

**ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH  
SCIENCE SCHOOL OF PUBLIC HEALTH**



**ASSESSMENT OF THE OPERATIONAL  
CAPACITY OF HEALTH CENTER  
GOVERNING BODY**

**Sokoru Woreda, Jimma Zone, Oromia, Ethiopia**

A Research Project Submitted to the School of Graduate Studies of  
Addis Ababa University in Partial Fulfillment as the Requirements for  
the Degree of Masters of Public Health

By Kemeredin Shifa (BSc)

Advisor Dr Demeke Aseffa (MD, MA)

June 2017

Addis Ababa, Ethiopia

## Table of Content

Acknowledgements .....	2
Abstracts .....	5
CHAPTER ONE INTRODUCTION .....	6
1.1 Background .....	6
1.2 Statements of the problem .....	8
1.3 Purpose of the Study.....	<b>Error! Bookmark not defined.</b>
CHAPTER TWO- LITERATURE REVIEW.....	10
1 Literature Review .....	10
CHAPTER THREE- OBJECTIVE.....	15
3.1 General Objective .....	15
3.2 The specific objectives were: .....	15
CHAPTER FOUR .....	16
4 Methods and Materials.....	16
4.1 Study Area .....	16
4.2 Study Design .....	16
4.3 Population.....	16
4.3.1 Source Population .....	16
4.3.2 Study Population .....	16
4.4 Study Period .....	17
4.5 Sampling calculation and procedure.....	17
4.6 Data collection and Measurement .....	17
4.6.1 Data collection methods and procedures.....	<b>Error! Bookmark not defined.</b>
4.7 Data analysis and interpretation .....	18
4.8 Ethical considerations.....	18
4.9 Limitations of the study.....	19
4.10 Dissemination plan .....	19
CHAPTER FIVE- FINDING .....	21
5.1 Socio-Demographic Characteristics of Study Population.....	21
5.5 Human Resource Management (HRM) .....	27
CHAPTER SIX-DISCUSSION .....	25
CHAPTER SEVEN-CONCLUSION .....	32
CHAPTER EIGHT-RECOMMENDATION .....	33
Further study.....	33
Reference .....	34
Annex 1 conceptual frame work .....	33
Annex 2 In-depth interview guideline .....	384
Annex 3 Management members of health Center .....	35
Annex 4 FGD Guideline .....	38

## **Acknowledgements**

First and foremost, I would like to extend my sincere, deepest gratitude and appreciation to my Advisor DR. Demeke Assefa, for his unreserved guidance, valuable advises comments and tireless and timeless support, and follow-up from the research proposal development all the way through completion of this thesis work.

I would also like to thank Addis Ababa University School of Public health, for providing me this opportunity to apply my theoretical knowledge in to practice and for the cooperation to the successful accomplishment of this research.

My heartfelt thanks go to colleagues for their moral as well as material support.

Finally, I would like to acknowledge the supervisors, data collectors and study subjects who have kindly cooperated in providing the required information

Great thanks to Jimma Zone health office and Sokoru Woreda health office staffs for their. My special thanks go to Oromia Regional Health Bureau their as I was being the candidate of this study and sponsorship.

I am great full for the governing body members of Sokoru, Deneba and Kumbi Health Centers participated in the study to give valuable response for my study questions.

Last but not the least my thanks go to my family for their patience and all rounded support without this work would not be a success.

## **List of Annexes**

Annex	1	Conceptual Frame work
Annex	2	Health Center Leadership and Governance Checklist
Annex	3	In-depth interview guideline
Annex	4	Focus Group Guideline

## **List of Acronyms**

1. AAU                    Addis Ababa University
2. DHS                    District Health Service
3. FGB                    Facility Governing Body
4. FMOH                  Federal Ministry of Health
5. FMHACA              Food, Medicine, Health Care Administration and Control Authority
6. GB/MT                Governing Body/Management Team
7. HCGB                 Health Center governing body
8. HCMT                 Health Center management team
9. HC                     Health center
10. HCF                  Health Care Financing
11. HP                    Health Post
12. HSDA                Health Service Delivery administration
13. ORHB-              Oromia Regional Health Bureau
14. PHCU                Primary health Care Unit
15. PHCS                Primary Health Care Service
16. WoHO                Woreda Health Office
17. ZHO                  Zonal health Office

## **Abstracts**

**Background** Governing body is responsible to provide strategic leadership at facility level. The facility governing body is committed to create and maintaining a strong bond between the health center and the community it serves. This governing body has the primary authority and responsibility for patient care, overall quality of service and on-going capability of the health center. To realize this, the introduction of health care financing has been introduced in Ethiopia since 1998 nationally.

