined by a diverse range of actors. In the first place, in its decision-making processes, the district health decision makers deal with many different actors. Secondly, multiple agendas need to be balanced in the planning and priority-setting process in the district, such as: health vs. other priorities, hospitals vs. front line, horizontal care vs. vertical programmes, local vs. national priorities, curative care vs. prevention and promotion. The district priority-setting decisions are guided by protocols and planning guidelines which come from central government. In addition, decisions are also influenced by the cultural norms and values of the actors involved.

Interventions of this type are generally complex and dynamic, often evolving in response to local circumstances, target group engagement and other events beyond the control of the implementers, and which can adversely (or otherwise) affect the impact of the intervention (Judge & Bauld, 2001). Pawson and Tilley have advocated the use of realist evaluation study designs that are capable of dealing with these issues (Pawson & Tilley, 1997). Realist evaluation aims at providing information to decision-makers and researchers to judge whether the lesson learnt could be applied elsewhere (Pawson, 2006).

Ray Pawson (2006) identifies four layers of contextual factors that shape the implementation of the social programmes; these include: the individual capabilities of the key actors; the interpersonal relationships supporting the intervention, including lines of communications in the organisation; the institutional settings (culture, informal rules, routines); and the national contexts (national policies, rules, guidelines) (see Figure 4). In line with this understanding, this thesis aims to depict how various contexts have facilitated or constrained the implementation of the Accountability for Reasonableness intervention in Mbarali district, Tanzania.

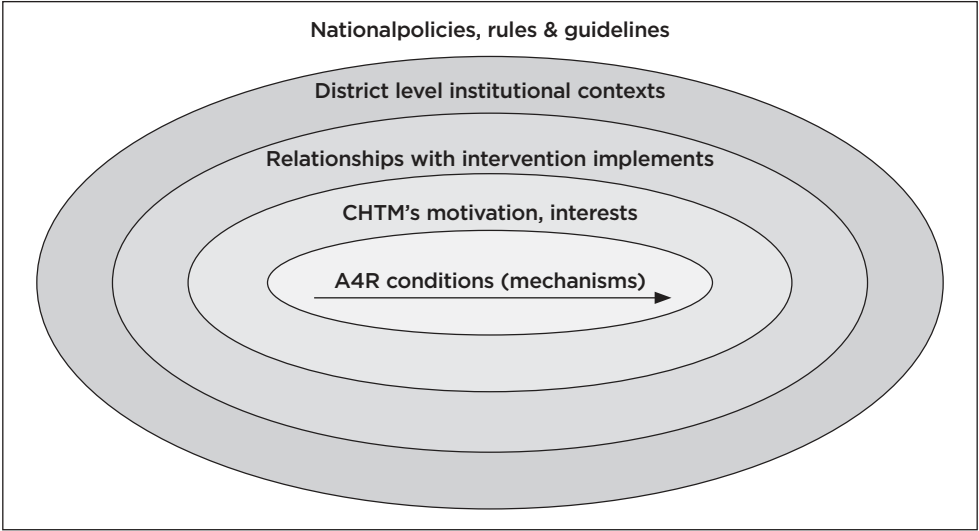


Figure 4: Interaction between mechanisms of the intervention and different layers of contexts (modified from Pawson 2006: 32)

3. 11 Sampling techniques

In order to cover a wide range of views of different cadres, the study used purposive sampling techniques to select key informants. Participants were purposefully selected by virtue of the positions they held either in the district administrative office, in the CHMT, the health facilities, or in the community. At the health fa-

cility level, committee members at the district hospital and health centres were interviewed. At the district level, members of the CHMT and Council Health Services Board (CHSB) were interviewed. Other individuals interviewed included the District Executive Director (DED), District Planning Officer (DPO), District Administrative Secretary (DAS), and councillors. Purposive sampling was also used to enable interviews with private service providers, including NGOs and faith-based organisations (FBOs). Participants were interviewed until ‘saturation’ was reached, meaning that no new information relevant to the study was identified in successive interviews (see Table 6 for a list of respondents).

3.12 Data collection techniques

The thesis used four sources of data: documentary reviews, non-participant observation, interviews with key informants directly and indirectly involved in the priority-setting process, and focus group discussion with members of the CHMT.

The first method was a review of relevant records. The documents reviewed included: the Comprehensive Council Health Planning Guidelines, which guide the planning process at the district level; the National Package of Essential Health Interventions in Tanzania, which outlines the national health priorities to be included in the district plans; guidelines for the Establishment of Council Health Boards and Committees, which outline the roles and functions of various health care committees; districts’ annual implementation reports, and minutes of the CHMT. These were all public documents, were available at the DMO’s office, and provided a perspective on the overarching regulations and guidelines from the national government that affect decision-making at the district level. I also reviewed published and unpublished articles and reports on the priority-setting process in Tanzania, as well as REACT project implementation documents (reports, minutes).

Secondly, planning meetings were observed by the REACT project focal person to get more insight on the planning and priority-setting processes. Decisions about what to observe were based on an expectation that these data would make a significant contribution to the themes being explored. The participants were aware of the reasons for observing their meetings and, after having provided a brief introduction, no further contribution was made to the meeting. Observation of the planning meetings provided information about the actual participants and the information being used, as well as the power dynamics.

Finally, interviews and a focus group discussion were conducted with key informants directly and indirectly involved in the priority-setting process. An interview guide was developed to guide semi-structured interviews with individuals and the focus group discussion. Walt & Gilson’s (1994) framework for health

policy analysis and the Accountability for Reasonableness framework were used as guides for developing interview questions. Questions were grouped according to the type of information that was required about the four areas of policy analysis (process, actors, content and context), as well as the four conditions of the Accountability for Reasonableness approach. Consistent with qualitative research methods, an open stance was maintained, probing into emerging themes and seeking clarification when necessary. The flexible structure allowed conversations to flow freely into the areas in which interviewees were most knowledgeable and willing to go. This helped to deepen the inquiry and understanding of the discussion. Interviews with key informants were carried out from October 2006 to February 2007, and between June and August 2008. Additional interviews on the implementation of the Accountability for Reasonableness intervention were conducted between January and February 2010. All interviews and focus group discussions, each of which lasted approximately one hour, were carried out at the respondents' workplaces. Interviews and the focus group discussions were also audio taped and transcribed to minimise potential misreporting of the participants' responses.

