WOREDA LEVEL DECENTRALIZATION AND ASSESMENT OF HEALTH SERVICE DELIVERY: THE CASE OF MIDAKEGNI WOREDA, OROMIA NATIONAL REGIONAL STATE

By

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Declaration

This thesis is my original work and has not been presented for a degree in any other university and that all sources of material used for this thesis have been duly acknowledged.

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ABSTRACT

Decentralized service delivery refers to the mode in which service delivery is done through delegation and devolution of power from center to local governments where by efficiency and effectiveness are likely to be achieved. The general purpose of this study is to assess the impact of Woreda Level Decentralization on health service provisions quality and quantity and to examine the impact of the decentralized legal, political, administrative, financial and stakeholder participation on health service delivery in Mida Kegn Mida Kegn Woreda, West Shoa Zone of the Oromia National Regional State.

To explore the impact of Woreda Level Decentralization on health services delivery mixed research approach was employed. Data were collected from Regional Health Bureau, Zonal Health office, Woreda Health Offices, Health centers, Health center Directors, health experts , kebele managers and beneficiaries through questionnaire, interviews and document analysis.

The study found that local communities have participated in health services delivery mainly in identifying local problems, planning, management, monitoring, control and evaluation of their also found that there has been weak and incoherent vertical or horizontal coordination between the health institutions.

In order to manage and sustain decentralization for effective delivery of health services, strong capacities in resources (human, finance and institutions) and active participation are mandatory.

ABBREVIATIONS

CBHI-Community Based Health Insurance

CHC-Community Health care Clinic

EPRDF- Ethiopia People Revolutionary Democratic Front

FDRE-Federal Democratic Republic Of Ethiopia

FMOH-Federal Ministry of Health

HC-Health Center

HCT-HIV testing and counseling

HP-Health Post

HSDP-Health Sector Development Programme

HSEP-Health Service Extension Programme

IPD-Inpatient Department

LLIN- Long Lasting Insecticide Net

NGO-Non-government Organization

OPD-Outpatient Department

PHCU-Primary Health Care Unit

PLWHA-Personnel Living With HIV/AIDS

PMCT-Prevent Mother Child Transmission

RHB-Regional Health Bureau

SHI-social health Insurance

TB-Tuberculosis

TGE-Transnational Government of Ethiopia

TM-traditional Medicine

TVET-Technical Vocational and Educational Training

USAID- United State America International Development

WHO-World Health Organization

WLDP –Woreda level decentralization process

ZHO-Zonal Health Office

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The participants among the Woreda chief administrator head stated that:

Woreda governments are the lower levels of governance which is close to people both geographically and decision makings. Therefore, they should be adequately empowered to enjoy decision making autonomy and power to address the communal interests. Federal constitution article 50/4 and furthermore, revised Oromia National Regional State constitution 2002 has clearly addressed local government power and responsibilities. Despite these constitutional promises, more decision making autonomy and powers are accumulated at regional and zonal administrative levels. As a result, the major decision (deploying, procuring and purchasing medical and drug equipment) making processes have influenced health sector to be decided by Regional Health Bureau. For example human resources are deployed by regional and zonal health offices, pharmaceuticals and medical equipment. According to the regional Health Bureau representative informant is the mandate of the bureau to human resources deploying, pharmaceutical and medical equipment make health service delivery more accessible all transparent, equitable and accountable to all communities in the state.

The decision making about human resource related matters, according to Ato Obsa Garoma and health center directors:

Human resource is one of the building blocks of health system needed to enhance the efficiency and effectiveness of health service delivery to beneficiaries or communities at all. To this end, the revised regional states constitution has empowered local governments to hire and administer their health personnel, both technical and non-technical.

However, the decision making process on human resource is highly concentrated at regional and zonal offices. The existing civil service system is strictly guided by regional civil service bureau. So, higher positions recruitment is decided at regional and federal levels. The technical staffs that have BSC or BA in health sciences are deployed by ministry of health and health personnel having held diploma in health sciences are deployed at zonal health offices.

Woreda have a power to hire only supporting staffs those whose salary is low. Though the positions are decided at Woreda level all recruitments of decisions have to be approved by the regional Civil Service Bureau. Thus, the presence of such kind of confined administrative environment does not allow the cultivation of the seeds of power devolution cultures and does

4.4.Factors Affecting the Implementation of Decentralization in Health service Delivery in Mida Kegn

Despite the significant improvements of health services access communities in Mida Kegn since the introduction of Woreda level decentralization, the performance of Mida Kegn is too low compared with the regional performance. This low performance is caused by constraints hindering the effective implementation of decentralized health services delivery in the Woreda, which is related to financial (high dependence on regional or federal block grants and dependence on out-pocket expenditure) and administrative (lack of experienced human resources, purchasing and procuring medical equipment and set health fees) problems.

Table 4.10: Access of health service at Regional and Woreda Level in 2016

	Health Service Delivery	Oromia performance	Mida Kegn performance
1	Health extension service	57	45
2	Maternal health services	69	57
3	Prevention and communicable diseases services	80	72.33
4	Clinical services		
	✓ Inpatient department	65	28
	✓ Outpatient department	77	42
	Total	69.6	48.866

Source: Mida Kegn and Oromia Regional Health Performance Report 2016 EFY

(i). Inadequate Administrative Powers autonomy

Health sector, have been carrying out through combination of delegation and devolution forms of decentralization. Analyzing shifts of administrative powers from the center to local government considers variety of projects and functions such as range of powers and responsibilities of "decision spaces" and discretion such as human resources hiring, procuring and purchasing medical and drug equipment, services organization, planning, access rule, governance and health autonomy are given to local administrations.

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were previously accorded to Zonal and state institution authorities. Yet still there is a huge gap between legal promises and practices of planning and budgeting. Furthermore, though the both Federal 1995 article 50 sub (4) and Revised Regional Constitution allows the creation of Woreda with their elected councils, lack of resources (skilled human power, financial, drug, medical equipment and infrastructures) challenged them to effectively engage in democratic self-rule and providing effective and efficient public service(Tegegne,2007:4). How did the Woreda level decentralization process of public health services delivery impact the provision of health services both in access and quality? This thesis attempts to answer this research question based on a case study of the Mida Kegn Woreda health service delivery.

1.3. Objective of the study

This thesis has general and specific objectives. The general objective of this study is to assess the impact of Woreda level decentralization on the provisions of services relating to public health service delivery of both access and quality. The Specific Objectives are:

- To assess whether Mida Kegn Woreda enjoys adequate local autonomy in health sector decision making.
- To examine the degree of sub national health sectorial lines of cooperation and coordination among Regional, Zonal, Woreda and kebele to deliver effective health service delivery.
- To evaluate participation of local communities and civil societies organizations in the area of health services delivery in Mida Kegn Woreda.

1.4.Research Questions

1. Does the Mida Kegn Woreda health sector have pass necessary health sector decision making?
2. Do sub-national (Regional, Zonal, Woreda and kebele) health sectors have coordination and clear inter-government relation?
3. Do participation of local communities and civil society organizations contribute to meet health services delivery demand in Mida Kegn Woreda?

1.5. Significance of the Study

The thesis identified problems, and attempts to recommend possible health services policy options at the local level. The researcher believes that the findings of the study would help policy

The FDRE Constitution, 1995 (Art. 50 (1)) states that the country is organized into federal and regional states. Art. 50 (2), states that both the federal and regional governments have legislative, executive and judicial functions. Each of the different government levels has a similar structure: legislative body, a court system and a number of sector specific administrations. The FDRE Constitution, 1995 (article 51 and 52) also defined the respective functions of the federal and regional governments. Accordingly, except for activities related to national defense, foreign policy and macroeconomic matters fiscal and monitory policy, regional states are empowered to decide and undertake economic, social and development plans as well as maintenance of law and order within their respective jurisdictions.

The Constitution granted regional states self-rule within their own defined territory and empowered them to participate effectively in the affairs of the central government through their representatives who are elected periodically. Regional states are given power and authority including the right to enact regional constitutions, establish elected regional councils, use their own national languages in schools and work places etc. They are also empowered to prepare their own socio-economic development plans, mobilize resources for local and regional development, and prepare and implement the regional budget (Federal democratic Republic of Ethiopia, Constitution 1995, article 52(2)).

At the initial stage, the devolution of power defined the relation between the centre and the states, leaving the powers of local government to the discretion of respective states. In 2002, the Woreda Level Development Program (WLDP), which was known as the second wave of the decentralization processes were moved from state to zone levels and Woreda levels. According to Ministry of Capacity Building (MoCB, 2004a) Woreda Level Development Program (WLDP) has many objectives, among these Institutional or organizational rearrangement - which includes activities to refine the functional assignment of Woreda, to improve local governance, build efficient organizational structure, and define the roles of kebeles; Woreda planning and fiscal control systems; Grassroots participation - to enhance democratic participation and empowerment of the rural population at grassroots level; State- Woreda revenue transfer and own revenue generation to allocate a budget required for local development on efficacy.

Article 50(4) of the FDRE constitution states that state governments shall be established at state and other administrative levels that they find necessary and adequate power shall be granted to

the lowest units of government to enable the people to participate directly in the administration of such units. This indicates that regional state can devolve adequate decision making authority and control over resources to lower levels of government in order to promote decentralization and bring government closer to the people.

Since the adoption of the Federal Constitution in 1995, the Oromia National Regional State constitution was issued to effectively devolve political, fiscal and administrative powers and functions. The Oromia National Regional State Revised Constitution of 2001 (Art. 45), establishes Regional, Woreda and kebele administrations with necessary legal, institutional and financial powers. This was aimed at making them effective and efficient institutions of local government for democratic governance and economic development and increase local service delivery.

Mida Kegn Woreda is also established in 2003 as one of the Oromia National Regional State woreda. Since then the Woreda has provided public services delivery in general and health services delivery in particular to communities under its jurisdiction.

1.2. Statement of problem

Until the turn of the 19th century Ethiopia was highly decentralized state and the constituent units were ruling their respective territories. Since 1855 Ethiopia centralized both governance and public service delivery though some regions, which had been peacefully submitted in to Menelik II expansion maintained their autonomy. Since the 1920s the centralization processes were highly intensified and those semi-autonomous regions had come under the centralized rule. This processes of centralization reached its climax during the Derg regime. After the downfall of the regime the country has undergone two phases of decentralization processes. The first phase of decentralization (1991-2001) was the devolution of power from the center to regions or states. It is a paradigm shift from highly centralized unitary state structure to federal type of state arrangement. This wave of decentralization was a response to the notion of 'national oppression' which emanated from the centralization processes (Zamalek, 2008, Tegegne and Kassahun, 2004).

The second phase of decentralization (2001-) was a concomitant rise to devolution of power from regional states Woreda. The objective of the decentralization measure was to ensure public

services delivery by enhancing public participation and crafting different developmental policies, strategies, plans and programs (Pastoralist Forum Ethiopia, 2003).

Decentralization from Regional sates to local governments ensured public services delivery by enhancing public participations through Woreda Level Decentralization Programme (WLDP) and Urban Management Programme (UMP). Unlike the first wave of decentralization, which was country wide, Woreda Level Decentralization Programme (WLDP) and Urban Management Programme (UMP) were initially limited to the four regional states of Oromia, Amhara, Tigray and Southern Nations, Nationalities and Peoples. Both Woreda level decentralization and urban management programs have enabled local governments to reform their fiscal, institutional, capacity development, etc. In terms of institutional restructuring, regional governments devolved more powers to local governments to arrange institutions solve their constituency problems. In terms of finance, local governments have been empowered to collect and retain some revenues as well as local governments are allowed to hire, administer, promote and transfer their civil servants. In general the devolvement administrative, financial and political power to local governments enable them to provide effective, efficient, qualified and quantified services to their constituencies (Kassahun and Tegegne 2004, Tegegne, 2007).

The services are meant to be delivered through decentralized manner is water supply, agricultural extension, rural road, public health, education as well as justice services. Specifically, public health services have been decentralized to local governments' zones, Woreda and Kebeles. Among the public health services decentralized to local governments are primary health care services such as health extension Programs and clinical services, which are conducted at primary hospitals, health centers and health posts. It has been 15 years since the decentralized health services delivery was launched to provide effective and efficient health services to communities by entrusting zones, Woreda and Kebeles with certain functions and responsibilities in the area of public health services delivery because health service is a multiple jurisdictional issues. Decentralization alone cannot improve health service inefficiency and ineffectiveness; it needs strong multilevel governances and community participation.

Despite the transfer of certain functions and responsibilities in area of public health services to local governments, *Woreda tended to face budget inadequacy to cover all the expenses of health services, and hence they were allowed to take over the duties of planning and budgeting which*

makers and decision makers to improve health services delivery at local levels in general and in the study in particular. On the whole, the thesis has the following significance. It may pay way for other scholars to conduct research on health services delivery at local levels. The findings and conclusion drawn from the thesis may help executives and legislative bodies in creating awareness on improving health services at local administration levels.

1.6. Scope of the Study

The scope of this study is geographically limited to Mida Kegn Woreda in west Shoa zone of the Oromia Regional State. It would not be possible to cover all the Woreda of the zone due to financial and time limitation.

Health service delivery is quasi-good that provided both by public and private sectors. However, this study focused largely on the health services provided by public sector institutions. This study attaches health services delivery with political, administrative, financial, legal and institutional aspects of decentralization to see a fully-fledged skeleton of health care provision. Preventative and promotive health services delivery is divided to in five Programmes. These Programmes include (1) health extension services (2) prevention and control of communicable diseases (3) maternal services (4) public health emergency and preparedness services (5) clinical services. Therefore, this study tries to assess the effects of decentralization in all of these programs.

1.7. Method of the Research

1.7.1.Research Design

Research method includes qualitative, quantitative and mixed approach. Qualitative research approach helps to conduct study in depth through exploring attitudes, behaviors and experiences by using key informants, focused group discussion and questionnaire so as to describe views and behaviors of a certain situation and events. On the other hand, quantitative research generates statistics and produces numerical data and mixed approach helps to undertake the combination of the two approaches (Kasley& Kumar, 1988).

This study has been mixed approaches and case study approaches because mixed method is used to explore views and behaviors pattern of by employing both qualitative and quantitative tools (Ibid). A case study design is used, because it conducted at institutional or community levels and

a descriptive research design is used to assess the impact of decentralization on health services delivery at local administration levels.

1.7.2.Source and Type of Data

Both primary and secondary data sources were employed to gather necessary data for the realization of the research. Secondary source data were collected from published and unpublished materials founded in the form of journal articles, proclamations, government policy papers, federal and regional constitutions, regulations, annual plans and performances and research papers were extensively consulted .The primary data source collected from government officials, health experts, health centers director's, health committee representatives and beneficiaries were interviewed.

1.7.3.Population of the Study

The study population includes controllers'[1] providers[2] and seekers[3].These are target population of the study because decentralization and health services delivery affect the whole sections of the Worde communities in one way or another. However, it is difficult and time consuming to approach all of them for data. Thus, samples from the controllers, providers and seekers which are expected to be representatives were considered.

1.7.4.Sampling Techniques and Sample Size

Cognizant of the aforementioned fact, the researcher applied both purposive and random sampling to select the sample units from the population. Purposive sampling helps the researcher to determine who can provide the best information to achieve the objective of the study. This type of sampling is useful to describe and explore a phenomenon in detail (R. Kumar, 2005). It is used for the selection of political appointees like heads of health office, finance and economic office and zonal health office, elected representatives such as Woreda chief administrator, Woreda council office, health center directors and Kebeles managers because these informants,

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[1]Governmental officials like Woreda chief administration, Woreda council head, Woreda health office head ,Woreda economic finance and cooperation ,and Kebeles managers

[2]core business process owners, supervisor, health extensions, private clinics owners, health centers director's, health committee representatives

[3] Local population benefited from health institutions

due to the position they hold, are supposed to have adequate knowledge and experience about the health policy, prospects and challenges of decentralized health service delivery in the Woreda.