Good health facility governance is characterized by responsiveness and accountability; an open and transparent policy process; participatory engagement of citizens; and operational capacity of government to plan, manage, and regulate policy and service delivery. Nevertheless the performance of this governing body is not well documented in Ethiopia

**Objective: the aim** of this study was to assess the operational capacity of health center governing body and management teams,

**Methodology:** Descriptive qualitative method was employed. Semi Structured questionnaire was used to interview management and governing body members of six health centers selected from sokoru woreda. In-depth interviews and focus group discussions were conducted with purposively selected health extension workers, health center staffs, community leaders and health managers from Woreda and Zonal Health office.

**Results:** - More than 15 (62.5%) of respondents indicated that they were concerned about the unclear authority of the health center governing body. Some expressed boundary problems with the health center management and other respondents emphasized the boundary problems with the woreda health office. The ambiguity in authority was apparent in statements about decisions concerning financial incentives for the staff, handling ethical issues, drug procurement, corrective action for employees, these result was supported by study conducted in Ethiopian hospitals.

**Conclusion and Recommendation:** These qualitative results were suggested that **strengthening governing body** to perform essential responsibilities may result in improved health center performance.

**Recommendation:** The performance of the governing body would be enhanced by ensuring proper selection, constitution, capacitation, integration and interaction with other institutions must be conducted.

## **CHAPTER ONE-INTRODUCTION**

### **1.1 Background**

Primary health care (PHC) The Alma-Ata Declaration of 1978 was an approach that focused on provided a lot of motivation to decentralization as one of the central reform agenda that should be implemented as part of the health sector reform process. Since 1990's, decentralization as a policy strategy has been implemented in many sub-Saharan African countries as part of a wider process of political, economic and technical reforms. <sup>1</sup>.

In addition, the World Health Organization (WHO) and the World Bank have supported decentralization as a key component of the health sector reforms. Decentralization - transfer of fiscal, administrative, ownership and/or political authority in the health sector from the Ministry of Health (MOH) to lower levels - has been advocated as one of the ways through which efficiency in delivery of health care services could be improved<sup>2</sup>.

Historically, the Ethiopian health care delivery system has not been very effective in responding to the health needs of the people. It was highly centralized, with the result that services were delivered in a fragmented way, relying on vertical programs for delivery. Health system decisions in Ethiopia have, traditionally, been taken at the central level of the government, through top-down decision-making and resource allocation, despite efforts to take development planning to the district level. Centralized health systems have been criticized for regional and woreda differences in the health service distribution, differences in resource allocations, and inequitable access to quality health services<sup>3</sup>.

Over the past decade, Ethiopia has committed to decentralize the country's health management system, to increase decision-making power for resource allocation and service delivery at the district and facility levels and to allow for greater community involvement in health management. Through gradual reforms outlined in the two Health Sector Strategic Plans, Health center management body and management teams have taken on responsibilities for facility-level operations within their facilities. During this period the accountability of facility managers was unclear. Facility managers did not take the initiative to implement innovative practices to improve service delivery because they did not feel a sense of ownership for their work or facility. Because health centers were not have the opportunity to plan, defend, and prioritize their

budgets; therefore, there was little or no opportunity to account for whether or not funds were utilized as per the set priorities<sup>4</sup>.

In order to solve these problems, the current government of Ethiopia has launched democratized and decentralized health policy in 1993 and implementing health care financing reform in 1998. Health Care Financing (HCF) reform implementation at facility level began in 2000 EFY in Oromia early endorsement of the HCF Strategy in 1999 EFY. The legal framework for the implementation of the reform includes Health Service Delivery and Administration Proclamation No. 93/1997, Regulation No.56/1997 and Directive No.001/1999. In reverse, the governing body and management team was poorly managing health center were identified during supportive supervision conducted in Oromia regional health bureau in 2014.

## **1.2 Statements of the problem**

The role and responsibilities of health center governing body have not performed as expected by body members and administrators. They have been ineffective with regard to management provision of health care services in the health centers. Oromia regional health bureau reported that due to lack of planning and management skills, governing body were not able to manage, support and inspect health center management teams<sup>5</sup>.

Most importantly, there was a weakness in ensuring transparent and accountable management of health facilities, especially in their responsiveness to community needs for access to quality health service. Facility managers did not have the authority to decide important issues, and strategic decisions were undertaken the authority of the high-level officials. A further problem was that poor target setting and monitoring mechanisms were trying to respond to community demands for improving the quality of health services. Responsibility and transparency in the use of locally generated funds has been a center of discussion with rampant cases of misuse being reported<sup>6</sup>.