Table 6: Categories of respondents

	Designation and responsibility	Number interviewed	
		Phase one	Phase two
1	Members of CHMT	10	7
2	Local government officials	6	2
3	Members of user committees and boards	8	3
4	Member of NGOs (advocacy group)	2	1
5	Private service providers/faith-based organisations	2	
6	Knowledgeable community members	3	
7	Heads of a health facility (health centres)		2
8	Health workers at the district hospital		5
	Total	31	20

3.13 Data analysis

This thesis adopted the thematic framework approach, in which data were classified and organised according to key themes, concepts and emergent patterns (Ritchie, Spencer & O'Connor, 2003). The thematic framework analysis involved a series of analytical steps (see Figure 5). Although presented as a linear, step-by-step procedure, the research analysis was an iterative and reflexive process. First, a code manual was developed based on the research questions. Second, the

transcripts of each interview were read through and responses were identified to the main questions raised by the study. Data were coded to initial themes and were then sorted and grouped together so that they were more precise, complete, and generalisable (Kvale, 1999). As patterns of meaning emerged, similarities and differences were identified. Finally, data were summarised and synthesised retaining, as much as possible, key terms, phrases and expressions of the respondents. After this analysis, data were triangulated to allow comparison across sources and different categories of stakeholders. The careful and systematic process of analysis and reflection served to ensure analytical rigour (Patton, 1990). Finally, all research activities were rigorously documented to permit a critical appraisal of the methods. Triangulation of interviews and documents was used to validate the analysis and the interpretations of respondents' views and perceptions of the priority-setting process.

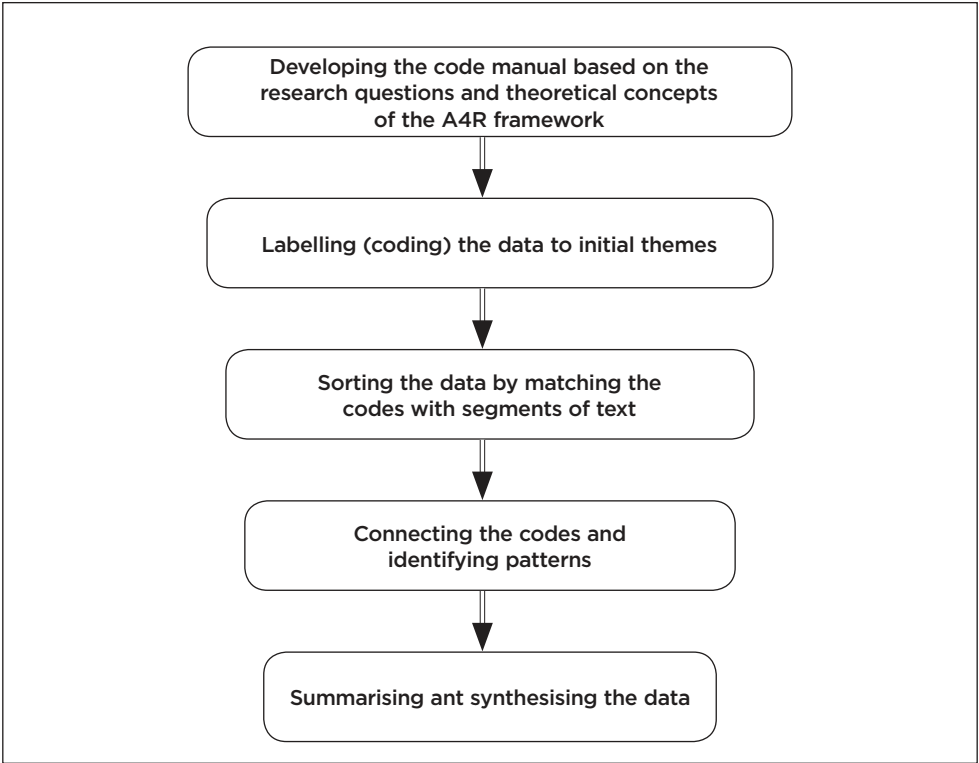


Figure 5: Analytical steps adopted in the data analysis

3.14 Ethical considerations

Permission to conduct the study was obtained from the University of Dar es Salaam, Tanzania. The clearance was presented to the regional and district authorities who approved the study in their respective areas. Oral informed consent was obtained from all study participants, who were informed of their right to completely withdraw from the study at any time they wished. All the interviews were voice recorded with the permission of the participants, and the resulting recordings and transcripts were kept confidential. The REACT research team now plans to disseminate findings to stakeholders for their information, inviting their comments on the way forward. Dissemination workshops will be held at the district and national levels in January and February 2011 respectively.

4. Main findings

In this section, findings from the baseline and A4R implementation experience study are presented. While findings are presented as discrete sections they should not be viewed as mutually exclusive issues because there is overlap between them.

4.1 Findings from phase one (paper I & II)

This section presents the findings from the baseline study. The study aimed at examining health care organisation and management systems in Tanzania. Specifically, the study analysed formal and informal rules guiding priority-setting decisions at district level. The study also explored the role, interests and position of various stakeholders in the priority-setting process in Mbarali district.

4.1.1 How are district level health care priorities developed?

In Tanzania, as part of HSRs, the process of identifying priorities has been devolved to the district health authorities. In the 2009/2010 planning cycle, the MoHSW further devolved decision-making to the frontline level by requiring that planning and budgeting begins at each individual facility, with the active involvement of the community. At the district level, the CHMT has been tasked with assessing the health needs of the population, and also to prepare annual district health plans, which have to make the best use of limited resources in meeting local needs. District-level priorities process involves three steps:

- The Ministry of Health and Social Welfare issues guidelines for planning. Typically the guidelines include the sector priorities and targets, budget ceilings, planning tools, and planning process.
- Planning workshops are then organised at the national, regional and district levels to orientate district health managers in the priorities for the year, and in the planning tools and process.
- Each district then develops its district health plan, which identifies areas of priority based on locally available epidemiological data and health service statistics. It must take into account the requirements of the nationally defined Essential Health Package (EHP) and set out activities to be undertaken on an annual basis. During the planning meeting, the district planning team defines district targets, identifies activities to be implemented and costs these activities.

4.1.2 Who sets health care priorities in Tanzania?

In theory, as part of the health sector reforms, the planning and priority-setting process has been devolved to the district and health-facility level. Identification of priorities has to begin at the grassroots, with district-level monitoring of adherence to budget ceilings, as well as to national policy requirements on core issues. Ideally, based on the scale set by the ministry and the roles and responsibilities prescribed for the different actors in the district, the process should result in health facilities (health centres and dispensaries) and community representatives providing input into district priority setting.

However, as the priority-setting process was studied, it was observed that this was not the case. Observations made during meetings of the CHMT and of discussions with key respondents revealed that health boards and committees had little impact on the planning and priority-setting process. Consequently, priority setting for health at the district-level depended heavily on the group dynamics within the CHMT rather than other actors.

