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A case study on Participatory Health Planning and Budgeting in Somali Region of Ethiopia

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Authors' contributions

This work was carried out in collaboration among all authors. Author OO conceived the manuscript documentation, drafted and finalized the manuscript. All the authors read, reviewed, and approved the final draft of the manuscript.

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Case Study

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ABSTRACT

Participatory planning and budgeting aims to democratically allocate public money for local services, enabling communities to decide how public funds are spent and the monitoring of the services. This case study described the process and outcome of a pilot project on participatory planning and budgeting in the health sector in 6 project woredas (districts) in Somali region of Ethiopia. The Social Accountability Committee members were selected using the World Bank's framework on accountability. The community members represented by the actively participated in all stages of the planning and budgeting process leading to the development of woreda health Joint Action Plans (JAPs) which are community prioritized health activities. Eighteen (49%) of the 37 activities in the Joint Action Plans were included in the woreda annual health budget which ranged from 29% to 80% across the 6 woredas. In addition, during the first half of the fiscal year, implementation has started in 10 (56%) of the 18 JAPs activities budgeted in the annual health woreda plans and ranged from 0% to 75% across the 6 woredas. The study highlighted the feasibility of engaging the community in participatory planning and budgeting process which resulted in allocation of woreda annual health budget to some of the prioritized items in the Joint Action Plans. In the bid to ensure sustainability, government ownership and ensure citizens' participation, the fund for the participatory budgeting process should be included in

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the woreda annual budget and proportion of the annual budget should be designated to the implementation and monitoring of the Joint Action Plans through appropriate legislation.

Keywords: Participatory budgeting; joint action plan; health; Woreda.

1. INTRODUCTION

Citizen participation in governance and public service delivery is increasingly being implemented in many countries in order to improve accountability and government performance [1,2]. Community participation in priority setting in health systems particularly in low resource settings has gained importance in view of government failure to provide adequate public-sector services for their citizens [3]. Incorporation of public views into priority setting is perceived as a means to restore trust, improve quality of healthcare and health outcomes, better accountability, and more efficient use of resources [4,5].

Participatory budgeting (PB) aims to democratically allocate public money for local services, enabling communities to decide how public funds are spent and monitoring of the services [6]. Participatory budgeting (PB) is a type of citizen engagement in which ordinary people decide how to allocate part of a municipal or public budget through a process of democratic deliberation and decision-making. Participatory planning and budgeting allows citizens or residents of a locality to identify, discuss, and prioritize public spending projects, and gives them the power to make real decisions about how money is spent [7,8].

Participatory planning and budgeting entails a multi-stage process, which typically concludes with citizens deliberating among themselves and with government officials to allocate funds for public goods based on their priorities [7]. The implementation of participatory budgeting has had several variants or models across countries and tailored to the different local context [9,10]. In Ethiopia, the concept for participatory budgeting involves the establishment of Social Accountability Committee made up of representatives of citizens including women and marginalized groups organized to participate in all social accountability processes [11].

The budget process in Ethiopia is guided by a directive, known as the Financial Calendar, issued by the Ministry of Finance and Economic Cooperation (MoFEC). The fiscal calendar runs from July to June annually. Based on the principles of fiscal federalism, fund transfers are made from the federal to the regional governments and from the regional governments to woredas(districts). At the woreda level each of the woreda sectors are provided indicative annual budget based on how much is allocated to each woreda. Each sector then allocates the budget based on their plan and priorities in term of recurrent and capital expenditures and submit to the woreda cabinet for approval [12,13]. A previous study in Somali Region found that the woreda planning and budgeting process was without active participation of the community members and suggested more participatory and inclusive process to ensure greater accountability [12].

This study aimed to describe the process and outcome of a pilot project on participatory planning and budgeting in the health sector in 6 project woredas (districts) in Somali region.

2. CASE REPORT

This woreda level participatory planning and budget project implemented between January 2021 – December 2021 has three essential components: (i) Participatory development planning (ii) Participatory open budget session and (iii)Participatory monitoring of implementation of approved health interventions. These are in line with the Ethiopia budget planning cycles. Table 1 shows the timeline for the annual budget process at the regional and woreada levels.

2.1 Participatory Planning

This involved activities conducted between January 2021-April 2021 which culminated into the development of the woreda Joint Action Plans(JAPs) for the health sector in the 6 pilot woredas. It focused on the involvement of the community members in the prioritization of health activities to be funded in the annual budget.

