Multi Stakeholder Partnership to Health Service Delivery in the Context of Developmental State: The Ethiopian Experience

Paper presented at

National Public Administration Conference Addis Ababa, Ethiopia, 21-22 September 2018.

By Hiwot Amare and Trui Steen

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1. Introduction

The challenges facing communities and countries in the twenty–first century are sufficiently complex in scope and scale as to require the involvement of a range of actors with complementary perspectives, expertise and resources (Sullivan & Skelcher, 2002). Therefore, governments in many parts of the world are becoming more collaborative, open and transparent, innovative and inclusive by engaging citizens, communities, NGOs and the private sector in devising and implementing together solutions to society's challenges (UN, 2014). In view of horizontal co-ordination, governments at different levels of government, increasingly engage in partnerships with civil society actors, these partnerships present a new way of organizing collective action. Partnerships include, among others, NGO-government, donor-government, public-community.

Although the need to engage in collaborative efforts between state and non-state actors might not be a new thing for literature, it has especially taken a particular form since the end of 1980s and the beginning of 1990s following the reforms in Public Administration. After 1990s the idea of partnership gained a significant place in public administration and management theory and practice (Gregory, 2003). The concept of partnership has gained tractions as a new form of governance in extensive literature. (Lowndes & Skelcher 1998; Osborne 2000; Sullivan& Skelcher, 2002; Teisman and Klijn, 2002; Sørensen & Torfing, 2005; Johnston, 2015). Consecutively, collaborative efforts are labeled as partnerships, or networks and developed as a practical approach with which to address complex social problems (Benner et al., 2004).

However approaches to partnerships vary greatly across and within nations. Different types of partnerships exist, and their share in the overall creation and production of government services varies too. This is especially related to the fact that partnerships exist in certain environment. For instance, Sørensen &Torfing (2005), argue that the level of political embrace and dependency on partnerships as new governance mechanism differ between countries, scales and policy sectors because of the past political cultures, traditions and institutions of the nations. Pattberg &Widerberg (2014: 30) also confirmed that "Partnerships are embedded in a political and social

context that will influence their chances to thrive". It is very imperative to say that the realization of partnerships as a new form of governance is in fact a highly divergent phenomena across national context.

Partnerships as new form of governance has received increasing attention in various theoretical and empirical studies, though it has not yet investigated thoroughly in different national context. A recent literature provide with the knowledge that the form and application of partnership initiatives is different everywhere (e.g. Greve & Hodge, 2007; Klijn, Edelenbos & Hughes, 2007).This entails us to ask: how far do the organizing, functioning, and the success of partnerships as new governing mechanism relate, among other things to the political context, in which they exist? How partnership as one model of new governance is being utilized in the current national context? Since Ethiopia embraced Democratic Developmental State (DDS) as guiding ideology, in this research we aim to develop knowledge on the organization, process, and outputs of horizontal partnership for co-production in Ethiopian DDS context.

In order to answer the above questions, this research Empirically investigate , how horizontal partnerships with civil society actors (businesses, not-for-profit organizations, NGOs and citizens) are organized, how they operate, and what results they produce. More importantly, the research is interested in identifying the conditions for the successful management of partnerships: what are the conditions for efficiency and effectiveness?

2. Research Questions

The thesis addresses the following core research question: *How do Ethiopia's MSPs organized for health service delivery works in the context of DDS?* , the remaining research questions have been divided into three parts. These correspond to three sequential steps that are followed in answering questions:

Part 1

1. How is MSP for health service delivery characterized from a legal, institutional, and practical perspective?
2. To what extent do the stakeholders in MSPs function collaboratively for health service delivery?

Part 2

3. How do MSPs organized for health service delivery fit in the DS ideology of the Ethiopian government?

4. How does the political condition affect the functioning of MSPs for health service delivery?

Part 3

5. What enabling conditions can be identified for effectiveness and efficiency of MSPs in the Ethiopian health service delivery?

3. Theoretical and Analytical framework

The conceptualization of the study is based on the notion that state and non-state actors, including citizens, collaborate (engage in partnerships) to provide health services. Our focus in this study is to examine the partnership of multi stakeholders (MSPs) for health service delivery in a DDS context. The theoretical part of this thesis surveyed the theoretical discourses on governance, modes of governance and reveled a number of key points. On the basis of these points we build a theoretical framework drawing network governance theory and subsequently apply to the specific cases. For the purpose of this paper, we skip the extensive text on theoretical chapter and present a brief note on network –governance theory and the prepositions in line with the analysis of the theoretical foundations and practical manifestations of DDS.

Network governance as a framework of analysis

In this section, the discussion on network governance is summarized and critically reflected upon in order to contextualize it to the focus of the research. Firstly, networks here are proposed as specific coordination mechanisms through which governance takes place. We first start with the argument that network is a governance mode next to hierarchy and market, as governance network theorists claim that governance networks are a distinctive mechanism of governance providing an alternative to the state and market (Mayntz 1991; Rhodes 1997b; Jessop 2002). Although some see networks as the defining feature of governance, others have distinguished bureaucratic hierarchies, networks and markets as different governance modes. We argue that governance can indeed rely on hierarchy, market and network; but if governance is used to describe the horizontal interdependent relationship between various actors, it implies networks.

Secondly, the defining characteristics of network arrangements are outlines as: interdependency among various actors, interaction through negotiation, institutionalized framework, ability to self–regulate and production of public purpose. If the partnership of actors is regarded as a descriptor

of network phenomena, the above characterization can be used as symbol for the interaction of various actors engaged in partnership arrangements. Therefore, MSPs are here analyzed from a network governance perspective, with a focus on how the different state and non-state actors collaborate for health service delivery. We thus conceptualize MSPs as networks formed by the collaboration of state actors and non-state actors for delivering health services. Therefore, the analysis in the study focuses on the set of actors involved in service delivery and the relations and resource exchanges in which they are involved.

We set forth the following propositions derived from network governance theory:

- MSPs organized for health service are characterized by a relatively stable horizontal articulation of interdependent, but operationally autonomous actors
- Actors in MSPs interact through negotiations
- MSPs as a network of actors take place within a relatively institutionalized framework that is created by interaction of actors
- MSPs are characterized as self-regulating within limits set by external agencies especially state actors and
- MSPs as network of actors contribute to the production of public purpose.

The above listed of propositions is derived from the network governance theory and it helps in answering research question one and two. We assume that this propositions are practically present in Ethiopia but their limited practical presence doesn't imply the total absence of network governance. However, it can only entails that the Ethiopian MSP, as it could be true in other cases, is unique to itself in a way that doesn't totally contradict the basic concept of network governance. In short, these propositions propose an ideal-type that can be used for analytical reasons but that thus not necessarily is completely identical to practice.