Interviews with members of user committees and boards revealed that they had recently been established in the district and did not seem to have played a major role in determining district health priorities. As stated by one member of a user committee:

“We are in the community and know many problems that occur here. Therefore our voices should be heard, but this does not happen” (interview with a member of CHSB).

Poor attendance of public meetings, lack of interest and education, scant information made available, lack of monetary gain, cultural barriers and suspicion were some of the reasons given for this. Further, interview data from all categories of key respondents, and observation notes, revealed that priority setting in the district often started late and uses unreliable planning data, which made it hard to conduct meaningful participatory planning. The fact that funds were earmarked for certain purposes was viewed as a problem, as were unexpected budget cuts and irregular budgetary remittances to the district. Figure 6 illustrates the discrepancies between the policy guidelines and the practice of resource allocation in the district.

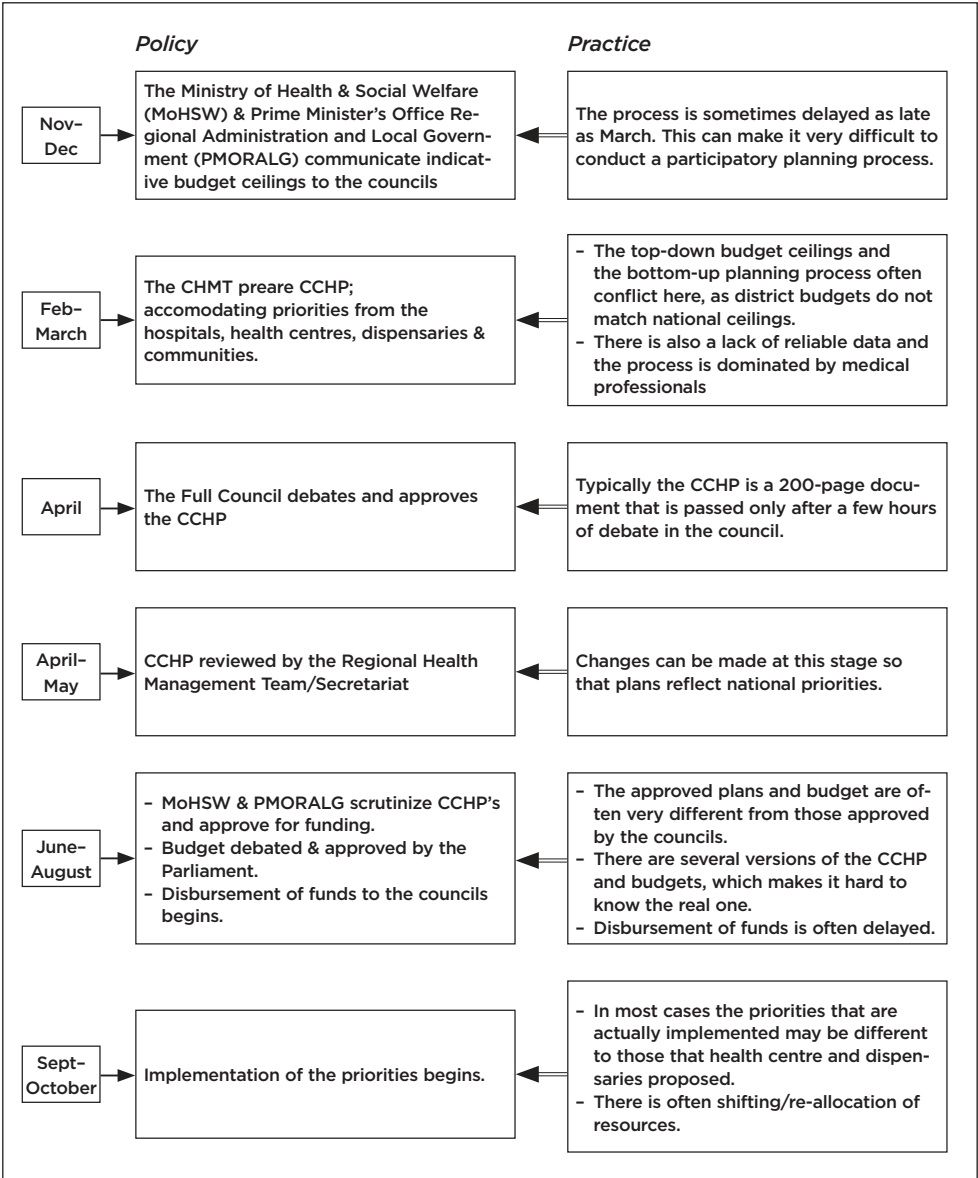


Figure 6: Policy vs. practice in the priority-setting process (Maluka et al, 2010b)

4.1.3 What influences the selection of priorities at the district level in Tanzania?

Two main factors influences priority setting at the district level. The most common influence mentioned was national-level priority, followed by district-level challenges. Ideally, planning guidelines that come from the national government

require that interventions in each priority area be selected on the basis of magnitude, severity, feasibility, and cost. The actual allocation of resources has to be based on budget ceilings, as specified in the National Basket Grant guidelines. However, interviews with district health managers, and analysis of field notes revealed that CHMT members use projections based on previous plans. So the plan was based largely on what was funded the previous year, with some minor adjustments for demographic or political factors. The use of epidemiological or cost-effectiveness evidence tends to be only a small component of the decision.

“...The process lacks accurate information which is useful in guiding priority setting... Information on morbidity and mortality is largely inadequate and not reliable” (interview with members of the CHMT).

The political contexts in which the CHMT operates also influence priority-setting decisions. These include both nationwide political decisions and politics at the district level. The priorities of the national government influence the priorities that the CHMT gives to particular areas of health policy. Many CHMT members indicated that, while some of their priorities came directly from the districts, in situations where district-level priorities conflict with national priorities, the national priorities take precedence.

“When identifying priorities we usually have district data along with instructions from the Ministry. What we do is trying and comparing problems identified at the national level with those which we at the district level have identified as priorities. National priorities which are similar to district problems are given first priority...However, even though we identify our own district priorities at the end of the day we must observe the national priorities” (interview with members of the CHMT).

Further, a minority of members of the CHMT who were interviewed pointed out that lobbying, professional experience and donors had influence in the priority-setting process. Figure 7 illustrates various factors that influence priority-setting decisions at the district level.

