University of Sunderland

The Political Economy of Spatial Child Health Inequalities in Ethiopia: Analysis of Public Policy

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Abstract

Addressing health inequalities is a pressing global challenge especially in low- and middle-income countries like Ethiopia, where research on ethno-regional health inequalities is notably limited. This thesis investigates the role of the broader political-economic environment and public policy practices in perpetuating regional inequalities in child health in Ethiopia from 2000 to 2016.

The study adopts a political economy lens to explore spatial child health inequalities, utilizing a retrospective policy analysis and a case study approach that includes interviews with policy actors and an examination of policy documents. The study identifies several interrelated factors contributing to persistent regional child health inequalities. Firstly, the historical context of governance and public policies has led to systemic disadvantages for certain regions and population groups. Secondly, shortcomings in institutional frameworks, notably governance at federal and regional level state institutions, have intensified these health inequalities. Thirdly, the influence of political ideologies and informal power dynamics has skewed resource allocation and decision-making processes, often disadvantaging marginalized groups.

The thesis also critiques Ethiopian policy design and implementation, noting a failure to integrate a strong equity focus, which has further perpetuated regional health inequalities. Additionally, it highlights the insufficient role of global governance actors in promoting equity-sensitive policies, attributing this to a lack of consistent, globally recommended pragmatic policy actions to advance an equity agenda in contexts like Ethiopia.

In conclusion, the study finds that Ethiopian public policy tends to prioritize overall health improvements (efficiency) over an equity-centred approach. It underscores the need for more rigorous attention to equity in the development and implementation of public policies, both in Ethiopia and other similar contexts. By prioritizing equity, governments, international organizations, and various stakeholders can more effectively tackle regional health inequalities and progress towards universal health equity.

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List of Acronyms

ACF	Advocacy Coalition Framework
ANDM	Amhara National Democratic Movement
CSA	Central Statistics Agency
CSDH	Commission on Social Determinants of Health
DAP	Development Assistance Partners
DFID	Department for International Development
EEA	Ethiopian Economic Association
EDHS	Ethiopian Demographic Health Survey
EFDRE	Ethiopian Federal Democratic Republic
EPRDF	Ethiopian People Revolutionary Democratic Front
FMOH	Federal Ministry of Health
GDP	Gross National Product
GFATM	Global Fund to Fight Aids, TB, and Malaria
GTP	Growth and Transformation Plan
HEP	Health Extension Program
HSDP	Health Sector Development Program
HTP	Health Sector Transformation Plan

IAD	Institutional Analysis and Development
LMIC	Low and Middle Income Countries
MDG	Millennium Development Goals
MSF	Multiple Streams Framework
NPF	Narrative Policy Framework
OECD	Organisation for Economic Co-operation and Development
OPDO	Oromo People Democratic Organisation
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PEA	Political Economy Analysis
PRSP	Poverty Reduction Strategic Papers
SEP	Socioeconomic Position
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
SNPDM	Southern Nations People Democratic Movement
TPLF	Tigray People Liberation Front
UN	United Nations
WHO	World Health Organisations
USAID	United States Agency for International Development

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Chapter 1: Introduction to the Study

1.1.Introduction

This thesis critically investigates the persistent spatial child health inequalities in Ethiopia from 2000 to 2016, paying close attention to how national political economy and public policy dynamics have contributed to these inequalities. Utilizing a framework that integrates political economy and public policy analysis, this research seeks to elucidate the reasons behind the persistently worse child health outcomes in certain areas, particularly the Afar regional state, as compared to other regions and the national average in Ethiopia.

This chapter outlines the study aim, scope, background, and structure, serving as a guide for the chapters that follow. It is structured as follows: Section 1.2 introduces the study's aim and research questions. Section 1.3 presents the conceptual and analytical approach. Section 1.4 provides a comprehensive overview of the socio-political and economic context of Ethiopia. Section 1.5 explores the broader theme of child health inequalities, placing the issue in both at global and Ethiopian context, with a special focus on the gap in knowledge in the structural determinants of spatial child health inequalities within Ethiopia. The section underscores the importance of this research in informing pertinent policies and practices. Finally, Section 1.6 concludes the chapter with a summary of the thesis structure, preparing the reader for a thorough examination of the issues discussed.

1.2. Aim of the Study and the Research Questions

The study aims to evaluate the impact of the political and economic context, as well as public policy processes, on the persistence of spatial child health inequalities in Ethiopia.

In light of this, the research has been structured around the following questions:

- How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?

- In what ways have policy stakeholders influenced the formulation and implementation of policies aimed at reducing spatial inequalities in child health?
- To what degree have public policies tackled the issue of spatial child health inequalities and its underlying causes?
- How suitable and pertinent were the policy goals, strategies, programs, and interventions in addressing spatial child health inequalities?

1.3. Conceptual and Analytical Framework

This study adopts a theory-driven approach to policy analysis, aligning with the recommendations of prominent policy analysis scholars (Sabatier,2007; Walt et al.,2008). It thoughtfully integrates insights from a range of disciplines to enhance both the depth and breadth of its analysis. In exploring social stratification, it draws on Bourdieu (1985) and Grusky (2010) to understand how societal structures and various forms of capital influence inequalities. Additionally, the study extends its analysis to the broader political economy using frameworks from Moncrieffe and Luttrell (2005) and Khan (2010), to examine how economic and political forces interact in shaping policy decisions.

Furthermore, it addresses the impact of political economy on spatial health inequalities, referencing the work of Bambra et al. (2019) and Solar and Irwin (2010), to explore how these inequalities manifest in different geographic contexts. The inclusion of Rawls' (1971) social justice theory adds an ethical dimension to the analysis. Simultaneously, the concept of governance as a multidimensional construct, as outlined by Foucault (1991), serves as a critical framework for scrutinizing governance within the context of policymaking. Lastly, the study incorporates the public policy analysis framework of Walt and Gilson (1994), offering a comprehensive approach to understanding and evaluating policy decisions and outcomes. By weaving together these multidisciplinary perspectives, the study aims to provide a rich, nuanced analysis of policy dynamics.

While various theories and concepts provide valuable insights and context, this study specifically focuses on examining the impact of public policy analysis within the context of the political economy on persistent spatial child health inequalities in Ethiopia. To this end, it employs a combination of the Political Economic Framework (Moncrieffe and

Luttrell, 2005) and the Policy Triangle Framework (Walt and Gilson, 1994). These frameworks form the foundational theoretical underpinnings for the schematic development of the study's conceptual and analytical framework (illustrated in the figure below).

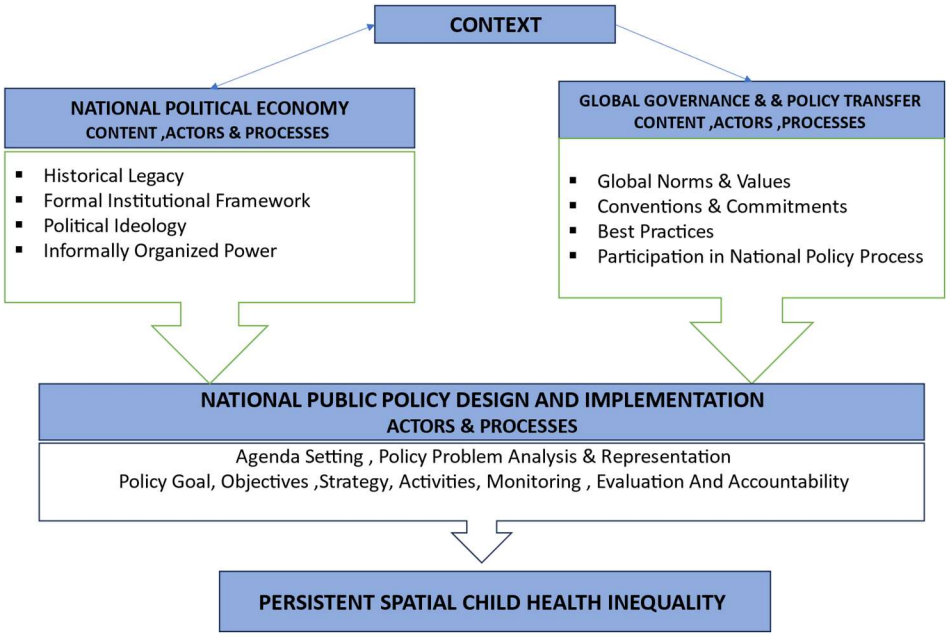


Figure 1: Conceptual and Analytical Framework for Political Economy of Spatial Child Health Inequalities in Ethiopia (Adapted from Moncrieffe and Luttrell, 2005 , Walt and Gilson, 1994)

1.4. Ethiopia Country Context

1.4.1. Socio Economic and Political Context

Ethiopia's historical narrative, extending over three thousand years, presents a rich mosaic of cultural diversity with more than 80 ethnic communities and a variety of religious traditions such as Christianity, Islam, and local spiritual beliefs. The nation has alternated between centralized control and a federation of semi-autonomous kingdoms, reflecting the complex nature of its history, often influenced by the political motivations of ethnic elites (Gudina, 2006 in Turton, 2006, p. 119; EPDR, 1987; Zewde, 2002).

The foundation of modern[1] Ethiopia traces back to Emperor Menelik II's reign beginning in 1889, characterized by territorial expansion from North Shoa in the current Amhara region. This expansion, especially following the victory against Italy at the Battle of Adwa in 1896, played a crucial role in shaping Ethiopia's international recognition (Zewde, 2002; Guidina, 2006). However, the expansion and state formation sparked controversy and political upheaval, leading to a 17-year civil war following Emperor Haileselassie's overthrow in 1974 by Mengistu Hailemariam. This period was marked by a centralized unitary state model, impacting the socio-economic structure, especially in less developed regions like Afar (Zewde, 2002; Guidina, 2006).

Geographically, Ethiopia, situated in the Horn of Africa, is a landlocked country with a diverse landscape including the Ethiopian Highlands, the continent's largest continuous mountain range. The nation experiences a variety of climates, ranging from temperate in the highlands to hot and arid in the lowlands (CIA, 2021; Encyclopaedia Britannica, 2021).

Ethiopia's cultural diversity is evident in its ethnic and linguistic variety (FDRE, 2023). With a population of about 117 million, it has a predominantly young demographic, with a median age of 18.9 years (World Bank, 2021). Politically, Ethiopia is a federal parliamentary republic, with a president as the head of state and a prime minister as the head of government (FDRE,1995). The Ethiopian People's Revolutionary Democratic Front (EPRDF) has governed since 1991, undergoing significant reforms under Abiy Ahmed since 2018 (Freedom House,2021).

The economy is largely based on agriculture, employing the majority of the workforce, and contributing a substantial portion to the GDP. Ethiopia is notable for its production of coffee and sesame seeds, with recent investments in infrastructure enhancing regional connectivity (World Bank, 2021).Despite economic growth, Ethiopia faces challenges like internal conflict, poverty, unemployment, and inequalities, compounded by recurrent droughts and the impacts of the COVID-19 pandemic on trade and tourism (ibid).

[1]

1.4.2. Health System Structure, Governance and Financing

The Ethiopian health system is organized into a three-tiered framework, with primary health care as its foundation. The first tier includes community-based health services delivered through health posts, health centers, and primary hospitals. These facilities focus on preventive care and basic treatments, offering services such as maternal and child health care, immunizations, and control of infectious diseases. The second tier comprises general hospitals, which provide specialized care and referral services for primary hospitals. At the top tier, specialized hospitals deliver tertiary-level care, including advanced surgeries and treatment for complex conditions (Assefa et al., 20).

At the national level, the Ethiopian health system is overseen by the Ministry of Health (MOH),which is responsible for developing policies, guidelines, and regulations for the health sector. The MOH also coordinates and supervises the implementation of health programs and services across the country. The regional health bureaus work in collaboration with the zonal and woreda (district) health offices to ensure the effective delivery of health services at the community level (Assefa et al., 2021).

The Ethiopian health system is mainly financed through public funding, with the government as the primary financier of the health sector. However, external sources such as development partners and non-governmental organizations have also provided significant funding. In recent years, the government has introduced health financing reforms aimed at increasing public financing for health and reducing out-of-pocket expenditures for health services (Godefay et al., 2019).

1.4.3. Spatial Child Health Inequalities in Ethiopia: The case of Afar Region of Ethiopia.

The Afar region is one of the eleven regional states in the Federal Democratic Republic of Ethiopia. The region lies in a predominantly semi-desert climatic zone in the Northeastern part of Ethiopia sharing international borders with Eritrea and Djibouti. Over 90% of the population are ethnic Afar. Over 95% of the Afar region population are Muslim.

A significant majority of the Afar population live in rural parts of the region and pastoralism is their primary mode of livelihood (CSA, 2020).

Figure 2: Afar regional state, Ethiopia.

Since the formation of the modern Ethiopian state, national development efforts have neglected the Afar Region, making it one of Ethiopia's poorest and least developed areas. Despite recent improvements in the provision of basic services such as road accessibility education and basic health services, the region has fallen behind in a number of socioeconomic development indicators during the past several years (Piguet, F. ; 2001). The most recent study by the Ethiopian Economics Association (EEA) of the socioeconomic development of the Afar region indicated that the region is still the least developed in the country (EEA,2021).

Despite its huge natural, physical, and human capital resources, the region has remained one of the least developed, food insecure, and impoverished regions of the country (EEA, 2021)

The trend analysis of the Child Mortality Rate in Ethiopia from 2000 to 2016 demonstrates that the Afar region consistently had one of the highest child mortality rates in the country. The most recent Ethiopian Demographic Health Survey (DHS) of 2016 revealed that Afar region had the highest child death rate in the country (EDHS, 2016). This persistent regional child health inequalities suggests the need for a thorough investigation and policy measures to tackle the problem.

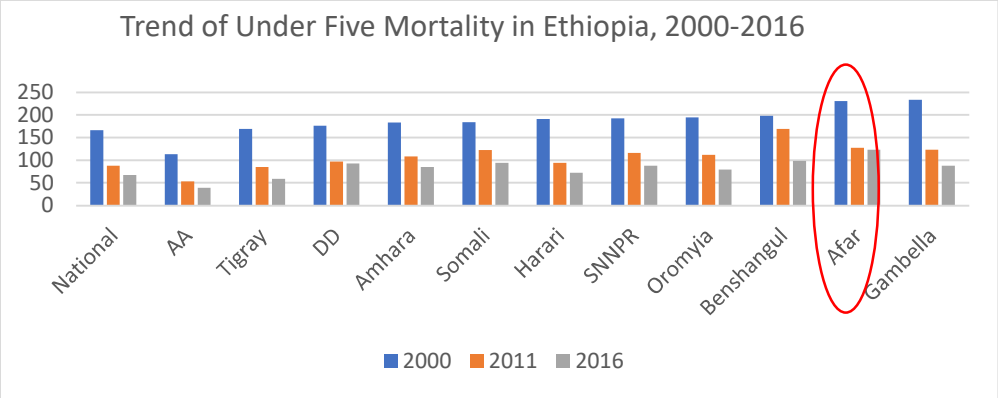


Figure 3: Trend of Child Mortality 2000-2016, Ethiopia. Source: CSA Ethiopia, with data visualisation by author.

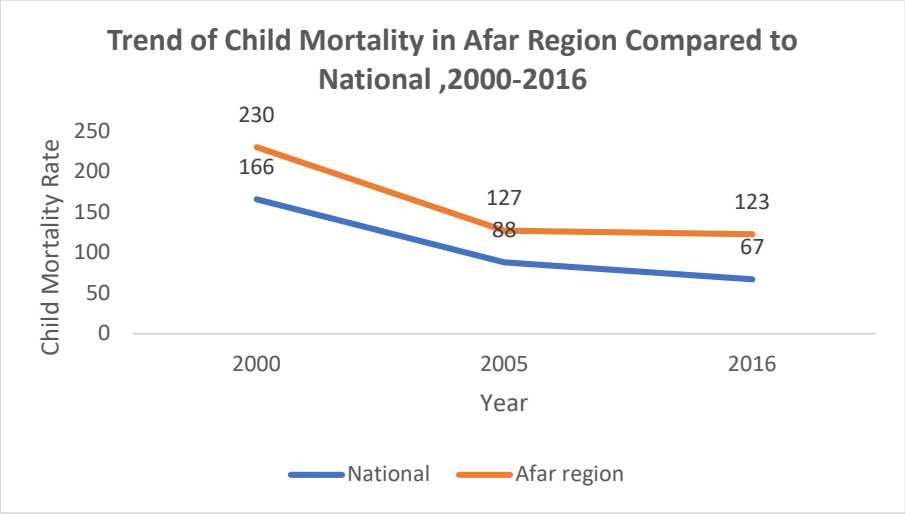


Fig 4: Child Mortality Rate in Ethiopia, 2016 Source: CSA Ethiopia, with data visualisation by author.

1.5. Health Inequalities Global and National overview

In recent years, there has been a growing recognition of the role that social factors play in creating and perpetuating health inequalities, both in developed and developing countries. This growing awareness has led to a worldwide call for effective policy actions to address these health inequalities, which exist across and within countries (Braveman & Gottlieb, 2014; Mishori, 2019a; Solar & Irwin, 2010; UN, 2022; WHO, 2008). Health inequalities are often seen as systematic, socially rooted, and fundamentally unfair, suggesting that they are preventable (CSDH, 2008; Whitehead & Daglan, 2007; Solar & Irwin, 2010). Addressing these inequalities is not only a health care issue but also an ethical challenge, requiring policies that balance fairness with economic efficiency (Solar & Irwin, 2010; WHO, 2008; Rawls, 1971). The emphasis placed on the Sustainable Development Goals (SDGs), particularly SDG 10, underscores the global priority given to addressing health inequalities. This focus is a clear testament to the international community's recognition of the importance of reducing inequalities in health as a critical component of its broader commitment to ensure that no one is left behind. SDG 10's specific objectives to tackle various forms of inequalities, including health inequalities, reflect a concerted effort by nations worldwide to confront and overcome these challenges as part of a unified agenda (UN, 2022). This alignment highlights the growing consensus on the need to tackle health inequalities as an essential part of achieving sustainable development and global equity.

SDG 10 outlines specific policy actions that countries should take to promote equality and combat inequalities (UN,2022). However, progress has been slow, and health inequalities have even been widening in developed regions like Europe (WHO,2020). Ethiopia is a prime example of this global trend, where regional child health inequalities are worsening, despite some overall health improvements. The country has been recognized for its progress towards the Millennium Development Goals related to child health, but health inequalities remain a significant challenge (Ruducha et al.,2017;Ambel et al.,2017; FMOH, 2016; Skaftun et al., 2014; Tesfaye et al., 2017; Woldemichael et al., 2019). Shockingly, the gap in under-five mortality rates across various regions in Ethiopia, a key

indicator of societal deprivation, has grown by 65% during the period 2000-2016 (Woldemichael et al., 2019; CSA,2016).

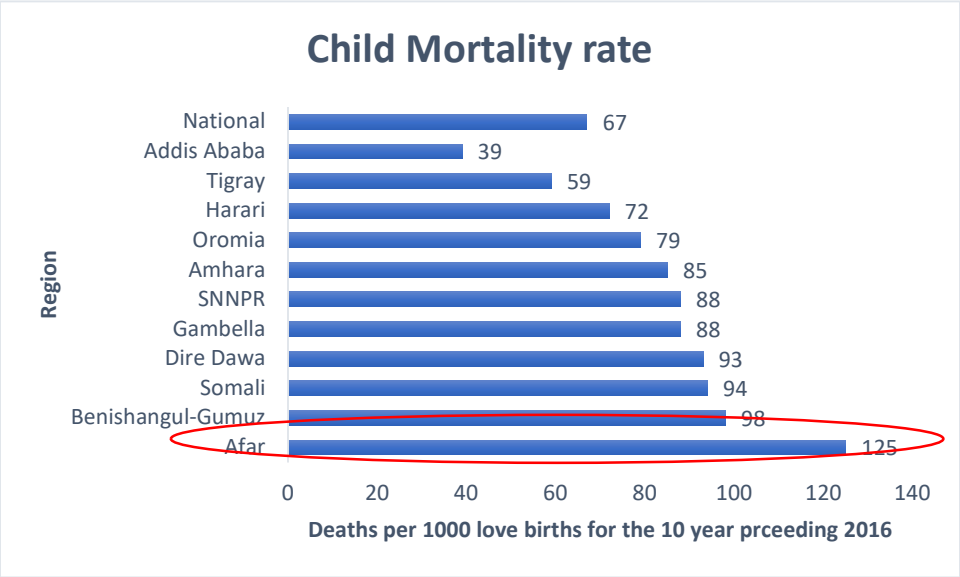


Fig 6: Child Mortality Rate in Ethiopia, 2016

Source: CSA Ethiopia, with data visualisation by author

The persistent child health inequalities in Ethiopia, even amidst general improvements in overall population and child health, underscore the urgent need for a deeper understanding of the shortcomings in existing health policies and practices. This situation serves as a compelling case for developing more effective strategies aimed at reducing the unfair distribution of child health outcomes. This necessity aligns with the recommendations of the World Health Organization's Commission on Social Determinants of Health (CSDH). In their 2008 report, "Closing a gap in a generation," the CSDH laid out key recommendations for addressing health inequalities. One of these critical recommendations focuses on the importance of generating and sharing new knowledge about the effectiveness of policies and interventions that target social determinants in order to lessen health inequities (WHO, 2008). This approach suggests that by better understanding and addressing the underlying social factors contributing to health inequalities, it's possible to make significant strides towards more equitable health outcomes for children, not just in Ethiopia, but globally.

1.5.1. The Political Economic Perspective to Health Inequalities

Health inequalities are the result of a multifaceted array of factors, as acknowledged by numerous experts in the field (Solar & Irwin, 2010; CSDH, 2008). Research on health inequalities necessitates a broad and multifaceted approach, extending beyond the narrow focus on healthcare and individual socio-economic status. It's essential to delve into the underlying structural factors that significantly influence these inequalities, as emphasized by Bambra et al.(2019), Bryant(2010), and Raphael & Bryant (2019). This comprehensive perspective is crucial for a deeper understanding and more effectively addressing of health inequalities(Bambra et al.,2019). There is an increasing agreement among researchers in this area that structural elements, particularly political and economic systems, have a significant impact on healthcare systems and the allocation of resources through public policies (Solar & Irwin, 2010; CSDH, 2008; Bartley, 2016). These factors ultimately affect the distribution of health across different population groups (Bryant, 2010; Raphael & Bryant, 2019). The concept of political economy in the context of health inequalities refers to the political and economic structures and processes at various levels (international, national, and local). These structures and processes shape, through public policy, the nature of the healthcare system, the distribution of economic and social resources, and the extent of health disparities among social groups (Bambra et al., 2019; Raphael & Bryant, 2019).

The significance and applicability of the political economy perspective in researching health inequalities have been increasingly recognized across both developed and developing nations (Bukenya, 2020; Raphael et al., 2020; Bambra et al., 2019). This approach extends beyond the conventional focus of health policy research which tends to focus narrowly on healthcare services delivery and tackling immediate health determinants. It deeply examines how political and economic environments influence the formulation and execution of health policies. Empirical research in the field of public policy practice, particularly from developed countries, reveals that policymakers often encounter difficulties in enacting health equity-favouring policies because of complex political and economic dynamics and interest groups such as the predominance of market forces, which frequently eclipse state interests. This situation renders public policy vulnerable to

the influences of corporate and business sectors, as well as to the broader impacts of economic globalisation, potentially exacerbating health inequalities (Raphael, 2015). Similarly, in developing countries, particularly within the African context, the scenario is shaped by distinct political economic dynamics. Power dynamics among various interest groups and political elites within institutions are significant drivers of regional inequalities in social development outcomes such as health (Abdulai, 2017).

These findings underline the necessity of viewing health equity and healthcare as inherently political issues, both in academic discourse and public policy practice (WHO, 2020). Researchers (Raphael,2012; Reich, 2019) advocate for a public health approach that recognizes the centrality of policy, power, and public involvement in decision-making, a perspective supported by key global health actors(WHO,2020).This approach emphasizes that addressing health inequalities requires a concerted focus on the political and economic structures that shape health outcomes (ibid). Numerous scholars, including Gilson et al. (2018), Gilson & Raphael (2008), Kickbusch (2015), Muntaner et al. (2011), and Raphael (2012), have supported this perspective. Reich (2019) emphasises the indispensable role of conducive political and economic conditions for attaining health-related goals suggesting the need for health inequalities research to employ political-economic perspectives.

While recognizing health inequalities as a crucial part of public policy and wider political economic is essential and a positive emerging trend, current research and policy interventions often have a limited focus(Gilson & Raphael, 2008; Gilson et al., 2018). They typically concentrate on healthcare interventions targeting immediate health determinants, especially in low and middle-income countries, and tend to overlook the fundamental structural factors that create and perpetuate health inequalities. This oversight fails to address the social dynamics that lead to an unequal distribution of health determinants among different population groups (Gilson & Raphael, 2008; Gilson et al., 2018). The case in Ethiopia appears to be no different (Ebrahim & Atteraya, 2023; GBD, 2022; FMOH, 2017; Ambel et al., 2016).[2]Therefore, applying a political economy lens to

[2] This has been confirmed by the finding of this study as detailed in chapter 5,6 and 7.

public policy analysis can offer valuable insights into the underlying structural determinants and their impact on health equity (Balarajan et al., 2015; Raphael, 2015; Reich, 2019).

In the context of Ethiopia, a country marked by its fragile and multifaceted political and economic context, these factors are believed to have a substantial impact on health equity (Lyons, 2019).However,the extent to which Ethiopia's unique political economy landscape influences health inequalities remains an under-researched area (ibid). This gap in research underscores the need for a deeper understanding of how Ethiopia's specific political and economic dynamics contribute to spatial health inequalities. By integrating the political economy perspective into health inequalities research, scholars and policymakers can gain a more comprehensive understanding of the systemic issues that drive inequalities in health outcomes, facilitating more effective and targeted interventions.

In recent years, there has been an emergence of a political economy-informed approach to public policy analysis in low and middle-income countries, including within the Sub-Saharan African region, although the volume of research in this area is still relatively limited (Loffreda, Bello, Kiendrébéogo, et al., 2021; Gilson, 2019). This methodology has shown its effectiveness in elucidating the complex interplay between health inequalities, public policy, and the broader political and economic context. Scholars such as Reich (2019) and Whaites (2017) have been vocal proponents of adopting this political economic perspective in the analysis of public policy and health inequality in similar settings. This approach is essential for understanding how political and economic structures, power dynamics, and policy decisions contribute to health disparities, thereby providing a more comprehensive framework for addressing these challenges in policy formulation and implementation.

The political economic perspective involves a comprehensive evaluation of the political environment. This includes mapping stakeholders, analysing power dynamics, understanding the positions of key political actors, and elucidating the influence of political

economy factors throughout the policy cycle. Studies by Sparkes et al. (2019), Reich (2019), and Gilson (2019) exemplify how this approach offers a nuanced understanding of policy development and implementation. By focusing on the interplay of political and economic forces, this perspective helps explain how policies are formulated, who they benefit, and why certain health outcomes persist, particularly in regions grappling with significant disparities.

In Ethiopia, there has been a limited number of studies on health inequalities, primarily focusing on analysing patterns of health status inequalities among population groups and their associated determinant factors. Recent studies (Ebrahim & Atteraya, 2023; GBD, 2022; FMOH, 2017; Ambel et al., 2016) have examined the pattern of health inequalities and associated socioeconomic factors. Other research on health inequalities in Ethiopia, such as those by Kifle et al. (2021), Hailu, Gebreyes & Norheim (2021), and Olsen, Norheim & Memirie (2021), has examined the impact of inequalities in healthcare resources availability and allocation on spatial and socio-economic-based health inequalities. These studies acknowledged the persistence of health inequalities and the need for concerted policy actions. However, they did not provide insight into the contribution of structural political-economic factors to the prevailing health inequalities in general and spatial child health inequalities in particular. Additionally, the scope of these studies has been confined to examining the health inequalities associated with socio-economic status, with limited investigation of the spatial (inter-regional) aspect of health inequalities and the underlying political, economic, and public policy context. Spatial inequalities are a facet of overall inequalities known to contribute to the explanation of inequalities when spatial and regional divisions intersect with ethnicity (Kanbur & Venables, 2005), suggesting that this is a dimension of health inequalities that deserves investigation from a wider structural perspective. Scholars (Bambra, Smith, & Pearce, 2019) assert that understanding spatial health inequalities, where neither individual socioeconomic characteristics nor contextual characteristics alone can fully explain the persistence of health inequalities, requires a more holistic, political and economic informed approach to the investigation of health inequalities.

From a review of the literature on health inequalities studies, it is evident that there is a gap in research on the inter-regional (spatial) dimension of child health inequalities and the influence of the underlying political-economic context and the public policy process. Globally, research on health inequalities, political-economic context, and public policy process has been conducted predominantly in developed countries with democratic and stable socio-political settings (Bambra, 2016; Erasmus & Gilson, 2008; Gilson et al., 2014; Gore & Parker, 2019; Mackenbach, 2014; Navarro et al., 2006). Limited work has been done examining the interaction of social inequalities and child health in sub-Saharan Africa (Cash-Gibson, Rojas-Gualdrón, Pericàs, & Benach, 2018), and policy analysis in this region has primarily focused on the content of policies rather than their implementation and performance in addressing health inequalities (Rispel et al., 2009). Often, these studies have not employed a multidisciplinary approach incorporating health systems, public policy, and social science theories (Reich, 2019).

This study seeks to examine the underlying structural political-economic context as well as the public policy process in Ethiopia to identify factors contributing to the nation's persistent regional child health inequalities. Specifically, it examined the influence of contextual factors on the performance of Ethiopian public policy in tackling spatial child health inequalities, the policy actors' influence in the design and implementation of policies, the extent to which public policies have addressed the problem of spatial child health inequalities and its determinants, and the appropriateness of the policy objectives, strategies, programmes, and interventions in tackling spatial child health inequalities.

In conclusion, this study was conducted with the aim of enhancing the understanding of the structural factors that drive spatial child health inequalities in Ethiopia, as well as evaluating the effectiveness of public policy in addressing these inequalities. As highlighted in the findings and discussion section of the thesis, the insights gained from this research are expected to have significant implications for policymakers, health practitioners, and other stakeholders who are committed to promoting health equity. The insights derived from this research are particularly pertinent not just for Ethiopia, but also for other low and middle-income countries facing similar challenges. By thoroughly

analysing the nexus of the political economy context, public policy and health inequalities, this study offers valuable recommendations for crafting strategies and interventions aimed at reducing child health inequalities and enhancing health outcomes for all.

1.6. Outline of the Thesis

The thesis is organised into 8 chapters. Below is a concise description of the forthcoming chapters in the thesis.

This **first chapter** sets the stage for the thesis, presenting the study's background, rationale, aims, objectives, and overall organization. This introduction serves to familiarize the reader with the research topic and provides context for the subsequent chapters.

Chapter 2 delves into existing literature on the social production of health inequalities. It is divided into three sections discussing the ethical underpinnings, intermediate/socioeconomic determinants, and political determinants of health inequalities. The discussion emphasizes the importance of structural determinants in regional health inequalities and advocates for the application of a political economy perspective in health inequalities research. This chapter identifies a gap in the literature, laying the groundwork for the study's conceptual framework.

In **Chapter 3**, the research paradigm and methodology are outlined. The interpretive epistemology, case study approach, data collection techniques (in-depth interviews and document review), and analytical methodology (thematic analysis using the Framework approach) are detailed. The chapter concludes with a critical appraisal of methodological considerations and a reflexive discussion of the researcher's positionality, ensuring transparency and credibility.

Chapter 4 outlines the conceptual and analytical framework guiding the study, detailing its elements, their operational definitions, and the linkages and pathways between them. It also elaborates on the theoretical underpinnings that justify the use of this framework and illustrates how it has been applied to guide the analysis and address the research questions.

Chapter 5 serves as the initial analysis chapter, focusing on the role of national context and actors in shaping public policy processes and their impact on spatial child health inequalities using the Afar regional state in Ethiopia as a case study. This chapter delves into the historical legacy, contemporary formal institutions, power dynamics, and political ideology, exploring how these factors interplay and contribute to health inequalities through public policy processes.

Chapter 6, the second analysis chapter, examines the influence of global governance context and actors on Ethiopia's national policy making and their impact on equity agendas in public policy. The chapter provides a nuanced understanding of the role played by global governance context and actors, exploring the primary channels through which they exert influence on Ethiopian public policy and their promotion of equity agendas.

Chapter 7, the final analysis chapter, scrutinizes policy design and implementation processes in Ethiopia, focusing on how health equity is addressed across various sectors, including health, water and sanitation, agriculture and rural development, and social protection policies. The chapter investigates the role of national and subnational actors in policy formulation and implementation, highlighting their contributions to promoting health equity in Ethiopia.

Chapter 8 serves as the discussion and conclusion chapter, synthesizing the study's key contributions and analysing the findings in relation to existing knowledge in the field. The chapter provides a comprehensive discussion of how the study's findings relate to existing theoretical and empirical literature on health inequalities and public policy processes. Additionally, it examines the contributions of the thesis, its limitations, and the implications of the study's findings for policy and practice, culminating with final concluding remarks based upon the preceding discussion.

Chapter 2: Literature Review

2.1. Introduction

This chapter offers an in-depth review of the literature surrounding health inequalities, public policy, and political economy. It delves into the complex interconnections and theoretical foundations of health inequalities, with a special focus on spatial child health inequalities. The role of a political economy perspective in researching spatial health inequalities is explored, highlighting its significance in understanding the nexus between political economy and public policy determining such inequalities.

The chapter begins by defining key terminologies in the health inequalities research, laying a solid foundation for further discussion. It engages with the pivotal debate between equity and efficiency in health policy, emphasizing the role of social justice theory in justifying the ethical imperative to address health inequalities. The discussion recognizes that health inequalities stem not only from avoidable social factors but also represent inherent injustices that require deliberate social action.

Moving forward, the review examines various social stratification theories and theories delineating the causal pathways that lead to health inequalities. It critically evaluates the limitations inherent in socio-economic explanations of spatial health inequalities, advocating for a more comprehensive approach that integrates political-economic insights with public policy analysis. This comprehensive perspective is supported by the latest theoretical and empirical research.

Furthermore, the chapter provides an extensive discussion on conducting public policy analysis from a political economy standpoint. It offers a conceptual framework for analysing the determinants of spatial health inequalities and evaluating the efficacy of public policy interventions in this context. This approach enables a deeper understanding of the multifaceted nature of spatial health inequalities, their political economy underpinnings, and the intricacies of the public policy process. This knowledge is pivotal in addressing the key questions and conceptual challenges associated with spatial health inequalities, political economy context, and public policy dynamics.

The chapter is structured to provide a clear and thorough understanding of these complex topics. Section 2.1 examines the definitions of health inequalities and the ethical rationale for addressing them. Section 2.2 focuses on the Socioeconomic Determinants of Health Inequalities, while Section 2.3 delves into the Determinants of Spatial Health Inequalities. Section 2.4 introduces the Political Economy Analysis Framework, and Section 2.5 evaluates Public Policy Performance and its impact on Health Inequalities.

A systematic approach was adopted in conducting this literature review, focusing on key terms such as 'health inequalities,' 'social determinants of health inequalities,' 'spatial health inequalities,' ‘ child health inequalities’, 'political economy of health inequalities,' and 'public policy analysis.' The selection of relevant papers and book chapters was based on their pertinence to the research questions, ensuring thorough and relevant coverage of the subject. Furthermore, a citation search was conducted within the reviewed literature, incorporating significant studies referenced in these sources. This meticulous method ensured a comprehensive exploration of the topic, allowing for the inclusion of both foundational theories and contemporary research, thus providing a well-rounded perspective on the various dimensions of health inequalities and their implications within the realms of political economy and public policy.

2.2. Ethical Underpinnings of Health Inequalities

2.2.1. Defining Health Inequalities

The concept of health inequalities is understood and defined in various ways. It's crucial to acknowledge a distinct regional variation in the use of health inequalities related terminologies. In the Americas, the phrase "health inequalities" often describes group differences in health that may not be inherently unjust, such as the higher mortality rate among the elderly compared to younger adults (Collyer & Smith , 2020). Conversely, "health inequity" is the more appropriate term in this region for describing health differences that are unfair and involve social injustice (Doe & Adams, 2021). In contrast, European discourse typically doesn't use "health inequity" as frequently, preferring

"health inequalities" to cover similar ground (Brown, 2019). Both health inequalities and health equity refer to socially produced, systematic, and unfair health differences that are amenable to policy action (CSDH, 2008; Solar & Irwin, 2010; Whitehead & Dahlgren, 2007). Additionally, the term "health inequalities" and ‘’health inequality ‘’ adds to the complexity, as it's used to signify either mere differences between groups or those differences that remain after considering various other factors (McCartney et al, 2019).

Spatial Health Inequalities: Understanding Place-Based Differences in Health

Due to the growing recognition of differences in health and other characteristics associated with place of residence, spatial inequalities have increasingly become a term used in public health and social development research and practice. Research has demonstrated the existence of spatial inequalities in both developed and developing country contexts (Kanbur & Venables, 2005a, 2005b; Kanbur, Venables, & Wan, 2006; World Bank, 2005).

The concept of spatial inequalities encompasses differences in health based on place of residence, as well as the physical ecological environment, socioeconomic and cultural characteristics of the population, accessibility to services, and the contextual impact of national and subnational macro political factors (Kanbur & Venables,2005; World Bank, 2006). The use of the more specific term "spatial inequalities" is justified as it places greater emphasis on the variation in health that is associated with the broader characteristics of a person's place of residence.

The discussion surrounding health inequalities and health inequities is deeply anchored in social justice principles (McCartne et al, 2019; Whitehead & Dahlgren, 2007) Precise distinctions and definitions of these terms are critical for shaping public policy and research. Such clarity is vital as it significantly affects the foundational values influencing policy-making decisions (Bravman et al., 2011). In the scope of this study, the terms "health inequalities", "health inequity" and "health inequities” are synonymously employed to describe health inequalities that are the result of social constructs, systematic in nature, and fundamentally unfair. These types of inequalities are particularly noteworthy because they can be effectively addressed through policy interventions. The study's approach

underlines the necessity of tackling these inequalities not merely as health concerns but as matters of equity and social justice, acknowledging the significant impact of societal structures and policies in both the genesis and continuation of these health variances (Bravman et al., 2011).

2.2.2. Health Equity and Efficiency Debate in Public Policy Making

In the context of public policy decisions aimed at addressing inequalities, achieving a balance between ensuring equity and maximizing efficiency can be a challenging task (Asamani et al., 2021; WHO, 2000). The pursuit of health equity is typically framed as a matter of social justice, yet the definition and associated values of social justice can vary depending on the specific context (Whitehead and Dghlan, 2007). As argued by Schwartz (1990), values are crucial in the public policy decision-making process, as they serve as principles or criteria for selecting what is good or better among objects, actions, ways of life, and social and political institutions and structures. The values that guide the formulation of public policy can be explicit or implicit. Regardless, when governments develop policies, they legitimize and promote certain values over others, and make value-laden judgments about aspects of public policy (Kenny and Giacomini, 2005). The notion that values impact the behaviour of institutions in various contexts is articulated scholars like, Bourdieu **(**1984), affirming the need for examining the guiding values that determine policy process.

In the realm of addressing health inequalities, policymakers often face a challenge in reconciling efficiency and equity arguments (WHO, 2000; WHO, 2013). While research has demonstrated that equity considerations are typically taken into account in policy-making processes, efficiency tends to be prioritized over equity, with a focus on achieving the highest possible health improvements for the general population while minimizing costs (Paolucci et al., 2015; Jehu-Appiah et al., 2008; Asamani et al., 2021). Scholars (Culyer, 2006) and the policy practice community (CSDH, 2008; Solar & Irwin, 2010) have emphasized the need for a careful examination of the ethical foundation of health inequalities-related public policies. As Culyer (2006) has noted, "if we cannot discuss

ethics explicitly as a foundation of policies for equity in health and healthcare policy, then I doubt we can do it anywhere else."

To better understand the values that underpin policy decision-making in the context of health inequalities, theoretical concepts on social justice can be leveraged. In the section that follows, the theoretical underpinning of the case of health inequalities using the social justice and welfare economy theories and the debate on reconciling equity and efficiency considerations in policy making is discussed briefly.

2.2.3. Theoretical Underpinnings of Social Justice in Health Inequalities

In academic and policy practice discourse on inequalities, there is an emphasis on the application of social justice-related moral concepts. These principles help to elucidate the ethical foundations that guide the pursuit of equity in society (World Bank, 2005; CSDH, 2008; Solar & Irwin, 2010). It is crucial to apply social justice principles when identifying and addressing the underlying social and economic structures that produce health inequities (Solar & Irwin, 2010). Inequalities in health are frequently systemic and firmly rooted in social structures and power dynamics, making it vital that these concepts be applied (Marmot, 2005). In addition, the application of social justice concepts can assist in guaranteeing that policies designed to reduce health inequalities do not create more inequalities. Whitehead (1992) argues that a policy that enables access to healthcare services can be made efficient, but if it does not address underlying social determinants of health inequalities or may unfairly benefit more advantaged groups and perpetuate health inequalities. Therefore, applying the social justice perspective provides a useful lens for analysing the characteristics of the public policy process aimed at reducing health inequalities.

John Rawls (1971), a notable proponent of the social justice perspective, argued that social justice requires the equitable distribution of society's resources and opportunities. Rawls's theory of social justice is founded on the concept of fairness, which he considered to be fundamental to a just society (Rawls, 2009). Rawls's theory emphasizes that a just society should prioritize the well-being of the least privileged members (Rawls, 2009). This principle is based on the concept of distributive justice, which requires that social

and economic resources be allocated in a way that benefits everyone, especially the most disadvantaged (Daniels, 2008). Rawls's difference principle, which he devised to operationalize distributive justice, says that social and economic inequalities should only be allowed if they benefit everyone, particularly the least advantaged members of society (Rawls, 2009). In practice, this means that social and economic resources should be distributed in a manner that prioritizes the needs of the least advantaged, including access to healthcare, clean water and sanitation, nutritious food, and safe housing, as well as other factors that contribute to positive health outcomes (ibid).

The health equity implications of Rawls's theory of social justice are substantial. One of the most significant implications is the need to address health inequalities, which are variations in health outcomes between population groups. Frequently, health inequalities are the result of social and economic inequalities that limit access to healthcare, healthy food, and safe housing, as well as other factors that contribute to good health outcomes (Marmot, 2005). Rawls's theory highlights the significance of correcting these inequalities to ensure that everyone has access to the basic goods and opportunities necessary for achieving well-being. Another significant aspect of Rawls's theory for health equity is the necessity to address socioeconomic determinants of health. The social determinants of health are the social, economic, and environmental variables that impact health outcomes (Raphael, 2011). Rawls's theory highlights the need to address poverty, unemployment, discrimination, and other social and economic inequalities that contribute to poor health outcomes.

Despite the link and application of John Rawls's justice theory in health equity policy research and practice, health equity scholars (Anand et al., 2005; Peter, 2001) have critiqued Rawls's theory of social justice, suggesting that it is inadequate for addressing health inequalities. Anand et al. (2005) says that Rawls's emphasis on distributive justice, which prioritizes the interests of the least advantaged members of society, fails to recognize the distinctive nature of health as a special good that cannot be adequately represented by traditional economic measurements (Peter, 2001). They propose that a broader concept of social justice is required to address health inequalities, one that encompasses a multidimensional approach that takes into account social, economic, and

environmental elements that influence health outcomes. Anand et al. (2005) proposes that a capabilities approach (Sen, 1999) to health justice, as articulated by Sen (1999), may be more suitable for tackling health inequalities. Sen's (1999) capability approach highlights that individuals should be able to pursue the kind of life they value and that social structures should be constructed such that individuals can develop and exercise their capacities. According to Sen (1999) good health is a fundamental capacity that enables individuals to accomplish their life goals, therefore this approach has significant implications for health equity.

Like Sen (1999), Daniels (2008) argues, based on social justice theory and the concept of equality of opportunity, that health is a fundamental social good and therefore health-related resources should be distributed such that everyone has an equal opportunity to obtain good health outcomes. He identifies three necessary prerequisites for achieving health equity, including the fulfilment of basic needs, the avoidance or reduction of health inequities, and the promotion of fair equality of opportunity for health. The first criterion is that all individuals have access to clean water, nutritious food, and safe housing, among other necessities. The second criterion aims to prevent or reduce health inequalities between different groups, especially among disadvantaged or vulnerable populations. The third requirement underscores the significance of establishing fair equality of opportunity for health, which entails ensuring that everyone has access to the necessary resources to attain good health outcomes.

In global public health policy practice, the social justice approach has been widely recognized and applied. In addition to peace, shelter, education, food, income, a stable ecosystem, and sustainable resources, social justice and equity are included as conditions for health in the Ottawa Charter (WHO, 1986). The report of the Commission on the Social Determinants of Health highlights the relevance of social justice and broad political and economic factors in the global health agenda (Muntaner et al., 2009; CSDH, 2008; Solar & Irwin, 2010).

Despite the widespread recognition of social justice's importance in achieving health equity, social justice theories are subjected to some criticism. Opponents assert that

social justice theories, particularly John Rawls's theory, fail to adequately account for the complexities of social and economic inequalities, the role of power dynamics, institutional structures, and historical context in generating inequalities (Fraser, 2005; Harvey, 2005; Marmot, 2005; Nussbaum, 2011; Sen, 1999; Young, 1990; Bourdieu,1984).

Both proponents and critics of social justice theory agree that inequalities, including health inequalities, is determined by a multitude of social factors beyond the healthcare system. Therefore, there is a need to explore health inequalities in the wider societal context. In the following section, the literature on the social production of health inequalities is discussed.

2.3. Social Determinants of Health Inequalities

2.3.1. Overview of Social Production of Health and Health Inequalities

The literature on the social production of health and the political economy of health affirms that socioeconomic circumstances have a significant impact on people's health (Krieger, 2001; Braveman & Gottlieb, 2014; Solar & Irwin, 2010). These conditions are referred to as social determinants of health (SDH) (Commission on Social Determinants of Health CCSDH), 2008). The SDH and health inequalities encompass both structural factors (power, income, goods, and services distribution) and daily life conditions, which together contribute to much of health inequalities (Lynch, 2019; Marmot et al., 2012; CSDH, 2008; World Health Organization (WHO), 2013).

The WHO's landmark report, along with other reviews (Kim & Saada, 2013; Marmot Review Team, 2010; Marmot et al., 2012; WHO, 2013; Drożdżak, 2015; Victorino & Gauthier, 2009), synthesized the evidence on the relationship between social determinants and health outcomes. The reviews showed that differences in health status among population groups can be explained by their exposure to various socioeconomic variables (CSDH, 2008). The influence of upstream structural determinants, such as political and power context, on material and social resources, such as income, occupation, and education, is widely recognized (Braveman & Gottlieb, 2014; Hacker et al, 2022).

Despite the need for further research and understanding, there is a strong consensus on the impact of socioeconomic determinants on health distribution globally (Marmot et al., 2012; WHO, 2013). Braveman and Gottlieb (2014) stated, "Despite challenges, controversies, and unanswered questions, the tremendous advances in knowledge that have occurred in the past 25 years leave little room for doubt that social factors are powerful determinants of health."

Empirical evidence from research has also identified context-specific factors associated with child health inequalities in various countries (Braveman & Tarimo, 2002; Amble et al., 2017; Coates et al., 2019; Heaton et al., 2016). The majority of determinant factors were related to socioeconomic factors and upstream structural determinants (Braveman & Tarimo, 2002; Coates et al., 2019). However, the key question of how these contextual factors interact to generate health inequalities in a specific context remains inadequately addressed in most studies (Bambra, 2011).

Theoretical literature provides various explanations and models on the mechanisms by which socioeconomic determinants interact to generate health inequalities (Cockerham et al., 2017). Various conceptual models have been proposed by scholars with a focus on elements of the SDH. Evans and Stoddart's framework highlight individual and societal influences on health outcomes (Evans & Stoddart, 1990), while the "rainbow model" of Whitehead and Dahlgren extends this concept by showing the socioeconomic determinants of health visually (Whitehead & Dahlgren, 1991). Diderichsen et al.'s policy entry points model highlights policy areas that can affect socioeconomic determinants of health (Diderichsen, Evans, & Whitehead, 2001). All three models emphasize the importance of addressing socioeconomic determinants of health to advance health equity and enhance overall health outcomes.

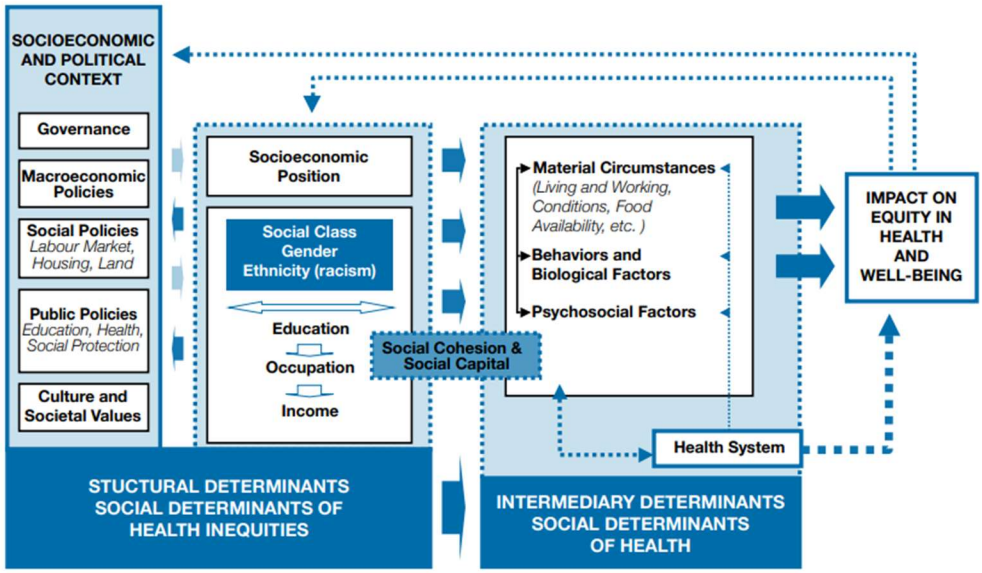


Figure 7: The CSDH (Solar & Irwin, 2010) conceptual framework for structural determinants of health inequalities

The CSDH conceptual framework (Figure 7) has been regarded as useful in guiding health inequalities research in developing country settings (Savela et al., 2022; Hamal et al., 2020; Kim & Saada, 2013; Målqvist & Thomsen, 2012). The framework highlights structural and intermediate variables as contributors to health inequalities (Solar & Irwin, 2010). Structural determinants are factors that create or perpetuate socioeconomic stratification in a society, resulting in health inequalities. Examples of these drivers include socioeconomic and political contexts, structural processes, and socioeconomic status (CSDH, 2008). Intermediate determinants are factors that work via a series of variables to generate various health-compromising circumstances. Examples of intermediate determinants include living and working conditions, access to healthcare, and others (CSDH, 2008). The framework emphasizes the explanatory significance of structural variables in producing inequalities in health risks and outcomes across population groups. It also highlights the role of power in generating social hierarchies and impacting the health outcomes of various groups.

Despite the increasing use of the SDH concepts and framework for health research, confusion and ambiguity have been observed in its application. Researchers and practitioners tend to conceive the SDH as just determining factors of health, rather than

both the determinants of health and the determinants of health inequalities (Graham, 2004; Islam, 2019). There is also ambiguity on what context-specific conditions are considered social determinants (Islam, 2019). Therefore, it is crucial to clearly define the various elements of the CSDH framework, related concepts, and terms in general and in the study context in particular.

The following sections of this chapter discuss the theoretical concepts underpinning the CSDH framework such as the concept of social stratification, socioeconomic position, the political economy perspective on health inequalities, and other related concepts.

2.3.2. Socioeconomic Position, Social Class Theory, and Health Inequalities

Socioeconomic position (SEP) is a commonly used concept in health inequalities research. Although terms such as social class, social stratification, and socioeconomic position are often used interchangeably, they have distinct theoretical bases and interpretations (Galobardes, 2002). SEP refers to the social and economic factors that influence people's positions in society's structure (Lynch & Kaplan, 2000). Krieger, Williams, and Moss (1997) suggest that SEP refers to "the social and economic elements that determine the positions people or groups occupy within the social structure" (p. 341). In health inequalities research, SEP is used to understand the significance of multiple exposures, resources, and susceptibilities that may impact health (Galobardes, 2002).

Theoretical literature on social class proposes that social and political mechanisms in a society determine class division, which in turn influences an individual's socioeconomic position in terms of power, prestige, and access to resources (Lynch & Kaplan, 2000; Solar & Irwin, 2010). To clarify the concept of SEP in health inequalities research, sociological traditions of class theory have been utilized (Lynch & Kaplan, 2000; McCartney et al., 2018; Solar & Irwin, 2010). The Marxist and Weberian schools of thought are the two primary schools of thought for conceptualizing social class, both of which focus on Western capitalist industrialized societies. The Marxist perspective bases social class on whether an individual owns/controls the means of production, such as a business, or is a labourer/worker in that business (Weber, 1978; Karmer et al., 2017). The

second conception of social class views it in terms of an unequal distribution of social resources and life chances (Weber, 1978; Karmer et al., 2017).