The major players in participatory planning and budgeting processes were the local citizens who took part through the Social Accountability Committees (SAC). To ensure inclusive participation, key community platforms/

Table 1. Timeline for the regional and woreda annual budget and planning process

Timeframe	Major activities
October -March	Annual budget preparation by regional government sector bureaus.
Dec - Jan	Preparation/revision of woreda budget subsidies distribution formula by Regional Bureau of Finance (BoF)
Jan	The regional cabinet approves the annual woreda budget subsidies distribution formula.
Jan- Feb	Regional BoF makes a call to regional government sector bureaus to submit their annual budget requirement
Feb	Regional BoF announces the estimated amount of subsidies that will be distributed to woredas
Feb-march	Regional government sector bureaus submit their annual budget requirement and requests to BoF.
April -June	Preliminary annual budget preparation at woreda and regional level
June	Preliminary annual budget approval at woreda and regional
June -July	The woreda and regional parliament approves the draft budget proclamation and approves the annual budget for implementation.
July	BoF announces the approved annual budget.
July -August	BoF distributes the approved annual budget to regional executive organs
Starting August	Monitoring and auditing of regional sector bureaus and woreda administration offices.

structures and administrative structures at woreda and kebele (sub district) level were identified, guided by the World Bank's framework on accountability: administrators, healthcare officials, healthcare providers and citizens [7]. Some of the community structures which represented the citizens included men' groups, women's groups, youth groups and vulnerable population specifically the physically challenged.

Each of the citizen/community groups nominated their representatives as members of the Social Accountability Committee (SAC) in each of the woredas through voting. The followings were the four categories of people in the committee for each woreda based on their expected roles in participatory planning and budgeting process :

- Budget makers at woreda level: (Woreda Health Officer and Woreda Finance Officer and representative of the Woreda Administrator)
- Service providers: (Head of the health facilities)
- Citizens: (representative of men, women and youth groups including vulnerable population where applicable)
- Local leadership: (traditional or religious leaders).

The Social Accountability Committee (SAC) in each of the six project woredas has 12 individuals selected as members, 3 from each of the four categories. The project took special account of the participation of women in the planning and budgeting process. Women's participation in the decision-making process was ensured in the project, each SAC has a minimum of two women and two of the six Social Accountability Committees were headed by women. The SAC members were trained by the members of the regional SAC Technical working group using the national guideline on participatory planning and budgeting process including the development of Joint Action Plan [14].

The second step of the participatory planning and budgeting process in the pilot project after the selection and orientation of the SAC members was the development of the Joint Action Plan (JAP) for the health sector. The development of woreda Joint Action Plans is the critical activity and cornerstone of social accountability and a benchmark to monitor and evaluate the social accountability program. This involved participatory processes of mapping of health infrastructure, supply and human resource, identification and prioritization of health problem, and identification and prioritization of health interventions using available data and information generated or provided by the members. This was done during a 2 -day participatory meetings in each of the project woredas. Through the various community platforms and groups, announcement was made

to invite the local people and representatives of various citizens groups to participate in the town hall meeting. The SAC members coordinated the participatory meetings and regional Social Accountability Technical Working Group members facilitated the meetings using the concept of Participatory Rapid Appraisal (PRA) exercises [15]. Ensuring local citizens' participation in the development planning process was one of the key dimensions of the project. About 100 participants attended the participatory meeting in each of the woredas and included women and other vulnerable population like the physically challenged. They actively participated in discussions and gave their opinions clearly and raised issues related to their concerns to be prioritized. At the end of the meeting a draft Joint Action Plan for the health sector for each woreda were developed. The draft was then further discussed by the SAC members with technical support by the facilitators who assessed the technical feasibility of Joint Action Plan to ensure they were in accordance with the service standards. The final Joint Action Plan for each woreda was then approved by the woreda health office head and the SAC chairman.

2.2 Participatory Open Budget Session

This was conducted between May 2021 and June 2021 which coincided with the period of preliminary annual budget preparation and approval at the woreda level. Each Woreda Social Accountability Committee participated in the pre-budget discussion and budget hearing process in each of the woreda to lobby for the inclusion of consolidated Woreda Joint Action Plan in their respective health sector plans before the submission of the annual woreda health budget proposal to the woreda cabinet/council.