According to Bureau of finance and economic development expenditure reports carefully to ensure spending as per the Bureaus guidelines, the sub process of Primary health care unit at regional health bureau has continued to receive complaints of cases of cheating from the health facilities<sup>7</sup>.

There is also a feeling of lack of ownership of health facilities by communities with some members condemning primary health care management body members of serving their own interests rather than the communities they sense to represent. Recent public debates (Good governance meeting) have been focused on the worsening conditions of the regions health facilities, poorly maintained medical equipment and lack of such vital medical inputs such as drugs and laboratory reagents. This is in spite of the fact that primary health care management body and management teams were created to ensure practical use of public resources in financing the improvement of health service delivery system<sup>8</sup>.

I have seen many papers were written on subject related to the functionality of health facility governing body and management teams mainly focusing on health care financing reform in Ethiopia. To the best of my knowledge, there is no study that documented on functionality of health center governing body and management teams in Oromia region.

It is against this all that this paper assesses the functionality of health center governing body and management teams, concerning what was expected of them as outlined in the Oromia health service delivery administration (HSDA) directives. The paper will also inform the implementation of Sector Wide Approach by the RHB since a high and demonstrable management capacity at the health center level is considered a key success standard for a Sector Wide Approach Process. Hence, the proposed study will assess the operational capacity of health center management body and management teams, in sokoru woreda, Jimma zone Oromia region, south west Ethiopia.

### **1.3 Rationale of the Study**

Health institution autonomy was important for improving health service delivery next to HCF reform implementation. Formation of a health facility governance body was an important mechanism for introducing autonomy, and more accountability and transparency.

The purpose of this study is that information obtained through this research will be taken as a baseline for further subsequent and large scaled study. In addition it will give clue for regional health bureau officials, decision makers and planners on designing their plan, resource allocation and program implementation to address the findings.

## CHAPTER TWO- LITERATURE REVIEW

### 1 Literature Review

For the last twenty years, many countries – whether rich or poor, authoritarian or democratic - have followed decentralization policies. Decentralization involves a central government transferring to local authorities some of its political authority and also, critically, some of its responsibility for delivering social services. Decentralization brings government closer to the people - or, putting it in a stronger way, decentralization enables local people to actually participate in government<sup>9</sup>.

In planning for health care services in any community, special arrangements have to be made to confirm the availability of services to persons who reside rural areas<sup>11</sup>. Today, millions of people in low- and middle-income countries do not have access to basic, good quality health services<sup>16</sup>. Most policy considerations of health care for rural areas deal in some fashion with the difficult issue of defining minimally adequate levels of service and equity in access to care<sup>11</sup>.

In the last two decades, decentralization as a policy strategy has been implemented in many sub-Saharan African countries as part of a wider process of political, economic and technical reforms. The Alma-Ata Declaration of 1978 that focused on Primary Health Care (PHC) gave a lot of motivation to decentralization as one of the central reform agenda that should be implemented as part of the health sector reform process. In addition, the World Health Organization (WHO) and the World Bank have supported decentralization as a key component of the health sector reforms 2. Decentralization - transfer of fiscal, administrative, ownership and/or political authority in the health sector from the Ministry of Health (MoH) to lower levels - has been advocated as one of the ways through which efficiency in delivery of health care services could be improved<sup>12</sup>.

The Ethiopian health system is characterized by very under financing, low protection mechanisms for the poor, and a lack of risk sharing and cost minimizing mechanisms result in unacceptable poor quality of health services. The Federal Government of Ethiopia through the Health Care and Financing Strategy has established the legislative framework for enhanced health center autonomy with authority decentralized to health centers in areas such as strategy, planning and budget development. To achieve this, Health center should be governed by a Governing Body that is responsible to appoint the Health center Manager who in turn leads on all Health center operations and functions<sup>13</sup>.

A number of measures were undertaken in the 1980s to strengthen health systems. These included decentralization and establishment of health districts, training of personnel for PHC management, creation of health or social welfare development committees, and integration of vertical programs within PHC. However, coverage of services remained limited. For example, 12 out of 32 countries, representing 54% of the population, had less than 50% population coverage of medical services<sup>14</sup>.

In the analysis conducted by Rohde and his colleagues, Ethiopia was not included in the top 30 low-income countries with the greatest average yearly reduction in mortality among children under the age of 5 years (1990–2006) as a marker of progress in primary health care. Together these countries accounted for 2.6 billion people, more than 40% of the world's population but only 1.43 million deaths of children less than 5 years of age, about 15% of the worldwide total. In this analysis, it is also worse mentioning that Sub-Saharan Africa was represented in the list only by Eritrea and Malawi<sup>15</sup>.