The Marxist social class and social stratification theory has been criticized for, among other things, being an oversimplification of the intricacies of social interactions and processes. Wright (1985) asserts that Marxist theory simplifies social stratification into a dichotomous connection between the bourgeoisie and the proletariat, while also neglecting the existence of intermediary classes and groups. Grusky (2001) goes on to argue that, in order to defend Marxist theory's position that capitalism is the sole cause of social stratification, the theory places an excessive amount of emphasis on economic determinism while ignoring the cultural, political, and psychological factors that also shape social stratification. According to Featherstone (2010), social status and power are not simply driven by economic reasons; rather, they are also determined by cultural values and social networks. Savage (2015) argues that Marxist theory has to be complemented by other theoretical views in order to adequately describe the intricacies of social stratification in the 21st century.

The Weberian position on social class has been criticized on the grounds that it ignores significant economic elements that play a role in the formation of social inequalities. Wright (1985) asserts that Weber's theory focuses too much on status and power while ignoring the economic component of one's social class. Grusky (2001) argues that Weber's theory of social stratification is weaker in its explanatory power because it does not adequately take into consideration the influence of economic forces. Collins (1986) provides a critique of Weber's theory that highlights the relevance of structural variables in producing social inequalities.

Bourdieu’s theory on Social Class, Capital, and Habitus

Bourdieu's theory of social class, capital, and habitus provides a unique perspective on social stratification that incorporates elements of Weberian and Marxist theories (Bourdieu, 1984). According to Bourdieu, social class is determined by the possession and utilization of various forms of capital, including economic, cultural, and social capital (Bourdieu, 1986). The similarity of these forms of capital among individuals brings them

together in social space and has the potential to form a social class (Bourdieu & Wacquant, 1993). In addition, the ownership of capital determines a person's position of authority in specific fields, which are structured systems of social positions (Crossley, 2001).

Bourdieu's concept of habitus refers to the idea that individuals act in a certain way due to their exposure to it and their dispositions (Bourdieu, 2000). People who live in similar life situations and occupy similar places in social space tend to adopt similar habitus and lifestyles (Shilling, 1993). As a result, there is a connection between the social space, people's lifestyles, people's interests, preferences, and behaviour are aligned with the configuration of social space (Bourdieu, 1984).

Bourdieu's theory of capital situates people in social space by considering the amount, composition, and evolution of three forms of capital (social, economic, and cultural) (Bourdieu, 1986). He highlights that the interaction between these forms of capital can be converted into one another, making the use and acquisition of a particular form of capital dependent on the other forms.

Bourdieu's theory has received criticism for its reductionist approach to social inequalities and its exclusive focus on economic hierarchy, ignoring other aspects such as race, gender, and culture (Savage, 2015). The emphasis on human action and choice in his theory has also been criticized for obscuring the structural and institutional processes that sustain social inequalities (Reay, 2017).

Despite these criticisms, Bourdieu's perspective on social class, capital, and habitus has been utilized to inform research on health inequalities (Grineski, 2009; Veenstra, 2007). This approach allows for the consideration of diverse resources in understanding health inequalities and provides insight into frequently ignored social structure indicators that impact health, such as cultural factors (Veenstra, 2007). It also helps to investigate the social space-based causes of health inequalities (Gartrell et al., 2004).

In this study, Bourdieu's perspective on social class, various forms of capital and the concept of habitus has been utilised to inform the investigation. The application of

Bourdieu's perspective has substantial benefits. First, it permits the consideration of diverse resources when attempting to comprehend health inequalities (Grineski, 2009). Second, it provides insight into frequently ignored social structure indicators that impact health, such as cultural factors (Veenstra, 2007). In addition, Bourdieu helps us investigate the social space-based causes of health inequalities (Gartrell et al., 2004).

2.3.3. Approaches to the study of Health Inequalities

As discussed in the proceeding section, studies have consistently shown a strong association between socioeconomic status (SEP) and health inequalities (Commission on Social Determinants of Health (CSDH), 2008; Marmot et al., 2008). One of the fundamental questions regarding the relationship between SEP and health status is whether low socioeconomic status leads to poor health or vice versa. Researchers have approached associating socioeconomic status with health by applying three perspectives: social causation, social selection, and life course perspectives. However, due to the consistent empirical evidence supporting the social causation perspective, the health inequalities study is dominated by the social causation perspective (Solar & Irwin, 2010).

Social causation

From the social causation perspective, socioeconomic status determines health. It is assumed that low socioeconomic status increases exposure to health hazards, while high socioeconomic status enables an individual to have access to resources that will minimize health-damaging exposures. Socioeconomic status determines a person's lifestyle and life conditions, and these determinants induce a higher or lower distribution of health problems (Drożdżak, 2015). Empirically in Ethiopia, Tesfaye et al. (2017) observed that the lowest socioeconomic groups were suffering more ill health and its consequences. For instance, child undernutrition rates and mortality levels were higher among children from the most impoverished families.

Social selection

The social selection or social mobility concept assumes that socioeconomic status is determined by health, as opposed to vice versa. It assumes that ill health is an

impediment to attaining a high level of education, a decent job, a high income, and the development of advantageous social networks (García-Gómez, van Kippersluis et al., 2013); hence, it hinders the chances for social advancement (Giddens, 1973; Goldthorpe, 1980). In Ethiopia, an empirical study has shown households with mentally ill and physically challenged (due to injuries) adults were more likely to experience poverty (Hailemichael et al., 2019). Globally, however, the available empirical evidence on the social selection (special mobility) perspective is inconsistent, which suggests that the social selection perspective cannot be regarded as the predominant explanation for health inequalities (Solar Irwin, 2010; Elstad, 2001; Marmot et al. in 1997).

Life-course perspective

The life-course perspective recognizes the importance of the linkage between exposure to health-damaging conditions and lasting consequences during the individual's life course and at an inter-generational level. This perspective directs attention to how social determinants of health inequalities operate at an individual's every level of development from early childhood to adulthood, immediately influencing health and producing a basis for lasting consequences. The disease pattern at the population level is understood through the life course perspective by examining how temporal exposure across one cohort's life course is related to previous and subsequent cohorts (Solar & Irwin, 2010).

The three perspectives appear to be more complementary than conflicting. They work together to provide a comprehensive understanding of the relationship between health status and socioeconomic position (Solar & Irwin, 2010). The theories of social production of health and health inequalities discussed in the following section, utilize these three perspectives to clarify the causal pathway linking socioeconomic position and health distribution. To set the scene for the discussion on the pathways of causal linkage between SEP and health, the following section starts by introducing the common measures of SEP and empirical evidence on importance of these variables in health inequalities research.

2.3.4. Measures of SEP and Health Distribution

The accurate measurement of social determinants of health inequalities is crucial in order to identify and address health inequalities (Krieger, 2011). Measuring social determinants of health inequalities can help identify disadvantaged groups and can help inform the development of targeted interventions aimed at reducing inequalities (Marmot, 2005).

Socioeconomic status (SES) is a crucial concept in health research, program targeting, and policy monitoring and evaluation, encompassing both resource-based and prestige-based indicators of social class status (Adler & Newman, 2002). The World Health Organization (WHO) acknowledges the necessity to monitor SEP in order to address health inequalities, adding that "lack of data typically implies denial of the problem" (CSDH, 2008, pp. 20). Understanding socioeconomic health inequalities involves not just data collection but also conceptual clarity on which socioeconomic indicators are being measured and why (Krieger et al., 1997).

In health inequalities research, there are several methods for assessing SEP, including resource-based measures such as income, wealth, and education and prestige-based measures based on occupational prestige, income, and education level. In certain research, area deprivation and subjective social standing are also employed (Smith, Hill, & Bambra, 2016). There is no ideal indicator of SEP for all research objectives, and the choice of measurement should be based on its usefulness for addressing the particular study topic and pathways relating SEP to health consequences (Bartley et al., 1999).

Researchers frequently make pragmatic judgements depending on the availability of data on which socioeconomic status indicators to employ. Rather than simply using individual metrics to rank the population, it is more common to utilise area-based measures. In research on social inequalities in child health in Ethiopia, wealth, place of residence, and mothers' education level have been utilised as indicators of socioeconomic status (Ambel et al., 2017; FMOH, 2016; Skaftun et al., 2014; Tesfaye et al., 2017; Woldemichael, Takian, Akbari Sari A, et al.,2019). These variables are related with child health inequalities and have been frequently employed in national and cross-national studies of health inequalities in low-income countries (Galobardes et al., 2006). In this study the

socioeconomic position (SEP) refers to indicators of an individual's possession or attainment of education, income, and wealth. The section below briefly features these SEP indicators and their association with child health inequalities.

Education status and child health inequalities

Education is frequently utilized as a proxy for knowledge-related factors and serves as an indicator of a person's socioeconomic status in early life and the resources they have access to as adults, such as employment and income, which are influenced by their level of education (Galobardes et al., 2006). However, using education as a socioeconomic status indicator has its limitations. For instance, changes in career opportunities and income levels due to historical events can alter the value of education between different birth cohorts. Additionally, the number of years of education and the level of education achieved may not fully reflect the quality of the educational experience or the knowledge, cognitive, and analytical skills that impact health outcomes (Galobardes et al., 2006).

The positive impact of maternal education on child health has been well established globally and in low-income countries (Bado & Susuman, 2016). However, there is limited evidence of the exact causal pathways between maternal education and child health. In sub-Saharan Africa, studies have shown that maternal education is a strong predictor of child health outcomes, including mortality (Bado & Susuman, 2016; Caldwell, 1994; Hobcraft, 1993). Women with higher levels of education and fewer financial barriers to medical care are more likely to have positive attitudes towards modern health facilities, reject domestic abuse, and have greater autonomy (Wang et al., 2013; Wang et al., 2014; Andriano & Monden, 2019). Maternal education leads to a better understanding and practice of health-promoting behaviours, resulting in increased utilization of health services and greater autonomy in daily life (Bado & Susuman, 2016). Furthermore, higher levels of education have been shown to increase proximity to health facilities (Wang et al., 2013; Wang et al., 2014). Despite its limitations, education remains a commonly used indicator of socioeconomic status.

Income and Child Health Inequalities

Income is regarded the most direct measure of material resources that might influence a person's or family's living standards and have direct health effects (Duncan et al., 2002). The link between income and health is viewed as having a "dose-response" similar to that of education, with income having a cumulative effect over the course of a lifetime despite short-term variations. Many mechanisms influence the relationship between income and health. Access to health-improving products and services, such as food, shelter, and healthcare, is made possible by income. Income also influences psychosocial factors, as it may boost self-esteem and social position, hence increasing social participation (Galobardes et al., 2006). So, income influences health not directly by having money, but indirectly through spending money and assets on health-improving products and services, which may be a more pertinent idea for evaluating how income affects health. Nonetheless, collecting expenditure can be difficult, is susceptible to recall bias, and may not be routinely included in population surveys (Howe et al., 2009). Another method for evaluating income in connection to need and health is to analyse it in terms of poverty. Utilizing poverty as a metric of socioeconomic status requires establishing poverty thresholds as a median or subsistence level tied to biological survival (Krieger et al., 1997).

A strong association between household income and child health outcomes has been observed in Ethiopia and other African countries suggesting the importance of income as measure SEP in determining health outcomes. Children from low-income households are more susceptible to malnutrition and infectious illnesses due to a lack of access to healthcare and inadequate sanitation. These variables raise the likelihood of child mortality, leading to child health inequalities in the country (Akalu, 2018, CSA, 2016). In Sub Saharan Africa, children from low-income households are more likely to have poor health outcomes, malnutrition, and elevated mortality rates (WHO, 2021). Numerous factors, including inadequate access to healthcare, poor sanitation, and low levels of education, exacerbate these inequalities.

Wealth and Child Health Inequalities

Due to individuals' reluctance to share their financial condition, it is difficult to acquire accurate data on income, consumption, and expenditure in developing countries. Hence, household surveys employ a wealth index to assess socioeconomic status (SES) (Rustein et al., 2014; Saif-Ur-Rahman et al., 2018). According to Kreiger (1997), wealth is the accumulation of assets through inheritance, savings, and investment. It is seen as a more objective measure of SES and serves as an indicator of a family's capacity to deal with emergencies or withstand economic shocks (Runstein et al., 2014).

In numerous developing nations, income is uncertain, and subsistence agriculture and non-monetary exchanges are common. Thus, wealth measured by possessions and access to services is frequently used as a measure of economic status (Heaton et al., 2016). Furthermore, household wealth has a significant impact on children's health and health-seeking behaviour, particularly in the modern health sector, as it determines the availability of health-enhancing material resources such as health care, nutritious food, clean water, adequate sanitation, and healthy housing (ibid).

Consistently, studies investigating the relationship between child health and household wealth in developing countries have demonstrated a high correlation between the two. Specifically, Lartey et al. (2016) discovered that children from wealthy households in Ghana were more likely to survive than those from poor households. Similarly, Yavneh et al. (2017) found that in Ethiopia, children from households with a median or higher wealth status were more likely to seek medical treatment for childhood illnesses than those from the poorest households, demonstrating inequalities in the use of child health services.

These SEP measures have considerable importance in health inequalities research. Firstly, SEP provides a summary of an individual's social and economic circumstances and enables researchers to examine the associations between SEP and health outcomes in a standardized manner (Marmot, 2005). Secondly, SEP enables researchers to compare health inequalities between different populations, countries, and over time, and to identify the patterns and trends in health inequalities (, 1997). Throughout this thesis SEP measures are used to refer to an individual’s or population’s possession of

resources, as discussed above. The following section discusses the use of SEP measures in providing an explanation for causal pathways of health inequalities.

2.3.5. Explanations for the Mechanism of SEP Influence on Health Inequalities

According to various theories of health inequalities such as the *mainstream materialist, cultural-behavioural, behavioural, life course and psychosocial* approaches, the social determinants of health are influenced by a person's socioeconomic position. The theories attempt to explain the uneven distribution of health among individuals and groups and offer different perspectives on the mechanisms and pathways that contribute to health inequalities (Bambra, 2011; Bartley et al., 2016; Mackenbach, 2012).

The *materialist* perspective focuses on the role of income in providing access to goods, services, and reducing exposure to physical and psychosocial risks, and structural contexts impacting health through living and working conditions, and access to material resources. This approach emphasizes the direct influence of socioeconomic status on health (Bambra, 2011; Krieger, 2014; Marmot, 2002).

The *cultural-behavioural* approach suggests that variations in health-related behaviours among different socioeconomic classes explain the link between socioeconomic status and health outcomes. These behaviours include smoking, alcohol and drug use, diet, physical activity, sexual behaviour, and healthcare utilization. This approach argues that lower socioeconomic classes may engage in more unhealthy behaviours due to social acceptability and disadvantages (Bambra, 2011; Bartley et al., 2016).

The *psychosocial* perspective emphasizes the role of psychological factors in health inequalities. Lower socioeconomic status and relative disadvantage lead to stress and negative mental states such as shame, worthlessness, and chronic stress, which activate the physiological stress response leading to ill health (Bambra, 2011; Kawachi & Kennedy, 1999; Wilkinson, 1996).

The *life course* approach suggests that health inequalities between different socioeconomic classes arise due to various mechanisms and processes that accumulate advantages and disadvantages across an individual's lifetime in terms of social,

psychological, and biological factors (Bourdieu,1984). This approach integrates different perspectives to explain the social gradient in health inequalities (Bambra, 2011a; Kuh et al., 2003).

In conclusion, the various theories of health inequalities offer different perspectives on the mechanisms and pathways that contribute to the uneven distribution of health among individuals and groups based on their socioeconomic position. They help us understand how people's socioeconomic circumstances determine their daily living conditions and health status and provide insights into potential policy actions (Krieger, 2014; Marmot, 2002). However, numerous scholars have identified notable limitations of these theories of mechanisms and pathways of social health inequalities. The limited capacity of explaining spatial (regional) health inequalities in particular is highlighted in the section below.

2.3.6. Limitations of Theories of Socioeconomic Based Explanations on Spatial Health Inequalities

Although materialist, cultural-behavioural, life course, and psychosocial approaches have made significant contributions to our understanding of health inequalities, they have limitations in explaining health inequalities in various contexts. These explanations overly emphasise access to material resources. However, empirical evidence suggests inequalities persist despite better access to material resources. For instance, in Western European countries with generous welfare programs, where there is universal access to healthcare and social services, health inequalities persist despite the availability of such resources (Bambra, 2011; Mackenbach, 2012). This suggests that the mechanisms underlying health inequalities are more complex than the mere availability of material resources. Furthermore, the existing theories of health inequalities have struggled to provide a comprehensive explanation for the inequalities experienced by individuals with disadvantaged gender and ethnic profiles. Hankivsky et al. (2017) and Holman et al. (2021) argue that health inequalities in these groups result from multiple and intersecting factors, including discrimination, cultural norms, and historical and structural factors.

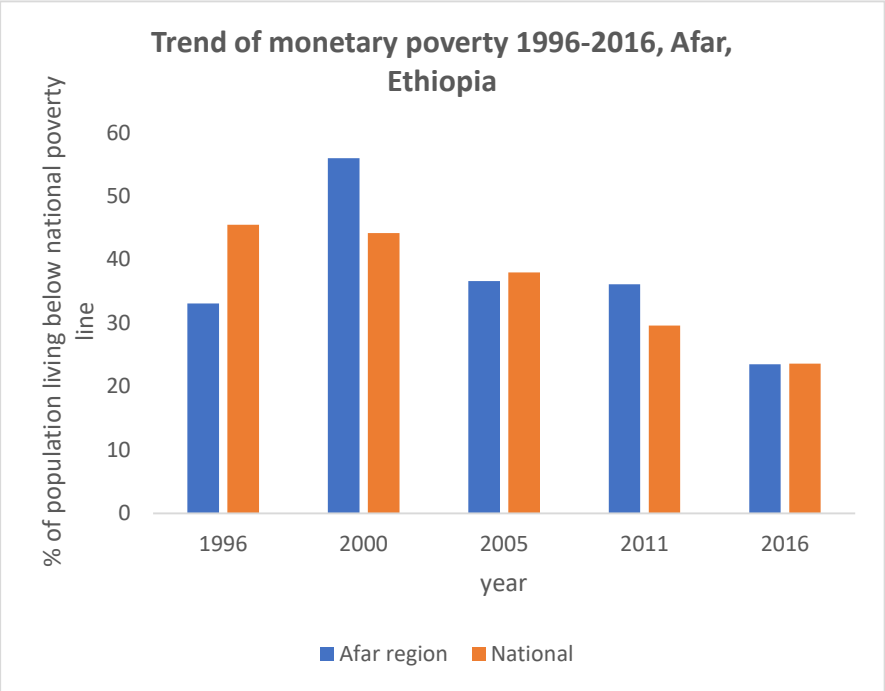
Similarly, Bambra et al (2019) argue that theories of health inequalities are inadequate in fully explaining health inequalities associated with geography.

These arguments suggest that explanations based solely on socioeconomic position (SEP) are insufficient in understanding health inequalities. Holman et al. (2021) contend that such explanations are one-dimensional and fail to account for other important categories, such as gender, ethnicity, and place of residence, despite their decisive influence on social status (Bartley et al., 1998; Eikemo et al., 2008). Furthermore, such explanations may exclude structural variables from the analysis, resulting in an incomplete understanding of the complex pathways underlying health inequalities and making health inequalities an "apolitical" matter (Beckfield & Krieger, 2009; Palencia et al., 2014).

To address the limitations in understanding health inequalities using the existing theories of health inequalities, scholars have proposed a comprehensive approach that considers both socioeconomic position and underlying structural factors that contribute to different socioeconomic positions (Bambra, 2011; Mackenbach, 2012; Bambra, Smith, & Pearce, 2019). Bambra (2011) asserts that no single theory can explain health inequalities within and across countries, and that existing theoretical explanations must be combined to empirically explain these inequalities. This is particularly important for understanding spatial health inequalities, where neither individual socioeconomic characteristics nor contextual characteristics alone can fully explain the persistence of health inequalities (Bambra, Smith, & Pearce, 2019).

This research focuses on the case of the Afar region of Ethiopia, where child mortality rates have consistently been the highest over the past two decades, at 123 child deaths per 1000 live births in 2016, nearly double the national rate of 67 child deaths per 1000 live births. Surprisingly, it appears there are no significant differences in socioeconomic indicators between the Afar region and the rest of the country, as demonstrated in Figure 5 and 6. These figures show that household monetary poverty and the degree of multiple child deprivation in the Afar region are not significantly different from most other regions in the country, except for large cities. Thus, the observed child health inequalities in the

Afar region may not be adequately explained by variations in socioeconomic position alone.



Source: UNICEF Ethiopia, data visualisation created by author

Figure 8: Trend of monetary poverty in Afar region Ethiopia, 1996-2016

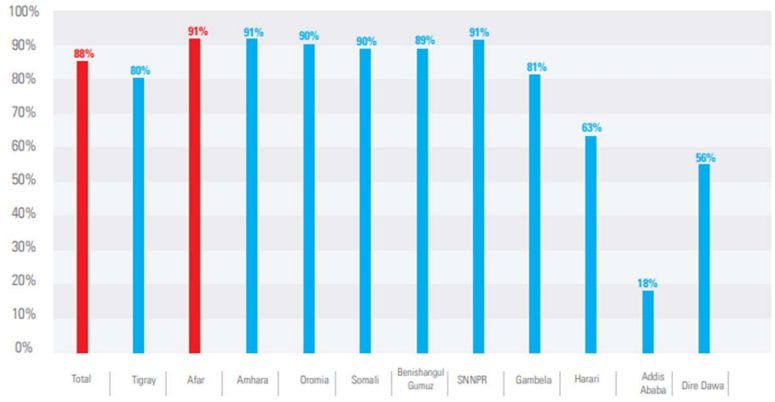


Figure 9: Rate of Multiple Child Deprivations 3 (3 to 6 deprivations) in Ethiopia by region,

Source: CSA and UNICEF, MCD in Ethiopia. First National Estimates, 2018

[3] MCD (Multidimensional Child Deprivation) constitutes individual child's deprivation related to Development, Nutrition , Health , Water , Sanitation and Housing. Figure 6 is based on CSA and UNICEF, Multidimensional Child Deprivation in Ethiopia. First National Estimates, 2018

It is evident from the reviewed literature thus far and the empirical evidence in Ethiopia context that the exclusive focus on socioeconomic status (SEP) variables may not yield an all-encompassing understanding of spatial health inequalities. Building upon the work of Bambra et al. (2019), it is posited that the scholarly discourse surrounding the political economy of health inequalities offers valuable insight into public policy processes and contextual elements that may exert influence upon health inequalities in a given context. This inquiry stands to benefit from taking into account the impact of these factors, in conjunction with SEP indicators, on the geographically rooted child health inequalities present inequalities in Ethiopia.

The subsequent section will undertake a comprehensive examination of the germane literature pertaining to structural determinants of spatial health inequalities.

2.4. Determinants of Spatial Health Inequalities

2.4.1. Introduction

This study endeavours to investigate the influence of the public policy process on the perpetuation of regional child health inequalities in Ethiopia. Public policy is a political phenomenon, and to scrutinize its relationship with health inequalities, it is essential to delve into the underlying structural factors in a specific context (Gilson et al., 2018). To this end, insights from the systems of stratification theory and the concept of power can shed light on the mechanisms of resource allocation in contemporary society. Scholars and practitioners have acknowledged that comprehending the root causes of health inequalities necessitates examining power imbalances at various levels, ranging from individual interactions to societal structures (Sriram et al., 2018), and systems of stratification (Grusky, 2010).

Drawing upon the social stratification theory, inequalities in valuable goods, including health, are posited as outcomes of a stratification system, a complex of institutions that generates inequalities in income, political power, social esteem, and other valued goods (Grusky, 2010). Grusky (2014) contends that social inequalities arise from the interplay between different social structures, institutions, and cultural norms that determine allocation rules for distributing resources to various social strata.

Power dynamics operating in a specific context play a pivotal role in determining allocation rules, i.e., who gets what (Grusky, 2010). Power refers to the ability to control resources and influence people (Buse et al., 2012). However, the nature of power is viewed from varying perspectives. Prominent scholars, Foucault(1991 in Graham Burchell, Colin Gordon, & Peter Miller (eds.),) and Bourdieu(1984) present distinct perspectives on power. Foucault envisions power as a pervasive, diffuse network beyond conventional agency or structure, emphasizing its elusive nature (Foucault, 1991 in: Graham Burchell, Colin Gordon, & Peter Miller (eds.)). In contrast, Bourdieu defines power as culturally embedded, continually legitimized through the interplay of agency and structure (Bourdieu, 1984). Central to Bourdieu's framework is 'habitus,' encapsulating enduring dispositions and structured tendencies that guide behaviour and thought. 'Habitus' serves as a conduit for societal norms becoming internalized within individuals (Wacquant, 2005; Navarro, 2006). While Foucault underscores the ubiquity of power, Bourdieu's focus on 'habitus' highlights how power operates through ingrained cultural and social norms, perpetuated within individual subjectivities. This study acknowledges the ubiquity of power and various channels through which power operates. Attempted to examine which of the channels power operates through has relatively more impact on public policy process.

In the context of the stratification system prevalent in contemporary society, power dynamics and relationships among elites, rulers, and the ruled determine resource allocation. The primary premise is that the allocation of resources is a matter of elite bargain, and the subordinate classes are dispossessed of major decisions on politics and the economy (Grusky, 2010). The inquiry into power dynamics encompasses various lines of cleavage between powerful elites, the cohesiveness of elite groups, and how dominant groups recruit and retain allies. In the context of regional child health inequalities in Ethiopia, understanding the power dynamics and allocation rules that perpetuate such inequalities is essential. The Ethiopian government is constitutionally responsible for providing health and social wellbeing services to the population, and the public policy process plays a critical role in determining how resources are allocated to different regions (FRDRE, 1995). However, the power dynamics at play, such as the

relationship between the ruling elites and the ruled, can result in the unequal distribution of resources and perpetuate health inequalities.

To investigate the role of the public policy process in perpetuating regional child health inequalities in Ethiopia, it is necessary to examine the power dynamic and systems of stratification in the Ethiopian context. This section discusses the literature on structural factors that impact spatial health inequalities via public policy channels. The main themes include why place (geographic setting) matters for health inequalities, the political determinants of geographic (spatial) health inequalities, the political economy perspective on spatial health inequalities, the concept of the welfare state and health inequalities, health care models and implications for health inequalities, and a political settlement as a political economic analysis approach suited for developing countries.

2.4.2. Place, Politics and Health Inequalities

The present investigation centres on inequalities in child health, which are linked to the residential location (region) and contextual characteristics pertinent to health inequalities. It is imperative to elucidate the existing knowledge concerning the association between place and health inequalities, as well as the significance of political factors in this relationship.

Health geography literature highlights the importance of distinguishing between the concepts of place and space to ensure their proper utilization and to enhance comprehension of the various ways geography can influence health outcomes (Bernard et al., 2007). Place refers to an individual's affiliation with political or administrative units, such as cities, states, or school districts, where numerous government-administered health programs and policies are uniformly implemented within their boundaries. Consequently, the health outcomes of these programs and policies are contingent upon individuals' association with a specific political or administrative entity rather than their physical location (Bernard et al., 2007). In contrast, an individual's exposure to spatially distributed health risks and protective factors, such as air pollution or proximity to health facilities, is influenced by their particular physical location (ibid).

For example, exposure to air pollution might aggravate asthma symptoms, while other geographically patterned health risks and protective factors encompass proximity to landfills and crime concentrations (Bernard et al., 2007). Therefore, distinguishing between place and space is essential when examining the relationship between geography and health to ensure a comprehensive and accurate understanding of the mechanisms driving health outcomes.

Research has demonstrated that an individual's place of residence significantly impacts their health and can result in inequalities in health distribution (Andrews et al., 2014). These studies have found that an individual's health is shaped by their social group and geographic context, encompassing their birthplace, residence, workplace, social interactions, and environmental experiences. Moreover, prior research has highlighted the importance of an individual's geographic location as a determinant of health inequalities (Elliott, 2018; Cummins et al., 2007; Cunningham et al., 2015).

The Composition and Context Debate on Spatial Health Inequalities

The composition and context debate on spatial health inequalities has been a prominent topic within the field of public health and geography. Despite the extensive research conducted on this issue, there remains a lack of consensus among scholars regarding the relative importance of compositional and contextual factors in shaping health inequalities (Bambra, 2016; Bernard et al., 2007; Curtis, 2004). The lack of consensus mostly lies on the emphasis given on whether the place and its context matters or the socio economic characteristics of people who live in the place (Curtis, 2004). This academic discourse is essential, as it helps to identify the most effective interventions and policy measures to address health inequalities across different spatial scales.

As mentioned earlier, the compositional explanation posits that health inequalities are driven by individual-level factors, such as socioeconomic status, education, and lifestyle behaviours, that cluster geographically (Macintyre et al., 2002). This perspective has been supported by numerous studies demonstrating that individual characteristics are significant predictors of health outcomes (Marmot, 2005; Wilkinson & Pickett, 2009). However, this explanation has been critiqued for its reductionist approach, as it may not

fully account for the complex interplay between individual and contextual factors (Bernard et al., 2007).

On the other hand, the contextual explanation emphasizes the importance of place-based factors in shaping health inequalities, such as environmental conditions, access to healthcare, and social cohesion (Macintyre et al., 2002). A growing body of evidence supports this perspective, highlighting the role of neighbourhood characteristics such as access to services, environmental conditions, crime and safety in determining health outcomes (Diez Roux & Mair, 2010; Kawachi & Berkman, 2003). However, critics argue that contextual factors may be confounded by compositional factors, making it challenging to disentangle their separate effects on health (Curtis, 2004).

Acknowledging the limitations of the context-composition approach, some scholars have called for a broader perspective that considers macro-political and economic factors in explaining spatial health inequalities (Bambra, 2016; Cummins et al., 2007). These factors, such as economic opportunities, social welfare policies, and political decision-making processes, can influence the distribution of resources and opportunities across different spatial scales, thereby shaping health inequalities (Pickett & Wilkinson, 2015; Skalická et al., 2009).

The Relational Perspective in Spatial Health Inequalities

In a more recent study, Bambra et al. (2019) posited that the context-composition approaches are not mutually exclusive, and that the health outcomes of a particular location are a result of the complex interplay between individuals and their broader environment. This stance aligns with the notable work of Cummins et al. (2007), who reintroduced a holistic 'relational' perspective to the study of health distribution and its relationship with place. The relational perspective, as articulated by Cummins et al. (2007), presents a comprehensive approach to examining spatial health inequalities, recognizing the reciprocal interdependence between compositional and contextual factors. This viewpoint highlights the dynamic and interconnected nature of the various elements contributing to health inequalities and supports the argument that health

outcomes arise from the intricate interactions between individuals and their surrounding environment (Macintyre et al., 2002).

Incorporating scale into the analysis of context relevant to health allows researchers to better apprehend the multifarious influences on health outcomes across diverse spatial levels, encompassing local neighbourhoods to global structures (Cummins et al., 2007). This approach enables examination of how broader political, economic, and social processes intersect with individual- and community-level factors to shape health inequalities, thereby offering a more refined comprehension of the underlying mechanisms of spatial health inequalities (Macintyre et al., 2002).

Furthermore, the relational perspective accentuates the significance of understanding the dynamic nature of places and the way they evolve over time. Places should not be viewed as static entities; rather, they undergo transformations due to fluctuating demographic patterns, economic development, and policy interventions, among other factors (Cummins et al., 2007). Adopting a relational approach can be useful in investigating how these shifts impact the interactions between individuals and places, and consequently, influence health outcomes across varying geographic regions. In the context of Ethiopian regional health inequalities, the relational perspective may shed light on many related and overlapping factors important in elucidating the persistent regional health inequalities.

Relational Perspective and Significance of Power

Scholars underscore the importance of power dynamics in shaping and conceptualising place. They contend that the demarcation of territories, allocation of services, infrastructure, and connections between places, and the portrayal of places are not neutral phenomena, but rather the consequence of dynamic social relationships and power struggles between groups in society (Harvey, 1989; Harvey, 1996).

Relational theorists argue that places are shaped and maintained by the actions of actors at different geographic scales, both near and far from the place in question (Conradson, 2005). These actors can take various forms, such as individuals, community groups, businesses, governments, institutions, and even abstract concepts like cultural

movements and norms (Emirbayer, 1997). The actors can be formal or informal and their actions can impact the accessibility of resources, goods, and services in a particular place. The distribution of facilities and their jurisdictions, social networks and power, interventions by various actors, and the level of regulation can all influence the availability and accessibility of resources, resulting in different layers of resources available to different members of local populations (Conradson, 2005).

Towards a Political Economic Perspective in Spatial Health Inequalities

Bambra et al. (2019) recently proposed a departure from the micro-perspective in the study of health inequalities and place, opting for a macro-oriented approach. This approach aligns with the relational perspective, which seeks to reconcile the context-composition oriented approach in a more holistic manner, centralizing the significance of power (Bambra et al., 2019).

The role of place in shaping health inequalities has primarily been studied through a focus on individual and local drivers, employing a context-composition framework (Bambra et al., 2019). While this has significantly enhanced our understanding of the effects of local environments on health and the importance of place in health outcomes, it has inadvertently marginalized the influence of macro-level political and economic structures on both place and health.

Bambra et al. (2019) suggests two critical points to address this limitation:

1. Scaling up the analysis: Researchers must take into account broader, vertical structural factors in addition to local horizontal drivers (Bambra et al., 2019). This will facilitate a more comprehensive comprehension of the relationships between place, political and economic structures, and health inequalities.
2. Linking analysis to policy: To effectively mitigate place-based health inequalities, the analysis of structural factors should be explicitly connected to suitable policy levers (Bambra et al., 2019). This can help ensure that research findings are utilized to inform and shape policy decisions that lead to meaningful change.

To illustrate the value of adopting a political economy approach, Bambra et al. (2019) refer to three case studies: the US mortality disadvantage, Scotland's excess mortality, and regional health divides in England and Germany. Through a political economy lens, the authors analyse these cases to emphasize the importance of considering macro-level structures in understanding and addressing geographical inequalities in health.

Bambra et al.'s (2019) paper advocates for a shift in focus from primarily local drivers to a more comprehensive approach that incorporates macro-level political and economic factors in the study of health inequalities. This broader perspective can provide valuable insights for the development of policies aimed at reducing place-based health inequalities.

In recent years, the wider acknowledgement of the importance of examining the power dynamic and the broader political, social, and economic setting in the study of health inequalities gave rise to the adoption of a political economy-informed perspective of analysis of the public policy process (Reich, 2019; Gilson et al., 2018). The Political Economy Analysis is about examining how public policies leading to health outcomes result from the exercise of power and allocation of resources in a given context. According to Reich (2019), "Political economy focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes" (p. 514).

The political and economic analysis of geographic health inequalities has recently been used in empirical research in public policy analysis in low-income countries in sub-Saharan Africa (Bukenya, 2020; Raphael et al., 2020) and in Europe in regional health inequalities studies (Bambra et al., 2019). These studies demonstrated that in-depth understanding of the underlying contextual factors causing health inequalities required to inform policy and programs to address inequalities is only possible from a comprehensive analysis incorporating assessments of the ways in which upstream factors - political and economic structures and processes (at international, national, and local levels) shape, through public policy, the nature of the healthcare system and the distribution of economic and social resources and the extent of health differences between social groups (Bambra et al., 2019; Raphael & Bryant, 2019).

2.4.3. Empirical Studies on Political Economic Determinants of Health Inequalities

Numerous policy initiatives have been implemented based on the Social Determinants of Health Inequalities recommendations to achieve health equity, but progress has been slow, and health inequities have even widened in some high-income European countries over the past decade (World Health Organization [WHO], 2020). This has spurred the need to re-examine why progress in tackling health inequalities has stalled or worsened.

According to the WHO (2020), political commitment is crucial in driving policy changes for health equity. Scholars such as Doyle (1979), Kickbusch (2015), and Bambra et al. (2005) have highlighted the political nature of health and its unequal distribution among social groups, as well as the modifiability of social determinants of health through political interventions. Numerous studies have investigated the relationship between political factors and health inequalities, including Kittelsen et al. (2019), Mishori (2019), Reich (2019), Raphael and Komakech (2020), and Sriram et al. (2021).

The most relevant conceptualization of politics for health policy and public policy is the politics of power, which pertains to the process of achieving desired outcomes in the production, distribution, and use of scarce resources across various aspects of social life (Heywood, 2000; Marsh and Stoker, 2002, as cited in Bambra et al., 2005). This perspective on power, essentially how resources are managed in society, aligns with the concept of 'governability'. Governability, rooted in the ideas of Foucault (1991, as cited in Graham Burchell, Colin Gordon, & Peter Miller (eds.)), goes beyond traditional political governance. It encompasses various practices, from societal norms and disciplinary methods to economic strategies and educational systems. Importantly, it provides a way to understand the complex layers of power, especially in recognizing the impact of governance actors (distinct from government entities) in shaping national health policies. This understanding is crucial because health governance operates at the global, national, and regional levels (Mackenbach, 2014; Navarro et al., 2006; Erasmus & Gilson, 2008; Gilson, Schneider, & Orgill, 2014; Gore & Parker, 2019).

A significant body of research, primarily conducted in developed Western countries, has examined specific political factors contributing to cross-national health inequalities, including welfare state arrangements, health inequalities between socioeconomic groups, and cross-national differences in health (Navarro & Muntaner, 2004; Schrecker & Bambra, 2015; Bambra et al., 2005; Krieger, 2003; Diderichsen et al., 2001. Studies (Navarro & Muntaner, 2004; Schrecker & Bambra, 2015; Bambra et al., 2005; Krieger, 2003; Diderichsen et al., 2001) have shown policies that improve working conditions and expand access to social protection can help reduce health inequalities. Addressing social inequalities, such as racism and poverty, is also essential for reducing health inequalities. Political will and action are necessary to promote health equity by addressing the social and economic factors that shape health inequalities (Bambra et al., 2005; Krieger, 2003).

Barnish, Tørnes, and Nelson-Horne (2018) conducted a systematic review of international studies and found substantial evidence supporting the link between political factors and population health outcomes, with a particular focus on the impact of social welfare policies and income inequalities. Further research is needed to better understand the complex interactions between political factors and population health outcomes and to identify effective policy interventions that can promote health equity.

Backfield (2018) reviewed empirical literature and demonstrated that globalization and neoliberal policies have contributed to widening health inequalities worldwide. Neoliberal policies, which prioritize free markets and individualism, have led to the erosion of social welfare programs, making it more difficult for individuals to access essential resources and services that promote health. Policies that prioritize equity and redistribution, as well as greater global cooperation, are needed to address health inequalities on a global scale.

Limited studies exist on health inequalities and political determinants of health in low- and middle-income countries. Gogoi and Sumesh (2021) demonstrated in a recent study in India that political actors and institutions play a crucial role in shaping the distribution of resources and healthcare services across different regions of India, leading to significant health inequalities. The lack of political will and commitment to prioritize health equity has resulted in inadequate investments in health infrastructure, human resources, and social

protection measures in disadvantaged regions. Addressing these political determinants of health inequalities will require a multi-sectoral and participatory approach, focusing on strengthening governance, promoting accountability and transparency, and ensuring meaningful participation of marginalized communities in health policy formulation and implementation.

In Myanmar, Campbell et al. (2018) highlighted political instability, weak governance, and limited policy space for pro-health equity policymaking as political determinants of regional health inequalities. The absence of political commitment to prioritize health equity, coupled with a lack of coordination between different government sectors, has led to inadequate investments in health infrastructure and human resources, particularly in disadvantaged regions.

Raphael and Komakec (2017) underscored the importance of government commitment to health equity and the role of social protection policies, including community-based health insurance schemes, in promoting equitable access to healthcare in their case study in Rwanda. The authors argue that understanding health equity in Africa requires a political economy of health lens that considers the social, economic, and political determinants of health.

Overall, the literature highlights the importance of considering political economy factors in public health policy and practice. Political decisions and policies significantly impact health inequalities, and addressing the social and economic determinants of health can positively affect population health outcomes. The prominent focus of existing studies revolves around the concept of the welfare state in developed countries, Health care models and the limited number of studies in low- and middle-income countries highlights the aspects of political settlement. These concepts help us elucidate the political economy of spatial child health inequalities.

The concept of the welfare state emphasizes the importance of social policies and institutions that aim to promote the welfare of individuals in society. The provision of universal healthcare, education, and social protection is essential in reducing health inequalities (Bambra et al., 2005; Navarro & Muntaner, 2004). The Health Care Models

are concepts highly linked to the Welfare State but require separate examination to get a more thorough insight about their relationship with health equity(McKee & Stuckler, 2017). The welfare state approach recognizes the role of the state in promoting health equity, and effective policies should prioritize equitable distribution of resources and services.

The concept of political settlement has been demonstrated to be useful in understanding health equity in low- and middle-income countries (Sriram et al., 2021; Khan, 2010, Sparkes et al., 2019). Political settlements refer to the agreements and arrangements among different societal groups and actors that determine the distribution of power and resources (Khan, 2010). The political settlement approach recognizes the importance of political institutions and governance actors in shaping health policies and outcomes. Effective policies that promote health equity in low- and middle-income countries require a thorough understanding of the political economy and the role of different actors in policymaking processes.

In the following sub-section, the concept of the welfare state and health care models, implications for health inequalities, and political settlement analysis will be discussed.

2.4.4. The Welfare State, Public Policy, and Health Inequalities

The literature on the social determinants of health and health inequalities underscores the imperative for policymakers to address broader social circumstances which indirectly influence individuals' health outcomes and life expectancy. This shift towards broader life conditions—such as childhood upbringing, education, employment, and economic resources—and their bearing on health outcomes has subsequently intensified focus on the broader policy milieu (Solar & Irwin, 2010; CSDH, 2008). Consequently, myriad policies and programmes addressing domains like education, employment, income, living environments, and access to health-promoting services have emerged as pivotal instruments to mitigate health inequalities through integrated governmental action (CSDH, 2008).

Historical analyses reveal that these policy and programme combinations are seldom arbitrary. Contrarily, the formulation and operationalisation of policies aimed at rectifying

inequalities in different welfare states are steered by distinct philosophical paradigms (Gore & Parker, 2019; Bourdieu, 1984). Pertinent to the welfare state concept within public policy analysis are two salient queries: firstly, what catalyses the typology and proliferation of contemporary welfare states, and secondly, how effective have varied welfare state strategies been in achieving their set objectives? Specifically, what typifies welfare states, and how efficacious have they been in attenuating health inequalities? Addressing these questions holds significance for policymakers, especially if evidence suggests certain welfare state archetypes more effectively enhance societal conditions, thereby bolstering health outcomes and diminishing inequalities.

It's widely recognised that policies and institutions of the welfare state can modulate the distribution of Socio-Economic Position (SEP) determinants (Lundberg et al., 2008). Consequently, welfare state public policies possess the capacity to mediate the relationship between SEP, locality, and health (Eikemo & Bambra, 2008). Notably, the bulk of welfare state policies and associated research predominantly emanate from developed Western democracies (Bergqvist et al., 2013; Soziol et al., 2019), prompting queries regarding the applicability of the welfare state paradigm to developing nations. The subsequent section delves into the advantages and limitations of incorporating the welfare state construct into this research.

Concept of Welfare State

In the dynamic landscape of modern economies, welfare state social policies are instrumental in structuring labour markets and insulating citizens from social adversities, such as unemployment, single-parenthood challenges, disability, and illness (Brennenstuhl et al., 2012). Bambra et al. (2007) articulates the welfare state as a state-driven provision of social amenities and services, encompassing housing, education, healthcare, and poverty alleviation, among others. Crucially, the welfare state concept transcends mere state intervention, encapsulating familial and market facets as delineated in diverse definitions. Chung et al. (2008) conceptualises the welfare state as the confluence of the state, market, and family in proffering benefits and services to a nation's populace.

Recent decades have witnessed an upsurge in empirical endeavours probing the nexus between health distribution across populations and welfare states, primarily via cross-national and intra-national comparative studies. Dahl and van der Wel (2007) identify three predominant methodologies characterising the welfare state in the context of health inequalities: regime typologies, social expenditure practices, and welfare institutions.

- **Regime Approach**: Esping-Andersen's (1990) regime approach stratifies countries based on their political constituents and the degree of assimilation of three welfare dimensions—decommodification, social stratification, and the private-public nexus. This approach demarcates countries into prototypical regime categories: liberal, conservative, and social democratic, among others. While extensively employed in empirical studies for descriptive objectives (Bambra, 2007; Hurrelmann et al., 2011; Schröder, 2019), its efficacy in elucidating the association between specific welfare state facets and health inequalities has been critiqued (Lundberg, 2008).
- **Expenditure Approach**: This methodology evaluates the welfare state's magnanimity and endeavour through the prism of public social protection and service expenditures, typically expressed as a GDP percentage (Gilbert, 2009). However, it's imperative to differentiate between effort and necessity, as elevated unemployment benefit expenditures might merely mirror a heightened unemployed demographic, rather than enhanced coverage (Dahl & van der Wel, 2013).
- **Institutional Approach**: This paradigm focuses on the design and implications of specific welfare programmes and their impact on health and health inequalities. It underscores the genesis and evolution of welfare institutions, social policies, and their interplay with public health (Korpi & Palme, 2007).

While regime typologies offer a panoramic view, the Institutional and Expenditure approaches delve into precise "welfare outcomes." Each methodology possesses distinct strengths and limitations (Susilo et al., 2019).

Hurrelmann et al.'s (2011) comprehensive model endeavours to elucidate the relationship between welfare state regimes and health inequalities, encompassing structural (macro),

organisational (meso), and individual (micro) dimensions. This model underscores the pivotal role of welfare policy architecture and its ripple effects on meso and micro dimensions, thereby influencing health inequalities.

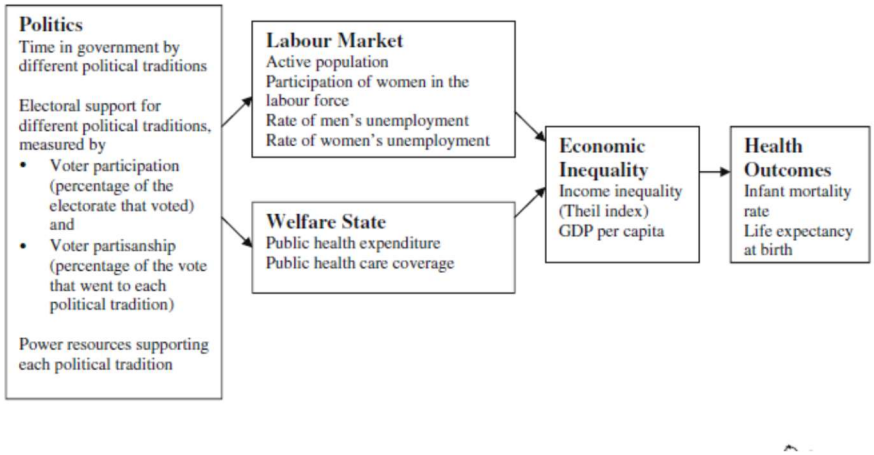


Figure 10: Relation between politics, economic inequalities, and health indicators. Source: Hurlimann et al. (2011)

This study uses the various concepts reflected in the Expenditure, Institutional, and Multi-level models because they allow for assessing the specific policies and programs, the fairness of expenditure levels between regions in Ethiopia, and the various levels of influence in the design and execution of public policies aimed at tackling child health inequalities.

Studies on the Welfare State and Health Inequalities

The nexus between the welfare state and health inequalities has been a focal point of academic discourse. This section delves into this relationship, spotlighting the institutional and expenditure approaches. It collates and synthesises research findings on the efficacy of welfare state policies and programmes, particularly those centred on addressing child health inequalities.

Empirical evidence underscores the efficacy of family benefits in offering a protective shield against health adversities, poverty, and unemployment, especially for single

mothers. Yet, the influence of income support programmes on health outcomes remains a subject of debate. Some empirical findings posit a salutary impact on maternal and child health, while others suggest negligible to moderate effects on adult health. Notably, studies rooted in low to middle-income nations have illuminated the largely positive repercussions of income support programmes on child health, albeit with differentiated impacts across socioeconomic strata (Marmot, 2005).

The magnanimity of unemployment benefits has been positively correlated with improved health indicators among the unemployed. This encompasses enhancements in mental well-being, subjective health perceptions, and financial resiliency. Furthermore, a marked generosity in unemployment benefits is inversely related to health inequalities, bridging the health divide between the employed and unemployed cohorts (Artazcoz et al., 2004).

Publicly funded and administered healthcare services manifest a decline in socio-economic health access inequalities. Concurrently, supplementary private health insurance is predominantly associated with higher income brackets, superior self-perceived health, and elevated specialist consultations. This suggests an advantage for high-income individuals accessing healthcare and consequent health improvements via private supplementary insurance (Blendon et al., 2010).

Public health interventions, with their preventive orientation, are pivotal in the quest to diminish health inequalities. Evidence demonstrates that broad-based interventions, such as promoting wholesome diets, resonate more effectively among socioeconomically disadvantaged groups. In contrast, interventions tailored for individuals are more efficacious among the socioeconomically advantaged, particularly in contexts like obesity and smoking cessation initiatives (Krieger et al., 2002).

The empirical terrain corroborates the significant influence of welfare state policies and programmes on health inequalities. This body of literature offers invaluable insights into the effectiveness and implications of family benefits, economic aid, unemployment benefits, healthcare access, and public health interventions. These revelations accentuate the pivotal role of the welfare state in navigating health inequalities and furnish crucial takeaways for policy architects and practitioners.

Limitations of Welfare State Approach in Low and Middle-Income Countries.

The concept of the welfare state was originally developed within the framework of Western capitalist societies. However, there is growing interest in its applicability to health inequalities policies in developing countries (Raphael et al., 2020). Although there is some debate regarding the relevance of the welfare state approach in Africa, Kunstler and Nollert (2017) suggest that it may not be applicable due to the lack of a comprehensive typology of African states that covers all relevant dimensions of welfare. Conversely, Raphael et al. (2020) argue that welfare concepts are critical in African countries, given their increasing transformation towards neoliberal market-oriented models similar to Western capitalist economies. These economic changes have altered the structure of African societies and their relationship with the state, resulting in pervasive inequalities (De Maio, 2014; Forster et al., 2019).

However, the unpredictable and intricate political-economic context of African countries like Ethiopia raises questions about the efficacy of applying a welfare state-based analysis to explain public policy processes and persistent child health inequalities. The existing welfare state regime typologies do not align with African states' political governance, and African states do not necessarily follow formal rules and regulations but instead depend on informal power structures such as ethnic alliances (Abdulai,2017;Khan, 2017 ;Khan,2010). Nevertheless, the welfare state approach to expenditure and specific redistribution policy measures could provide valuable insights into the appropriateness and relevance of sector policy programs (Kingdom) in the Ethiopian context. The World Health Organization (2008) suggests policies and programs with similar objectives and approaches to welfare states, such as altering social stratification, decreasing people's exposure to health-damaging factors, increasing disadvantaged groups' resilience, and relying on health and healthcare delivery systems. Therefore, combining the welfare state concept and the political-economic reality of sub-Saharan Africa could be helpful in understanding why geographical child health

inequalities persist in Ethiopia. Recent studies in Sub Saharan Africa employed combination of these perspectives(Raphael and Komakech ,2020, Abdulai,2017)

2.4.5. Health Care Models and Health Inequalities

Healthcare models have been recognized as crucial frameworks or approaches that guide the provision of healthcare services to individuals and populations. It has been observed that healthcare models employed by a particular country or region can significantly impact health inequalities (McKee & Stuckler, 2017). Countries that use socialized healthcare models, such as Canada and the United Kingdom, provide universal access to healthcare services, irrespective of the individual's ability to pay (Morgan et al., 2016). This approach can effectively reduce health inequalities as everyone has access to necessary healthcare services, regardless of their income level. Conversely, countries that use market-based healthcare models, such as the United States, often have healthcare services that are dependent on the individual's ability to pay (Squires & Anderson, 2015). This can lead to significant health inequalities as those who cannot afford healthcare are more likely to experience negative health outcomes.

In addition to impacting access to healthcare services, healthcare models can also influence the types of services available to individuals. In socialized healthcare models, preventative healthcare services such as vaccinations and regular check-ups are often provided free of charge, thereby reducing health inequalities (Morgan et al., 2016). On the other hand, in market-based healthcare models, preventative healthcare services may only be accessible to those who can afford them, leading to significant health inequalities (Squires & Anderson, 2015).

Various healthcare models have been employed globally, with each having its strengths and limitations. This essay will compare and contrast three healthcare models: the Beveridge Model, the Bismarck Model, and the National Health Insurance Model.