Furthermore, the researcher employed multi-stratifying sampling technique to select informants from the three agro-ecological areas: high land, mid high land and arid. The first two agro ecologies have health posts and health centers, but there is no health center in the arid Woreda. For example, the high land has one health center, three health posts and three Kebeles. The mid high land has three health centers, twelve health posts and twelve Kebeles and arid has nine health posts and nine Kebeles. The researcher also selected 40 informants from 400 outpatients who had been treated from1/6/2009-30/6/2009EFY at Chukala and Balemi Health Centers by lottery method. The lottery was applied in two levels. First listed all the name of the outpatients alphabetically who had been treated in both health centers and then simply one unit was considered every ten outpatients.

Table1.1: The Sample Kebeles selected by agro ecology

No	No. of total Kebeles	Agro -ecology	Kebele selected
1	3	high land	Tuye
2	12	Mid-high land	Didiksa, Goda-Galan, Balemi, Gobe
3	9	arid	Garedo, Mafcee, Gambella
	Total		8

Source: Mida Kegn Woreda Health Office Report, 2016

Table1.1reveals, the researcher selected Tuye, Garedo, Mafcee, Gambella, Didiksa, Goda-Galan, Balemi and Gobe Kura kebeles because, they are highly populated ones and big in areal size, which implies higher demands to health services access. This implies that, these Kebeles need due attention from the Woreda administration to gain better health care.

Table1.2: Distribution of health institutions by agro ecology in the Woreda

No.	Health Institutions by agro ecology		selected Sample units
1	Health centers	high land	1
		Mid-high land	1
2	Health posts	high land	1
		high land	3
		arid	3
	Total	29	9

Source: Developed by Researcher

Table1.2 indicates that once Kebeles sample units were identified, health posts found in the Kebeles are selected. The researcher purposely selected Balemi and Chukala health centers because both health centers have access to transportation services and have relatively long experiences.

Table1.3: List of institutions and sampling size selected purposively

Name of institution	Purposefully chosen number of informants
Woreda Health Office Head	1
Woreda Council Office Head	1
Woreda Administration Head	1
Finance and Economic Development Head	1
Zonal Health Office Head	1
Oromia Health Bureau Head	1
Health Centers Directors	2
Health Centers Committees	2
Kebeles Managers	8
Total	18

Source: Developed by Researcher

Table1.3 shows that the office head, finance and economic office and zonal health head office, Elected Representatives such as Chief Administrator of the Woreda, Woreda Council Head Office, Health Center Directors, Kebele Managers were selected as informants due to the position they hold, as they are supposed to be familiar with the health policy, prospects and challenges of decentralized health service delivery in the Woreda.

Table 1.4: Health Personnel Sample Units

No	Providers type	No. individual questioned
1	Health officers	4
2	Nurses	6
3	Health Extensions	7
4	Mid wives	2
5	Pharmacists	2
6	Administrative Experts	2
7	Core Business Process Owner	2
	Total	25

Source: Developed by Researcher

Table 1.4 indicates the health personnel working in health office, health centers and health posts: health officers, midwives, nurses, pharmacists, administrative workers and health extension workers selected based on lottery method.

Table1.5: Sample size outpatients

No.	Name of health center	No. of patients questioned	Filled out the questionnaires
1	Chukala	15	10
2	Balemi	25	20
	Total	40	30(75%)

Source: Developed by Researcher

Table1.5 reveals that the researcher selected the outpatients who had been treated in Balemi and Chukala health centers from 1/6/2009-30/6/2009. During the month, 400 outpatients, of which150 and 250 had been treated at Chukala and Balemi health centers respectively.

Table 1.6: Summary of the participants in the study

Number of participants	Number of individuals interviewed or questioned
Woreda Health Office Head	1
Woreda Administration Office Head	1
Woreda Council Office Head	1
Finance and Economy Cooperation Office Head	1
Zonal Health Office	1
Oromia Health Bureau	1
Health Centers Directors	2
Kebele Managers	8
Health Centers Committees	2
Core Business Owners	2
Beneficiaries	30
Administrative Workers	2
Health Professionals	23
Total	73

Source: developed by Researcher

Table1.6 reveals that 73 informants participated in the study either through interview or questionnaire.

1.7.5.Data Collection Instruments

In order to achieve the purpose of the thesis the researcher employed document analysis, interview and questionnaires data collection instruments.

1.7.5.1.Document Reviews

Published and unpublished documents regarding decentralized health services delivery such as journals, policy papers, proclamations, plans and regulations, federal and regional constitutions, reports and research papers have been reviewed.

1.7.5.2. Interview

In-depth interviews were conducted with political appointees like head of Woreda Health Office, two Health Centers, Woreda Administration Office, Woreda Council Office, Finance and Economic Cooperation Office, Manager of the sample Kebeles, Core Business Owners[4], zonal Health Office Head and Oromia Health Office Head. The informants were purposively selected based on the knowledge they are supposed to have in decentralized health services delivery in the Woreda.

Questionnaires were developed, administrated and distributed by the researcher. They were prepared in English and translated into Afaan Oromo language in order to ease data collection. They were given to the selected informants.

1.7.6.Methods of Data Analysis

The analyses of the study was mainly descriptive that combines both primary and secondary data. As stated above, questionnaires and interview are good instruments for collecting relevant data from primary data source such as controllers, providers and seekers. Relevant documents were also reviewed. Data have been summarized using tables and percentages to give a condensed picture of the study.

1.8.Organization of the Study

The first chapter deals with introduction, statement of the problem, objective of the study, research questions, research methods, significance and organization of the thesis. Chapter two to conceptualize decentralization, theories and empirical studies related to decentralization, types and forms of decentralization and rationales of decentralization. The third chapter gives the overview of the Decentralized Ethiopian health delivery system. Chapter four is all about the description of study area, data analysis and interpretation of health service delivery access and quality care at Mida Kegn Woreda. The last chapter deals with summary, conclusion and recommendations.

[4]Department coordinators

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Introduction

The central aim of this chapter is to discuss the concept of decentralization. Under this chapter decentralization will be defined and its various forms of will be discussed. Also arguments both in favor and against decentralization will be deliberated. Finally empirical evidences will be discussed.

2.2. The Concept of Decentralization

There is no single internationally accepted definition of decentralization. It is defined contextually from the perspective of a writer who sees the subject. This means that decentralization is defined differently depending on the perspective of the department that is dealing with it.

Decentralization refers to the process of dispersing power and responsibilities from the central level to local governments. These powers and responsibilities include planning, human resources administration, decision making, financial and political powers (Murugu, 2014:19).

According to Rondinnelli (1983:13) decentralization "the transfer of responsibilities of planning and managing resources have been rising to allocate, it from central government to field units of central government ministers or agencies, subordinate units of governments, semiautonomous public authorities, regional and functional authorities"

Similarly for Anon (2003:35) decentralization is a means to empower and bring decision making back to the sub national governments and grass roots levels. Moreover, Tegegne and Kassahun (2004:36) define decentralization as transfer of social, economic and political authorities from central and its affiliates to sub-national governments in the process of making decision and managing diversity. In general, it is the way of governance to devolve, delegate and deconcentrate resources and powers concentrated at the hands of central government.

For Merera (2004:5) decentralization is the "devolution of power" to local level authorities or "sharing of power" with local authorities.

Fjeldstad (2004:20) has defined decentralization as "administrative changes in which, the higher level of governments devolved political, administrative and financial powers to lower level governments to deliver services. Politically, electorates are empowered to elect and put pressure on politicians to translate their demands and requirements. Politicians on the other hand, are supposed to monitor and control the bureaucrats to ensure services delivery"

As discussed above different meanings of decentralization are given by different scholars but, for the purpose of this study, the definition given by Fjeldstad (2004:20) adopted because, his definition gives due emphases to service delivery.

2.3. Theories and empirical studies related to decentralization

Different theories have been used to understand decentralization process. For the purpose of this thesis, democratic participation and systematic approaches theories have been used to explain decentralization process in Ethiopia because the aim of decentralization in Ethiopia is to promote democracy and democratization at national, regional and Woreda by encouraging community participation (USAID, 2009 cited in Mulugeta, 2102).

It is a theory that deals the interaction among the central, regional, local governments and citizens. It advocates the empowerment of local governments to have political, financial and administrative powers that enable them to decide on their affairs (Ibid).

Democratic participation theory is manifested in the form of authority, accountability, autonomy and capacity. Authority refers to the devolvement of political, financial and administrative powers to enable local governments to decide on their own affairs. Autonomy refers to the right that is constitutionally given to local government in order to decide on their affairs that falls under their jurisdiction without the interferences of third bodies. Accountability refers to the responsibility of locally elected officials horizontally to their people and vertically to higher government as well as capacity refers to the ability of local governments to hire human resource, raise taxes and constructing infrastructures that enable them to provide public services to their constituencies' falls under their jurisdiction (Ibid).

Furthermore, systematic approach theory is a theory that advocates a multilevel participation and coordination of federal, regional, local government and community to promote democracy and democratization. According to this theory even if all multi-level actors coordinated on the promotion and implementation of democracy and democratization, it advocates the autonomy of local governments to pass their own decision independent of higher government interventions (Norman, 1999:19)

The federal constitution of 1995, stipulated the devolution of political, fiscal and administrative powers and functions. Politically, it states that power belongs to the citizens and that their elected representatives could decide their own fate within their jurisdiction. In fiscal matters, tax powers are categorized into federal, state and concurrent (FDRE constitution article 96, 97 and 98). In terms of administration, the states have the power to administer their human resources and financial. It is based on regional functions with sectorial division of activities among regions and Woreda. The devolution of powers are needed in health services "to develop better preventive and promotive as well as curative and rehabilitative of health care by including all segments of the population and assure accessibility and equity of health care by mobilizing and utilizing internal and external resources"(TGE,1993). Due to this, health services delivery are devolved first at regional levels followed by Woreda levels.

Administratively, decentralization can be explained in the form of decocentration, delegation and devolution. Decocentration is administrative types of decentralization whereby powers and responsibilities of decision making, finance and implementation of a certain public functions shift from central government and regional governments to local government branch offices. Though certain public functions are transferred to local governments, central government has maintained full responsibilities to decide about services to be provided by local governments (Turner & Hulme, 1997:153 154).

In general it merely shifts some part of administrative decentralization from central government and regional government offices to local government offices with strong field administrations or supervisions of central government ministries. This type of decentralization is practiced mostly in unitary state (Annon, 2003 cited in Dessalegn, 2015).

The roles of local governments are implementing centrally or regionally determined activities especially administrative aspects of activities. Despite the fact that, it is the first step towards

improving services deliveries particularly in countries where there are no experience with the other forms of decentralization (ibid).

It is the weakest form of decentralization in which, the most crucial powers (political, financial, administrative and institutional powers) are retained by central government and implementation powers are left to local governments. (Ibid)

Delegation is a more extensive form of decentralization in which local governments are responsible for implementing the decision-making and administration of certain public functions on behalf of the central government or regional government authorities with proportional accountabilities (Matinussen, 1997:211). Despite the fact that the transferred powers are not constitutionally guaranteed, it is not entirely controlled by either the central government or regional government. Local governments are not suffered by strong supervision or field administration of central ministries or regional government bureaus rather central government expects proportional accountabilities from local governments.

It is characterized by "principal-agent relationship in which local governments act as closely as possible in accordance with the needs of central or regional governments" (ibid: 154).Under delegation, local governments have usually a great deal of discretion in decision making .They may be exempted from strong field administration or supervision of central ministries or regional government bureaus.

Devolution is the most extensive form of decentralization that is constitutionally devolved to local governments in order to manage a country's political, social and economic activities and provide effective and efficient public services by enhancing public participations in decision making at the local levels (Dessalegn, 2015;Kumera, 2006).Devolved forms of governance is usually transferring full mandate and responsibility to make more effective and efficient decision making through mobilizing resources, increasing popular participation so as to create more political space conducive to actors (Ibid).

In a devolved system, local governments have clear and legally recognized geographical boundaries over which they exercise authority and deliver public services (Turner &Hulme, 1997)

2.4. Public Service

Alike to decentralization the definition of public service is ambiguous for a number of reasons. First, the term public service is used interchangeable with the term public good (no clear distinction between good and service). Second, those services or goods which are termed as public in some groups of countries may be termed as private in others. And third, even there is no uniformity in demarcating between private and public sector itself among countries. This section of the paper tries to summarize literatures on these three points.

Phillip Maurice defined public goods or service as a product upon which there exists non-exclusion in consumption. That is to say one persons consumption is not affected by all other person's consumption of the same product (Maurice, 1992, P-60). In other words, Public goods or services are goods whose possession by one member of the public does not prevent its possession by others. By implication public goods are goods which are if available to one, should be equally available to all and when consumed by one, are still available in the same amount to others. Therefore, the consumption of public goods or services is open to all people and difficult to prohibit an individual from consuming it (Maurice, 1992). For this is due to the main reason that public services are considered as those services which are mainly, or completely, funded by taxation (public fund). As such, they can differ markedly from commercial private-sector services in a number of ways. These differences need to be both acknowledged and discussed, because of their potential implications for the development of delivery systems.

Most typically, public services would include health services, education, defense, justice, and non-commercial semi state organizations (Humphreys, 1998, p-6). But Peter C. Humphreys further argued that it is particularly important to appreciate that such a broad functional definition of the public service can vary both through space and over time.

As some researchers has observed, in relation to 'social public services' within the developed nations for instance European Union (EU), there are significant definitional differences between public administrations in the EU member states and it is mistaken to regard public, private or voluntary services as discrete and non-interactive spheres of human activity. As any attempt at cross national comparisons of services makes abundantly clear, the same activities (e.g. health or education) may be undertaken by either the public and/or private and/or voluntary sectors

depending on the country concerned. With regard to the services provided, the relationship between these three sectors can also vary significantly (Humphreys, 1998). In the case of developing countries most of the services indicated above such as education, health, including water supply, roads etc. are mostly provided by government agencies and some of them is provided in collaboration/jointly or partially by the private sector.

Therefore, in developing countries by and large, services which are related with broad public consumption issues are provided by government agencies and termed as access to basic rights or services available to citizens and contributes to human needs or development. In varying degrees, basic public sector services like water supply and sanitation, housing or shelter, primary health care, education and roads are largely provided at local level.

2.5. Why Decentralization in Public Service Delivery?

This section focuses on the review of linkages between decentralization as mechanism of resource mobilization and decentralized service delivery as desired policy direction and local rural-based outcomes form services delivered.

Traditionally, service delivery is based on either public or private provision depending on a variety of factors like political and economic structures, interest and capability of private providers, local finances, consumer or societal preferences, geographic dispersal of service beneficiaries, equity and properties of the service itself. Hence, a country may organize service delivery in a variety of ways and levels ranging from private to public and from highly centralized level to highly decentralized level. Accordingly, Public services are often distinguished by an absolute, or at least comparative, lack of competition in the normal market sense of seeking to entice customers away from their competitors or rival service providers. Indeed, public services are often monopolistic or oligopolistic. As a result, many of the basic features of a commercial market place are quite simply absent from the delivery of public services. In addition, given the regulatory role often performed by public services such as tax collection and law enforcement, not only are public services often monopolistic or oligopolistic in character, but they can also be mandatory. In the public services, different guiding principles, such as equitable treatment and the allocation of resources according to need, pervade the processes of decision making, management and provision (Humphreys, 1998, p-9).

As tried to show above among the objectives of decentralization improved efficiency and improved governance are basically concerned or directly linked with public service delivery because the provision of some public goods is more economically efficient when a larger number of local institutions are involved than when a larger number of local institutions is the provider (Rondinelli, 1989: 59).