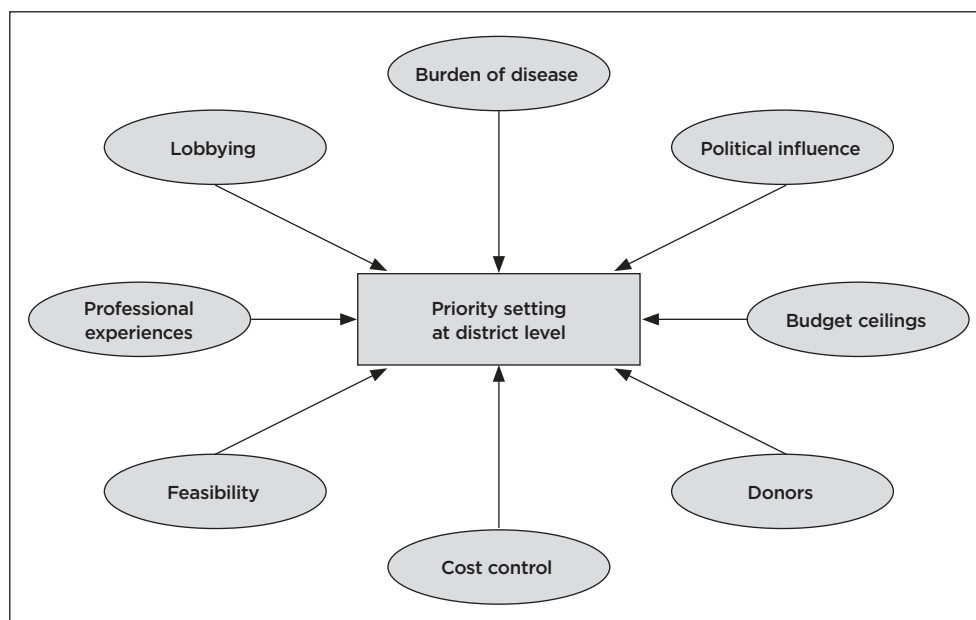


Figure 7: Factors influencing CHMT's priority-setting decisions (Maluka et al, 2010b)

4.1.4 Which institutional factors influence the district level priority-setting process?

This thesis has documented a number of institutional and organisational factors that influence the district-level planning and priority-setting process. First, there appears to be no clear delineation of responsibilities and relationships between the levels of local government and health committees and boards. The planning guidelines were not clear in explaining how power relations should work between the various bodies created by the councils. For example, the Council Health Services Board (CHSB) did not have an automatic mechanism for collaboration with other bodies such as the Hospital Governing Committee. As a result, problems of mutual concern were not discussed and solved. These bodies appeared to work in parallel learning very little or nothing from each other, even though they were supposed to be working to achieve similar goals. The lack of clear channels of power and responsibility thus limited accountability mechanisms at the district level.

Second, there appeared to be limited accountability mechanisms within the decentralised structure in the district. Interviews revealed the limited capacity of the CHSB to oversee and scrutinise district health plans and priorities. It was indicated that members of the CHSB had received no formal training on planning, budgeting and the prioritisation process to enable them to perform their duties. In addition, for quite a long time, the CHSB had not held meetings due

to limited funds. In most cases, district health plans and reports were submitted to the Full Council, without first being scrutinised by members of the CHSB, as required by the planning guidelines.

Furthermore, the district health plans were not scrutinised properly in the Full Council meetings. Although Comprehensive Council Health Plans were tabled at the Full Council meetings, local councillors appeared to approve them without an adequate understanding of their implications.

“At the Full Council meetings, although all members are involved, in my experience, there are many people who do not understand the issues which are discussed there because most health issues discussed are not understood by non-medical personnel...they just vote to accept the resolution without a thorough understanding. You may find that the resolution was passed by all, but in reality it was a decision proposed by one person due to his/her influence because others don’t understand health-related issues properly (interview with a councillor).”

According to some respondents, this was due to insufficient time allocation for Full Council meetings to enable councillors to read and understand all the items in the district health plans before approval. Some respondents also felt that, because most of the members of the Full Council are politicians, they had insufficient knowledge of health care priority setting.

The lack of accountability at the district level meant that policy implementers (the CHMT members) did not have to worry about any objections to their proposals or actions. Thus, although district health plans and budgets were made, supervision of, and adherence to these was not a priority. Both health workers and the general public had no mechanism to hold district health managers accountable.

4.1.5 Whose voice was heard in the priority-setting process and how?

A review of how the budgeting process was undertaken showed an unequal distribution of power between the various actors involved in the planning and priority-setting process. All stakeholders interviewed at district level felt themselves powerless to influence the amount of funding coming to them from the central government. It was evident that the national government had more power over the purse strings than the bottom level, despite the popular policy claim of bottom-up planning and budgeting.

Power asymmetries were manifest even between the CHMT and planning team members. Findings from interviews indicate that power asymmetries within the CHMT and the planning team were most clearly exemplified in terms of the degree

of authority they exercised, and the varying amount of planning information to which they had access. There was also evidence that the managerial position of the District Medical Officer (DMO), District Planning Officer (DPLO), and the District Treasurer (DT) gave them the power to set the agenda, provide technical advice, and control the priority-setting process in the district. The DMO was thought to have had the final authority in the actual decision-making process.

Power imbalances were also reflected in the differences in the differences in the granted preparation time and access to the available planning information and guidelines. Clear power differences were also revealed between district health professionals (public) and representatives from the private sector and FBOs. Access to the planning guidelines appears to have been confined to the DMO and a few CHMT members. Planning guidelines were kept in the DMO's office and were sent to the planning meetings the same day. Many members of the planning team, particularly those from the private sector and NGOs had no time to review the planning guidelines and information before the planning meetings. Consequently, participation by representatives from FBOs, NGOs and the private sector was minimal, and they expressed that their views were hardly incorporated in the final CCHP.

4.2 Findings from Phase 2 (Papers III & IV)

This section presents experiences of implementing the Accountability for Reasonableness approach to priority setting in Mbarali district, and highlights both the perceptions of stakeholders regarding the framework, as well as how the Accountability for Reasonableness intervention was shaped by contextual factors.

4.2.1 What were stakeholders' perceptions of the Accountability for Reasonableness framework?

The picture of the relevance of the Accountability for Reasonableness framework emerging from the respondents was, overall, a positive one. The approach was seen as an important tool that could be used for improving priority setting and health service delivery. First, all respondents shared the opinion that involving multiple stakeholders would ensure that a wide range of relevant values and principles were taken into account and thus would improve the fairness, transparency and legitimacy of the process. Second, all respondents recognised that transparency has the potential for enhancing the democratic process by helping members of the community learn how to allocate health care resources thoughtfully and fairly. Further, most respondents shared the view that a formal appeals mechanism would provide opportunities for people to express their dissatisfaction with the decisions taken.