The Beveridge Model, named after William Beveridge, a British social reformer who proposed it in the 1940s, is characterized by a nationalized healthcare system that is funded and administered by the government. Under this model, healthcare services are

provided to all citizens at no cost, with the government responsible for the payment of healthcare providers. The Beveridge Model eliminates the need for individuals to purchase private health insurance, reducing the financial burden on citizens. However, the model has some limitations, including long waiting times, shortages of healthcare providers, and potential bureaucratic inefficiencies (Saltman & Figueras, 1997).

The Bismarck Model, named after Otto von Bismarck, the German Chancellor who proposed it in the late 19th century, is characterized by a social insurance system that is funded by both employers and employees. This model provides healthcare services through private healthcare providers who are paid via a combination of government and private insurance funds. The Bismarck Model encourages individual responsibility for healthcare by requiring individuals to contribute to the insurance fund and provides a high quality of healthcare services due to competition between healthcare providers. However, the model has limitations, such as unequal access to healthcare services based on an individual's ability to pay and the potential for insurance companies to deny coverage for certain services (Frenk et al., 2010).

The National Health Insurance Model, characterized by a system where the government provides insurance coverage for all citizens, but healthcare services are provided by private healthcare providers, is employed by countries such as Canada and Taiwan. Under this model, the government collects taxes or premiums and uses the funds to pay healthcare providers. The National Health Insurance Model provides universal access to healthcare services while promoting competition among healthcare providers and eliminates the need for individuals to purchase private health insurance, reducing the financial burden on citizens. However, the model has limitations, such as potential long waiting times and administrative inefficiencies (Lu & Hsiao, 2003).

The Out-of-Pocket Model, commonly used in low-income countries, is characterized by a system in which individuals pay for healthcare services out of their own pockets without insurance or government subsidies. This model has the advantage of low administrative costs but has several disadvantages. These include unequal access to healthcare

services based on an individual's ability to pay, limited availability of healthcare providers and facilities, and a financial burden on individuals and families (Mills et al., 2014).

The choice of healthcare model depends on the social, economic, and political context of each country While each model has its strengths and limitations, the ultimate goal is to ensure that all citizens have access to affordable and high-quality healthcare services. In the context of Ethiopia further study may be required to clearly determine which model or combination of models are suitable to the context. The public policy analysis in this study has examined aspects of health care financing modality and the extent to which it impacts spatial child health inequalities.

2.4.6. Political Settlement and Spatial Inequalities in Developing Countries

The analysis of public policy in sub-Saharan Africa using political economic-based frameworks, such as developed countries' welfare regimes, democracy, and political tradition, has limitations in its explanatory potential. As Khan (2017) argues, these frameworks do not provide sufficient explicit and explanatory questions to address public policies in African contexts, where the functioning of formal institutions is unpredictable and does not conform to written rules. Furthermore, the application of welfare regime typologies in the least-developed African countries is limited, as they do not fit neatly into a typical Western welfare state typology (Lundberg, 2008).

In understanding social development outcomes, such as regional inequalities in health, it is more important to examine the power relationships within which institutions are embedded rather than the functioning of regime types or welfare state formal institutions (Abdulai, 2017). The Political Settlement approach, which considers the balance or distribution of power between competing social groups and classes, is more appropriate for analysing the political economy context in sub-Saharan Africa (Di John & Putzel, 2009). Abdulai (2017) argues that the Political Settlement approach has strong explanatory potential in contexts with persistent regional inequalities, such as Ethiopia.

Political Settlement analysis has been used by various researchers to explain state failure, conflict resolution success and failure, and development policy success and failure

(Jones et al., 2010; Lindemann, 2010; World Bank, 2011; Menocal, 2015; Khan, 2010; Pritchett et al., 2017; Whitfield et al., 2015). A recurring theme in most Political Settlement analysis studies is that political context and power dynamics influence the functioning of institutions and policy performance (Kelsall & vom Hau, 2020). To conduct a thorough analysis of the public policy process and outcome, it is essential to understand the political context and power dynamics, as they can facilitate or constrain the state's ability to pursue certain development outcomes (ibid).

Kelsall and vom Hau (2020) argue that there is no single Political Settlement configuration that has the potential to result in positive social development outcomes. Instead, various configurations of Political Settlement can be effective in achieving specific desired outcomes. Therefore, it is crucial to examine the different actors, their interactions, power dynamics, interests, and incentives to understand and explain why public policies succeed or fail. In other words, analysing the political economy context within which a certain public policy has been designed and implemented using the Political Settlement approach has a better explanatory potential for understanding why desired outcomes were not achieved.

To better understand the potential of Political Settlement analysis in explaining public policy outcomes, it is important to examine how different political settlement variants can facilitate or hinder elite commitments and the dedication of a dominant political leadership to pursuing a social development outcome and the state's capacity to implement policy decisions. This requires a nuanced analysis of the political context and the distribution of power among actors involved in the policy process (Khan,2017).

For example, in a context where a dominant political elite has entrenched interests in maintaining the status quo and preventing change, policies aimed at promoting social development outcomes may face significant obstacles. In contrast, policies aimed at enhancing the power and resources of marginalized groups may be more successful in a context where there is a balance of power among different social groups (ibid).

Furthermore, Political Settlement analysis highlights the importance of understanding the incentives that shape actors' behaviour and the ways in which power is exercised within

a particular political system. This includes examining the role of external actors such as international organizations, donors, and multinational corporations, who may have significant influence on policy outcomes (Abdulai,2017).

The argument above asserts that Political Settlement analysis has significant potential in explaining public policy outcomes in sub-Saharan Africa (Abdulai,2017 ;Khan,2017; Khan,2010. By examining the power dynamics and incentives that shape the behaviour of actors, this approach can provide a more nuanced understanding of the political economy context within which policies are designed and implemented. This can help to identify the key challenges and opportunities for achieving social development outcomes in a particular context and inform the design of more effective policies. In this study the political settlement conceptualisation of power dynamics within the broader political economy perspective of health inequalities research is applied to facilitate the analysis process.

2.5. Political Economy Analysis Framework

Political economic analysis, particularly relevant to developing countries, diverse frameworks have been employed (DFID,2009; Fritz, Kaiser& Levy,2009). Among these, the Political Economic Framework by Moncrieffe and Luttrell (2005), is especially noteworthy for its in-depth exploration of the interconnections between political decisions, economic policies, and their influence on development outcomes, such as health equity.

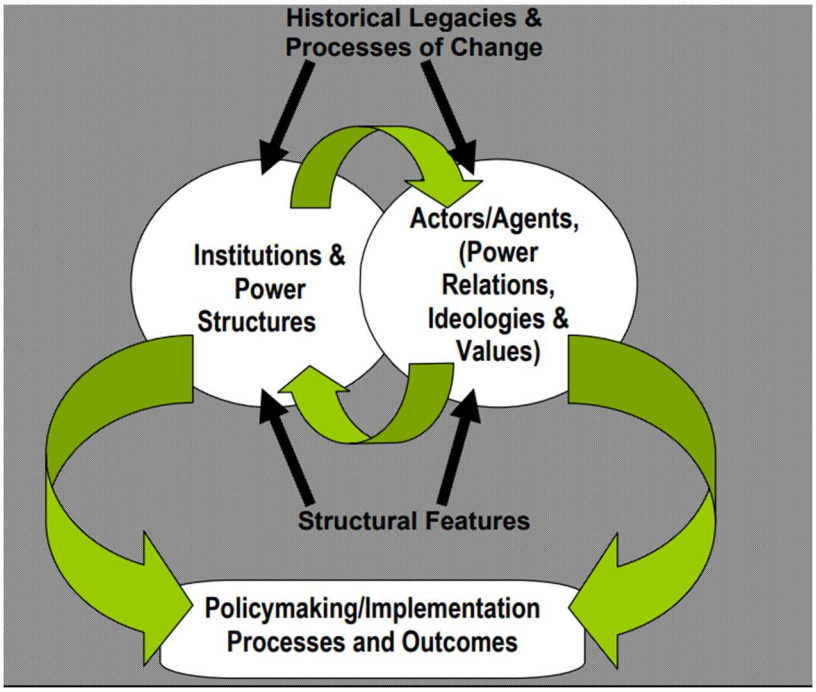


Figure 11 : The Political Economic Framework, Moncrieffe and Luttrell (2005)

Key elements of the Moncrieffe and Luttrell (2005) framework include:

Political Systems and Institutions: This involves a thorough examination of the nature, stability, and efficacy of political systems and government institutions, with a focus on the distribution of power, political participation, and competitive dynamics within the political arena (Moncrieffe & Luttrell, 2005).

Economic Structures and Policies: The framework places a strong emphasis on dissecting economic systems and policies, considering aspects like economic growth, the distribution of resources, and the interactions between state and market forces (Moncrieffe & Luttrell, 2005).

Social Structures and Dynamics: It delves into the configuration of social classes, the roles played by different ethnic and religious groups, and the overall distribution of wealth and resources (Moncrieffe & Luttrell, 2005).

Historical Context: Acknowledging the critical role of a country's historical backdrop in moulding its present-day political and economic systems is a pivotal aspect of this framework (Moncrieffe & Luttrell, 2005).

Role of External Actors: It evaluates the influence of external forces like international organizations, donor countries, and multinational corporations on the internal political and economic landscape (Moncrieffe & Luttrell, 2005).

Ideologies and values: refers to beliefs and practices which are deeply held by individuals, play a significant role in influencing and potentially determining their actions. These ideologies and values can vary greatly both within and across different sectors. Such variations are often crucial in shaping policy decisions and outcomes.

Informal Institutions and Practices: The framework also sheds light on the impact of informal practices, such as patronage systems and corruption, in shaping political and economic outcomes (Moncrieffe & Luttrell, 2005).

Moreover, the Moncrieffe & Luttrell (2005) Political Economic Framework is distinguished by its attention to sectoral public policy and various dimensions of political settlement (Khan, 2010), which includes understanding the underlying agreements and power dynamics among different groups that define governance and policy outcomes.

The application and recognition of the Moncrieffe & Luttrell (2005) Political Economic Framework within the policy research and practice community, particularly in developing countries, underscores its significance and practicality. Its incorporation in scholarly works (Copestake & Williams, 2014; Fisher & Marquette, 2013; Moncrieffe, 2007; Bekele, 2017) and its usage in examining complex political and economic scenarios in countries like Ethiopia (Bekele, 2017; Bekele et al) illustrate its effectiveness for such analyses. Additionally, its adoption in the operational strategies of major international development agencies, demonstrated in the World Bank's 'Problem-Driven Political Economy and Governance Analysis' (Fritz, Kaiser, & Levy, 2009) and the DFID's 'Political Economy Analysis How-To Note' (DFID, 2009), further accentuates its utility.

However, the Moncrieffe & Luttrell (2005) framework does not comprehensively cover the policy process, an essential component of this study. Hence, the Walt Policy Triangle Framework is utilized to facilitate an in-depth examination and analysis of the Ethiopian public policy design and implementation process.

In this study, Moncrieffe & Luttrell (2005) framework assists in addressing the question, 'How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?' Accordingly, the 'context' analysis elements of the study's conceptual and analysis framework described in chapter 4 is drawn from Moncrieffe & Luttrell (2005) framework.

2.6. Public Policy Performance and Determinants of Health Inequalities

As stated in the introductory chapter, this study seeks to examine the Ethiopian Public Policy and provide an explanation of why regional child health inequalities persisted despite improvement in the overall health status of child health across the country. In other words, the study attempts to provide an explanation for performance of public policy in tackling child health inequalities in Ethiopia. The literature on policy performance indicates that evaluating the success or failure of public policies is often controversial, as there is no commonly agreed criterion for what constitutes success or failure (Boyne, 2003; Marsh & McConnell, 2010). While many scholars consider the achievement of policy outcomes as the primary indicator of success, others highlight the importance of the process of engagement and buy-in by the public, as well as the political dimension of policy decisions (Moore, 1995; McConnell, 2010). McConnell (2010) suggests that policy performance should be assessed based on three dimensions: program, process, and politics, which are interrelated and overlap with each other. The program aspect evaluates whether the policy is implemented as per objectives, whether objectives are achieved, and whether resources are used efficiently. The process dimension refers to the deliberative engagement with stakeholders and the settling of controversies during and before making decisions. The political aspect considers the impact of policy decisions on the reputation and power of politicians to manage political agendas.

A policy is considered successful if it achieves its goals and attracts no significant criticism or has universal support. In contrast, a policy is deemed a failure if it does not achieve its goals, faces significant opposition, or has little support. However, policy failure is not an absolute concept, and degrees of failure depend on various parameters chosen by policy analysts (McConnell, 2010). Therefore, in this study, the success or failure of policies will be evaluated by considering all dimensions of policy performance and gauging where they lie within the range of possibilities in the success-to-failure continuum.

The study of policy performance is important as it provides insights into how public policies are designed, implemented, and evaluated in practice. It allows policymakers to learn from past experiences and improve future policies, and it provides accountability to the public. However, the evaluation of policy performance is not straightforward, and policymakers and researchers face various challenges in assessing the success or failure of policies. One of the challenges is that policies may have unintended consequences that were not considered during the policy development stage (Schofield, 2004). Additionally, policies may face external factors such as economic or social changes that affect their outcomes. Furthermore, policies may not be implemented as planned due to factors such as insufficient resources, resistance from stakeholders, or inadequate monitoring and evaluation (Boyne, 2003). These challenges highlight the need for a comprehensive approach to evaluating policy performance that considers all dimensions of policy design, implementation, and outcomes.

The concepts discussed under the political determinants of health will be useful in providing a framework to provide program, process and politics related explanations to public policy performance in tackling health inequalities in Ethiopia. In the Ethiopian context, there is a need to critically examine the policy process and evaluate the performance of public policies in addressing health inequalities. Understanding the factors that have contributed to inability policies in reducing health inequalities. Accordingly, this study will examine the policy process in Ethiopia, identify key questions, and evaluate the success or failure of policies in addressing health inequalities, taking into account the program, process, and political dimensions of policy performance (Schofield, 2004; Boyne, 2003; McConnell, 2010).

2.6.1. Approaches to Public Policy Analysis

Policy analysis theories provide a structured approach for analysing policies and evaluating their impact on different stakeholders. These theories offer distinct perspectives on the policymaking process, emphasizing various aspects of policy development, implementation, and evaluation (Dye, 2013). Nevertheless, it is crucial to recognize that each theory possesses inherent strengths and limitations. This section critically examines the dominant policy analysis theories in contemporary discourse and research, acknowledging that the field of policy analysis is dynamic and evolving, with new frameworks emerging or being redeveloped in recent years (Weible & Sabatier, 2017). A comprehensive presentation of theories yet to be empirically applied widely is beyond the scope of this thesis.

Stages Heuristic Framework: The Stages Heuristic framework, a traditional approach in policy analysis as described by Sabatier (2007), offers a structured, linear perspective on the policy process. It delineates distinct stages, including agenda setting, policy formulation, adoption, implementation, and evaluation. While lauded for its simplicity and clarity in understanding policy processes, it has faced criticism for its oversimplification and neglect of the interplay between different stages, failing to capture the true complexity and dynamism of policymaking.

Multiple-Streams Framework (MSF) Developed by Kingdon in the 1980s and further elaborated by Birkland (2015), the MSF offers a more nuanced understanding of policymaking. It posits that the convergence of three 'streams' – problems, policies, and politics – is essential for opening a policy window and catalysing significant policy change. MSF is acclaimed for its capacity to capture the dynamic and non-linear nature of policymaking. However, it has been critiqued for its lack of focus on the role of policy actors and institutions, an aspect crucial in the complete understanding of policy dynamics.

Advocacy Coalition Framework (ACF): The ACF, developed by Sabatier and Jenkins-Smith in the late 1980s, centres around the role of advocacy coalitions within a policy subsystem. Emphasising the importance of belief systems and learning processes, it

provides insights into how policy outcomes are shaped over time. The ACF is particularly effective in analysing long-term policy change but has limitations in explaining the intricacies of short-term policy dynamics.

Narrative Policy Framework (NPF): The NPF, as introduced by Jones & McBeth (2010) and further discussed by Shanahan et al. (2018), underscores the pivotal role of narratives and storytelling in the policy process. It suggests that the framing and communication of issues significantly influence policy outcomes. While valuable for understanding the power of language and communication in policymaking, the NPF's subjective nature poses limitations, especially in its adaptability to various policy and political contexts.

Institutional Analysis and Development (IAD) Framework Developed by Elinor Ostrom (2011), the IAD framework focuses on the role of institutions in shaping policy outcomes. It offers a comprehensive approach to analysing the institutional arrangements and their impacts on policy effectiveness. The IAD framework is particularly useful in unravelling the complexity of institutional dynamics. However, its application can be challenging due to its inherent complexity, especially in contexts involving multiple actors and institutions.

Challenges of applying Policy Analysis Frameworks in developing countries

The application of policy analysis frameworks described above which are developed and applied in countries with established democratic systems, like those in Western Europe and North America, often faces challenges in the context of health systems research in developing countries, particularly in sub-Saharan Africa(Mhazo & Maponga, 2021). The distinct political, social, and economic environments in these regions necessitate adaptations to these frameworks (Gilson, Orgill, & Shroff, 2018).

Addressing this gap, Walt and Gilson (1994) introduced the policy triangle framework, emphasizing the importance of analysing policy context, content, process, and actors. This framework is aligned with a political economy perspective, relevant for examining the influence of public policy on health inequality in low- and middle-income countries. It

underscores the role of macro-level structural determinants—politics, economy, and welfare policies—in shaping health outcomes (Bambra, 2011; Barnish et al., 2018). The subsequent section offers a concise overview of this framework's application in policy analysis, particularly in the context of addressing health inequalities in these regions.

Policy Triangle Framework, introduced by Walt & Gilson (1994) and empirically validated in various studies (Gilson and Raphaely, 2007; Kapologwe et al., 2018; Moyo, 2007; Islam & Mezbaul, 2017), stands out for its applicability in health policy analysis, particularly in developing countries. Comprising four elements – context, content, process, and actors – this framework offers a holistic approach to policy analysis.

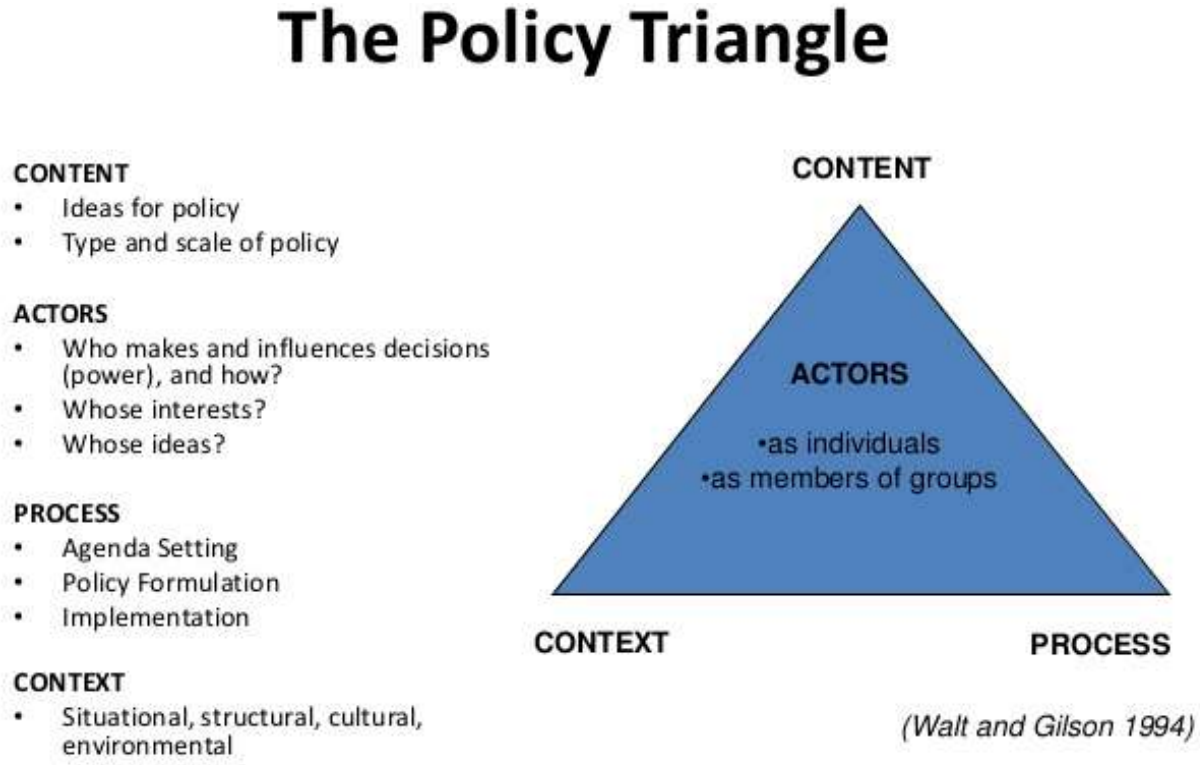


Fig 11: The Policy Triangle, Source,Walt, and Gilson,1994.

1. **Context**: This component pertains to the socio-political, economic, and cultural environment where policies are formulated and implemented. Understanding these contextual factors, particularly in developing countries, is crucial for effective policy analysis.

2. **Content**: This element focuses on the substance of the policy, including its goals, objectives, and strategies. Analysing policy content is essential to determine its relevance and adequacy in addressing the intended issues.

3. **Process**: This involves examining the various stages a policy undergoes, from formulation to implementation and evaluation. Insight into the policy process is key to identifying potential barriers and facilitators for effective policy implementation.

4. **Actors**: This refers to the individuals and groups involved in or affected by the policy-making process. In developing countries, a diverse range of actors, including government agencies, NGOs, international organisations, and local communities, can significantly influence health policies.

In the context of spatial child health inequalities in Ethiopia, the Policy Triangle framework offers a comprehensive approach to policy analysis. It allows for a holistic examination of how various factors, including political and economic contexts, policy content, implementation processes, and the roles of different actors, interact to shape policy outcomes.

It is also important to introduce pertinent public policy concepts such as policy formulation (agenda setting and representation) policy transfer and policy implementation in order to employ policy analysis theories fully effectively in this study. In the section below these concepts are discussed.

2.6.2. Policy Analysis Key Concepts

Policy Agenda Setting and Representation

Agenda setting, a concept articulated by Kingdon (2003), is the process through which issues garner the attention of policymakers. Problematization, conversely, involves framing these issues as necessitating policy interventions. This process is shaped by variables such as shifts in public opinion, scientific research findings, and media focus. Hall (1993) contributes to this dialogue by underscoring the significance of social learning

in evolving policy paradigms, which constitute the foundational assumptions and beliefs guiding policy decisions. Similarly, Stone (2011) accentuates the intricacies inherent in policymaking, particularly the strategies policymakers employ to frame problems and devise solutions.

Policy Implementation

The research predominantly centres on a retrospective analysis of the policy process, with a keen focus on policy implementation. Conceptualised by scholars like Lasswell (1956) and elaborated by Hogwood and Gunn (1984), and Dror (1989), implementation is viewed as a critical stage within the broader policy cycle, encompassing agenda-setting, formulation, execution, and evaluation. This sequential understanding, however, has been critiqued for its oversimplified and rationalistic view (Nakamura, 1987). Mazmanian and Sabatier's (1983) definition of implementation is employed in this study, portraying it as a multi-staged process, from the enactment of the foundational statute through to the policy outputs, compliance, impacts, and eventual revisions. This perspective recognises that policy formulation is an ongoing process, subject to adjustments during implementation.

Analyses of policy implementation have historically oscillated between top-down and bottom-up approaches. Top-down theorists, like Mazmanian and Sabatier (1983), focus on the critical influence of policy designers and the stipulations in statutes on the outcomes of policy implementation. In contrast, bottom-up theorists highlight the determinative role of contextual factors at the level of implementers. A synthesis of these views is advocated by scholars like Matland (1995) and O'Toole, Hill & Hope (2002), who argue for a balanced perspective for a comprehensive understanding of policy implementation.

Matland (1995) introduces the ambiguity-conflict model, aiming to reconcile these divergent theories. This model, illustrated in Figure 10, posits that the choice of an appropriate implementation approach should be contingent upon specific factors like the level of ambiguity in policy goals and the degree of conflict among involved organisations. For example, when ambiguity and conflict are low, an administrative approach, where

resources dictate outcomes, is deemed suitable. The preliminary review of the policy environment in this study revealed high ambiguity and low conflict, particularly in health policy implementation. Consequently, the study applies the insights from this implementation approach, recognising that outcomes may vary significantly across different contexts due to varying factors.

To effectively apply theoretical concepts in policy formulation and implementation specific questions and themes have been used in policy research. The Analysis of Determinants of Policy Impact (ADEPT) framework, as proposed by Rutten et al. (2010), aligns well with Kingdon's and Walt and Gilson's (1994) approaches. ADEPT is particularly useful for analysing policy documents, as it focuses on policy goals, resources for implementation, actors' roles and responsibilities, and opportunities for policy design and implementation. This approach has proven valuable in evaluating the alignment between policy statements and intended outcomes in public health policy studies (Cheung et al., 2010). The utility of ADEPT in policy document analysis addresses the gap in tools available for such analysis, making it an ideal choice for this study.

Policy Transfer and Multilevel Governance

The influence of global governance on national policymaking has been widely acknowledged in the theoretical and empirical literature (Knack et al., 2020; Daniel & Kay, 2017; Cluster et al., 2015; Esmael Zaei, 2014; Bernstein & Cashore, 2012; Edwards, 2004). According to these authors, it is crucial to consider the impact of global actors and context when analysing the national public policy process. Gilson et al. (2018) and Østebø, Cogburn, and Mandani (2018) argue that a global governance-oriented analysis can complement the examination of the national context-specific policy process, providing a more comprehensive explanation for public policy decisions and the extent to which national governments are constrained.

The notion of global governance has garnered substantial scholarly attention, with its contemporary application pertaining to the management of interdependent associations in the absence of governmental jurisdiction, as exemplified in multinational collaborations (Rosenau & Czempiel, 1992). Global governance constitutes an intricate system of

normative, social, legal, institutional, and other processes and customs that influence and, under certain conditions, govern and direct the dialectical interplay between globalization and fragmentation (Clarke & Edwards, 2004, p. 6). The UN CDP (2014) and Weiss (2009) delineate a comparable notion that accentuates the affirmative role of global relevance as a system consisting of institutions, laws, rules, practices, norms, initiatives, and procedures by which diverse governments and citizens address transnational matters.

Global governance for development encompasses a range of participants, including "actors relevant to global problem-solving" (Weiss & Thakur, 2010, p. 9) and those who influence national policy formation (Cluster et al., 2018). Key players in global governance consist of multilateral organizations with a universal nature, bilateral aid agencies and multilateral development banks (Cluster et al., 2018), elite multilateral groupings such as the G8 and G20 (Ocampo, 2011), and distinct coalitions pertinent to specific policy subjects (e.g., climate change) (Alexandroff, 2010; Weiss, 2009). In a globalized and rapidly evolving world, the governance and policy formulation processes are no longer restricted to states, and the political architecture and policymaking of sovereign nations are increasingly susceptible to external pressure and influence (Esmael Zaei, 2014).

Governments are compelled to collaborate with or solicit support from a multitude of global governance actors, including international financial institutions, United Nations agencies, bilateral and multilateral donors, global health partnerships, and international non-governmental organizations (Clarke & Edwards, 2004). These international actors acknowledge the importance of working alongside national policymakers and establishing conducive policies for the successful implementation of development aid. Both international agencies and developing nations' governments concede that analytical and advisory assistance increasingly affects the formulation and implementation of national policies (Cluster et al., 2015; Knack et al., 2020). Internationally recognized development objectives, such as the MDGs and SDGs, progressively serve as the impetus for international development policy (UNDESA, 2007) and are considered a tool of 'global governance by goal setting' (Biermann, Kanie, & Kim, 2017, p. 26).

Scholarly work on policy transfer highlights the policy components frequently transferred or influenced in national policymaking and the diverse influence mechanisms (Dolowitz & Marsh, 2000; Bernstein & Cashore, 2012). The conduits through which global governance actors and mechanisms impact national policy formulation consist of international commitments/conventions, international norms and discourse, market formation or intervention, and direct access to domestic policy processes (Bernstein & Cashore, 2012). These channels encompass issue-specific treaties, the policy prescriptions of influential international organizations, and international norms and rhetoric that can delineate and regulate acceptable domestic behaviour. Direct access to domestic policymaking processes can be attained through funding, education, training, assistance, and capacity-building, as well as initiatives fostering co-governance facilitated by partnerships between domestic and international public and corporate actors and authorities. Lastly, the markets pathway entails approaches or tactics that aim to utilize, collaborate with, or leverage markets to effectuate domestic policy change (ibid.)

The academic literature on policy transfer delineates the various factors that are often transferred or influenced in national policymaking, along with the numerous mechanisms through which this occurs. Dolowitz and Marsh (2000) identified eight categories of transferable policy elements, namely policy objectives, policy substance, policy instruments, policy programmes, institutions, ideologies, ideas, attitudes, and negative lessons. Similarly, in a study on the influence of global governance on national policymaking, Bernstein and Cashore (2012) outlined several avenues through which global governance actors and mechanisms impact national policymaking. These channels include international commitments and conventions, international norms and discourse, market formation or intervention, and direct access to domestic policy processes.

Influence through international rule-based commitments entails the implementation of issue-specific treaties and the policy prescriptions of powerful international organizations such as the World Bank, whether perceived as consent-based or coercive. In contrast, international norms, and rhetoric, whether institutionalized or created through broader global governance processes, can define and regulate acceptable domestic conduct. As

a result, they use both a logic of appropriateness (guided by norms without considering consequences) and a logic of consequences (based on utilitarian calculations) (Bernstein & Cashore, 2012).

Direct access to domestic policymaking processes can be achieved through various means, including direct funding, education, training, assistance, and capacity-building. It can also occur through initiatives at co-governance facilitated through partnerships between domestic and international public and corporate actors and authorities. The markets pathway entails methods or strategies that aim to exploit, cooperate with, or leverage markets to effect domestic policy change (Bernstein & Cashore, 2012).

2.7. Chapter Summary

This chapter reviewed the literature on the social production of health and political economy of spatial health inequalities. This review has established that health inequalities has been defined as differences in health status between individuals and groups, while health inequity has been referred to as socially produced, systematic, and unfair health differences that were amenable to policy action.

The review has highlighted the fact that public policy to address health inequalities is regarded as a matter of striking the right balance between efficiency and equity values. The potential of theoretical concepts of social justice in understanding the values that underpinned policy decision-making to address health inequalities has also been discussed.

The review has emphasized the importance of understanding the social determinants of health and the concept of social stratification and socioeconomic position. Materialist, psychosocial, cultural-behavioural, and life course theories have been discussed, along with their mechanisms for explaining the social production of health inequalities. However, the limitations of these theories in understanding underlying factors leading to spatial health inequalities have also been highlighted.

The political-economic perspective to spatial health inequalities study has been deemed beneficial as it has addressed vertical structural factors in addition to local horizontal

drivers, facilitating a more comprehensive comprehension of the relationships between place, political, and economic structures, and health inequalities. The analysis of structural factors should be explicitly connected to suitable policy levers to effectively mitigate place-based health inequalities. This could help ensure that research findings are utilized to inform and shape policy decisions that led to meaningful change.

Furthermore, the chapter has highlighted gaps in the literature that were more relevant to low and middle-income countries. Overall, the chapter has provided insight into laying the groundwork for the study's conceptual framework, providing insights that could help guide policymakers and researchers in addressing spatial health inequalities.

Chapter 3: The Research Paradigm, Methodology, and Methods

3.1. Introduction

In this chapter, the methodology adopted and methods applied for the study are presented and discussed. First, the study's paradigmatic orientation is discussed. This is followed by a presentation of the study design and methods used. To set the scene for the subsequent discussions about the justification for the choice of methodology and methods, the study's overall aim and specific objectives are restated. Furthermore, the chapter provides a thorough justification of the methodological approach and the methods chosen, ensuring alignment with the research objectives and the paradigmatic framework.

3.2. Aim of the study

This study aims to assess the influence of the public policy process on persistent spatial child health inequalities in developing countries where the socio-political context is complex and fragile. Given the research aims, the study's focus is to assess the influence of the public policy process (development and implementation) and contextual factors in determining geographic child health inequalities in a developing country such as Ethiopia.

In light of this, the research has been structured around the following questions:

- How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?
- In what ways have policy stakeholders influenced the formulation and implementation of policies aimed at reducing spatial inequalities in child health?
- To what degree have public policies tackled the issue of spatial child health inequalities and its underlying causes?
- How suitable and pertinent were the policy goals, strategies, programs, and interventions in addressing spatial child health inequalities?

3.3. Ontology and Epistemology

The nature of knowledge within scientific research is reflected and explored in its research project. The research paradigm encompasses a shared set of beliefs and consensus among scholars about how a phenomenon should be conceived and addressed in pursuit of understanding it (Kuhn, 1962). An explicit statement of one's research paradigm is of paramount importance, as it influences the methods applied, the approaches to interpretation, and the ground rules for applying theory when observing phenomena (Mitroff and Bonoma, 1978). In this research project, the choice of paradigm was not arbitrary; it was carefully considered to align with the study's objectives, the nature of the research questions, and the philosophical assumptions underlying the inquiry.

The choice of methods and the analysis and interpretation approach in this research project are deeply influenced by the research paradigm I adopted. This paradigm, rooted in my academic, research, and career background, reflects my understanding of ontology (the nature of reality) and epistemology (the nature of knowledge and its generation). My academic background in public health and public policy, combined with my work experience in social welfare and health, has shaped my recognition of society and social problems as complex phenomena with no single, linear answers. These insights align with the constructivist worldview, which asserts that reality is subjective and socially constructed, rather than fixed and objective.

My ontological and epistemological perspectives are informed by this constructivist stance, which sees knowledge as being co-created through human interactions and shaped by social contexts. These philosophical assumptions are consistent with the views of scholars such as Wellington et al. (2005), who argue that a researcher's professional experience, life background, and interests significantly influence their choice of methodologies and methods. In this case, my understanding of knowledge as dynamic and context-dependent has directly influenced the choice of methodology, ensuring that it aligns with the overarching research aims and objectives.

In the following sections, the ontological and epistemological considerations underpinning this research project are detailed, providing a justification for the constructivist paradigm adopted. This justification is crucial, as the methodology and methods applied are not

only informed by but are integral to the ontological and epistemological assumptions of the study (Hennink et al., 2011).

Ontology

Societies, policies, and institutions are constructs of the human intellect, shaped and modified by human endeavor. These entities, being products of human thought and effort, are inherently dynamic and subject to change. Variations in reality arise from the diverse interpretations of these socially constructed phenomena. Standpoint theorists, for instance, emphasize that an individual's societal position molds their perception of reality, thereby influencing their understanding of society and personal experiences (Harding, 2004). The theory posits a negative correlation between one's privilege in societal structures and their ability to discern the foundational social framework and its associated power dynamics. Privileged individuals, benefiting from the existing societal order, often remain oblivious to these dynamics, while those from marginalized backgrounds have a clearer perspective on the structures of inequality (ibid).

Given this study's focus on inequalities and social stratification within the Ethiopian context, the assumption that reality is socially constructed and subjective is fundamental. My ontological stance rejects the notion of a singular social reality, embracing instead the existence of multiple subjective realities shaped through human interaction. This aligns with Bryman's (2012) concept of constructionism, an ontological perspective that will be elaborated upon in the subsequent discussion.

Constructionism

Constructionism is an ontological position asserting that social phenomena are not fixed but instead have multiple subjective realities, each socially constructed through human interactions (Brown & Dueas, 2020). This perspective challenges objectivism, which views social phenomena as existing independently of human perception and accessible through objective scientific methods (Bryman, 2012). Constructionism posits that social realities are dynamic, constantly produced and reproduced through social interaction and interpretation (ibid).

This study, which explores the role of public policy in explaining spatial child health inequalities, is grounded in a constructionist ontological framework. The research recognizes that understanding geographic health inequalities requires an in-depth examination of the contextual and structural factors that influence them. Public policy processes, as widely acknowledged in social science, are complex social and political phenomena constructed through human action rather than naturally occurring events (Gilson et al., 2011). By adopting a constructionist stance, this research emphasizes the importance of understanding policy phenomena as deeply rooted in context and shaped by the dynamic interplay of social and political factors.

Constructionism is particularly relevant for health systems and public policy research, as it supports the generalization of findings from contextually rich, knowledge-driven analyses. This perspective enhances the rigor of public policy research by ensuring that interpretations are firmly grounded in the realities of the social systems being studied (Gilson et al., 2011). Therefore, the methodological paradigm and the methodological choices in this study are a deliberate reflection of the constructionist perspective, offering a robust framework for analyzing and interpreting the complex social realities underpinning public policy and health inequalities

Epistemology

Interpretivism

Interpretivism asserts that understanding knowledge and meaning requires interpretation, emphasizing that objective knowledge is unattainable and inherently shaped by human thought processes. This perspective stands in stark contrast to positivism, which upholds the belief that knowledge is objective and can be reliably measured through empirical and scientific methods (Bryman, 2012). While positivists rely on scientific methodologies to test hypotheses and assess facts, interpretivists argue that such methods are insufficient

for studying human behavior and social phenomena, as they fail to account for the subjective and interpretative nature of human experience.

Under the interpretivist paradigm, knowledge is viewed as subjective, deriving from individual perceptions, diverse experiences, and interpreted meanings that collectively shape our understanding of reality (Brown & Dueñas, 2020). This paradigm prioritizes meaning over measurement, advocating for a closer and more personal engagement between researchers and participants to uncover the nuanced interpretations and complexities of societal phenomena (Kaplan & Maxwell, 1994). This emphasis on context and interaction makes interpretivism particularly well-suited for exploring complex, socially constructed phenomena.

To achieve a deep understanding of the study's context, interpretivism often employs qualitative research methods, which facilitate prolonged and meaningful interactions between the researcher and participants (Antwi & Hamza, 2015). Such methods are instrumental in uncovering the layered, context-specific interpretations that underlie social realities, allowing researchers to gain a profound grasp of the phenomena under investigation (Ulin, Robinson, & Tolley, 2004).

The attributes of the interpretivist perspective align seamlessly with this research, which aims to explore the policy-making process within a specific context through interactions with policymakers and implementers. This approach acknowledges that individuals' actions are not governed by objective facts alone but by the meanings they ascribe to their experiences and circumstances. By recognizing the interpretative and socially constructed nature of policy-making, this paradigm allows the study to examine health-related public policies as entities shaped by societal actors and imbued with meaning drawn from their lived experiences. Borrowing from Gilson et al. (2011), this research perceives public policies as dynamic constructs, created and animated by the interpretations and actions of social actors.

Consequently, the knowledge produced in this study is co-created through the researcher's engagement with policymakers, offering insights that are deeply contextual and reflective of the complex interplay of individual and collective interpretations. This

focus on the subjective and interpretive dimensions of knowledge further justifies the adoption of an interpretivist epistemology as the foundation for this research. The researcher's role and positioning within the study will be elaborated upon in subsequent sections of this chapter.

3.4. Methodology

In the previous section, the foundational assumptions influencing the choice of a research paradigm for the investigation were discussed. This section delves into the research strategy, which represents the general approach adopted for conducting the study, as described by Bryman (2012).

Social science research is traditionally categorized into quantitative and qualitative methodologies, but Layder (1993) critiques this rigid separation, arguing that it limits the flexibility required for diverse data collection and interpretation. This perspective underscores the importance of selecting a methodology that aligns with the philosophical assumptions and objectives of the research. The distinction between quantitative and qualitative research goes beyond the use of measurements; it reflects deeper epistemological and ontological differences that must inform the research approach.

Bryman (2008) highlights three key dimensions that distinguish quantitative and qualitative research: (a) the role of theory in the research process, (b) the epistemological stance of the researcher, and (c) the ontological perspective of the researcher. These dimensions provide a robust framework for justifying the selection of a methodology that aligns with the study's philosophical underpinnings and research objectives.

In terms of theory, quantitative research often employs a deductive approach, validating existing theories, whereas qualitative research emphasizes the development of new theories through an inductive approach. This study employs a hybrid approach, combining deductive and inductive methodologies. While established theories on policy processes and the political economy of health disparities guide the research design, the analysis of emerging data also generates new theoretical insights. This dynamic interplay between theory and data aligns with Hammersley's (1992) argument that research

inherently oscillates between deduction and induction, bridging abstract concepts and empirical evidence.

From an epistemological and ontological perspective, quantitative research is aligned with positivism and objectivism, whereas qualitative research aligns with interpretivism and constructionism (Bryman, 2012). As discussed in the previous section, this study adopts a constructionist and interpretivist paradigm, which gravitates naturally towards a qualitative methodology. This alignment ensures that the chosen methodology captures the subjective, socially constructed realities inherent in the research context.

The qualitative research approach is particularly well-suited to this inquiry due to its distinct attributes. Ritchie and Lewis (2003) emphasize that qualitative methodologies facilitate a profound and interpreted understanding of participants' societal contexts, utilize small, purposive samples, and employ data collection techniques that foster deep researcher-participant interactions. These characteristics enable the exploration of evolving issues and the acquisition of rich, detailed data, which are essential for achieving the objectives of this study.

In the domain of policy studies, qualitative techniques are well-established as effective tools for data collection and analysis. Yanow (2006) identifies observation, interviewing, and document analysis as central methods in interpretative policy analysis. These techniques are complemented by methodologies such as case studies, content analysis, discourse analysis, and grounded theory, which are routinely used to uncover the complexities of policy-making processes.

To meet the objectives of this research, a qualitative approach is essential to gain deep insights into the policy process, including the roles of stakeholders, decision-making dynamics, and the contextual factors shaping various policy dimensions. Document analysis alone would provide a limited perspective, necessitating supplementary insights from interviews with policymakers and other key actors. This integration of document analysis and qualitative interviews ensures a comprehensive understanding of the beliefs, experiences, and behaviors of policy stakeholders, enriching the analysis of policy development and implementation.

By incorporating qualitative data collection and analysis techniques, this methodology ensures that the research captures the complexities and nuances of the policy landscape. This approach provides a richer and more contextually grounded understanding of the phenomena under study, allowing for a deeper exploration of the policy-making process and its implications.

3.5. Research Design and Methods

In the preceding section, the overall orientation of the proposed study was discussed. However, that discussion does not outline the detailed approaches for collecting, analyzing, and interpreting the data. The research design, discussed in this section, serves as a framework that provides a blueprint for the systematic process of data collection, analysis, and interpretation (Nachmias & Nachmias, 1992).

Bryman (2012) identifies five prominent research designs in social science: (a) experimental and related designs, such as the quasi-experiment; (b) cross-sectional designs, the most common of which is survey research; (c) longitudinal designs, including panel and cohort studies; (d) case study designs; and (e) comparative designs. The choice of research design depends on the type of research question, the degree of control the investigator has over behavioral events, and the study's focus on contemporary issues (Yin, 2003). While a detailed comparison of all research designs is beyond this section's scope, the case study design has been identified as the most appropriate for this study based on these criteria. The rationale for its selection is discussed below.

3.5.1. Case Study Design

A case study design is uniquely suited to this research due to its emphasis on interpretation and its alignment with the study's epistemological perspective (Stake, 1995; Yin, 2003). The case study approach is widely used in sociology and political science because it allows researchers to examine complex social phenomena holistically, capturing meaningful characteristics of real-life events (Yin, 2003). It is particularly effective in understanding individuals, groups, and organizational, social, and political

events. These attributes make the case study design ideal for investigating the policy process within institutional and sociopolitical environments.

The case study design facilitates the explanation, description, and illumination of specific situations, making it well-suited for analyzing the Ethiopian public policy process. It is particularly advantageous in retrospective research that relies on methods like document analysis, as opposed to direct observation or experimentation. Additionally, case studies are valuable for comparative research, as they allow for the identification of differences and similarities in the policy process across various administrative jurisdictions.

Yin (2014) argues that case studies are effective for explicating causal links in real-world interventions that are too complex for survey or experimental approaches. This is particularly relevant for this study, which seeks to understand the intricacies of policy-making processes.

Specifically, this research employs a single case study with multiple units of analysis, also known as an embedded case study design, which is appropriate for studies examining subunits within a larger case (Yin, 2003). In this study, while the overarching case is the Ethiopian public policy process, the units of analysis include the national (federal) and sub-national levels. This approach ensures that both the broader policy context and the specific dynamics within subunits are examined comprehensively.

Addressing Criticisms of Case Study Design

Critics often raise concerns about the limited generalizability of case studies and their time-consuming nature. However, case studies, like experimental designs, are generalizable to theoretical propositions rather than populations (Yin, 2003). This means the insights gained from a single case study contribute to the development and refinement of theories, providing valuable theoretical generalizations despite the limited population scope.

Qualitative studies, including case studies, prioritize validity and reliability overpopulation generalizability, ensuring the credibility and transferability of research findings (Yin, 2003). This focus on quality assurance addresses concerns about the broader applicability of case study results.

Moreover, concerns about the time-consuming nature of case studies have been mitigated by advancements in technology. Data analysis software and electronic data sources significantly reduce the time required for data collection and analysis, enhancing the efficiency of case study research.

In conclusion, the case study design provides the necessary tools to capture the complexities and nuances of policy processes in Ethiopia. Its ability to facilitate deep, contextualized insights into subunits of analysis while maintaining a holistic understanding of the broader case makes it the most suitable design for this study.

Case selection

Cases for this study were strategically selected from federal (national) and regional (subnational) units of analysis to ensure a comprehensive understanding of the public policy process at different levels of governance. At the federal level, policy actors from federal ministries and key stakeholders were chosen to provide insights into national policy formulation and implementation. For the subnational level, the Afar region was selected as the focus due to its consistently poor child health status, making it a critical case for understanding spatial health inequalities in Ethiopia. The selection of Afar region aligns with the study's objective of examining the intersection of policy processes and child health disparities in the most affected regions.

This deliberate case selection ensures that the research captures both the broader national policy landscape and the localized implementation dynamics in a region with stark health inequalities. By including federal and subnational cases, the study provides a nuanced understanding of the interplay between policy development and implementation across governance levels.

The data collection methods relied on document analysis and semi-structured interviews with key informants, ensuring a diverse and in-depth exploration of the selected cases. The rationale for the sampling technique used in the study is discussed in the next section.

Sampling

Purposive sampling was employed to generate a sample tailored to the study's objectives, ensuring the inclusion of information-rich cases relevant to the research questions. As the study seeks to assess the influence of the public policy process on spatial child health inequalities, the target subjects were policymakers, implementers, and relevant policy documents. Purposive sampling is particularly suitable for qualitative research, as it allows the selection of individuals or groups who are well-informed, experienced, and knowledgeable about the topic of interest (Patton, 2002).

This sampling technique is justified by its efficiency in utilizing limited resources while focusing on respondents capable of providing articulate, expressive, and reflective insights (Cresswell & Plano Clark, 2011; Spradley, 1979). In this study, key informants were selected based on their availability, willingness to participate, and depth of knowledge about the policy processes under investigation.

The strength of qualitative methods lies in their ability to achieve a breadth of understanding about a phenomenon. To ensure the quality and depth of findings, sample size will be determined by the principle of saturation—collecting and analyzing data until no new substantive information emerges (Miles & Huberman, 1994). This approach ensures that the study captures the complexity and nuances of the public policy process without overextending resources.

3.5.2. Data Collection

Effective data collection is pivotal in ensuring the credibility and depth of any research endeavor. In this study, multiple qualitative methods were employed to capture the complexity and multidimensionality of policy formation and implementation processes. The primary approaches include document analysis and semi-structured interviews. These methods were selected for their complementarity and ability to provide a comprehensive understanding of the research subject (Bryman, 2012; Denzin & Lincoln, 2005).

Documentary analysis offers a robust foundation by systematically examining policy documents to uncover historical, contextual, and institutional insights. This approach enables researchers to analyze the explicit and implicit messages embedded in policies, including their alignment with values, norms, and governance structures. It is particularly effective in exploring how child health equity is framed, prioritized, and operationalized across various levels of policy-making (Yamot, 2006; Abbott et al., 2004).

Semi-structured interviews, on the other hand, provide an opportunity to capture the perspectives of key informants directly involved in the policy-making process. By engaging with policymakers, program implementers, and stakeholders at both national and sub-national levels, this method facilitates a deeper exploration of the experiences, challenges, and decision-making processes that shape policy outcomes (Mason, 2002; Walt & Gilson, 1994).

The integration of these methods ensures that the study benefits from both the depth of textual analysis and the richness of lived experiences. This triangulation not only enhances the reliability of the findings but also provides a nuanced understanding of the dynamics at play (Forster, 1994; Yin, 1994).

The following sections detail the step-by-step processes of data collection, including the rationale for choosing each method. By doing so, the study underscores the systematic and deliberate approach taken to address its research objectives effectively.

Document Analysis

Documentary analysis, a recognized and rigorous research method in social and health sciences, is especially effective in analyzing policies and their implications (Bryman, 2012; Denzin & Lincoln, 2005; Elston & Fullop, 2002). It involves a systematic review and interpretation of diverse types of documents, including legislative records, policy drafts, government reports, meeting notes, organizational memos, and even personal correspondence (Yamot, 2006). This method is justified in this study as it provides an in-depth understanding of the policy landscape by uncovering both explicit policy content and the underlying contexts, motivations, and power dynamics.

Unlike some methodologies that rely heavily on human interaction, documentary analysis offers unique advantages by focusing on pre-existing materials. It complements interview-based research, serving as a critical tool for validating, questioning, or enriching findings from other qualitative approaches, thereby ensuring a more comprehensive analysis (Bryman, 2012; Forster, 1994).

Key Methodological Approaches

The use of **content analysis** and **discourse analysis** in documentary research enhances its analytical depth.

1. **Content Analysis**: This approach quantifies information within documents, categorizing textual data to identify trends and patterns. For example, it allows researchers to track the frequency of terms like "child health equity," helping to quantify its prioritization in policy discussions (George, 2009).

2. **Discourse Analysis**: This method delves deeper into language use, focusing on the meaning, context, and power relations reflected in policy language. By examining policy language critically, researchers can uncover implicit biases, cultural assumptions, and the framing of issues that influence policy outcomes (Paltidge, 2006; Bryman, 2012).

Ethical and Practical Aspects of document analysis

One of the significant strengths of documentary analysis lies in its ability to sidestep ethical concerns typically associated with human subjects. By analyzing pre-existing documents, this method avoids the ethical complexities of obtaining consent and interacting with vulnerable populations, making it an ideal choice for sensitive areas like child health policy. Moreover, this approach is cost-effective, offering researchers access to rich historical and contemporary data without extensive fieldwork.

Despite its advantages, the method is not without challenges. Issues such as biased selectivity and incomplete documentation require critical evaluation of sources to ensure

findings are balanced and contextually accurate (Abbott et al., 2004; Yin, 1994). This research mitigated these challenges by cross-referencing multiple document sources, critically appraising their content, and situating them within broader policy and societal contexts**.**

Application in This Study

In this research, documentary analysis is employed to explore the formation, implementation, and implications of policies related to child health equity. This method is particularly suitable as it aligns with the study's goal of understanding policy dynamics across global, national, and sector-specific levels.

A thematic analysis framework was adopted for this purpose, enabling a structured and nuanced examination of the documents. This process included:

1. **Data Familiarization**: Immersion in the content through extensive reading to identify initial themes.
2. **Systematic Coding**: Extraction and categorization of significant data features, ensuring comprehensive coverage of relevant themes.
3. **Theme Development and Refinement**: Identifying broader patterns and aligning them with the research objectives.
4. **Theme Definition and Naming**: Clarifying the essence of each theme and its relationship to the research question.

This systematic approach ensures that the analysis captures both the explicit directives and the underlying assumptions within the policy documents, providing a robust foundation for examining policy effectiveness and equity considerations.

Categories of Policy Documents

The study focused on three key categories of documents, each offering unique insights:

1. **Global Governance Policy Documents**: These include international conventions, best-practice guidelines, and non-binding commitments that shape global norms and standards. Their inclusion ensures an understanding of the international influences on national policy-making**.**

2. **National Overarching Public Policies**: Documents like the Ethiopian constitution and national development strategies were analyzed to understand how broad, multi-sectoral objectives influence child health policies. **This highlights the integration of child health within broader national priorities.**

3. **Sector-Specific Policies Focused on Child Health**: Policies from health and intersecting sectors such as education, water and sanitation, and social welfare were included. **This category ensures a holistic understanding of child health initiatives across interconnected domains.**

Analytical Dimensions

The analysis delved into several critical dimensions to provide a comprehensive understanding of the policy environment:

- **Context**: Examination of historical, political, economic, and social factors influencing policy development and implementation. This contextual analysis reveals how broader forces shape child health priorities.

- **Reflection of Values and Norms**: Identification of ethical principles and ideologies underpinning policies. This provides insights into the moral and cultural drivers of policy choices.