Besides the efficiency values, Wolman also proposed improved governance as the main factor of decentralization. Good governance refers to (a) responsiveness and accountability, (b) diversity, (c) and political participation. Wolman argues that: Decentralization, by placing government closer to the people, fosters greater responsiveness of policy-makers to the will of the citizenry and, it is argued, results in a closer congruence between public preferences and public policy.

This is not only because decision makers in decentralized units are likely to be more knowledgeable about and attuned to the needs of their area than are centralized national government decision-makers, but also because decentralization permits these decision-makers to be held directly accountable to the local citizenry through local elections (Wolman in Bennet, 1990: 27). Moreover, as the World Bank summarized the central government is elected by the national electorate. One of the prime functions of an elected government is to manage the national economy in ways that the citizens, irrespective of location, benefit from government's interventions. In order to meet up with these expectations, governments are required to decentralize to institute local authority dialogue lines by empowering local communities to decide on what is good for them. By decentralization, the decision making process on community resource utilization and related infrastructures are initiated by the concern community and then pass up to hierarchy for implementation. Decentralization creates an environment for democratic governance. An environment necessary for the central government to dialogue with the populations they serve and get their feedback before packaging required services. It enables the government to provide acceptable cost benefit services as prioritized by the beneficiaries. (World Bank: Decentralization and Local Authority in Africa) http://www.freetocharities.org.uk/edgf/13.pdf accessed 02/01/2016

2.6. Empirical Evidences

The existing theories of decentralization in developing countries offer a variety hints on the impact of the implementation of this system itself. Those impacts are still debatable as to whether or not this system was bringing benefit to citizens. There is much empirical evidence to suggest that in some cases, decentralization have positive impacts to service delivery, government performance, economic growth or reducing corruption. In the other hand, there are also some results, which show that decentralization creates higher perceived corruption and poorer service delivery performance. Countries have different motives to adopt decentralization. Some countries have changed their governance systems because of civil war like Uganda or political crises in Indonesia or responses to ethnic desire to have greater participation in political process like Ethiopia (Kumara, 2006 and Dasselegn, 2015).

Besides political benefits, decentralization system is promoted to enhance community participation, accommodating diversity, conflict resolution and promoting public services effectively and efficiently.

Decentralized political system reserved more power to local governments and grassroots communities through subsidiary principle by enabling communities to participate in idea generating, planning, monitoring, implementing, managing and evaluating issues that affect their activities. Subsidiary principle also enhances communal participation in decision making directly and indirectly through their representatives. This communal participation in decision making, idea generating, planning, monitoring, implementing, managing and evaluating has enhanced accountability, effectiveness, responsibility and efficiency of local governments to its constituencies (Dasselegn, 2015, kumara, 2006).

Decentralized political system plays an important role in promoting diversity by giving political, financial and administrative powers to a certain cultural groups that are not shared by a large group of people. It enables a certain cultural groups to preserve and promote their culture, language, history and heritages as well as promoting in a decision making at national, regional and local levels. In general decentralized political system is response to diversity demands (Dutter, 2009).

Decentralization process has devolved political, financial and administrative powers to all ethnic groups. This devolution of power helps to prevent or reduce conflict by empowering all ethnic groups to decide on their own issues without the interferences of other ethnic groups. It also promotes peace by reducing actual or perceived disparities may be emerged among various inter or intra ethnic groups and regions by allowing them to provide utilize their resources in order to improve their own wellbeing's (Norman, 1999).

Decentralized political system has promoted efficiency and effectiveness of decision making and public service delivery by closing information to local governments by reducing in order to make decision timely and quickly (Kumara, 2006).

It has also enabled local government to be more flexible than central government to fulfill the preferences of the grassroots community as well as enforced locally elected official to be responsible to their constituencies (Dasselegn, 2015).

As says goes on 'delaying service is denying services.' Decentralized political system speeds up decision making and public services delivery by responding local claims and demands in timely manner. Due to this efficiency and effectiveness of public services have increased.

Decentralized political system is not a panacea for all centralized political system. It has also its own pitfalls. These pitfalls are creating disparities among inter and intra regions, creating spillover effects, macroeconomic instability and creating unfair competition among intra and inter regions (kumara, 2006, Dasselegn 2015). Furthermore, decentralized political system reduces capital movement from regions to region by favoring the 'sons of soils' as well as "it increases corruption at grass roots level" (Zamalek, 2008:10).

Conclusion

In this chapter basically concepts, theory and rationale of decentralization reviewed. Decentralization processes transferred power and responsibility to lower level of governments. These responsibilities include political, administrative and financial. These three aspects of decentralization were given to local governments through decocentration, delegation and devolution. Decentralization has promotes effective and efficient service delivery, promote peace and stability, democracy and promote public participation and as well as it creates macroeconomic stabilities and unfair competition among intra and inter regions.

CHAPTER THREE

3. OVERVIEW OF THE ETHIOPIAN DECENTRALIZED HEALTH SERVICE DELIVERY SYSTEM

3.1. Introduction

The following chapter discusses about historical development of modern health services delivery in Ethiopia, institutional frame work of decentralized health services delivers and financial sources of health services delivery.

3.2. Decentralization and Health Services Delivery in Ethiopia

Until the turn of 19th century, there was no modern public health system. Health treatment was entirely carried out by traditional healers like traditional medicine, prayer and holy water. The genesis of modern health services in Ethiopia was pioneered with European Christian missionaries and expeditions.

The notion of modern public health [illegible] begun in the country around the beginning of 20th century. The first modern hospital, Me[illegible] was built, in 1906 in Addis Ababa having 30 beds with eight health professionals (four doctors and five nurses (EPHA, 2012).

The emperor Haile SillaseI had introduced different health institutions that contribute for services improvement such as establishment of Ministry of Health and health teaching institutions, formulation a national health policy which run for three consecutive five years developmental plan from 1959-1973 with objective of raising health services coverage from 15%-30% by the end of the third five year plan and to establish anti-epidemic campaign to combat Malaria, Leprosy and Tuberculosis.

The health status of Ethiopia was so poor during Emperor Haile SillaseI comparing to sub-Saharan Africa. For example access to primary health care was 15% as compared to 33% in sub-Saharan Africa in 1973 (Ethiopia Health Profile, 2015).Furthermore maternal and child mortality was high. Maternal and child mortality rates were 1600/100,000 and child mortality350/1000 births in 1973 (Ethiopia Health Profile, 2015).

Communicable diseases such as malaria, Tuberculosis, Leprosy and sexually transmitted diseases were also among the top killer diseases. More than three fourth of the country used to be suffered by malaria. Even though the government took positive action by launching malaria, TB and leprosy control and elimination projects with support of USAID, their impacts were low.

Even if the regime attempted in expanding modern public health service, the way of the service provision method was highly centralized. That is the provinces and local governments had no say in when and how health institutions established as well as how and when anti-malarial treatment should be delivered. Sexually transmitted diseases were common diseases according to WHO (1970s) estimation. More than 50% of the people were suffered and sterilized by these diseases (Ibid). Due to this centralized system, health service delivery was inefficient and ineffective.

In general during the imperial regime health problems were caused by flown policy, budget constraints and centralization of health services. In terms of policy, the national health policy was biased to curative while more than 90% of the health problems were caused by preventive and promotive health service. Low budgets had been assigned to health sectors relatively, to securities and education sectors. The major health problems of the emperor Haile SillaseI regime was highly concentration of health services deliveries at urban centers like Addis Ababa and Asmara. While more than 95% of rural populations were suffered from and died by absence of health services.

During the Derg regime maternal and child mortality rates were high, but made slight improvements. Maternal mortality was 1400/100,000 and child mortality was 205/1000 births in 1990 (Ethiopia Health Profile, 2015).

There were attempts made by of the regime to prevent and control such as malaria, Tuberculosis, leprosy, sexually transmitted diseases, small pox and measles by intensifying single disease control and elimination of projects and immunization Programmes.

In general, there were the improvements of health service delivery during the regime. These health sector achievements were registered as a result of the national health policy that prioritized diseases prevention and control, rural areas health services and promotion of self-reliance and communities' involvement. The regime had also accessed modern public health to

all communities across the country, deurbanized health service and in terms of finance largely there was no fee collected from users for health services ideally. It had also designed 10 year development plan putting emphasis on the rural areas and preventive and promotive health services delivery and the immunization Programmes.

In spite of this, health services delivery was inefficient, ineffective and low covering due to the centralized nature of the then political system, low finance and little or no human resource. Local governments had no say on how and when health services delivery should be given a part from implementing what was decided at the top. Not only the massive centralization but also the regime lacked leadership commitment to address and maintain active popular participation in translating policy into action. The bulk of the national resources were committed to meet 'Everything to the War Front' slogan which left little public investment for development activities in any sectors (EPHA, 2012).Thus, health services access remained very low.

With the coming of EPRDF to power in 1991, the century –old centralized system had been abolished and a decentralized political system was introduced. The regime has conducted two phases of decentralization since 1991/2. The first wave of decentralization was to forge federalism in the country in order to 'answer nationality question' emerged since Menelik II military expeditions to the south and south east of Shoa. The federal system is supposed to address the century old suppression and exclusion of non-Amhara ethnic groups.

The second phase of decentralization was aimed at addressing the chronic problem of inefficiency and ineffectiveness of public services delivery which had faced all regimes. EPRDF government conducted the second waves of decentralization since 2001/2 in order to enhance effective and efficient public services delivery to all communities in the country.

The incumbent government have reduced maternal and child mortalities. Maternal and child mortality rate for Ethiopia was 420/100,000 and64/1000 births respectively in 2013 (Ethiopia Health Profile, 2015).

Communicable diseases such as malaria, Tuberculosis, leprosy, sexually transmitted diseases, small pox and measles have highly reduced. For example malaria, leprosy, TB, STDs (except HIV and AIDS) showed reduction by 75%, 100%, 75%, and 75% respectively where as small pox and polio completely eradicated (Ibid).

Some 20%of the country's areas became free from open defecation (ODF) in 2015 (FMOH, 2015). These significant health service improvements or developments were gained due to the policy, budget and devolution of power from the center or regions to local governments. In terms of policy, the 1993 national health policy, identifies preventive and promotive services, curative and rehabilitative services, but officially did not give attention to curative and rehabilitative service in practice it, favor both curative and preventive services.

3.3.Legal Framework for decentralized health service delivery under FDRE

In federal political system expenditure responsibilities are divided among different levels of governments federal, regional and local.

Since1991 Ethiopia is a federal system in which powers and functions are divided between federal and regional governments. The powers and functions of both levels of governments are derived from the federal constitution (FDRE constitution 1995, article 51/52). Powers and functions of local governments are derived from the powers and functions of respective regional states (FDRE constitution, article 50/4).In general, the provisions of health care are shared responsibilities of all levels of governments. All levels of governments have their own powers and responsibilities or mandates.

3.4. Health Care Financing Policy in Ethiopia

Health service delivery is quasi-public goods. It is neither completely a public good nor left to a private sector. Health service financing policy is also critical issue. As the service is a quasi-public good, health economics theories and international practices reveals that, health services are financed by public on the principles of beneficiary benefits and NGOs.

The current Ethiopia health care financing strategies focus on financing primary health care services in a sustainable manner by mobilizing adequate resources mainly from government budget, out-of-pocket expenditure, health insurances, including payments in private wing in public hospitals, revenue retention and utilization. Poor nationals have the right to get health services through fee waiver and exemption polices (FMOH, 2005).

(i). Government Budget

This refers to health expenditures spend by various levels government INCLUDING federal, regional and local governments. This health expenditure is generated from public treasury and external sources (donations and assistances).

Table 3.2: Ethiopia' s Total health expenditure, in USD million

Fiscal year	General health expenditure	Public expenditure[5]		Private expenditure				Per-capita	Share of GDP
		Total budget	Share in %	Total budget	Out-of-pocket [6]	Capital budget	Share in %		
1995	230	93	40.6	137	107.55	29.45	59.4	4	3
2000	357	195	54.6	162	128.3	33.7	45.4	5	4.4
2005	520	319	61.4	201	128.5	72.5	38.6	7	4.2
2010	1837	995.7	54.2	841.3	618	223.16	45.8	21	6.9
2011	1996	1137	57	859	634.8	224.2	43	22	6.5
2012	2435	1397.69	57.4	1037	807.8	229.2	42.6	26	5.2
2013	2368	1347.392	56.9	1021	790.3	230	43.1	25	
2014	2584	1521.98	58.7	1062.02	829.4	238	4.9	27	

Source: World Data Atlas: https://knoema.com/atlas/Ethiopia/topics/Health/Health-Expenditure, 2016

The above Table depicts that health expenditure increased by about 11 folds from 230 million in 1995 to 2584 million US dollars in 2014. Government health expenditure also grew by 16 folds, from 93 million in 1995 to 1521.98 million dollars in 2014, with exception decline of government budget in 2013. The share of private expenditure on health is also significant. It comprises, on average 59.4% in 1995 and 43.1 % in 2014 of the total health expenditure. Government health expenditure consists, on average 40.6 % and 58.7 % in 1995 and 2014.

Ethiopian health services have been financed by private insurance though it share are too low. Different governmental organizations such as Tele communication, Sugar Corporation and non-government business organizations such as financial sectors have used private insurances for their employees.

[5]Public expenditure includes federal, regional and local governments

[6]Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups

(ii). Initiation of social health insurance scheme

The federal government issued social health insurance proclamation in order "provide quality and sustainable universal health care coverage to beneficiary through pooling resources and reducing financial burdens during treatments"(FDRE Proclamation,690/2010 Article 4)

According to Article 6 of the Federal proclamation 690/2010 the social health insurance scheme shall have the following sources of finance:

- 3% of the gross salary of employers'
- 3% Employers contribution and
- Investment income

A pensioner shall contribute 1% of his/her pension allowance and 1% Employers contribution

According the Federal Regulation article 271/2012 article 3(1) any beneficiary of social health insurance scheme shall have the right to receive the following health services from health institutions which have contracted with agency:

a. "Outpatient care,
b. Inpatient cares,
c. Delivery services
d. Surgical services
e. Diagnostic tests and drugs included in the drug lists of the agency , and prescribed by medical practitioners"

Nevertheless, the health insurance scheme has not yet implemented because the National Regional Government of Oromia was not in a position to implement in its region due to the then violence.

Most of governments owned hospitals are allowed to operate a private wing in public hospitals to address health workers' retention and providing alternatives to private health service users as well as generating additional income for health institutions (USAID, 2016).

(iii). Fee waiver system

Fee waiver system is one of the major components of health care financing reform. Waiver system is implemented in public health facility, to increase access for those who cannot afford cost of health service, to increase the financial capacity of health facilities and to improve health service quality by using the reimbursed cost of the services they provide through fee waiver system. According to Ministry of Federal Health Manual (2007) the following is receive as a beneficiary, households or Individuals who cannot afford to pay for health services and thus are provided waiver certificates from Woreda, street children and homeless citizens who can provide evidence from the bureau of labor and social affairs and persons receiving 24 hours' emergency care provided by health institutions, who cannot afford to pay for the service.

Woreda and Kebele fee waiver selection committee identify the poor individuals by using procedures, and, Woreda and city administration fee waiver selection committee reviews and organizes list of potential fee waived it received from respective kebele fee waiver selection committee and, approve the final beneficiaries (Ibid).

Woreda Kebele committees use, the following points to select the eligible households for the fee waiver. For rural areas Size of land holding, number of dependents, number of livestock holding, Level of harvest, physical ability to work and earn income, earning less than minimum wage, household size in relation to income. For urban areas homeless, and street dwellers, orphaned children who have no financial support from relatives or no adequate inheritance from their parents, households earning less than minimum wage, households whose living is based on petty trades and unable to meet their daily subsistence, physical ability to work and earn income, household size in relation to income, and also for both area use of other objective criteria in the locality to identify the poor.