Health care financing strategy is one of health sector reform it has established by Ministry of health and recommended by the council of ministers in 1998. As the policy shows, the objectives of implementing the reform include increasing available resources for health services, increasing efficiency of resource utilization in health, promoting continuity of health services through sustainable financing, improving quality and coverage of health services, and ensuring equitable distribution of health services<sup>16</sup>.

Health reforms are building a health financing system that provides various financing and decentralized management mechanisms. The reform proclamation encourages local retention and utilization of users' fees by collecting facilities for use at those facilities to improve quality of health services. The retention of users' fees by the collecting facilities was result in a net increase in resources available to these health care facilities as the user fees are improver to the budget they receive from existing regional block grants. The reform packages also insure a person pay for health services according to their ability and protects the poorest from financial obstacles to health care service. These packages also provide greater authority and accountability to health center to manage service delivery through establishments of management body.<sup>17</sup>

Moreover, Health sector financing reform supports the facility in the local retention and utilization of resources, establishment and functioning of Health center management body and functioning of protection mechanism for poor<sup>17</sup>.

The governance body and management committees were implemented to permit delegation of the responsibility and authority from the regional level to local/woreda levels. This health facility governing body was planned to reduce the administrative difficulty, improve effectiveness and efficiency of management, increase accountability for public funds, creates a sense of ownership by management, increase the role of the local community, respond better to local needs and improve resource mobilization by allowing local decision making<sup>18</sup>.

According to the constitution of the nation, the national council of people's representatives is the supreme power the federal state. As part of the executive body/government, the federal ministry of health (FMOH) over sees the health sector primarily at the level. In the same manner, regional health bureaus and Woreda health offices managing and directing health systems at the corresponding level are answerable to their respective regional and Woreda councils.<sup>19</sup>

The process of decision-making in which a community or group organizes itself and exercises authority to achieve particular ends. Governance includes setting a strategic direction; formalizing the decisions taken through making laws, regulations or resolutions; allocating resources to implement the decisions; and overseeing the implementation of decisions taken. The health center are governance reform which led to formation of governing body with representation of community members and the local leadership is helping improve the performance of health facilities through better decision-making to address the needs of the community they serve<sup>19</sup>.

Governing body and management committee meetings are principally held quarterly, but this varies by Region, zone and facility with some meeting more frequently and some less frequently or not at all. Normally formal minutes of the meetings are taken and reviewed. The management body of facility approves the health facility plan and budget, decide on revenue retention and utilization, review implementation of the new fee waiver system and evaluate performance of health facilities, among other duties. Additionally, governing body enable health facilities to advocate for more resources and implement advanced income generating activities that could be used to improve the quality of services<sup>20</sup>.

As per the legal framework for the health service delivery administration, governance and management, health facilities shall be administered by a joint governing body established with representation from the community, health institutions' staff, and other government offices<sup>28</sup>. Therefore, among the 3,351 health facilities which are under the reform 1218 health centers have established governing body; most of them were functional in 2014<sup>21</sup>.

Closely 48.5 percent of health centers' governing body meets every month. Moreover, 75 percent of the health centers confirmed that their respective governing body approved their expenditures in 2010/11. Of these, 61 percent of the health centers indicated that their governing body submitted a facility budget to their respective Woreda health office. Additionally, nearly 58 percent of the health center reported that their retained revenue utilization plan was approved by their respective councils<sup>22</sup>.

Deferent survey reports have recommended that capacity building on leadership, management and governance in order to address the serious problems in the health facility. These areas of improvement include the capacity to: implement responsive health care system; improve the use of health services<sup>23</sup>.

The health center governing body and management teams were to undertake greater responsibilities for managing and running health facilities in their authority, facilitated by the Regional health bureau through issuance of a single grant and training on how to prepare health plans based on the health needs of the respective health centers<sup>24</sup>.

Health facility governance is about ensuring modern leadership at facility level. According to the HSDA legal framework of the region, governing body is responsible to provide strategic leadership at facility level. In addition; it supervises performance of health centers and provide appropriate support, guide them on how to provide quality health service, etc. Members of health centers governing body are constituted from among different government offices, community members and HF staff. This creates collaboration in addressing health centers problems due to the resulting professional mix, experiences and decision making power<sup>25</sup>.