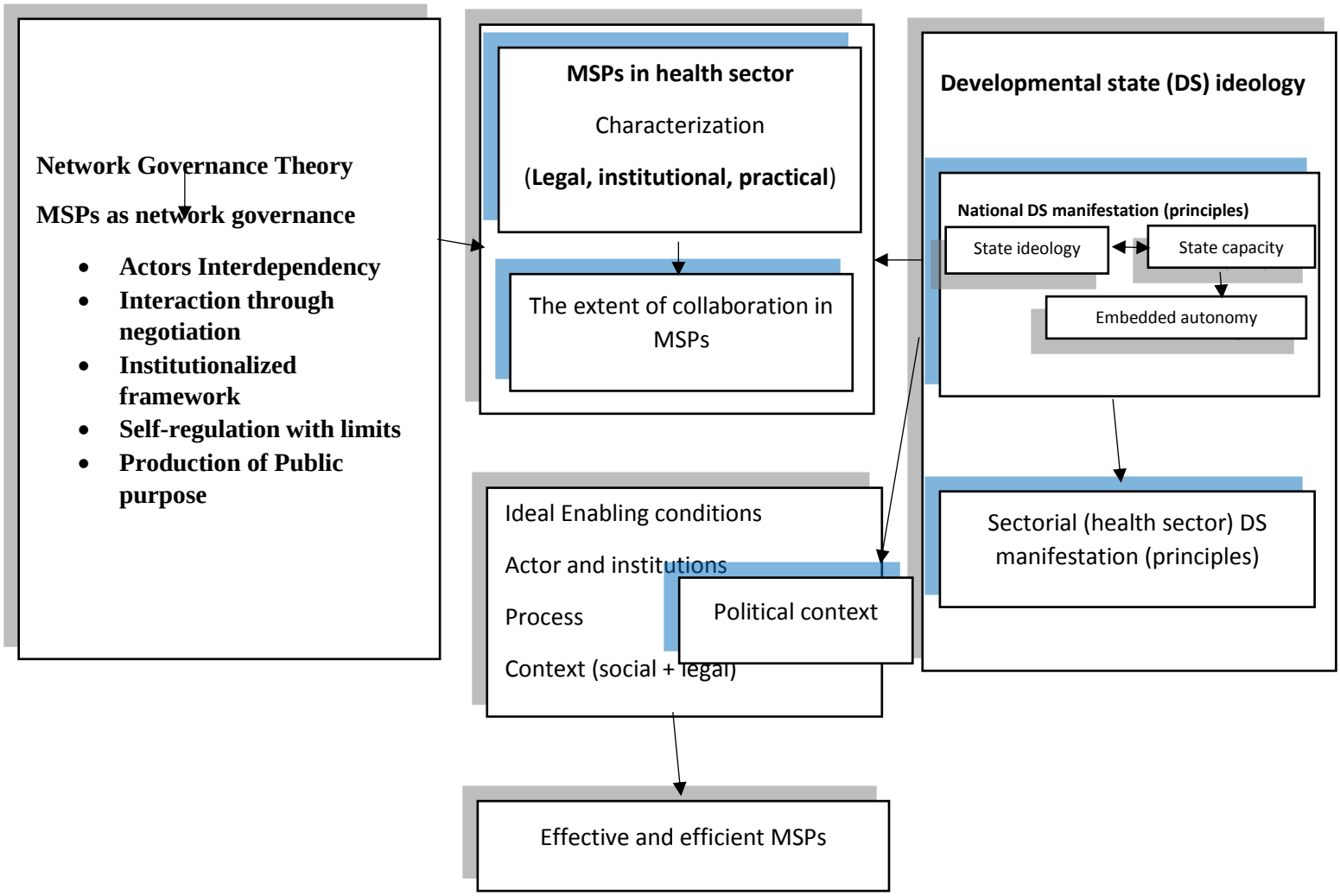
Developmental State

It is difficult to find a commonly agreed upon definition of the DS; rather the discussion revolves around the state as being the key player in development. At its core, the "developmental state" is committed to uplifting economic development. It can be seen as "a state that intervenes and guides the direction and pace of economic development" (Caldentey, 2008; pp.28). Based on the works

of Johnson (1982) and Evans (1995), we understand a DS as a state that possesses the vision/ideology and capacity to bring about the desired development within a specified period of time. While holding the developmental vision, the state strengthens its capacity or structure through two fundamental institutional features called 'autonomy' and 'embeddedness" (Routley, 2012).According to Edigheji (2005), in the context of the DS, state autonomy refers to the existence of state agencies that are coherent and independent and are able to formulate and implement developmental goals. The aim of building a coherent bureaucracy is to block the influence of the various forces outside the bureaucracy that might attempt to capture the state. At the same time, embeddedness entails building co-operative and collaborative relationships with various sectors of society, including the citizenry at large, civil society, and the private for profit sector (Evans, 1995). The combination of the two has its own flavor, what Evans (1995) calls 'embedded autonomy'. On the one hand, the DS is autonomous as it maintains corporate coherence through highly selective meritocratic recruitment and long-term career prospects. On the other hand, the state cannot be too separated from society. Thus, it must also be embedded in society, that is, '[connected to] a concrete set of social ties that binds the state to society and provides institutionalized channels for the continual negotiation and renegotiation of goals and policies' (Evans, 1995: pp.12).

The application of these concepts is, however, different from nation to nation. Authoritarian DS's are found to ignore or even suppress interest-group demands, in order to sustain their necessary bureaucratic autonomy (Wade, 1990; Vu, 2007). After the mid-1990s, scholars (e.g., Evans, 2010a; Hochstetler & Tranjan, 2013; Leftwich, 2010; White, 1998, 2006) suggested the concept of Democratic Developmental State (DDS), rejecting the idea that developmentalism and authoritarianism are synonymous. The concept of DDS has attracted the attention of policy makers in many countries, especially for African states which were in need of economic growth, the DDS became an alternative bridge towards socio-economic transformation. For a DDS to succeed, government needs to be well organized and possess all the capacity to plan and regulate society and institutions (Wade 2003). A 'true' DDS must have the capacity to mobilize and coordinate the resources and skills of its social partners toward the realization of common goals (Marks et al., 2011).

Figure 1: Analytical framework



Source: own construction

4. Case Selection

The Ethiopian Health Sector

The choice of the Ethiopian health sector as the main study domain can be attached to different reasons. First, following the 1991 reform in Ethiopia, the new Government of Ethiopia developed a first national health policy which gives a sound direction for the involvement of stakeholders in the health sector. We believe that it is reasonable to study a sector that officially put partnership as a direction in its policy document. Second, unlike other sectors, the Ethiopian health sector is characterized by the involvement of a wide variety of NGO's, Civil Society Organizations (CSOs) both national and international. "Rapid expansion of the private for profit and NGO sectors is augmenting the public, private and NGO partnership for health and boosting health service coverage and utilisation." (FMOH, 2010:4).We, therefore, believe that adequate involvement of non-state actors in the health sector can be used as an opportunity to select the cases. In addition to focusing on the health sector of Ethiopia, the study will focus on a specific program of the sector, which is maternal and child health. Thus, the focus of the research is on MSPs that are organized for working on maternal and child health. Since the Ethiopian health sector is broad and involves various programs, concentrating only on maternal and child health will make the study to be more focused and manageable.

In this paper, the units of analysis are the different multi stakeholder partnerships organized for health service delivery. Based on the multiple cases method we select three cases. Although there are limitations to the generalizability of findings based on three case studies, given the level and history of MSPs functioning in Ethiopia, we believe that three in-depth case studies will give a chance to show the picture of partnerships in Ethiopia and provide the necessary information. We also expect three cases can provide the appropriate level of information within my time, budget and research objective framework.

Selection criteria for Multi-stakeholder partnerships

Selecting three relevant cases for the study requires the screening or mapping of potential cases. In our cases, it requires identifying working multi-stakeholder partnerships as cases, based on previously determined attributes or operational criteria. Thus, we propose the following criteria;

- MSPs that are organized for health service delivery;
- MSPs working on maternal and child health;
- MSPs organized with civil society (private sector, not-for-profit NGO and CSO, citizen participation for the purpose of providing and supporting services in the health sector. MSPs preferably involves three types of actors, private, public and civil, with at least one public sector representative and at least one civil society representative. But I target to select MSPs that involve a maximum of actors as it gives me a chance to see their complex interaction patterns and different perspectives on the issues that will be raised.
- MSPs that is initiated at local, regional or federal level;
- The MSPs must be functioning for at least 1 year, before January 2016 (the starting time of the empirical research) and must at least (plan to) continue until five months in the future.

Although the cases might fulfil the above general requirements, we assume that the MSPs in the Ethiopian health sector are diverse in type and level of engagement, implementation modality, and effectiveness. Hence, depending on the availability of the cases, we will try to select diverse cases in terms of the actors' structural and practical engagement. Studying diverse cases helps to capture a fuller picture of partnership nature in health sector, and hence in meeting the first research question, which is characterizing MSPs s organized for health service delivery. Moreover, such diverse cases will help me explore the challenges in comparative terms. However, in order to categorize the cases in terms of their difference, and select from different categories, we conduct a detailed preliminary research that take place at the beginning of the field work in Ethiopia. Guided by the analysis of the preliminary data and consecutive field work between august 2015 and January 2016 in Ethiopia, we purposely select three cases. Since we get the impression from our preliminary analysis that partnerships are a newly emerging phenomenon in Ethiopia, it is difficult if not impossible to identify a well-developed MSPs in the actual conceptual and theoretical sense of the term. Therefore, we made a careful analysis of each organization's website, contacted the organizations in physical, phone and email to select cases with the maximum number

of actors and that most resemble our definition of MSPs. In that connection, we use purposive sampling to select the three MSPs that actively engaged in maternal and child health.