Kebele fee waiver selection committee, Woreda fee waiver selection committee, Woreda and city administrations community, mobilization, labor and social affairs office and food security, disaster prevention and preparedness commission and office involve in fee waiver selection prose and all have specific duty and responsibility. And the waiver certificate is valid for one year. Based on the principle "no service is free" there is no free care in the health facility there is reimbursement mechanism of fee waiver from Woreda Finance and Development Cooperation quarterly. And hospitals reimbursed by regional health office. And also each facility should have recording mechanism to make easiest the reimbursement prose. Health facilities present quarterly

reports on services rendered to waiver certificate holders to board/governing body, Woreda Health Office, Woreda and City administration and Woreda Finance and Development Cooperation.

(iv). Exemption services

Ethiopia has provided health services free of charges through exempted system for selected public health services such as health education and treatment of tuberculosis patients, HIV/AIDS and immunization services to children under the age of five and women and family planning, counseling and testing and deliver services to women (USAID, 2012).

Conclusion

Modern health services delivery is begun in Ethiopia during Emperor Menelik II and all successive regimes have expanded. Imperial Haile SillaseI had tried to improve health service delivery by formulating national health policy, building health institutions and establishing different projects used to tackle Malaria, Leprosy and TB.

Derg regime had also tried to expand health service delivery by introducing especially primary health care units and expending immunization programme more and more. Due to this Child mortality and maternal mortality rate reduced and EPRDF regime has also improved health delivery by formulating clear health policy give attention to preventive diseases and favors rural communities.

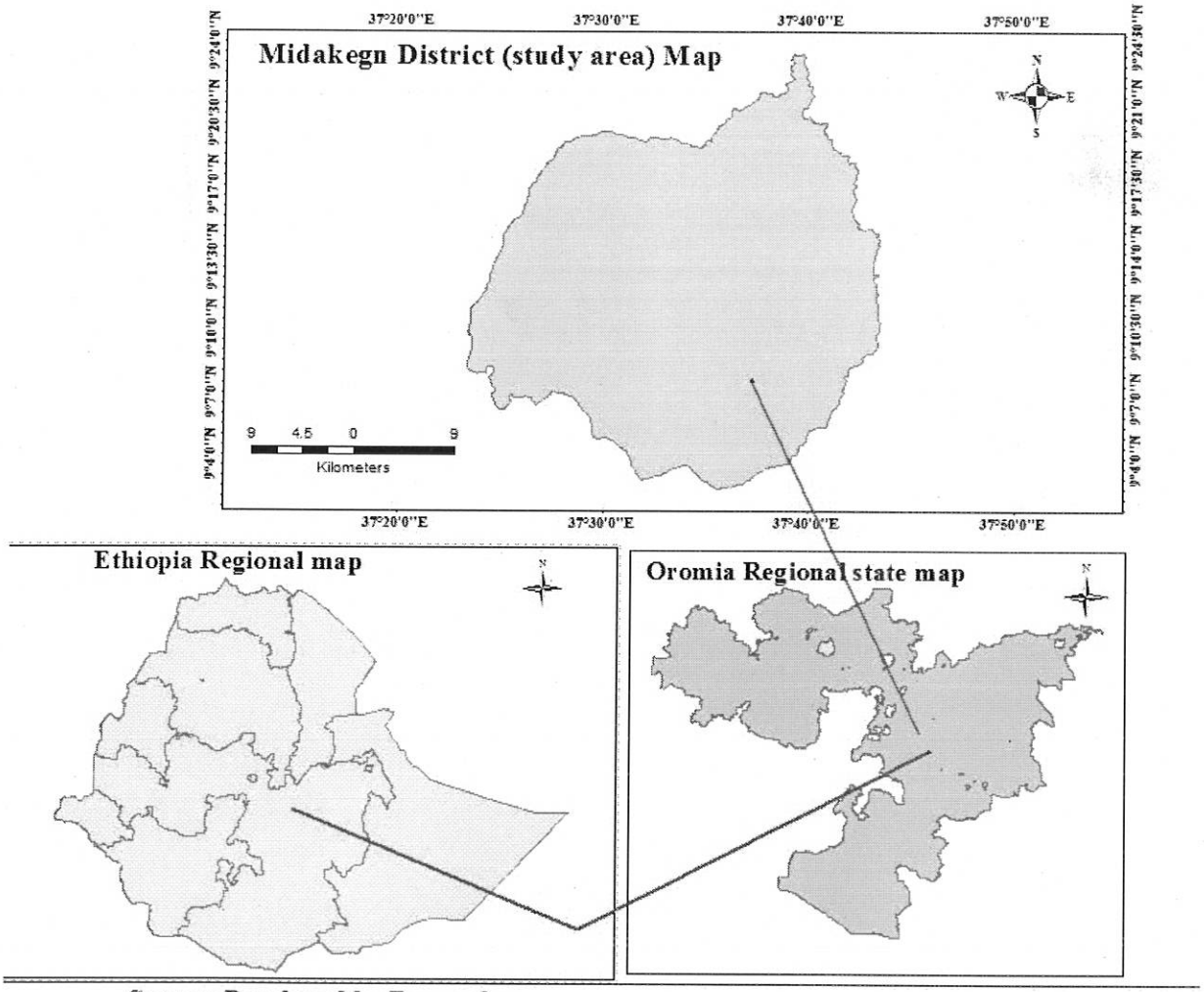
CHAPTER FOUR

4. DATA ANALYSIS AND PRESENTATION

4.1.Study Area Description

The location of the study is Mida Kegn Woreda, West Shoa zone, Oromia National Regional State. It shares boundary with Horro-Guduru Wollega in the North, Chalia Woreda in the South, Ambo in the East and Horro-Guduru Wollega and Chalia in the west.

Figure 4.1: Map of Mida Kegn Woreda



Source: Developed by Researcher

According to Rural Land Environmental Protection office documents (2016), the total area of the Woreda is 990km2. It has three agro-ecological zones: - 12 % highland, 52 %t mid-highland and 36 percent low land). It has an estimated population of 103,452 of which 50,691 (49%) are male and the remaining 52,761 (51) female. From the total populations, 7034 (6.8%) is urban and 96,452 (93.2 %) rural residents (Town administration Document office, 2016). There are 30 sectors and 25Kebeles administrations in the Woreda of which of 16 Kebeles[7] administrations have wireless telephones and 9 Kebeles administrations have 24 hours of power supply, 4 health centers[8]in Woreda administrations and 25 have health posts[9].

There are 39 state owned schools, of which, 4 are first cycle primary schools (first cycle 1-4) schools and the rest 30 schools are second cycle (5-8), 4 secondary high schools, 1 preparatory and 1TVET.85% of Woreda population have access to primary education in 2016 and 91% of Oromia population have access to primary education in 2016(Woreda Education Office Report, 2016). There are 123 potable water points, which provides 47% of total population of the Woreda comparing 65%of total population of the region in 2016 (Mida water and Mineral Woreda office report, 2016).With regard to road access, the Woreda has 95 km rural roads that connect Kebeles to Woreda and Kebeles to Kebeles (Woreda administration sector office documents, 2016).

4.2.Characteristics of Respondents

As it is indicated in chapter one, Woreda Health Experts, Woreda Chief Administration, Woreda Economic and Cooperation Offices, Core Process Owners, Health Center Directors, Health Experts, Kebeles Managers, Beneficiaries, Elders, Health Center Committees, Zonal Health Office Head and Regional Health Bureau Head were respondents of the researcher.

Semi-structured interviews were held with 18 individuals from Woreda Chief Administration office, Woreda Economic and Cooperation Offices, Core Process Owners, Health Center Directors, Health Experts, Kebeles Managers, Beneficiaries, Health Center Committees, Zonal Health Office Head and Regional Health Bureau Head.

[7]Kebele is the lowest tier of government consisting 3000-5000 population
[8]It health institutions that is built for 25000 population
[9] It is the lowest level of health institutions that served 3000-5000 population and gives preventative services

Questionnaires were filled out by Health Experts, Health Extension workers and Beneficiaries. A total number of 57 questionnaires were distributed and 45 were properly filled out and returned which showed 78.94% response rate

Table 4.1: Characteristics of Participants by Gender, Work Experience and Educational Status

Description		Number and percentage of respondents and informants												
		offices heads[10]		Kebeles Managers		Health Workers		Beneficiary		Health center directors		Health center committee		Total
		No	%	No	%	No	%	No	%	No	%	No	%	
Gender	Male	6	100	8	100	15	65	10	33	2	100	1	50	40
	Female	-	-	-		8	35	20	67	-	-	1	50	33
Subtotal		6	100	8	100	23	100	30	100	2	100	2	100	73
Work Experience	1-5	6	100	-	-	13	56	-	-	2	100	2	100	23
	5-10	-	-	8	100	4	17	-	-	-	-	-		8
	10-15	-	-	-		4	17	-	-	-	-	-		2
	>15	-	-	-	-	2	-	-	-	-	-	-		2
Subtotal		6	100	8	100	23	100							37
Education Level	< 8	-	-	-	-	-		15	50					15
	8-12	-				-		10	33					15
	Certi	--				4		-	-					4
	L/ IV	-		4	50	10				2		2	100	18
	BA	4	66.6	4	50	4		5	16			-	-	18
	MSC	1	16.6			-						-	-	1
	M.D	1	16.6			-						-	-	1
Total		6		8		23		30		4		2	100	73

Source: Own Survey Result (March 2017)

Table4.1 reveals the composition of the informants[11] in terms of sex, work experience, and levels of education. Out of the total informants, 40 (54.79%) and 33(45.2%) were male and female respectively, Size of participants represent fair gender mix, which entails that health services delivery is the concern of the both gender and theinformants23 (31.5), 8(10.9%), 2(2.7%) and 2(2.7%) have 1-5, 5-10, 10-15 and >15 years of work experiences respectively.

In terms of level of educations, informants constituted 15(20.54%), 15(20.54%), 4(5.4%), 18(24.65%), 17(23.28%), 1(1.36%) and 1(1.36%)< grade8, Grade 8-12, Certificate, Level IV, BA/BSC, MSc and M.D respectively.

Participants' background on experiences and levels of education assisted the researcher in getting a clue about their understanding of health services delivery at different times.

[10] Woreda health experts, Woreda chief administration, Woreda economic and cooperation offices, Zonal health office head and regional health Bureau head

[11] The individuals who have given their ideas either as respondents and interviewees

4.3.Health Service Delivery in Mida Kegn Woreda

Introduction

The 1993 national health policy, generally categorized health service delivery into two: Preventive and promotive and Curative and Rehabilitative services

Preventative and promotive health services delivery are divided into five Programmes, health extension service, prevention and control of communicable diseases, family services, public health emergency services and preparedness services and curative and rehabilitative services comprises clinical services.

4.3.1.Health Extension services (HEP)

Health extension service strategy is introduced nationally in 2003 to promote the health well-being of all communities in the country. Mida Kegn Woreda administration implemented health extension services as one of its strategies to promote preventive and promotive health services to communities by mobilizing health extension workers and health experts as well as organizing and establishing health centers and health posts. Besides, this mobilizing health experts and organizing and establishing health institutions Woreda administration has supervised health workers and health institutions and equipping health institutions with by the necessary medical equipment and drugs are needed to provide health services both at health posts and health centers. Kebeles administrations have mobilized different social organization like one 1-5 networks, development teams, health development army and communities to promote health service to local communities. Kebeles and Woreda Councils have evaluated and supervised health posts and health center performance.

As the socio-economic status of communities have improved and demand for quality services of health services delivery of beneficiaries' increases from day to day. To respond beneficiaries' demands, all levels of government have strengthened the capacity of health extension workers. To strength health extension capacities federal government has introduced second generation of Health Extension Workers, regional governments training and local governments are recruiting. The aim of the second generation of health extension is to upgrade health extension workers educational status from certificate to level four community health nurses (Ethiopia Health Profile,

2015). Due to this, 29 and 5 health extension workers upgraded and are upgrading their educational status from certificates to level four community health nurses (Mida Kegn Woreda Health Office Report, 2016).

Table 4.2: Hygiene and Environmental Sanitation Coverage Progress

Indicator	Plan 2003	Performance in 2003	Plan in 2008	Performance in 2008	Changes 2003-2007
Proper and safe solid and liquid waste management	10%	0%	100%	30%	30%
Health supply safety measures	15%	5%	75%	55%	50%
Foods hygiene and safety measure	15%	5%	100%	75%	70%
Healthy home environment	15%	0%	90%	70%	70%
Personal hygiene	15%	5%	90%	75%	70%
Latrine	70%	(53%)	100%	93%	40%

Source: Mida Kegn Woreda Health office performance report (2016)

As far as health extension package is concerned, hygiene and environmental sanitation is one of the major components. Mida Kegn Woreda administration played a crucial role in the improvement of hygiene and environmental sanitation by hiring, training and mobilizing health extension workers, and health experts, and organizing and establishing health centers and health posts. Besides, the mobilization of human resources, the Woreda administration supported and supervised and gave feedback to health extension workers, health posts and health centers and organized training to communities and rewarded role model households for who had made cleaning their homes and environments and making hygiene and sanitation part of their day to activities. Kebeles Administrations have also mobilized different social organizations like 1-5 networks, development teams, health development army and communities to promote health service to local communities and also create awareness in order to protect their environmental hygiene and sanitations. Kebeles and Woreda councils have evaluated and supervised and gave feed backs to health extension workers and health posts and health centers performance.

Despite the improvement of environmental hygiene and sanitations since 2003- 2007 EFY, still there is a huge gap between plan and performances of environmental hygiene and sanitation.

Three points are forwarded as reasons. According to the Health Office Head, under performance of hygiene and environmental sanitation emanated from lack of commitment from health extension workers, health professionals to aware and educate the communities.

However, all health extension workers argue that the underperformance of hygiene and environmental sanitation is caused by mismatch in the deployment of health workers with the area size of the Kebeles. Most of the Kebeles are too large to cover by two health extensions workers. Moreover, health extension workers confirm that Woreda health office does not adjust any means of transportation like bicycle. This problem makes difficulty to reach all corners of communities on foot every day.

Health center directors, environmental hygiene and sanitation did not meet its target because communities did not internalize health education and communications frequently were given by health extension workers. Besides, health education is not included in print and electronic exclusively oral education and communication.

All respondents pointed out that health institutions, Woreda administration, Kebeles managers, education and religious institutions are doing their best to declare Open Defecation Free (ODF)[12] by building public latrine around Kebeles office, schools, churches, along road side and market areas and encourage communities to have their own latrine, however, open defecation is still high in the Woreda because of lack of awareness to use latrine regularly.

As we know devolution of power is argued to promote local participation at grass roots level. This local participation is supposed to enable local governments to improve public services performances. However, local governments have achieved less in ODF according to health office head and health center directors *"Even if open defecation free belongs to Health Extension Workers regular job, most of the time, it is done by campaign. In campaign the major problem is lack of balancing all field jobs as is carried out at the same time. Secondly, health extension Programmes have needed communities' participation. The mobilization of grass roots communities need the commitment of political leadership. However, there is lack of political commitments from officials"*

In general all informants confirmed that health outcomes gained from the implementation of environmental hygiene and sanitation has reduced over 80% morbidity of communicable diseases such as diarrhea, typhoid, typhus, Jardia and ameba.