Experiences have shown that health centers with strong governing body performs better in terms of effective implementation of health care financing reform and improving provisions of quality health services. Especially, those governing body that work hand in hand with woreda/city administration office and community members are performing well<sup>26</sup>.

As to the establishment of the Governing Body, respective woreda Health Office is responsible to facilitate the establishment of governing body for all functional health centers under its communities. Each governing body, as indicated in the HSDA legal framework, should have 7 members: 4 persons represented from among woreda government sector offices, 2 persons from health facility staff and 1 person from local community representative<sup>28</sup>.

Woreda administration office, woreda finance & economic development office, woreda health office and woreda women affairs office are the sector offices from which the members are

represented from. According to the HSDA Directive, the PHCU Director is the secretary of the Governing body while the chairperson is Woreda administrator<sup>29</sup>.

According to supervision reports of MOH 93.3% of health centers have established governing management body. The establishment of governing body improves effective decision-making by cutting unnecessary bureaucratic chains as well as the responsiveness of health institutions to their local communities<sup>30</sup>.

Generally, the literature on functionality of health center governing body focuses on their role and responsibilities in terms of enhancing the delivery of health care services at health center was assessed in sokoru woreda, jimma zone Oromia Region.

## **CHAPTER THREE- OBJECTIVE**

### **3.1 General Objective**

The overall objective of the study was assessing the operational capacity of Health center Management body and management teams of sokoru woreda of jimma zone.

### **3.2 The specific objectives were:**

1. To assess the performance status of health center governing body and management team,
2. To assess the linkage between governing body, management team and catchment population of health center
3. To identify operational constraints faced by health center governing body and management teams;

## CHAPTER FOUR

### 4 Methods and Materials

#### 4.1 Study Area

This study was conducted in health center of sokoru woreda, in Jimma zone. Sokoru woreda is one of the 19 woredas of jimma zone, found in the south west of the region. Its capital is sokoru is located about 250 km away from Addis Ababa the capital of Ethiopia. The woreda has a total area of 1,022 km<sup>2</sup> and its location extends from 7 degree 13'N to 8 degree 56'N and from 35 degree 52'E to 37 degree 73'E. According to the projection made from 2007 population and housing census, the total population of the woreda is was 161135 in the year 2016. Out of which the majority (90%) are rural residents,.

#### 4.2 Study Design

Descriptive study that employed and qualitative method was used

#### 4.3 Population

##### 4.3.1 Source Population

For the in-depth interview all kebele leaders, health extension workers, health centers governing body members, woreda and zonal health office management members of sokoru woreda jimma zone. While for focus group discussion all health centers of sokoru woreda management teams were the source population

##### 4.3.2 Study Population

For the in-depth interview Four kebele leader (manager of the kebele), four health extension workers, four health centers heads (health center directors), ten governing body members (Representatives of community members, women affaires, finance and economy office, education office, woreda health office head and woreda administrator) from four health centers of sokoru woreda, two deputy heads of woreda and zonal health office, a total of 24 in-depth interview participants were participated. For focus group discussion thirty management comity members (section heads and unit leaders) of four health centers from sokoru woreda were participated in three focus group discussions.

Availability of relevant written documents such as health center governing body and health center management committee meeting minutes, annual plan, copy of monthly, quarterly and annual report, copy of supervisory schedules and checklist, financial monitoring system (record and report) were checked in every assessed health post, health centers and woreda health office.

In addition to these availability and adequacies of different facilities such as water supply, sanitation, lightning and ventilation etc were checked in assessed PHC facilities against WHO/AFRO standard

#### **4.4 Study Period**

The study was conducted from November<sup>1st</sup> week to December<sup>3rd</sup> week of 2016

#### **4.5 Sampling calculation and procedure**

All six health centers available in sokoru woreda and four health posts were purposively selected from sokoru woreda

#### **4.6 Data collection process**

##### **4.6.1 Data collection methods and procedures**

For the in-depth interview semi structured questionnaire and observation checklist were filled by trained data collectors and supervised by principal investigator. The interviews were tape recorded besides not taking after convincing study participants. For focus group discussion open ended interview guides were used by trained and experienced moderator and not taker. The discussion was recorded by tape recorder besides not taking after convincing study participants.

The research instruments employed includes interview guides, semi structured questionnaires and observation checklist adapted from guideline for assessing the functioning health systems WHO/AFRO Brazzaville, 2003 (29), proclamation number 93/2005 “Health service delivery and administration of regional state of Oromia (19) and statement of organisational responsibilities at each level within Oromia regional state (30) .