2.3 Participatory Monitoring of Implementation of Approved Health Activities

This was conducted after the budget approval. It focused on the monitoring of the health activities in the annual approved health budget for the woredas. The SAC members had monthly and meetings to review the outcome of the approved health woreda budget and identified which activities in the Joint Action Plans (JAPs) were included in the annual budget. The SAC during the meetings set up monitoring system for the project implementation. The analysis of the woreda Joint Annual Plans and approved annual Woreda health budget as detailed in Table 2 shows that 18(49%) of the 37 health interventions in the JAPs were included in the woreda health annual budget. Some of the heath interventions in the JAP included rehabilitation of health facilities, procurement of equipment and supplies, recruitment of additional staffs and provision of incentives for outreaches, supervision and night shift, installation of water and toilets in health facilities, maintenance of ambulance, community awareness campaign to promote health seeking behaviour, procurement of generators, procurement of motorcycle for outreaches and supervision.

During the 1st half of the year, implementation has started in 10 (56%) of the 18 JAP health interventions budgeted in the annual health woreda plan and ranged from 0% to 75% across the 6 project woredas.

3. DISCUSSION

The study described the process for the implementation of community engagement in Participatory health planning and Budgeting. The outcome of this was the inclusion of the Joint Action Plan in the annual health budget in the 6 project woredas. This to our knowledge is the first study on participatory planning and budgeting in the region.

A critical component of participatory budgeting is the selection of the community representatives which is expected to be inclusive from various categories of community structures. In the study, the community representatives were selected by the community members themselves through voting and they represented different community structures in the woredas. This is unlike studies in Bangladesh of participatory budget which reported that the selection of the community representative engaged in the budget discussion in most of the Union council/ parishad were either the members of the political party or their relatives or local elites which made the SAC process paper-based activity and not achieved the expected aspiration of the community [14,16]. Studies have reported that when participatory processes become politicized it leads to deficient and non-meaningful participation [17,18,19]. The studies suggested that to ensure high level of citizen participation, and inclusive participatory process, selection of the citizen should be done openly to avoid any political interference as done in our study [17,18,19].

In this study, the training and orientation provided to the woreda health officers who were members of the SAC on the importance of community participation in woreda planning and budgeting helped in ensuring inclusive participation and engagement of the community representatives in the prioritization of the health needs. This is unlike studies in Tanzania where health professionals were reported to have tendency to dominate priority settings and limited the involvement of the community members in the prioritization of health interventions to be implemented [20,21].

Similarly, the orientation and training provided for the SAC members helped in ensuring effective participation of community members during the prioritization and budgeting process which has been reported in many studies a major challenge in participatory budgeting [20,22,23]. These studies reported that most community members or their representatives, particularly in the rural areas could not participate fully in the planning process at the grassroots level because they have not been exposed to formal training in planning and budgeting process skills, knowledge and confidence [20,22,23].

In the study, about half of the Joint Action Plans (JAPs) were included in the annual woreda health budget which is however lower to finding in a previous study in Ethiopia which reported allocation of annual budget to more than 60% of the activities in the JAP [24]. Most studies that evaluated participatory budgeting outcomes did not provide information on the proportion of community prioritised interventions that were funded as done in this study. Most evaluation only reported improved allocation of funding to public services prioritised by the community and in some instances shifting of expenditure focus to local needs such as clinics, roads repair and water as opposed to what had earlier being prioritized such as vehicles and office equipment [25-29].

There were no agreed criteria used by the woreda council in deciding the activities in the JAP that were included or excluded in the budget. This is unlike other studies where defined criteria were used to rank demands and allocated funds and voted on the investment plan presented to be included in the budget [25,30]. These studies suggested that such criteria should be transparent and subject to popular debate, in order to avoid possible distortion of community/citizen preferences under the guide of “technical” analysis [25,30]. Budgetary constraint which was the reason given for not accommodating all the proposed community priorities activities in the JAP into the annual budget is similar to other studies which reported that budget constraints led to citizen’s proposals not materializing and was noted in the studies to negatively affect the public confidence in the community engagement in participatory budgeting process [25,26,30].

In the study, the JAP was only based on the annual budget funded from the block grant from Federal government unlike other studies where additional resources were provided to implement the Joint Action Plans including use of locally generated revenues [31,32].

This study being a project-based implementation faces the challenge of sustainability and ownership. This is concern raised in previous studies on social accountability which reported that social accountability mechanisms that were introduced externally, project-based and short term without government ownership are not usually sustainable and faced with limited political will for implementation [32,33].