[12]The entire community(household's, schools, religious institutions etc.) stopped the practices of open defection

4.3.2.Maternal Services

(i). Newborn Maternal Health Services

Mothers have faced three problems during pregnancy in seeking medical treatment. These problems include:

- ☐ At homes in connection with harmful traditional practices
- ☐ On the roads caused by lack of adequate transportations and,
- ☐ Lack of health facilities owning to poor infrastructural facilities and inadequate drugs and professional cares

The Woreda administration designed an unprecedented plan to curb maternal death. To achieve the plan, it set three strategies. The first strategy to address mothers 'problem at home is through hiring, training and deploying health extension workers at every Kebele. Hence Kebele administrations organized Health Development Army in order to initiate mothers to go to health institutions while they are pregnant to seek medical care. In line with this, Kebele administrations of Mida Kegn Woreda had organized and mobilized 523Health Development Army to raise awareness the communities to visit health institutions regularly during pregnancy and before they come across labor (Mida kegn Woreda Health office Report, 2016).

The second strategy was through facilitating modern transportation systems using Ambulances[13]. The Woreda administration relied on two ambulances to address problem of transportation mothers faced on the road in times of delivery (Mida Kegn Woreda Report, 2016). Besides, Kebele administrations readied their own means of transportations system locally known as cultural ambulances. It locally made from leather products and wood. Kebele administrations have also taken a number of actions towards improving maternal care in their own creative ways. Each *garee*[14]or team has its own culture ambulances and totally the Woreda administration has 523 cultural ambulance services (Woreda Health Office Report, 2016).

The third strategy is reliance on forming 'compassionate, respectful and caring work force' (CRC) to solve the problems of mothers at health institutions by giving long and short term

[13]One from federal government donation and the other from Oromo Development Association

[14] sub Kebele administrative division in Oromia .It is the second smaller , administrative system next *tokko shanee(1-5) network*

training, improving the living conditions of health professionals an dhiring additional health professionals such as midwives and providing adequate drug ,medical supplies and equipment.

These strategies helped in reducing home delivery from 83% in 2003 EFY to 42% in 2008 and maternal and child mortality from 820/100,000 persons in 2000 to 420/100,000 to 2008, 100/1000 persons in 2000 to 64/1000 persons in 2008 EFY respectively. Home delivery decreased from in 41% 2003 to 2008 EFY. These strategies contributed to improving access to safe, affordable and effective care delivery. Performance of skilled delivery increased from 5% 1995 to 53% in 2008 EFY. All tiers of administrations have high commitment to make maternal death zero by making home delivery zero. They have showed their commitment to end maternal death sticking to the principle that a mother does not lose her life to give life *(FMOH, 2016).*

Table 4.3: New born Maternal Health Coverage (EFY 1995) Baseline and 2008 Performances

Indicator	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Skilled delivery[15]	5%	6%	7%	9%	8%	12%	19%	23%	17%	18%	27%	45%	56%	58%
Home deliver	-	-	-						83%	82%	73%	55%	44%	42%

Source -Mida Kegn Woreda Health office performance report (2016)

However, the above table reveals that, still 42% of mothers delivered at home in 2008 EFY. This shows that home delivery was high and that the possibilities of maternal and child mortality was also high. The principle was not fully translated in to practice. In that the same period home free delivery was42, 38 and 32 of at national, Oromia and Mida Kegn Woreda levels respectively. The Mida Kegn home delivery was high when compare with regional and national health performances. The Mida Kegn Woreda home delivery was caused by poor access to health services, lack of adequate transportation services and health facilities (drug, professional care and etc.).

[15]All women who have access to skilled care during pregnancy and childbirth to ensure prevention, early detection and management of complication.

(ii). Maternal Reproductive Health

Table 4.4: Maternal Reproductive health coverage (EFY 1995) baseline and 2008 performance

Indicator	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ANC[16]	-	-	1	4	12	20	30	38	55	76	90	93	100	100
PNC [17]	-	-		9	10	10	13	17	23	58	57	72	72	72
FP [18]	-	-		24	18	24	29	35	48	43	60	72	61	60

Source: Mida Kegn Woreda Health office performance Report (2016)

The above table shows the improvement in antenatal and post-natal care as well as increment in family planning from 1999 to 2008 EFY is attributed to the health professionals. These developments were strengthened with the efforts of Woreda administration. These efforts included providing free planning, free counseling and guidance before and after birth and as well as training, mobilizing and organizing health sector officials at all levels.

Kebele administrations have also improved maternal reproductive by training, mobilizing and organizing different social arrangements like 1-5 and health development army to aware mothers to take advantage of family planning services. Moreover, the Woreda administration has built one health post at Kebele level meant to serve 3000 persons and one health center for 25,000 persons to increase mothers and adolescent access to institutions. Kebele administrations have also supervised and monitored health posts and health extension workers in order to give better guidance and counseling to mothers pre, during and post-natal times.

100% informants noted that the improvements of maternal reproductive have brought many benefits. The antenatal cares reduced delivery risks from time to time. The fear of death during delivery among the community in general and family in particular have shown. Furthermore, the antenatal care services boosted confidence of pregnant women owing to series interventions and reproductive health services.

In general, the interventions on reproductive maternal health services enhanced awareness on risks during pregnancy, delivery and the postnatal period.

In spite of the post-natal care improvement, yet still about 28% of mothers are not able get health professionals after birth. According to health office head, health center director and health

[16] Is the access and use of health care during pregnancy

[17] The proportion of women and new born get care, at least once during the first 7 days after delivery for reason relating to post-partum services.

[18] The service clients are provided with counseling, physicals and exam, follow-up care and contraception.

professionals, the low level of post-natal care is attributed to poor awareness about communities' to postnatal care services. Al most all interviewees and respondents also reaffirmed gap in awareness on post-natal care.

Family planning is a means to improve maternal health. The table 4.4 reveals that performance of family planning increased from 24% in 1998 EFY to 60% in 2008 showing progress in the same period. 100% underlined that the outcome gained due to family planning substantially reduced problems occurring in connection with pregnancy and delivery. Nevertheless, yet about 40% mothers do not rely on family planning.

About 12 (46.15 %) interviewees and 22(45.83%) respondents pointed out that the delay in using family planning especially in the Woreda happened as a result of attitudinal problems toward family planning and women fertility.

About 14 (53.8 %) interviewees and 23(51.1%) informants responded that as women face family planning fatigue, headache and the disorder in menstruation cycle and husbands force them not to use family planning.

(iii). Counseling Services

Table 4.5: Maternal Counseling and HIV test (2003EFY) Baseline and 2007EC Performance

Indicators	2003			2004		2005		2006		2007		Changes from 2003-2007
	T [19]	Per[20]	%	Per	%	Per	%	per	%	Tar	Per	%
Pregnant women counseled and tested.	3257	418	13	788	24	1236	37	1768	53	3419	1903	56
HIV +ve pregnant women	4	1	25	1	13	-	9	75	4	1	1	16

Source: - Mida Kegn Woreda Health Office Performance Report (2016)

Table 4.5 reveals above indicates that pregnant women counseled and tested plan increased by 106 pregnant women counseled and tested from 2003 to 2007 EFY When this performance is compared with the planned target of services it increases on average 43%.

Woreda administration was providing free counseling, testing and guidance by training, mobilizing and organizing health sectors officials at all levels of Kebeles to supervise follow up

[19]Tstands for target
[20] Per stands for performance

to pregnant women counseling and tested before, during and post-natal there by providing antiretroviral therapy to infected mothers.

Kebele administrations participated in counseling by mobilizing and organizing different social arrangements like 1-5 and health development army to aware mothers to protect them from HIV/AIDS and tested at near health institutions and health posts. Kebele administrations have also supervised and monitored health posts and health extension workers in order to give better guidance and counseling and testing to mothers before, during and post-natal. The positive developments gained from counseling and testing is "rapidly declining" HIV infected mothers in the Woreda and reduced orphan-hood.

4.3.3.Prevention and Control of Communicable Diseases

(i). Malaria Prevention and Control

Malaria is one of the major health problems in the Woreda. More than half of the Woreda population is at risk of malaria infection .In order to control the expansion of malaria in the Woreda, a triangular efforts of the federal Ministry of Health, State Health Bureau and Mida Kegn Woreda administration are doing their best by distributing bed nets, spring insecticide treated nets and mobilizing communities to clean their environment and Woreda administration has conducted Indoor Residual Spray (IRS) due this most mosquitoes places have been eliminated and controlled.

Table 4.6: Number of people gained LLIN, beds nets and laboratory confirmation services (2003- 2008EFY)

Activities	2003			2004		2005		2006		2007		
	Tar	Perf	%	Tar	%	Tar	%	Tar	%	Tar	Per	%
LLTN	2534	2534	100	9524	93	3136	95	2584	93	3172	3172	100
Bed nets	-	-	-	22100	100	-	-	69000	100	-	-	-
Lab. confirmed	10200	5718	56		28	2250	17	1025	13	1360	1270	93

Source: - Mida Kegn Woreda Health Office Performance Report (2016)

Table 4.6 shows that of long-lasting insecticide treated were sprayed plan increase by 638 from 2003 to 2007 EFY. When this performance is compared with the planned target it increased by 100% on average

Bed nets distribution plan increased by 46,900 from 2003 to 2007 EFY. When compared with performance in the previous year it increased by 100% on average.

100% respondents and interviewees mentioned that distribution of bed nets, long lasting insecticide treated spray and laboratory supported treatment reduced mortality and morbidity caused by 95% in the Woreda.

(ii). Tuberculosis Prevention and Control

TB is another health problem that has affected both rural and urban people in the Woreda. In order to contain the expansion of TB in the Woreda, a triangular efforts of the Federal Ministry of Health, Oromia National Regional Health Bureau, Woreda Administration of Mida Kegn and Kebele administration did their best by examining TB patients, treating and supervised and Kebeles administration mobilized communities to aware and TB patients go health centers.

Table 4.7: People who contracted TB identified, detection rate and leprosy detection rate services (2003- 2007EFY).

Activities	2003			2004		2005		2006		2007		Changes from 2003-2007
	T	per	%	Per	%	Per	%	per	%	per	%	%
TB suspected	950	197	21	245	26	30	45	46	10	850	80	59
Detection rate	82	14	15	30	41	42	45	43	90	50	51	37
Leprosy detection	5	5	100	4	80	6	100	6	-	4	100	100

Source: Mida Kegn Woreda Health office performance report (2016)

From the above table it is possible to conclude that the performance of TB suspected identification and detection rate is still low comparing with the plan.

The health office head stressed that the causes of low level, TB suspected identification and detection rate due to the low level of budget constrain, human resources constraint, communal awareness and mobilization in order to encourage the suspected ones to visit health institutions. However, health extension workers argued that the low level of TB suspected, detection rate emanated from, the low level of attention from health office and health centers. Moreover, prevention and control of communicable diseases are shared responsibilities of health posts and health centers. In spite of this, health centers are biased toward curative services.

100% informants confirmed noted that the positive development gained from TB suspected identification and detection rate reduced mortality and morbidity caused by Tuberculosis. Health office head and health center directors stated that the achievement was gained due to the awareness creation and commitment of community to bring suspected leprosy to health centers. 100% informants pointed out that illness and disabilities caused by leprosy on average of elimination due to strict follow up by health institutions and awareness and commitment of communities to bring leprosy patients to health centers.

Furthermore, all health extension workers and health professionals noted that, the disappearance of leprosy emanated from expansion of immunization program and other clinical services.

4.3.4.Public Health Emergency Preparedness and Response

This refers to "the process of anticipating, preventing, preparing for, responding to and recovering from impact of epidemics and health consequences of natural and manmade diseases. It includes preparedness, early warning, response, epidemic intelligence service and recovery" (FMOH, 2008).

Table 4.8: Public health emergency preparedness and response (2003- 2008EC).

Activities	2003			2004		2005		2006		2007			Changes from 2003-2007
	Tar	Per	%	Per	%	Tar	%	Per	%	Tar	Per	%	100
Anthrax	3	3	100	4	10	4	100	4	100	4	4	100	100
Dysentery	2	0	0	2	0	0	2	0	0	3		0	25
Measles	2	3	110	2	100	2	100	2	100	4	4	100	100

Source: - Mida Kegn Woreda Health Office Performance Report (2016)

The Woreda administration mobilized health development army, health extension workers and other health experts to investigate monitor and inform public health emergency preparedness and response and making high surveillance on those diseases such as measles, meningococcal meningitis, dysentery, suspected anthrax and their negative health consequences. Kebele administrations participated in reducing public health emergency preparedness by mobilizing communities at grass root level to follow up and monitor the symptom of aforementioned diseases and report to nearest health institutions.

Despite public health emergency preparedness and response, no suspected rabies surveillance was conducted, while most of the Woreda people are highly suffered from rabies cases. All Kebele managers and respondents noted rabies cases need due attention from Woreda administration. Furthermore, all interviewees and respondents mentioned that, sudden outbreak measles of, meningococcal meningitis, dysentery and suspected anthrax have reduced.

Woreda administration has the inspected and making surveillance of private clinics and professional practices, health centers, schools, grain mills, hotels, cafeteria, restaurants, food, laboratory chemicals and reagents, medical equipment and cosmetics. The inspection and surveillance of regulatory services have improved the quality of health service delivery through institutionalizing of accountability, transparent and separation of purchase, providers and regulator of drugs, laboratory chemicals and reagents and medical equipment.

Despite these positive developments, regulatory services do not well function because there are no environmental health professionals assigned to the department. For this reason, the regulatory department is conducted by delegation. The delegates are working simultaneously with their assigned job. In this situation, delegates focus on their main duty rather than regulatory tasks, which are side job assigned to them.

4.3.5.Clinical Services

Clinical services are services that are given both at private and public health institutions. In the public and private health institutions both inpatient and outpatient departments services are given.

Table 4.9: Trends of health services from 2003-2007 EFY in Balemi and Chukala health center. The researcher selected Balemi Health and Chukala centers because these health centers are serve more people and long experience.

Activities	2003			2004		2005		2006		2007			2003-2007
	Tar	Perf	%	Perf	%	Perf	%	Per	%	Tar	Per	%	Performance
OPD[21]	4424	864	19	8942	25	9986	33	13293	38	49271	20561	42	19697
IPD[22]	4402	421	10	584	17	659	21	1424	25	9854	2720	28	2299

[21] Is the average number of outpatient visits include first and repeated visit per person.

[22] The number of patients admitted including transferred from other health facilities during the reporting per 1000 population. It includes all patients admitted to

- Wards(all patients under the care of the inpatient case team should be included ,even if they are admitted to a trolley or stretcher .i.e. do not have a bed
- Clinical facilities(like intensive care units, ophthalmic units

Source -Mida Kegn Woreda Health Office Performance Report (2016)

Table 4.9 reveals that outpatient performance increase by 19,697from 2003 to 2007 EFY. When this performance is compared with the planned target it increased BY 23%average. Inpatient department plan increases by 2299 patients from 2003 to 2007 EFY. When this performance is compared with the planned target it increased by18% average.

Woreda administration has improved clinical services to communities by improving drug and medical equipment, facilitating transportation services, adjusting beds, hiring professional experts and providing free treatment to lowest income communities through free waiver systems. To provide free treatment the Woreda administration allocated 50,000ETB per year. Despite these facilities, clinical services performances are too low.

Health office head and health center directors affirmed that, the low level of clinical services are caused by the low level of communal behavior seeking medical treatment and lack of drug availability and medical equipment communities are going to private clinics.

Three Kebele managers (Mafcee, Gerado and Gambella) noted that low level of clinical services caused by the residents of the arid areas are far from health institutions due to this some are treated in the neighboring Woreda and others left without any treatment. Furthermore, the interviewees affirmed that, most of residents in the arid areas travelled over 10kms to get to health centers. Furthermore, 35% respondents indicated that the low level of clinical services caused by lack of drug and absences of bedroom in the health centers. About 40% of respondents noted that the low level of clinical services is caused by low level of communal behavior seeking medical treatment. Some12% of respondents indicated the low level of clinical services is caused by low level the communities' attitudinal problem that they might not contract any diseases. And 3% of respondents pointed out that the low level of clinical services are caused by the remoteness of health centers from arid dwellers where as 10% of respondents indicated that the low level of clinical services are caused by financial problems.