The data collection tools were translated into the local language, Afan Oromo and finally back translated to English by different linguistics from oromia education bureau to ensure consistency

#### **4.6.2 Recruiting and training of data collectors and supervisors**

Six in-depth interviewer, all BSc and above educational level were selected from adjacent woreda health offices. Three supervisors, all MPH holders were also participated from zonal health office, Three well experienced focus group moderators and not takers were selected from regional health bureau based on their experience and dedication for such exhaustive activities.

Training for two consecutive days was given for both data collectors and supervisors mainly on the purpose, instruments, and handling ethical issues and on how to conduct interview and fill observation check list. Role-play was exercised by data collectors and supervisors to master the procedures.

#### **4.7 Data quality management**

Research questionnaire was adapted from manual of WHO/AFRO and the above mentioned relevant proclamation and guidelines of Oromia regional health bureau. Supervisors and data collectors were health professionals trained for two consecutive days.

Research questionnaire was pretested out of study area before actual study and correction was made accordingly. The pretested questionnaire was used for data collection process under strict supervision. If missing information was observed in the filled questionnaire, the data collectors and the supervisors were responsible to discuss on the problem & repeat visit was made accordingly.

#### **4.8 Data analysis and interpretation**

This data was complemented by information obtained from the document review data. The tape recorded qualitative data was transcribed and translated verbatim and analysed thematically interpreted to answer the research question.

#### **4.9 Ethical considerations**

After the proposal is reviewed and ethical clearance is obtained from ethical review body of Addis Ababa University, Official letter was taken from Addis Ababa University to Oromia regional Health Bureau and hierarchically to Jimma zonal health office, sokoru woreda, and six health centers where the research was conducted.

Ethical issues regarding their interpersonal communication with responsible person were communicated. While, going from place to place for data collection, they were greeting each individual and ask permission for participation the study.

After clearly describing the objective and purpose of the study, the interview process to the respondents, verbal consent of respondents were obtained. Each study participants were recruited only after his/her willingness is asked. When refusals exist, additional clarifications were given on unclear points and if still they refuse to participate, they were not be forced by any means. Instead, they were skipped and the next person was asked. Confidentiality and privacy of the individual was kept secured thought the study process.

#### **4.10 Dissemination plan**

The ‘research user’ was in regular contact with the researcher and mentor to make sure that the research project produces relevant information for decision making in the Jimma Zonal Health System. At the end of the research project regional dissemination workshops was conducted to communicate the findings to relevant stakeholders of the Ethiopian health system. Dissemination of the research findings through publication in peer-reviewed journals is also planned. More over presentation on professional conference was attempted.

#### **4.11 Operational Definition**

**Management Activities:** - for this study only it implies that, the existing structures have operational plan and all members are participated in plan development and evaluation meeting, develop, implement, monitor and evaluate their plan with their stakeholders. Manage health resources including human, financial and material, the presence and use of technical, financial and personnel guidelines, standards and norms.

**Community participation:** - for this study it includes, community’s involvement in decision making process through utilisation of different feedback mechanisms.

**Primary health care unit:** One health center with five health posts in the catchment area service for 25.000 populations.

**Health Facility governing body:** it includes representatives from different government offices (Women affair, Finance and economy office, education office, woreda health office and woreda administrator) community members and HF staffs. It provides /

ensuring modern leadership at facility level and it can be work /confirm significant impact on the quality and efficiency of the PHCU.

**Fee Waiver:**-A fee waiver is a right conferred to a household or individual that entitles the household/individual to obtain health services in certain health facilities at no direct charge or at reduced price.

**Operational capacity:** According to the health service delivery administration legal framework of the Oromia region, health center governing body was responsible to provide strategic leadership at facility level. In addition; it supervises performance of health centers and provide appropriate support, guide them on how to provide quality health service, and do have considerable decision-making autonomy with regard to operational issues, such as hiring/firing staff, initiating/closing services and a wide range of capital, operating, financing and budget issues. This health facility governing body was planned to reduce the administrative difficulty, improve effectiveness and efficiency of management, increase accountability for public funds, creates a sense of ownership by management, increase the role of the local community, respond better to local needs and improve resource mobilization by allowing local decision making

#### **4.12 Limitations of the study**

Relevant documents were not sufficiently available at some health centers that surely affected the quality of the study. Some of respondents may not be available during the study period; poor recording and reporting system of management body and management team might be present.