- **Policy Agenda Articulation**: Analysis of how issues are framed, prioritized, and addressed within policies. This highlights the processes of problem recognition and solution development.

- **Institutional Frameworks and Governance**: Evaluation of administrative structures responsible for policy execution. This dimension explores the efficiency and accountability of governance mechanisms.

- **Child Health Equity Goals and Strategies**: Assessment of the extent to which policies explicitly target equitable health outcomes for children, particularly in spatial distribution. This reveals the prioritization and operationalization of equity principles.
- **Integration of Equity in Policy Development and Implementation**: Critical analysis of how equity considerations are incorporated into policy formulation and execution. This underscores the inclusivity and fairness of the policy-making process.

Contribution to the Study's Objectives

By employing a methodical and multilayered approach, documentary analysis provides a deep, contextual understanding of policy dynamics related to child health equity. It uncovers both the explicit strategies and the implicit assumptions embedded in policies, offering invaluable insights into their effectiveness and areas for improvement.

Drawing on frameworks like those proposed by Kingdon (1995), Moncrieffe and Luttrell (2005), and Walt and Gilson (1994), the analysis aligns with the study's emphasis on understanding the roles of actors, processes, and institutional frameworks in advancing equitable health outcomes. This method ultimately justifies its use in the study by enabling a comprehensive exploration of how child health equity is framed, prioritized, and operationalized within policy frameworks.

The Document Analysis Process

The document analysis process utilized in this study is grounded in a systematic, thorough, and iterative methodology. Drawing on the frameworks of Appleton and Cowley (1997) and Denzin and Lincoln (2005), the process adheres to established scholarly guidelines to ensure reliability, validity, and depth. This structured approach is designed to extract meaningful insights from policy documents, making it an essential tool for addressing the research questions and achieving the study's objectives.

Initial Steps: Defining Scope and Selection Criteria

The process begins with the definition of the research question, followed by the development of clear and robust inclusion and exclusion criteria. By establishing these parameters, the study ensures that the documents selected are highly relevant, targeted, and capable of providing the necessary depth of information to explore the research problem effectively. This phase includes:

- **Identifying document types** that align with the research focus (e.g., policy frameworks, legislative texts, program reports).
- **Setting clear boundaries** for the time frame, policy levels (global, national, subnational), and sectors of interest (health, education, social development).

This strategic approach guarantees the inclusion of diverse, representative documents that address both the breadth and depth of the policy landscape.

In-Depth Reading and Note-Taking

Once the documents are selected, the process advances to a detailed reading and note-taking phase. This step is foundational for building a comprehensive understanding of the content, themes, and potential areas of relevance within the documents. Key actions during this stage include:

- Highlighting recurring themes or terms that signal priorities or concerns within the policy.
- Identifying explicit objectives, stated values, and contextual details that underpin the policies.
- Recording initial reflections to guide subsequent stages of analysis.

Systematic Coding Using a Framework

The data from the documents are then systematically coded using a predefined framework tailored to the research objectives. This phase involves breaking down the data into manageable units, categorizing information to uncover patterns, and identifying recurring themes across the dataset**.** The framework addresses key aspects such as:

- **Content and context**: What is the policy about, and what circumstances shaped its creation?
- **Language and tone**: How are issues framed, and what implicit messages are conveyed?
- **Stakeholder roles**: Who are the key actors, and what are their contributions or influences?

The coding process ensures that the analysis is transparent, replicable, and capable of producing nuanced insights into the underlying dynamics of policy-making.

Iterative Refinement and Thematic Analysis

One of the defining features of this document analysis process is its iterative nature. Rather than following a linear trajectory, the analysis revisits earlier steps as new patterns and insights emerge, ensuring a flexible and adaptive approach.

- Themes identified during coding are reviewed and refined to ensure accuracy and coherence.
- Relationships between themes are explored to uncover deeper layers of meaning and connection.
- Initial findings are revisited to incorporate emerging insights, adding depth and rigor to the analysis.

This iterative process ensures that the analysis evolves in response to the data, allowing for a richer and more comprehensive understanding of the policies under examination.

Tailored Analysis for Policy Documents

The analysis framework, influenced by Alexander (2013), Bell and Stephenson (2006), Busher (2006), and Cardno (2018), is customized to address the specific characteristics of policy documents. This tailored approach considers critical dimensions such as:

- **Document Production and Location**: The origin and context of the documents, providing insight into the socio-political environment of their creation.

- **Authorship and Audience**: Identifying the creators and intended recipients of the policies to understand their priorities, biases, and communication strategies.
- **Policy Context**: Situating the policies within historical, economic, and social frameworks to reveal external influences on policy decisions.
- **Policy Text**: Analyzing the explicit content, including language, structure, and key directives.
- **Stakeholder Roles and Engagement**: Exploring the involvement of key actors, including governmental bodies, international organizations, and civil society.
- **Policy Consequences**: Evaluating the intended and unintended impacts of the policies, particularly concerning their stated objectives.

Selection of Policy Documents

The researcher applied systematic criteria to select a diverse range of documents from global, national, and subnational levels. This ensured a comprehensive representation of policy frameworks relevant to the research questions**.** Key categories of documents included:

- **Global Governance Documents**: Conventions, guidelines, and best-practice recommendations that shape international policy norms.
- **National Policies**: Frameworks such as constitutions, multi-year development strategies, and overarching governance policies.
- **Sector-Specific Policies**: Policies addressing child health and intersecting sectors, including education, social protection, and rural development.

By selecting documents from various levels and sectors, the study captures the interconnectedness of policy-making, revealing how broader governance frameworks influence specific policy outcomes.

Critical Questions Guiding the Process

The analysis is informed by theoretical frameworks from Cardno (2018), Kingdon (1995), and Walt and Gilson (1994), posing key questions such as:

- What are the policy's objectives and priorities?
- How is the policy constructed and implemented?
- What are the contextual factors influencing its development?
- Who are the key stakeholders, and what are their roles?
- What are the measurable impacts of the policy on its target population?

These guiding questions ensure that the analysis remains focused, rigorous, and aligned with the research objectives, allowing for a deep exploration of policy processes and their implications.

Contribution of the Document Analysis Process

Through this structured and iterative process, the document analysis provides a robust mechanism for understanding policy dynamics, uncovering implicit assumptions, and evaluating the equity considerations embedded in policies**.** This approach is particularly effective in addressing the complexities of policy-making, revealing the interplay between stated objectives, stakeholder priorities, and real-world impacts.

By integrating rigorous selection criteria, systematic coding, thematic analysis, and iterative refinement, the document analysis process justifies itself as an indispensable method for uncovering the multi-dimensional nature of policy frameworks and their implications for the study's objectives.

The selection criteria for including and excluding specific policy documents were developed by taking into account the timeframe the study focuses on and the scope of the study.

Inclusion Criteria:

- Global level policies linked to health, human rights, global development goals , global conventions, social development, and social inclusion in low-income countries.
- National government policy documents
- Country-specific policies and strategies of international stakeholders

- Documents that exclusively focus on public policies linked to health inequalities.
- Documents have been developed and implemented in the period 1991–2021.
- Documents labelled as policy, policy guidelines, policy and implementation guidelines, and action /strategic plans.
- Public sector various meeting and conference proceeding reports.
- Official statements indicating the position of government institutions.

Exclusion Criteria:

- Documents labelled as technical guidelines, and these are quite technical oriented mainly relate to delivering services by frontline workers.

Collection of policy documents: policy documents were collected in electronic and hard copy. The electronic copies were accessed from the websites of government and non-governmental organisations. Hardcopies were collected in person from relevant government ministries. A total of 22 global-level policy (governance) documents that meet the inclusion criteria were selected. 31 national policy documents, comprising 25 sectoral and cross-sectoral policies, and 6 overarching policies, were selected.

Semi-structured interviews

Semi-structured interviews were employed in this study to collect data from key informants, including policymakers and implementers involved in public policy development. This method was chosen because it is particularly well-suited for exploring complex, multifaceted issues in depth, allowing researchers to gather rich, detailed information directly from individuals with firsthand experience and insights into the policy-making process (Jones, 1985; Mason, 2002). The flexibility of semi-structured interviews enables participants to express their perspectives in their own words and allows the researcher to probe deeper into specific areas of interest. This adaptability is crucial for this study, as it aims to understand the nuanced experiences and interpretations of policy actors across different levels of governance in Ethiopia.

Appropriateness of Semi-Structured Interviews for this study

Semi-structured interviews are appropriate for this study because they facilitate an in-depth exploration of the experiences and perspectives of key policy actors involved in child health policy development and implementation in Ethiopia**.** The method allows for open-ended responses, providing participants with the opportunity to discuss their roles, challenges, and insights without being constrained by a rigid questionnaire. This is essential for capturing the complexities and contextual factors that influence policy-making in a decentralized governance system. Moreover, the flexibility of the interview format enables the researcher to adapt questions based on the participant's expertise and the conversation's flow, ensuring that relevant themes are thoroughly investigated. By using semi-structured interviews, the study can obtain nuanced data that would be difficult to gather through more structured methods, thereby enhancing the depth and quality of the research findings.

Selection of Key Informants

Key informants were selected through purposive sampling, complemented by snowball sampling to identify additional participants (Glaser & Strauss, 1967). The purposive sampling strategy ensured that participants were selected based on their relevance to the research objectives, focusing on their articulateness, reflectiveness, and direct involvement in policy design and implementation**.** Efforts were made to include informants from both federal and regional levels, recognizing the centralized nature of child health policy development in Ethiopia and the regional adaptation of these policies. This diverse representation of participants ensures a comprehensive understanding of the policy environment and reflects the multi-sectoral nature of child health policy-making.

Senior officials from various governmental bodies—including the Federal Parliament, Federal House of Federation, Ministry of Health, Ministry of Peace (Federal Affairs), Ministry of Finance and Economic Development, and Ministry of Water Resources at both the federal and Afar regional state levels—were included. This inclusion of high-level policymakers and implementers enhances the credibility of the data collected and

provides insights into the strategic decisions that shape policy outcomes (Walt, 1994; Walt & Gilson, 1994; Dye, 2007).

Development and Testing of Interview Guides

To capture the varied experiences and perspectives of policy actors, four tailored semi-structured interview guides were developed for different categories of informants: national government actors, national-level stakeholders, regional government actors, and regional stakeholders. These guides were designed to address the specific mandates and contexts of each group, ensuring that the questions were relevant and elicited rich data. The specific questions were crafted to elicit in-depth responses that align with the research question, facilitating a thorough exploration of the subject matter. Draft interview guides were field-tested and refined based on feedback from three experienced policy actors, enhancing the reliability and validity of the data collection tool.

Recruitment Process

The recruitment of participants followed a systematic process:

- **Initial Mapping**: Information was collected on the participants' current and past roles, affiliations, and contact details.
- **Communication**: Participants and gatekeepers were contacted via email and phone, provided with a study information sheet, consent form, an introductory letter from the University of Sunderland, an ethical clearance letter, and the researcher's curriculum vitae.
- **Consent**: Written consent was obtained from all participants, ensuring ethical compliance and transparency.

This meticulous recruitment process ensured that the participants were well-informed about the study's purpose and their role in it, which likely contributed to the high participation rate. Out of 36 potential participants contacted, 22 expressed interest in participating, resulting in 21 completed interviews.

Interview Implementation

A total of 21 key informant interviews were conducted from March through July 2021. Sixteen interviews were conducted remotely, accommodating participants' schedules and logistical constraints. Recognizing the importance of including critical informants who preferred in-person interactions, the researcher traveled to Ethiopia to conduct five interviews face-to-face. This commitment underscores the importance of these participants' contributions to the study.

Most interviews lasted between 45 and 60 minutes and were recorded and transcribed with the participants' consent. Recording and transcribing interviews enhance the accuracy of data analysis and ensure that the participants' insights are captured verbatim, which is vital for the reliability of qualitative research.

Table 1: List of participants and their sectoral affiliations

S/N	Sectoral Affiliation	Administrative Jurisdiction
1	Ministry of Health	National
2	Member of parliament	National
3	Ministry of Health	National
4	Ministry of peace (Federal Affairs)	National
5	Ministry of Finance and Economic Development	National
6	Ministry of Health	National
7	Advisor to parliament	National
8	Advisor to Parliament	National
9	Member of parliament	National
10	Member of parliament	National

	(ex-sub national public official)	
11	Multilateral International Development partner (Ex-member of ministry of health regional level)	Sub National
12	Bilateral International Development partner	National
13	Multilateral International Development partner	National
14	Ministry of Health	Sub national
15	Multilateral International Development partner (former Ministry of water resources at Sub-national level)	Sub National
16	Multilateral International Development partner (Ex-member of the ministry of health regional level)	Sub National
17	Multilateral International Development partner	National
18	Bilateral International Development partner	National
19	Multilateral International Development partner (former Ministry of health advisor at Sub-national level)	Sub national
20	Multilateral International Development partner (former Ministry of health advisor at Sub-national level)	National
21	Ministry of health	Sub National

Constant Comparison and Iterative Enrichment of the Data Collection Process

The process of constant comparison was integral to this study's semi-structured interview methodology, enabling an iterative enrichment of both data collection and analysis. Constant comparison involves systematically comparing new data with previously collected data to refine themes, questions, and insights as the study progresses, ensuring a deeper understanding of the phenomena under investigation (Glaser & Strauss, 1967). This approach was applied throughout the data collection and analysis phases to ensure the study remained responsive to emerging insights and maintained a high level of methodological rigor.

Implementation of Constant Comparison

1. **Early Coding and Thematic Development**
   After the initial interviews, data were transcribed, and preliminary coding was conducted to identify emerging themes and patterns. **This early analysis provided insights into key areas of interest, which were then used to refine subsequent interview guides.**

2. **Adapting Questions Based on Emerging Insights**
   As themes began to emerge from early interviews, the semi-structured guides were iteratively refined to probe deeper into these areas. For instance, the challenge of coordinating child health policies across governance levels became a key area of inquiry in subsequent interviews.

3. **Cross-Participant Comparison**
   By systematically comparing responses, the researcher identified both alignments and divergences in perspectives. This approach highlighted systemic trends and unique contextual challenges, ensuring a holistic understanding of policy-making processes.

Outcome of the Constant Comparison Process

- **Rich, Contextually Grounded Data**: Iterative refinement ensured that data captured the complexity and diversity of policy-making experiences.
- **Enhanced Thematic Framework**: Emerging insights were integrated into a robust thematic framework, capturing both macro and micro perspectives.
- **Identification of Unanticipated Themes**: New and critical themes, such as the role of international development partners, were uncovered.

The use of semi-structured interviews in this study is fully justified by their ability to elicit rich, detailed, and contextually grounded data. By engaging key informants through a flexible yet structured approach and incorporating constant comparison, the method captures the depth and complexity of policy-making processes across different governance levels and sectors. This iterative and methodologically rigorous approach ensures that the study's findings are both comprehensive and robust.

3.5.3. Data Analysis

Data analysis in qualitative research is a meticulous and systematic process of examining, categorizing, tabulating, and synthesizing data to address the study's research questions (Yin, 2003). This process is inherently interpretive and subjective, requiring the researcher to play an active role in deriving meaning from the data and generating actionable insights (Pope and Mays, 2006). For this study, Framework Analysis was employed, aligning with the research's methodological orientation and the applied policy focus. Framework Analysis was selected for its structured yet flexible approach, which enables the efficient exploration of complex policy-related phenomena within tight timelines (Ritchie and Spencer, 1994).

Justification for Framework Analysis

Framework Analysis is particularly well-suited for policy research because it accommodates both deductive and inductive reasoning. This dual capacity ensures the method's adaptability in addressing predefined objectives while allowing the discovery

of emergent themes, making it ideal for exploring the multifaceted nature of policy-making processes (Guest et al., 2014). Additionally, the structured stages of Framework Analysis—familiarization, thematic framework identification, indexing, charting, mapping, and interpretation—offer clarity and replicability in the analysis process. These characteristics make Framework Analysis a practical and effective choice for policy studies requiring actionable insights**.**

Stages of the Framework Analysis Process

1. **Familiarization**
   The initial stage involved full or partial transcription of interview data and comprehensive reading of the transcripts to develop an in-depth understanding of the content. This step enabled the identification of initial themes and patterns that informed subsequent analysis stages.

2. **Thematic Framework Identification**
   A preliminary thematic framework was developed based on both a priori themes derived from the literature review and research questions, and emergent themes identified during familiarization. This iterative approach ensures that the analysis is grounded in theoretical insights while remaining open to new findings within the data.

3. **Indexing**
   The thematic framework was applied systematically to the data through coding, categorizing individual data items into distinct themes. This process facilitated the organization of complex data into manageable units, ensuring that all relevant information was accounted for during the analysis.

4. **Charting**
   Data were reorganized into charts under thematic headings, allowing for cross-case and within-case analysis. This step enhanced the clarity and accessibility of the data, enabling the identification of patterns and relationships across respondents and themes.

5. **Mapping and Interpretation**
   The final stage used visual representations and conceptual mapping to identify patterns, correlations, and explanations within the data. This phase synthesized the findings, providing actionable insights and addressing the study's research objectives.

Development of the Analytical Strategy

To guide the analysis, a detailed analytical strategy was developed early in the research process. This strategy ensured alignment with the study's objectives while remaining open to emergent themes and unanticipated issues (Miles and Huberman, 1994). The strategy was informed by theoretical pluralism, incorporating insights from multiple disciplines, with a focus on the Political Economic Analysis Framework and the Policy Triangle Framework. These frameworks provided a robust foundation for the study's conceptual and analytical framework, enabling a comprehensive exploration of the research questions.

Iterative Refinement of the Analytical Framework

At the start of the analysis, a preliminary framework comprising 14 thematic categories and 74 codes was developed. This framework was informed by theoretical propositions, research questions, and early familiarization with the data, ensuring its relevance and comprehensiveness**.** As the analysis progressed, the framework was expanded to 18 themes and 114 codes to reflect the richness and complexity of the data. This iterative refinement highlights the dynamic nature of qualitative research and the method's capacity to adapt to new insights.

Use of Nvivo 12 for Data Analysis

To enhance the efficiency and accuracy of the analysis, Nvivo 12 software was used for coding and thematic categorization. Nvivo facilitated the systematic organization and retrieval of data, ensuring that the analysis process was both rigorous and transparent.

This software-supported approach enabled the researcher to handle large volumes of data efficiently, ensuring that all relevant information was considered.

Outcomes of the Data Analysis Process

1. **Rich, Contextually Grounded Findings**
   The structured yet flexible approach of Framework Analysis provided a nuanced understanding of the policy environment, capturing both systemic trends and localized variations.
2. **Emergent Themes and Expanded Insights**
   The iterative refinement of the framework revealed unanticipated themes and complex relationships, enriching the study's findings. This adaptability underscores the value of using a qualitative approach for exploring dynamic and multifaceted issues.
3. **Actionable Insights for Policy and Practice**
   The final mapping and interpretation phase generated actionable insights relevant to policy-making processes, addressing the study's objectives effectively. These insights provide a robust basis for developing strategies and recommendations for improving child health policy in Ethiopia.

Conclusion

The use of Framework Analysis in this study is justified by its structured yet adaptable nature, which aligns with the research's objectives and methodological orientation. **By systematically organizing, coding, and interpreting the data, Framework Analysis enabled the study to uncover rich, nuanced findings and generate actionable insights into policy processes and outcomes.** The iterative refinement of themes and the integration of theoretical frameworks further enhanced the depth and quality of the analysis, ensuring its relevance and rigor.

3.5.5. Positionality and Reflexivity in the Research Context

In qualitative research paradigms, the co-constructive nature of findings is a fundamental principle, emerging from the dynamic interplay between participants and researchers. This co-construction of knowledge situates findings within a context that is reflexively shaped by both parties involved (Yin, 2009; Ritchie, Lewis, et al., 2013). Recognizing this, it becomes essential to articulate my positionality within the overarching theme and specific questions of this research, and to examine the impact of my epistemic stance on the richness of the data collected.

As an Ethiopian native with extensive professional experience across African, South Asian, and Middle Eastern regions, my background has inevitably influenced this research. My early years in Ethiopia deeply ingrained a cultural and contextual understanding of the nuances of health and policy in the Global South. Coupled with my global assignments in public health and policy—particularly through my work with the United Nations—my perspective has been shaped by exposure to a diverse range of sociopolitical and health system contexts. These experiences have provided me with a macroscopic view of policy dynamics and global health, which serves as a unique strength in identifying systemic inequities and fostering a commitment to equity-driven research (Bourke, 2014).

However, my positionality also introduces epistemic biases that could affect the research process**.** My commitment to social justice, while a guiding principle, could predispose me to emphasize certain narratives over others, particularly those that align with my ethos. Additionally, my absence from Ethiopia since 2008 has positioned me in a dual role as both an insider and an outsider: an insider due to my origins and cultural knowledge, and an outsider owing to my geographical distance and detachment from current, on-the-ground realities (Chavez, 2008). This dual role has implications for the access I have to certain types of data and the interpretive lens I bring to the analysis.

Acknowledging these biases, I have deliberately employed reflexivity throughout the research process. Reflexivity has not been treated as a one-time exercise but as a continuous, iterative process of self-examination and critical engagement**.** I have incorporated strategies such as triangulation of data sources, prolonged engagement with participants, and iterative reflection to identify and mitigate the influence of my

positionality on the data (Carter et al., 2014). These methodological safeguards have allowed me to strike a balance between leveraging my unique perspective for richer insights and ensuring objectivity in the interpretation of findings.

Furthermore, my professional connections within global policy circles, while advantageous for contextualizing broader systemic issues, have required careful navigation to avoid over-reliance on macro-level frameworks. Recognizing the risk of this epistemic bias, I have integrated participant-driven insights as a counterbalance, ensuring that local voices remain central to the research narrative. By incorporating diverse perspectives and remaining open to disconfirming evidence, I have worked to ensure that the findings are both credible and inclusive (Lincoln & Guba, 1985).

This reflective approach has underscored the importance of humility and critical awareness in the research process**.** My professional expertise and personal experiences, while invaluable, have been carefully scrutinized to ensure that they enrich rather than skew the study. Conscious efforts have been made to maintain methodological rigor, academic integrity, and a commitment to presenting a balanced and nuanced account of the findings (Miles & Huberman, 1994).

In conclusion, my positionality as a researcher has undeniably shaped the lens through which this study has been conducted. However, by embracing reflexivity and implementing rigorous methodological checks, I have worked to ensure that this research remains credible, reliable, and an authentic representation of the co-constructed knowledge it seeks to uncover.

3.5.6. Reliability, Validity, Reproducibility, and Transferability

In qualitative research, reliability, validity, reproducibility, and transferability serve as fundamental criteria for ensuring methodological rigor and trustworthiness (Lincoln & Guba, 1985; Yin, 2009). While these concepts have their origins in quantitative research paradigms, they have been adapted in qualitative inquiry to reflect the subjective and context-dependent nature of qualitative data. Reliability in qualitative research emphasizes consistency and coherence, focusing on the dependability of the research

process and whether it produces stable findings under similar conditions (Riege, 2003; Bryman, 2012). Validity, often framed as credibility in qualitative studies, pertains to the authenticity and trustworthiness of the findings in representing participants' experiences and perspectives (Lewis & Ritchie, 2003). Reproducibility in qualitative research, while not aiming for identical results, ensures that the methodology is transparent, allowing others to replicate the research process and produce comparable insights (Ritchie & Spencer, 1994; Guest et al., 2014). Transferability, which parallels generalizability in quantitative research, assesses whether findings can be applied to other similar contexts, emphasizing the provision of sufficient detail for readers to evaluate their applicability (Lincoln & Guba, 1985).

This study systematically addressed these aspects to ensure robust and trustworthy results. **Reliability** was achieved through the use of a clearly defined and meticulously documented research process. Semi-structured interviews were guided by standardized interview guides tailored to different participant groups, ensuring consistency while allowing for flexibility to explore emerging themes. The use of a predefined analytical framework, Framework Analysis, further ensured consistency in coding and interpreting the data (Ritchie & Spencer, 1994). An audit trail of decisions made during data collection and analysis was maintained, providing a transparent record of the research process that can be reviewed and replicated (Bryman, 2012).

To address **validity**, the study employed strategies that enhanced credibility and authenticity. Triangulation of data sources, including document analysis and semi-structured interviews, allowed the integration of multiple perspectives, strengthening the depth and robustness of findings (Yin, 2009). Participant validation was conducted by sharing key interpretations with respondents to ensure that the findings resonated with their experiences and insights (Lewis & Ritchie, 2003). Reflexivity was integral to the research process, with the researcher critically reflecting on biases and assumptions to minimize their influence on data collection and analysis (Riege, 2003). Thick descriptions of the context, participant perspectives, and research findings further enhanced the study's credibility, providing a rich, nuanced understanding of the phenomenon under investigation (Lincoln & Guba, 1985).

Reproducibility was ensured through a systematic and transparent approach to the research methodology. Detailed documentation of each stage of data collection and analysis, including interview protocols, coding frameworks, and thematic development, allows other researchers to replicate the study process in similar contexts (Guest et al., 2014). By adhering to the structured steps of Framework Analysis, including familiarization, indexing, charting, and mapping, the study provided a clear and logical roadmap for analysis, ensuring reproducibility even in a qualitative context (Ritchie & Spencer, 1994). This structured approach supports future researchers in following similar methodological trajectories to explore comparable phenomena.

The study addressed **transferability** by providing detailed contextual information about the Ethiopian public policy landscape and governance structures, including both federal and regional dynamics. This rich contextualization allows readers to assess whether the findings are applicable to other settings with similar sociopolitical and health policy challenges (Stake, 1995; Yin, 2003). The study's selection of cases from both federal and regional governance levels ensured a comprehensive understanding of the interplay between national policies and localized implementation, enhancing the relevance of the findings across different contexts. Additionally, the findings were situated within broader theoretical frameworks, enabling their application to similar research questions and settings experiencing analogous health and policy disparities (Gilson et al., 2011).

By systematically addressing reliability, validity, reproducibility, and transferability, this study established methodological rigor and trustworthiness. These measures not only ensured the robustness of the findings but also enhanced their applicability and relevance to broader discussions on public policy and health equity, particularly in contexts characterized by spatial health inequalities.

3.5.7. Ethical Consideration

In this research, ethical considerations were central to maintaining the integrity, dignity, and rights of participants, alongside the pursuit of knowledge aligned with the study's

broader social and academic goals. Ethical adherence was not merely procedural but reflected a deep commitment to respecting the intrinsic value and autonomy of human participants and addressing the societal implications of the research findings.

The ethical conduct of this study began with rigorous adherence to institutional and local regulatory frameworks. Approval was obtained from the University of Sunderland's ethical review committee, which involved a detailed review of the research design, risk mitigation strategies, and participant protections (Lobzhanidze et al., 2016). Additionally, recognizing the cultural and legal context of Ethiopia, authorization was sought and granted by the Ethiopian Ministry of Health. This dual approval process underscored the study's commitment to respecting both international academic standards and local customs and laws.

The research was guided by principles of beneficence, justice, and respect for human dignity. Beneficence ensured that the research design sought to maximize societal benefits while minimizing potential risks or harm to participants (Lobzhanidze et al., 2016). The principle of justice was upheld through fair and equitable selection of participants, ensuring that no group was disproportionately burdened or excluded from the study's potential benefits. Respect for human dignity was a foundational value, emphasizing participant autonomy and informed decision-making. This included clear communication about the study's purpose and scope, ensuring participants were fully informed and empowered to provide or withhold consent without coercion.

During data collection, these ethical principles were operationalized through meticulous practices to ensure participant comfort and autonomy. Participants were approached respectfully, initially through email and later through phone or workplace follow-ups when necessary, always accommodating their schedules and preferences. Before participation, they were provided with a detailed Key Informant Information Sheet and consent forms, which outlined the scope of the study, their rights, and the confidentiality measures in place (see Appendices 3 and 6). On the day of interviews, participants were briefed again, and informed consent was obtained, with the option to opt in or out of voice recording explicitly stated.

Throughout data collection and analysis, strict confidentiality protocols were maintained. Participant identities were anonymized by referring to their sectoral or organizational affiliations rather than personal identifiers. Data were securely stored in password-protected systems, and any potentially traceable information was excluded from the final report to ensure anonymity. This approach protected participant privacy and fostered a sense of trust.

Moreover, the research prioritized ethical data handling by implementing robust security measures to prevent unauthorized access and employing data anonymization techniques to safeguard participant information. Participants were reassured that their data would be used solely for research purposes, further reinforcing the ethical standards underpinning the study.

In conclusion, this research exemplified a holistic approach to ethical adherence, ensuring that the rights and well-being of participants were prioritized at every stage. By integrating ethical rigor with a commitment to values such as dignity, justice, and beneficence, the study maintained academic credibility while fostering a respectful and safe environment for all participants (Lobzhanidze et al., 2016). This approach highlights the responsibility of academic research to balance its pursuit of knowledge with the moral imperative to respect and protect those who contribute to it.

Chapter 4: Conceptual and Analytical Framework

4.1. Introduction

This study adopts a theory-driven approach to policy analysis, aligning with the recommendations of Sabatier (2007) and Walt et al. (2008). It thoughtfully integrates insights from a range of disciplines to enhance both the depth and breadth of its analysis. In exploring social stratification, it draws on Bourdieu (1985) and Grusky (2010) to understand how societal structures and cultural capital influence and maintain inequalities. The study also delves into the broader political economy, using frameworks from Moncrieffe and Luttrell (2005) and Khan (2010), to examine how economic and political forces interact in shaping policy decisions.

Furthermore, it addresses the impact of political economy on spatial health inequalities, referencing the work of Bambra et al. (2019) and Solaris and Irwin (2010), to explore how these inequalities manifest in different geographic contexts. The inclusion of Rawls' (1971) social justice theory adds an ethical dimension to the analysis, while Foucault's concept of 'governability' (1991), as discussed in Burchell, Gordon, & Miller, eds., provides a critical lens for examining governance in policymaking. Lastly, the study incorporates the public policy analysis framework of Walt and Gilson (1994), offering a comprehensive approach to understanding and evaluating policy decisions and outcomes. By weaving together these multidisciplinary perspectives, the study aims to provide a rich, nuanced analysis of policy dynamics.

While various theories and concepts provide valuable insights and context, this study specifically focuses on examining the impact of public policy analysis within the context of the political economy on persistent spatial child health inequalities in Ethiopia. To this end, it employs a combination of the Political Economic Framework (Moncrieffe and Luttrell, 2005) and the Policy Triangle Framework (Walt and Gilson, 1994). These frameworks form the foundational theoretical underpinnings for the schematic development of the study's framework(figure12). The Moncrieffe and Luttrell (2005) Political Economic Framework is instrumental in examining the policy context and its

impact on spatial child health inequalities via policy design and implementation, while the Policy Triangle Framework offers an in-depth analysis of specific elements of public policy grounded in the political economic context.

This chapter outlines the conceptual and analytical framework guiding the study, detailing its elements, their operational definitions, and the linkages and pathways between them. It also elaborates on the theoretical underpinnings that justify the use of this framework and illustrates how it has been applied to guide the analysis and address the research questions. First, the chapter presents the research aims and questions. This is followed by an in-depth overview of the analytical framework, including its schematic representation and detailed theoretical and conceptual foundations. Concurrently, the chapter demonstrates how this framework has been effectively employed to analyse policy in Ethiopian political economy context where spatial child health inequalities have been persistent.

The application of a theory-driven approach, reinforced by the diverse theoretical perspectives mentioned, ensures that the analysis is firmly rooted in strong theoretical foundations. Moreover, it highlights the study's relevance and its customised adaptation to address the distinct objectives of the research. This comprehensive approach underscores the study's commitment to a thorough and nuanced exploration of the subject matter.

4.2. The Aim of The Study And The Research Questions

The study aims to evaluate the impact of the political and economic environment, as well as public policy processes, on the persistence of spatial child health inequalities in Ethiopia.

In light of this, the research has been structured around the following questions:

- How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?
- In what ways have policy stakeholders influenced the formulation and implementation of policies aimed at reducing spatial inequalities in child health?

- To what degree have public policies tackled the issue of spatial child health inequalities and its underlying causes?
- How suitable and pertinent were the policy goals, strategies, programs, and interventions in addressing spatial child health inequalities?

4.3. Overview Of the Study Conceptual And Analytical Framework

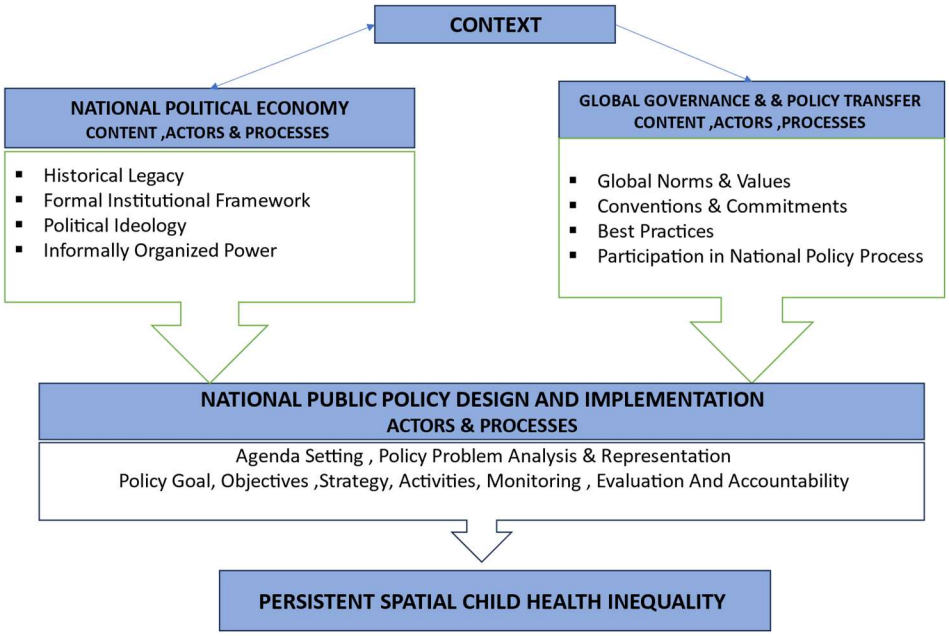


Figure 12: Conceptual and Analytical Framework for Political Economy of Spatial Child Health Inequalities in Ethiopia

The schematic representation of the conceptual and analytical framework for this study encompasses three primary components: The Context, Policy Design and Implementation, and the Outcome. Additionally, it underscores the critical role of actors and processes in shaping policy. The framework also highlights the significance of content, as policies are articulated in official documents.

Context: This element of the framework refers to the political, social, economic, and cultural circumstances that shape the development, implementation, and outcomes of policies. Influences at both national (Moncrieffe and Luttrell, 2005; Walt) and global levels

(Walt; Dolowitz and Marsh, 2000; Bernstein and Cashore,2012) are considered, providing insights into how global governance impacts national policy. The context is further enriched by acknowledging the roles of power, institutions, actors, and processes.

National Political Economy Context: This aspect delves into the economic, social, political, and institutional factors that drive or impede change within a specific country. National political economy analysis (Moncrieffe and Luttrell, 2005) involves examining historical legacies, constitutional frameworks, social structures, foundational issues of the country, the degree of institutionalization of government apparatus, political ideologies, formal and informal institutions, and the distribution of power across these institutions.

Global Governance and Policy Transfer: This component explores the mechanisms and pathways through which global governance actors and processes influence national policymaking. In a globalised world, low and middle-income countries are particularly susceptible to these influences. The influence pathways include conformity with international norms and discourse, commitments and conventions, and direct impact on domestic policy processes through best practice recommendations and financing (Dolowitz and Marsh, 2000; Bernstein and Cashore, 2012).

Policy Design and Implementation: As noted by Walt and Gilson(1994) policies are not designed and implemented in a vacuum; they are shaped by the underlying political economy and the influence of global governance. The interplay of global and national contexts determines the policy's design and implementation. This influence is manifested in the policy agenda setting, the values reflected, policy problem representation, goals, objectives, activities, resource allocation, strategies, monitoring, evaluation, and accountability mechanisms (Dolowitz and Marsh, 2000; Bernstein and Cashore, 2012.

Persistent Spatial Child Health Inequalities: The framework posits that the combined effect of contextual determinants and the public policy process ultimately shapes the outcome, which in this study is the persistence of spatial child health inequalities. The framework provides a comprehensive lens to examine how various elements of the national political economy and global influences converge to impact child health outcomes in specific spatial contexts.

4.4. Why a Political Economy Perspective and Analysis Framework?

This study adopts a political economy perspective to explore spatial child health inequalities in Ethiopia from 2000-2016, drawing on the theoretical underpinnings and justifications provided by key scholars in the field. The recognition of the limitations in socioeconomic status-based explanations for health inequalities, as detailed in Chapter 2, necessitates a more nuanced approach. Hankivsky et al. (2017) and Holman et al. (2021) have highlighted that health inequalities are influenced by a complex interplay of factors beyond material resources, including discrimination, cultural norms, and structural elements. This complexity underlines the importance of the political economy perspective advocated by Bambra et al. (2019), which offers a comprehensive framework encompassing the interplay of political, economic, and social systems.

The political economy perspective integrates broader vertical structural factors with local horizontal drivers, as emphasised by Bambra et al. (2019), allowing for a deeper understanding of the relationships between geographical location, political and economic structures, and health inequalities. This approach is not only academically robust but also crucial in shaping effective policies to mitigate health inequalities. It ensures that the findings of the study are directly applicable in formulating policies that can bring about meaningful change.

The multidisciplinary nature of Political Economy Analysis, blending theories from economics, politics, and social science, is pivotal in understanding how power dynamics, resource allocation, and public policy processes influence health outcomes. This approach has been empirically validated in various contexts, with studies in both developed and developing countries, including sub-Saharan Africa and Europe, demonstrating its effectiveness in understanding, and addressing regional health inequalities (Bukenya, 2020; Raphael et al., 2020; Bambra et al., 2019).

In the context of Ethiopia, the political economy lens is especially relevant. It facilitates an in-depth understanding of how international, national, and local structures and processes shape public policy, healthcare systems, resource distribution, and consequently, health inequalities. Thus, this study employs a political economy perspective to provide a

comprehensive, multidisciplinary, and policy-relevant analysis of spatial child health inequalities, acknowledging the complexities and multifaceted nature of these disparities and the need for considering broader structural factors alongside local conditions.

4.5. A Policy Analysis Framework Grounded on Political Economy Perspective

In this study, the conceptual and analytical framework primarily draws upon the Moncrieffe & Luttrell (2005) Political Economy Analysis Framework and the Walt and Gilson Policy Triangle Framework, which are discussed in detail in Chapter 2. Below, key elements of these frameworks are outlined, along with their relevance and appropriateness for this study, particularly in addressing the research questions through the analysis of data.

4.5.1. Political Economy Analysis Framework

The Moncrieffe & Luttrell (2005) framework, as expanded by Moncrieffe and Luttrell (2005), primarily focuses on the interplay between political decisions and economic policies, highlighting their impact on development outcomes such as health equity. This framework encompasses elements including political systems and institutions, economic structures and policies, social structures and dynamics, historical context, the role of external actors like international organizations, donor countries, and multinational corporations, and informal institutions and practices (Moncrieffe & Luttrell, 2005). In this study, elements from Moncrieffe & Luttrell (2005) 's framework are employed to address the research question, 'How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?' The 'Context' and its subcomponents – National and Global context – are drawn from Moncrieffe & Luttrell (2005) 's framework.

Significant recognition and application of the Moncrieffe & Luttrell (2005) framework within the policy practice and research community, especially in the context of developing countries, underscore its relevance and utility. Its adoption in scholarly works (Copestake & Williams, 2014; Fisher & Marquette, 2013; Joshi, 2014; Moncrieffe, 2004) and its

applicability in Ethiopia, as evidenced by Yeshtila (2017), illustrate its suitability for analysing complex political and economic dynamics in developing nations. Moreover, the integration of the Moncrieffe & Luttrell (2005) framework into operational strategies by international development agencies, such as the World Bank's 'Problem-Driven Political Economy and Governance Analysis' (World Bank, 2009) and the Department for International Development's (DFID) 'Political Economy Analysis How-To Note' (DFID, 2009), further highlights its efficacy.

However, the Moncrieffe & Luttrell (2005) framework does not extensively cover the policy process, a crucial aspect of this study. Therefore, the Walt Policy Triangle Framework is employed to assist in the in-depth examination and analysis of the Ethiopian public policy design and implementation process.

4.5.2. Policy Triangle Framework

Introduced by Walt and Gilson (1994) and detailed in Chapter 2, the Policy Triangle Framework is an essential analytical tool for exploring the influence of public policy on spatial child health inequalities in Ethiopia. It includes four key components: context, content, process, and actors (Buse, Mays, & Walt, 2012), each playing a critical role in comprehensive policy analysis.

Policy Context

The context of the policy refers to the political, social, economic, and cultural circumstances influencing policy development and outcomes. In developing countries like Ethiopia, factors such as political instability, resource constraints, and cultural diversity significantly impact policymaking (Buse, Mays, & Walt, 2012). Understanding these factors is crucial for addressing how Ethiopian public policies are affected by various contextual elements, particularly in tackling spatial inequalities in child health.

Policy Content

Content refers to the objectives, goals, and specific interventions or strategies within policies. Critical assessment of policy content should consider its relevance to the context, its evidence base, and alignment with the target population's needs (Walt & Gilson, 1994).

This study's focus on policy content through document analysis and interviews directly addresses questions related to policy problem representation, objectives, activities, strategies, and accountability mechanisms, evaluating their effectiveness in addressing spatial child health inequalities.

Policy Process

The process involves the stages of policy development, from agenda-setting to implementation and evaluation. Analysing factors like decision-making, policy-making capacity, stakeholder engagement, and accountability mechanisms (Buse et al., 2012) is crucial. This analysis helps understand how policy stakeholders influence the formulation and implementation of policies aimed at reducing spatial inequalities in child health.

Policy Actors

Actors in the policy-making process include a range of individuals and organizations in Ethiopia, such as national and local governments, NGOs, civil society groups, and international organizations. Assessing their roles, interests, influence, and the dynamics of their relationships is key to understanding the formulation and implementation of policies, especially those targeting spatial inequalities in child health.

The suitability of the Policy Triangle Framework for this study is further validated by its successful application in various international contexts. Gilson and Raphaely (2008) underscored its utility in analysing health policy in low- and middle-income countries. Its application in diverse settings such as health policies in Tanzania (Kapologwe et al., 2018), land reform in Zimbabwe (Moyo, 2007), and rural electrification in Bangladesh (Islam & Mezbaul, 2017) demonstrates its versatility and appropriateness for the Ethiopian context. This comprehensive empirical support ensures that the framework offers a thorough and insightful approach to analyzing policies concerning spatial child health inequalities in Ethiopia.

4.6. Chapter Summary

This chapter lays the theoretical and analytical groundwork for the study, adopting a multidisciplinary approach that weaves together theories from political economy, social

stratification, and public policy analysis. This broad theoretical base is pivotal for a holistic understanding of the subject matter. The chapter acknowledges the value of a theory-driven approach to policy research, as advocated by scholars like Sabatier (2007) and Walt, Gilson, Shengelia, and Murray (2008), underscoring the importance of theoretical grounding in policy analysis.

Given the study's primary focus on policy analysis in the context of the Ethiopian political economy, a combined framework that integrates policy analysis with a political economy perspective is deemed essential. To this end, the Moncrieffe & Luttrell (2005) Political Economy Analysis Framework and the Walt and Gilson (1994) Policy Triangle Framework are utilized. These frameworks have been widely used in policy research in developing countries and offer a comprehensive guide that aligns closely with the research questions of the study.

The chapter serves as a precursor to the presentation of the study's key findings in the next three chapters, laying a solid groundwork for the subsequent analysis. By integrating these frameworks, the study aims to provide a thorough and nuanced examination of policy dynamics in the context of Ethiopia's political and economic landscape.

Chapter 5: National Political Economy Context

5.1. Introduction

Chapter 5 builds upon the discussions from Chapters 2 and 4, which highlighted the essential role of investigating the political, social, and economic context in analysing the public policy process. The importance of such a context-specific analysis is widely recognized among policy scholars (Bambara et al., 2019; Gilson and Raphaely, 2008; Walt and Gilson, 1994). This approach not only enriches our understanding of policy decisions but also sheds light on their resultant public health consequences (Gilson et al., 2018; Steb, Cogburn, and Mandani, 2018).

The analysis in this chapter is guided by four key assumptions, integrating insights from political economy analysis (Moncrieffe and Luttrell, 2005; Khan, 2010), policy triangle frameworks (Walt and Gilson, 1994), and social stratification theories (Bourdieu, 1985; Grusky, 2010). These assumptions are:

1. **Historical Legacy**: The historical political economy and resultant public policies may have contributed to the persistence of significant regional inequalities, posing challenges to rectification through contemporary public policy.
2. **Power Dynamics**: The design and implementation of public policy are influenced by power, exercised both through official institutions and informal channels.
3. **Role of Formal Institutions**: Understanding the role of formal institutions and their governing rules is crucial for comprehending how informal political power undermines their legitimate function.
4. **Impact of Informal Power**: Informally organized political power plays a critical role in the distribution of resources, thereby impacting equity in social development in Ethiopia.

The chapter is structured to first discuss the influence of historical legacy on current policy dynamics and outcomes. Following this, there is an analysis of formal institutional frameworks and their impact on the spatial distribution of child health. Lastly, the chapter examines how ideology , informal power within formal institutions affects the

public policy process and equity. The socio economic context of the Afar region of Ethiopia is discussed in Chapter 1, Section 1.4.3.

5.2. Historical Legacy of Past Political Economy

In this subsection, the legacy of the past political economy and its enduring contribution to contemporary persistent spatial child health inequalities in Ethiopia are discussed. In this context, the historical past refers to the modern Ethiopian governments before the Ethiopian People Revolutionary Democratic Front (EPRDF)-led era of federal governance. First, the significance of historical legacy in affecting the design and implementation of policies (the policymaking process) and the distribution of important public goods such as health is emphasized. Then, the key characteristics of Ethiopia's political economy prior to the rise of the EPRDF, as well as its effects, are explored. Interview data, policy documents, and historical archives are analysed to provide the findings.

5.2.1. Why Historical Legacy Matters for Spatial Inequalities?

Examining the legacy of historical political economy is important in order to comprehend the contextual circumstances that led to the persistence of the spatial child health inequalities, as well as so many other socioeconomic dimensions in general (Moncrieffe & Luttrell, 2005). One of the most important components of a political economy-informed analysis is the examination of contextual factors, such as historical legacy, which may have had an impact on shaping current or recent past social problems such as health inequalities (ibid,2005). Similarly, as shown in this study, participants and reviewed documents constantly emphasized the importance of the past political economy's legacy on the current health inequalities and socioeconomic conditions in Ethiopia in general.

The past political economy context has had a significant and long-lasting effect on how present institutions operate, the power structures and interactions, prevalent beliefs, and perceptions, which in turn influence policymaking, the implementation process, and socioeconomic consequences. The political economy analysis approach (Moncrieffe & Luttrell, 2005) emphasizes the importance of investigating historical legacies (structural and contextual issues) in order to comprehend the long-term impact of past political

economy contexts on current public policy challenges. To accomplish this, it is necessary to evaluate the durability and likely effects of historical legacies on present public policies. Such an approach provides historical explanations for public policy and its effects by incorporating variables such as ethnicity, religion, various forms of political and other alliances, cultural norms, regional differences, demographic trends, and degrees of socioeconomic development (Moncrieffe & Luttrell, 2005).

Nearly all of the participants in the study acknowledge the importance of historical legacies on Ethiopia's persisting child health inequalities. On the list of Ethiopian regions negatively affected by the legacy of the former political economy, primarily pastoralist regions such as Afar rank high. On the significance of evaluating historical legacies, however, two opposing viewpoints are presented. The vast majority of policy actors who participated in the interview stated that the legacy of the past has had a substantial impact on the persisting geographical inequalities in child health over the past two decades. They contend that the persisting inequalities gap between regions such as Afar and the national average is largely due to the accumulated, "difficult- to-narrow" inequalities generated by the legacy of past political economic context and policies adopted.

It is obvious from the findings that a comprehensive and objective evaluation of the past is required to appreciate the long-term effects of the historical political economic context setting on contemporary inequalities.

In contrast, a small percentage of respondents believed that the influence of the previous political economic context may be significant, but the ongoing spatial inequities in child health in Ethiopia are primarily the result of policy failures by the administration in the last over two decades, and it is more appropriate to attribute the inequalities problems to the current administration. In general, there is unanimity that analysing the past political economic context may have considerable value, since it provides a comprehensive picture of the factors that may have contributed to Ethiopia's chronic inequalities.

The data analysis revealed that the impact of the legacy of past political economic context on current inequalities stems from four main features of Ethiopia's political economic history: **I**. the formation and management of the modern Ethiopian state; **ii**. the way the

Ethiopian state handled political settlement and political participation in pastoral areas; **iii.** the dominant socio-cultural narrative, stereotype, and attitude towards pastoral areas; **iv.** 'bad' policies and programmes pursued in the past. In the section that follows, studies elucidating how these aspects of Ethiopia's past political economy led to ongoing geographical inequalities over the preceding two decades are presented.

5.2.2. The Formation of The Ethiopian Modern State and How It Was Run

Ethiopia is an ancient nation with a well-documented history spanning over three millennia. It is best defined as a diverse nation with over 80 ethnic groups, including Christians, Muslims, and adherents of traditional religions. According to historical records, the Ethiopian state was at times centrally controlled and at other times comprised of loosely connected semi-autonomous kingdoms (EPDR, 1987; Zewde, 2002). The formation of the modern state of Ethiopia and how it has been perceived is a contentious issue in contemporary Ethiopian politics. There is a spectrum of opinions ranging from those who insist Ethiopia has always been a unified state dating back to the Biblical era to those who view it as a state formed by aggression and internal 'colonization' by predominant Amharic-speaking Orthodox Christian Emperors who hailed from the North highlands, North Shoa of the present-day Amhara region of Ethiopia and dominated the remaining territory in present-day Ethiopia (Guidina, 2006).

> *The various competing elites presented markedly different interpretation of Ethiopian history. In another words, history was rewritten so that it could serve the current political interests of the various competing ethnic elites (Guidina, 2006 in Turton, 2006 p. 119).*

Many would agree that the establishment of modern Ethiopia in its current territorial configuration and with Addis Ababa as its administrative capital dates back to the time of Emperor Menelik II, a controversial figure who influenced the modern/contemporary state architecture of Ethiopia (Zewde,2002; Guidina,2006). Menelik II pursued a territorial expansion effort after ascending to the throne in 1989, extending from his roots in North Shoa of the present-day Amhara Region to non-Amharic speaking territories. These regions currently go by the names Beneshangul-Gemuz, Gambella, Southern Nations

and Nationalities, Afar, Oromia, and Somali Regions. These regions of modern-day Ethiopia were subject to the feudal system of the Ethiopian Empire. The triumph of Imperial Ethiopia over Italy at the Battle of Adwa in 1896 encouraged European colonial countries to recognize Ethiopia's territory and contemporary statehood due to Menelik II's subsequent assertion of his uncontested rule over the present-day Ethiopian.

The monarchy lasted after the death of Menelik II until 1974, when Emperor Haileselassie, the last descendant of the Solomonic dynasty, was deposed by a military junta commanded by Mengistu Hailemariam. Simultaneously, the numerous student groups united ‘Ethiopianists’ and ethno-nationalists, who had become politically active. The country was engulfed in civil conflict for seventeen years. During the imperial era and the Derg dictatorship, the state functioned as a centralized unitary state, as opposed to a federated state. During this period state and society had just a hostile and authoritarian relationship. This has had a significant impact on the economic life of society, particularly in contemporary developing regions such as Afar (Zewde,2002; Guidina,2006)..

The establishment of the modern state, which was accomplished in large part by the use of force, was unable to bring about stability and prosperity in Ethiopia. After the passing of Menelik II, the monarchy continued till 1974 when Emperor Haileselassie, the last descendant of the Solomonic dynasty was toppled down by the military junta led by Mengistu Hailemariam. Concurrently the various student movements unified Ethiopianist and ethno-nationalists became active in in the political sphere. The country was immersed in 17 years of civil war (Zewde,2002). Throughout the imperial ear and during the Derg regime the state operated as centralized unitary as opposed to federal state. The state to society relationship was hostile and authoritarian (Guidina,2006). This had profound impact on the socioeconomic life of society particularly more so on the present-day developing regions such as Afar.

> *Though centre-periphery interaction had varied in time and space, both during Menelik's period and afterwards, visible marginalization, relative under development, and less integration have been durable features of the border areas within Ethiopia (Mulugeta, 2002).*

It is not the purpose of this study to provide an exhaustive account of the PE history of Ethiopia. We concentrate on how the foundation of the state and its operation affected pastoral areas such as the current Afar region, which is still one of the least developed in terms of socioeconomic development to this day (World Bank, 2014).