5. Case Analysis: Case Study of the MSP at Tarmaber District in Ethiopia

In this section we provide the case analysis for one of the case study conducted in the field work followed by a presentation of key findings and conclusion. This chapter is devoted to empirically discuss one of the multi stakeholder partnerships for health service delivery at local level through a profound examination of the interactions between state and non-state actors at local level. The chapter consists of two major sections. Section one discusses the overall functioning of the MSP for health service delivery. Section two of the chapter deals with how the MSP fits and functions within the current political ideology of the incumbent government.

The Overall Functioning of the MSP at Tarmaber District

Ethiopia as many of the developing countries is struggling to ensure access to basic health services for large proportion of its rural poor citizens. These efforts are shared by the different government tiers in the structure of the government from federal to regional to local. Despite some improvements in the health sector, various problems reside in the society that need a joint effort. For instance, according to the UNDP Human Development Report, Ethiopia is a country where 353 women die from pregnancy-related causes for every 100,000 live births (UNDP, 2015). Therefore, health in general in Ethiopia and maternal and child health in particular require the contribution of various actors. Following this, health service delivery in Ethiopia takes place through an array of state and non-state networks.

AMREF Health Africa (also known as African Medical and Research Foundation) is an international health development organization based in Africa that works with diverse actors - including local NGOs, and government agencies – to create and strengthen local programs for ensuring access to health services. AMREF took the initiative to bring a specific program named Maternal, Neonatal and Child Health Care (MNCH) to the region studied. This Amref MNCH project aims to improve sexual and reproductive, maternal, neonatal and child health status of the people in the project's area. Starting from 2014, the program became the main focal area in the

North Shewa Zone. Amref takes an integrated approach toward maternal and child health care, combining this with Sexual and Reproductive Health (SRH). As a result, joint activities incorporating different partners are directed toward this initiative. These activities include strengthening the functional level of health facilities, building the capacity of the health system, especially at district level, building the capacity of health workers, and mobilizing community demand and ownership over maternal and child health care interventions. Most of these activities take place at district level and sub-district level where health centers are located.

Next to Amref, the project involves both state and non-state actors. Especially, regional government institutions at zonal and district level involved, assuming different roles. At zonal[1] level, the Zone Office of Economic and Development (ZOFED), the Zonal Health Department, and the Women and Children Affairs Department signed an agreement with Amref representing state and later on they assume the role of supervising the project. At district level, the district administration, the District Health Office, the District Economic and Development Office and the Women and Children Office are involved in the project. Amref as initiator and major NGO in the project also created an alliance with three local NGOs that joined in implementing the project, namely Talent Youth Association (TYA), Youth Network for Sustainable Development (YNSD) and Family Guidance Association (FGA).

It is on the district level that all actors are pulled together and work together in practical matters. The project activities are also extended to the sub-district (Kebele) level where the health centers and health posts are located. The major state partners are all health offices at different levels from region to zone to district. Yet, the district office has a strong role in the partnership at it is placed at the core of the partnership and mobilizes the available health institutions and actors within the state structure. Amref doesn't only want to create the partnership with organized institutions, but it wants to engage with others also. Working with state agents such as Health Extension Workers (HEW) and community volunteers (e.g., the Health Development Army (HDA)) was key to this. In the past few years the Ethiopian government invested in designing and installing a health service delivery structure with resilient focus on Health Extension Programs (HEP). The program has been implemented through the active and dedicated role of actors, including the HEWs and HDA. Both

[1] Zone is a local government tier in between region and up district

HEW and HDA are involved in the project activities. Generally, the partnership engages both state and non-state actors tied by formal agreement and in every possible way.

Having described the partners involved in the MSP under study, we next describe the overall functioning of this MSP by referring to interdependency between actors, interaction, institutional structure, self–regulation, and the extent to which the MSP results in the production of public purpose**.**

Interdependency of Actors in the MSP

A number of interdependent actors participate in Amref-RMNCH project. With differing missions and resources, the project helps organizations to come together and work on various health issues that are prevalent in Tarmaber district. The instigation of the project as network form implies the mutual dependencies of the organizations because of the division of resources and the interdependency of goals.

According to our respondents, there is an explicit interdependency among actors working in the project that is mainly attributed to the fact that all actors included in the partnership bring resources and specific competencies that can be a certain value to other actors. For example, Family Guidance Association (FGA), is more experienced in reproductive health service provisions with extensive health facilities and model clinics, which can be more valuable in connection to reproductive health activities. TAYA, a local NGO, has good experience in youth-related works, so it focuses on youth focus intervention services. Amref, as a lead NGO, primarily focuses on resource mobilization, negotiating with donors and to bring international experience. Actors in the partnership bring important resources that range from material to human to financial to the collaboration. It was evident during the project activities that the state actors possesses important resources and expertise that the project requires, such as infrastructures, human resources(professionals), and even some resources that are difficult to be possessed by the non–sate actors like information, authority to permit. In addition to some unique competencies and expert knowledge, non-state actors bring various resources to the collaboration, including materials, supplies, money, time and information.

Interviewees recognize that there is a need to find a way to pool fragmented resources and competencies from various sources. This is especially emphasized from state respondents where

they point out that there are resource constraints that require joint actions. For instance, respondent SR9 points out that

"From the government side, the annual budget allocated for health is not enough to execute activities, 15% of the district budget is supposed to be allocated for health, but we can't even get 10 percent, so we still need support from partners."

In fact, while their statements support the overt reality of the country, they specifically show the gaps in their district. Specifically, in the health centers there are shortages of medical supplies, medical equipment, inadequate infrastructure, and most importantly there is clear limitation on professional knowledge, skills and capacity needed to address varied reproductive, maternal and child health issues in the district. With its overstretched capacity, state lacks resources and necessary competencies to provide services and bring the desired change in health within a short period of time. The other actors also confirm that they require a certain competencies from other actors, the international NGO respondent (NSR2) explained that its organization seeks the local knowledge and specific expertise of the other local NGOs, the facilitating role of the state, and the collaborative effort of the agents and community groups. Other non-state respondents (NSR3, NSR4) respond that their organization wants international experiences from the international NGO. In this sense, the Amref RMNCH collaborative interactions are purposive to the extent that actors with varying resources and competencies are collected to work together to deliver the health services.

In Amref-RMNCH project , actors had a chance to bound their interaction through reciprocal actions to realize their respective mission as perceived In governance networks, actors' mutual interdependency is expected as there is a division of resources and interdependency of goals (Lee, 2003). Respondents explicitly recognized the reciprocal actions involved in the process. Some of the local NGOs are asked to join the Amref RMNCH project because their mission areas are tangibly relate to reproductive and maternal health, and because there is an identified need for a particular expertise. In general, district officials welcomed the Amref-initiated project as it aligned with their objective. The majority of interviewees indicated that they perceive their own organizational goals to be furthered by establishing partnerships with other organizations on health issues. However, collaboration occurs between partners implementing the activities related to

maternal and child health because it is impossible for each partner to function filled with complex problems without partnering with other. A State respondent (SR) specify that;

"There are a lot of problems in our district that require a lot of expertise and resources because of the fact that neither the state organ nor non-state organ has sufficient capabilities and expertise to address the complex and broad range of problems in health."

Throughout the partnership process, strong cooperation is required between both non-state actors and state actors at different levels; from district administration to local health centers professionals to implement the partnership activities. The project activities would not be realized if the state actors do not facilitate the ground for non-state actors participation; and in turn, without the program, the state could not effectively help mothers to deliver children at health center level, both due to the lack of basic health delivery instruments and supplies (provided for free by Amref) and its lack of trained professionals (provided by a FGA in collaboration with Amref). Hence, there is visible interdependency in Amref-RMNCH project among actors working together for health service delivery. We had also the chance to observe the resources mobilized in the Tarmaber District. In the Armenia Health Center, which is one of the sub-district health center, there were various materials supplied by Amref. Among others oxygen unit and vacuum were very essential in assisted delivery of pregnant women. Immaterial resources are also transferred in the form of training for the health professionals. Midwiferies in the health center receive training that equips them to perform some health procedures for the society. This suggest that the participants are pooled together based on the specializations needed to carry out the project's wide array of activities. MSPs as a form of network can be important vehicles for resource pooling, mutual exploration, and knowledge creation (Agranoff, 2006). Most importantly, they can open up new possibilities that would be hard for one, two, or even three organizations working together to achieve.