## CHAPTER FIVE- FINDING

### 5.1 Socio-Demographic Characteristics of Study Population

With regard to the socio-demographic characteristics of study population, total of 53 community leaders, health service providers and health service managers those who have different professional background and work experience of one year and above in current position /responsibility were voluntarily involved in the study. Majority of the respondents (79.2 %) were from health centers. Among them 74.4% were male by sex. 62.3 % of them were with in age categories of 20-30 years and 41.5% were diploma holders by their educational status

**Table-1 Socio Demographic Characteristics of Study Participants of Health Service of Sokoru 2017**

Level	Number	%
• Kebele (Kebele Mangers)	4	7.55
• Health Post (HEWs)	4	7.55
• Health center (HC) · HC Management Committee · HC Governing body members	42	79.2
• Woreda Health Office	2	3.8
• Zonal Health Office	1	1.9
<b>Sex</b>		
• Female	12	22.6
• Male	41	77.4
<b>Age categories</b>		
• 20-30	33	62.3
• 31-40	10	18.7
• 41-50	7	13.3
• > 50	3	5.7
<b>Educational status</b>		
• First degree and above	23	43.4
• Diploma	22	41.5
• Certificate	6	11.3
• Less than grade 10	2	3.8

\* HEW, KHC, HCMT, HCGB WHMT, WC and MT

Majorities (41%) of the study population have less or equal to two years of experience for current position.

All interviewed health center management committee (HCMC) members stated that lack of experienced staff both at health center management team (HCMT) and health center governing body (HCGB) were the major obstacle they faced to satisfactorily perform their duties. Majorities (65%) of study population were team leaders /section heads and cabine members while a few were staff members by their role and responsibility.

Result of this study shows that, only 5 people (9.4 %) of study population has attended management related in-service training of more than two weeks in additional to their professional course. Health service managers at zonal health office level involved in in-depth interview approved that they have not provided management related training to Health Center and woreda health office management committee. But to improve overall management capacity of woreda health office and health center they give chance for 5 health managers to participate in different management related in-service training programme.

All of HC managers and woreda health office head participated in this study were politically assigned. Interviewed heads of woreda cabine said that *“heads of Woreda health office. Chairperson of HCGB, health center (HC) Directors are politically assigned. As to the criteria for political assignment of those mangers is concerned, political participation /being member of the ruling party, educational status / minimum of diploma holder and relevant work experience were used. But members of HCMC were assigned as to regional guideline”*.

## **5.2 Management Structure**

Structures related to management of HC supposed to be available and functional at primary health care units (health centers and health posts), Health center management team (HCMT), Health center Governing Body (HCGB), Woreda management Team (WMT) District cabinet (DC), Kebele cabinet and village health committee (VHC).

In this study, presences of all these supporting structures per Health center were reported only in 4 out of 6 studies HC. HCMC is still under the process of establishment in 2 out of 6 studied health centers. VHC members are members of kebele cabinet, which were found in every kebele but not functional throughout the study area.

One of interviewed district cabine heads (Head of governing body) also agreed that HCMC has not started its function; rather it is on process of establishment in their respective health centers while the already established VHC were not uniformly functional. One of the district cabine

member noted: “*Kebele cabinet members have been divided into four coordinating committees, based on different tasks to be undertaken. These include the committees of administration and security, agriculture and development, health and education and training. Therefore the availability of VHC is universal but functionality is not*”.

All study participants confirmed that health center governing body has authority and responsibility set by law. The major functions of HCGB were correctly reported by only 3.3% of respondents as technical and administrative. Most of HCGBs were not aware about the correct frequency of their regular meetings. Only 2 out of 6 HCs have reported as they have conducted sufficient round of management meeting in the last six months of the year, according to guidelines of Oromia RHB. During the record review, minutes of HCGB meetings were observed in all of the study HCs even though the meetings were irregular.

HCMT is already established in four studied health centers and has its own guidelines. Regular meetings of HCMT were both not satisfactorily conducted and participated by majorities of its members. With regard to the reasons for not participating in regular meetings, absence of regularity of meeting was reported by majorities of study population. Minutes of HCMT meeting were available in four study health centers; it is confirmed during observational study.

### **5.3 Health Center Governing Body**

According to assessment result there were 6 HCs with established governing structure. Evidence generated from assessment shows that, the following facts with regard to the performance of the HCF reform components. As to the health facility governance, all HCs had established their respective governing body. The numbers of governing body are 7 persons as specified in the health service delivery administration (HSDA) Directive. Only one health center was establishing governing body as recommended in HSDA directive. In the remaining five HCs have members less than 7 persons.