Political Participation

Prior to the 1990s, the Afar people hardly had any substantial official political representation at the central level. It is possible to characterise the relationship between the central administration and the Afar people as antagonistic, and the primary reasons for this are the Afar people's long-standing animosity with the centre and disagreements over land rights.

> *Relations between the middle valley Afar pastoralists and the emperor's government were inflamed not only by these intruders on Awash grazing lands but also by the cession of prime middle valley pastorage to Princess Tegegnework, the Emperor's daughter, who subsequently interfered with plans made to develop its grazing potential.* (Harbeson, 1978, p. 481*).*

Clan leaders and Sultans are the key figures in Afar society's traditional administrative structure. These local traditional leaders had a limited degree of authority and influence over the central government's policy. Prior to the early 1990s, there was hardly any well-established formal administrative center in the Afar region. The region was administered under the jurisdiction of three separate provincial administrations, each of which had its headquarters in a different part of the present-day Amhara and Tigray provinces, as well as in the state of Eritrea. This changed when the establishment of the Afar regional state took place took place in the early 1990s. Clan leaders and Sultans are the key figures in Afar society's traditional administrative structure.

> *When a modern administrative system was introduced in Ethiopia after the Second World War, the Afarlands were partitioned into different*

> *governorate-generals that later weakened the Afar traditional administrative system* (Yasin, 2008, p. 45*).*

Due to the extremely centralized administrations of the past, all research participants agree that the Afar population had few opportunities to participate in public policy decisions. Low involvement and exclusion from political decision-making reduced the likelihood that the Afar people's voice would be heard in policy decisions that affected their life. A participant with nearly thirty years of experience in political leadership in the Afar area and at the federal level described the absence of engagement in past public policy decision-making.

> *Before coming to power of EPRDF and subsequent formation of Afar region, the Afar population was subdivided into numerous provinces with administrative centers located far from the population. We did not have educated representatives in provincial administrations back then. Those in high positions were unfamiliar with our culture and did not speak our language. How can one expect the Afar people to actively participate in decision-making when they are not represented in provincial administrative leadership?* **(Participant 9).**

The rationale for the post-1991 EPRDF formation of ethnic-based self-governing regional states acknowledges that ethnic groups such as the Afar had been denied the right to participate in social, economic, and cultural decision-making, and that the decentralized federal arrangement could rectify these historical inequalities.

> *The EPRDF proposed the ethnic-based federal arrangement because it believed that there were significant inequalities among ethnic groups, and these inequalities could be better addressed if ethnic groups were given their own territories so that they could develop their own programs and policies (Wubneh, 2017. P. 129)*

Even after the Afar regional administration was founded, the prolonged absence of formal government administrative structures put the region's social development

initiatives in the hands of unskilled and uneducated regional officials. This is believed to have hindered the region's ability to catch up with the rest of the nation in terms of socioeconomic growth.

> *At the time the Afar regional government was founded, I recall that only one member of the regional leadership held a bachelor's degree, while the rest of us, including myself, had only completed elementary school. One cannot conceive that, with such minimal leadership ability, you might improve the region and reduce the existing inequalities* ***(Participant 9).***

Analysis of participant responses and examination of historical records reveals that the interaction between former formal administrations and the Afar community and traditional administrative structures was frequently hostile and not conducive to participation in policy decision-making. In addition, administrative structures were not located in close proximity to the people, making it difficult to bring social development concerns to the attention of decision-makers. Furthermore, it is evident that the legacy of prior admiring relationships with the Afar people left a leadership void in the region, which continued even after the Afar regional administration was established during the EPRDF-led federal arrangement.

According to Bourdieu's (1986) definition of structural restrictions and unequal access to institutional resources based on class, gender, and race, the historical occurrences witnessed in the Afar region have resulted in diminishing social capital. This ultimately results in a disadvantaged social position that impedes the possibility for power and resource advantage (ibid.). Overall, the phenomena observed in the Afar region in the past led to diminished social capital that, according to Bourdieu (1986), constitutes structural constraints and unequal access to institutional resources based on class, gender, and race. This ultimately leads to having a disadvantaged social position that hinders the potential for advantage for power and resources (ibid).

Unresponsive Central Administration

The Afar and other similar pastoral regions are located in arid and semiarid regions of the country where drought and food insecurity are prevalent. In addition, the Afar region has remained near or at times the epicenter of internal conflicts between the government and various rebel forces. There have been interethnic conflicts between Somali Issa tribes and Afar for several years (Yasin, 2008). The combination of frequent drought and conflict had caused tremendous human and animal suffering. Even by Ethiopian standards, the area lacks essential infrastructure and services such as education and healthcare. The responses of most respondents to a question about the fundamental cause of persistent child health inequalities indicate that previous Ethiopian administrations were unresponsive to the Afar region's basic service requirements. The response provided below is representative of the typical response provided by participants.

> **Interviewer**: *What do you think are the underlying causes of child health inequalities in Afar?*
>
> **Participant 14**: *In order for health sector to ensure equitable access to health care, there has to be a good infrastructure such as road, electricity, and potable water supply. As far as these infrastructures are concerned the Afar region has for long time been at disadvantage. Past administrations had excuses for low level of investment in provision of basic infrastructure. One of the common reasons was that as the Afar region is sparsely populated and major investment on infrastructure is likely to be inefficient. We heard similar excuses time and again even in recent years. I would say the state ignored the people for quite long time. What you see as a major development gap between Afar and rest of the country is result of non-responsiveness of past administrations to address the basic services needs of the Afar region.*

The inadequate efforts of the central administration to solve the infrastructure deficit and the myriad of other issues kept the population in a continual cycle of conflict (due to

frustration and rivalry for limited resources) that had a lasting impact on the area's social development.

> *The conflict in the Awash Valley has its roots in processes of inequitable political and economic development, differential access to vital resources between groups in society, obstructions to seasonal migration and to the impact of large-scale development projects by the state and private interests* **(UNDP-EUE,2011, p. 7)**

It is apparent that the central government's inability or unwillingness to handle the socioeconomic difficulties of the region has persisted for decades. The cumulative impact on the socioeconomic development of the Afar region has been emphasized in significant historical (1970s to 1980s) and contemporary studies.

> *The Afar have been among the poorest of the poor. In a country with one of the lowest per capita incomes in the Third World, they have participated very little in the limited socio-economic modernization that has occurred. In a country that is 10% literate, the Afar are almost totally illiterate* (Harbeson, 1978, p. 490).

> *Despite its huge natural, physical, and human capital resources, the region has remained one of the least developed, food insecure, and impoverished regions of the country (*Ethiopia Economics Association (2021, p. XV)***)**

In the circumstances indicated above, participants interviewed, and historical documents reviewed show that the Ethiopian central administrations of the past have been less responsive to addressing the basic services needs of the people leaving the region to lag behind the rest of the country. The administrations had provided various economic arguments for the low level of infrastructure investment and for the difficulty of provision of basic services for a sparsely populated and mobile population. Participants have also noted that similar justifications were offered throughout the EPRDF era, which demonstrates how prior attitudes among policymakers and institutional biases can persist and influence policy decision making. In addition, this raises the ethical question of

whether economic efficiency was prioritised over the objective of social justice in public policy decisions aimed at guaranteeing equity. The economic argument conflicts with the objective of addressing unfairness, which is based primarily on ethical imperatives and not economic efficiency (WHO CSDH, 2008).

> *For policy, however important an ethical imperative, values alone are insufficient. There needs to be evidence on what can be done and what is likely to work in practice to improve health and reduce health inequities (WHO CSDH, 2008 p. 42).*

The recommended strategy for designing policies to alleviate unfairness is to strike a balance between ethical imperative and economic efficiency. In Afar, it appears that economic efficiency is favoured over the ethical imperative. There is no evidence to show that the central administrations of Ethiopia denied the Afar community access to basic services and obstructed infrastructure development on purpose. Either insufficient attention was paid to the gap between the Afar region and the rest of the country, or the disparity was not prioritized on the development agenda. It appears that previous administrations believed that, given limited resources, investing in the provision of basic services for sparsely populated areas was inefficient. Given the historical political economy context described above, the Afar community had limited opportunities to sufficiently contest public policy decisions.

5.3.3. Stereotypes and Ineffective Policies.

The participants almost entirely agree that policy design in Ethiopia is a highly centralized practice with limited participation of the regional authorities. Such practice itself is an outcome of the legacy of the past during which regions such as Afar were considered peripheral. The stereotype of viewing regions such as Afar as peripheries and the pastoralist way of life as ‘wrong and uncivilized’ has continued to influence policy design practice in Ethiopia. The Afar population is predominantly pastoral nomadic. The population and livestock move seasonally in search of grazing land and water. There have been several attempts to improve the lives of the Afar population. The majority of such efforts did not succeed, among other reasons, due to the perception, attitude and

stereotyping of policy makers in the centre. The nomadic way of life is regarded as ‘backward’, ‘undesirable’, ‘wrong’ and ‘uncivilized’. The Ethiopia policy makers and technocrats alike are mainly from highland non pastoral areas and have little understanding of the pastoral way of life. There has not been a significant attempt to change this attitude. As a result, stereotypical attitudes and perceptions persist to this day and impact policy advice, design, and implementation. As one participant with several years of experience remarked,

> The policies are formulated in Addis Ababa, at the federal level, where the policy design actors hail predominately from agrarian and highland communities and have limited understanding of the pastoralist way of life. Consequently, the policies and programmes created do not fit the circumstances of Afar and similar locations. This is exemplified by the Ethiopian Health Extension Program, which improved the health status of the majority of Ethiopians but failed in Afar because it was built with just the Agrarian and sedentary way of life in mind while ignoring the pastoralist way of life ***Participant 12.***

Such statements illustrate how historically based prejudices, opinions, and attitudes of policymakers can undermine the design of contemporary policy and result in the failure of programmes. Policymakers with a limited awareness of the sociocultural context of pastoralists are more likely to design policies and initiatives that are not customized to the pastoralist setting.

Overall, it can be concluded that past PE undermined the political participation of the Afar people, which contributed to their marginalization, impacted the fair allocation of resources, and weakened the role of informal and formal institutions that promote the equitable distribution of resources and power. Decades of indifference on the part of Ethiopia's central governments to the plight of the Afar people led to a development deficit that widened the divide between the rest of the country and the Afar region. The perceptions and attitudes have had a lasting impact on the design and implementation of contemporary public policy. Public policies frequently failed to account for

pastoral/nomadic lifestyles and were frequently dominated by agrarian/highland-centric one-size-fits-all measures. The implementation of prior policies has compromised livelihood opportunities, impacted the environment, and consequently led to low socioeconomic outcomes that have persisted and left "impossible to fill gaps" in the social development of the Afar region.

5.3. Institutions, Power Structure and Public Policy Implications

5.3.1. Introduction

This section presents the findings of an analysis of official institution policy documents and interview data. Here, formal institutions relate to entities that engage in formulating operational standards and guidelines (Moncrieffe & Luttrell, 2005). The analysis tackles the research question: To what extent do contextual factors influence the design and execution of public policy in Ethiopia with respect to addressing spatial child health inequalities? The primary focus of the analysis is on how power was intended to be exercised in formal institutions, how power was exercised through informally organized structures, and its influence on the allocation of crucial resources, which ultimately determine the spatial distribution of child health in Ethiopia. The macro-level analysis is guided by political economy and political settlement frameworks.

5.3.2. To what Extent Formal Institutions Promote Policy on Spatial Child Equity?

The analysis utilized overarching policy[4] documents, including the Constitution of the Federal Democratic Republic of Ethiopia (FDRE) and the government's multiyear social development policies from 1994 to 2016. In addition to the examination of policy documents, associated findings from interview data are presented. Important themes presented below include Representation of Equity and social justice-related norms and values in policy documents and institutional frameworks; the influence of these values and norms in shaping policy orientation and objectives; the extent to which inequity is acknowledged in policy documents; and the implications of the overarching policy on

[4] Overarching policy documents are not sector-specific but rather policies that are likely to shape the formulation of sector-specific policies.

accountability, regional autonomy, and engagement with traditional governance structures.

Table 2: The overarching policy documents FDRE.

Policy document	**Year of publication**
Constitution of the federal democratic republic of Ethiopia	1994
Interim Poverty Reduction Strategy Paper 2000/01- 2002/03	2000
Sustainable Development and Poverty Reduction Program (SDPRP)	2002
Plan for Accelerated and Sustained Development to End Poverty (PASDEP) 2006-2009	2005
poverty reduction strategy paper, (PRSP): Growth and Transformation Plan 2010/11–2014	2010
Growth and Transformation Plan II (GTP II) (2015/16-2019/20)	2016

5.3.3. Norms and Values in Ethiopian Overarching Public Policy

After the fall of the Derg military regime in 1991 and the subsequent formation of the transitional government of Ethiopia (TGE), the current national constitution of Ethiopia was enacted on December 8, 1994, by representatives elected from the country's many ethnically constituted communities. The regional states comprising the federation subsequently approved their separate constitutions by exercising their legislative, executive, and judicial authority. Some contentious parts of the regional and federal constitutions, such as the right of ethnically constituted states to self-determination and cessation, remain a source of friction between diverse segments of the population. Nevertheless, the constitution is mostly consistent with internationally accepted equality and social development-related standards and agreements, and it specifically declares

that the country's adherence to these international conventions is an integral part of the constitution**.**

> *All international agreements ratified by Ethiopia are an integral part of the law of the land* ***(Art. 9, noNo.4, FDRE, 1995).***
>
> *Human rights and freedoms, emanating from the nature of mankind, are inviolable and inalienable (***Art.10, No.1, FDRE, 1995).**

In addition, the preamble affirms the state's commitment to promoting social and economic development through the exercise of people's rights. Respect for human and democratic rights is a key pillar of the constitution. About one-third of the 106 provisions of the constitution (Articles 13-44) deal with fundamental rights and freedom. The content of these fundamental rights and freedoms is mostly consistent with internationally accepted standards and ideals, such as those outlined in the United Nations Convention.

Representation of Equality and /or Social Justice values

In accordance with the United Nations convention on human rights and the convention on the social, economic, and cultural rights of individuals, equality and/or social justice are represented as key values. Several provisions of the Constitution contain 31 mentions of terminology directly connected to equity, such as 'discrimination,' 'equal,' 'equality,' and 'equitable.' Respect for the rights of all individuals without regard to their race, nation, nationality, or other social origin, skin colour, sexual orientation, language, religion, political or other viewpoint, wealth, place of birth, or other position is unequivocally underlined (ibid, Art, 25). Article 41, paragraphs 3 and 4, and Article 90, paragraphs 1 and 2, outline the state's commitment to allocate resources to the provision of essential services such as health and education and to ensure equal access to publicly funded social services. Art. 43, No.1 & No.2; Art. 89, No.2 & No.6 indicate the right to health-promoting conditions such as improved living standards and participation in the design and implementation of policies and programmes impacting their communities.

Equity and Social Justice Values Guide Public Policy Objectives

In the section of the constitution titled "Structure and Division of Government Powers," the aims of social and economic development are outlined. The objectives highlight the government's commitment to achieve equity by offering equal opportunity to enhance social and economic conditions and to promote equitable wealth distribution (FDRE 1995, Art. 89, No.2). Moreover, Article 89, number 4 indicates the necessity for special aid to boost underprivileged parts of the population:

> *Government shall provide special assistance to Nations, Nationalities, and Peoples least advantaged in economic and social development (FDRE, 1995, Art. 89, No.4).*

This article can be seen as crucial in terms of the acknowledgement of the rights of disadvantaged groups and directing government policy in addressing equality through the provision of special support to pastoralist regions like Afar. Both aspects are important in addressing equity. Art. 89, No.8 states the right of pastoralist populations to receive an equitable share of the national wealth commensurate with their contribution and this premise shall guide the State in the formulation of economic, social and development policies (ibid, Art. 89, No.8). The state commitment to bring about social development in an equitable manner is stated to varying degrees in the Ethiopian government's overarching policy documents implemented from two thousand – 2015 (MoFED, 2002; MoFED, 2005; MoFED, 2010).

> *Ethiopia's development strategy seeks to promote rapid broad-based and equitable growth by focusing rural development and improvement in physical and human capital and deepening the devolution process to empower the people, expand the choices, and control that people have over their lives.*
>
> *(MoFED, 2002, p. 36)*

While there are no contradictions between the constitution and the overarching social and economic development policy documents and internationally recognized norms, values, and conventions pertaining to health, social development, and equity, the analysis has uncovered a number of deficiencies in

these overarching policy documents that may have contributed to insufficient progress in ensuring equity over the past two decades. In spite of the fact that having a relatively better articulated overarching policy(the Ethiopian development policies were overall well aligned with global development agenda in comparison with the past[5] administrations policies), including a constitution, is a commendable aspect, according to the participants in the study, this does not inevitably result in government pledges being translated into actions that are consistent with the stated policies.

> *We have well written policies that could impress the international organizations and development donors. The problem we have is these written commitments often were not translated into actions that change the reality on the ground* **(Participant 2).**

Despite this, the analysis found gaps (reported below) in the written document(s) and considers the implications of those gaps for the design and implementation of the policy**.**

5.4.4. Deficiencies in Overarching Public Policy

Acknowledgement of Spatial Inequalities

In Ethiopia's overarching policy documents and policy community, the absence of a concrete statement of policy actions to alleviate spatial inequalities is a fundamental weakness. The existence of gender-based, socioeconomic, and geographic inequalities is acknowledged in the Ethiopian constitution and other broad policy texts, as well as in political discourse. For instance, women's discrimination is acknowledged more openly, and there is a determination to rectify its historical legacy through affirmative action. Similarly, the distinction between urban and rural extreme poverty is widely acknowledged, and appropriate policy

[5] Ethiopia's Plan for Accelerated Development , and Growth and Transformation Plan I and II resulted in fast economic growth. Ethiopia has one of the fastest-growing economies in the world. Its 2013 GDP growth 1 rate of 9.7% – and its average rate of 10% for the past decade – compares very favorably with the 6.2% average of the comparator countries2 (see Figure 1.1) (Source : Development Effectiveness Review, 2015, Africa Development BanK,2015)

measures are suggested. In contrast, while the disparity between regions (the horizontal) is acknowledged as a problem, policy responses are not explicitly expressed. When it comes to the inequalities of pastoral areas, policy documents and the popular discourse/rhetoric tend not to identify which geographical regions are most affected by inequalities and there is no identification of the corrective measures to be implemented.

> *The historical legacy of inequalities and discrimination suffered by women in Ethiopia taken into account, women, in order to remedy this legacy, are entitled to affirmative measures (FDRE, 1995, ART 35, No.3).*
>
> *Government shall provide special assistance to Nations, Nationalities, and Peoples least advantaged in economic and social development (FDRE, 1995, ART 89, No.4).*

However, lately, spatial inequalities has become a concern and requires '*customized development solutions'* by the development assistance community in Ethiopia and there is a revisitation of existing polices.

> *Despite the progress achieved over the past decade, there are still intra-regional inequalities in resource endowments and access to services. Certain regions (such as the lowlands) or population groups (such as pastoralists or women) may require customized development solutions to meet their particular needs. Using a* ***spatial approach****, efforts will be made to ensure that all regions and people have access to the full range of quality services, from health and education to water supply (****The World Bank, 2017****).*

Road Density *Road Access*

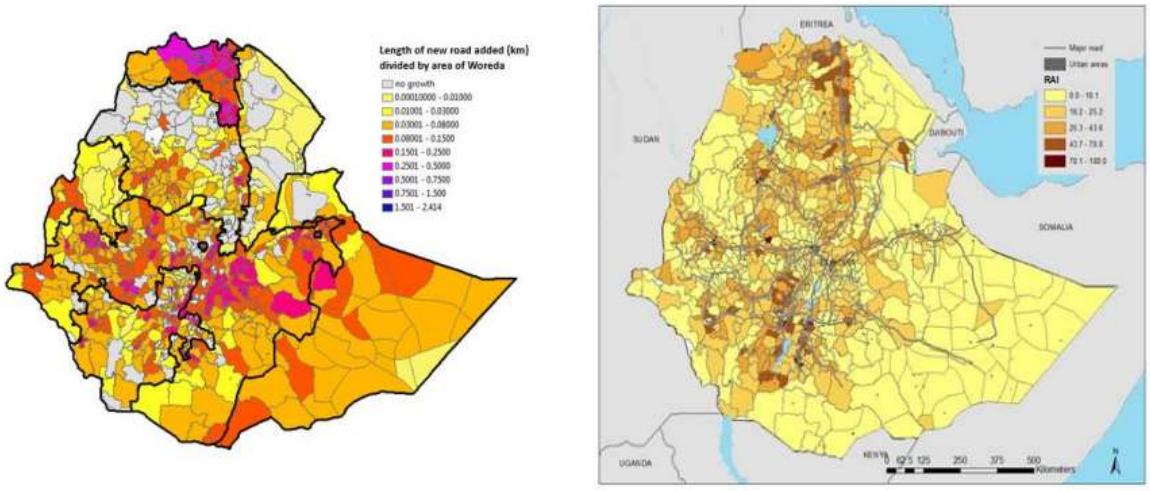


Figure 16: Road Density and Rural Access in Ethiopia 2016[6]

Source: The World Bank, 2017.

> *"Ethiopian government and its development partners' policies and programs have been pro-poor and pro-rural. Hence there is marked improvement in rural poverty and social development in general. The political commitment and focus on marginalized has been there"* ***(Participant 8).***

Specifically recognizing disadvantaged groups in the Ethiopian setting appears to have aided in the development of public policies that improve the living conditions of disadvantaged groups, such as the rural population. In this regard, Ethiopia's rural development-focused policy over the past two decades has likely improved in numerous ways. Various overarching policy documents, as well as political rhetoric and policy documents, highlight, for instance, the unfair inequalities between rural and urban populations and lower socioeconomic classes, and they describe essential policy and program steps to address the issue (MoFED, 2002; MoFED, 2005; MoFED, 2010).

[6] The predominantly pastoralist are located in the Northeast (Afar region) and Southeast of Ethiopia. In both regions road density and access is very low as compared to rest of the country,

Possibly, these have made Ethiopia's state policies more pro-poor and rural-focused, with some effectiveness in decreasing poverty and expanding access to basic services. When it comes to reducing spatial (regional) inequalities, however, efforts to strengthen policy measures appear to be missing.

The Mandate and Autonomy Of The Regional States

In the formulation and implementation of public policies, the regional states' jurisdiction and autonomy are murky. As stated in Article 51 of the constitution, one of the major powers of the federal government and its structures (parliament, house of federation, the council of ministers, the legislature) is the formulation of policies, strategies, and standards for social development sectors such as the health sector. Art. 52 similarly empowers regions to develop and implement their own policies. However, it is unclear if regional states can formulate their policies in a manner that may or may not closely resemble/align with federal policies, or whether their duty is to reproduce and/or contextualize federal policies.

Multiple study participants express this ambiguity. Neither the Afar region nor the regional states have ever adopted region-specific policies for social development. The daily norm has been to adhere to federal policies. This has led to one-size-fits-all governmental policies that have frequently failed in regions such as Afar.

> *To tell you the truth, I do not have a very good understanding of what their function is in terms of their mandate in developing their very own contextual strategy. In any case, I believe it is within their jurisdiction to contextualize any national plans or initiatives. In my experience, I have not come across any regions that have developed context-specific strategies that significantly deviate from one another in their approach. For instance, in industrialized western countries with federal states, the states have the authority to accept, partially accept, or reject policy direction from the national level* ***(Participant 13).***

Another significant obstacle is the uncertain mandate of regional states to mobilize resources through international development partners, as engagement at this level of collaboration/negotiation is generally regarded as a federal responsibility. This ambiguity impacts the availability of resources to improve the living conditions of the inhabitants in locations such as Afar where the capacity to collect tax revenue is relatively limited.

Lateral cooperation between regional states

The lack of clarity in the constitution on lateral and interregional cooperation is an additional significant barrier to the reduction of horizontal inequalities. It is unclear how horizontal relationships are managed and how regions can cooperate with one another, as well as how human resources and capacities can be transferred from one region to another. This lack of clarity regarding the horizontal relationships across regions has resulted in significant issues. In the past two decades, interregional border disputes and violent skirmishes have become commonplace. The limited migration of human resources from a region with better performance to regions such as Afar was a result of the tense or indifferent relationship between regions, which made it difficult to foster interregional cooperation**.** A good example is the resettlement program, which was restricted to movement within regions out of concern that ethnically organized regions would be unable to accept immigrants from other regions. There is no legislative incentive that encourages professions to transfer from one place to another with regard to the mobility of experienced and qualified workers. Even if human resource capacity migrates to locations such as Afar, professionals cannot assume leadership positions; these positions are reserved for native-born affiliated individuals. Many viewed the EPRDF regime's lack of clarity in the constitution and other policy papers regarding the horizontal interaction of regions as a "divide and rule" tactic. As a result, it has deprived the movement of resources and capacities that could have helped reduce inequalities in terms of access to high-quality basic services.

Accountability

The federal and regional leaders' mutual accountability is ambiguous. The border between the roles of federal and regional executives, collaboration, and accountability is

ambiguous. This becomes difficult when it comes to holding regions accountable for poor performance in the delivery of public services (owing to inadequate leadership capacity and resource misappropriation) in a particular region. It is unclear how accountability can be achieved if regions do not interact and do not execute or utilize nationally allocated resources efficiently. There is a provision in the constitution (Article 94) that states regions must account for federally granted resources. However, this is ambiguous and somewhat contradictory to the practice that once regions get resources (block grants) from the federal government, they are responsible for allocating and utilizing the funds.

> *There is question regarding responsibility. The performance gaps are not directly addressed because the federal executive lacks control over the regional level, yet the federal executive is responsible for the performance of the entire nation. There are occasionally indirect and informal approaches to identifying performance gaps. I am aware that performance concerns are being discussed at the highest level of regional leadership. However, these are ad hoc measures not supported by official rules* ***(Participant 6)***

The Federal Special Support to regional States

The study participants mentioned various technical, advisory, budgetary and leadership support provided from national level ministries to Afar and similar developing regions. However, it is unclear how and when the federal government supports the development and implementation of regional policies. In regards to the role of the federal executive or line ministry in the regions, the triggers for support or involvement are unclear. Also vague are the limits of federal state action in supporting regions. Several participants reported that tension has always existed between federal officials and professionals who provide assistance to locations like Afar.

> *Frankly speaking the support is good. The challenge is on how the support is perceived. The financial support specifically is seen suspiciously. They would like the money to be given to them. There may also be lack of empowerment by technical support team* ***(Participant 6).***

The technical advisers appointed to regions by national-level ministries are occasionally influential and have access to the bureau's senior leadership. The technical advisors identify obstacles to policy execution, and sometimes the issues are remedied. However, the contact between federal officials and experts and regional senior leadership in influencing decision-making generates distrust among local specialists, who believe the federally assigned employees may have ties to influential federal politicians. Overall, the lack of clarity regarding the criteria and considerations for federal support to regional states and the manner in which it is managed may have diminished the benefits of the Afar region's technical support. This insufficient and ineffective assistance structure may have reinforced the disparity between the Afar area and the rest of the country.

Engagement with traditional institutions

Traditional institutions have a significant influence in the daily lives of the Ethiopian population, and this is especially true in the Afar region. Clan chiefs organize communities, have decision-making authority, and play a leadership role. The constitution is silent on the critical role of these institutions and how they must interact with formal government organizations. Overall, the role of traditional clan leadership is not specified.

> *Government shall at all times promote the participation of the People in the formulation of national development policies and programs; it shall also have the duty to support the initiatives of the People in their development endeavors (EFDRE, 1995, ArtNo.).*

The lack of clarity around how formally traditional institutions can work with the government and play a vital part in various development projects is both disempowering to communities and a squandered chance to maximize their contribution.

5.4. Ideology, Power Structure and Policy Implications

It is widely acknowledged that political power influences the design and implementation of public policy. Understanding the dynamics behind the distribution of power and, by extension, the control and allocation of resources in a given setting is crucial for policy analysis. Barker (1996) asserts, "Resources, ideas, and technology are all essential, but

their utilization is contingent on the distribution of power in society" (Barker; 1996: 79). This study examines the power relationships, ideology, and interests that drive the allocation of power and resources in order to comprehend the effects these dynamics have on the public policy process. Data from interviews, media archives, and official party and government records were utilized in the analysis. First, the findings about the influence of the dominant party's ideology on the allocation of resources, political engagement, and policy decision-making are provided. Second, the mode of operation of the dominant ruling party and its influence on the policymaking process are examined. Following this examination, the analysis of the power dynamic inside the dominant political party and its impact on public policy decision-making is presented.

The EPRDF (Ethiopian People Revolutionary Democratic Front) has administered Ethiopia since 1991, nearly 28 years. EPRDF is a coalition of four parties, however, it has been dominated by the Tigray People's Liberation Front (TPLF). The Tigray People's Liberation Front (TPLF), an ethnic party from northern Ethiopia's Tigray region, has dominated Ethiopian politics for nearly three decades. Before gaining power in 1991, the TPLF created the coalition EPRDF (Ethiopian People Revolutionary Democratic Front) alongside the Oromo Peoples Democratic Organization (OPDO), the Amhara National Democratic Movement (ANDM), and the Southern Nations Peoples' Democratic Movement (SNPDM). This was not an equal partnership between the TPLF and these three groups. TPLF dominated the coalition that ruled Ethiopia for over three decades without challenge. There are regional parties that are not members of the EPRDF but are referred to as "allies," such as parties from pastoral regions such as the Afar region. The status of these parties has always been seen as inferior to that of the TPLF, and the TPLF/EPRDF seemingly directs the internal operations of these parties. In light of the power structure reality that has persisted in Ethiopia for the past three decades, the influence of ideology on the policy process in the Ethiopian political realm can be better understood by analysing the TPLF/EPRDF (Lyons, 2019).

The TPLF/EPRDF had an ideology that may be characterized as Marxist from the inside but was dubbed democracy so as not to disturb its western friends (Berhe, 2008). The TPLF/EPRDF philosophy revolves around land ownership, ethnic identity, and political

representation (ibid, 2008). All of these factors have had a significant impact on the formation and implementation of public policy. To illustrate this impact, the Afar context is discussed below. The TPLF (Tigray people Liberation front), an ethnic party which hails from Norther Ethiopia's Tigray region, has dominated Ethiopian politics for nearly three decades. Before coming to power in 1991, toppling the Derg regime by armed struggle, the TPLF formed the EPRDF (Ethiopian People Revolutionary Democratic Front) coalition with three other dominant ethnic oriented parties: the Oromo Peoples Democratic Organization (OPDO), the Amhara National Democratic Movement (ANDM) and the Southern Nations Peoples' Democratic Movement (SNPDM). The alliance of the TPLF with these three parties was not a marriage of equals. The TPLF had undisputed dominance within the alliance which ruled Ethiopia for nearly three decades. In addition to the EPRDF, there are other regional parties which are not members of the EPRDF but are called 'allies,' such as parties from pastoral areas such as the Afar region. These parties have less than equal status with the TPLF and are their day-to-day activities are under the direction of the TPLF/EPRDF. Therefore, given the power structure reality that persisted in Ethiopia for almost the last three decades, the influence of ideology on policy process in the Ethiopian political sphere can better be understood by examining the TPLF/EPRDF (Lyons, 2019).

> *The legal framework that underlies Ethiopian politics is an elaboration of the political ideology of the party that won the civil war in 1991, the TPLF/EPRDF, and has not changed much* (Abbink, 2011).

The TPLF/EPRDF had an ideology that may be described as Marxist from the inside but was pretended to be democratic and to some extent liberal so as not to upset its western allies (Abbink, 2011; Berhe, 2008). Land ownership, ethnic identity, and political representation are central to the TPLF/philosophical EPRDF's outlook (ibid, 2008). All of these elements have had a substantial impact on the development and implementation of public policy. The Afar incident is presented below to highlight this impact.

According to the TPLF/EPRDF, the state should administer and control the means of production (land) in order to protect the rural peasantry from urban capitalists (public).

This means that the government may evict tenants of land or property if deemed necessary in the "public interest." Unquestionably, the TPLF/EPRDF land policy was one of the most crucial vehicles for imposing total power.

> *The right to ownership of rural land and urban land, as well as of all natural resources is exclusively vested in the state and the peoples of Ethiopia. Land is a common property of the nations, nationalities, and peoples of Ethiopia* (**FDRE, 1995, Art. 40).**

Meles Zenawi (long-time head of the TPLF/EPRDF) said, "over our dead bodies" when questioned about the possibility of the government liberalizing land policy (Ethiopian Parliament records, 2005). The majority of the population of Ethiopia resides in rural, agriculturally dependent areas (World Bank, 2020). Agriculture accounts for around two-thirds of employment (FAO, 2022). In the context of Ethiopia, land ownership rights might be considered an issue of survival. This demonstrates the extent to which the TPLF/EPRDF's firm hold on land ownership (property right) has been perceived as the primary tool for exercising power. This perceived intention of property rights has started to become evident in large scale state transfer of land to investors.

> *The commercialization of land has served as a political advantage to the state since it enhances its power vis-à-vis rural communities, and leads to the greater concentration of authority in the hands of public agents and local administrators (Rhameto, 2011)*

In the context of the Afar region, land is arguably the most valuable asset. The Afar region, particularly the Awash valley, is endowed with the most fertile irrigable arable land, an ever-flowing Awash river, salt and mineral deposits, and grazing land for cattle production. On the allocation and use of land in Afar, the policies and initiatives followed by the TPLF/EPRDF-led central government appear to have impacted the lives and livelihoods of the people.

> *By law, the state has juridical ownership of the land and in contrast peasant farmers and pastoralists have the right of use only, it is the state which in*

> *effect has been responsible for land grabbing: it has used its statutory right of ownership to alienate land from those who have customary rights and rights of longstanding usage, and transferring it, without consultation or consent, to investors from outside the communities concerned as well as from outside the country itself (Rhameto, 2011).*

Some government projects, such as the Villagization programme, have a negative impact on the population's standard of living, as indicated by interviews and studies on land ownership rights-related topics.

> *Villagization in Ethiopia has been highly contested. Some studies contend that villagization was planned to favour the introduction and expansion of new state-owned and private commercial agriculture. These studies also suggest that villagization constituted a mechanism of land grabbing by the state and private sectors at the expense of pastoralist people, since it is claimed to have resulted in the scarcity of grazing land, reduced access to customary pasture and water sources, and restricted movement corridors to practice pastoralism* (Degefu et al, 2020).

The majority of Afar are pastoralists who make a living by raising livestock. Afar communities migrate seasonally in order to find water and grazing pasture for their livestock. The government's control of land and its allocation to investors and mega-public projects did not benefit Afar communities, but rather impeded their pastoral livestock activities. The cattle grazing land had shrunk, resulting in decreased yield and a decrease in herd size. Consequently, communities were deprived of livestock and economic possibilities. The commercial agriculture initiatives and mega-projects have not demonstrated a substantial commitment to community support. Consequently, the Afar community has remained disenfranchised and badly harmed by an ineffective land policy governed by the TPFL/EPRDF doctrine of control over means of production. As a result, the Afar population's livelihoods were disrupted, and they lacked access to better economic options that may have improved their living conditions and ultimately contributed

to the state of their health. A statement from a 2010 vulnerability assessment of pastoralists illustrates the impact of the TPLF/EPRDF-inspired land policy.

> *The pastoralists perceive themselves as 'forgotten people' and distrust governmental interventions due to the past experiences of socio-political marginalization and expropriation of land. A mixture of disappointment and anger characterizes this discursive storyline which argues that governmental interventions have ignored and still ignore pastoral interests (Rettberg, 2010, p. 260).*

The ruling EPRDF/TPLF ideology regarding right/control over means of production was reflected in the Ethiopian constitution and has been widely implemented throughout the last three decades. Studies indicated lands dispossessed from pastoralists were given to commercial farms such as state-owned sugar plantations. The implementation of the land ownership policy has compromised the livelihood of Afar population, leading to lower economic opportunities and poor social development (Degefu et al, 2020).

Another component of TPLF/EPRDF ideology is ethnic identity politics. In contrast to the liberal belief that the voice and rights of the individual matter, the TPLF/EPRDF emphasizes the voice or rights of ethnically organized groups. The influence of the Stalinist definition of 'nations' on these ideologues led to the development of federated ethnically organized regions. While the devolution or self-administration part of the development of regions is considered as positive, the tension it has provoked has had a significant impact on numerous facets of contemporary Ethiopian life.

> *I really like the idea of decentralization and self-administration through ethnically organized regions. The leadership comes from same region, speak the language, and know the culture. The downside is it repels those with the right experience and qualification from coming to the region and take up positions in key technical areas. That is unfortunately the reality. It has impacted negatively the Afar region which suffers from lack of qualified and experienced professional* **(Participant 16).**

The limited mobility of people across regions is one of the most significant negative effects of ethnically organized regions. The mobility of people in pursuit of employment and economic opportunities has remained within their own regions of origin. Due to the fact that the regional states operate as autonomous entities, there is little to no representation of non-natives or individuals of non-regional ethnic origin. This fact has affected the public sector's human resource capabilities in Afar over the past three decades. In the 1990s and the most of the 2000s, the Afar region had a significantly smaller number of experienced medical personnel and professionals in related fields. This is due in part to the fact that professionals from more developed regions are less interested in moving to pastoralist areas, primarily due to a fear of exclusion. Career advancement and executive positions are nearly as difficult for non-locals. Although the Afar area attempted to promote the migration of professionals to the region, it failed to attract as many as anticipated due to widespread mistrust.

Interviews and document reviews have revealed that party power structure plays a significant role in determining who receives certain advantages and resources. In the context of Africa, the ruling party is literally superior to the state (Abbink, 2011). Formal and informal power structures inside the party determine crucial decisions. In Ethiopia, the EPRDF party has been equated with the state itself. To comprehend the impact of a party's power structure on the public policy process, it is crucial to comprehend the decision-making process, the many interest groups, and the elite interactions inside the party. Examining the ruling party's official and informal power structure and the interaction amongst elites within the EPRDF may therefore shed light on the impact of party politics on the public policymaking process.

As indicated previously, the EPRDF consists of four ethnically organized parties. The TPLF is the most dominant of the four. In the early days of the EPRDF, the allocation of authority, such as important cabinet positions, reflected who dominated the EPRDF and the country's politics in general. The TPLF possessed all significant military, intelligence, foreign affairs, and finance sector roles. Meles Zenawi, who also leads the TPLP, has led

the party for many years. The EPRDF central committee is a panel of 36 high-ranking coalition party leaders. The executive committee reports to the central committee. Similar to the Chinese Communist Party (Britannica, 2022), the EPRDF's decision-making process is based on democratic centralism, with central committee decisions cascading downwards. Regarding the participation of non-EPRDF but affiliated parties within EPRDF, their function is merely that of observers. Given EPRDF's tremendous influence, EPRDF makes all significant policy choices in the country. Allies, such as the ruling party of the Afar area, play a minor role. Even though the EPRDF and Allied parties do not have a formal hierarchical relationship, the influence of the EPRF (primarily TPLF) on allied parties has never been in question. This influence is exerted through the TPLF network, a well-organized elite that holds crucial positions in the party, government, and commercial sector.

The primary question posed by the data analysis was what impact the party power structure had on policy decisions in the Afar area and nationwide. Two linked themes were identified: the patron-client relationship between the Afar political leadership and the EPRDF core (the TPLF) and the lack of accountability to the Afar population.

The majority of research participants believe that the impact of the powerful elites within the EPRDF, primarily the TPLF elites, on regional political elites has been extremely substantial during the past three decades. The majority of those in positions of regional policy decision-making were TPLF loyalists. Their capacity for leadership and the support of their constituents had been less significant factors in their selection. Because of this, the regional leadership is typically concerned about how they demonstrate commitment to their patrons. The implication was that as long as they remained loyal to their patrons, their poor performance or lack of accountability to the local populations would not have a significant impact on their political careers. Although study participants have various degrees of familiarity with the specifics of this patron-client relationship, they all acknowledge its presence and the effect it had on the policymaking process, particularly with regard to public accountability. Some of the participants provided a detailed account of the patron-client relationship, which is described here.

Back during early days of the EPRDF government 1990s and early 2000s, there was a federal affairs unit under the office of the prime minster. The official purpose of the unit is to support underdeveloped regions such as Afar. There were even expert groups assigned. However, I would say, majority, 80%, their agenda and priority has been more political than anything that has to be the improvement in living standard of pastoralist communities. The use these assigned people for controlling the regional officials ***(Participant 9).***

Similarly, the lack of accountability and weak leadership capacity of the regional officials during the 1990s and early 2000s was described by participants who had experience in the Afar region during that period.

They didn't know in depth the problem of the people; they were mostly after enriching themselves and their cronies. They appoint regional officials and control them, demand them to take orders. The regional level appoints often are afraid of resisting orders. Partly because these regional officials themselves are not capable, they are less educated and experienced. They are just 4-5 years of primary education. They regional officials were not capable of adequately analysing the people's problem and voicing it appropriately. This has been happening the last 20-30 years ***(Participant 10).***

Similarly, a study which examined the ethno-regional federal administration in Ethiopia highlighted the problems of exercising self-rule/autonomy by regional authorities, and the weakness of regional leadership.

Part of the federal structure is the aim of decentralization and devolution of power and decision-making to the ethno-regions: regarding budget, revenue collection, self-administration, the judiciary, and local development planning. This programme of decentralization has had limited results over the past two decades, but it can be seen in the adoption of the locally dominant languages for administrative purposes and the staffing of the new

> *bureaucracy by ethnic locals. A great problem is always said to be ‘‘the lack of capacity’’, but the more important one has been that of corruption and nepotism.* (Abbink, 2011, p 601).

The lack of accountability to public, weak leadership capacity coupled with the patron-client relationship between regional leadership and TPLF elites had an impact on policy process. Participant No.10 gave an account of a specific policy proposal that could have benefited the population and transformed the region, which according to him was misdirected.

> *I have to tell you that the federal government was not committed in bringing solutions/policies that can transform the socio-economic situation of the population. For instance, Afar people could benefit a lot if there had been a well-functioning cross-border trade with neighbouring Djibouti. We proposed such mechanism to be created, but in the end, those affiliated with the Arat Killo [7]politicians benefited. Such initiatives if done properly with intention fundamentally creating better economic opportunities to the local community, they could have improved peoples living standard, could have created alternative livelihood opportunities, but it didn't happen, the wealthy friends of politicians benefited and enriched themselves* ***(Participant 10).***

Some participants also recognize that the regional leadership has less option when it comes to choosing being loyal to influential political elites at federal level or to the public. Like everywhere in the country, the EPRDF was autocratic and political dissent by citizens was not tolerated. Therefore, the public had a difficult time rallying behind local, political personalities.

> *The regional politicians literally sandwiched between pressure from Arat Killo and not adequately empowered population who do not demand their right… This makes politicians not to take too much risk in voicing the public demand. Public do not have awareness and practice of demanding their*

[7] Aratkilo is the equivalent of the Whitehouse in Ethiopia. It is a place where the prime minster's office and the national palace is located. It is a symbol of power and influence.

right to social services in organized way, they do not hold public officials accountable, and were afraid ***(Participant 9).***

Overall, the power structure of the party and the dominant interest groups within the EPRDF had a significant impact on the policy process at both the federal and regional levels, as was the case in the Afar region. The patron-client relationship between the dominant political elites led to clientelism, diminished the capacity and potential for improved regional leadership, undermined accountability to the general public, and hampered the development and implementation of potentially high-impact policies.

Chapter 6: Global Governance and Public Policy Process in Ethiopia

6.1. Introduction

The influence of global governance on national policymaking is a critical aspect of policy analysis, receiving considerable attention in both theoretical and empirical literature (Knack et al., 2020; Daniel & Kay, 2017; Bernstein & Cashore, 2012). The concept of global governance and policy transfer have been discussed more in details in chapter 2 highlighted the importance of it to national policy process. This approach underscores the necessity to consider the impact of global actors and the wider global context in national policy processes. Scholars like Gilson et al. (2018) and Østebø, Cogburn, and Mandani (2018) emphasize how a global governance-oriented analysis complements national-specific examinations of policy processes, providing a more comprehensive understanding of public policy decisions.

Global governance, as conceptualized by Rosenau &Czempiel(1992), involves managing interdependent relationships beyond governmental jurisdiction, evident in multinational collaborations. This governance includes a complex mix of normative, social, legal, and institutional processes that navigate the interactions between globalization and fragmentation (Clarke & Edwards, 2004).

The literature on policy transfer, particularly the works of Dolowitz & Marsh (2000) and Bernstein & Cashore (2012), highlights the elements and mechanisms through which global governance influences national policymaking. This influence manifests in various ways, including international commitments, norms, market interventions, and direct involvement in domestic policy processes, illustrating the multifaceted ways in which This chapter presents the footprint/hallmarks of the global governance (and players) role in Ethiopia's public policy landscape and to examine how the design and implementation of public policy was influenced, resulting in persistent child health inequalities.

In the examination of the study data, the following main questions were investigated.

- What were the primary characteristics of global governance's impact on Ethiopia's overarching public policies?

- To what extent were global norms, values, discourse, commitments, and conventions favourable/unfavourable for equity-oriented national public policy in LCDs in general and in Ethiopia in particular?
- What role did international actors have in participating directly in the national public policy process?

Using Bernstein and Cashore's (2012) influence pathways of global governance as an analytical framework, the findings are organized into three thematic categories: conformity with international norms and discourse, influence through international commitments and conventions, and direct access to domestic policy processes.

In accordance with this, the results of the analysis are presented in three sections. The initial section discusses global norms, values, and discourse, followed by a section on conventions and commitments. Finally, the findings regarding the role of global governance players in national policy formulation are presented. The analysis is based on an examination of global and national policy documents, key national policy documents, and key global organisation policy documents, as well as interviews with key informants.

Table 3: National and global policy documents analysed

Policy document	**Year of publication**	**Published by**
Constitution of the federal democratic republic of Ethiopia	1994	Ethiopian Government
Interim poverty reduction strategy paper 2000/01- 2002/03	2000	Ethiopian government
Governance for the millennium development goals: Core Issues and Good Practices.	2006	United Nations
The Abuja declaration: ten years on	2011	Who
Primary Health Care – Alma-Ata Declaration.	1978	WHO

Substantive issues arising in the implementation of the international covenant on economic, social, and cultural rights.	2000	Un- economic and social council
Implementing the Millennium Development Goals: Health Inequalities and the role of global health partnerships.	2009	UN- CDP
Convention on the Rights of the Child: General Assembly resolution 44/25 of 20 November 1989.	1989	United Nations
International Covenant on Economic, Social and Cultural Rights: General Assembly resolution 2200A (XXI) of 16 December 1966	1966	United Nations
Human Development report 2005. International Cooperation at crossroads. Aid, trade, and security in an unequal world.	2005	UNDP
World Development report 2006. Equity and Development.	2006	The World Bank
A guide to sector wide approach for health development.	1997	WHO,DANIDA,DIFID, European Commission
United Nations Universal Declaration of Human Rights 1948.	1949	United Nations
Healthy development: the World Bank strategy for health, nutrition, and population results.	2007	The World Bank
The Paris Declaration on Aid Effectiveness (2005) Accra Agenda for Action (2008)	2008	OECD countries and LMICs

United Nations Country Assistance Framework	2012	United Nations Country Team Ethiopia
The World Bank Ethiopia Country Partnership Strategy	2012	The World Bank Ethiopia
FAST TRACK BRIEF Ethiopia Country Assistance Evaluation, 1998-2006	2008	The World Bank Independent Evaluation Group
The World Bank Ethiopia Country Partnership Strategy	2008	The World Bank Ethiopia
Operational Plan 2011-2015 DFID Ethiopia	2011	DFID Ethiopia
Operational Plan 2011-2016 DFID Ethiopia Updated December 2014	2014	DFID Ethiopia
USAID Ethiopia Country Development Cooperation Strategy 2011 – 2015	2012	USAID Ethiopia

6.2. Global Norms, Values, Conventions and State Commitments

Theoretically informed examination of policy documents revealed characteristics of global policy and major actors' values, norms, and prevailing discourse on health inequalities and public policy. Key themes that emerged, included health and human rights, social justice, and inclusion, the responsibility of the state in guaranteeing health for everyone, and the need for multisectoral public policies to enhance people's living conditions. Simultaneously, the analysis of important overarching Ethiopian public policy documents was conducted to determine whether or not they matched the key characteristics of global norms, values, and discourse on health equity. The important findings are provided in the following subsections.

6.2.1. Health, Child Health, Equality and Human Rights

Since its establishment in the aftermath of World War II, the United Nations has remained an essential global governance organization. The United Nations has enacted numerous international conventions intended to influence the national policies of its member states. The International covenant on economic, social, and cultural rights (ICESCR) and the Convention on the rights of the child are among UN agreements that have had an impact on national-level child health policy formulation. In 1966, the ICESR was opened for signature, and in 1976, it entered into force. In 1993, after nearly 27 years, Ethiopia, one of the UN's founding members, joined the agreement. The convention on the rights of the child opened for signatures in 1989 and went into effect in 1990. Ethiopia signed and ratified it in 1993 (UNOHCHR, 2021; UNTC, 2021). The purpose of both conventions and the United Nations charter is to promote universal respect and observance of human rights and freedoms by member nations.

> *Everyone has the right to a standard of living adequate for the health and well-being of 74 himself and of his family* ***(Article 25 73 1United Nations Universal Declaration of Human Rights 1948 United Nations (UN)).***
>
> *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (****Article 12 1. ICESCR, 1966).***
>
> *States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services* ***(International Convention on the Rights of the Child, 1989).***

These conventions recognize health in general and child health wellbeing and survival as a human right; affirm that every child should have access to the highest achievable level of health; hold states accountable for enacting the necessary legislation and ensuring the rights are respected; and promote international cooperation to advance these rights.

ICESR and ICRC also recognize the right to health-promoting services, such as universal primary education, social security, the ability to work, and a sufficient standard of life.

The International Convention on the Elimination of All Forms of Racial Discrimination (ICESR) outlines the particular steps states must take to ensure the realization of children's rights, including efforts to reduce newborn and child mortality and promote healthy child development. Similarly, the Convention on the Rights of the Child reiterates the need for states to take measures to: "Reduce infant and child mortality; provide health care to all children with an emphasis on the development of primary health care; combat disease and malnutrition; and inform all segments of society, particularly parents and children" (UNHOCHR, 2021). Accessibility, availability, acceptability, and quality are interrelated and fundamental parts of the right to health in all its manifestations and at all levels (Committee on Economic, Social, and Cultural Rights, 2000, p. 4).

In the years preceding the year 2000, the UN Development Committee identified substantial concerns stemming from the ICESR's implementation. An explanation of article 12's interpretation was published. The 'right to health and the right to be healthy' and 'the greatest achievable quality of health' were among the topics discussed. The right to health is not synonymous with the right to health. The committee clarified that the right to health includes both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, as well as the freedom from interference, such as the freedom from torture, non-consensual medical treatment, and experimentation. In contrast, the entitlements include the right to a health protection system that affords everyone an equal opportunity to enjoy the maximum achievable degree of health. The committee called for state parties to make adjustments in their policies based on the clarifications made on the important elements of the convention.

‘*Highest attainable’ refers to socioeconomic preconditions and a State’s available resources*

> *The notion of “the highest attainable standard of health” in article 12.1 takes into account both the individual’s biological and socio-economic*

*preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health (**Committee on Economic and Social Rights, 2000).***

6.2.2. Health and Social Development

All overarching social development strategies of international governance actors such as the United Nations and the World Bank continuously assert that health is an intrinsic component of human development and that there exists a vicious circle in relation to population health status and economic growth. The argument for ensuring that everyone has the best possible health condition is considered not only as a moral imperative, but also as an investment in broader societal development. The increased health of individuals and populations helps economic expansion. In turn, economic expansion results in improved health condition for individuals and populations, ultimately contributing to the social development as a whole. Although equitable health status is an important societal aim in its own right, recognizing the irreplaceable significance of population health in the pursuit of social development has far-reaching policy consequences, according to the argument.

These assertions demonstrate this argument:

Health and health equity are values in their own right, and also important prerequisites for achieving many other societal goals **(WHO HIAP,,2014).**

Economic and human growth, as well as the reduction of poverty, are fundamentally dependent on health policies (World Bank, 2006). The fact that Health goals are essential components of the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) indicates unequivocally that national and global policies aimed at improving the health status of the population should be pursued in order to achieve holistic development. While health is accorded its appropriate place in the MDGs and, to a lesser extent, in the SDGs, the distributional aspect of health status has not been adequately highlighted in these global policy texts. The UN Development Report (2005) emphasized unequivocally that the MDGs did not effectively advance the concept of guaranteeing health equity.