An additional form of interdependency can be created when networks are able to pool actors who can demonstrate that they have a stake on the issue at hand. Interdependency is confirmed in the stakeholders' acknowledged, shared mission and objectives concerning health and health-related issues and their determination to decrease maternal and child health. Health is one of the most

important focus areas in Ethiopia and state demonstrated this by taking the responsibility to lead the activities of health at all levels. The non-state actors involved in the partnership demonstrate that they have a mission to shoulder the problems of the society through their commitment and long-standing effort in the community. This element of interdependency is also well reflected in our case related to HDA and HEW. Respondents from both groups clearly stipulated that they have a stake on health issues. Respondent (SR4) puts it as follows:

"……, at least for alleviating mothers and children deaths everyone and every segment of the society has the responsibility. I can say everyone shares the same value and the responsibilities are shared at each level of the society whether you say it at Kebele (sub-woreda) level, or community group arrangement level."

As we observed, HDA as community group serves the community without any incentives as they understand they have a stake on the issue and want to contribute something of value to the collaboration effort.

Interaction through negotiation

Negotiating at the start of the MSP

International and national non-state actor can only form a partnership with state institutions by navigating the federal agencies or regional legal and administrative processes. They are first required to be legally registered and certified and also to enter into a general agreement with a relevant agency to which they have to periodically report. They are required to prepare a proposal, there is a proposal evaluation team at both the federal and regional level which is responsible for evaluating the proposals before non-state actors sign any agreement. A team of experts evaluate the proposal and identify gaps that are open for negotiation with non-state actors. As the respondent from the FMOH, (SR1) and a member of the proposal evaluation team explained, the government puts its own criteria to evaluate the proposals that come from non-state actors, and they only accept those proposals that match strategies, priority areas and interest put forward by the government. Finally, the team will call back the non-state actors and negotiate on areas that they can amend and work on together. According to the state representatives at federal level (SR2), the proposal

evaluation system set by state provide give an opportunity for negotiation in the sense that state representatives at federal and regional level focused on continues communication, and discussion with non-state actors instead of merely taking decision. However, a respondent from non-state actors (NSR1) explained that at the federal and regional level these negotiations are subject to subjugation. First, all civil society organizations are expected to work on state's agenda, and prepare proposals based on state programs and strategies. Thus the negotiation circulate around the details of the program not on the overall program areas. Second, sometimes the negotiation takes place with framework that hinder understanding and joint action. This usually happen as public authorities focus on strict formalities and administrative issues rather than the real significance and benefits of the joint action. For instance, at the start of the Amref-RMNCH project, a there were briefing on project activities and negotiation at regional health office. The regional office demand for Amref to take out the name and responsibilities of other local NGOs from the proposal as they want to make an agreement with Amref independently. Although, the regional office is well aware of the fact that at local level the operation take place with the involvement of all actors, it only want to make an agreement with Amref as it want to make Amref a sole responsible over resource distribution .With no common consensus, Amref agreed and took the alliances and make an agreement with regional helath office.

However, we were able to observe that government negotiate with non-state actors with its own terms and conditions while non-state actors also come up with the gap that are already pre-identified by government. Hence, often times the negotiation outcomes are in favor of both sides. Even if they are not happy, decisions will often be made on the basis of a "rough consensus" where grievances are unavoidable, but tolerable.

In general, formal agreement was used within this partnership to establish a clear division of roles and responsibilities among the signing actors. As described in the introduction, Amref as a lead agency signs an agreement with regional government and designated with roles and responsibilities specified in a MOU .However, much discretion is left to the local state agencies and non-state actors to determine an action plan to transform the proposal into activities. Though state actors here seems the one to put the ground for play, but their dependency on the other actors induce them to negotiate with other actors to attain the resources needed to achieve health related

goals. The non-state actors are also willing to negotiate as they are dependent on the others for accomplishing their goal.

Negotiating during the implementation of project

Negotiations also occur when non-state actors go down to the local level and work with state actors at a practical level. The negotiation here is actually different from what happens at federal or regional level. Actors here negotiate on the magnitude, nature, time and modalities of activities' implementation in the community. Hence, unlike the negotiation at the federal level which can be characterized as a "take it or leave it" negotiation, at local level negotiations end up in relative consensus. This is basically because government actors at local level accept that, on the one hand, non-state actors already passed the criteria at the federal or regional level and, on the other hand, as state actors they need the non-state actors' support. For example, both state and non-state actors (SR7 and NSR2) explained how they executed a given activity through negotiation within the project. The goal of the activity was to provide customer friendly services at different health centers. Amref, FGA and Woreda health office, which was representing the state, sit together and negotiate on different issues, like which and how many health centers to include, or which activities to finish first. Each actor has its own expertise and responsibilities to execute. Amref was assigned to furnish the centers, renovate the service provision areas and supply materials and equipment. FGA's task was to train the health professionals in the health centers, and the state actor was expected to facilitate and coordinate the whole implementation process. At the end, they managed their negotiation and executed the activities in sequence and on time. Unlike the negotiation at regional level, this take pace in wider framework of deliberation that facilitate understanding and many respondents confirmed that the negation helps them to identify their roles, responsibilities and obligation.

In comparison with regular-often authoritative and command – interaction that occur in state institutions, interaction procedures in the Amref project was, according to respondents characterized by discussion. All Respondents acknowledge that, whenever they face some issue that requires negotiation in their joint activities, they engaged in discussion, reached an agreement, and afterward executed the decision with the sense that they are fulfilling their responsibility. Though most respondents acknowledged there is a room for negotiation and reaching an

agreement, some of the respondents from non-state actors take an extra caution in their negotiation with state actors as they don't want to damage their smooth relation afterward. A respondent from NGO (NRS2) stressed:

> *"When we face something that requires negotiation with others, we are very systematic, and we usually come with some ideas in our mind which could possibly satisfy the interest of state actors while maintaining our interest. Otherwise we wouldn't agree on the issue and later on, our relationship would be spoiled"*

Hence their caution in negotiation and thereby compliance to the decision does not come from fear of legal sanction. Rather they comply with the decision in order to avoid unnecessary problems with state actors. In doing so, non-state actors internalize the government system and regulations which indirectly help them to play the rule of the game.

Institutional Setting

The interaction of actors in MSP takes place in specific institutional setting that involves social interaction and formal rues. Both formal and informal agreements provide the institutional setting for the MSP involves while specifying the roles and responsibilities of the actors.

Regulatory framework: Memorandum of Understanding and an action plan

The interaction and negotiations of actors in Amref project take place within institutionalized framework. The institutional setting for actors involved in MSP can be established when state and non-state actors enter into a formal agreement. In the case study, Amref as lead NGO signed a Memorandum of Understanding (MOU) with federal, regional and zonal state authority. The MOU provides the framework for the working relationship between the parties by specifying actors' "duties and responsibilities". Hence, for the partnership the first layer of the framework comes from the agreement with the federal and regional government. After signing the MOU, the project proposal and accompanying documents are sent to the district level. Even if district government has the jurisdiction to accept or reject an intervention, it cannot authorize non-state actors' intervention without higher authority's approval. All interviewees mention that the MOU is used to formalize relationships between participants and later it is used by state agencies as a basis to monitor the activities. All stakeholders in the MSP indicate that there are formal meeting opportunities involving all actors. They meet and conduct the mid mid-term and terminal

evaluation regularly, sometimes they even go to the project sites. There is also GO-NGO forum at district level organized by state institutions. This forum serves as an evaluation stage for the project. However, it seems that stakeholders give more attention to communication and discussions that are held in the MSP when the need arises.

The second binding agreement between actors comes at district level when actors sit and develop an action plan based on the proposal presented at higher level. A document containing the action plan and program details is send to each stakeholder involved in the project and later on it is used to evaluate the activities. The program document stipulates each actor's activity, role and responsibility, and the timetable for executing the activities. The MSP is functioning in a stipulated regulatory framework that provides roles and procedures for overall interaction of actors in the MSP.