Table 2. Analysis of Joint Action Plan (JAP) and approved annual health budget for each woreda

Name of Woreda	Number of health interventions in the JAP	Number of health interventions in the JAP included in the woreda annual budget n (%)	Number and percentage of health interventions in the Annual budget being implemented during 1st half of the year n (%)
Danot	5	4(80)	3(75
Kebridahar	4	3(75)	1(33)
Bohr	6	2(33)	0(0)
Kalafo	8	4(50)	3(75)
Kebribeyah	7	2(29)	1(50)
Awbare	7	3(43	2(67)
	37	18 (49)	10(56)

4. CONCLUSION

The study highlighted the feasibility of engaging the community members in participatory planning and budgeting process which resulted in allocation of woreda annual health budget to some of the prioritised health interventions in the Joint Action Plans.

5. RECOMMENDATIONS

In the bid to ensure sustainability, government ownership and ensure citizens' participation in participatory planning and budgeting the followings are suggested:

- Fund for the participatory planning and budgeting process especially to fund the activities of the citizens in the process (awareness, meetings, trainings) should be included in the woreda annual budget.
- Proportion of the annual budget should be designated to the implementation and monitoring of the Joint Action Plans through appropriate legislation.
- Implementation of participatory planning and budgeting with adequate representation of the citizens should be one of the key indicators for evaluating performance of the annual woreda health budget.

6. LIMITATIONS OF THE STUDY

The study was based on a pilot project implemented in only 6 woredas in the region. Whilst this was limited in its geographical coverage it provided opportunity for better understanding of engaging community and other stakeholders in participatory planning and budgeting at the woreda level in the health sectors. The lessons learnt will provide the guidance for implementation participatory planning and budgeting in other sectors and in scaling up into more woredas.

DISCLAIMER

The view expressed in the articles are those of the authors and not that of the affiliated institutions.

ETHICAL APPROVAL

The approval for the study was provided by the Somali Regional Bureau of Finance

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. McCoy D, Hall JA, Ridge M. A. Systematic review of the literature for evidence on health facility committees in low-and middle-income countries. Health Pol Plann. 2012;27:449-466.
2. World Health Organization. Primary health care: now more than ever. The World Health Report. Geneva: WHO; 2008.
3. Kamuzora P, Maluka S, Ndawi B, Byskov J, Hurti A. Promoting community participation in priority setting in district health systems: experiences from Mbarali district, Tanzania, Global Health Action. 2013;6(1):22669, DOI: 10.3402/gha.v6i0.22669.
4. Frumence G, Nyamhanga T, Mwangu M, Hurtig A. Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. Glob Health Action. 2016;20983 – Available:http://dx.doi.org/10.3402/gha.v6i0.20983
5. World Bank. World development report making services work for poor people. Washington, DC: World Bank; 2004.
6. Dias N. Hope for democracy: 25 years of participatory budgeting worldwide. Sao Bras de Alportel: In Loco Association; 2014.
7. Anwar S. Participatory Budgeting. Public Sector Governance and Accountability. Washington, DC: World Bank. © World Bank; 2007. Available:https://openknowledge.worldbank.org/handle/10986/6640 License: CC BY 3.0 IGO."
8. United Nations Human Settlements Programme (UN-HABITAT), Municipal

Development Partnership Eastern and Southern Africa. Participatory Budgeting in Africa: A Training Companion with cases from eastern and southern Africa. Volume I: Concepts and Principles. United Nations Human Settlements Programme and Municipal Development Partnership for Eastern and Southern Africa; 2008. Available:https://www.internationalbudget.org/wp-content/uploads/Participatory-Budgeting-in-Africa-A-Training-Companion-with-Cases-from-Eastern-and-Southern-Africa.pdf