When asked about district health plans and budgets both before and after the Accountability for Reasonableness intervention was introduced, respondents were overwhelmingly receptive to the change. The planning and priority-setting processes were now perceived as more participatory and transparent. Respondents felt that some decisions and ideas, including priorities from hospital staff and community were, as a result, being considered in the district health plans. This involvement of hospital health staff has widened the representation of views and ideas and values.

“I think there are very big changes. In the 2008 planning year, the CHMT sat alone in identifying district priorities. After the start of the REACT project, it was deemed necessary to widen the scope and involve many more stakeholders in the process of preparing the district health plan. Last year (2009), we sent letters to health facilities requesting their committees to prepare their priorities and submit to the CHMT” (interview with a member of CHMT).

With regards to publicity, it was evident that district health priorities had become readily accessible to the members of the CHMT and hospital workers. The district priorities were communicated to programme leaders and other hospital staff through the staff meetings. Priorities were also translated into Kiswahili (the national language) and were pinned on the notice board at the district hospital, health facilities and ward offices.

“I would say there are significant changes. Starting from 2009 we have seen hospital priorities displayed on notice boards and in offices. In the past, even the content of the district health plan was not usually known. You would just be told that there was going to be a seminar or training but you would never know what the plans were and whether they were implemented or not” (interview with health worker).

When they were finally asked about changes in power asymmetries within the CHMT, respondents were also receptive to the change dynamics. A vast majority of CHMT members believed that their involvement in planning and priority setting had increased over the past two years. The CHMT members reported that they were now able to appeal against DMO decisions.

“As days pass by there are gradual changes. In the past very few people dominated the meetings. But currently there is room for other members to air their opinions” (interview with a member of CHMT).

“The REACT project has opened our eyes. We have now gained confidence and we are able to argue firmly in front of the chairperson” (interview with a CHMT member).

It was observed in the 2009/2010 planning and budgeting process that members were given the chance to raise issues and engage in discussion, though the chairperson appeared to continue to dominate the discussion and have influence on the final outcome. All this amounts to an increased awareness of the need to prioritise explicitly in view of the many demands on limited resources.

4.2.2 How was the A4R intervention shaped, enabled and constrained by contextual factors?

This thesis identified a number of factors that positively or negatively influenced the implementation of the Accountability for Reasonableness conditions in the planning and management of district health services.

The presence of participatory structures under the decentralisation framework, coupled with the central government’s call for partnership in district level planning and priority setting, appeared to be the main factors that facilitated the adoption and implementation of the Accountability for Reasonableness intervention in the district. The decentralisation process meant that there was already a commitment from top politicians to devolve power, authority and accountability to the districts. In other words, the political commitment from senior officials, at both the national and district levels, to support decentralisation provided an environment that helped the adoption and implementation of the Accountability for Reasonableness intervention.

Whilst national health policy documents were important, in most cases local contextual factors also appeared to facilitate the implementation process. It was evident that the desire of the CHMT to engage different stakeholders, and listen to their views and expectations of the priority-setting process, influenced the application of the Accountability for Reasonableness conditions. All sources of data utilised in this thesis show that CHMT members invested a considerable amount of effort and resources in identifying the relevant internal and external stakeholders, and to involve them in the planning and priority-setting process. Before the start of the Accountability for Reasonableness intervention in the district, pre-planning meetings for developing district health plans involved only seven core CHMT members, but this number was increased to about 18, including a coordinating person from NGOs, the District Planning Officer (DPLO) and the Community Development Officer. Most recently, representatives from groups representing women, youth, the elderly, and the disabled are expected to attend the next annual priority-setting meeting.

Additionally, the importance of having a project focal person and the Action Research Team (ART), dedicated to the development and implementation of a fair and explicit approach to priority setting became evident in the district. The collaborative efforts between researchers and district health managers were seen by many CHMT members as the way to build the people's confidence that this project really was about benefiting the district. The fact that the Primary Health Care Institute (PHCI) had established a long working relationship with the study district facilitated the adoption and implementation of the intervention. Further, frequent meetings between the researchers and district health decision-makers seemed to have increased the level of trust, and facilitated receptivity to the adoption and implementation of the Accountability for Reasonableness innovation.

However, while some significant progress was made to involve multiple stakeholders and disseminate priorities to health workers and the public, a number of contextual factors appeared to constrain the full implementation of the Accountability for Reasonableness approach. First, the existing structures at the grassroots level (such as village council meetings, village general assemblies, and health facility governing committees) that could be used to steer stakeholder engagement were not functioning well due to lack of incentives, limited resources and a low level of awareness of their roles and responsibilities. Interviews with user committees and boards revealed that many board members did not know what was expected of them. In addition, the Health Facility Governing Committees (HFGCs), with representatives from community and village health committees, were not always involved in decision-making on crucial issues such as the utilisation of locally-generated funds—this undermines the community's involvement in health matters.

The CHMT's efforts to implement the Accountability for Reasonableness approach to priority setting were also stymied by the delay in the disbursement of funds by the central government. Further, the CHMT members felt that interference from higher authorities hindered efforts to implement a fair and transparent priority-setting approach. One respondent remarked:

“Many responsibilities and instructions from higher administrative levels also affect our desire to implement a transparent and fair priority-setting process. Sometimes things are brought to you and you are told that it must be included in the plan and if it is not there the plan wouldn't be accepted at higher levels” (interview with a member of the CHMT).

Lack of funds and planning guidelines imposed by the national government were also frequently mentioned by CHMT members as barriers to stakeholder involve-

ment in the planning process. Almost all CHMT members felt that involving more stakeholders in planning would require additional resources, which, according to district budget ceilings, were not there. Many CHMT members felt that there were too many constraints tied to the national basket system, which prohibited the CHMT from spending above its budget allocation. They stated that the system often determined how to spend the money and how much could be spent on certain items or expenditures. For example, one CHMT member explained the constraints placed on the districts thus:

“Some of the items in the guidelines hinder us from doing what we like. For instance, the guidelines prescribe the percentage of resources, which should be allocated to each priority. In effect, a lot of money is allotted to priorities that are not very critical in our district, while priorities that are of great importance to the district get insufficient funding. So, there should be flexibility, as far as resource allocation is concerned” (interview with a member of the CHMT).

Further, interview data showed that the low level of public awareness and lack of appeals culture were barriers to achieving explicitly fair approaches to priority setting in their context. Figure 8 summarises the contextual factors that facilitated and/or constrained the implementation of Accountability for Reasonableness.