> *The distributional blind spot of the MDGs is a weakness… progress should be for all, regardless of economic status, gender, parents' wealth, or location in a country. Yet the MDGs do not remind governments that success in advancing towards the MDGs should be measured for all of society, and not just in the aggregate* **(UN Development report ,005)).**

Similar limitations have been observed in the poverty reduction strategy papers (PRSPs) of the World Bank and IMF, which were adopted by LCIDs, such as Ethiopia, beginning in the early 2000s. The PRSPs identify health as one of the pillars of poverty reduction and socioeconomic development initiatives in which nations must invest. However, the emphasis on depth and breadth of analysis of health sector problems is very limited, and the required context-specific activities outlined in the PRSPs papers are vague. In addition, they do not identify specific priorities or minimum goals that states must meet. Therefore, the influence in terms of advancing the health and health equity agenda is limited and simply does not extend beyond recognizing the need for health as a national social development goal, without going into the specifics of how the unequal distribution of health among population groups is addressed.

In general, global governance players recognize the positive relationship between health and social development, as well as the necessity to make population health improvement a key policy objective within the context of broader social development policy. One key

caveat is that these global policy texts and discourses on health and social development lack detail regarding what countries must do to achieve improved health status for all population segments in an equitable manner.

6.2.3. Best Practice Recommendations on Tackling Health Inequalities

WHO-coordinated global expert groups have developed a number of suggestions for global policy actions to address health inequity. The committee on social determinants of health inequity was one such panel (CSDH). The CSDH published a policy recommendation document titled "Closing the Gap" that proposed evidence-based actions that governments should consider taking. The CSDH begins by emphasizing that health inequalities is a moral obligation and that inequalities should be considered an unjust act. Any endeavour to address health inequalities is regarded as a component of ensuring social justice in the society.

> *Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is, for the Commission on Social Determinants of Health (hereafter, the Commission), an ethical imperative. Social injustice is killing people on a grand scale* **(WHO CSDH, 2008).**

The CSDH developed a causal framework and narrative that can guide the policy problem definition at country level.

> *These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces* **(WHO CSDH, 2008).**

Besides the CSDH, there is an emphasis on the crucial impact of public policies in creating and sustaining health inequalities.

Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted **(WHO CSDH ,2008).**

The recommended policy actions and strategies have also been highlighted in the CSDH. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programs must embrace all the key sectors of society not just the health sector.

Recommended policy actions include improving daily living conditions, tackling the inequitable distribution of power, money, and resources; and, measuring and understanding the problem and assessing the impact of action. In order to address health inequities, the inequitable conditions of daily living need to be addressed. Governments need to demonstrate their commitment to equity by allocating necessary resources, designing conducive policies, and ensuring accountability in the public sector. Acknowledging that inequalities is a problem and ensuring that health inequity is measured within country administrative units is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and evaluating the health equity impact of policy and action. The adoption of these recommendations in an Ethiopian context will be discussed in the chapter on policy design and implementation.

6.2.4. Commitment To Declarations And Conventions

Universal Health Coverage

The Alma-Ata Declaration on Primary Health Care, issued by the World Health Organization in 1978, is regarded as one of the most significant global health governance milestones of the twentieth century. At the declaration, 134 states and 67 worldwide organizations stated that health is a condition of holistic well-being and that attaining the highest standard of health should be viewed as an essential national and global societal aim. It called for a break from the system of health care at the time, which placed greater

emphasis on medical care and was characterized by isolation between the health system and social and development mechanisms (WHO, 1978).

The declaration underlines that the highest level of health should be attainable through social and economic action. In addition, it highlights the relationship between health, social and economic development. It explains why a country should invest in health as part of its economic and social initiatives.

> *Health development is therefore essential for social and economic development, and the means for attaining them are intimately linked. For this reason, actions to improve the health and socioeconomic situation should be regarded as mutually supportive rather than competitive. Discussions on whether the promotion of health only consumes resources, or whether it is an economically productive factor contributing to development, belong to the academic past* (WHO, 1978, p. 44).

To address socioeconomic development and improved health status, recognition of health as a critical development goal and coordination with sectors like food security, water and sanitation, education, housing, and environmental protection are essential in developing nations (ibid, p. 10). Moreover, the declaration makes a strong case for a health care system centred on equity. The necessity for governments to address the health inequalities across and within nations was one of the most pressing issues of concern. It is suggested that, while aiming to guarantee universal coverage of primary health care, focus should be given to the special needs of segments of the population with the least access to health care due to geographic, political, social, or economical constraints.

> *Recognizing the special needs of those who are least able, for geographical, political, social, or financial reasons, to take the initiative in seeking health care, and expressing great concern for those who are the most vulnerable or at greatest risk,*

> *Recommends that, as part of total coverage of populations through primary health care, high priority be given to the special needs of women, children, working populations at high risk, and the underprivileged segments of society, and that the necessary activities be maintained, reaching out into all homes and working places to identify systematically those at highest risk, to provide continuing care to them, and to eliminate factors contributing to ill health (WHO, 1978, p. 26).*

The declaration places a strong emphasis on the role of the government and the sustainability of political commitment as the single most important factor in the achievement of universal primary health care. It advises that governments demonstrate their political will by making a continuing commitment to the implementation of primary health care as an essential component of the national health system and within the context of overall social and economic development.

> *Affirming that primary health care requires strong and continued political commitment at all levels of government, based upon the full understanding and support of the people, RECOMMENDS that governments express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health system within overall socioeconomic development, with the involvement of all sectors concerned; to adopt enabling legislation where necessary; and to stimulate, mobilize, and sustain public interest and participation in the development of primary health care (WHO,1978, p. 30).*

In Ethiopia, Primary Health Care has always been the main focus of government health policy. However, achieving universal health coverage has not been realized yet.

Per capital spending on health - Abuja Declaration

In April 2001, the heads of state of African Union nations gathered and pledged to allocate at least 15 percent of their annual budgets to the improvement of the health sector. Simultaneously, they urged donor nations to "meet the unmet goal of 0.7% of their GNP

as official Development Assistance (ODA) to developing countries." This drew attention to the lack of resources required to improve health in low-income areas. Since 2001, twenty-six countries have increased their allocation of total government expenditures to health (GGHE/GGE). However, only Tanzania has met the Abuja Declaration's goal of "at least 15 percent" (WHO, 2010).

Although Ethiopia's government spending on health has increased throughout the 1990s, it remains very low compared to peer nations and the World Health Organization's recommendation of $60 per capita by 2015 for the delivery of critical health services. In different years, health expenditures accounted for between 3.5% and 5.6% of the gross domestic product. This is lower than the 7 percent average that a previous WHO report indicated for low-income nations (USAID, 2018; WHO, 2017).

The Millennium Development Goals (MDG) and Equity Agenda

Ethiopia was applauded by the international community for achieving child and maternal health targets of the MDG. As indicated in the literature review of this study, despite improvement in overall child health, geographic child health inequalities has persisted in Ethiopia. While the MDG targets were viewed as significant milestones that the government aimed to fulfil by 2015, there was a lack of attention and commitment on achieving equity. The MDG has been criticized for failing to address equity and the situation in Ethiopia is reflective of this failure.

> *The MDGs do not directly address inequalities. In this sense they are distribution neutral. Progress is measured by aggregating and averaging change at a national level. In theory, the MDGs could be met even if, say, households with low incomes were falling behind on the income poverty and health targets, or if the rate of reduction in child deaths among boys was sufficient to compensate for a slower rate of reduction among girls (**United Nations, 2009 p. 51).***

In establishing the MDG targets, it was assumed that equity would be addressed by universal health coverage. However, the international community understood that the

Millennium Development Goals (MDGs) did not address equity. In addition, the MDG country targets were not disaggregated by different administrative regions of countries, so concealing inequities within each country.

> *The distributional blind spot of the MDGs is a weakness. The MDGs themselves are rooted in ideas about global justice and human rights. They are universal entitlements, not optional or discretionary allowances. It follows that progress should be for all, regardless of economic status, gender, parents' wealth, or location in a country. Yet the MDGs do not remind governments that success in advancing towards the MDGs should be measured for all of society, and not just in the aggregate (**United Nations, 2009 p. 51.)***

Overall, the analysis of policy documents has shown Ethiopia conforms to the global norms, values, and discourse on health and health equity. Ethiopia has also shown some level of commitment to global conventions and commitments but falls short in major equity related targets such as inequalities in child survival as measured by child and infant mortality(CSA,2016)

In Ethiopia, health is regarded as a human right but the state's ability to shoulder this responsibility of providing universal health care is doubted. Equity is a well embraced value but interpreted differently. Spatial and socio-economic based health inequalities is confused. There is also a misconception that inequalities is difficult to tackle even in developed countries. Inequalities is considered as a second thought or is a new emerging focus.

It is recognized that the state has an obligation to health-enhancing living conditions, but the state is not strong enough to do it alone. Ethiopia as a member of the UN and signatory of the UN Human Right Deflations has committed to respect, protect, and fulfil the rights. This is affirmed by the Ethiopia Constitution.

> *All international agreements ratified by Ethiopia are an integral part of the law of the land" (FDRE, 1995, p. 3). Furthermore, it stipulates "The*

> *fundamental rights and freedoms specified in this Chapter shall be interpreted in a manner conforming to the principles of the Universal Declaration of Human Rights, International Covenants on Human Rights and International instruments adopted by Ethiopia* ***(FDRE, 1995 p. 4).***

Overall, there is recognition of health as a right and a means of ensuring social justice. The constitution and Health Policy recognizes health and health-promoting, living conditions, such as education, clean water, housing, food, and social security as constitutional rights (FMOH, 1993; EFDRE, 1995). Article 41 (Economic, Social and Cultural Rights) states,

> *Every Ethiopian national has the right to equal access to publicly funded social services. The State has the obligation to allocate an ever increasing resources to provide to the public health, education, and other social services* ***(EFDRE, 1995 p. 14).***

Similarly, the rights of people to improved living standards is reiterated in Article 43 (ibid, 1995). It also acknowledges in Article 89 that "government endeavours to protect and promote the health, welfare and living standards of the working population of the country" (ibid, p. 34).

The Health policy states that the policy is "founded on commitment to democracy and the rights and powers of the people." Furthermore, it underscores that health development is seen as a means of advancing social justice, "health development shall be seen not only in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and equity" (FMOH, 1993 pp. 3- 4). Health is acknowledged as a right. Nevertheless, these rights to health and health-promoting living conditions are met only to the extent that the country's resources allow (FDRE, 1995, p. 34).

6.3. Participation in national policymaking

One major pathway through which global governance actors influence national public policy process is through direct participation in domestic policy-making processes. The

policy transfer and global governance literature has shown that the engagement of global actors can occur through financing, provision of training and capacity-building, support to service delivery and co-leadership in policy dialogue.

In this study the role of global governance actors in the national public policy process in Ethiopia has been examined. The analysis of interview data and document review generated important themes that attempt to answer the research question 'To what extent global contextual factors influenced the Ethiopian public policy process that may have contributed to persistent spatial child health in equality?' The three major themes that emerged are:

- The level and type of participation of the global actors (development assistance partners) in Ethiopia policy process.
- The extent to which development assistance partners priorities and conditionalities promoted equity.
- The extent to which the development assistance partners influenced the design of public policy conducive to tackling child health inequalities.

International governance actors, specifically the development assistance partners, play an important role in Ethiopia policy environment. The Ethiopian government recognizes the importance of global partners in the policy process. It appears the global actors' positive influence is welcomed in the policy community.

> *International partners have been, and continue to be, very important in the development of child survival and health programmes in Ethiopia* (**FMOH, 2005, p. 58).**

> *The most influential international commitments that have providing direction to the HSDP-IV[8] are the global declaration of MDGs, the African Health Strategy 2007-2015, Paris Declaration on Aid Harmonisation (20050, Accra Accord on Aid Effectiveness (2008) and Abuja Declaration on Health Care Financing in Africa. HSDP-IV is the expression of the GoE's renewed*

[8] The HSDP is the Ethiopian Health Sector 5-year strategic plan.

commitment to the achievement of MDGS as a top Global Policy influencing national development policies and strategies. MDGs that are relevant and directly linked to the health HSDP-IV 2010/11-2014/15 Draft Version 16 Jan 2011 34 sector include goals 1, 4, 5, 6, 7 & 8. Of these goals, three of them particularly fall under the domain of the health sector with specific targets calling for accelerated health interventions. The design and content of HSDP-IV specifically takes stock of the health MDGs by giving utmost attention to the prevention and control of poverty related diseases ***(FMOH, 2010, HSDP-IV, pp. 33-34).***

Ethiopia is among the Least Developed Countries (LDCs) heavily reliant on international development assistance. Over the last twenty years, Ethiopia received over US45 billion in official development assistance and official aid (World Banks, 2020). The development assistance covered health and other social development related sectors. The major global actors in the sphere of Ethiopian policy making comprise of bilateral, multilateral entities, and non-governmental organizations.

Table 4: Participation of international partners in Ethiopia's policy process

Agency	**Area of Support**
UNICEF	Support to Child and Maternal health policy and service delivery
WHO	Support to Child and maternal policy and health service delivery
USAID	Support to Child and maternal policy and health service delivery, Health Care Financing policy
UNDP	Expansion and rehabilitation of health infrastructure, health sector human resource development
African Development Fund	Expansion and rehabilitation of health infrastructure

The World Bank	Support to child and maternal health service delivery; Expansion and rehabilitation of health infrastructure
Italian Cooperation	Expansion and rehabilitation of health infrastructure
Irish Aid	Water and sanitation, training of community health workers nationwide focus on SNNPR and Tigray Regions
JICA (JAPAN)	Provision of vaccines and medicines for reproductive health and child survival and cold chain
The Netherlands	Human resource development, water and sanitation, HIV control and Prevention
SIDA (Sweden)	Training of midwives and other health personnel, HIV control and prevention activities, IEC, and materials development
SC- USA	Child Health, maternal and neonatal health service delivery
SC- UK	Child health service delivery
SC- Denmark	Child Health service delivery

Source: FMOH 2005

During the period 2000-2016 the development partners and the Government of Ethiopia (GoE) engaged through The Development Partners Group (DPG) forum comprising about 30 bilateral and multilateral development partners. The Ethiopia Development Partners Group engages with government ministries through multiple high level and technical forums. At High Level Fora (HLF) the focus is on policy. A Harmonization Secretariat within the Multilateral Cooperation Department of Ministry of

Finance Economic Development (MoFED) works closely with DPG. The chairmanship of some DPG thematic policy dialogue groups have been led by the key ministerial heads. The World Bank, with UNDP and one bilateral donor, have been one of the rotating co-chairs of the DPG. The main objective of the GPG is to promote policy dialogue and coordinate/ harmonize development partners' support for effective implementation, monitoring, and evaluation of the national development plan (DAG Ethiopia, 2022).

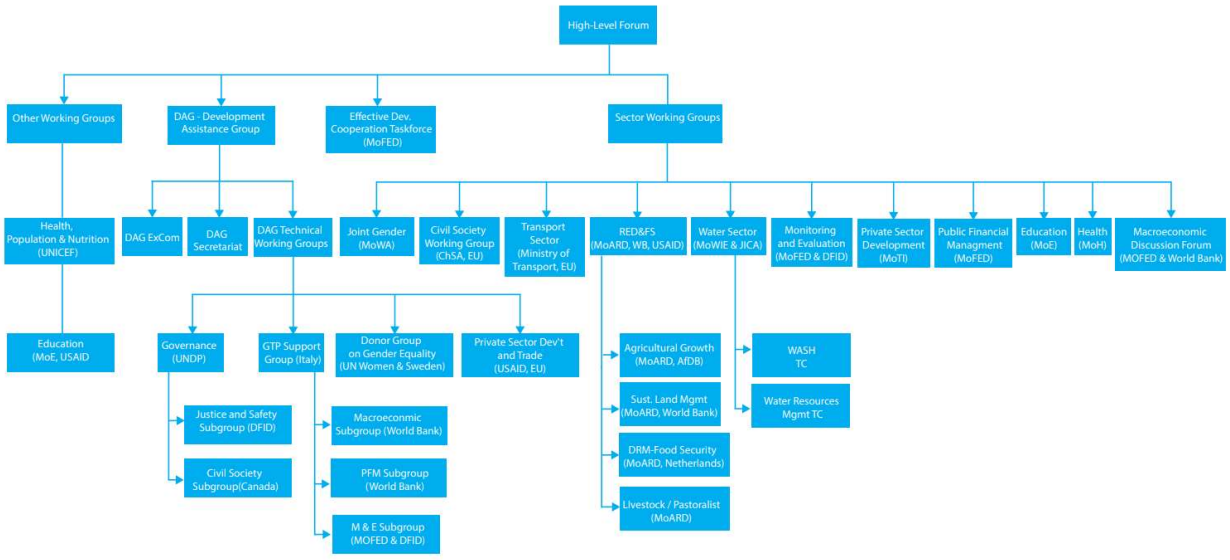


Figure 17: The Government and development partners' partnership structure, Source: DPG, UNDP Ethiopia

The analysis identified that the main focus areas of DAPs included development financing, policy dialogue, training, transfer of good practices and supporting services delivery. The health sector specifically has been one of the important areas of collaboration between international partners and the Ethiopian government.

> *The importance of this partnership lies particularly in: Increasing access to and coverage of health services - about ten percent of health facilities are currently provided by the NGO and private health sectors; Introduction of innovative interventions and systems, especially at community level;*

> *Transfer of good practices and experiences; Filling resource gaps; and Development of the capacity of the health system through training* **(FMOH, 2005, p. 58).**

According to the study's respondents, financing is the key tool used to influence policy reform. International development partners exert further influence on policy implementation through direct support for service delivery that satisfies DAP and GoE common priorities. DAPs employ non-financial means to influence the national policymaking process, such as the hiring and secondment of policy and technical experts to the government.

> *Use of non-monetary approaches – policy expertise of staff, engagement with stakeholders, convening power – will be complemented with support for exposure tours, impact assessments, support for visits of well-known international experts and other low cost additional approaches.* ***(USAID Ethiopia CDCS, 2011-2019).***

The key informants from important donor organizations and the government ministries consistently highlighted the importance of DAPs in the Ethiopian policymaking process. A remark from a former top MoH official emphasizes this fact.

> *During the early 2000s when I was in my role at senior level in Ministry of Health, our financial and human resource capacity was very low. The UN and Donor countries played a very important role basically in almost everything we do... whether it is development of strategy, guidelines, training, financing of services delivery, and even by signing technical experts to support health sector at all levels* ***(Participant 1).***

Both government officials and DAPs staff agree the successful influence of DAPs in policy process has been achieved through their technical expertise and knowledge of best global practices relevant to the Ethiopian context.

> *The donors, NGO and UN partners are valuable members of our task force for the development of program strategies and technical guidelines. They*

hire experienced and qualified advisors who support the ministry in design and implementation of policy ***(Participant 16).***

*Much of the success of policy efforts to-date has been based on time and effort rather than financial resources, and these efforts, on a multi-donor basis, will be increased (****USAID Ethiopia Country Cooperation Strategy 2011-2014, p. 5)***

One of the major donor strategic documents underscores the strength of coordination through the Development Partners Group formerly known as the Development Assistance Group (DAP).

Donor collaboration – via the 11 working groups of the Development Assistance Group (DAG) – is very active in Ethiopia in all sectors, with USAID playing a leading role in a number of areas. Consultation in the health, education, safety nets, humanitarian issues, governance, and agriculture sectors are particularly strong. A very good basis for donor cooperation has been set up in these areas, which provides an agreed-upon framework with the government, combining different mechanisms – such as funding both directly through partners and through pooled funds – that build on the strengths of both approaches (**USAID Ethiopia Country Cooperation Strategy 2011-2014, P. 13).**

It appears that the DAP's interaction with the government on certain politically delicate matters has not been without friction. The DAPs illustrate the difficulties encountered in coordinating and engaging on politically delicate matters such as democratization, good governance, and macroeconomic policy. Consequently, the DAPs had differing perspectives and attitudes to such politically delicate agendas.

The strong donor consultation and coordination on the critical issues of democracy and governance has not always resulted in a willingness to take a strong, united stance against clear abuses of constitutional commitments,

> *legislation, or democratic processes* ***(USAID Ethiopia Country Cooperation Strategy, 2011-2014, p. 13)***

Similarly, the World Bank evaluation report indicated disagreement with GoE on contentious issues such as the role of the private sector in the economy, economic liberalization and governance.

> *International Development Assistance effectiveness is hampered in the absence of consensus with the Government on the needed direction and pace of reform* ***(The World Bank Ethiopia Country Assistance Evaluation, 2008 p.)***

Despite some resistance to DAP policy recommendations, Ethiopia's reliance on international development assistance has been substantial. Ethiopia's investments in the health sector rely heavily on external assistance.

> *Ethiopia is not an exception to the influences of Global Policies initiated by organizations such as the World Bank, WHO, UNICEF, UNAIDS and the World Trade Organization. Such Global Initiatives are also associated with some form of financing the interventions that would significantly augment the resource of the Government* ***(FMOH, 2010, HSDP-III, p. 45).***

The Ethiopian Health Sector financing surveys during the years 200The Health sector development assistance show significant contribution of international DAPs to heath sector investment in Ethiopia.

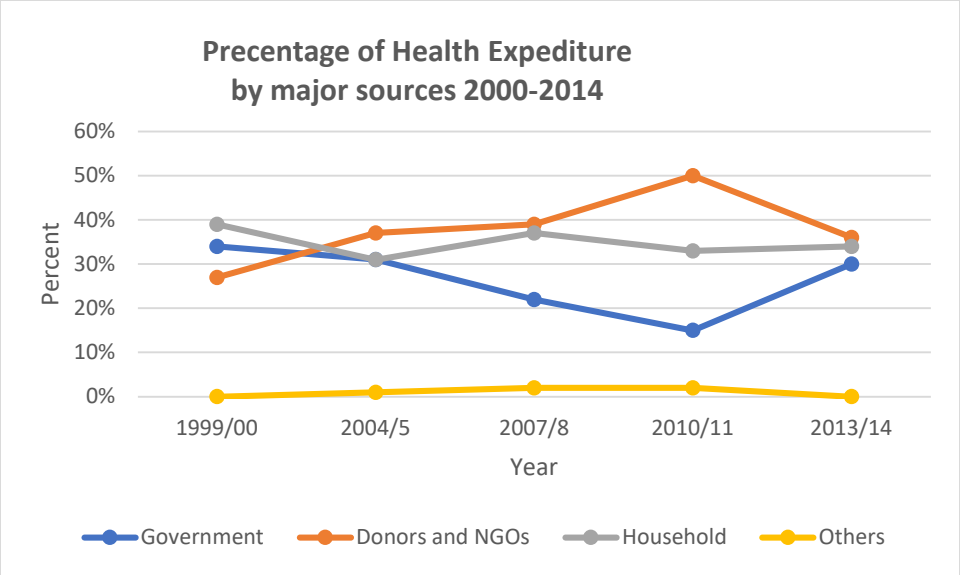


Figure 18: Health care expenditure, Ethiopia 1999-2014

Source: National Health Accounts, 2003-2017

The analysis of international development assistance received by Ethiopia during the years 2000-2016 shows an increasing trend in financing the Ethiopian development programs. It is also indicative of the level of engagement of DAPs in the Ethiopian public policy process.

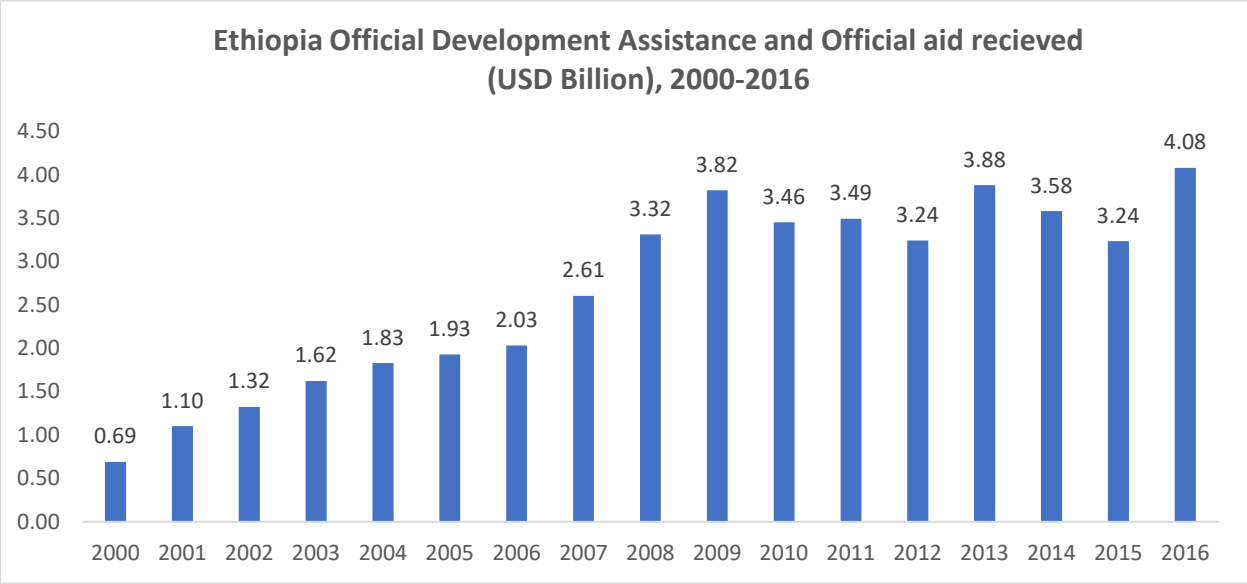


Figure 19: Official development assistance

Source: the World Bank, Official Development assistance, visualisation by author.

During the period 2000-2016, Ethiopia received USD45.26 Billion in development assistance which is equivalent to about USD2.66 Billion per year. The health sector in particular has been among the main focus areas for funding by DAPs. About USD 12.4 Billion has been provided to Ethiopia from international development partners for priority global health programs through various channels.

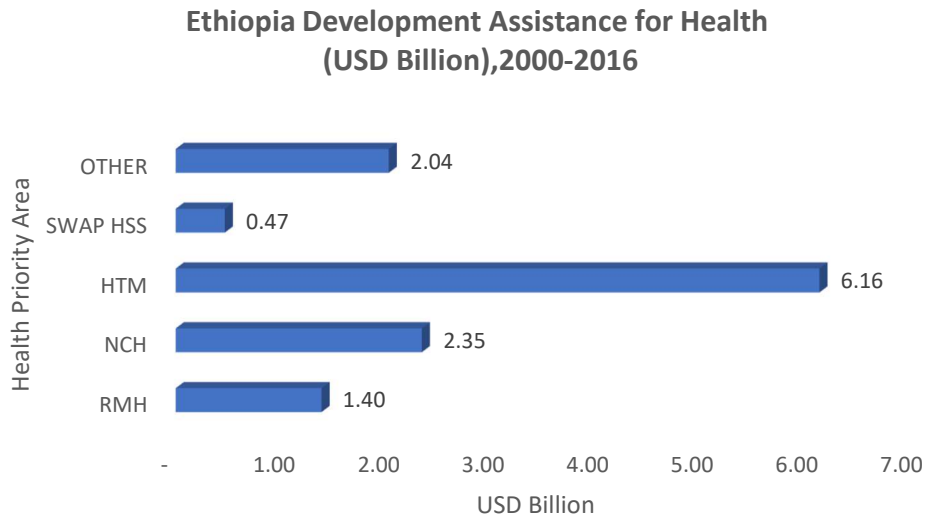


Figure 20: Official development assistance

Source: the World Bank, Official Development assistance, visualisation by author.

The priority health program areas include child and neonatal health, reproductive and maternal health, malaria, TB, and HIV. Ethiopia also received development assistance funding for supporting the system strengthening of the health sector.

The US contributes the highest amount of Development assistance to the Ethiopian health sector followed by the Global Fund against AIDS, TB, and Malaria (GFATM), the UK, The World Bank and UN specialist agencies.

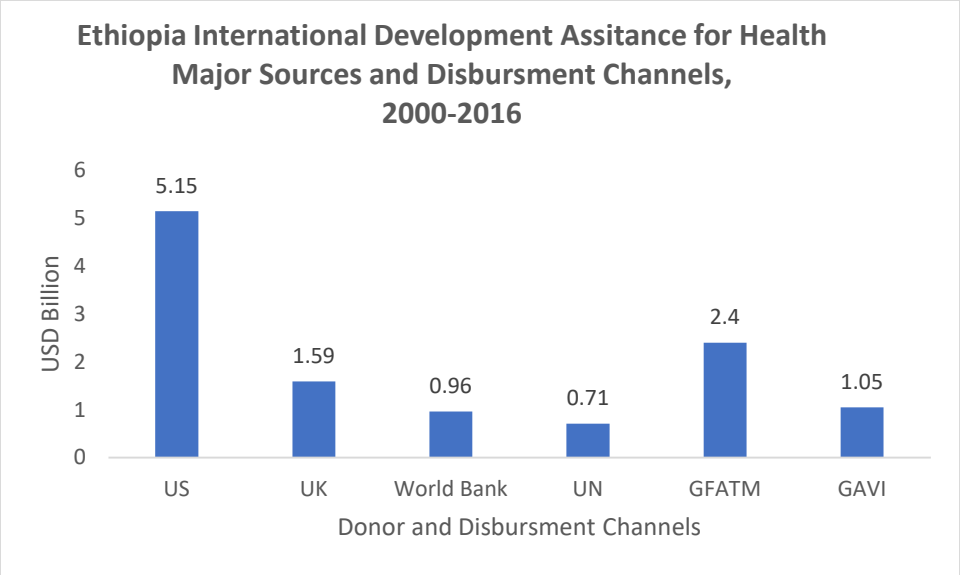


Figure 21: Official development assistance

Source: the World Bank, Official Development assistance, visualisation by author.

All the major contributors of DAH to Ethiopia have their respective strategies that guide priorities and preconditions for funding. It is expected they fulfil the Aid effectiveness commitments and follow the key principles that guide engagement with recipient countries. The Paris declaration on Aid Effectiveness and the Accra Agenda for action stipulate the key commitments of donor and recipient countries. The commitments include country ownership of development priorities.

> *Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions* **(The Paris Declaration on Aid Effectiveness (2005) and Accra Agenda for Action 2008).**

According to **The Paris Declaration on Aid Effectiveness,** donors should also respect the leadership of the country and assist in strengthening its capacity to exercise it. Donors also agree to integrate their total contribution with the national development strategies, institutions, and procedures of the partner nation. It is anticipated that the partner country's systems and institutions will be highly harmonized.

Donors should align as closely as feasible with central government-led strategies. If this is not possible, they should maximise their use of country, regional, sector, and non-government systems, avoiding practises that hinder the development of national institutions, such as circumventing national budget processes or setting excessive wages for local employees **(The Paris Declaration on Aid Effectiveness (2005) and Accra Agenda for Action 2008).**

Mutual Accountability is an additional commitment made by donors and partner countries. Donors and partners bear responsibility for development outcomes. Enhancing mutual responsibility and transparency in the utilization of development resources is a top priority for partner nations and donors. Donors and partner countries commit to managing and implementing aid in a manner that focuses on intended outcomes and employs data to improve decision-making. In the preceding section, the amount of DAP engagement in the Ethiopian policy environment and the governing principles are explored. Clearly, DAPs play a vital part in Ethiopia's social development initiatives. They possess substantial influence over policy formation. They leverage their finance, and their financial contributions position them to co-lead donor and country policy conversation forums. In the section below, donors' priorities in Ethiopia, policy engagement agendas, and equality statements are summarized. In general, the policy environment in Ethiopia shows clear signs of the influence of international development partners. It does not appear that their input has a significant impact on advancing equity.

Table 5 : List of participants and their sectoral affiliations

Donor/Development Assiatance Partner	Health and Health related priorities 2000-2016	Policy engagement priorities	Equity promoting statements
US /USAID	"Improved performance of the agriculture sector; increased livelihood transition opportunities; increased resiliency to and protection from shocks and disasters (Disaster assistance and productive safety net programs); improved nutritional status of women and young children; **increased Utilization of Quality Health Services"**	**Finance Reform**: "Establish an institution dedicated to the identification, analysis and diffusion of financial instruments suited for agriculture and other underserved market segments." **Trade and Customs Reform**: "Create a trade centre that links academia, the private sector, and the public sector. Facilitate the streamlining of customs processes."	"Pastoral Ethiopia" (population 15 million) comprises 60% of Ethiopia's land, experiences very low rainfall and frequent droughts; " ; "Majority of Ethiopians have not had the benefit of formal education and/or training. This continues to be true for marginalized populations, such as pastoralists or remote areas. Address the non-formal education needs of the unreached and the marginalized – pastoralists"
UK/DFID	"Protect the most vulnerable by building the resilience of the very poorest by reducing food insecurity and improving livelihoods and security in fragile and/or conflict-affected areas; support, extend and improve proven programmes to expand access to quality basic services"	Empower citizens and building domestic accountability; improve the accountability of public services and increase tax revenue, continue to work on building better state institutions; innovative thought leadership within the development community; champion aid effectiveness.	"Addressing geographical inequalities that is cause and consequence of fragility and conflict by providing significant resources to conflict prone regions of the periphery for basic services; responsive and accountable authorities at the local and regional level; governance, peace and security in four regional states of Ethiopia is based on national data of exclusion and inequalities in development indicators; We will continue to address inequalities through supporting the most vulnerable– in particular women and girls and the developing regional states."

THE WORLD BANK	"Increasing access to and quality of infrastructure – electricity, roads, and water and sanitation; increasing access to quality health and education services; enhancing the resilience of vulnerable households to food insecurity; reduce food insecurity; foster improved governance - enhance accountability and responsiveness of government; citizens are empowered by and engaged on development processes; improving public service performance management and responsiveness; enhancing space for citizen participation in the development process; enhancing public financial management, procurement, transparency and accountability."	Address macroeconomic issues by gradually establishing a dedicated dialogue mechanism and providing financial support to support macroeconomic stability through budget support; policy dialogue on macroeconomic and private and financial sector issues.	"The policy commits GoE to prioritize additional provision for vulnerable groups through programs such as social safety nets, livelihood schemes, social pensions and those programs addressing inequalities in basic services; It is well established that improving gender equality in the country would lead to large leaps in achieving many of the other key development goals."
UNITED NATIONS	Increases in agricultural production; provide minimum package of social protection; improved food security; improved access to and use of quality health, nutrition and WASH services; equitable access created and quality education provided to boys and girls at pre-primary, primary and post primary levels with a focus on the most disadvantaged and vulnerable children and localities; promote, protect and enjoy human rights and constitutional rights as enshrined in the Constitution and in line with international and regional instruments, standards and norms; improved mechanisms that promote	UN response to national priorities identified in the Growth and Transformation Plan; efforts to deepen harmonization through joint programming and joint programmes will be intensified.	"Four out of the nine regional states of Ethiopia are lagging behind in almost all development indicators. Ensuring equity; promoting gender and youth empowerment and equity; equitable access created and quality education provided to boys and girls with a focus on the most marginalized and vulnerable children and localities; The Government also recognizes that inclusive, equitable and sustainable economic growth."

	inclusiveness, participation, transparency, accountability and responsiveness in national development processes.		

As shown in the table above , almost all development partners acknowledge various forms of inequalities and spatial inequalities in Ethiopia. In terms of level of emphasis of articulating the equity agenda in donor policy documents, there is inconsistency. Some donors refer to socio economic based inequalities while others highlight the inter-regional inequalities in specific sectors such as education. The policy measures supported by donors to improve equity seem to be selective focusing on specific sectors such as Education in pastoral areas . Overall, the promotion of equity agenda seems to lack uniformity which makes it difficult to mobilize donor support for coordinated comprehensive policy measures supported by donor community in Ethiopia.

Chapter 7: Policy Design and Implementation

7.1. Introduction

In the preceding chapters, this study has explored the Ethiopian national political economy and the impact of global governance on formulating equity-focused public policies. These discussions have laid the groundwork for understanding the broader context and its role in shaping equitable policymaking. This chapter shifts focus to the specifics of policy design and implementation within various sectors in Ethiopia. The analysis recognizes that policy development is deeply influenced by the contextual dynamics at both the national level and within the Afar regional sub context, involving a range of actors at these levels.

Previously, in chapters 2 and 4, the importance of examining policy content, stakeholder perspectives, and the overall policy process was highlighted. This approach is crucial for a comprehensive understanding of the policy lifecycle and its outcomes. This chapter's analysis encompasses specific sector policies, including health, water and sanitation, social protection, education, and pastoral rural development. The focus is on the technical aspects of these policies, particularly how they address the problem, set goals and objectives, strategize, allocate resources, foster collaborations, and establish monitoring and evaluation mechanisms. This technical analysis aligns with Kingdon's (1995) concept of problem and policy streams within his multiple streams theory.

Kingdon's framework divides public policy decision-making into three streams: problems, policies, and politics. The problem stream concentrates on the definition and evidence-based support of policy issues, ensuring they gain the attention of key players. The policy stream examines the technical feasibility and alignment of policy interventions with prevailing political ideologies and goals. The politics stream, in contrast, focuses on the political dynamics, negotiations, and events like elections that influence policy decisions. This framework, particularly relevant to policy analysis in low-income African contexts, has been empirically validated in various studies, including those by Ridde (2009) and Rawat and Morris (2016).

In this chapter, the analysis is grounded in the theoretical foundations provided by Walt and Gilson (1994) and Kingdon (1995), building upon the discussion of their relevance in chapter 2. To operationalize these theories, the study employs the ADEPT (Analysis of Determinants of Policy Impact) framework by Rutten et al (2010), which complements the concepts from Kingdon and Walt and Gilson. ADEPT is instrumental in dissecting policy goals, implementation resources, stakeholder roles and responsibilities, and design and implementation opportunities. This framework has proven effective in policy document analysis, particularly in public health studies, as noted by Cheung et al (2010).

This chapter, therefore, employs a set of tailored questions and themes informed by ADEPT and related studies, applying them to the analysis of policy documents and interview data. This approach ensures a nuanced understanding of the sector policies under review and the various factors influencing their design and implementation. The analysis of the findings addresses the research questions:

- To what extent have the public policed address the problem of spatial child health inequalities and its determinants?
- To what extent were the policy objectives, strategies, programs, and interventions appropriate and relevant in tackling spatial child health inequalities?
- How did policy actors influence the design and implementation of policies to narrow spatial child health inequalities in the study context?

In the section below, the findings of the analysis are presented in three sections. The first section presents the policy problem and agenda setting in which evidence of the level of acknowledgement of spatial child health inequalities is discussed. The second section discusses the findings on the various health and health equity related sector policy design – the appropriateness of the policy goals, objectives, strategies, and resource allocation. The final section presents the findings, mainly from key informant interview data analysis, relating to the policy implementation process.

Table 6: Health Sector policy documents reviewed

Policy document	Year of publication	Published by
National Strategy for Child Survival	2005	Federal Ministry of Health, FDRE
Health Sector Development Plan (HSDP-III) 2005/6-2009/10	2005	Federal Ministry of Health, FDRE
Health Development Plan (HSDP-IV) 2009/10-2014/15	2010	Federal Ministry of Health, FDRE
Health Policy Of The Transitional Government Of Ethiopia	1993	Ministry of Health, Ethiopia
Federal Democratic Republic Government Of Ethiopia Education And Training Policy	1994	Ministry of Education, Ethiopia
National Social Protection Policy Of Ethiopia	2012	MINISTRY OF LABOUR AND SOCIAL AFFAIRS, FDRE
The Federal Democratic Republic of Ethiopia Food Security Strategy	2002	Ministry of Agriculture and Rural Development, FDRE
Government Of The Federal Democratic Republic Of Ethiopia Rural Development Policy And Strategies	2003	Ministry of Finance and Economic Development, Ethiopia
Ethiopian Water resource management policy: Water Supply and Sanitation Policy	1999	Ministry of Water Resources

Productive Safety Net Programme Phase IV Programme Implementation Manual	2014	Ministry of Agriculture, FDRE
Health Extension Tension Program in Ethiopia	2007	Federal Ministry of Health, FDRE
National Health Equity Strategic Plan: 2020/21-2024/25	2021	National Health Equity Strategic Plan: 2020/21-2024/25
STATE OF INEQUALITIES In Ethiopian Health Sector	2016	Federal Ministry of Health, FDRE
Ethiopian Demographic Health Survey (DHS) 2000	2000	Central Statistics Agency (CSA)
Health Sector Transformation Plan (HSTP)-I, 2015/16-2019/20	2016	Federal Ministry of Health, FDRE
Ethiopian Demographic Health Survey (DHS) 2005	2005	Central Statistics Agency (CSA)
Ethiopian Demographic Health Survey (DHS) 2011	2011	Central Statistics Agency (CSA)
Ethiopian Demographic Health Survey (DHS) 2016	2016	Central Statistics Agency (CSA)

7.2. Policy Agenda Setting

7.2.1. How Inequalities is Understood

All study participants explicitly expressed their views that inequalities or the equity concern is a problem worth tackling in Ethiopia. They emphasized that every segment of

society should equally benefit from socioeconomic development in the country. The response from a senior level policy maker at federal level sums up the idea that inequalities in health and social development in general is unfair and warrants action to remedy the situation.

> *I believe every stakeholder be it government, nongovernment actors and community recognize the inequalities in Ethiopia. There is no disagreement on the need for taking measures towards improving inequalities. Important policy documents such as the constitution, poverty reduction plans, federal level budget allocations do acknowledge the existence of inequalities problem and do consider equity as an important desirable outcome in socioeconomic development in the country. My office's main role for instance is to ensure that resource allocation and development opportunities are given to every region in an equitable manner* ***(Participant 8).***

Major policy documents such as the Ethiopian Health policy, emphasize the need for recognizing equity as an essential component of social and economic development**.**

> *In general, health development shall be seen not only in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and equity* ***(FMOH, 1993).***

Similarly other health related sector policy document reviewed acknowledge the need for ensuring equity in their respective sectors.

> *As far as conditions permit, every Ethiopian citizen shall have access to sufficient water of acceptable quality to satisfy basic human needs. Management of water resources shall ensure social equity. All allocations of resources for developing water resources shall be based on equitable and efficient socioeconomic criteria* ***(Ministry of Water Resources, 1999).***

While inequalities is consistently described as an undesirable social problem in policy documents and by study participants, the urgency to tackle the problem does not seem to be adequately pronounced in equity discourse. There is a perception that tackling inequalities is challenging even for developed countries and success in addressing inequalities should be measured in the progress made in narrowing rather than eliminating it.

> *What we are envisaging is to contextualize the equity strategy and ultimately narrow the gap. We can't eliminate inequity. We can narrow it. I don't think any country, Europe or USA can eliminate inequity* ***(Participant 3).***

References to equity in policy actor interviews and policy documents encompassed income, access to basic services and infrastructure, the enjoyment of a healthy lifestyle, and living conditions such as access to food and potable water. When it comes to describing the type of inequalities: rural versus urban, and lowest (poorest) versus highest (better off), socioeconomic group disparity is the most frequently mentioned concern in policy documents and key informant interview responses, followed by regional (geographic) inequalities***.***

> *In Ethiopia demographic health surveys have shown various forms of health inequalities. The inequalities is seen in socio-economic, place of residence – rural urban residence, geographic inequalities like the one between pastoralist also known as developing regions and the national and highland /agrarian regions* ***(Participant 17).***

Overall, policy actors and sector public policy documents in the Ethiopian setting regard equity as a significant aspect in the policymaking process and as a priority requiring state action to rectify the situation. In Ethiopia, inequalities is viewed as an undesirable and unjust social problem. There is a reasonable distinction between vertical (socioeconomic) and horizontal (spatial, place-based, or regional) inequalities, but it is perceived as difficult to eliminate; and that even developed countries struggle with its elimination.

7.2.2. Representation of the Child Health Inequalities Problem

There is strong and dependable evidence with regard to the existence of spatial persistent child health inequalities in Ethiopia. Major public policy documents such as periodic demographic health survey reports from 2000 to 2016 have shown spatial child health inequalities. Key indicators such as child mortality, child morbidity rates, and access to health services have been presented by disaggregation by region. The existence of regional/spatial child health inequalities trends has been indicated in the DHS reports.

> *Regional differences: Regions show large variations in childhood mortality. Under-5 mortality ranges from a low of 39 deaths per 1,000 live births in Addis Ababa to a high of 125 deaths per 1,000 live births in Afar* ***(CSA, 2016 p. 123).***

Similarly, the social welfare surveys and Ministry of health and health related indicator annual reports feature data on health inequalities and child health related living conditions such as access to water and sanitation, household income, and educational status of parents. The ministry of health published a health inequalities report in 2016 which highlighted the regional disparity in health status, access to health services and resource availability and the level of investment in the health sector disaggregated by region.

> *When we compare the key health indicators in Ethiopia, for example those related to the Millennium Development Goals, we are struck with the unfair delivery of health, within regions, across regions, and population subgroups (****FMOH, 2016 p. 8).***

The importance of using this evidence for crafting appropriate policy is highlighted in the report.

> *The results of this study will be discussed with all national stakeholders so that policies and strategies are developed to respond appropriately to our people's needs* ***(FMOH, 2016 p. 8)****.*

The Health Sector strategic plans (Health Sector Development plan I, II, III, and IV) highlighted the underlying causes of inequalities.

> *The four Emerging Regions, i.e., Afar, Somali, Beneshangul-Gumuz and Gambella, present unique challenges for health service delivery and health system development. These regions are characterized by poor infrastructure, hardship environmental conditions, and pastoral or semi-pastoral populations* ***(FMOH, HSDP-IV, p. 55).***

Key informant interviews revealed the awareness of actors about the existence of regional child health inequalities. Participants from health and health related sectors in government and non-government institutions both at national level and regional level in Afar regions were able to identify the regions such as Afar with the worst child health indicators.

> *If you look at in the context of Ethiopia regions such as Afar, Somali, Gambella, Benishangul Gumuz in nineties and 2000s, these regions do not just suffer from poor health status of population, they also have high level of poverty* ***(Participant 8).***

Most participants think that an overall improvement in health status has been seen across the country, including developing regional states[9] in the last two decades. Some policy stakeholders who were interviewed think progress has been made in narrowing inequalities between 'developing regions' such as the Afar region and the rest of the country. This is contrary to the evidence from population level studies, which showed persistent and worsening inequalities (CSA, 2016). It is evident that a significant improvement in health status have been made in both developing regions and the rest of the country, however the progress has not been in a manner that narrows the inequalities gap.

In recent years there has been a considerable departure from just focusing on overall improvement in health status across the country towards a greater focus on ensuring

[9] Developing Regional States (DRS) are Afar, Somali, Gambella and Benishangul Gumuz

that progress is made in an equitable manner. The ministry of 2015/16-2019/20 Health Transformation Plan (HSTP) clearly indicated equity in health services and outcome as one of its flagship priorities.

> *Transformation in equity and quality of health care – This is central to HSTP. The substantial inequalities still existing in health outcomes based on differences in economic status, education, place of residence and gender need to be addressed* ***(FMOH, 2016 p. 14).***

Key policy actors currently participating at national-level health-sector high-level coordination forums confirmed the most recent attention that the Ministry of Health is giving to the geographic inequity problem in Ethiopia**.**

> *When it comes to health inequalities agenda it is very important to be clear on which period we are referring to. The period after 2015 is a bit different from earlier 15 years. Since 2016 and 2017 the polices within ministry of health have started to give emphasis and address health equity. That was not the case before 2015. We have seen more attention to health equity in recent years in comparison with the past* ***(Participant 17).***

The latest Health sector strategic plan, HSTP, has addressed equity much better than the strategic plans in the preceding two decades .This shift in policy appears to be as a result of recognising health inequalities as major problem in Ethiopia and without addressing equity overall improvement in health across the country cannot be sustained.

> *As far as HSTP is concerned, I think it does the analysis of the equity problem in the country. In addition, we have national newborn and child health strategy which is an important policy document specifically focusing on child health. This document highlights equity, it talks about who are under served, the poorest, why they are under served, how can these marginalized underserved communities can benefit from child health services etc. It also recognizes the importance of underlying multi-sectoral factors that have impact on child health equity. It recognizes the fact that*

improvement in overall reduction in child mortality has been the result of multi-sectoral action within and outside health sector ***(Participant 17).***

The HSTP also indicated that equity is one of its success indicators.

> *The success of HSTP will mainly be measured by the quality of health service and how equitable the health outcomes are. A detailed roadmap with innovative strategies will be developed to ensure that every Ethiopian is reached with essential, quality services. The possibility of establishing a centre or institute for health equity will also be explored* ***(FMOH, 2016 p. 14).***

Despite ample evidence regarding the regional persistence of child health inequalities during the period preceding 2016, the policy makers' focus has been on overall improvement in health status across the country with insignificant attention to equity. Lately, in the most recent Ethiopia Health Sector strategic plan, there is recognition that the equity agenda requires more focus and more action.

7.2.3. Underlying Causes of Child Health Inequalities

Contextual analysis of the underlying causes of inequalities is an important starting point in order to formulate a public policy to tackle the problem. The WHO Committee on Social Determinants of Health recommends policy actions that improve living conditions (the circumstances in which people are born, grow, live, work and age) and actions to tackle unequal distribution of power and resources (CSDH, 2008). It is evident that tackling child health inequalities can only be realized by addressing the underlying causes of it.

Analysis of interview data from this study showed policy actors have a sound[10] understanding of likely underlying causes of spatial child health inequalities in Ethiopia. Participants recognize the need for a comprehensive multisectoral public policy to addressing the underlying causes in order to tackle inequalities. The relative importance of the underlying causes of spatial inequalities varied among the respondents. However,

[10] Sound understanding is judged by comparing the study participant response with the underlying causes mentioned in the globally recognised literature such as the WHO CSDH, 2008 report.

there was considerable similarity regarding the factors mentioned. The most highlighted factors included: infrastructure, access to basic services -water, education, environment-harsh climate, leadership capacity, national politics and the policy making process.

Infrastructure And Access To Basic Services

Participants believe the persistently highest child mortality rate and overall poor child health status in the Afar region, as compared to national and other regions, is induced by poor infrastructure and limited access to basic services. The road, telecommunication and power infrastructure has been at a very low level over the last two decades in comparison with the rest of the country. The access and utilization of basic services conducive to wellbeing of children has remained very low.

> *Major obstacle in Afar region is that in comparison with other regions basic infrastructure has been totally lacking … such as road access and communication. Out of 32 districts 29 didn't have a proper road infrastructure that connects districts to district. Now the situation is improving slowly* ***(Participant 8).***

The poor infrastructure and limited access to basic services has been the main impediment to economic opportunities and better incomes for the population of the Afar region.

> *The road, the electricity, telecommunication, and other basis services infrastructure in the regions was lacking. In order to have industry, private business and in general all economic sector requires basic infrastructure. However, because the basic infrastructure are lacking no major economic investment can be attracted and find these areas attractive. Therefore, people have less alternative to economic opportunities and their livelihood couldn't change much* ***(Participant 19)****.*

All agree that in comparison with the past there has been an improvement in infrastructure and access to basic services. However, the progress has not been to the extent that narrows the disparity between the Afar region and most of the rest of the country.

Environment and harsh climate

The impact of the natural environment and harsh climatic conditions is among the most commonly cited reasons for overall low socioeconomic development in the Afar region. The harsh climate is believed to have increased people's vulnerability to food insecurity and diseases. The Afar region is predominantly arid with low and erratic rain fall. The temperature ranges from 20-48 centigrade. The region has experienced several episodes of cyclical droughts which has led to suffering of people and death of livestock.

> *There is increasing environmental degradation and vulnerability to drought and flooding, exacerbated by climate change, and interacting with other factors to cause disease outbreaks, pressure, and conflicts over resources such as water and grazing land. There are both recurrent and prolonged emergency situations in Afar region.The extreme climatic conditions coupled with sparse settlement of population and mobile pastoralist mode of livelihood has made it difficult for public investment on infrastructure* (UNDP-EUE, 2001*)Another important factor is the budget allocation by the federal government. As you know the federal government allocated budget based on the population size without taking into account how expensive it could be to implement the same type of program in a very challenging environment like Afar where almost all of the region is harsh environment and sparsely populated nomadic population* ***(Participant 8).***
>
> *These locations are mostly arid, population is scattered, and in many ways are not conducive for health. It cost a lot to set up mechanisms that help people cope with the risk of harsh environment. The settlement of population is scattered, distributing social services for such scattered population is expensive and can not be adequately addressed with the limited resources the country has. Health professionals who graduate from universities, do not want to go to Afar. No one wants to go to Afar. Because the infrastructure is poor, the environment is arid and very hot, boring to*

live, and difficult. So overall the health sector was poorly staffed ***(Participant 19).***

The UNICEF report on the situation of children in Afar region alludes to the fact that justifying return on public investment in sparsely populated and harsh environment

> *Amidst many competing priorities, a low level of understanding and buy-in for the high returns from investment in child focused program interventions (UNICEF,* Situation Analysis of Children and Women: Afar Region, 2020 p. 5)

As a result of economic efficiency concerns, investment on infrastructure and provision of basic services has been challenging.