The partnership involve regulatory aspect of the institutional framework through the utilization of MOU and action plans. This in turn leads to the emergency of rules that regulate the behavior of actors and facilitate interaction with in the partnerships. Such rules are relevant as they facilitate interaction in networks, thus reducing transaction costs and influencing the performance of networks (Ostrom, 1986; Koppenjan and Klijn, 2004).

Administrative structure of the MSP

When actors agree to work together in MSP, they enter a network-based form of cooperation which significantly differs from the usual top-down working style of local government. In executing their activities, actors may follow different forms of structure, which give an institutional frame for their activity. According to Bryson et al. (2006), actors in network type of relation realize their activities in varying forms: (1) by self-government in regular meetings; (2) a formal coordinating organization in the network; or (3) an administrative organization, which is supporting the network in technical matters.

In our case, we can see the administrative structure of the network at two levels. First, the organized non-state actors created two project groups/committees, namely a technical committee and a steering committee. The project's steering committee is designed to include all partner organizations' representatives and meet four times a year. As respondents explained, the committee does not meet per schedule. The committee discusses administrative issues, donor

questions and solves pressing problems. The technical team is designed to include organizations representatives that are close to the technical works of the project and meets every month to review technical issues at implementation level. Generally, it is a platform for the actors to trace the project progress, exchange information and plan activities together.

Second, MSPs as a network involve the deployment of a coordinating organization to regulate activities. The position of the BoFED in the MSP merits attention. When the office signs an agreement with the non-state actors as partner, it is guaranteeing its formal coordinating role in the partnership. The current administrative structure of the country provides the finance, economic and development offices at different level of the state structure with the responsibility to coordinate, and control the budget utilization of collaboration activities. The assignment of such coordinating organization in MSPs shows that extensive controlling and coordinating responsibilities are completely monopolized by the state.

Among other, the institutional setting of the Amref MNCH project involves funding. All respondent from non-state mention the use of grant contract to formalize relationships between participants. Amref as a lead organization brings the funds from international donors and it is the only source of financial resources within the MSP. Amref acts as a donor in its relation with the other non-state actors and their relation is characterized as a grantee and sub-grantee. They have a common document that guide their relation called sub-partners/grantees management guideline. The document outlines guiding principles on how to work, at what level they should engage and how to utilize funds. A respondent (NSR2) from Amref stated;

"*The allocation of funds through sub-grantee to local NGOs are used to support activities that directly complement the project, and basically roles to sustain relationships are determined by stipulations within the grant contract document*."

On the other hand, state actors assume the role of controlling budget utilization of the project. When an agreement signed at the start of the project, Amref preset the activities and budget planning and BoFED as coordinating state actor takes the responsibility to monitor the utilization of the budget according to the activities.

Communication as informal agreement

In addition to the formal agreements, informal agreements are also used in forming the institutional setting for the MSP. In service delivery projects that involve various stakeholders, there is always a need for communication and many communication patterns can emerge between actors in the project. We found that actors built a strong bond and that they tend to rely on phone, email communication or by seeing each other in the field. A respondent from the district office indicated (SR2):

"Our works are interdependent; we read and communicate each other to execute the activities in sequence and on time. We make desk review, we sit together and discuss, plus we use email, we have also frequent day to day communication on phone."

Other interviewees suggested that there is a strong bond in the project that bring them to consider each other as a friend. Beyond contract stipulation, actors are able to execute their responsibilities through dialogue, and good relationship. Such communications patterns are significant because non-state actors are able to avoid the regular – often bureaucratic – communication procedure followed by the Ethiopian state institutions.

The level of self-regulation within MSP

The state structure is devolved as involving different levels of government that are related in a chain of command but partnerships are formed aiming to work differently from the state structure. As described in the case study, the formal agreement of actors in the partnership is specified in the MOU with no party is identified as lead organization in the partnership rather both parties are identified with related obligations for project implementation. However, much discretion is left up to the non-state actors and local state actors where the project is implemented to determine a details of activities and complex negotiation involved to move forward. This in turn give a chance for interdependent actors in the Amref-RMNCH project to bring their ideas, resources and innovation to production of services. For example, quality improvement initiative were implemented in one

of the health center as part of the whole project. Though the initiative was applied as a pilot program, it was found successful and there is an effort to scale up to various health centers.

According to the participants of the MSP, a program document is prepared at the start of the project that illustrate each actors' ideas, resources and capabilities and is used in directing their activities afterwards. The program documents serve as an action plan and it portrays activities to be performed, time period for executing and responsible partner for the activities. Actors in the MSP are executing their agreed-on activities within the institutional framework they established through regular interaction. This helps them to use their own ideas, resources and capabilities to regulate the production of services in the project rather than receiving order through the chain of command. Thus, there is less chance for the MSP to go into the formal chain of command and lose its self-regulation completely. This shows that the MSP is able to retain some form of closedness, which according to van Bortel (2009: pp.171) "enables organizations to retain their focus and incorporate only a limited amount of the complexity and environmental turbulence into their activities. Closedness is often the result of the power and autonomy of the actor(s) involved." From the perspective of executing activities, the partnership is self-regulating; it is working in accordance with the agreed plan. The establishment of this formal arrangement for executing activities creates opportunities for participants to identify ways to provide health services using a holistic approach. Interviewees recognize the collaborative arrangement as a way to execute the activities on Tarmaber district through a network approach. Discussion during focus group discussion reveled that each partner addresses the piece of activities assigned, and each piece of activities impacts the larger health stsym.it was evident during the interviewees that participants feel personally connected to the work they do and care about the project.

However, the MSP is not able to retain its self-regulation completely as it involves a complex interaction between state and non–state institution in a certain environment. First, the operating environment at different levels is filled with state actors that regulate the partnership. For instance, RHB and Zonal health department supervise the progress of the project and regulate actors' activities. They control and follow up the implementation of activities at local level by means of reports, evaluation protocol and sometimes field visits. Therefore, state actors are acting as a

partner and as a regulatory body in the network which affects the self–regulating capacity of the network.

Even at local level, where there exists a close collaboration and daily interaction, state actors have a tendency to put pressure on the partnership; as one of the respondent from the district administration (SR9) said:

"*At district level, we follow those non–state actors that come to work in our district and we control them and take action if necessary. For example, if they are building a health center, they put the fund on our finance account, and then they are expected to justify their expenditure, and the district engineers follow the construction, we also give feedback. If we find the construction under standard, we abolish it."*

This finding aligns with the idea put forward by Agranoff (2006) that networks can sometimes deliberate new strategies and programs, but in many networks, government administrators at all levels present themselves as a core actor and they use their position to inject legislative, regulatory and financial consideration into the network mix.

Second, MSP participants indicated that state exerted effort to put into place a regulatory structure at different level of the state structure that sets strong accountability measures for collective actions. As one of the state actor specifies it (SR1)

"In *order to check whether the activities are going in accordance to the rules and agreement, government has set controlling department in every level of the government structure. So the department controls whether the project is going on as agreed on, benefiting society as it was designed and if there is a problem, efforts will be made to correct it in the middle. Finally, with all stakeholders' presence, the activities will be evaluated.*"

More specifically, the partnership is accountable to BoFED and district administrative council. Both state institutions monitor the performance of the partnership. Thus, the self-regulation of the MSP is limited by the accountability measures set by the state. One of the important concepts in self-regulation is how accountability measures can erode autonomy (Hodgson, 2004). Given the accountability measures set by the state, state and non-state actors in the MSP are not autonomous from the state. This finding typically coincides with Johnston's (2015) finding that the state, although a participant in networks, plays a dominant role in governance networks.

Production of Public Purpose

In any type of collaborative arrangement, the engagement of actors towards production of public purpose requires a common understanding about the issue that pools them together and the shared purpose among the actors. Shared understanding of the issue is a vital value that all stakeholders in the MSP have to create (Poocharoen & Ting, 2015) as it helps to avoid "miscommunication and misdirection of efforts" (Ansell and Gash 2007). All participants in the MSP hold a common understanding which is about creating a healthy society more specifically to decrease maternal and child mortality rate. This is especially significant given the fact that Ethiopia is a developing country dealing with many health problems. Mobilization of resources and networks towards this cause is of national interest. To that end the joint contribution of state and non-state actors in the sector in general, and in maternal health in particular, is exemplary. One of the factors that can create harmony is a common understanding about the issue at hand, and all respondents show the same idea of the nobleness of the cause for which they are working.