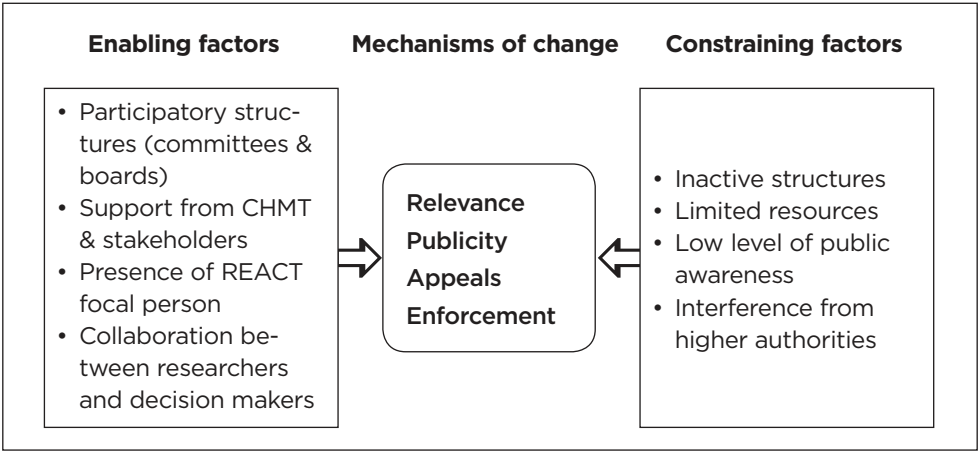


Figure 8: Contextual factors that facilitated and constrained the change process

5. Discussion

This thesis aimed to analyse priority-setting process at the district level and explore the applicability of the Accountability for Reasonableness framework to priority setting in the context of resource poor settings with relatively weak organisations and fragile democratic institutions. In the context of low-income countries, a few empirical studies have used Accountability for Reasonableness as a conceptual framework to evaluate priority setting and decision-making processes (see for example Maluka et al., 2010b; Kafiriri, et al., 2007; Kafiriri & Martin, 2006; WHO, 2006). Other studies have recently compared the elements of fairness described in the Accountability for Reasonableness framework to the elements of fairness as perceived by decision makers (Kafiriri, Norheim, & Martin, 2009). However, this is the first study to document the actual experience of implementing Accountability for Reasonableness framework in the planning and priority-setting process in low-income country.

This thesis revealed that, despite the indisputable national rhetoric on decentralisation, practice in the district involved little community participation. Official government documents clearly state that the planning and priority-setting process in the context of decentralisation would be done in line with the principles of public participation, democracy, transparency and accountability at all levels-from the national level to the community level. Emphasis is placed on devolving power and resources to the community level and, in particular, on the role of the health care committees and boards.

The thesis showed that decentralisation, in whatever form, does not automatically provide adequate space for community engagement. The conventional assumption, that when power and authority are devolved to the local governments, the community would then demand transparency, accountability and involvement, is far from the reality.

In the first place, the content of the annual district health plans seemed to be largely dictated by national priorities despite the emphasis on decentralisation of decision-making and budgeting. Secondly, the high level of conditionality associated with local government funding gave the CHMT little room to alter funding allocations, especially in the recurrent budgets. However, national guidelines could be an important tool for effective decentralisation. Given the weakness of accountability mechanisms at the district and grassroots levels, guidance is needed on the criteria to be debated in the priority setting and resource-allocation processes. Decentralisation may become problematic if local decision-making on how to use resources is made without guidance on citizen rights and local-level responsibilities. Nevertheless, it is important that such guidance does not

impose new outside criteria, but both operationalises and balances established planning criteria.

In addition, grassroots participation (the community, health centres and dispensaries) appears to have little impact on the planning and priority-setting processes, despite the existence of planning guidelines and the presence of health committees and boards at the facility and village levels. District health plans are the products of a few members of the CHMT, with community bodies and private partners operating at best as a rubber stamp to approve the decisions taken. The thesis found that user committees, boards, and the public, seemed unable to affect quality of the decentralised health care planning and priority-setting processes. It was evident that the laws, bylaws and regulations, boards and committees in many places were non-functional. Some members were not active, some not replaced, and often they did not know what was expected of them. One could argue that decentralisation has both 'supply' and 'demand' sides. Demand for accountability by citizens requires education, mobilisation and democratisation at the grassroots.

Further, this thesis found that Accountability for Reasonableness was perceived as an important approach for improving priority setting and health service delivery. Accountability for Reasonableness helps to operationalise the concept of fairness at the district level. Traditionally, health workers, patients, and the public have been excluded from planning and priority setting. Accountability for Reasonableness provides not only a justification for including these groups in priority setting (meeting the condition of fairness) but also provides practical guidance for decision makers to enhance inclusiveness of their priority-setting process and day to day managerial decision-making processes. Thus, Accountability for Reasonableness assists in creating a fair balance within finite resource limits between mainly expert-defined need, programmatic and other supply pressures, stakeholder interests, and demands from service users, their representatives and their communities. The focus on the process of priority setting, rather than priorities, is an innovation that responds to the long-standing calls for an increased focus on process and context to enhance the delivery of quality services (Gilson & Mills, 1995).

However, while the Accountability for Reasonableness approach to priority setting was perceived to be relevant in strengthening transparency, accountability, stakeholder engagement and fairness, integrating the innovation into the current district health systems was challenging. National guidelines, budget ceilings, interference from higher authorities, unreliable and untimely disbursement of funds, inactive grassroots participatory structures, and low awareness of health staff, stakeholders and communities were the major obstacles to the implementation of the Accountability for Reasonableness intervention.

5.1 Implications of the findings to the Accountability for Reasonableness approach to priority setting

So what do these findings mean in terms of what is known about the applicability of the Accountability for Reasonableness approach to priority setting in resource constrained settings with weak organisations and fragile democratic institutions? The results suggest that three important points should be taken into account.

First, there is need for greater engagement of affected communities in relevant decision-making processes than currently exists. Although Daniels (2008) acknowledge that stakeholder participation may improve deliberation about complicated matters, he believes it is neither a necessary nor a sufficient condition of Accountability for Reasonableness. While Daniels' view, that the mere fact of public involvement in priority-setting ensures neither true representation nor a better quality of decision-making process is persuasive, without greater opportunities for engagement of affected communities, it is uncertain how the priority-setting process can enhance legitimacy. Stakeholders affected by the decisions should have an input in determining how priorities are ranked.