> *Even sometimes arguably effective program such as Mobile health clinic have been interrupted because the federal government thought it is more expensive. There shouldn't be expectation that it should be costing same amount enough for every region as compared to other regions. Afar is a unique situation. So, as you can see budgeting has been one of the major governance issue that may have contributed to this persistent inequalities* ***(Participant 16).***

Regional Leadership Capacity, National Politics And Policy Making Process

Analysis of participant interviews and a review of the policy documents revealed the weakness of the capacity of the Afar regional state leadership and the national public policy design process as major factors that led to persistence of inequalities in various socioeconomic dimensions. The weakness of the Afar regional leadership is expressed in terms of inability to design , contextualize appropriate policies; lack of technical insight about social development; inefficient use of resource and lack of accountability.

> *Politically speaking, the federal system was meant to give autonomy to regions to device context specific policies to address regional specific problems. In practice, in case of Afar when I was there, perhaps situation may have changed it now, the region didn't have the level of strategic and*

technical leadership capacity that challenges the federal level prescription and come up with context specific alternatives ***(Participant 8).***

While there has been improvement over the years, the leadership capacity is still a major problem that impacted resource allocation and efficient use of scale resources.

To me, the underlying cause in Afar context is lack of leadership… if there is good leadership, all other challenges can be addressed creatively. The leadership can make use of scare resources and can work towards increasing public awareness.

When we talk about the leadership, it can be lack of technical awareness and experience of assigned person. In Afar regions, the assigned leadership up until recently, almost 50-60% have been political appointees with little or no background in the health sector. They simply lack the required level of understanding of concept of health development and social development matters. They may not have insight about the transformational power of health. The lack of experience / not technical background makes conversation with technical staff difficult. They do not know priorities and the short term and long term benefits of public health ***(Participant 12).***

The national level policy formulation process has been top-down in approach. Such practice has made it difficult to design tailored policies that fit the Afar region context.

The problem starts with the policy design. If the design is flawed, implementation is likely doomed to fail. There is realization that, our design issues have been main hurdle and because of our failure. Our policy formulation process is top down. The regions although constitutionally are autonomous in policy decision making, they simply replicate the direction /plan developed at federal level ***(Participant 16).***

The mandate of the regional level sector bureau's role in policy design is not clear. Some high-impact policies and programs such as the health extension program of the ministry of health could not succeed in the Afar region party because of lack of contextualization.

Honestly, I do not have clear idea of what their role is in terms of their mandate in coming up their own contextual strategy. But I think they have mandate to contextualize national policies or strategies. In my experience, I have not seen any region which came up with context specific strategy with major deviation in approach. For instance, in federal states such us in USA, the states have autonomy to accept or partially accept or reject some policy direction from national level. That has not been the case in Ethiopia, although we follow a federal governance arrangement ***(Participant 20).***

Many participants agree that the top down approach of policy design is a persistent and systemic issue in Ethiopia and has not changed for several years. While the influence of the national level administration is significant, the inability of regional states to take initiative is also a challenge.

This trend has been going on and has not changed it. The developing regions such as Afar did not have the required high calibre technical experts who can come up with their bottom up input to strategic planning ***(Participant 20).***

When it comes to within region level budget allocation and utilization of various priority sectors, it is entirely the role of the regional administration. However proper prioritization of important public problems, allocation of resources and efficient utilization of public resources has not been satisfactory.

The regional context, capacity of leadership, inefficiencies in utilization of resources and inability of regions to carefully identify their priorities instead of just following the federal blueprint is a gap ***(Participant 8).***

7.3. Policy Goal, Objectives, Interventions, strategies

In this sub-section, the findings of analysis of the policy documents from health and the sectors focusing on improving living conditions of people are presented. Given that the focus of this study is on retrospective analysis of child-health inequalities related public

policies designed and implemented prior to 2016[11], the policy documents under implementation prior to 2016 were reviewed.

The policy documents were reviewed and analysed to address one of the research questions "To what extent were the policy objectives, strategies, programs, and interventions appropriate and relevant in tackling spatial child health inequalities?'' The WHO Committee on Social Determinants of Health (CSDH) recommendations published in the flagship report on addressing health inequalities(CSDH, 2008), were used as a benchmark to assess the appropriateness and relevance of the policy objectives, program interventions, and strategies. The CSDH (2008) overarching recommendations encompass policy measures to improve the daily living conditions of people, enable overall political economy to tackle the inequitable distribution of power and resources, and provide a better understanding of the nature of health inequalities in a specific context. The analysis of the political economy context was discussed in the first two analysis chapters. In this sub-section, the findings of analysis of the various sectors' goals, objectives, activities, and strategies in relation to improving daily living conditions is presented. The policy documents were also examined to find evidence of the level of contextual analysis and understanding of the nature of health inequalities in the Ethiopian context. First, the findings from the health sector policy document are discussed. This is followed by the findings on education, water and sanitation, rural development and agriculture; and social protection policy documents are presented.

7.3. Equity sensitivity of the Health Sector

The Ethiopian overarching health policy was published in 1993 following the downfall of the Derg regime[12] and formation of the transitional federal government of Ethiopia. The overarching health policy document is ten pages, outlining the key priorities and principles of the public health sector in Ethiopia. Since 1993, the Ethiopia Federal Ministry of Health (FMOH) developed various detailed policies on various aspects of the health policy. The overarching health policy is still considered as the guiding principle that provided the

[11] The most recent evidence of regional child health inequality was published in 2016. Therefore, the study focused on the policy implementation during the period proceeding 2016.
[12] The Derg is a military administration which led Ethiopia from 1974-1991

foundation for the development of a more specific policy document during the period 1993-2016, which is the period this study focuses on.

The Ethiopian health policy considered child health among its top priorities and sought to attain improvement in child health status across the country.

> *Special attention shall be given to the health needs of the family particularly women and children* ***(FMOH, 1993, p. 6).***

The health policy underscores its commitment to human rights, equity, and governance values. Health is regarded as a human right and an essential element of socioeconomic development that must be enjoyed by all segments of the society**.**

> *It is founded on commitment to democracy and the rights and powers of the people that derive from it and to decentralization as the most appropriate system of government for the full exercise of these rights and powers in our pluralistic society. It accords appropriate emphasis to the needs of the less-privileged rural population which constitute the over-whelming majority of the population and the major productive force of the nation* ***(FMOH, 1993 p. 3)***

Health development shall be seen not only in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and equity ***(FMOH, 1993, p. 4)***

> *Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of recourses.* Assurance of accessibility of health care for all segments of the population *(****FMOH, 1993 p. 4)***

The health policy recognizes the importance of an intersectoral perspective for comprehensive health development. It emphasizes on the complementarity between health sector and other sector policies which focus on improving the living conditions of people.

> *The Government believes that health policy cannot be considered in isolation from policies addressing population dynamics, food availability, acceptable living conditions and other requisites essential for health improvement and shall therefore develop effective intersectorality for a comprehensive betterment of life* ***(FMOH, 1993 p. 4).***

The need for a decentralized governance in general and in the health sector in particular is emphasized in the health policy. The decentralization of the health system governance can be considered as a very significant shift in the Ethiopian context in comparison to the pre-1991 era. At least in principle, the decision-making mandate of regional states in the governance of the health sector is clearly indicated in the policy.

> *Decentralization shall be realized through transfer of the major parts of decision making, health care organization, capacity building, planning, implementation, and monitoring to the regions with clear definition of roles* ***(FMOH, 1993, p. 6).***

In terms of ensuring equity in health, various sections of the policy highlighted the most disadvantaged target groups and the approaches to ensure these groups enjoy health status in an equitable manner. Children, rural population, the poorest households, and pastoralist populations in developing regions such as Afar have been referred to as disadvantaged groups.

> *Special attention shall be given to the health needs of the family particularly women and children, those hitherto most neglected regions and segments of the population including the majority of the rural population, pastoralists, the urban poor and national minorities* (***FMOH, 1993, p. 6).***

> *Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay*. ***(FMOH, 1993, p. 4).***

Subsequent to the 1993 publication of the overarching health policy, various child health related policies have been developed[13]. These include: the National Strategy for Child Survival; the Health Extension Program in Ethiopia; and four phases of Ethiopian Health Sector Development Plans (HSDP) 1999 -2015. The CSDH (2008) health sector specific recommendations fall into three overarching categories: building health services on the principle of universal coverage focusing on primary health care; public sector leadership in health care financing to ensure coverage of health care regardless of ability to pay and minimizing out-of-pocket health spending; and health sector workforce development to ensure fair distribution of health workers. In addition, the CSDH (2008) recommends that the health sector conducts contextual analysis on the problem of health inequalities which may include identifying the various disadvantaged groups and understanding their profile. Drawing from CSDH (2008), the analysis of health policy goals, objectives, activities, and strategies identified various themes that fall under two categories: health equity groups and actions towards universal health coverage.

7.3.1. Health Equity Groups

Identifying disadvantaged equity seeking groups is an important part of addressing health inequities (Hosseinpoor et al, 2018). The extent to which public policies identify various disadvantaged groups and make commitment to address inequalities is reflective of the appropriateness and relevance of the policy. Understanding the various groups' characteristics and their relative level of disadvantage and the degree of exposure to determinants of health inequalities is important in designing appropriate policy actions (Graham and Kelly, 2004). The analysis of Ethiopian health policy documents in this study explored the extent the policy documents referred to various disadvantaged groups, their characteristics and tailored policy actions to address inequalities. Children of the poorest households, poor women, and pastoralist populations have been cited as the most disadvantaged groups.

> *The analysis of the current health situation in Ethiopia clearly shows that reaching the MDGs implies not only a dramatic scaling up of key services,*

[13] 'The National Health Policy is an overarching policy document', HSDP-IV, p. 33, FMOH, 2010

but also implementation of mechanisms to ensure adequate and efficient utilization of the services by the whole community, particularly by the rural populations, the poor women, and children ***(FMOH, 2005, HSDP-III, p. 33).***

*High impact and cost-effective child survival interventions will be implemented at high coverage levels by focusing on children of the poorest and most marginalized sections of the population (****FMOH, 2005, HSDP-III, p. 39).***

Overall, the health policy documents consistently indicate the focus of the health sector on the needs of the rural population.

*The health policy has also emanated from commitment to democracy and gives strong emphasis to the fulfilment of the needs of the less privileged rural population (****FMOH, 2005, HSDP-III, p. 6).***

With regards to pastoralists[14], the child survival strategy and the HSDPs implemented from 1998 – 2015 highlight the pastoralist population as the most disadvantaged group and emphasize the need for a tailored approach to addressing their health problems.

*Pastoralists constitute about 10% of the total population of Ethiopia. Even though they are among the most economically important groups in the country; they have a relatively poor socio economic condition. The conventional health service delivery system in the country also doesn't seem to take into account their particular requirements (****FMOH, 2005, HSDP-III, p. 87).***

*Nomadic and pastoral communities have many special health needs that are not completely met by the largely static facility-based health system that has been established for the rest of the country (****FMOH, 2011, HSDP-IV, p. 39).***

[14] Pastoralist areas are often referred to as Emerging Regions or Developing Regions in policy documents. These regions include the Afar regional state.

While the health policy documents recognise the pastoralist population as a disadvantaged group of special need, the underlying factors that led this population to an unequal position in health status and socioeconomic development in general have not been thoroughly discussed in policy documents. This has been indicative of the low level of emphasis given on equity agenda in policy problem analysis and policy design. Only superficial factors contributing to unequal distribution of health in pastoralist areas have been highlighted. Mostly, factors relating to availability and access to health services have been discussed which made the characterization of the profile of Afar and other pastoralist disadvantage groups shallow.

> *The conventional health service delivery system in the country also doesn't seem to take into account their particular requirements. They are naturally mobile looking for water and grazing fields for their cattle with changing seasons. Low level of education, strong cultural influences, shortage of infrastructure and hard climatic conditions make it difficult to provide basic health service through the conventional health service delivery, which is static. This led to poor access and utilization of health services by this group of people (**FMOH, 2005, HSDP-III, p. 87**).*

The underlying determinants of spatial inequalities or inequalities in general have not been addressed thoroughly in the policy documents. The statement below is an example of a common way the policy documents describe the regional comparison in achievement of health services utilization and/or progress towards improved health status.

> Five regions (Addis Ababa, Harari, Amhara, Tigray, and SNNP) have persistently attained immunization HSDP-IV 2010/11-2014/15 Draft Version 16 Jan 2011 11 levels above the national average for the last three consecutive years, while levels in Gambella, Afar and Somali regions are the farthest below the targets (***FMOH, 2010, HSDP-Iv, p. 10).***

The HSDPs implemented from 1998-2015 did achieve overall progress in health status across the country and disaggregated by region. However, the progress reports did not provide details of why the rate of improvement in some regions such as in Afar is lower.

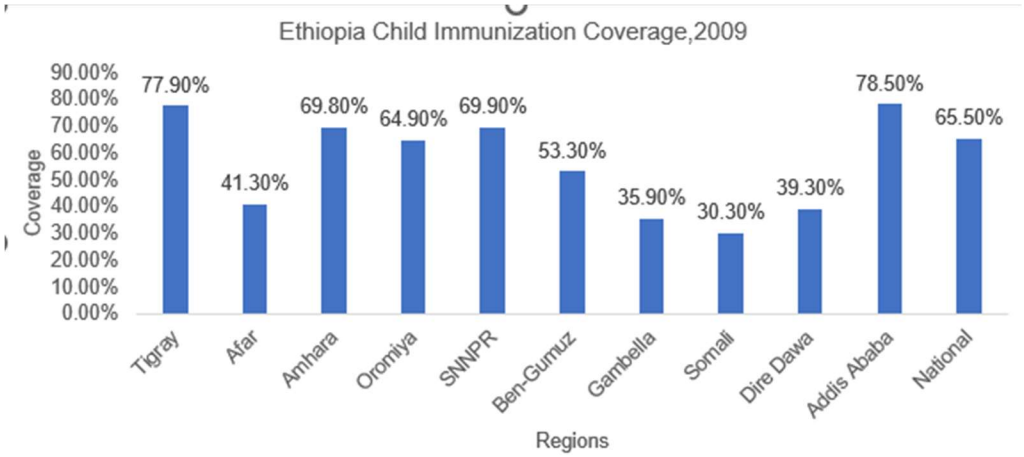


Figure 22: Ethiopia Child immunisation coverage, 2009

Source: FMOH, Ethiopia.

It is evident that the underlying sociopolitical factors that have resulted in in the poorest socioeconomic situations (low level of education, strong cultural influences, shortage of infrastructure) in pastoralist areas such as the Afar region have not been elaborated on in the policy situation analysis.

However, the health policy documents mentioned various tailored multisectoral actions deemed necessary to improve living conditions and promote health in pastoralist areas and eventually enable the pastoralist population to catch up with the rest of the country.

> *The Government has given due attention to improvement of the living conditions of pastoralists and has developed a program for the accelerated development in the pastoralist areas. The Ministry of Federal Affairs has handled the issue of providing a multisectoral support to this group of people. A board composed of members recruited form six ministries was established under this Ministry and, subsequently, a technical committee has been set to gather momentum and coordinate multisectoral efforts geared towards provision of integrated support to the Newly Emerging Regions. The Ministry of Health is a key member of this board (**FMOH, 2005, HSDP-III, p. 87**).*

Without through context specific analysis of the relative importance of the multisectoral interventions for the equity group, in this case the pastoralist population such as in the Afar region, the success of multisectoral interventions is questionable.

As part of the federal government led initiative of supporting the pastoralist populations (Developing regions) the Ministry of Health also tried to introduce a tailored primary health care package and service delivery modality in pastoralist areas.

> *As part of developing appropriate health service delivery for the pastoralist population, the HSEP has been modified to suit to the context of the pastoralists. The package has to be finalized and implemented. Otherwise, poor health service coverage in the pastoralist areas will be a bottleneck to the achievement of universal primary health service coverage by 2008 (**FMOH, 2005, HSDP-III, p. 87).***

Two core objectives were included under the pastoralist health component of the HSDP.

> *This gap prompted FMoH to establish two core objectives under HSDP-II regarding Pastoralist health services and systems. These were: a) to establish an appropriate health service delivery for the pastoralist population and b) to increase coverage and utilization of health services in pastoralist population (**FMOH, 2010, HSDP-IV, p. 31).***

Although delayed, as seen in the Health Sector Strategic Plan 2010-2015 (HSDP-IV), the Ministry of Health has incorporated a tailored approach to delivering health service to pastoralist populations.

> *Nomadic and pastoral communities have many special health needs that are not completely met by the largely static facility-based health system that has been established for the rest of the country. The FMoH developed a concept paper, "Health Service Delivery to Pastoralists". The 16 HEP packages were adapted to pastoralists' needs and translated into local languages. Following the redesign and implementation of CSRP and the BPR in HSDP III, one of the major organizational transformations in the*

> *FMoH was creating the Pastoralist Health Promotion and Disease Prevention Directorate to focus attention on health of the pastoralist populations (**FMOH, 2010, HSDP-IV, p. 31).***

The Ethiopian Health sector policy overall identified important equity seeking groups such as the pastoralist region of Afar. This implicitly acknowledges the presence of horizontal/regional or spatial inequalities. The policy strategy documents present the regionally disaggregated data on progress in the health status of children periodically. The analysis of this interregional inequalities is to some extent used to inform policy design and develop a tailored approach towards disadvantaged groups such as the Afar population. The various important socioeconomic and cultural characteristics of the equity seeking groups is discussed to highlight the significance of these features in designing appropriate tailored policy actions to address the unique challenges of pastoralist populations. There is recognition that the underlying causes of the unequal progress in child health improvement among various regions is beyond the health sector and the solution to address the inequalities among regions requires a multisectoral intervention. However, causal analysis of the spatial child health inequalities seemed shallow and did not highlight the underlying socio economic and political dimensions that affected how the health promoting living conditions were distributed among various equity groups.

7.3.2. Actions towards universal health coverage and child health equity

Universal health coverage refers to ensuring all people's access to sufficient quality of preventive, promotive, curative, and rehabilitative services without being exposed to financial hardship (WHO, 2010).

The CSDH public policy recommends the adoption of a universal principle to provision of comprehensive health care to all segments of population.

> *Universal coverage requires that everyone within a country can access the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency, and that people are*

> *empowered to use these services. It extends the same scope of benefits to the whole population (**CSDH, 2008, p. 100).***

However, in low-income countries such as Ethiopia, given the low level of public spending on health, a targeted approach towards building a universal health care system is recommended. The implication is that the public sector should preferentially allocate scare resources for health care to poor and disadvantaged groups in the short term to medium term and follow a universal coverage trajectory for long term. WHO argues a targeted approach to health care provision has importance in tackling inequalities and is not contradictory to universal coverage in the long run.

> *While it is important that all countries build a universal health care system, ensuring that services preferentially benefit disadvantaged groups and regions can be an important strategy in the short term. Geographical or group-specific targeting and universal access are not contradictory policy approaches (**CSDH, 2008, p. 99)***

The CSDH (2008) recommends that the health care sector be built in line with the principle of universal coverage of quality services, focusing on Primary Health Care; the public sector to assume leadership in employing health-care systems financing schemes that ensure universal coverage of health care regardless of ability to pay, and minimizing out-of-pocket health spending; public investment in medical and health personnel, balancing health-worker density in rural and urban areas.

The health care documents reviewed conform to the CSDH recommended principles for action on determinants of health inequalities. A targeted incremental approach to universal health care coverage seems the approach employed in Ethiopia. The policy documents emphasize the needs of the most disadvantaged groups, particularly the rural population. However, the policy goals and objectives are not specific enough as to how these disadvantaged groups are preferentially provided with health care services. The policy goals and specific objectives are too general and expressed in aggregated national level targets.

> *The ultimate goal of HSDP-III is to improve the health status of the Ethiopian peoples through provision of adequate and optimum quality of promotive, preventive, basic curative, and rehabilitative health services to all segments of the population(**FMOH, 2005, HSDP-III, p. 58).***

The Child specific objectives do not have set targets for improving the health of disadvantaged groups such as children in pastoral communities.

> *To increase DPT3 coverage from 70% to 80% and increase the proportion of fully immunized children from 45 to 80% **(FMOH, 2005, HSDP-III, p. 58).***

> *To increase the proportion of neonates with access to proper neonatal resuscitation and Ampicillin/Gentamycine for neonatal sepsis from 6% to 32% **(FMOH, 2005, HSDP-III, p. 58).***

Lack of regional level disaggregated targets specifying the disadvantaged groups published in national level policy documents makes it difficult to appreciate the level of commitment of the national and regional governments in addressing inequity. Without publicized regional level outcome targets such as child mortality it is difficult to transparently track the rate of progress in improving the health status of children especially in emerging regions such as Afar; and this makes timely remedial action more difficult.

In terms of appropriateness of interventions in the health sector, overall, the packages of the health services can be considered comprehensive, conforming to the Universal Health Care recommendation of providing a range of preventive, promotive, curative and rehabilitative services through the PHC. Important health sector policy measures for ensuring equity such as Health Care Financing, expansion of primary health care facilities, and investment and equitable assignment of human resources for health are included in the HSDPs implemented from 1999-2015.

7.4. Spatial Equity Sensitivity of Health Sector Policies

Table 7: Spatial Equity Sensitivity of Health Sector Policies

	Policy Objectives, Activities, and strategies	Equity focus (Disadvantaged groups targeted)
Expansion of Primary Health Facilities Coverage	**Objective**: "**Access to Services: Health Facility Construction, Expansion and Transport.** e the general potential health services ge from 72% to 100 %. nd furnish 80% of the health facilities as standard. and furnish 80% of the Health facilities" **Activities:** "Supervise the construction and equipping and furnishing of 10,736 health posts; 253 new health centres; upgrading of 1,457 health stations into health centres. • Ensure proper allocation (one car/ambulance per health centre), maintenance and functioning of vehicles for health activities in the woreda."	"Design appropriate health service including health service relevant to the pastoralist population. Inadequate Health Service Delivery to Pastoralists Population." "As part of developing appropriate health service delivery for the pastoralist population, the HSEP has been modified to suit to the context of the pastoralists."
Health Care Financing	Objectives: "To increase overall health expenditures per capita from 5.6 USD to 9.6 USD. • To double the share of health as a proportion of total Government budget (domestic spending and Direct Budget Support).	"Promote equitable health resource allocation for the vulnerable and high need group." "Put in place the legal framework of HCF and introduce a system of effective hospital governance, waiver and exemption, facility

	• To ensure retention and utilization of 100% of revenue generated at hospitals and health centres. • To expand special pharmacies to cover 100% of hospitals from the current level of 82% and 100% of health centres from the current level of 58%. • To design and implement social health insurance for employees in the formal sectors and pilot test community health insurance."	revenue retention, introducing private wing in public hospitals, outsourcing non-clinical (ancillary) services."
Investment and equitable assignment of human resource	Objectives: • "Increase HEWs to population ratio to 1:2,500. • To increase the ratio of midwives to women of reproductive age group from 1:13,388 to 1:6,759. • To staff all health facilities according to the standard and RHBs and Woreda Health Offices as per their respective organizational structure. • Establish implementation of transparent and accountable human resource management at all levels." Activities: • "Assign at least 2 diploma level nurse midwives who are able to do BEOC and one health officer with	"Consider gender equality on human resource development and management. Improving geographic distribution of HRH." "Conduct study on health labour market to assess necessary nature and levels of incentives for health workers to exert in rural areas." "There is poor deployment and most of these limited number of staff operate in urban areas. As a result, the rural areas have faced a continuous shortage of human resources."

	EOC training and practical exposure in each health centre. • Make available (existing plus new): - o General Practitioner 2,200 o 1,050 specialists o 5,000 Health Officers."	"Lack of clear, transparent, and flexible transfer and release rules and regulations particularly in remote areas. Salaries for health workers are very low in absolute terms and in comparison to the international market, even though they are high relatively to the GDP. This makes migration very attractive for highly qualified health professionals. Furthermore, non-conducive working environment, shortage of staff housing and transport facilities for highly qualified personnel to stay in remote areas".

Multisector Policy Goals, Objectives, Interventions And Strategies

The CSDH (2008) recommends health and other sector policy actions to improve the daily living conditions in which people are born, grow, live, work, and age. The conditions people live in and their risk of exposure and vulnerability to ill health and its negative consequences depends on their employment or income, education level, their house and immediate environment. A child born in a family with low educational level or low-income status and living in an unhealthy environment is more at risk of experiencing ill health as compared to a child who has higher socio economic status and better living conditions. The health equity literature has concluded that tacking inequalities in health requires ensuring equitable multisectoral actions towards improving the daily living conditions of children. Actions to improve early childhood and schooling, employment/income opportunities for families, and housing and living environment are recommended.

The policy documents from education, water and sanitation, rural development, agriculture, and social protection sectors were reviewed to identify evidence of equity consideration. Equity is represented as an important value in all the policy documents. However, the policies lacked equity specific goals, objectives, concrete actions, and strategies to ensure equity

Table 8: Spatial equity sensitivity[15] of health related sectors' policies objectives, activities and strategies.

Sector	Equity focused Policy statements, Objectives, Activities, and strategies.
Education	• "Develop the physical and mental potential and the problem-solving capacity of individuals by expanding education and in particular by providing basic education for all''. • "To date, it is known that our country's education is entangled with complex problems of relevance, quality, accessibility and equity". • "The gross participation rate of primary education is below 22% of the relevant age cohort. Of these a large number discontinues and relapse to illiteracy. The disparity among regions is high. Illiteracy is an overall problem of the society."
Water and Sanitation	• "Provision of as much as conditions permit, sustainable and sufficient water supply services to all the peoples of Ethiopia." • "While herding their cattle from place to place in search of green pasture following rainfall, they move away from centres of social services like health care, clean water, education." • "In order to attain sustainable and equitable solutions to these problems due attention has been accorded by FDRE government to find policy options." • "Satisfy water supply requirement of livestock."

[15] Any statement in the policy which makes reference to the disadvantaged status of the pastoralist population and the need for tailored policy action.

Food Security and Agriculture	• "Food insecurity is one of the defining features of rural poverty, particularly in the moisture deficit northeast highland plateaus and some pastoral areas." • "Ensuring household access to food poses a formidable challenge in view of the fact that chronic food insecure households are predominantly located in drought prone moisture deficit areas and peripheral pastoral areas. These areas are chronically food insecure in several respects: they do not produce enough food to feed themselves, food production is highly variable, and there are many households with insufficient income to secure enough food through the market." • "The goals of agricultural activities in pastoral areas are increasing livestock farm productivity and improving the welfare of the people through voluntary and non-coercive settlement in consultation with local communities. This necessitates integrated intervention programs and setting up a culturally acceptable mechanism to oversee the utilization and management of resources".
Ministry of Federal Affairs Multisectoral **Special support to emerging regions**	• "The four Emerging Regions, i.e., Afar, Somali, Beneshangul-Gumuz and Gambella, present unique challenges for health service delivery and health system development. These regions are characterized by poor infrastructure, hardship environmental conditions, and pastoral or semi-pastoral populations. HSDP I, II and III have emphasized the need for regionally tailored approaches and ***support to bring them to equal footing with the rest of the country."*** • "These avenues include: o Participate in multi-sectoral planning under the coordination of the Ministry of Federal Affairs. o Provide special support for health planning, budgeting, implementation, monitoring & evaluation of health programmes. o Provide needs-based capacity building to ensure sustainability; • Develop & implement a contextualized health service standard"

The excerpt from major health sensitive sector policies indicates lack of proper articulation the equality agenda in policy objectives , activities, and strategies. This indicates the multisectoral effort to tackle health inequalities has lacked coordinated effort from multiple ministries

Chapter 8. Discussion and Conclusion

8.1. Introduction

This chapter aims to contextualize the main findings of the study within the existing theoretical and empirical literature on health inequalities and public policy analysis. Specifically, this chapter summarizes and discusses the principal findings, establishes connections between the theoretical and empirical literature and the study's findings, examines the thesis's strengths and limitations, and highlights the contribution of the study to knowledge. Prior to this, a brief summary of the study's aim, specific objectives, conceptual framework, and methodology are presented below.

This study seeks to assess the impact of the public policy process and the underlying political economic context on persistent spatial child health inequalities in Ethiopia, a developing nation with a complex and unstable sociopolitical context (World Bank, 2021).

In light of this, the following research questions have been formulated:

- How have various contextual factors affected the effectiveness of Ethiopian public policies in addressing spatial inequalities in child health?
- In what ways have policy stakeholders influenced the formulation and implementation of policies aimed at reducing spatial inequalities in child health?
- To what degree have public policies tackled the issue of spatial child health inequalities and its underlying causes?
- How suitable and pertinent were the policy goals, strategies, programs, and interventions in addressing spatial child health inequalities?

Drawing on a diverse array of concepts and theories, discussed in detail in the literature review chapter (Chapter 2), and Conceptual and Analytical Framework chapters (chapter 4) the study incorporates insights from social stratification (Bourdieu, 1985; Grusky, 2010), broader political economy analysis frameworks (Moncrieffe and Luttrell, 2005; Khan, 2010), spatial health inequalities (Bambra, Smith, Garthwaite, Joyce, and Hunter, 2019; Solari and Irwin, 2010), social justice theory (Rawls, 1971), governance

('governability' as discussed by Foucault, 1991, in Burchell, Gordon, & Miller, eds.), and the public policy analysis framework (Walt and Gilson, 1994). These multidisciplinary perspectives enrich the study's analytical depth and breadth.

While various theories and concepts provide valuable insights and context, this study specifically focuses on examining the impact of public policy analysis within the context of the political economy on persistent spatial child health inequalities in Ethiopia. To this end, it employs a combination of the Political Economic Framework (Moncrieffe and Luttrell, 2005) and the Policy Triangle Framework (Walt and Gilson,1994).As stated in Chapter 3, the study adopts a constructionist ontological position that recognizes that social phenomena have multiple subjective realities, each of which is socially constructed by and between individuals (Creswell & Creswell, 2017). Moreover, the study employs an interpretative epistemological perspective that recognizes knowledge as subjective and obtained from a multitude of subjective perceptions, varying experiences, and interpretation of meanings that form reality and credible knowledge (Schwandt, 1994). The study follows a single case study design with multiple units of analysis (Yin, 2014) and employs interviews with key informants and document analysis as data collection methods (Bowen, 2009). A thematic analysis was conducted using the Framework analysis approach (Ritchie & Spencer, 1994).

The findings of the study concentrate on the influence of the national political economy on the equity sensitiveness of the public policy process, the role of global governance in the national policy process and its impact on promoting/undermining equity-sensitive public policy, and the appropriateness of public sector policy design and implementation. This chapter links the study's key findings to the relevant theoretical and empirical literature on the topic and concludes with a discussion of the study's contributions, policy and practice implications, prospective future research directions, and limitations.

The study's findings on national contextual variables of the public policy process that eventually may have contributed to Ethiopia's persistent spatial child health inequalities are discussed in section 8.2. Section 8.3 discusses the impact of the global governance context on Ethiopia's national public policy process. Section 8.4 presents important

aspects of Ethiopian public policy design and implementation that may have contributed to spatial child health inequalities. Specifically, it discusses policy objectives, strategies, programs, and interventions aimed at reducing health inequalities and identifies the factors that facilitated or hindered their success.

The chapter concludes by discussing the study's contributions to knowledge and policy and practice implications. The study's contributions to the theoretical and empirical literature on health inequalities and public policy analysis are highlighted, and it's to inform policy and practice in Ethiopia and other low-income countries is discussed. Finally, prospective future research directions are suggested, and the limitations of the study are acknowledged. The chapter brings the thesis to a close by putting forward some concluding remarks.

8.2. Influence of National Political Economy Context on Spatial Child Health Inequalities

This study investigated the influence of the national political economy context on the public policy process and resulting regional child health inequalities in Ethiopia. The findings indicated that the historical legacy of the past political economy, the overarching policies governing current formal institutions, and the power structure in formal and informal settings mediated by the design and implementation of public policy all had a significant impact on the prolonged persistence of regional child health inequalities in the country.

In examining the historical legacy, the study found that the impact on regional child health inequalities stemmed from four main features of Ethiopia's political economic history: the formation and administration of the modern Ethiopian state, the handling of political settlement and participation in pastoral areas, the dominant socio-cultural narrative and attitude towards pastoral areas, and the policies and programs pursued in the past.

The significance of examining historical legacies in understanding present public policy problems has been highlighted by scholars such as Moncrieffe and Luttrell (2005). They

argue that historical legacies, including structural and contextual variables, have a long-lasting impact on existing institutions, power structures and relationships, attitudes, perceptions, policies, implementation processes, and socioeconomic outcomes. Empirical studies, such as Libman and Obydenkova's (2019) investigation of income inequalities in Russia and Walle's (2007) examination of regional inequalities in Sub Saharan Africa, have demonstrated the lasting impact of historical legacies on contemporary equity.

8.2.1. Impact of Historical Legacy on Public Policy and Inequalities

The hostile path to the establishment of the contemporary Ethiopian state, the dynamics of state-society interaction, and the way formal governing structures were established and administered have collectively contributed to the creation of a legacy of persistent and pervasive inequalities across Ethiopia's diverse regions. The findings on the impacts of historical legacy on the public policy process and persistent child health inequalities indicated that fair access to resources for health-promoting living conditions was constrained due to the governance of the past administrations in Ethiopia. This appears to have been driven primarily by the absence of platforms for participation by disadvantaged populations such as the Afar region in decision-making and opportunities for rightful engagement.

The process of foundation of the Ethiopian modern state, the interaction between the state and society, and the way the formal governance institutions were administered, all had an impact on the creation of a legacy of difficult-to-narrow inequalities across the various regions of Ethiopia. As highlighted in chapter 5, the formation of the modern Ethiopian state was an outcome of a territorial expansion spearheaded by elites hailing from a dominant ethnic and religious group. Historical accounts indicated that the establishment of the modern Ethiopian state, which was accomplished in large part using force, was unable to bring about stability and prosperity in Ethiopia. The country was immersed in decades of civil war. Throughout the imperial feudal administration era and during the Derg regime the state operated as a centralized unitary authority as opposed to a federal state. The state to society relationship was hostile and authoritarian. Though

interactions between the centre and periphery have varied through time and generations, Ethiopia's peripheral regions such as Afar have been marked by evident marginalization, relative underdevelopment, and less integration.

Due to the extremely centralized authoritarian administrations of the past, populations like Afar had relatively lower opportunity for meaningful representation and participation in public policy decisions. Low involvement and exclusion from political decision-making diminished opportunities for the voice of the Afar people to be heard when policy decisions were being made that affected their lives. The interaction between former formal administrations and the Afar community and traditional administrative structures was frequently hostile and not conducive to participation in policy decision-making. In addition, administrative structures were not located in close proximity to the people, making it difficult to bring social development concerns to the attention of decision-makers. Furthermore, the legacy of prior centralized formal administration left a leadership void in the region with weak and nascent bureaucracy which continued even after a decentralized Afar regional administration was established during the EPRDF-led federal arrangement. As a result, in comparison with the majority of the country, the Afar region lagged behind in the establishment and expansion of formal governance institutions across the newly created administrative units. The governance institutions were either non-existent in close proximity and/or were inaccessible to allow the participation of the Afar community in public policies, programs and services that affect them.. The analysis presented in chapter 5 underscored the fact that configuration of the past political economy had a profound impact on the socioeconomic life of society, particularly on present-day developing regions such as Afar. One of the notable reasons the analysis identified for the persisting inequalities gap between regions such as Afar and the national average is largely due to the accumulated, difficult-to-narrow inequalities generated by the legacy of the past which did not allocate power and resources in a manner that promotes equity across the country. As the case study findings seem to indicate the fair allocation of resources for health-promoting living conditions could not happen in the absence of platforms for participation in decision-making and opportunities for rightful engagement.

These findings are consistent with the empirical and theoretical literature on social determinants of health and social stratification which demonstrated how inequalities is generated as a result of underlying political economic context. An individual's place in social space is determined by the possession of social, economic, and cultural capital (Bourdieu, 1984). The social and political mechanisms in a society influence class division, which in turn determines an individual's socioeconomic standing within hierarchies of power, prestige, and access to resources (Lynch & Kaplan, 2000; Solar & Irwin, 2010). According to Bourdieu's (1986) definition of structural restrictions and unequal access to institutional resources based on class, gender, and race, the historical occurrences witnessed in the sub national case of the Afar region have resulted in diminishing socioeconomic capital. This ultimately results in a disadvantaged social position that impedes the possibility for power and resource advantage (ibid.). Health inequities between population groups are caused by the unequal distribution of power, income, goods, and services, and the resulting unfairness in people's access to basic services (CSDH, 2008; Marmot et al., 2008). This study has shown the past political economy system did not give the population in pastoral regions such as Afar a fair opportunity to participate in decision-making on the public policy process; and this appears to have undermined access to and utilization of health-promoting resources. As a result, in comparison to most parts of Ethiopia, the Afar population remained in a disadvantaged position in terms of its possession of social and economic capital that could have contributed to enjoyment of an improved and equitable health status.

The study's findings demonstrate that preconceived stereotypes held by policy actors have a significant impact on contemporary policy processes, based on the historical legacy of such stereotypes. Policymakers' prejudices, opinions, and attitudes, stemming from their historical biases, can lead to the failure of public policies and programs. Specifically, policymakers' perspectives and beliefs, coupled with a centralized approach to policymaking, seem to have led to generic public policies that failed to account for the specific needs and circumstances of pastoral communities.

Historically, the Ethiopian mainstream discourse has considered pastoralist populations, such as Afar, as peripheral and the pastoralist way of life as backward and undesirable,

necessitating adjustment. The study shows that such attitudes are still prevalent, and policymakers who are unaware of the sociocultural context of pastoralists are more likely to design policies and initiatives that do not fit the pastoralist setting. Despite a constitutionally recognized federal system of governance, policy formulation in Ethiopia is a highly centralized top-down activity, with limited leadership roles for regional authorities. This practice is considered a legacy of a former era, and policymakers and technocrats are primarily from non-pastoral regions, which may lead to a distorted view of the pastoral lifestyle.

Similar studies conducted in India (Gogi & Sumesh, 2022) and South Africa (Ataguba & Alaba, 2012) have also demonstrated how the historical legacy and dominant perspective among elite policy actors contribute to a centralized policy-making process that often fails to account for the interests of disadvantaged groups. This study suggests that even in countries without colonial legacies, such as Ethiopia, the legacy of dominant group preconceptions can influence the contemporary policy process.

The findings demonstrate that the policy-making process in Ethiopia has been top-down in approach, with policy actors having limited familiarity with the context of equity-seeking groups such as pastoralist populations, making it difficult to design tailored policies. Previous policy documents on public health in pastoralist areas, such as the Afar region, have not adequately analysed the underlying causes of inequalities or articulated appropriate policy actions to address inequalities. Without context-specific analysis of the factors contributing to inequalities and tailored interventions for equity-seeking groups, such as the pastoralist population in the Afar region, the success of public policy interventions to address equity is questionable.

The role of policy actors within formal and informal institutions in the policy process is a crucial element (Evans, 2020; Walt & Gilson, 1994; Lipsky, 1980). Policy actors can be organized interest groups or individuals exercising discretionary power in the policy process and influencing the formulation and implementation of public policy (Walt & Gilson, 1994; Lipsky, 1980). An individual policy actor's familiarity with a specific context, as well as their perceptions, attitudes, and values, can potentially affect policy decision-

making (Moncrieffe, 2015). Moncrieffe and Luttrell (2005) argue that one way in which historical legacies manifest a strong and lasting influence on policy decision-making is through perceptions and values that remain embedded within institutions and within the minds of actors. The findings of this study strongly recognise the influence of perceptions held by policy actors within public institutions, and the effects of this influence on the creation of policies and programs that do not account for the realities of disadvantaged groups. This could be one of the plausible explanations for the ineffectiveness of policies and programs, such as the Ethiopian Health extension program, in pastoral areas that were successful in other parts of the country.

In summary, this study demonstrates that the historical legacy of Ethiopia's establishment and governance structures has contributed to persistent and pervasive inequalities across the country's diverse regions. The centralized and authoritarian approach to governance in the past led to marginalized populations like the Afar region having limited opportunities for meaningful representation and participation in public policy decisions, ultimately impeding their access to and utilization of health-promoting resources. The findings highlight how preconceived stereotypes and biases held by policymakers based on historical attitudes towards pastoralist populations can influence contemporary policy processes, leading to policies and programs that fail to account for the specific needs and circumstances of disadvantaged groups. The highly centralized top-down approach to policymaking in Ethiopia, coupled with policymakers' limited familiarity with the context of equity-seeking groups, makes it difficult to design tailored policies that address underlying causes of inequalities and appropriately address inequalities.

8.2.2. Formal Institutions, Public Policy And inequalities

The analysis of public policy through the lens of political economy-informed public policy analysis involves an examination of the characteristics of formal institutions to explain the performance of public policy. Through a careful examination of formal institutions, researchers can identify and understand the standards and rules of operation that shape policy formulation and implementation. Understanding how institutions and actors interact and how their interactions influence policymaking and implementation processes is critical

in explaining the outcome of the public policy process (Moncrieffe & Luttrell, 2005; Walt and Gilson, 1994).

In the context of Ethiopia, this study aimed to answer the research question: What has been the influence of contextual factors on the performance of Ethiopian public policy in tackling spatial child health inequalities? To address this question, the study examined the formal institutions at the macro (federal) level of governance and at regional (meso) level. Formal institutions in this context refer to entities that engage in formulating operational standards and guidelines (Moncrieffe & Luttrell, 2005). The analysis primarily focuses on how power was intended to be exercised in formal institutions, how power was exercised in practice, and its influence on the allocation of crucial resources, which determine the spatial distribution of child health in Ethiopia.

Important thematic categories revealed through the analysis include the extent of representation of equity and social justice-related norms and values in policy documents and institutional frameworks, the influence of these values and norms in shaping policy orientation and objectives, the extent to which inequity is acknowledged in policy documents, and the implications of the overarching policy on accountability, regional autonomy, and engagement with traditional governance structures.

The study finds that Ethiopian major overarching policy documents such as the constitution embrace equity and social justice norms and values and are consistent with globally recognized equality and social development-related standards and agreements. The state officially declares the country’s adherence to global universal human right standards and affirms its commitment to promoting social and economic development through the exercise of people's rights. The overarching public policy objectives highlight the government's commitment to achieving equity by offering equal opportunity to enhance social and economic conditions and to promote equitable wealth distribution. The study further emphasizes the need for appropriate framing of health equity by incorporating dominant norms in public policy to ensure a successful outcome (Baum et al., 2022).

However, the analysis reveals a number of deficiencies in the overarching policy documents that may have contributed to insufficient progress in ensuring spatial equity in child health over the past two decades. Although having an overarching public policy sensitive to equity agenda is commendable, according to the study's findings, this has not translated into government pledges being consistently converted into actions that are consistent with the stated overall policy commitment to ensure equity.

The study identifies various salient features of the Ethiopian overarching public policy and institutional framework that may have been obstacles to translating overarching policy equity-sensitive values and state commitments into concrete outcomes. Identifying various contextual conditions that create ‘ambiguity and conflict’ in a policy implementation process can provide insight into what may explain the outcome of policy (Matalan, 1995, p.156). In addition, examining the various features of the context helps in understanding whether the formal instructional setting has provided ‘sufficient and generally necessary conditions’ for the successful formulation and implementation of public policies to achieve spatial child health equality (Sabatier, 1986, p.23).

One of the significant obstacles to translating overarching policy equity-sensitive values and state commitments into concrete outcomes is the lack of a concrete statement of policy actions to alleviate spatial inequalities in Ethiopia's overarching policy documents and policy community. In addition, the study finds that the regional states' jurisdiction and autonomy in the formulation and implementation of public policies are ill-defined.. Although the Ethiopian constitution empowers regions to develop and implement their policies, it is unclear if regional states can formulate their policies in a manner that closely aligns with federal policies or whether their duty is to reproduce and contextualize federal policies. This ambiguity has led to one-size-fits-all and top-down public policies that have failed to achieve consistent desired outcomes in all regions. Furthermore, the study identifies the uncertain mandate of regional states to mobilize resources through direct collaboration with international development partners as another significant obstacle. Engagement with representatives of foreign entities, including donor countries, is generally regarded as a federal responsibility, and it is not clear what the scope of engagement of regional authorities with international partners is in soliciting resources for

region-specific social development projects. This ambiguity impacts the availability of resources to improve the living conditions of the inhabitants in locations such as Afar, where the capacity to collect tax revenue is limited.

The study also indicates that the lack of clarity in the constitution on lateral and interregional cooperation is an additional significant barrier to the reduction of horizontal inequalities. It is unclear how horizontal relationships are managed and how regions can cooperate with one another, as well as how human resources and skills can be transferred from one region to another. As a result, it seems to have hindered the movement of human resources that could have helped reduce inequalities in access to high-quality basic services.

The findings of the study also reveal that mutual accountability between federal and regional leaders is ambiguous. The border between the roles of federal and regional executives, collaboration, and accountability is unclear. This becomes difficult when it comes to holding regions accountable for poor performance in the delivery of public services (owing to inadequate leadership capacity and resource misappropriation) in a particular region. It is unclear how accountability can be achieved if regions do not interact and do not execute or utilize nationally allocated resources efficiently. It has remained unclear how and when the federal government supports the development and implementation of regional policies. In regards to the role of the federal executive or line ministry support to the regions, the triggers for support or involvement are unclear.

Moreover, the lack of clarity around how traditional institutions can work with government institutions and play a vital part in various development projects is both disempowering to communities and a squandered chance to maximize their contribution. Traditional institutions have a significant influence on the daily lives of the Ethiopian population, especially in the Afar region, where clan chiefs organize communities, have informal decision-making authority, and play a leadership role in their communities. The constitution and overarching policies are silent on the critical role of these traditional institutions and how they legitimately interact with formal government organizations.

In conclusion, the study's findings reveal that the characteristics of institutional settings may determine the effective implementation of public policy and its outcome (Sabatier, 1986, p.23). The various features of the Ethiopian formal institutional framework highlighted in this study indicate the relevance of these factors in explaining why Ethiopian public policy failed to tackle persistent spatial child health inequalities. The study identifies the most prominent features of the instructional setting that may have hindered the design and effective implementation of equity-sensitive public policy, including the lack of concrete statements of policy actions to alleviate spatial inequalities, the ambiguity regarding the mandate of regional states in formulating (or contextualizing) their context-specific policies, the uncertain mandate of regional states to mobilize resources and utilize independently, lack of clarity in the constitution on lateral and interregional cooperation, unclear accountability (who holds whom accountable) between regional administration and federal executives, lack of a legal framework to govern lateral interregional cooperation, and engagement of public institutions with traditional institutions. The study highlights the importance of clarity in policy intent and the means by which the policy is meant to be implemented to shape policy success (Matalan, 1995). The study's findings provide important insights for policymakers and researchers seeking to address persistent spatial child health inequalities in Ethiopia and other similar contexts.

8.2.3. Political Ideology , Power Dynamics, and Policy Implications

It is widely acknowledged that political power influences the design and implementation of public policy (Kingdon, 1995; Bambra, 2005; Bambra, 2019). Understanding the dynamics behind the distribution of power and, by extension, the control and allocation of resources in each setting is crucial for policy analysis. Barker (1996) asserts, "Resources, ideas, and technology are all essential, but their utilization is contingent on the distribution of power in society" (Barker, 1996, p. 79). Here, the study applied the definition of politics as '*the process through which desired outcomes are achieved in the production, distribution, and use of scarce resources in all areas of social existence*' (Heywood, 2000; Marsh and Stoker, 2002 cited at Bambra et al. 2005, p. 190). The political context and power dynamics influence the functioning of institutions and policy performance (Kelsall

and vom Hau, 2020). Analysis of policy performance should go beyond just analysis of the institutional context and the technical soundness of the policy design. Understanding the political context and the power dynamics is vital for a thorough analysis of the public policy process and outcome (ibid, 2020). Politics is one of the major determinants of spatial health inequalities (Bambra, 2005; Bambra, 2019). Cognizant of the critical importance of politics in determining public policy and its outcomes, the study used a political settlement framework (a political economic perspective argued to be more suited to the Sub Saharan Africa context) to guide the analysis of the power dynamics among political elites and its impact on public policy process and equity in an Ethiopian context.

The study investigated the influential role of the ruling TPLF/EPRDF party in shaping Ethiopia's socioeconomic context over the past three decades. As discussed in Chapter 5, the study argues that the TPLF/EPRDF ideology on land ownership and ethnic identity representation, as well as the party's internal mode of operation in decision-making, and the influential position of elites within TPLF/EPTRDF, have had a significant impact on the development and implementation of public policy and its outcomes. The study findings are in line with Baum et al.'s (2022) research, which demonstrated the crucial role of political party ideology in promoting pro-health equity policies. Additionally, Bekele et al. (2016) indicated the detrimental importance of property rights, political representation, and the role of elites in driving the Ethiopian state-society relationship.

The Ethiopian Constitution reflected the ruling EPRDF/TPLF ideology regarding control of means of production (property rights), which was widely implemented throughout the last three decades. The study found that land appropriation was common, and lands dispossessed from pastoralists were given to private commercial farms and state-owned sugar plantations. The implementation of the land ownership policy seems to have compromised the livelihood of the Afar population, leading to fewer economic opportunities for better employment and income. The limited mobility of people across regions is one of the most significant negative effects of ethnically organized regions. The mobility of people in pursuit of employment and economic opportunities occurs only within their own regions of origin, and there is little to no representation of non-natives or

individuals of non-regional ethnic origin. This fact has affected the public sector's human resource capabilities in Afar over the past three decades.

The majority of research participants believe that the impact of powerful elites within the EPRDF, primarily the TPLF elites, on regional political elites has been extremely substantial during the past three decades. The patron-client relationship between the Afar political leadership and the EPRDF core (the TPLF) and the lack of accountability to the Afar population were identified as two linked themes. The party power structure had an impact on policy decisions in the Afar area and nationwide. The implication was that as long as regional leaders remained loyal to their patrons, their poor performance or lack of accountability to the local populations would not have a significant impact on their political careers. The study shows how the patron-client relationship between national and sub-national elites encourages sub-national policy actors to become loyal to their patrons rather than being accountable to their constituency.

Overall, the power structure of the party and the dominant interest groups within the EPRDF had a significant impact on the policy process at both the federal and regional levels, as was the case in the Afar region. This finding is similar to studies in Africa, such as Arriola's (2009) study on the pervasive use of patronage to sustain power by African states by paying low regard to accountability to constituents. The study findings also support Fox & Reich's (2015, p1038) observation that in sub-Saharan Africa, ethnic patronage politics has tended to characterize partisan political dynamics more than a defining left-right ideology. In contrast to a similar study in Ghana that investigated the contribution of politics to persistent spatial inequalities, this study did not identify inequitable allocation of resources (budget) as the main reason for persistent inequalities.

8.3. Global Governance and National Public Policy to Tackle Spatial Child Health Inequalities

It is widely acknowledged in the theoretical and empirical literature that global context and global governance actors have a significant influence on national policy decision-making (Knack et al., 2020; Daniel & Kay, 2017; Cluster et al., 2015; Esmael Zaei, 2014; Bernstein & Cashore, 2012; Edwards, 2004). To comprehensively understand the national public policy process, it is essential to consider the impact of global players and

context (Gilson et al., 2018). Such a global governance-oriented analysis complements the national context-specific examination of the policy process by providing a more comprehensive explanation of why certain public policy decisions were made, and outcomes, such as inequalities, resulted (Gilson et al., 2018; Østebø, Cogburn & Mandani, 2018).

Global governance actors, such as international financial institutions, United Nations agencies, bilateral and multilateral donors, global health partnerships, and international non-governmental organizations, influence the national-level policy process through numerous avenues, including international commitments/conventions, international norms and discourse, market formation or intervention, and direct access to domestic policy processes (Bernstein & Cashore, 2012). The policy transfer may be manifested in eight categories of transferable policy elements: policy objectives, policy substance, policy instruments, policy programs, institutions, ideologies, ideas, attitudes, and negative lessons (Dolowitz & Marsh, 2000). This study aimed to explore how global governance context influenced the public policy process and eventually contributed to the persistence of spatial inequalities in child health in Ethiopia, utilizing the Walt and Gilson (1994) policy triangle framework and policy transfer theoretical concepts (Bernstein & Cashore, 2012; Dolowitz & Marsh, 2000).

The findings of this study indicate the critical importance of global governance context and actors in Ethiopian national public policy process. Ethiopia is a long-time member of numerous global governance entities, such as the United Nations, and a signatory of commitments under global governance institutions. In addition, the United Nations specialized agencies, such as the World Health Organization, are knowledge leaders and norm-setting entities from which countries emulate best practices. Ethiopia is also among the heavily donor-dependent countries, having received over US$64 billion on official development assistance and official aid from 2000-2020 (World Bank, 2020)

The analysis identified global norms, values, best practices, and discourse related to equity, social inclusion, social development, and health equity, as well as global conventions and commitments aimed at ensuring health equity in least-developed

countries. The analysis examined the extent to which Ethiopia has been receptive or resistant to the influence of global governance commitments, global governance actors' policy recommendations, and prescriptions. The influence of global governance on national policy-making in Ethiopia was manifested in four major ways: (i) the extent to which globally recognized values, norms, best practices, and dominant discourse on equity, social justice, and health inequalities have been reflected in the national public policy guiding principles; (ii) the extent to which Ethiopian public policy goals have been set based on global commitments on equity-enhancing public interventions; (iii) the degree of progress towards reaching the goals and targets on equity-enhancing interventions based on global benchmarks; and (iv) whether or not the international development assistance priorities and support to Ethiopia have had an equity focus.