It was evident during our discussion that all actors perceive that the partnership is contributing to the production of health services that can help in alleviating the health problems. However, little evidences presented that could attach the partnership with the production of polices and values that can extend more than the immediate need of the society. Though all respondents try to assure that the partnership is a good forum that has been helpful in bringing solution to the current pressing problems, it seems that they have less agreement on specific objectives they aim to achieve in practice beyond tackling the maternal and child health problems. This mainly concern the state actors as most of them perceive that the current collaboration is meant to fill the current gaps and solve problems. This is well described by one of the expert from district health office (SR7);

"Focusing on current problems and filling the gaps often times marginalize other issues, most importantly it prevents us from realizing the full potential of the NGOs."

On the other hand non-state actors are content how the project is helping them in developing their capacity.

There are some examples that the interaction of state and non-state actors in collaboration setting could help to produce public purpose beyond the stated goals and this is in especially found relevant for state institutions in Amref-RMNCH project. For example, societal actors may demonstrate new ways of conducting activities at local level which are difficult for state agencies (Clark, 1995).This in turn helps them to document their experience and share this with state actors which could be used as input in policy formulation. One way to share experience at local level is through a government–NGO (GONGO) forum. Such a forum is organized by BoFED and gives opportunity for both non-state and state actors meet and share experiences. The non-state actors found this forum important to create awareness in government of the effects of the health policy on the different sections of population. An important aspect of the horizontal relation of multiple actors in networks was the enhancement need for negotiation and discussion. This involves brining new ideas and applying different mechanisms. Respondent indicated that the Amref-RMNCH project allowed the incorporation of ideas and new initiatives this is significant because it helps for creation of understanding and values. Thus, the practices in partnership could be a good opportunity input for local state institutions to acquire flexibility as compared to the traditional strict command rule.

Despite the existence of this shared purpose, some respondents raise the short life of the partnerships as a problem that affects their effort toward production of public purpose. The fact that the partnerships are mostly project-based poses a question of reliability and sustainability of engagement towards continued progress in the sector. Moreover, state actors in the area also believe that networks and partnerships are not governance systems upheld at a policy level to exist across times. State respondents argue that non-state actors' role will no more be needed when the government is capable to deliver all health services by itself.

Effects of Political Ideology on the Function of MSP

In this sub-topic, we deal with how the MSP is functioning within the context of the current political ideology. We try to answer our research question "how do MSPs organized for health service delivery fit with the DS ideology of the Ethiopian government?" To answer the question, we investigate how DS principles manifest in the health service delivery and particularly discuss

how the MSP as a governance network fits in the DS ideology. We support this analysis with data from the interview and secondary document.

MSP in DDS Context; Developmental role, state autonomy and embeddedness

A dominant role of state in development

At national level, health is now one of the very critical development endeavors of the state and this mainly manifests itself through a substantial increment of investment in the health sector over the past two decades (FMOH, 2014), well-developed strategic plans, and programs that are part of the broader national development plans. The central role of healthcare in improving the economic and social wellbeing of the citizens is widely recognized in different national development plans. Pursuing economic and social expansion, the state articulated long-term development strategies such as the Sustainable Development for Poverty Reduction Program, the Plan for Accelerated and Sustained Development to End Poverty, and the Growth and Transformation Plan. These multilayer plans together with sector documents like the Health Sector Development Programs paved the way for the development of different programs in the health sector.

Our case illustrate that various state institutions at regional and local level are willing to work in cooperation with non-state actors. Regional and zonal authorities sign MOU with Amref that will allow the implementation the program at district level. At the start of the partnership, these institutions develop proposal with Amref as they found it important to incorporate their need and interest. Local state institutions also show willingness to work collaboratively while incorporating other societal actors situated within the district and developing a detail plan for the project. Multiple state actors and officials at district level indicated that they perceive state helath goals to be furthered by establishing cooperation with other actors. Like the rest of Ethiopian districts, the Tarmaber district possesses a service provision system that is attached to state bureaucracy. However, resource constraints in addressing basic services push local administrators to open up their service domain to non-state actors. The district administration gives extra attention to partners who fill the gaps in the annual health service delivery plan and align with the priority health care intervention areas. This is in line with the nation's direction that sees the role of civil society consisting of 'policy implementation and filling of gaps in services' (Connolly, 2007, p. 16 cited by (Stel & Abate, 2014). Likewise, when Amref first brought the initiative to the district, it was

well accepted by the district administration as the project was designed to fill gaps in the district. All the respondents agreed that the MSP is well recognized for filling gaps in service at the district while mobilizing different actors with expertise and knowledge that are very essential for the service delivery.

However, both state and non–state actors in the MSP recognized that state is the major service provider. In most discussions, respondents representing non-state organizations in the partnership identify their role as a supporter since the line share for policy formulation and delivery is controlled by state institutions. Moreover they are not allowed to come with their own program or strategy; state actors reflected that the role of state in leading the development is irreplaceable. For instance, most of the state actors in the MSP believed that the only reason that pushes state to work with non–state actors is its resource inadequacy and that without resource constraints there is no need for the involvement of non-state actors in public services which could possibly be covered by state independently. However, we found this argument deviate from the party stand. At the party level that DDS is viewed as transition phase to pure liberal policy and eventually Ethiopia will follow liberal policies when the market is adjusted (EPRDF, 2010). The creation of a market-based economy pushed by the developmental state is presented as the way forward. In discussion with the politicians and experts they assured that DS and liberalism do not completely contradict each other. Even there is a chance in Ethiopia for networks and partnership to flourish more in the future. But, at local level we get the impression that state actors perceive non-actors will have no place in the future. This may be related to the fact that at the in the early age of DDS in Ethiopia, there were a direct attack on civil society organizations, especially NGOs as a liberal outcome. State actors and state agencies were socialized to treat NGOs as potential threats. Taking the non-state actors perception towards collaboration, one can judge the dominant role of state in health development stands as a valued principle among state actors. This kind of understanding among the actors comes as they base their understanding on the basic principles of DS ideology that there is the need for the national government to stay in control of the public policy and to be able to influence the economy and society.

Interviews (NSR1, NSR3) from non-state actors recognize their partnerships with state actors as executing government strategies and programs. But, it seems that all non- state actors are in agreement with the current arrangement at least in practice. When the Amref project was initiated

all actors are aware of the contexts and agreed to work with state institutions and they confirmed that their goals and missions are tangible with what the government put as a strategies. Even in focus group discussion, non-state actors confirmed that no organization compromise its missions or goals to enter to these project , as their all share the goal to alleviate the health problems in Ethiopia especially maternal and child health problems . Hence, the project operations appear to run smoothly with common understanding.

Basically attributing to the DS ideology, the health sector is one of the sectors that demonstrates the extensive role of the government. Among other issues, maternal and child health get the most attention in past few years. Opening the service domain to those partnerships that contribute towards maternal and child health issues shows state's desire for the production of tangible results throughout the country. The Tarmaber MSP work on maternal and child health which is now the very critical priority of local administration. Respondents recognized the crucial role of the MSP in bringing change in maternal and child health. A health professional in one of the district health center (SR5) stressed that:

In addition to strengthening the already existing limited services, the MSP made available new services, provided materials and health equipment that are critically essential but may not be found at district level under normal circumstance. These in turn radically transformed the services provided to the community and it is contributing to decreasing maternal and child health problems in the district.

State autonomy

State autonomy is presented as one of the features of the Ethiopian DDS. According to the late prime minster Meles Zenawi's argument, later endorsed by the party, state should have relative autonomy from the private sector in terms of politics and economy (EPRDF, 2010). While the theory on DS insists that for state to have autonomy from the private sector a strong, independent and competent bureaucracy is needed (Evans, 1987, 1995; Johnson, 1982; Leftwich, 1995), the Ethiopian DDS misses this imperative (Lefort, 2013). This is because, independent bureaucracy, has not considered as the basic requirement for state autonomy in designing the Ethiopian DDS. On the contrary, for EPRDF the whole issue of state autonomy revolves around the basic assumption that the ruling party has a strong social base. This social base is usually associated with

the privileged and ideological links with the peasantry and provide freedom for EPRDF not to require the political and economic support of private actors on election or other political activities (EPRDF, 2010).