Whereas Norman Daniels is correct that, even with stakeholder participation, a process not aimed at accountability for reasonableness will not achieve legitimacy (Daniels, 2008:129), it would be important for the *relevance* condition aiming for inclusion of stakeholders in the mechanism for achieving compromise. In this respect, the Accountability for Reasonableness conditions may be mutually supportive, but the strongest possible initial focus on involvement across formal and informal power differences is likely to accelerate the desired change. There is, therefore, an urgent need to broaden the involvement of stakeholders from the demand side, making sure also that representatives of vulnerable groups are present and heard. Having a wide range of stakeholders participating in deliberation helps include the full range of relevant arguments, enhances legitimacy and facilitates the implementation of the decisions made. Further, in order to make the most of channels of stakeholder influence, deliberate efforts to sensitise the public, health care staff, ward and village development committees, and village health governing committees, to the importance of priority-setting using Accountability for Reasonableness is necessary.

However, while encouraging the existing engagement with health boards and committees, it is important also to acknowledge the accountability deficits, i.e., who is speaking for whom and with what degree of legitimacy. Communities are characterised by complex and unequal relations of power, and a consensus-participatory process may serve to downplay or conceal these, creating a situation where it is only the voice of the powerful that is heard. Inequalities in cognitive skills, gender, ability to express oneself and, not least, social status, creates an

overrepresentation of already powerful groups as well as strong inequalities in bargaining power. Some studies have documented successful ways of fostering group deliberation, generating collective choices, and incorporating the public's preferences and values into decision-making processes (Goold et al., 2005; Shani et al., 2000; Lenaghan, 1999). These studies suggest that, given enough time and information, the representatives of the general public could effectively engage in debates about the allocation of limited resources for health care.

Second, the findings of this thesis underline the need to recognise and deal with power asymmetries among various actors in the priority-setting process. More attention needs to be paid to issues of difference and the challenges of inclusion. It was evident that while priority setting was meant to be participatory, this was not the case. In practice, most of the district health plans were products of a few members of the CHMT, with private partners and community bodies at best operating as a rubber stamp for decisions taken without their input. The findings suggest that simply establishing institutional arrangements of participatory planning, priority setting and governance-in the absence of prior awareness and without the strong capacity for exercising countervailing power against persisting 'rules of the game'-will not result in greater responsiveness to community needs and priorities. Rather, the best-intentioned mechanisms for participatory planning and priority setting might simply be dominated by the local elite.

This thesis reinforces the findings of an earlier study in high-income countries, which advocated the need to add the *empowerment* condition in the Accountability for Reasonableness framework (Gibson, Martin & Singer, 2005). The empowerment condition requires that steps should be taken to optimise effective stakeholder participation and minimise the impact of power differences in decision-making (Ibid.). In this case, empowerment of user committees and boards enables them to be pro-active, to suggest solutions to local authorities, and to insist on decisions being made and implemented. One of the tools in empowering boards and committees is the provision of good information, more so if they are involved in its collection. Well-informed members of boards and committees will be in a better position to make sound and informed decisions, and to participate effectively in the implementation of priorities. Another way to empowerment could be to engage the committees and boards in identifying not only community needs but also the available local resources, and in working out acceptable solutions (Kapiriri, Norheim & Heggenhougen, 2003).

Third, this thesis suggests that attempts to establish fair priority-setting mechanisms have to recognise constraints in the local contexts of socio-political conditions and traditions. The desired change is unlikely to come about without direct attention given to such existing socio-political conditions and traditions. In this

case, the Accountability for Reasonableness framework should be implemented with flexibility to allow for the local context. Since Daniels and Sabin developed Accountability for Reasonableness in the context of US private care organisations, their fourth condition focused on public or voluntary regulation, which is the most obvious means of enforcement. In Mbarali district it was evident that the enforcement mechanism needed to go beyond a voluntary or public regulation of the process, to ensure that the *relevance, publicity and appeals/revisions* conditions are met. While Tanzania has adopted a number of policies, rules and regulations that enforce transparency, accountability, and stakeholder participation, for almost two decades little has been done at the district and grassroots levels to translate the same into practice. This thesis, therefore, re-emphasises the need to build strong and effective organisational leadership and oversight that ensures the implementation and sustainability of the Accountability for Reasonableness approach. *Leadership* can be described as a process whereby an individual influences a group of individuals to achieve a common goal. Good leadership is about providing direction to, and gaining commitment from partners and staff, and thereby facilitating change. In building the leadership capacity of district health care leaders, there is a need to go beyond the skills of medical practitioners to the skills of teamwork, advocacy, negotiation, lobbying, data management, governance, and accountability to achieve results that are fundamental in making a district health system effective. These skills could be acquired through a variety of means, including coaching, mentoring and action learning.

Further, since the Accountability for Reasonableness approach emphasises inclusiveness, participatory planning, and priority setting, the approach could be seen as threatening to some members. The implementation of the Accountability for Reasonableness approach thus requires strong support from oversight institutions. At present, an increasing range of oversight institutions, such as the Full Council, CHSB and Facility Governing Committees and Boards, are too weak to hold district health managers accountable. There is an urgent need to build the capacity of these institutions through training and sensitisation to enable them carry out the range of functions required for effective district health system governance, including overseeing the implementation of agreed health priorities. The capacity-building plan would, amongst other things, entail refresher courses on the roles and functions of boards and committees, management and governance, participatory planning and priority setting processes, and an overview of the health services within the local authority.

5.2 Reflections on methodological approaches

This thesis adopted a policy analysis framework as a guide to prompt and organise possible analytical issues (process, contexts and actors dynamics) affecting policy implementation and the interrelations among these factors. The use of policy analysis framework in this thesis has contributed to the understanding of actors' dynamics and processes related to health policy-making; it has also demonstrated that analysis of power and process can add value to those attempting to influence policy change. Policy analysis framework facilitated in-depth analysis of how and why some problems and issues are prioritised in district health plans while others not. Additionally, policy analysis approach brought attention to the fact that actors' differences in position, their interests, relationships and so forth can and does alter the outcomes of policies. It is evident that relationships, particularly power imbalances between actors, as well as institutional contexts, including management practices and capacities, had a deep impact on how the decentralised health care priority-setting process was implemented in the district. Power analysis is thus critical to understanding the extent to which new spaces for participatory governance can be used for transformative engagement, or whether they are more likely to be instruments for reinforcing domination and control.

Secondly, this thesis also adopted a *realist evaluation* approach because health care organisations are complex. Given the focus of realist evaluation in uncovering what works, for whom, and under what circumstances, its application to this research was valuable. The findings of this study are more detailed conclusions that indicate how the Accountability for Reasonableness intervention was carried out, which effect it had and how it worked; they also offer insights in the contextual factors that constrained the full implementation of the framework. Such analysis helps to overcome the limitations of traditional case studies to explain change of the intervention in an open system setting (Pawson, 2006).