Summary

Since 2001 Mida Kegn Woreda administration is doing its level best to access health service to all Woreda communities irrespective of geographic barriers, financial barriers, gender, religion and political points of view. The contribution of the Woreda of government to access health care service are mobilizing and enhancing stake holder's awareness such as communities and nonprofit organization and government organizations, Providing basic infrastructures such as transportation like ambulances, drug and medical equipment, Evaluating and monitoring ,implementing and supervising the activities of health posts and health centers, Mobilizing financial resources to improve health access to Woreda people especially women and children by providing to service free of charge and poor through providing waiver system and Hiring human resources have been needed to provide and promote health service delivery.

not even give option regarding technical human resources. Still, there is a big gap between constitutional promises genuine and devolved powers in practice. The solely recruitment of human resource violates the local government powers and autonomy to deliver health services.

The other dimension of decision making power has manifested in pharmaceutical and medical equipment procurement and purchasing areas. According to Woreda Health Office Head and Health Center Directors, pharmaceutical and medical equipment is the backbone for effective health services delivery in order to address local communities need. To provide effective, accessible and efficient health services local administrations need to exercise their constitutionally guaranteed powers and responsibilities in pharmaceutical and medical equipment procurement. However, in practice pharmaceuticals and medical equipment procurement and purchasing is conducted by Regional Health Bureau.

According Oromia regional health bureau head, to make drug procurement and purchasing processes transparent and accountable it should be purchased and procured at state levels. To exercise the power of purchasing and procuring the State health Bureau monopolized drug and medical equipment procurement and purchasing and it signs agreement with organization who deliver drug and medical equipment. And then it distributes states administrations and public health institutions such as hospitals, health centers. Until 2007 the Bureau had been purchasing from Pharmaceutical Fund and Supply Agency (PFSA).

According to Zonal and Woreda Health Office heads interviewees, since 2007, the Bureau has shifted its customer from Pharmaceutical Fund and Supply Agency (PFSA) to *Biftu Adugna* state owned enterprise without any consultation with Woreda health offices and respective institutions The shift in drug procurement and purchasing was from Pharmaceutical Fund and Supply Agency (PFSA) *Biftu Adugna* due to weak procurement processes with the former supplies. Since 2007 EFY *Biftu Adugna* overtook form the Pharmaceutical Fund and Supply Agency (PFSA).

However, the challenge of drugs and medical procurement has not been improved. *Biftu Adugna* pharmaceutical supply procurement is also weak and its prices drugs are higher than the previous one. It does not consider the drugs and medical equipment demand of local governments.

Furthermore, the interviewees also noted that, weak procurements process of *Biftu Adugna* pharmaceutical supply leads to problem of drug affordability[23] (because it adds up to 35% on the normal price). When the enterprise ads the prices of drugs, the health institutions are obliged to transfer up to 25 %'.As an effect, availability of essential drugs[24]is flexible from time to time. Additionally, drug wastage has been increasing from time to time because the enterprise does not keep the request of the health situations. The price increment seen in connection with *Biftu Adugna* pharmaceutical supply drugs emanated from its poor bargaining power and managerial inefficiency. However, this purchasing and drug procurement process violates the local government powers and autonomy.

(ii). Human Resources Capacity

Health workforce is a very crucial part of health system health performance and its effectiveness and efficiency so as to achieve community health needs. According to Ethiopian Health Standard Agency (2013), each health center has to have to be 30 workers both technical and non-technical. However, in practice, health centers in Mida Kegn do not have adequate skilled manpower.

Table 4.11: Required professionals at a health center in number and types

Professional Required	Required human resources in qualifications'			Available man power		
	Certificate	Diploma	Degree	Certificate	Diploma	Degree
Health officers		-	2	4	56	3
MD(Optional)		-	1			
Midwife		2	1			
Nurse		-	3			
Ophthalmic nurse		-	1			
Psychiatry nurse		-	1			
Environmental health		-	2			
Laboratory technician		1	1			
Pharmacists/druggist		2	2			
Cleaners	5					
Archive workers		6				
Maintenance officers	-	1				
Morgue attendant	-	1				
Total						

Source: Ethiopian Standard Agency 2013

[23] It refers to the ability to buy. It is calculated as the minimum government employed salary divided to 30 day.

[24] It is the proportion of months in the time period under consideration for which given tracer drugs was available when needed. It include drugs used in preventative and curative services, including contraceptive and vaccines such as Amoxicillin, Oral rehydration salts, Arthemism, Mebendazole, Tetracycline eye ointment, paracetamol, Refampicine, Medroxyprogesterone injection, Ergometrine maleate tablets, Ferrous sailt Plus Folic acid ,Pentavalent DPT-Hep-Hib vaccine

Table 4.12: Existing Health Workers of Health Centers at Mida Kegn Woreda, 2017

Professional Required	Existing HR in each health centers, in qualifications'											
	Chukala			Balemi			Kegni			Bitile		
	Cer[25]	Dip[26]	BSC[27]	cer	Dip	BSC	cer	Dip	BSC	cer	Dip	BSC
Health officers			1			-			-			-
MD(Optional)			-			-						
Midwife		2	-		2	-	-	3	-		2	-
Nurse		6	1	-	6	-	-	6	-	-	8	1
Ophthalmic nurse			-					-				
Psychiatry nurse	-	-	-	-	-	-	-	-				
Environmental health	-	-						-				
Pharmacists/ druggist		1			1			1			1	
Cleaners	2			2			2			2		
Archive workers		5		5				6			6	
Maintenance officers		-		-			-				-	
Morgue attendant		-		-	-		-					
Cleaners	2			2			2			2		

Source Mida Kegn Human Resource document, 2017

The above table shows that Chukala Wange health and Kegn health center full filled 60% of their human resource need where as Balemi and Bitile met 53.3% of their human resources demand. Currently existed human resources in each health center have below the standard set by Ethiopia Standard Agency. These low levels substandard of human resources are caused by budget constraints.

Table 4.13: Requirement and existing human resources of Mida Kegn Woreda Health Office

Professional required	Requirement	Currently, existing health workers[28]
Health officers	10	4
Nurse	10	4
Environmental health professional	2	-
Pharmacists or pharmacy technicians	1	-
Biologists	3	1
Administrative health personnel	10	5
Total	36	14

Source Mida Kegn Human Resource document, 2017

Table 4.13 indicates that the Health Office needs 36 workers of which, 26 should be professionals' and 10 administrative personnel. However, currently, Woreda Health Office has,

[25]Cer stands certificate
[26] Dip stands for Diploma
[27] BSC stand for bachelor of science
[28]it refers to both technical and nontechnical (Administrative workers)

14 health personnel of which and 9 are technical and while the remaining are administrative workers. Additionally, the Woreda Office has no environmental health and pharmacy professionals at all. In general the health office has 38% of health workers from its total demand human resources.

Mida Kegn is facing serious problem and has weak strategies to retain its health workforces. According to Mida Kegn Health Office Report, 2016 at least 35% attrite per years. The attrition of health personnel has negatively affected health performance, effectiveness and efficiency in serving communities. Health Office Head and all Health Personnel participants said, "*There are many factors that cause the attrition and turnover of experienced health professionals. These are market finding, delay of duty payment and under duty in comparison to other Woreda. Moreover, the attritions of health personnel is caused by lack of infrastructures services such as potable water, electricity, road, telecommunication in the Woreda and the poor leadership and limited motivation of Woreda officials to handle the qualified staffs*"

(iii). Weak Community Participation in Idea Generation, Planning and Monitoring

One of the main problems of social services delivery in most developing countries is excessive concentration of decision-making power and resource in the hands of central governments. To alleviate concentration of decision making powers at the Centre, the EPRDF led government entirely changed the system of governance from unitary state structure to federal based state structure. Furthermore, the regime has continuously reformed and reshaped different government activities and produced policy frameworks to empower grass roots communities. Woreda Level Decentralization is one of the socio economic development and policy frameworks produced in 2002 to decentralize the powers concentrated at the hands of regional governments to Woreda.

The central objective of Woreda level decentralization is to empower local communities' interest and need, developing democratization and improving delivery of basic services. One of the means to ensure communities interest and need are participation of communities in idea generation, planning, monitoring, implementation and management process (Kumara, 2006).

Decentralization has four components such as administrative, political, financial and institutional aspects. Administrative decentralization is a basic aspect of decentralization which focuses on how planning, human resource administration and financial administration be functions in

various government tiers. Planning is one of the basic fundamental responsibilities and duties Oromia constitution has granted to Woreda governments (Oromia Revised Regional constitution, 2002 article 91/1f). Constitutionally, Kebele level governments, besides implementing plan has been set at Woreda level and can set prepare additional plan to meet interest of the residents of the Kebele concerned (Ibid, article 98/7) ,unfortunately Kebele administrations do not actively participate in the planning process. They simply involve at stage of implementation through labor and financial contribution. Financially the Kebele government collects grain and money from households annually, which are used during delivery for mothers, when they stay at health centers. In terms of labor Kebele communities involve in construction of public latrine and construction of health post and extension houses rather than idea initiation in prioritization, planning and monitoring. Community and Kebele participation is largely confined to labor and financial contribution. Kebele administrations are hindered to participate in planning, prioritization and monitoring due to institutional commitments, personal weakness and resources constraint to prepare their own plan.

All health institutions in the Woreda such as health centers, health posts and Woreda health office have core business processes come together and prepare depending on an indicative plan of Oromia Regional Health Bureau.

(iv). Poor Physical Facilities

According to the Ethiopian health standard (2103) every health center has to its own drinking clean water, Contrary to this fact, out of four health centers only one Bitile health center has its own drinking clean water.

Road is needed to connect living both in rural and urban areas in order to access them transportation and other economic activities conducted in a given across a region or with in a region (Hamid, 2012).

A rural road density of Mida Kegn, Oromia and national was 91,115 and 130/1000 in 2016 respectively. When Mida Kegn rural road density is compared with Oromia and national levels it is too low. The rural roads at Oromia and national levels are service all season. But, the Mida Kegn road is used only in winter season. Due to this, transportation systems both ambulance and public services are very difficult during summer.

(v). Health Equipment Related Problems

According to the standard adopted by Ministry of Health (2005), a health center serves25, 000 residents and a health post is expected to serve 5,000. On the basis of this standard, the Mida Kegn Woreda has four health centers and 25 health posts .When we relate the number of health centers and health posts with the population size, the Woreda health infrastructure fulfills the standard.

Ethiopia Standard Agency (2013) stated that a primary hospital should be constructed for 60,000 inhabitants. Mida Kegn inhabitants reached 103, 000 in 2016. Therefore, primary hospital should be constructed for the Woreda inhabitants. Despite these Woreda inhabitants has no primary hospital yet. According to Woreda health Office and Zonal Health Office heads interviewees even if the standard allows the construction of primary hospitals for 60,000 inhabitants the government of Oromia set a requirement for construction of hospitals. These requirements are the distance from any hospital and prevalence of diseases. Mida Kegn Woreda is found on 40kms for Gedo primary hospital and there no more prevalent diseases affecting the population compared as other Woreda in the region. This requirement enabled regional government to make an even distribution of primary hospitals in the region. To solve frequent refers to hospitals OR block under construction, which could be used for medium operation of any type and delivery services for women.

The physical accessibility of health institutions are not enough by itself. It must be equipped with necessary materials used for administrative and technical purpose including computers, printers, electricity, regular health supply, generators, extinguishers, separate and adequate space for storage of drugs, refrigerators, corridors, dispenser, ventilations, well mounted thermometers and latrine (Ethiopian Standard Agency, 2013). Failure to put in place these infrastructural facilities at Woreda level is challenging provision of qualified and quantified health services delivery.

(vi). Lack of clear Inter-Governmental Relations among Regional, Zonal and Local Governments

The revised Oromia Regional Constitution (2002) indicates three levels of governments in the region namely Regional State, Woreda and Kebeles. The constitution clearly stipulated states powers and functions of each tiers of governments. Even though, the powers and functions of

Woreda administrations and Woreda councils are not clearly defined by FDRE constitution article 50/4, implicitly, it devolves powers and functions to local governments. Oromia Regional National State Constitution has clearly defined powers and functions devolved to Woreda administrations and Woreda councils. However, the constitution has not explicitly devolved powers and functions to Woreda Governments. Therefore, it seems that powers and functions of the Woreda governments are derived from powers and functions of Woreda councils and Woreda administrations because Woreda governments are composed of Woreda Administration and Woreda Councils.

Powers and Functions of Woreda Administrations

- ✓ "It shall formulate and implement economic and social policies and strategies.
- ✓ It shall also have full authorities to regulate laws and justices in the Woreda.
- ✓ It shall formulate and execute policies, strategies and plans for their economic and social developments" (ORNS constitution article 79, 2002).

Powers and Functions of Woreda Councils

- ✓ "It shall administer all elementary schools found in the Woreda.
- ✓ It shall administer medium medical centers.
- ✓ It shall construct and maintain small rural roads.
- ✓ It shall protect and administer basic agriculture and natural resources.
- ✓ It shall collect and decide the Woreda land tax, agricultural production tax service.
- ✓ It shall approve plans on social services economic development polices and plans of the Woreda.
- ✓ It shall aware and organize the people for development activities.
- ✓ It shall elect chairman, deputy chairman, and secretary and council members of the Woreda.
- ✓ It shall formulate its own internal rules and provisions.
- ✓ It shall utilize source of income apart from what which is collected and administered by the regional state.
- ✓ It shall also prepare and approve its own budget.
- ✓ It shall formulate policies for the maintenance and sustainability of peace and security" (ORNS constitution article 85, 2002).

Although the Oromia constitution grants powers and functions to its local government on paper, the actual practices of inter-governmental relations among state levels, zonal and Woreda governments remain unclear. This has created tension in many cases. For instance, the division of responsibilities between zones and Woreda is unclear and also created a confusion of accountability and lack of transparency between the tiers. From this we can infer, though the law recognizes the formal independences of each tiers of governments, the governmental structures are generally characterized by the top-down mode of control and supervision.

However, sub-national governments have greater coordination, the major objective is to have the One-Plan, One-Budget and One-Report approach at all levels of the health system.

All government levels had implemented HSDP I-V since 1997-2016 and Growth and Transformation plans I and II from 2010- present. These national plans guide all health sectorial plans. One plan helps to ensure vertical and horizontal alignments in the health intervention priorities of the sector as well as these planning system created a platform for joint planning by all stakeholders at all levels of the health system including health development partners. This exercise also improved the capacities of Woreda health offices in conducting evidence-based planning, which has returned remarkable results (FMOH, 2010).

One budget means that all available funding for health activities (government and donor sources) are effectively pooled and should flow through government channels. Another important issue is that all funds for health activities should be reflected in just one plan and one documented budget (Ibid).

The aim of one report is to ensure information availability for evidence-based health planning and decision making by establishing Health management information system. Due to this all health institutions are access to health information (FMOH, 2010).

(vii). Lack of Political Commitment

Oromia Regional health Bureau has set-out specific policy frameworks (such as local government acts and proclamations) to guide the activities of decentralized health services delivery at local levels. Furthermore, detailed guidelines about the relations among different administrative structures of health service sectors (that includes activities related to supervision, reporting, monitoring and evaluation) were prepared by Oromia Regional health Bureau. Dessalegn (2015:64) confirmed that, *"Despite clear and detailed guide lines; there is lack of institutional commitments, personal weakness and resources constraints that holds them from*

implementing the stated guidelines and directives. After all, writing the guidelines by itself is not enough; more effort is needed on practically performing the stated directions within the daily office routines."