State autonomy involves the capacity of state agencies at different level of state structure and the relation between state agencies and non-state actors. Local officials indicated that state institutions are becoming strong, and well established in line with the current development and changes. They consider this mainly from maintaining their independence in their interaction with non-state actors. As one respondent from state actor (R6) stressed:

"*It is not always possible to be dependent on partners and seek support from them. The teaching and principle of the DDS help the local structure of the state to develop resistance and self–reliance."*

But other state actors contradict these statement as they see the loopholes in the system and how dependent on non-state actors. For instance the head of the health center from one of the sub-district (R11) explained that;

"As health center, we found working with partner organization collaboratively is very essential. Because our budget allowance is limited assigned from the district health office, we have problems in providing services fully but non- state actors fill our gaps."

Based on the financial decentralization, districts now have the authority on finical decision making and allocating their budget, however they are still struggling on fulfilling the gaps. In relation to the autonomy of the bureaucracy, it is evident form the case that at grassroots level, the bureaucrats are party members. Hence it is impossible to say that policy is placed in the hands of a technocratic and autonomous bureaucracy. Rather State resorted to other ways to maintain its autonomy and we have seen some of the ways in our case study.

First, non-state actors are only allowed to work on programs and strategies determined by state. State takes the initiative to develop priority areas, so that non-state actors can only collaborate on identified areas. Hence, collaborative activities are only directed to areas that are prioritized as important by state. Discussion during an interview with local officials and politicians revealed that state want to maintain policy autonomy as they consider NGOs bring donor driven agenda that will compromise the state interest. This shows that state monopolizes the agenda setting and this

is well recognized by the non-state actors. A respondent from one of the NGO stressed that (NSR3):

"Our basic business is here to support the government, we don't have our program or strategy, and we work in line with the government strategy or when our business plan matches theirs. We execute government strategies and plans"

More importantly, MSP participants indicated that state agenda setting initiatives came with new modes of participation in health service delivery which are indicated as 'selective intervention'. Since the Amref –RMNCH project match the state agenda, it is allowed to function at Tarmaber district. Despite their active participation, almost all non-state participants are disappointed as they often face the challenge that state is only willing to allow them contributing to priority areas which have been unilaterally set by the state at policy level. According to one of the non-state respondent (NSR1) this arrangement basically "*…hinders them from supporting the government and the community in full capacity.*" However, state actors perceived selective intervention helps them to avoid those non-state actor initiatives with hidden agendas and most importantly it brings efficient utilization of resources while directing actors to focus on specific objectives.

In fact all of the non-state actors agree that the current activities are pressing to demand immediate attention. But we have seen that both state and non-state actors have no equal understanding on issue like female gentile mutilation, women empowerment and early marriage. For state working on these issues are considered as waste of resources and luxury while comparing with dying mothers and children. But non-state actors insisted that there is a demand for these services. The challenge for non-state actors is that they are not able to address all issues which they consider pressing. But they still maintain their collaborative actions on issues which state prefer to take act on. The exclusive authority on developmental endeavor, give state institutions an opportunity to set the agenda. However, they keep encouraging cooperation that match their agenda. Hence, it is more logical to assume that, the balance between state dominance and cooperation is maintained through discourses, and negotiation at practical level.

Second, state arranges for collaborative activities to be performed within the government structure. This is mainly related to the fact that non-state actors are not allowed to create parallel structures in the current health sector of Ethiopia. The Tarmaber MSP is using the state structure to

implement the project programs and activities. This includes among others applying the programs and activities on health centers and health posts which are the prominent element of the state structure. State actors found this strategy very valuable as it allows them to retain transferred knowledge, skills and operational excellence while they were working in collaborative initiative. Some even insisted that non state actors should use the state structure as it can help them reducing their unnecessary administrative costs and we encourage them to minimize administrative cost using our system. Surprisingly, in our study we found that all non-state actors are comfortable in using the state structure and even appreciate it as providing them with necessary link with the community.

We found that, the MSP in Tarmaber district has managed to integrate its activities into state structure at local level. The innovative acclaimed health extension program in Ethiopia has been implemented through the active and dedicated role of actors/agents (HEW) and structure (HDA). They are considered as a basic tool by the state to bring about the desired change in health sector. Respondents clearly acknowledged that these community level structures are instruments for ideological promotion and mobilization of the community. Though the interviewed HEW said that being the member of the party is a matter of choice not obligation. The experience shows that, HEW are expected to be party member as they will be a member of the sub-district committee that only involves party members. The committee involves representatives from different state organs like education, agriculture, health. The HEW take different teaching on the party ideology, in different occasions and they are expected to transmit this information to the community.

It seems that the participant of the MSP understands the importance of these tools for effective and efficient partnership and implementation of activities. Therefore, when the actors in the MSP designed the specific intervention activities of the project, they focus on further empowering the HEW and HDA through continuing capacity building, mentorship, and training. The fact that MSP adopted such tools to address the grassroots community coincided with state effort to apply embeddedness principle in the ground which helps the MSP to maintain positive perception from district administration.

We found that both HDA and HEP generated ample opportunities for the MSP to execute its activities. First, the Tarmaber MSP includes these programs into the partnership and utilized it as an entry point to the community. More specifically, the HEW and HDA implement the programs at community level .While advising the family members at a home to home base, HEW and HDA create demand for the services availed by the interaction of state and non-state actors. They mobilize the society to go to health centers and use the available services, and also apply knowledge and skills they have received from the joint action of state and non-state actors in their everyday activity like child immunization, maternal health, sanitation, and child care.

Third, government authorities at the project area try to maintain state autonomy through regulating the partnership. In the current state structure many pubic authorities at different governmental levels possess the authority to control the partnership activities. In Amref –RMNCH project, the region, zonal and district health officials actively engage in monitoring and evaluating the joint activities. Public officials from both the federal and the Tarmaber district acknowledge how state regulations are essential for shaping societal actors orientation and their activities to the fulfillment of collective goals. Especially, Interview with district finance and economic office representative (SR 17) reveled reasons why state attentively monitor project activities;

> *"first, state want to make sure, state want to make sure that activities are being implemented in accordance to the agreement , benefiting society as it was designed. Second, we want to make sure that no activities are against the value of the society."*

Since the public authorities have applied the different monitoring mechanisms, the actors in Amref –RMNCH project have no choice but to function according to the stipulated agreement. Although state regulations are aimed to evaluate project activities implemented through joint action, the regulations are more directed to regulating non-state actors. For instance, Amref as a leading NGO is supposed to provide regular reports to zonal and regional health offices referring joint activities performed within a specific period. In more practical context, a respondent from non-state actor side described the mid-term evaluation platforms as dominated by state actors where non-state actors are defending the joint activities while state actors taking less responsibilities for activities

performed. This is noteworthy because the collaboration between state and non-state actors will can take place in environment which Fritz Scharpf (1994) call it, a "shadow of hierarchy". However, state actors from the district administration claim that state institutions take responsibility especially if there is less achievements in the implementation of project. State actors also participate in evaluation, review meeting and take a major responsibility when public authorities conduct field visit.

Embeddedness

In addition to state autonomy, we are able to see the embeddedness principle of DS ideology in the health sector. In more obvious way, state is working with various actors in the health sector. In addition to organized non-states actor in the health arena, state also involves citizens. State organizes the society into different grass root community groups - including 1 to 5 arrangement (community grouping that put five individuals in one group while charging one individual as a leader to the group), HDA groups, youth league, and women league -which are directly or indirectly involved in health and health-related issues at community level. The Tarmaber MSP can be a typical example of how embeddedness manifests itself in the health sector. The partnership involves multiple stakeholders. A key feature of embeddedness in the health sector related to the fact that state invest more in developing and sustaining cooperative relation with citizen at large and community groups. Two innovative programs for community involvement are worth attention: the HEP (Health Extension Program) and HDA structure. State forms HEP that mobilizes Health Extension Workers (HEW) for reaching the community at large. HEW are a double-edged sword in the health sector. On the one hand, they give professional services to the community in line with the health packages set by the government. On the other hand, they are also instruments for community mobilization and participate in major political decision making at Kebele level. Within the HDA structure, the community are especially women who are organized to assist the health delivery process. To that end they closely work with HEW.