However, realist evaluation poses a number of methodological challenges for the researcher. Perhaps the most important challenge is defining and identifying mechanisms of change. In this case it was difficult to identify the mechanisms that were driving change processes in the district. I decided to interpret the four conditions of Accountability for Reasonableness as mechanisms of change. Equally important, given the fact that this study was conducted two years after the active intervention period in the district, the study could not assess the outcomes. In this case, the study decided cautiously to focus on monitoring how the intervention was shaped, enabled and constrained by the interaction between mechanisms and contextual factors.

5.3 Strengths and limitations of the thesis

The design of any study has its strengths and limitations. Similarly, the interpretation of research findings may be conditioned by methodological issues. These strengths and weaknesses are considered below.

Methodologically, this thesis adopted a qualitative case study design. The two sub-studies were limited by its participants. While an effort was made to sample respondents from different levels of decision-making in the district, the views and results from each study are not generalisable to other stakeholders. The study setting was only one district and represented perspectives of a relatively small number of participants. However, even though generalisability was not the intention, the rich description this study has presented still provides a valuable contribution to the knowledge base of priority setting. The thesis sheds light on how the priority-setting process is actually done in the context of resource-poor settings, weak organisations and fragile democratic institutions, and how the process can be strengthened. Studying more stakeholders in other contexts would provide an ever-richer description and there is potential for future research and refinement of the ideas presented in this thesis.

It is possible that the views provided by participants in the two sub-studies were shaped by social desirability bias, and responses given in the interviews might not correspond to what respondents actually do in terms of priority setting. However, no obvious inconsistencies were found between the interview data and the field notes, suggesting that what participants were saying was in line with what was actually happening in the district.

Further, the thesis contributes to our understanding of the acceptability of the Accountability for Reasonableness framework in improving planning and priority-setting processes in low-income countries. It enhances understanding of the processes and mechanisms of the Accountability for Reasonableness framework that trigger changes in the priority-setting process, as well as the contextual factors that appear to both facilitate and constrain the integration of the Accountability for Reasonableness intervention. This thesis, therefore, would help health care analysts, decision-makers and others improve their understanding of the health care system and form the foundation for many of the ongoing efforts to improve health and health systems across Tanzania.

6. General reflections and the way forward

In Tanzania there seems to be a particular need for the Accountability for Reasonableness approach to priority setting, due to the complexity of district health team situations and the need for, and recent plans to strengthen, priority-setting processes at health centre and dispensary levels.

In addition to Mbarali district, and in connection with the insights from the REACT project, four other districts (namely: Mufindi, Songea, Mbinga and Ludewa) piloted the application of Accountability for Reasonableness to fully develop priority setting and Accountability for Reasonableness-based marketable capacity-building packages for the Primary Health Care Institute (PHCI) to offer widely. PHCI is a zonal centre under the Ministry of Health and Social Welfare, supporting district health capacity building. Several lessons have been learnt and further improvements can be made, but overall the process has been successful and the final results are being evaluated.

A training package has been developed based on the REACT project as an independent programme of the PHCI. It has involved a needs assessment, development of training guides, and has been tested in the four districts named above. It is intended to draw on the expertise of Tanzanian trainers in implementing the training and support a one-year starting process. It is anticipated that the programme in Tanzania will include a Zonal workshop and programme set up, as well as a districts training round and a quarterly team follow-up in each chosen district by team members.

7. Conclusion

This doctoral thesis aimed to analyse the existing health care organisation and management systems in Tanzania, and explore the potential and challenges of implementing the Accountability for Reasonableness approach to priority setting. The thesis has revealed that, despite the indisputable national rhetoric on decentralisation, practice in the district involved ineffective and limited participation. The findings of this thesis demonstrate clearly that the setting up of health priority-setting structures alone is unlikely to lead to significant improvements unless accompanied by the putting in place of transparency and accountability mechanisms aimed at ensuring the effective use of resources. In this regard, one could rightly argue that the participatory priority-setting approach (including decentralisation and the Accountability for Reasonableness approach) which has no stakeholder participation, and minimises the impact of power differences in the decision-making context is less likely to bring about strong and effective health systems.

Additionally, the thesis has shown that the road to strengthening fairness, transparency and accountability in resource-poor settings is neither straight nor smooth. There is a need for a broader and more detailed analysis of health system elements and socio-cultural contexts, and such research can help promote better prediction of the effects of the innovation and pinpoint stakeholders' concerns, thereby illuminating areas requiring special attention and fostering sustainability. Equally important, the thesis encourages the intensification of social networks between decision-makers and researchers to build sound working relationships, which foster the adoption and integration of innovations in health care settings. Furthermore, the study suggests a need for building strong and effective organisational leadership as an important factor in the successful implementation and sustainability of the Accountability for Reasonableness approach. In building the leadership capacity of district health care leaders, there is a need to go beyond the skills of medical practitioners to promote the skills of planning, negotiation, lobbying, data management, governance, and accountability to make district health systems effective.

The Researcher

I was born in 1978 in Ngindo Village, along the shores of Lake Nyasa in the southern part of Tanzania. During my childhood, I loved being a fisherman, which was the only real economic activity in my village. Soon, however, I became interested in teaching because most of my brothers and sisters were teachers.

I began my teaching career at the University of Dar es Salaam, Tanzania, in 2000 and graduated with a Bachelor of Arts (Education) in 2004. I worked as a secondary school teacher for one year. In 2005, I joined the Institute of Development Studies, University of Dar es Salaam, for a Masters Degree in Development Studies. It was during this time I came to learn more about Health and Development. I became interested in the socio-political dimensions of health.

In 2007, when I was finalising my MA studies, I was recruited by the Institute of Development Studies as a Tutorial Assistant. It was during this time I became aware of the REACT project, which, by then, was in its first year of the implementation. The Institute of Development Studies was one of the research institutions in Tanzania with the mandate of implementing the Accountability for Reasonableness approach to priority setting in Mbarali district.

Professor Peter Kamuzora, who taught me health and development course at the Institute of Development Studies, was by then a country coordinator for the REACT project, and introduced me to Anna-Karin Hurtig (one of the partners in the REACT project). Having an interest in health policy and implementation research, I joined the PhD programme at Umeå International School of Public Health in 2008.

My PhD studies at the Division of Epidemiology and Global Health have given me enormous opportunities to participate in international forums. These platforms provided me avenues to present my work and learn from experts in the field of health policy and systems. I have also been involved in many activities related to health policy and systems research in Tanzania and elsewhere. Undoubtedly, the new knowledge and skills gained during my PhD training will dynamise the Health and Development Research Cluster at the University of Dar es Salaam and beyond.

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