8.3.1. Global Values, Norms, Commitments on Equity, Social Justice, and Health Inequalities

Global norms, values, conventions, and commitments related to social development, health, human rights, and social inclusion have been reflected in various global governance policies. The United Nations (UN), established in the aftermath of World War II, remains a crucial global governance organization that has enacted numerous international conventions intended to influence the national policies of its member states. These conventions recognize health in general and child health wellbeing and survival as a human right, affirm that every child should have access to the highest achievable level of health, hold states accountable for enacting necessary legislation and ensuring rights are respected, and promote international cooperation to advance these rights.

The importance of health-promoting services, such as universal primary education, social security, the ability to work, and a sufficient standard of life, is well recognized. All overarching social development strategies of international governance actors such as the UN and the World Bank continuously assert that health is an intrinsic component of human development and that there exists a vicious circle between population health status and economic growth. The crucial importance of health policies in promoting economic and human growth, as well as the reduction of poverty, is well emphasized.

Global actors such as the World Health Organization (WHO) also recognize and assert that ensuring health equity is an ethical imperative. Health and health equity are considered values in their own right. Thus, the argument for ensuring that everyone has the best possible health condition is considered not only as a moral imperative but also as an investment in broader societal development. The fact that health goals are essential components of the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) indicates unequivocally that national and global policies aimed at improving the health status of the population should be pursued in order to achieve holistic development.

However, global actors' policies seem to lack the potency to promote equity in health or enhance health equity in other sector's public policies at the national level. The weakness appears to be more to do with the emphasis given to the equity agenda in the global policy priorities. For instance, although health is accorded its appropriate place in the MDGs, the distributional aspect of health status has not been adequately highlighted in this global policy commitment. The UN Development Report (2005) concluded that the MDGs did not effectively advance the agenda of guaranteeing health equity. Similar limitations have been observed in the poverty reduction strategy papers (PRSPs) of the World Bank and the International Monetary Fund (IMF), which were adopted by low-income countries, such as Ethiopia, beginning in the early 2000s.

In general, global governance players recognize the positive relationship between health and social development, as well as the necessity to make population health improvement a key policy objective within the context of larger social development policy. However, the global policy content and discourse on health and social development lack detail regarding what countries must do to achieve improved health status for all population segments in an equitable manner. There has been a relatively recent attempt to articulate recommended public policy actions to promote health equity, but these recommendations have not yet been fully implemented at scale, and adequate lessons have not been drawn to replicate the best practices.

Overall, the analysis of policy documents has shown that Ethiopia conforms to the global norms, values, and discourse on health and health equity. Ethiopia has also shown some level of commitment to global conventions and commitments but falls short in major equity-related targets.

In Ethiopia, health is recognized as a fundamental human right, but there are concerns about the government's capacity to provide universal healthcare. While the value of equity is widely embraced, it is interpreted differently, particularly with regards to spatial versus socioeconomic-based health inequalities. There is also a misconception that inequalities is difficult to address, even in developed countries. Nevertheless, the state has an obligation to improve living conditions, including education, clean water, housing, food, and social security, in order to promote health. Ethiopia has committed to respecting, protecting, and fulfilling these rights as a signatory to the UN Human Rights Deflations. There is a general recognition that health is a right and a means of achieving social justice, as reflected in the constitution and Health Policy. Public policy documents also recognize the right of people to improved living standards.

Ethiopia's track record in fulfilling globally set equity-enhancing commitments has been mixed. For instance, despite progress towards the Abuja declaration on increasing per capita spending on health, government spending on health remains very low compared to peer nations and the World Health Organization's recommendations. Although Ethiopia was commended for achieving the child and maternal health targets of the Millennium Development Goals (MDGs), geographic child health inequalities persists, indicating a lack of attention to equity. The MDGs have been criticized for failing to address equity, and the situation in Ethiopia is reflective of this.

Studies conducted on policy transfer in sub-Saharan Africa have shown that international development assistance actors play a crucial role in shaping healthcare financing reform policies in various African countries, including Ethiopia (Kiwanuka-Mukiibi, 2015). These actors have used knowledge-based resources as a key channel for policy transfer, relying on norms, discourse, and commitments to influence national policymaking (Tumusiime, 2018).

However, it remains unclear to what extent global governance actors prioritize health equity, and there is limited evidence on how they influence pro-equity national policy. A narrative review by Tumusiime (2018) has highlighted that while international actors use equity as a normative principle in their global health governance work, they often prioritize other values and interests, such as promoting economic growth or political stability.

Moreover, the concept of equity itself may be interpreted differently by different actors, and there is a lack of clarity on how international development actors understand equity in the context of allocating and distributing aid (Lee & Walt, 2014). In general, the equity agenda has not yet become a prominent focus of global governance actors (Tumusiime, 2018).

Overall, the role of international development assistance actors in shaping healthcare financing reform policies in sub-Saharan Africa, including Ethiopia, is significant. However, there is a need for greater clarity and transparency in how global governance actors prioritize equity in their work and understand the concept of equity itself.

8.3.2. Participation In International Policy Making: International Development Assistance Priorities and Equity Focus.

In the field of global governance, one significant way through which global governance actors influence national public policy processes is by participating directly in domestic policy-making processes. As indicated by the policy transfer and global governance literature, global actors can engage in a variety of ways, including financing, providing training and capacity-building, supporting service delivery, and co-leading in policy dialogue. This study aimed to determine whether the international development assistance priorities to Ethiopia had an equity focus. Specifically, the study explored the level and type of participation of the global actors (development assistance partners) in Ethiopia's policy process, the extent to which development assistance partners' priorities and conditionalities promoted equity, and the extent to which the development assistance partners influenced the design of public policy conducive to tackling child health inequalities using various channels of influence.

The findings revealed a significant level of participation by global actors in Ethiopia's public policy process, with development assistance actors directly participating in service provision, technical support, and financing. However, despite their extensive involvement in the national public policy process, there was little evidence to suggest that they had an impact in promoting the health equity agenda in Ethiopia. This lack of exercise of leverage by global governance actors in influencing national pro-health equity public policy is notable.

In low- and middle-income countries, there is no significant empirical evidence regarding how global governance actors influenced equity-sensitive national public policymaking. According to Jones (2009), pro-equity policies can be promoted by global governance actors through providing services, influencing government policies, and embedding equity in decision-making. Donors can encourage the adoption of equitable principles in policymaking by utilizing the "normative appeal" of their proposals, suggesting the potential influence of global actors in national policy making (Jones, 2009, p. 35).

Stone (2013) studied the role of international organizations and transnational advocacy networks in shaping global governance. He argued that global actors can have significant influence on national policy-making processes, but this influence is often limited by power imbalances, institutional constraints, and political resistance. He also highlighted the importance of understanding the dynamics of policy-making networks and the role of ideas and discourse in shaping policy outcomes. Similarly, Grindle, M. S. (2004) argues that policy-making processes in these contexts are often highly politicized and fragmented, and that external actors such as aid agencies and international organizations can have both positive and negative effects on policy outcomes.

As highlighted, none of these studies indicate the extent to which global actors promoted equity sensitivity in national policy process. However, they emphasize the critical importance of international actors in the national policy making process in developing countries.

8.4. Equity Sensitivity of Sectoral Policies

Examining the content, actors, and policy process in conjunction with the overall context is vital in understanding public policy decision making and explaining its outcomes (Walt and Gilson, 1994). This study examined the content of Ethiopian public policies in the health, water and sanitation, social protection, education, and pastoral rural development sectors in order to understand the equity consideration in policy formulation. The various policy actors' perspectives on the policy process was explored. The analysis identified themes relating to the extent the policy documents and views of policy actors address the policy problem, the policy overall goal, objectives, activities and strategies, resources allocation and utilization, the collaborations among various actors, monitoring, evaluation setup and accountability mechanisms. Such 'technical level' sector policy analysis is in line with Kingdon's (1995) problem and policy streams of multiple streams theory and Rutten et al's (2010) analysis of determinants of policy impact (ADEPT) framework questions. As discussed in chapter 7 these questions elicit explanatory responses to why policy outcomes have been/not been achieved.

The study findings addressed the research questions:

- To what degree have public policies tackled the issue of spatial child health inequalities and its underlying causes?
- How suitable and pertinent were the policy goals, strategies, programs, and interventions in addressing spatial child health inequalities?

The analysis identified themes: policy agenda setting; policy actors' perceptions; policy problem analysis and representation and policy goals, objectives, interventions, and strategies. The section below discusses a summary of the findings of this study and its links with relevant literature.

8.4.1. Equity Agenda Setting, Problematization and Representation in Public Policy

In accordance with Kingdon's (1995) problem stream, this study was conducted with the premise that agenda setting, framing, and problematization of equity are crucial in explaining how policy formulation has contributed to the inability of Ethiopian public policy to address persistent spatial child health inequalities. The policy agenda-setting shapes how the equity problem is perceived as a public policy agenda worth pursuing, and the level of emphasis and effort put into tackling it (Kingdon, 1995).

This study found that inequalities or equity concern is represented as a problem worth tackling in Ethiopia. In Ethiopia, inequalities is viewed as an undesirable and unjust social problem, and there is a reasonable distinction between socioeconomic and spatial, place-based, or regional inequalities. Ethiopian public policy documents and actors emphasize that every segment of society should equally benefit from socioeconomic development in the country. Policy actors and sector public policy documents in the Ethiopian setting regard equity as an important consideration in the policymaking process and as a priority requiring state action to rectify the situation. The agenda of regional equity seems very politically sensitive and is given due consideration in policy decisions such as federal budgetary allocations. Overall, it appears health inequalities is perceived as matter of social justice value in the Ethiopian context. The importance of considering inequity as a matter of social justice is emphasized in academic and policy practice literature (Daniels, 2008; CSDH, 2008; Solaris & Irwin, 2010) as an important step towards ensuring equity in health.

While there is a reasonable level of understanding of the situation of inequalities and its underlying drivers among policy actors, the analysis of health inequalities appears to be shallow and lacks important details on how specific contextual factors impact one region more than others. There is a strong body of evidence supporting the existence of persistent spatial inequalities in child health in Ethiopia. Key indicators, such as child mortality, child morbidity rates, and access to health services, have been presented through disaggregation by region, highlighting the importance of using this evidence to

craft appropriate policies. Most policy actors demonstrate a good level of awareness about regional child health inequalities and some of the underlying drivers. However, more attention seems to have been given to technical matters such as access and availability of services as dominant causal factors for health inequalities. In contrast, there is a lack of attention to key drivers of inequalities, such as the political economy context of the country in policy documents.

While policy actors appear to possess a decent understanding of the regional inequalities in child health and some of the root causes, their problem analysis has primarily been on technical aspects, such as the relationship between health inequalities and variations among regions in terms of accessibility and provision of basic services. Conversely, there has been a dearth of emphasis on critical drivers of inequalities, such as the political and economic context of the nation.

There are discrepancies in opinions regarding the progress made in tackling spatial inequalities over the past two decades. Policy actors from health and health-related sectors in government and non-government institutions are able to identify regions such as Afar with the poorest child health indicators. However, some policy stakeholders erroneously believe that progress has been made in narrowing inequalities between developing regions like Afar and the rest of the country. In contrast, population-level studies indicate that inequalities persist and are even worsening. While there has been significant progress in overall health status in both developing regions and the rest of the country, there has been no corresponding progress in narrowing the gap. It appears that some policy actors perceive overall aggregate progress at the national level as the ultimate success indicator for improving health status in Ethiopia.

Despite the consideration given to equity in national policy agenda-setting, there is little evidence suggesting that the translation of intent to tackle equity to actual effective policy measures. A 2020 report by the WHO European region report highlighted a similar challenge of translating intention to action among policymakers despite a better understanding of determinants of health inequalities and evidence-based policy actions (WHO, 2020).

One of the main explanations for the gap between intention and action is related to the dilemma between following the equity social justice value in principle (policy design) and economic efficiency in policy implementation. In the case of Ethiopia, while policy documents unequivocally state equity as a matter of distributional justice and human right, policy actors within the public sector perceive equity as a difficult reality that the country has to learn to live with. Although inequalities is consistently described as an undesirable social problem in policy documents and by policy actors, the urgency to tackle it does not seem to be pronounced adequately in equity discourse in the country. There is a perception that if overall improvement in health and other social development is achieved, inequalities could naturally subside. In addition, there is a perception that even developed countries face difficulties addressing equity, and developing countries like Ethiopia should perhaps first focus on overall improvement in health in the near future. The argument behind indirectly 'de-prioritizing' equity and focusing more on increasing coverage of public health services to ensure overall improvement without due regard to equity, in health across all segments of society is concerned with 'economic efficiency'. This is consistent with studies which have observed the impact of the human right (ethical), social justice (equity) versus economic efficiency dilemma on public policy process (Baum, 2022; Townsend et al., 2020; WHO, 2013) among policymakers. This study observed that while policymakers may not necessarily dismiss the idea of equity, they often struggle to find a healthy balance between equity and efficiency objectives. Some scholars (Culyer, 2006; Asamani, et al, 2021; WHO, 2013) argue equity and efficiency are not contradictory and policymakers and experts should find the right framing of equity in order to ensure public policy is sensitive to equity. As observed in this study, reconciling the equity and efficiency considerations in policy decision-making appears far more challenging in resource-constrained countries such as Ethiopia where the bulk of the health sector and overall social development fund context, such as the budget, is mobilized through international development assistance.

Ujewe and van Staden (2021) put forth an argument about why it is challenging to apply the equity and social justice principle in the African context given the value differences in equity and social justice between the developed world and countries in sub-Saharan Africa. According to Ujewe and van Staden (2021) the ethics of communal responsibility

is dominant in Africa and the application of equality of opportunity-based equity principles which is dominant mainly in the western world and global policy could be challenging. However, this study's findings did not confirm the Ujewe and van Staden (2021) observation. It is evident that the globally dominant social justice and equity values are embraced by policy actors and policy documents in the Ethiopian context although translating into action the commitments to those values has been challenging.

Baum et al. (2022) suggest the need for framing health equity policy options (from economic efficiency and human rights perspectives depending on the target group) in a manner that makes it more likely to be adopted and implemented. In the case of this study, the framing has mostly been from an ethical (human rights and distributional justice) point of view. However, it seems that this framing of equity in health in Ethiopia should be supported by the economic efficiency argument to maximize the likelihood of being widely adopted and implemented.

8.4.2. Problem Analysis of Causes of Spatial Child Health Inequalities

The results of the analysis indicate that the policy actors interviewed possessed a comprehensive understanding of the likely factors contributing to spatial child health inequalities in Ethiopia. Furthermore, they emphasized the need for a multisectoral public policy that addresses the underlying causes of spatial child health inequalities. The analysis of interview data revealed that the relative importance of underlying causes of spatial inequalities varied among the respondents, but there was considerable similarity in the factors mentioned. Infrastructure, access to basic services such as water and education, the harsh climate, leadership capacity, and the policy-making process were among the most commonly highlighted factors. The underlying factors highlighted by the majority of policy actors are more to do with intermediate factors described in the CSDH framework of determinants of health inequalities (CSDH, 2010; Solaris & Irwin, 2010). According to policy actors' understanding and available evidence (CSA, 2016), access to basic services conducive to the well-being of children remained very low in Ethiopia, especially in regions such as Afar.

Moreover, the analysis of participant interviews revealed that the weakness of the regional leadership in developing regions such as Afar, the capacity of regional state leadership and the national public policy design process were among the factors contributing to the persistence of inequalities in various socioeconomic dimensions. The study found that the weakness of the Afar regional leadership was expressed in terms of its inability to design and contextualize appropriate policies, its lack of technical insight about social development, its inefficient use of resources, and its lack of accountability.

Policy actors reflect the highly centralized and top down policy making process and the lack of rich expertise and experience among regional leaders and bureaucracy in developing regions such as Afar, which has been a challenge that hindered the contextualization of public policies to fit into each context at the sub-national level. Campos & Reich (2019) suggest that it is crucial for policy actors to possess both commitment and competence when designing, contextualizing, and implementing policies. They also stress the importance of having health leaders with strategic insight, technical expertise, and political savvy, and ethical values to oversee policy formulation and implementation. The argument policy actors make is that in a country like Ethiopia with a population of over 100 million with diverse ethnic, cultural, socioeconomic, contexts, it can be challenging to develop generic public policies that can effectively address the specific needs of various population groups. While the influence of the national-level administration was significant, the inability of regional states to take initiatives was also a challenge.

The findings highlight that despite the federal and decentralized system administration structure in Ethiopia and the recognition of regional autonomy in the constitution, the policy formulation process remains highly centralized. While the regional administrations are primarily responsible for the implementation of policies and programs, their role in the formulation of sectoral public policies is minimal. It appears that federal executives (ministries) play a far more significant role in the design of public policies.

Several notable scholars have pointed out the drawbacks of top-down policy design, where policies are formulated at a high level and implemented downwards. Scholars

including(Boin. Hart., McConnell, & Preston, 2017). argue that these policies suffer from a lack of local knowledge, ownership, and insufficient transparency and accountability (Boin et al., 2017, p. 46). Stone and Peters point out that top-down policy design often fails to take into account the complexities of local contexts, resulting in unintended consequences (Stone & Peters, 2018, p. 14). Ovadia suggests that top-down policies often lack local ownership, participation, and accountability (Ovadia, 2018, p. 345). Additionally, Howlett and Ramesh argue that top-down policy design can result in a lack of understanding of the realities of implementation, the local context and culture, and the possibility of unintended consequences (Howlett & Ramesh, 1995, p. 175). These scholars suggest that a balance between top-down and bottom-up policy design is necessary to ensure that policies are effective, relevant, and sustainable.

The findings suggest that despite the seemingly equitable formula of federal budget allocation to regions, in practice, the investment in basic infrastructure, such as water and education, did not sufficiently consider the significant gap in less developed regions such as Afar. This raises a question about whether the fiscal federalism exercised in the country has failed its purpose of ensuring equity. The politics of budgetary decision and allocation has been noted as having a significant impact on policy implementation (Campos & Reich, 2019). Furthermore, the study's findings suggest that efficient utilization of public resource utilization and accountability appear weak in regions such as Afar.

8.4.3. Spector Specific Policy Goals and Priorities

The Ethiopian health policy places a high priority on improving child health status across the country. It underscores the government's commitment to values of human rights, equity, and good governance. The policy recognizes health as a fundamental human right and an essential element of socioeconomic development that must be accessible to all members of society. The health policy recognizes the importance of a comprehensive and intersectoral approach to health development. It emphasizes the need for complementarity between health sector policies and other sector policies that aim to improve living conditions for people. It also emphasizes the need for decentralized

governance in the health sector, which represents a significant departure from the pre-1991 era in Ethiopia. The policy outlines a clear mandate for regional states to participate in decision-making regarding the governance of the health sector. In terms of ensuring equity in health, the policy highlights specific target groups that are most disadvantaged and proposes approaches to ensure that these groups have access to equitable health status. The policy identifies children, rural populations, the poorest households, and pastoralist populations in developing regions such as Afar as being among the most disadvantaged groups.

The overarching policy or specific policies and programs lacked equity-specific targets and goals. There is no specific milestone for achieving equity indicated in the policy documents. The strategy for ensuring equity has not been adequately articulated. It appears as though the priority has been to scale up health coverage to the general population and provide targeted support to disadvantaged groups (low-income and poorest of the poor households) through payment waiver and exemption schemes. While this could be useful in supporting low socioeconomic status households, it did not seem to directly address spatial child health inequalities which is associated more with place of residence (residence of regional administration) context.

The study reviewed policy documents from various sectors to identify the extent to which equity considerations were incorporated into the policies. The findings suggest that while equity was acknowledged as an important value, policies did not go far enough to ensure that equity was embedded in their objectives and actions. This lack of equity-specific goals and strategies may lead to the perpetuation of health inequalities, particularly among vulnerable groups

The importance of explicit statements of commitments of the government in health equity policy is well recognized. Brown et al (2014) suggest government policy documents should explicitly deal with accountability and governance of delivery of social determinants of health inequalities. The clear definition of roles and responsibilities of national, regional, and local level governance actors is vital (ibid). The findings of this

study indicate these aspects have not been adequately addressed in the health sector policy priorities, objectives, and strategies.

8.4.4. Sector Specific Policy Activities and Strategies.

The CSDH (2008) recommends that the healthcare sector be built on the principle of universal coverage of quality services, focusing on Primary Health Care (PHC). The public sector should take a leadership role in employing health care systems financing schemes that ensure universal coverage of healthcare, regardless of ability to pay, and minimize out-of-pocket health spending. Public investment in medical and health personnel should balance health worker density in rural and urban areas.

The health care policy documents reviewed conform to the CSDH recommended principles for action on determinants of health inequalities. A targeted incremental approach to UHC seems to be the approach employed in Ethiopia. The policy documents emphasize the needs of the most disadvantaged groups, particularly the rural population. However, the policy goals and objectives are not specific enough about how these disadvantaged groups are preferentially provided with healthcare services. The policy goals and specific objectives are too general and expressed in aggregated national level targets.

The child-specific objectives do not have set targets for improving the health of disadvantaged groups such as children in pastoral communities. The lack of regional level disaggregated targets specifying the disadvantaged groups published in national level policy documents makes it difficult to appreciate the commitment of national and regional governments to address inequity. Without publicly available regional level targets, it is challenging to track progress transparently in improving the health status of children, especially in emerging regions such as Afar, and take timely remedial action. Brown et al (2014) suggest periodic monitoring and reporting on important tacking indicators for health equity disaggregated by demonstrative units.

Regarding the appropriateness of interventions in the health sector, overall, the healthcare service packages can be considered comprehensive, conforming to the UHC

recommendation of providing a range of preventive, promotive, curative, and rehabilitative services through PHC. Important health sector policy measures for ensuring equity, such as health care financing, expansion of primary healthcare facilities, and investment and equitable assignment of human resources for health, are included in the Health Sector Development Plans implemented from 1999-2015.

8.4.5. Targeting of Health Equity-Seeking Groups

In Ethiopia, children of the poorest households, poor women, and pastoralist populations are among the most disadvantaged groups, according to the analysis of Ethiopian health policy documents. The policy documents consistently emphasize the focus of the health sector on the needs of the rural population, and the health policy has emanated from a commitment to democracy, which emphasizes the fulfilment of the needs of less privileged rural populations.

However, the analysis of the policy documents reveals that the underlying determinants of spatial inequalities or inequalities, in general, have not been thoroughly addressed. Factors such as low levels of education, strong cultural influences, and shortages of infrastructure contribute to the unequal distribution of health in pastoralist areas such as Afar. Although the policy documents highlight the need for tailored multisectoral actions to improve living conditions and promote health in pastoralist areas, the underlying sociopolitical factors that contribute to the poorest socioeconomic situations in pastoralist areas have not been elaborated.

The policy documents have incorporated tailored approaches to delivering health services to pastoralist populations, such as developing appropriate health service delivery and increasing coverage and utilization of health services. However, the success of multisectoral interventions is questionable without thorough context-specific analysis of the relative importance of these interventions for equity groups such as pastoralist populations.

The policy documents also indicate a need for interregional inequalities analysis to inform policy design and come up with tailored approaches towards disadvantaged groups such

as the Afar population. However, the causal analysis of spatial child health inequalities seems shallow and does not highlight the underlying socioeconomic and political dimensions affecting the distribution of health-promoting living conditions among various equity groups.

In summary, the Ethiopian health sector policy has identified important equity-seeking groups such as pastoralist regions, implicitly acknowledging the presence of horizontal/regional or spatial inequalities. While the policy strategy documents periodically present regionally disaggregated data on progress in the health status of children, there is a need to address the underlying determinants of inequalities in policy analysis. A comprehensive analysis of the socioeconomic and political dimensions affecting the distribution of health-promoting living conditions among various equity groups seems missing in the policy design.

Overall health and health-related sector policies in Ethiopia have not yet adequately incorporated or implemented the recommended global best practices aimed at tackling health inequalities as indicated in the CSDH(2008) and Brown et al (2014) recommendations adopted in the European region.

8.5. Challenges and Limitations of the Study

This section delineates the limitations of the current study, which must be considered when interpreting the results. These limitations arise from the study's scope, data validity, data availability, and the characteristics of the study participants.

First, the study's emphasis on the macro-level political economic context and the public policy process constrains our capacity to investigate the discretionary role of frontline public service workers and street-level bureaucrats in policy implementation. Street-level bureaucrats, such as educators, social workers, and healthcare providers, may exert considerable influence on policy outcomes, including spatial health inequalities (Lipsky, 2010). While this study provides an extensive examination of the broader policy landscape, it does not account for the ways these frontline workers may impact policy outcomes through their daily actions and decisions. Subsequent research should explore

the role of street-level bureaucrats in the context of health policy implementation in Ethiopia.

Another limitation concerns the validation of politically sensitive data generated by government sources. The study depended on data regarding socioeconomic indicators, like the poverty headcount and the percentage of individuals below the national poverty line, produced by government agencies whose political neutrality might be dubious. Due to the politically sensitive nature of these indicators, the data might not be entirely reliable, as significant regional variations could be concealed or manipulated by the government (Mosley, 2017). This limitation highlights the necessity for independent data verification and the creation of alternative sources of socioeconomic information to guarantee data accuracy and comprehensiveness.

Additionally, the study is restricted by the availability of official statistical data on health inequalities in Ethiopia. The accessible data covers the period between 2000 and 2016, without representative national population survey data on child health status before 2000. The lack of data from the period before 2000 is problematic, as it would have offered invaluable insights into the historical trajectory of health inequalities in Ethiopia, which is widely acknowledged to have been worse than the period between 2000 and 2016 (World Bank, 2016). The limited data availability may affect our understanding of the broader trends and patterns of health inequalities in the nation.

Finally, the high turnover of development partner (donor) staff presents challenges for the study. Most of the study participants who participated in the interviews had held their positions for merely 5-7 years, limiting their capacity to provide a comprehensive account of donor involvement in Ethiopia's public policy process. To mitigate this limitation, the study employed policy documents produced by donor agencies and gathered government staff's opinions regarding donors' roles in the policy process. Nevertheless, this approach may not have captured the full extent of donor engagement and influence over the years, and future research should seek to include more long-term staff members or other sources of historical information to better comprehend donor participation in Ethiopia's public policy process.

Overall, the limitations of this study must be acknowledged when interpreting the findings. Future research should aim to address these limitations by focusing on the role of street-level bureaucrats, ensuring data validity, broadening the range of available data, and incorporating the perspectives of long-term development partner staff members. By addressing these limitations, future research can contribute to a more nuanced understanding of the factors influencing health inequalities in Ethiopia.

8.6.Contribution of the Study

The contribution of this study to the existing body of knowledge lies in its distinct approach to examining health inequalities within a developing country context characterized by complex and fragile political economic connections. Unlike most previous studies, this investigation offers a comprehensive understanding of structural determinants of health inequalities rather than focusing solely on individual-level socioeconomic characteristics. By delving into the spatial dimensions of health inequalities and moving away from a purely socioeconomic, individual-centric perspective, the study sheds light on macro-level factors that influence health inequalities in a developing Sub-Saharan African country.

In terms of approach, this study stands out for its multidisciplinary nature, which combines elements of social epidemiology, public policy, and political science. This innovative methodological framework allows for a more comprehensive and nuanced understanding of the complex factors that contribute to health inequalities in a developing country context. By integrating these diverse fields of inquiry, the study goes beyond traditional disciplinary boundaries and generates insights that may otherwise have been overlooked in a more narrowly focused analysis.

In addition, the conceptual framework developed for this study holds significant potential for replication in similar contexts, as it offers a comprehensive and adaptable approach to understanding health inequalities. By integrating elements of social epidemiology, public policy, and political science, this multidisciplinary framework allows researchers to delve into the complexities of health inequalities and their underlying determinants in different settings.

In terms of empirical findings, one of the key contributions of this study is its examination of the role that perceptions and biases of policy actors play in shaping the policy process. This is particularly important in a context where the welfare state and health system structures are underdeveloped. By analysing the application of a political economic perspective, the study highlights the significance of historical legacies in the policy process and the influence of party politics and informal power structures on policy development and implementation.

The empirical findings of this study demonstrate how the ongoing debate on equity and efficiency in health policy unfolds in practice. This is a significant contribution, as it provides evidence-based insights into the real-world implications of policy decisions, especially in a developing country context. The study also critically examines the role of global governance actors, such as international organizations and donors. Despite their substantial financial contributions, these actors have not effectively leveraged their influence to positively impact national policymaking. This finding is crucial, as it underscores the need for a more nuanced understanding of the relationship between global actors and national policy processes.

Furthermore, the study emphasizes that embracing global norms and values on equity and social justice is necessary but not sufficient for promoting health equity-sensitive policies. This finding is of particular importance for policymakers and practitioners in the health sector, as it highlights the need for a multifaceted approach to addressing health inequalities that goes beyond the adoption of international norms and principles.

In conclusion, this study makes a contribution to the understanding of health inequalities in developing countries by examining the complex interplay between structural determinants, spatial dimensions, and the role of policy actors. It provides valuable insights into the policy process and the challenges faced by developing countries in promoting health equity. By moving away from a narrow focus on individual socioeconomic characteristics and embracing a more comprehensive approach, this study paves the way for future research and policy development aimed at addressing health inequalities and achieving greater equity in health outcomes.

8.7. Conclusions

In addressing the research questions and meeting the study objectives, this study leads to the following key conclusions:

1. This study highlights the influence of historically based prejudices, opinions, and attitudes of policymakers on the design of contemporary policy processes in Ethiopia. The findings suggest that policymakers with limited awareness of the sociocultural context of pastoralists are more likely to design policies and initiatives that are not customized to the pastoralist setting, resulting in the failure of public policy and programs. The highly centralized top-down policy process, coupled with policymakers' distorted view of the pastoral lifestyle, may have contributed to the formulation of one-size-fits-all public policies that largely disregarded the pastoral population context.

2. The fair allocation of resources for health-promoting living conditions cannot happen in the absence of platforms for participation in decision-making and opportunities for rightful engagement. Thus, it is critical to address the impact of historical legacy on public policy and inequalities to promote equitable development and socioeconomic progress in Ethiopia.

3. This study adds to the existing literature on the influence of dominant group preconceptions on contemporary policy processes, as demonstrated in previous studies in India and South Africa. The findings suggest that even in countries where colonial legacy is non-existent, the historical legacy of dominant group preconceptions can influence the contemporary policy process. Therefore, policymakers and technocrats must recognize the importance of understanding the sociocultural context of diverse communities and designing policies that are customized to meet their unique needs. This study underscores the need for policymakers to recognize and address their historically based prejudices, opinions, and attitudes to design effective public policies that promote equity and social justice.

4. The study's findings reveal that the characteristics of institutional settings may determine the effective implementation of public policy and its outcome. The various features of the Ethiopian formal institutional framework highlighted in this study indicate the relevance of these factors in explaining why Ethiopian public policy failed to tackle persistent spatial child health inequalities. The study emphasizes the importance of clarity in policy intent and the means by which the policy is meant to be implemented to shape policy success.

5. The study's findings provide important insights for policymakers and researchers seeking to address persistent spatial child health inequalities in Ethiopia and other similar contexts. The study highlights the need for appropriate framing of health equity by incorporating dominant norms in public policy to ensure a successful outcome. Moreover, the study underscores the importance of establishing clear guidelines and mechanisms for interregional cooperation and accountability to ensure effective implementation of policies that promote spatial child health equity. It also emphasizes the need to engage with traditional institutions to maximize their contributions to development projects while ensuring that their involvement is consistent with the overall policy objectives.

6. This study sheds light on the problematization and framing of equity in Ethiopian public policy, particularly in the context of persistent spatial child health inequalities. The findings of this study suggest that policy actors in the Ethiopian setting consider equity to be an important consideration in the policymaking process, particularly when it comes to regional equity, which is a sensitive political issue that is given due consideration in policy decisions.

7. The study also reveals a dilemma between following the equity social justice value in principle and economic efficiency in policy implementation. While policy documents unequivocally state equity as a matter of distributional justice and human right, policy actors within the public sector perceive equity as a difficult reality that the country has to learn to live with. This dilemma has contributed to the persistence of spatial child health inequalities, and there is a need for policy

options to be framed in a way that balances both ethical and economic considerations to maximize their likelihood of adoption and implementation.

8. Overall, this study highlights the importance of emphasizing the urgency to tackle spatial child health inequalities in equity discourse to ensure that it remains a priority in policy formulation and implementation. In this regard, it is important to ensure that policy actors have a good understanding of the underlying drivers of spatial child health inequalities and the need to address them through appropriate policy interventions. Ultimately, addressing spatial child health inequalities requires a comprehensive approach that combines both ethical and economic considerations in policy formulation and implementation.

9. Finally, the study highlights the importance of political will and commitment to addressing spatial child health inequalities. The study's findings suggest that a top-down approach to policy design and implementation is insufficient to address the underlying causes of inequalities in Ethiopia. Rather, a more participatory and collaborative approach, which involves a range of stakeholders, including regional and local leaders, could contribute to the development of more effective policies and interventions to reduce spatial child health inequalities

In conclusion, the study highlights the complex and multifaceted nature of spatial child health inequalities in Ethiopia and underscores the need for a multisectoral public policy approach that addresses underlying causes. The study reveals that despite the federal and decentralized administrative structure in Ethiopia, the policy formulation process remains highly centralized, with regional administrations having minimal roles in formulating sectoral public policies. Additionally, the study raises concerns about the effectiveness of fiscal federalism in ensuring equitable investment in basic infrastructure in less developed regions such as Afar. The findings also demonstrate that weak leadership capacity at the regional level and shortcomings in the national public policy design process contribute to persistent socioeconomic inequalities. Overall, the study underscores the need for a more bottom-up approach to policy design that empowers

regional administrations to take initiative and prioritize important public problems, allocate resources efficiently and improve public resource utilization and accountability.

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Appendices

Appendix 1: Ethical Clearance Approval Letter

University of Sunderland

Downloaded: 09/03/2021
Approved: 18/01/2021

Anteneh Gebremichael Dobamo
Social Sciences

Dear Anteneh Gebremichael

PROJECT TITLE: Why have spatial child health inequalities in Ethiopia not improved? : Analysis of public policy
APPLICATION: Reference Number 007754

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 18/01/2021 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 007754 (form submission date: 18/01/2021); (expected project end date: 31/10/2021).
- Participant information sheet 1013725 version 1 (12/11/2020).
- Participant consent form 1014635 version 1 (17/12/2020).
- Participant consent form 1013723 version 1 (12/11/2020).

If during the course of the project you need to deviate significantly from the above-approved documentation please email ethics.review@sunderland.ac.uk

For more information please visit: https://www.sunderland.ac.uk/research/governance/researchethics/

Yours sincerely

Veronique Laniel
Ethics Administrator
University of Sunderland

Appendix 2: Semi-Structured Interview Topic Guide

University of Sunderland

Interview Topic Guide for Federal Level

Introduction

The research concerns the implementation of public polices to address geographic child health inequalities in Ethiopia. The focus of the research concerns the development and implementation of policies from 2000 -to date I am interested in your own thoughts, opinions, and experiences; anonymity and confidentiality are guaranteed.

Background:

1. Could you tell me about your background position in your ministry ?

2. What does your work involve?

Theme 1: Policy problem representation

1. What living conditions (give example from the sector) do you consider have an effect on health? (the health of the population / the health of children under the age of five)? In What was your sector contributes to the health of a child?
2. Could you tell me about your organizations involvement in polices, programs,activities that contribute to improvement of child health?
3. Is inequalities considered a concern in your region policy making and program implementation ? if yes, What are the equity concerns in your sector in this region ?
4. What do you think were the underlying causes of regional inequalities in your sector ?

5. What are the major contextual factors specific to your region that contributed to persistent inequalities ? Probe Economic, Political, Cultural, Historical, Security, environmental factors.
6. In your opinion what does ensuring equity in general or geographic(regional) equity means in your sector ?
7. What policy measures have been taken in the last 15 years to narrow the inequalities between your region and the rest of the country in your sector?
8. To what extent the national policy(program) in your sector addressed the equity problem?

Theme 2: Policy Design

9. What was the main goal of health related policy in your sector? (Universalism / targated / egalitarian / generosity of welfare system)
10. What was the main objective of the policy in terms of addressing equity?
11. To what extent the policy objectives were specific (identifying target group), realistic, attainable, and measurable ?
12. What were the strategies for implementing programs addressing regional inequalities in your sector?
13. Were the human, financial and other resources required for successful implementation considered in the policy design?
14. Was there a monitoring mechanism for the implementation of the policy?

Theme 3: Implementation

15. What guidelines/strategies do you have to narrow the inequalities gap between your region and rest of the country or urban rural variation in providing programs with contribution to child health?

16. How were financial resources (in addition to budget allocation by Regional Administration) and technical support provided to Regions in your sector?

17. Given the decentralized powers to regional state, how does the your Ministry (RHB) operate in terms of reducing and monitoring inequalities of service coverage?

18. What were the positive service benefits and/or challenges child health related programs in your sector from a national point of view?
19. Budgeting for sector ministries at regional level is done by the respective region, What is the Regional response when woredas are unable or unwilling to allocate adequate resources for the implementation of a program?

20. Not all regions are effective in implementation of programs. What measures were taken to provide support to underperforming regions ?

21. What do you think were the reasons for underperformance in regions such as xxx (To be specified)?

Proposed Changes?

1. Can you think of ways in which the policy could be improved?

2. Its implementation could be improved?

Closing

- Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them by email or skype is one or two additional questions arise.
- Offer to be contacted at any time should questions/concerns arise via the contact details on the consent form

University of Sunderland

Interview Topic Guide for Regional Level

Introduction

The research concerns the implementation of public polices to address geographic child health inequalities in Ethiopia. The focus of the research concerns the development and implementation of policies from 2000 – to date. I am interested in your own thoughts, opinions, and experiences; anonymity and confidentiality are guaranteed.

Background:

1. Could you tell me about your background position in your ministry ?

2. What does your work involve?

Theme 1: *Policy problem representation*

1. What living conditions (give example from the sector) do you consider have an effect on health? (the health of the population / the health of children under the age of five)? In What was your sector contributes to the health of a child?
2. Could you tell me about your organizations involvement in polices, programs,activities that contribute to improvement of child health?
3. Is inequalities considered a concern in your region policy making and program implementation ? if yes, What are the equity concerns in your sector in this region ?
4. What do you think were the underlying causes of regional inequalities in your sector ?

5. What are the major contextual factors specific to your region that contributed to persistent inequalities ? Probe Economic, Political, Cultural, Historical, Security, environmental factors.
6. In your opinion what does ensuring equity in general or geographic(regional) equity means in your sector ?
7. What policy measures have been taken in the last 15 years to narrow the inequalities between your region and the rest of the country in your sector?
8. To what extent the policy(program) in your sector addressed the equity problem?

Theme 2: ***Policy Design from regional policy makers and program managers perspective***

9. What was the main goal of health related policy in your sector? (Universalism / targated / egalitarian / generosity of welfare system)
10. What was the main objective of the policy in terms of addressing equity?
11. To what extent the policy objectives were specific (identifying target group), realistic, attainable, and measurable ?
12. What were the strategies for implementing programs addressing regional inequalities in your sector?
13. Were the human, financial and other resources required for successful implementation considered in the policy design?
14. Was there a monitoring mechanism for the implementation of the policy?

Theme 3: ***Policy Implementation***

15. What guidelines/strategies do you have to narrow the inequalities gap between your region and rest of the country or urban rural variation in providing programs with contribution to child health?

16. What is the planning process at your office? How do you narrow the inequalities gap between your region and rest of the country in child health related program coverage Probe: (urban/rural), Regions

17. Who leads equity reduction interventions in your office? (Is it a team? Unit? How does its structure look like?)

18. How have you addressed the underserved poor and rural community in your strategic plan ?

19. How were financial resources (in addition to budget allocation by Federal support) and technical support provided to woredas(districts) in your regions?

20. Given the decentralized powers to regional state, how was your Ministry (regional level) operating in terms of reducing and monitoring inequalities of service coverage?

21. What were the positive service benefits and/or challenges child health related programs in your sector from a national point of view?
22. Budgeting for sector ministries at regional level is done by the respective region; What has been the Regional response when woredas(districts) are unable or unwilling to allocate adequate resources for the implementation of a program?
23. How do you see the intersectoral collaboration with relevant sectors ?

24. Not all woredas are effective in implementation of programs. What measures were taken to provide support to underperforming woredas (districts) ?

Proposed Changes?

1. Can you think of ways in which the policy could be improved?

2. Its implementation could be improved?

Closing

Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them by email or skype is one or two additional questions arise.

Appendix 3: Consent Form

CONSENT FORM

Study Title: Why have spatial child health inequalities in Ethiopia not improved?: Analysis of public policy

Participant Code:_____

	Please initial box
I confirm that I am over the age of 18 years.	☐
I have read and understood the information sheet for the above study and have had the opportunity to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
I agree to take part in the above study.	☐

	Please initial box	
	Yes	No
I agree to the interview / focus group / consultation being audio recorded.	☐	☐
I agree to the use of anonymised quotes in publications.	☐	☐
I agree that my data gathered in this study may be shared (after it has been anonymised) with other researchers.	☐	☐
I agree that my data gathered in this study may be shared (after it has been anonymised) may be used for teaching purposes.	☐	☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

Appendix 4: Semi-Structured Interview Participant Recruitment Email Message

University of Sunderland

Semi-structured Interview Participant Recruitment Email Message

Dear Participant

I hope this email finds you well.

I am a Doctor of Philosophy candidate in the School of Social Sciences, University of Sunderland, United Kingdom. As part of a requirement for Phd degree in Public Policy and Health Equity, I am conducting a study entitled ***'Why spatial child health inequalities in Ethiopia have not improved?: Analysis of public policy'*.** The data collection in the research project involves interviews with current and past government officials and stakeholder experts at federal and regional level in Ethiopia. The focus of the research concerns the development and implementation of health and health related policies during years 2000 to date. I believe your insights and experience can provide a rich source of information for the study.

I am contacting you to kindly request for your availability for an approximately 45 minutes tele-interview (Skype, Zoom,MS teams, WhatsApp etc, whichever is convenient for your) during March 16- 22,2021. You may want to pick a suitable time at your best convenience.

I would like to assure you that your response will remain anonymous throughout the process and confidentiality is guaranteed.

Attached find my curriculum vitae, letter of university ethical approval and synopsis of the research project.

Look forward to hearing from you at your earliest convenience. I would be happy to respond should you have questions. I thank you in advance for your cooperation.

With Best Regards,

Anteneh Gebremichael Dobamo

Appendix 5: Introductory Letter

University of Sunderland

FACULTY OF EDUCATION & SOCIETY

REG VARDY CENTRE
SIR TOM COWIE CAMPUS AT ST PETER'S
SUNDERLAND SR6 0DD
UNITED KINGDOM

3 March, 2021.

To Whom It may Concern:

This is to inform you that **Anteneh Gebremichael Dobamo** is a Doctor of Philosophy candidate in the School of Social Sciences, University of Sunderland, United Kingdom.

The researcher is conducting a study entitled ***' Why spatial child health inequalities in Ethiopia have not improved? : Analysis of public policy'***, as part of a requirement for his degree in Public Policy and Health Equity.

As part of the data collection in the research project, he needs to conduct interviews with key government officials and stakeholder experts at federal and regional level in Ethiopia.

The University of Sunderland has granted ethical clearance to the research project on January 18, 2021. I believe the findings of this research contributes to advancement of knowledge in health and public policy field in general. The research output could potentially shape future policy design and implementation in Ethiopia and similar contexts.

As Anteneh's Director of Studies, I appreciate the support you will extend to him and I thank you in advance for your cooperation.

Bruce Marjoribanks

Dr Bruce Marjoribanks SFHEA

Senior Lecturer and Programme Leader for MA Childhood and Youth Studies

bruce.marjoribanks@sunderland.ac.uk

VICE-CHANCELLOR
& CHIEF EXECUTIVE
Sir David Bell

Appendix 6: Key Informant Interview Information Sheet

Key informant interview information sheet

About the research project:

Citizen's enjoyment of Health is part of social development. The Ethiopian state in its constitution recognizes every citizen should equitably enjoy the benefits of social development including health. Article 41 (3) grants the right to equal access to public funded social services. Article 89(2) obliges the government to provide equal opportunities to improve their economic conditions to all Ethiopians. Additionally, this sub-article requires the government to promote an equitable distribution of wealth among Ethiopians. Article 90 (1) refers to the provision of access to public health services, education, clean water, housing, food, and social security to all Ethiopians. Article 89 (4) which reads: "Government shall provide **special assistance** to Nations Nationalities and peoples advantaged in economic and social development."

As a founding member of the UN and signatory of various UN convention such as the social,economic and cultural rights, Ethiopia had long affirmed its commitment for equitable enjoyment of social development by its people. The new Sustainable Development Goals (SDGs) which Ethiopia is a state party, involve moving from a technical approach for increasing human development towards an equity/inclusion approach that focuses on 'leave no-one behind' (Starfield, 2007).

Years of evidence shows, there has been persistent inequalities in health sector among regions of the country. The Afar, Benishangul, Gambella and Somali regions are among the regions with higher child mortality rate as compared to national average and other major regions such as Amhara, Oromia, SNNPR, and Tigray.

This research project aims at investigating why there has been persistent regional inequalities in social development (specifically in health sector) over the last 20 years. It focuses on examining Ethiopian public policy and structural (political, economic, social, and cultural) determinants of equity. More specifically, it

attempts to thoroughly investigate to what extent formal and informal institutions, public policy design and implementation facilitated (otherwise hindered) attainment of equitable social development.

Why your response matters: Your organization as a public institution in charge of making policy decision in public finance plays crucial role in shaping the social development of the Ethiopian society. The priorities for public finance ,the consideration taken in budget allocation, strategies pursued , and the actual implementation(efficiency & equity) of public finances determines the level of attainment of equitable benefit to the society. Insight from your area of technical expertise and leadership role potentially provides a valuable input towards answering the research question.

Note: ***All your response will be processed anonymously and confidentiality are guaranteed.***

The interview takes about 30-45 minutes of your time.

If it is convenient for you the interview preferably can be done by phone.

Guiding questions for the interview

1. How does the Ethiopia public finance for social development allocated at Federal level?
    a. What does the process look like ?
    b. who is involved ?
    c. What considerations are taken?
2. What are equity related considerations (Eg. Special assistance to emerging regions) in allocation of public finance to regions?
3. In your assessment to what extent the public finance approach pursued over the last years promoted equity?
4. How does the public finance /budget allocation of regions work at regional and woreda administration levels?
5. What do you think are the major problems in efficient and equitable allocation and utilization of public finance (resources) at regional? To what extend do you think these problems contributed to persistence of inequity among regions such as Pastoral regions (Afar for example)?

Appendix 7: Analytical strategy: Identifying a Framework, and Coding

University of Sunderland

Analytical strategy: Identifying a framework, and coding

Developing analytical strategy (*defining what to analyze and why*) earlier on in the data collection and analysis process is critical (Yin,2003). Such strategy minimizes data overload, eases data retrieval (Miles and Huberman,1994), facilitates fair treatment of emerging evidence, generate solid analytical conclusions, and rule out alternative interpretations(Yin,2003). Having an analytical strategy is about being mindful of the purposes of the study and the conceptual lenses used as a basis for investigation while allowing oneself open to learn emergent issues including ones not expected in the data collection and analysis process (Miles and Huberman,1994). One way of developing analytical strategy for a case study design is use of *theoretical propositions* which shaped the formulation of research questions, guided the literature review, and informed the developmnet of data collection tools and plan.

This research employs the ' Framework approach to applied policy research' which involves identifying a framework at earlier stage of the data collection and analysis process. The framework facilitates sifting and sorting of data (Managing and organizing dataset), mapping and interpretation and ultimately answering the research questions (Ritch and Spencer,1994).

Drawing from(Miles and Huberman,1994; Ritch and Spencer,1994), the identification and construction of the framework is informed by:

- *Relaying up on theoretical propositions* – the Policy Trainable*(Walt and Gilson,1994*), the Welfare Architecture framework (Hurlimann et al,2011), and Policy Implementation analysis (Hill and Hupe,2002)
- Prior issues (based on the original research aims, issues reflected in the interviews topic guide)-

- *Familiarization stage of the Framework approach - Emerging issues from familiarization with the* issues raised by interview respondents and document analysis. So far 5 policy documents and 1 Key informant interview has been used to identify emerging issues

As more data is collected, at later stage the framework will be revisited based on analytical themes arising from the recurrence or patterning of particular views or experiences. Identifying an analytical framework involves creating thematic categories and aligning with the codes(indexes) (Parkinson et al,2016). Codes are 'tags or labels for assigning units of meaning to descriptive or inferential information compiled during a study' (Miles and Huberman, 1994, p. 56.)

Thematic Categories and Codes

Before the start of data analysis,14 thematic categories and 74 codes have been identified based on review of theoretical propositions(identified during literature review), priori issues highlighted in the research questions and interview topic guide and familiarization with the data (1 key informant interview transcript and 5 policy documents review). After embarking on data analysis of both policy documents and key informants 18 themes and 114 codes have been identified.

Data Analysis: Thematic categories, themes emerged and corresponding codes

Thematic Categories	**Themes**	**Codes**
1. Policy Context: Political Economy analysis		
1.1. Global Context and influence	Global norms, discourse and evidence based recommendations (prescriptions)	Health is human right Health is core of social development State lead role

in national policy process		Equity is important value Equity is socially determined Origin of inequity is political Addressing equity is political Healthy Public Policy Health in all policies Sector wide approach Addressing inequity Policy actions
	Deficiency of global norms,discourse and evidence based advice	Equity vs universal Equity action evidence is new thing Less evidence from LIC Policy Actions not context specific Pro Poor vs Geographic Success in addressing inequity scarce.
	Rules, conventions, commitments with regards to equity and health	Human rights Child Right convention Adoption of health for all State political commitment Global Health Partnership

		Global health and development goals SAP and Poverty reduction Plans Global performance based funding
	Global actors' participation in national policy making and the extent of promotion of equity agenda	Internal equity polices of major actors Financing preconditions Financing priorities Equity in cooperation frameworks
1.2. National Political Economy influence on equity policy	Political Causes of inequalities	Historical Legacy Political Party organization Inequitable distribution of resources One size fits all approach in policy Centralized policy making-Top down Constrained regional autonomy Leadership Competency of regions Misplaced equity agenda Accountability Stereotype and bias Political Marginalization Political power of health decision makers

		Context specific policy
	Welfare state architecture	Dominance of pro-rural Egalitarianism in civil and human rights Level of Universalism Generosity of social security arrangements
	Socioeconomic determinants of inequalities	Low access to basic services Poor infrastructure Extreme unhealthy environment Women illiteracy Economic opportunities Wealth, income, and poverty Chronic emergency and food insecurity
	Sociocultural context	Mobile/nomadic lifestyle Dependence on traditional medicine Health seeking behaviour Gender role and role of women Community engagement

	Policy makers perception of inequalities/equity	Disparity in access Variation in utilization Equity and Poor Performance Most vulnerable /marginalized focus Lone Sector agenda
2. Content -Policy design and influence on persistent child health inequity	Policy problem representation	Problem overall acknowledged The degree of inequalities acknowledged Causes of persistent inequalities Explicit refence to determinant of inequalities Multi-Sectoral comprehensive solution considered Recognize the need for non-health sector action Propose alternative solutions
	Policy goals and objectives	Explicit goal on ensuring equity Goal only for universal access Goal for most disadvantaged regions Target set for equity Timeframe for equity target

	Appropriateness of policy interventions for improve living conditions	Early childhood development Coverage and utilization of health care Quality of health care Mothers/girls education Water and sanitation Household income and wealth protection Social safety net (protection)
	Clarity of roles and responsibilities /mandates of agencies specified by sector	Policy design Strategic planning Budgeting Staffing Capacity building Monitoring and supervision Accountability and commitment Coordination and engagement

	Clarity of roles and responsibilities /mandates of agencies specified by level of administration	Federal Regional Woreda (district) Community (kebele)
	Strategy for implementation	Decentralized Tackles barriers to access Tailored to community Promotes utilization Engagement with stakeholders Inter-sectoral collaboration
3. Policy Implementation	Institutional processes	Operational planning Human resources allocation Finance allocation Capacity building Stakeholder engagement
	Implementation Processes – Monitoring and supervision	Indicators Means of verification

		Adequacy of monitoring frequency Responsible body Feedback loop
	Implementation processes and actors (lower level bureaucrats competency and perception	Notion of equity Causes of regional inequalities Appropriate actions within health sector Appropriate actions outside health sector