4.5.Planning and Budgeting Process

In Oromia National Regional State planning and budgeting activities take place by hybrid systems (Top down and Bottom up). The Oromia Regional Government first prepares indicative plans and sends to Zones Woreda. Then the Woreda set out their priorities and dispatch to Kebeles. Kebeles send their lists of demands to respective Woreda. The latter compiles its plan and budget in line with the national and regional sector development programs as well as specific local priorities.

The Mika Kegn Woreda office for Economic Development and Cooperation is responsible to compile plans for Woreda sector development program and budget. After all Mika Kegn Woreda offices prepare their financial and developmental plans, they submit to Mika Kegn Woreda Finance and Economic Cooperation office. The Mika Kegn Woreda Finance and Economic Cooperation oversee all Mika Kegn Woreda office plan and submit to Mika Kegn Woreda Cabinet. The Mika Kegn Woreda Cabinets discuss the draft plans and make adjustment both fiscal and financial plan and submit to the Mika Kegn Woreda council. Then the Mika Kegn Woreda Council approves the plan and budget.

After the Mika Kegn Woreda council approves the plan and budget, it becomes Mika Kegn Woreda administration Plan. Then the plan enters into implementation phase, after the fiscal year budgets are released and transferred from the regional treasury to the Mika Kegn Woreda bank account (Woreda Chief Administrator).

4.6.Decentralized Financing to Provide Health Service Delivery

For seventeen years Ethiopia was within a prolonged civil war, in which, health infrastructures and health services system were dysfunctional. There were no or little physical access to health services institutions like health stations and hospitals. Those health institutions highly deteriorated and the existed ones were concentrated at urban areas. The Derg regime believed that health services delivery should be provided for free, but huge budget was spent on war.

Financial problems and political instability gave rise to poor health services delivery and as well as the existed financial resource utilization and administration was also highly centralized.

Since 1992 the Federal Government has attempted to decentralize financial power to Regional Governments in order to collect adequate finances that enable them to discharge powers and functions which are assigned to them (FDRE Constitution article, 97, 1995).

Oromia National Regional State formulated 93/2005 proclamation to generate revenue from internally generated revenues, fee revision and to initiate community based health insurance scheme to improve health quality and access to all communities by generating additional revenues since 2005.

This financial decentralization had largely been seen at regional government levels. It enabled regional governments to improve health services delivery in their respective regions. However, the financial decentralization at regional level did not entirely solve health services delivery of grass roots levels. Due to this, financial resources allocation, utilization, and administration had been decentralized to local governments since 2005 to enable local governments utilize and administer efficiently. Financial power decentralized to local governments' is revenue retention and utilization, outsourcing clinical services and user fees setting.

In 1998 the Ethiopia government had developed and endorsed a health care financing strategy to decentralize health finance to sub-national government in order generate adequate revenues needed local governments. In line with this, Oromia National Regional Government formulated proclamation number 93/2005 in order to identify and obtain resources that can be dedicated to preventive, promotive, curative, and rehabilitative health services, increase efficiency in the use of available resources, promote sustainability of health care financing and improve the quality and coverage of health services(Health system20/20,2012).

The 93/2005 proclamation Oromia National Regional Government article 15/1-3 reveals various sources of financing the public health services such as government budget, internal revenue and health insurance.

(i). Genera government Budget

In Oromia, the highest proportion of Woreda health budget both (recurrent and capital) is granted by Oromia Regional Government, in the form of Woreda block. The Oromia government forced to allocate capital expenditure at least 10%. However, in practice less than 3% allocated to capital expenditure gets out the total budget in 2016.The recurrent budgets composed of salary and petty cash, which are mostly used for administrative and operational expenditures.

Table 4.14: Mida Kegn Woreda Health Office Budget

Year	Woreda health office budget					Salary in %	Operational cost	Capital share%
	Total	Salary	Drug purchasing	Project	Ambulance Services			
2003	1,653,903	161,9738	319900	21300	-	97.9	1.9	1.3
2004	1,960,938	189,7116	114500	-	-	96.74	3.26	-
2005	2,238,316	189,7116	261200	-	80000	84.75	15.25	-
2006	3,520,516	2,931,219	493200	-	96,097	83.26	16.74	-
2007	5,824,059	4,704,293	928266	120,500	71000	80.77	17.15	2.06

Source: Mida Kegn Woreda Finance and Economic Development Office 2017

The trend in salary expenditure has shown consistently increase than operation costs. Salary expenditure ranges between 80.77% and 97.9% while operation costs lie between 1.9% and 17.25% in the years between of 2003/04-2007/08. Hence, the bulk of the Woreda health office budget goes to payment of salaries of health professionals in the Office. Additional assignment of new employees and salary increment for health personnel are among the reasons that resulted in increased salary expenditure in the Woreda. The above data also indicate that operational costs grew shortly over time. Even though some improvements seen in operational and capital budgets, still it is inadequate to satisfy the local needs of the Woreda. This is a challenge to cope with the ever-growing demand for expanding requirements of health service delivery and budgets constraints. Despite lack of financial constraints of Woreda administrations, local governments have autonomy to spend on the prioritized areas of social sectors. Due to this, Woreda health services sector shares 12% of the Woreda total budget.

(ii). Out-of-pocket expenditure

According Mika Kegn Woreda Health Office Report, 2016 40 % of Woreda health services are mainly financed by out-of-pocket expenditures. It includes out-of-pockets fees during the treatment and health insurances

(iii). Initiation of health insurance Scheme

To tackle financial barriers to health care access, the government has initiated and is implementing two types of health insurance systems, namely, the Community Based Health Insurance (CBHI) for the rural population and urban informal sector and the Social Health Insurance (SHI) for the formal sector employees.

According to Abebe, Zonal health office head confirmed that, beginning 2006 EFY, CBHI was implemented in 11 woreda's of West Shoa Zones having a total members of 30000 households and at the end of 2008 EFY, CBHI has been implemented in 17 woreda's of West Shoa Zones having a total of 99000 households members.

(iv). Revenue Retention and Utilization

Before proclamation of health finance decentralization collected from local governments was transferred to regional treasury. Since 2005 revenues collected from local governments are being retained and utilized by local governments. The Oromia Government legalized health related revenue retention and utilizations of local governments by adopting proclamation number 93/2005. The proclamation has empowered local governments' to retain, utilize and administer internally generated revenues. Local governments become autonomous to collect, utilize and administer revenue generated from own sources. As far as revenue retention and utilization has concerned its primary aim is to improve health services by public health providers. The Oromia Regional Government regulates the accountability and efficiency of internally generated revenue by determining the internal revenue to purchase drugs and use for administrative services. Health centers utilize 60 % and 40% for drug purchasing and administrative services respectively. Oromia Woreda Administrations have a legal power to collect revenue from the drug purchase, laboratory services, fee services and card services. Local governments in Oromia are autonomous not only to collect, utilize and administer but also set the prices of non-clinical services fees collected from contracting non clinical services like cafeteria and selling grass in their compounds.

Woreda administrations have operated internally generated revenues according to the range set by Oromia Regional Government and internally generated revenue routine utilization and operation is controlled by financial regulation of Oromia.

The Regional Governments are empowered to levy and collect user fees setting and revisions. The regional laws vary in terms of mandating the user fee revision and setting. For instance in Oromia, this mandate is given to Regional Government, while the Southern Nations, Nationalities and Peoples Governments have given mandate local governments. Local governments' on Southern Nations, Nationalities and People are relatively more autonomous than the Oromia Local Governments to set and revise users' fees. Therefore, Oromia Local Governments have no power to consider community's willingness and ability to pay additional

costs to gain better services from public health institutions. According to the researcher's respondents or informants, are willing to pay additional fees to gain better the health services from public health institutions (Health system 20/20, 2012).

The Regional Health Bureau decided 11.5% health budgets from internal revenues, however, in practice health centers so far, collect on average collected maximum up to 5%. Health centers are unable to collect 11.5% from internal revenues, because the assignments of revenues collection responsibilities to Woreda was decided by the Regional Bureau of Revenue Administration Authority without considering revenue potentials or capacity of the health institutions and even without consultation with the concerned local government administration. The financial burden is transferred to respective Woreda administration because the difference has to be covered from the Woreda budget. That is the portion as internal assigned revenue should be deducted in advance from the Woreda budget.

This top-down health financing approach without prior studies about revenue generating capacity (potential) of Woreda health institutions and to the consultation concerned Local Government administration have resulted in negative impact on the quality of health service delivery in the Woreda.

In general, financial decentralization has positively impacted better services by:

(i). Improving availability of essential Drugs and Diagnostic capacities of Health Institutions

Before the implementation of revenue retention and utilization of internally generated one from clinics, health centers and hospitals, the drug budgets were covered only one-quarter of the year and health centers were experiencing stock-out of essential drugs for most of the year. Since then stock-outs of essential drugs have been substantially reduced. In 2007/08, supportive supervision data revealed that 52 percent of total expenditure from retained revenue was used for procurement of drugs and medical supplies and 8 percent was used to transport drugs and medical supplies.

(ii). Improving Operational costs and Health infrastructure

Before the introduction of revenue retention and utilization, health institutions did not have an adequate budget to cover their operational expenses, including payment for their bills, and buy essential medical and nonmedical supplies. Some 40% of retained revenues are used for buying office supplies, printing services, perdiem health, repairing and constructing additional blocks and digging water wells.

(iii). Improving Quality of Health Care Continuously

Retention and utilization of internally generated revenues has continuously improved health services quality care because about 60% of it is used to buy essential drugs, medical equipment and supplies. The improvement of retention and utilization of internally generated revenues have reduced stock-out of essential drugs, medical supplies and non-functioning diagnostic equipment and it maintained and operationalized the whole health institutions activities.

(iv). Improved community health by providing free waiver scheme and exempted services

Family planning and deliver services such as pre, natal and postnatal care, childhood Immunization, tuberculosis and leprosy treatment and voluntary counseling and testing for HIV services are given freely to the communities.

According to the informant Mida Kegn Woreda has given fee waiver services to poor communities by allocating budget and in 2008 EFY the office allocated 50000 ETB to beneficiaries who were screened and certified by authorized bodies. Despite this, it need still the recruitment of the users are not on timely basis rather local authorities had been issuing (and is still issuing in some regions) fee waiver certificates to the poor as verified through local social justice systems at the time of sickness. This resulted in cumbersome procedures that caused delays in the poor's ability to access care.

Health facilities are implementing exempted services that include immunization, antenatal care, postnatal care, delivery at primary health care unit, treatment of tuberculosis, another public health services. Health facilities are posts lists of exempted services and this is helping to educate users about these services, including which ones are free. The major problems encountered while providing exempted health services included shortage of drugs and medical supplies such as gloves and glucose.

The Woreda level decentralization Programme has enabled local governments to collect revenues from their internally generated sources to cover expenditure responsibilities are given to local governments.

4.7.Local community and civil society participation in Health Service Delivery

Community participation in improving the quality and quantity of is paramount. Local communities in Mida Kegn Woreda engage in health services delivery through mobilizing local resources such as collecting grain and money, which are used during delivery ceremony by the mothers' deliverer at health institutions. Such community contributions at list have couple of benefits. First it alleviates fiscal pressure on the budget of health center. Secondly, community participation increases transparency and accountability in resource use by increasing the flow of information and interaction between users and government (Azfar et. al., 2005).

Thirdly, community participation enabled local communities to invent or promote indigenous knowledge. For instance, local communities use 'kareza,' cultural ambulance for transporting patients in the absence of ambulance. Fourth, community participation enabled local people to educate in cleaning their environment by setting periodic hygiene campaign programs and digging private and common latrine and preparing proper and safe solid and liquid waste management.

Fifth, local community participate in maternal and child mortality rate reduction by creating awareness and helping health extension workers during immunizing of children's and preparing balance diet at home using locally available cereals, vegetables and enabled local community to participate in preventing communicable diseases such as TB, malaria and etc., by using their own knowledge and resources.

Local people know their problems more than government officials and civil servants .They could identify their problems and find solutions to their problems. Community participation increases the interaction of community and administration personnel. Community participation in administration directly or indirectly through their representatives enabled them to challenge bad governances, corrupt and inefficient officials through exposing them through democratic system by collecting petition. They also took part in various administrative committees (Dessalegn, 2015).

Community can participate in administration directly or indirectly both in a formal or informal way. Some individuals assume office or position within the social strata of the community by becoming a member of a formal political organization. The other participation in administration

is based on the knowledge or expertise. The other mechanism of participation is that people are selected based on their experience and the level of acceptance they have from the community members (Ibid).

The participation of the people in different sectors both formally and informally helps to strengthen the principles of transparency and accountability that in turn helps health service delivery to get feedback and to respond to the pressing needs of the community members timely and properly. However, the involvement of the communities in, idea initiation planning and monitoring related health projects is low (Kumara, 2006).

4.8.Health Centers Governance Board

Before 2007 Oromia health institutions are ruled by Woreda Health office, Zonal Health Office and Regional Health Bureau. Since 2008 Oromia Regional government has formulated legal framework enables all health institutions to govern themselves. Due to this all health institutions are established Board of Governance that rules their activities. According to the Directive number 08/2014 of Oromia Regional Government article 8(1-8), Board of governance of health centers composed from 8 members. Its members are appointed rather than elected by the respective health centers constituency as well as Board did not address representation of farmer association, teachers associations, business and religious organizations.

Table 4.15: Member of health centers governance Board

Responsibility in Government Office	Responsibility in boards
Woreda administrator	Chairperson
Mayor	Deputy chairperson
Health center director	Member
Health office head	member
Finance and economic development head	member
Women and children affairs head	member
Communality representatives	member
School director[29]	member

Source: ONRS Directive 08/2014 article 8 (1-8)

The Governance Board has three mandates:

- ✓ Linking communities with health centers
- ✓ Increasing resources mobilizations

[29]The director school of Kebele which health centers found in

- ✓ Generating ideas, planning, monitoring, evaluating and implementing health related issues (ONRS Directive, 08/2014 article 9(1-3)).

4.9.Assessing Quality of Health Services Delivery

The quality of health services is commonly defined as:

"The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Ethiopia Medical Care,2008:12).The usual approach to assessing quality is, therefore, to focus on those factors that are preconditions for quality health services, such as the availability of qualified staff, infrastructure, equipment, drugs and supplies.

Local administrations have responsibilities to provide effective, efficient and qualified health services delivery to its constituencies. Due to this, Mida Kegn Woreda government administration has improved health services from time to time by hiring health personnel, allocating budgets needed to purchase drugs, medical equipment, facilitating transportation services and producing compassionate, respectful and caring health personnel. Despite, the attempts made to promote availabilities of key inputs to improve enabled health services delivery qualities, still it is a big challenge to provide quality health service by making available key health input sat health institutions level. This includes health personnel, physical infrastructure and medical equipment and drug supplies.

Availability of qualified and motivated staff is a key to provide adequate and quality health services. However, each health center does not have sufficient health professionals. Moreover, the existing health professionals attiring from time to time is high.

Availability of infrastructure is a key factor for quality of health services delivery everywhere. Moreover, most of the time each health centers does not get continuous electric power and adequate clean water.

Availability of health equipment such as child weight scale is essential in health posts to follow child growth and development, but the health posts lack this equipment. Moreover, health centers lack ophthalmoscope and horoscope for the examination of ears and eyes and infusion kits for intravenous fluids, which is important for instance, to treat patients who are dehydrated. These

are important instruments for the diagnosis of serious diseases. In general, this equipment is not available in health institutions at all.