As we have seen in the first section, public authorities in district level remain receptive for the contribution of the joint action especially the presence of Amref in their district. Permanent relation have been institutionalized within the district. But the relationship is reinforced by the informal interaction between the state and non-state actors. According to our respondents, the MSP includes

non-state actors that have a good reputation and experience which help the partnership to build a good reputation within the community. This has resulted in trust and positive perception by state institutions at all levels. For instance, against the conventional business modality, at one instance the district administration asked the MSP to work on specific district that was in need of immediate intervention and was given the leading role in implementing selective intervention.

We found that the good reputation of the non-state actors contributes to the development of good interaction with state actors within the partnership as the state actors develop trust. This is found very significant for the functioning of the MSP in the district as it positively influences the perception by state institutions. According to a state respondent (SR8), the commitment and good experience of actors in the MSP "brings good results in our district". This has helped to ease the controlling role of state on the partnership. Social capital also helped smoothen communication and reduced rules of interaction. For instance, actors from the MSP develop a way to communicate with district and zonal authorities through email and phone. Respondents agreed that smooth communication and strong bonds with the district authorities give them a chance to ease the negotiation process and pass the usual long and formal procedures in implementing activities in the district.

6. Key findings and conclusion

This case study of the MSP in Ethiopian health sector has brought some key findings. In this concluding chapter we first summarize the discussion on the functioning of MSP that were investigated in the case study, followed by an evaluation of the MSP in DDS context. At the end, we briefly reflect on the theoretical and practical implications.

Explaining MSP from network governance perspective

In developing countries where resource are scarce to produce and distribute public services, the presence of networks is bound to become more prevalent. There is much to explore in terms of how they are organized and operate in actual ground. The thesis is interesting in explaining how horizontal partnerships for public service delivery are organized and operate in Ethiopia. To this end, we have proposed a theoretical framework derived from network governance theory and analyze the case. We derived a list of theoretical propositions from the theory and confronted them

with the empirical evidence collected in the course of the research. In what follows we focus on the first and second group of research in turn, and discuss the findings.

In explaining the organization and operation of MSP, we found that network governance theory pose an important insights. First, the interdependency of the various societal actors play a significant role in establishing the MSP in the case of the studied district. We have seen that interdependency embedded by the collection of actors with different competencies and resources helps the district to provide health services which otherwise will be difficult to do. Recognizing the interdependency, the MSP also stretches into incorporating the community groups that have resources and stake on the issue. We therefore, suggest that interdependency of various societal actors play important role in establishment of the horizontal partnerships. Second, we consider a related proposition of the network–governance theory; interaction through negotiation. Negotiation lies the heart actor's relationship in network form of coordination as it give a chance for the actors to interact through discussion and deliberation. Therefore, this proposition entails that actors in horizontal governance interact through negotiation. In this case, we found that actor's interaction at local level is more framed by negotiation as compare to regional and federal level. Certainly the day to day relation of actors bound by the interdependency frame their interaction through negotiation that further common understanding and action. This in turn enhance the functioning of the MSP in contributing for health service delivery. We have seen also how the negotiation of actors at federal and regional level was constrained by strict administrative formalities and pre deigned framework despite the recognized need for common effort towards alleviating maternal and child health problems. This is not to say that the negotiation at the local level are perfect, which is not the case, but the day to day interaction of the actors at local level pave the way for the smooth negotiation. In the case of institutional framework, we have emphasized that formal agreements and action plans frame the interaction of the actors in the MSP through establishing roles and procedures. Informal agreement through dialogue and strong bond was found, as important as the formal agreement in forming the institutional framework, thus positively affecting the operation of MSP. Such informal agreement helps to establish values like trust and commitment which further provide normative framework for the interaction of actors in the MSP. Despite the chance that the institutional framework can involve more elements, it was dominated by regulatory arrangements that spread rules, role and procedural elements. We argue that, a network governance stipulation about self-regulation of networks help explain the

organization and function of MSP in the case study district. The key point is that the limits on self-regulation of the MSP can influence the organization and functioning the MSP. We also found evidence that support the argument. For instance, in formation of the MSP, state agencies present themselves with the supervision role and they demand non- state actors to report about the overall activities. Production of public purpose in MSP to some extent help to explain the organization and function of the MSP. We have seen that the collaboration effort can help the societal actor to develop new methods and techniques that can be scaled up to various areas and be an input in policy formulation. However, meeting short term objectives and supporting immediate need seems more prominent in the case study as compared to production of public purpose.

MSP in DDS context: developmental role, state autonomy and embeddedness

The thesis was not only interested in explaining how MSP are organized and function in Ethiopia, but also in investigating how MSP function in DDS context. We consider the developmental role of the state and how it is affecting the functioning of MSP in the studied case. Developmental state in Ethiopia has generally made it easy for the state to control the public service provision and enact policies and strategies. But this is not to say that it made it easier than it was the case before the declaration of developmental state. Because public health service delivery has always been the domain of government in Ethiopia. In this respect DDS led the state to maintain its dominant role in health sector, despite the overstretched capacity and limited resources within the sector. However, our study illustrates that to execute its developmental role, government coexist with various societal actors while assuming the major responsibilities for shaping their orientations, coordinating their activities and providing a structure to the fulfillment of developmental goals. A critical point here was the development of policies and strategy documents which have generally been effective in putting direction to ensure the collaboration of various societal actors at different levels.

The state autonomy element of DDS in Ethiopia has put its own effect on the formation and operation of the MSPs. We argue that state relies on a mix of strategies, ranging from installing controlling mechanisms to creating a bureaucratic sphere, to protect its autonomy. These strategies had an instrumental role in determining the design and the function of the MSP while limiting the role, function and direction of the participating actors, specifically CSOs. Therefore the state

strategies were not preferred as compared to the presence of independent bureaucracy which could provide different structure while helping state to keep its autonomy.

Turning to embeddedness, in this case DDS as a state ideology has partly achieved its goals in which the state structures at different level are able to mobilize the societal actors towards developmental goals in health sector. There is evidence that health goals has been executed through collaborative efforts of various societal actors and embeddedness is one the DDS elements explaining this change. However, though embeddedness, is acknowledged as a good element of DDS providing the opportunity for various actors in emerging state policy arena, the level of utilizing this element has thus been limited. The case study revealed that the state embedded its bureaucrats in society through public participation and popular initiatives. There are initiatives in the health sector that create a concrete set of social ties that could possibly bind the state with society (e.g. the HEP and HDA). However, the need for the Ethiopian government to work with various civil societies and their enormous engagement on service cannot be taken for granted. The Role of society in general and of CSOs in particular in policy formulation and negotiation is limited. Even within formally institutionalized channels for policy negotiation, the state usually fails to accommodate CSOs' opinion and suggestions into policy. Most importantly, the controlling system discourages broad civic participation in the policy advocacy and policy-making process.

Theoretical and practical implications

A detail theoretical implication will be made when we finalize all case analysis, however for this case purpose we will provide brief theoretical implications followed by practical implications. Linking empirical data to prepositions derived previously from the literature is significant from a theoretical perspective because it helps researchers better understand how partnership work in different context. But the most important issue in theoretical aspect of this study related to a crtistim of governance theory which posit that the theory is questionable when state's authoritative role create asymmetries in governance networks. However, we have mentioned that we have taken a network-governance theory perspective which to some extent consider the dominant role of state in networks. Considering the DDS aspect of the country the study support the argument that the state, although a participant in networks, maintains a hegemonic role in governance networks. In our case, we paid particular attention to the key insights of the theory and applied network – governance as framework to explain the formation and functioning of MSP. We paid particular attention to the role of state actors /agencies at different state structure. Generally, we found it important taking this perspective and applying to the case study.

This study has also implications for practice. There is always unresolved issue about partnerships and the role of state, especially in countries like Ethiopia where DDS is declared. The assumption underlying this confusion is that DDS mean the restricted relation with non-state actors. While we find evidence in our study for this hypothesis, we suggest that there are well proven ways in which state can protect its autonomy while developing and maintaining strong partnerships with non-state actors.

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