9. Goncalves S. The effects of participatory budgeting on municipal expenditures and infant mortality in Brazil. World Dev. 2014; 53:94–110.
10. Krenjova J, Raudla R. Participatory Budgeting at the Local Level: Challenges and Opportunities for New Democracies." Halduskultuur – Administrative Culture. 2003;14 (1):18-46.
11. Ethiopia Social Accountability Program. Social Accountability Guide, First Edition, Ethiopia Protection of Basic Services Social Accountability Program; 2012. Available:http://esap2.org.et/socialaccountability-
12. Oladeji O, Pieterse P, Robins A, Oladeji B. Health Budgeting at Woreda level and Effect on Access and Quality of Health Services in Somali Region of Ethiopia Texila International Journal of Public Health. 2021;9(1):26-31.
13. Budget Process in Ethiopia: Budget Process In Ethiopia: the case of Kobbo Woreda Paperback by Abdu Muhammed Ali (Author) LAP LAMBERT Academic Publishing; 2013. Available:https://www.amazon.com/Budget-Process-Ethiopia-Kobbo-Woreda/dp/3659475394
14. Chowdhury S, Panday K (editors). Process of Participatory Planning and Budgeting at the Local Level 2018;83-98. DOI:10.1007/978-3-319-73284-8_5.In book: Strengthening Local Governance in Bangladesh. Projects.
15. Pepall E, James RW, Earnest J. Guidelines for Conducting Rapid Participatory Appraisals of Community Health Needs in Developing Countries: Experience from Tulikup, Bali. Asia Pac J Public Health. 2006;18(3):42–48.
16. Ahmed T, Rashid MH, Ahmmed KN, Razzaque F. Social Accountability Mechanisms: A Study on the Union Parishads in Bangladesh, Special Publication Series. No. 2, BRAC Institute of Governance and Development, Dhaka; 2016.
17. Cooke, William and Uma Kothari (eds). Participation: The New Tyranny? London: Zed Books. Online version: Participation. London; New Yor: Zed Books, (OCoLC). 2001;606538275.
18. Rodgers D. Contingent Democratisation? The Rise and Fall of Participatory Budgeting in Buenos Aires." Journal of Latin American Studies. 2010;47(1): 1-27.
19. Gianpaolo B. Participation, Activism, and Politics: The Porto Alegre Experiment and Deliberative Democratic Theory. Politics and Society. 2001;29(1): 43-72.
20. Frumence G, Nyamhanga T, Mwangu M, Hurtig A. Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. Glob Health Action. 2013;201 6:20983 – Available:http://dx.doi.org/10.3402/gha.v6i0.20983
21. Maluka SO, Hurtig A, Miguel SS, Shayo R. Decentralization and health care prioritization process in Tanzania: from national rhetoric to local reality. Int J Health Plann Manage. 2011;26:e102-e120.
22. Massoi L, Norman AS. Decentralization by devolution in Tanzania: reflections on community involvement in the planning process in Kizota Ward in Dodoma. Public Adm Policy Res. 2009;1:133-40.
23. Roy S, Sharma BBL. Community participation in primary health care. Health Popul Perspect Issue. 1986;9:165-91.
24. Lucia Nass and Meskerem Girma (Editors). Most Significant Change Stories. Social accountability in Ethiopia. Ethiopia Social Accountability Program Phase 2 Grant Agreement [TF099878] - Part of Promoting Basic services. Fogera woreda, Amhara region education sector; 2015. Available:http://www.cib-uclg.org/sites/default/files/most_significant_change_stories_booklet.pdf
25. Goncalves S. The effects of participatory budgeting on municipal expenditures and infant mortality in Brazil. World Dev.2014; 53:94–110.
26. Devas N, Grant U. Local Government Decision-Making—Citizen Participation and Local Accountability: Some Evidence from Kenya And Uganda. Public

Administration and Development. 2003;23: 307–316.
27. Touchton M, Wampler B. Improving social well-being through new democratic institutions. Comp Polit Stud. 2014; 47(10):1442–69.
28. Boulding C, Wampler B. Voice, votes, and resources: evaluating the effect of participatory democracy on well-being. World Dev. 2010;38(1):125–35.
29. Campbell M, Escobar O, Fenton C, et al. The impact of participatory budgeting on health and wellbeing: a scoping review of evaluations. BMC Public Health. 2018;18:822.
Available: https://doi.org/10.1186/s12889-018-5735-8
30. Muriu AR .Decentralization, citizen participation and local public service delivery: A study on the nature and influence of citizen participation on decentralized service delivery in Kenya, Schriftenreihe für Public und Nonprofit Management, No. 17, Universitätsverlag Potsdam, Potsdam; 2013.
Available:http://nbn-resolving.de/urn: nbn:de:kobv:517-opus-65085
31. Dr Samuel Tadesse (editor). A guidebook: Social Accountability in Ethiopia: Establishing Collaborative Relationships between Citizens and the State. Lulu Publishing Services; null edition December 20; 2017.
32. Abbey C, Azeem VA, Kuupiel CB. Tracking the Ghana district assemblies common fund, in Demanding good governance: Lessons from social accountability initiatives in Africa, M. McNeil and C. Male, Editors. The World Bank: Washington, D. C; 2010.
33. Vian T, Kohler JC, Forte G. Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance. J of Pharm Policy and Pract. 2017;10:18.
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