Table 4.16: Availability of drugs and Medical supplies

Availability of Drugs	Availability of Medical Supplies
Antibiotics	Spatulas
Antimalarial	Wound dressings
All EPI vaccines	Bandages
Oral Rehydration Salts	Syringes disposables
Multivitamins	Syringes for lumbar aspiration
Iron	Catheters for IV
IV fluids	Nasal tubes
Anti-tuberculosis	Nasogastric tubes
Anti-leprosies	Gloves
Antifungals	Masks
Against helmintiasis	Protection clothes
Against schistosomiasis	
Against filariasis	
Against sleep sickness	
Analgesics (painkillers)	
Antipyretics	
Anti-inflammatory	
Anti-hypertension	
Diuretics	
Cardio tonics	
Anti-asthmatics	
For cough	
Anti-histaminic	
Antacids	

Source: Ethiopia Standard Agency 2013,

Availability of medical supplies multivitamins, iron, anti-tuberculosis, anti-leprosies anti-fungals, against helminthiasis, against schistosomiasis, against filariasis, against sleep sickness, analgesics (painkillers), antipyretics, anti-inflammatory, anti-hypertension, diuretics, cardio tonics, anti-asthmatics ,cough, anti-histaminic and antacids, those drugs are essential especial health centers to treat both communicable and non-communicable diseases, but the health centers, lack this drugs. Moreover, health posts lack Oral Rehydration Solution, iron and anti- malarial, which is important to treat patients who had diarrhea and iron anemia and anti- malarial. In general, those drugs are not available mostly both in health hosts and health centers.

As standard all health centers mandatory to have all these drugs such as, multivitamins, iron, anti-tuberculosis,anti-leprosies anti-fungals, against helminthiasis, against schistosomiasis, against filariasis, against sleep sickness, analgesics (painkillers), antipyretics, anti-inflammatory, anti-hypertension, diuretics, cardio tonics, anti-asthmatics ,cough, anti-histaminic and antacids,

however ever, Balemi, Chukala, Bitile and Kegn health center has only 57%, 48%,52% and 51% respectively among the needed drugs. Furthermore, as standard all health centers mandatory to have all these equipment such as spatula, wound dressing bandages, syringe disposables ,syringes for lumbar aspiration, catheters for IV, nasal tubes, nasogastric tubes, gloves, masks, protection clothes. But, Balemi, Chukala, Bitile and Kegn health center had only 59%, 51%, 57% and 54% respectively. From these empirical data availabilities of key inputs are still immaterialized (Mida Kegn Health Report, 2016). Due to this, health quality is under threat. In general, decentralization of health services delivery had relatively brought health access at the expense of health quality care.

4.10. Supervision of Health Service Delivery

To deliver effective and efficient health care provisions at grassroots level, supervision is the most common instrument. Supervision is the way by which higher government bodies support, cooperate, monitor and evaluate through formulating legal provision through legal frameworks in a constitutional, proclamation, regulation, directives and manuals. Accordingly, Oromia Regional State Health Bureau issued directives of 08/2014 and Regulation 56/2005 and Ethiopia Standard Agency to supervise performance of health institutions like health centers.

The Oromia regional health bureau regulates or supervises health centers under its jurisdiction in line with the minimum standard set by the Ethiopia Standard Agency manual (2013). The minimum standards are required for the establishment and maintenance of health centers in order to protect the public interest by promoting the health, welfare and safety of individuals. These minimum standards includes requirements of human resource and type of services (medical services, nursing services, emergency services, delivery and maternal, child health services, laboratory services, pharmaceutical services and medical recording). All these services should have been given for 24 hours.

The Health Office Head and Health Center Directors pointed out that, the supervision power of the Health Bureau is delegated to Zonal health office, which takes place quarterly. By annual supervision is also conducted twice by the regional health Bureau. Woreda government administration had supervised through both executives and legislatives bodies, the legislative body does not regularly supervise and monitor the health institutions it

rather receive reports and give based feedback on the report. The supervision of executive bodies is more effective than the legislative organs (Health Centers Directors interviews, 2017, Balemi and Chukala).

CHAPTER FIVE

5. SUMMARY, CONCLUSION AND RECOMMENDATION

5.1.Summary

Decentralization is one of the main feature of federal system, has been adopted in Ethiopia to solve the difficulty to manage a country's political, social and economic activities only from the center or region. The center and the region have increasingly proved to possess neither the capacity nor the time to deal with all issues surrounding services delivery which could be better handled at the local level (Kumara, 2006) and to provide effective and efficient public service by enhancing public participation in decision making (Dessalegn, 2015). As a result of effective decentralization, quantity and quality of service provision could be improved. Providing some sort of decision making power to local managers could facilitate improvement in service provision. Public participation could also be promoted by increasing the involvement of stakeholders either on their own or through their representatives.

Woreda Level Decentralization Programme increases the efficiency and responsiveness of government, locally elected leader know their constituents better than authorities at the national level and so should be well-positioned to give the public services in accordance with the local residents want and need. It also improves governments' responsiveness to the public and increases the quantity and quality of services it provides.

Before the Woreda Level Decentralization Programme, Woreda delivered public services under the mandate of Central, Regional and Zonal Offices. Accordingly, Mida Kegn Woreda Administration was delivering public services in general and health services delivery in particular under the supervision of Regional Bureaus and Zonal Offices. After Woreda Level Decentralization Programme, Local Governments are conducting under the legal protection rather dictation of higher offices. Despite these opportunities, decentralized health services have faced different challenges that affected health service provision. These problems were financial, human resources, weak coordination between Regional, Zonal and Local governments, health infrastructures, drug and medical equipment.

The study has raised different questions related to decentralized health services including autonomy of local governments in administrative decision making related to purchasing and

procure drug and medical equipment, hiring human resources and set health service fees, Woreda sectorial lines cooperation health service stakeholders, responsibilities assigned to local institutions like Woreda and Kebele health services delivery, participation of local communities and civil society's organizations in the provision of health service delivery in Mida Kegn.

In doing so, this study has assessed the performance of health services delivery, the financial and manpower capacity, the local institutions in view of the responsibilities given to them and level of community participation in line with decentralized health services delivery. Related literature was also reviewed, and the data was collected using interviews, questionnaire and analysis of documents reviews.

Accordingly, the data from various sources with different data collection methods were critically discussed. The adoption of Woreda level decentralization enabled the Woreda government to raise expenditure on the health from 5ETB in 1993 EFY to 5,723,471in 2007 EFY in order to provide better health service to Woreda population. There is a significant improvement of human resources and health institutions from one nurse and one guard to 157 health workers and from one clinic government owned to 25 health post, 4 health center and 1 OR block due to the fact, health care access increased from 2003 to 2007 dramatically. For example, there were remarkable achievements in health care coverage, namely antenatal (ANC) coverage 100%, postnatal care (PNC) 75%, family planning 75%, and home delivery and open defection dramatically reduced in from 83 % in 2003 to 44% in 2007, and 95% in 2003 to 50% in 2007 respectively. But there was declining performance especially in family planning coverage with a significant decrease from 63 %in 2014/2015 to 60 % in 2015/16.

The study identified that the Woreda communities have shown sharp interest to pay additional cost to gain better health services delivery from public institutions, contribute in cash, labor and material support for the construction of health posts and health extensions house as well as mobilizing, educating communities besides health extension workers. Despite this fact, still communal participation in identifying problems and prioritizing their needs, planning and monitoring is weak in the Woreda.

The findings indicated that revised Oromia Regional State constitution devolved duties and responsibilities to Woreda administrations to provide better health services delivery to their respective communities. Woreda Administrations have powers and responsibilities for

discrimination free-waiver treatment and exempted services. These efforts have improved health services access to grassroots communities.

2. Local communities have participated in health services delivery largely at implementation and participated in identifying local problems, planning, management, monitoring, control and evaluation of their development. However, communities' participation in the planning, management, monitoring, control and evaluation of their health services delivery are at an infant stage.
3. Decentralized health services delivery require ample amount of financial resources. In order to realize the decentralized health services duties and responsibilities, proportionate amount of budget should be allocated to Woreda Health Office, Health Centers and Health Posts. However, lack of revise and set users charges in the Woreda, the Woreda health sectors faced budget shortage. To this effect, capital budget is minimal.
4. Beneficiaries in the Woreda have willingness to pay additional costs to gain better health services delivery. Unfortunately, Woreda administration has no power to charge additional fees on users to provide better health services delivery to communities.
5. Adequate transfer of administrative powers in administrating human resources by hiring, firing, promoting and transferring and deploying and recruiting health extensions.
6. Woreda administration is autonomous to decide on their budget expenditure and it has spent on areas highly prioritized by constituencies.
7. High attrition of experienced health personnel.

In general, Woreda Level Decentralization Programme has guaranteed better health services delivery access to grassroots communities. It enabled Local governments to hire health expert, purchase and procure medical equipment and drugs and supplies as well as mobilize 12% Woreda expenditure toward health sector. Due to this healthcare quantity and quality has improved, though not as expected.

5.3.Recommendation

To provide better health services both in quality and quantity, availability of qualified human resource, drugs and medical equipment and transportation services are necessary. To fulfill all these preconditions, it needs to have adequate finance. To mobilize adequate finance to provide better health services in quality and quantity:

1. The Oromia Regional Government should implement both health insurance schemes, community-based health insurance scheme and social health insurance schemes. It has many advantages. First, it reduces financial grant dependencies on higher governments. Second, it ensures availability of drugs and medical equipment. Thirdly, it contributes to retain and attract experienced health experts through paying better salary. Fourth, adequacy of finance at local levels makes local governments autonomous to exercise their powers and responsibilities.
2. The Oromia National Regional Government should transfer users fees revision and setting to Local Government by setting minimum and maximum user fees. Adequate budget generated by local governments enabled them to cover large portion of their expenses. This in turn, allows them to exercise their power to engage in democratic self-rule effectively and to provide effective and efficient health service.
3. The community representation should be strengthened at all levels in identifying major health problems such as budgeting, planning, implementation, monitoring and evaluating health activities like procurement of drug and medical equipment.

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APPENDICES

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

College of Law and Governance

Centers for Federal Studies

Master's Program in Federal Studies

Name Feyissa Gedissa

Questionnaire and interview will be filled in by key officials, experts, elders and beneficiaries

Dear Respondents,

The objective of this Interview and questionnaire are to assess the impact of Woreda Level Decentralization on Health Service Delivery in Mida Kegn Woreda. The information you provide would be very crucial and valuable for the study. Your participation in this study is completely voluntary and there are no risks associated with it. The information you provide will be strictly confidential.

A. Interview prepared for Regional Health Bureau official

1. Name _____
2. Position held since _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. What is the impacts of Woreda level Decentralization on :-

Impact of WLDP on Health service delivery	Base	Target	Performance	Access	Quality
1.1. Maternal health services					
1.2. Child health					
1.3. Health extension services					
1.4. Hygiene and Environmental health					
1.5. Prevention and control communicable diseases					
1.6. Non communicable diseases					
1.7. Clinical services					

7. What is the planning process in Health sector? Bottom Up or Top down

8. What serious constraining has faced RHB ----------
---
9. What are the solution----------
---?
10. How does Oromia Regional Health Bureau regulate health services provisions?
11. Are there health services related issues being raised by communities? Yes, what are they
---
---
12. What is your institutional respond? ----------
---
13. How is health service financed in Oromia? A. government B. NGO C. community D. beneficiaries
14. How does medical and pharmaceutical purchasing looks like?
15. How health deployment personnel do looks like in Oromia?
16. What are the major constraints in implementing decentralized health service delivery? What are the solutions?
17. How is the health service financed in Oromia?

Thank you

B. Interview prepared for Zonal Health Office officials

1. Name _____
2. Position held since _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. What is the impacts of Woreda level Decentralization on :-

Impact of WLDP on Health service delivery	Base	Target	Performance	Access	Quality
1.1.Maternal health services					
1.2.Child health					
1.3.Health extension services					
1.4.Hygiene and Environmental health					
1.5.Prevention and control communicable diseases					
1.6.Non communicable diseases					
1.7.Clinical services					

7. What is the planning process in Health sector? Bottom Up or Top down

8. What is the serious constraining has faced Zonal office ----------
---?
9. What is the solution?----------
---
10. Are there health services related issues being raised by communities? Yes, what are they
---?
11. What is your institutional respond----------
---?
12. How is health service financed in west Shoa Zone? A. government B. NGO C. community D. beneficiaries
13. What are the major constraints in implementing decentralized health service delivery? What are the solutions?

Thank you

C. Interview prepared for Woreda Administration office chairman

1. Name _____
2. Position held since _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. What is the impacts of Woreda level Decentralization on :-

Impact of WLDP on Health service delivery	Access	Quality
1.1.Maternal health services		
1.2.Child health		
1.3.Health extension services		
1.4.Hygiene and Environmental health		
1.5.Prevention and control communicable diseases		
1.6.Non communicable diseases		
1.7.Clinical services		

7. At what extent does community participated in health service delivery? And how?
- ✓ Idea initiation
- ✓ Planning
- ✓ Monitoring
- ✓ Implementation
- ✓ Evaluation

8. Is there any no profit organization participated like NGOs, wealthiest people and etc. to provide health service delivery? ----------

Thank

D. Interview prepared for Woreda Council Office Head

1. Name _____
2. Position held since _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. What is the impacts of Woreda level Decentralization on :-

Impact of WLDP on Health service delivery	Access	Quality
1.1.Maternal health services		
1.2.Child health		
1.3.Health extension services		
1.4.Hygiene and Environmental health		
1.5.Prevention and control communicable diseases		
1.6.Non communicable diseases		
1.7.Clinical services		

2. At what extent does community participated in health service delivery? And how?
   - ✓ Idea initiation
   - ✓ Planning
   - ✓ Monitoring
   - ✓ Implementation
   - ✓ Evaluation
3. What is the serious constraining has faced Woreda----------
   ---
   ---

10. What is the solution?----------

    ---

4. Are there health services related issues being raised by communities? Yes, what are they -----
   ---
   ---

5. What is your institutional respond?----------

   ---

6. How is health service financed in Mida Kegn?

Thank you

E. Interview prepared for Woreda Health Office Head, Health Centers Directors, Health Center committees and Core Business Owner

1. Name _____
2. Position held since _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. What is the impacts of Woreda level Decentralization on :-

Impact of WLDP on Health service delivery	Access	Quality
1.1.Maternal health services		
1.2.Child health		
1.3.Health extension services		
1.4.Hygiene and Environmental health		
1.5.Prevention and control communicable diseases		
1.6.Non communicable diseases		
1.7.Clinical services		

7. At what extent does community participated in health service delivery? And how?
- ✓ Idea initiation
- ✓ Planning
- ✓ Monitoring
- ✓ Implementation
- ✓ Evaluation

8. What is the serious constraining has faced Woreda Kegn and respective health centers----
---?
9. What is the solution? ----------
10. Are there health services related issues being raised by communities? Yes, what are they
---
11. What is your institutional respond ----------?
12. What is the planning process in Health sector? Bottom Up or Top down
13. How is health service financed in Mida Kegn Woreda? A. government B. NGO C. community D. beneficiaries
14. What are the major constraints in implementing decentralized health service delivery in the Woreda and your respective health centers? What are the solutions?

Thank you

F. Interview be prepared For Kebele Managers

1. Institutional name _____
2. Institutional position of the person _____
3. The amount of years is leaded by the person _____
4. Educational status _____
5. Sex _____
6. At what extent does community participated in health service delivery? And how?

- ✓ Idea initiation
- ✓ Planning
- ✓ Monitoring
- ✓ Implementation
- ✓ Evaluation

7. What is the serious constraining has faced Kebele ----------
   ----
8. What is the solution?----------
   ----
9. Are there health services related issues being raised by communities? Yes, what are they
   ----
10. What is your institutional respond? ----------

Thank you