Governing body meeting was not held regularly (Quarterly) in two studied HC as per the demand of the HSDA Directive. Only four HCs that conducted governing body meetings have managed to conduct quarterly regular meeting. The remaining two HCs that conducts meeting did so either once every six months, or only once a year. Major issues the governing body oversee includes planning and budget approval of the HC, the implementation of the HCF reform components such as the *fee waiver system* and *exempted health services, facility level and overall performance of the HCs*. In most of the HCs the governing body lacks setting strategic direction to improve quality of health services.

More than 15 (28.3%) of respondents indicated that they were concerned about the unclear authority of the health center governing body. Some expressed boundary problems with the health center management (being unclear about what was under the authority of the health center management versus the governing body) and other respondents emphasized the boundary problems with the woreda health office (confusion over what was within the authority of the governing body versus what was the responsibility of the woreda health office). The ambiguity in authority was apparent in statements about decisions concerning financial incentives for the staff, handling ethical issues, drug procurement, corrective action for employees, HC Director Supervision, and overall budgeting for the health center.

One of In-depth interview members said that *“It would be good if the role and responsibility of GB and health center management had clear demarcation. Even though health center employees have ethical problems, the governing body could not take action because its role has not been clearly stated”*.

Another in-depth interview member said that *“It would be better if the Director could report directly to the governing body instead of the woreda health office (from one respondent). Sometimes the woreda finance and economy office interfere with budgeting, which was a governing body responsibility. One of governing body member said that “ The GB has no autonomy; decisions made by the governing body have been violated by the woreda health office”*.

Other issue described by respondents was poor commitment of governing body members to meet regularly and to attend meetings. Respondents suggested that the incentives were insufficient. Before two years back, chairs were overcommitted to more than one governing body; in other cases, cabinet members from the woreda levels, who were too busy to prioritize their governing body responsibilities. Community members were also described as sometimes too busy to commit to attending health center governing body meetings, and respondents emphasized insufficient of financial incentives for GB members being a weakening to the functioning of the governing body. For instance, respondents said the following:

One of governing body members said that *“In our woreda, one person represents three HC, which is inconvenient because he does not have enough time to get to know all information about the HCs. Most of the governing body members are cabinet members and they do not dedicate enough time to the governing body. One of kebele leader said that “Community representatives*

*have not attended meetings as needed because they have private businesses (another respondent).The GB is not performing well due to inadequate payment.”*

Poor communication and collaboration with Woreda health office in addition to ambiguity about the governing body versus the woreda health office roles, lack of communication and collaboration between the structures were also described as limiting governing body functioning. Although this concern was less frequently noted, respondents expressed that the relationships could be more effective in some cases.

One of governing body member said that *“There is no relationship between GB and the Woreda health office; health center data have exclusively been reported to the woreda health office rather than to the GB and then to the woreda health office.”* Another governing body member said that. *“The GB reports to the woreda health office, so the woreda health office should work closely with the GB, follow challenges of the GB; solve financial and human resource problems”*

Most of respondents believed that frequently governing body members did not have the needed background or training to be effective in the position. The following descriptive statements highlighted that.

Most of governing body members said that *“Training should be given to GB members before they start work as GB members. If GB members have received training on project designing, effective management style, how to give incentive to health center staffs and retain them, they would do a better job”* One of health center management team said that *“There should be an orientation program for new governing body members and all additional training should be provided on site, rather than outside of the district”*.

Most of kebele leaders described concerns about insufficient representation of the community or more local levels of government on the health center governing body. The majority of respondents who identified this issue stated more community representation was needed, although some also thought greater diversity across districts was required, particularly for health centers that served people from multiple kebeles. Overall, the sense of those concerned was that the governing body did not have adequate representation from the communities the health center served and still depended too much on leadership from the woreda level.

One respondent said that: *It would be better if the GB composition included of more community representatives. It would be better if the GB members delegate from community were nominated from the kebele [more local] administration than from woreda administration. The current GB*

*includes members from the same kebel administration, so it would be better if the composition could from different kebeles (that the health center serves).*

#### **5.4 Health facility based revenue retention and utilization**

Following ratification of the required legal frame work and adoption of operational guides, health facilities were able to retain and use their internally generated revenue as additive to their regular government budget

##### **5.4.1 Major achievement of revenue retained and use were:-**

###### **Availability of essential drugs increased.**

According to the study result 70 % of total expenditure from revenue was used for procurement of drugs and medical supplies and 30% was used to transport drugs and medical supplies, fuel and lubricant for facilities vehicles. Diagnostic capacity of health facilities improved. All HCs procures essential diagnostic and health service delivery equipment.

**Continual quality of care maintained:** - Health centers that have had nonfunctioning diagnostic equipment and vehicles because of budget shortages managed to maintain and operationalize their retained revenue.

**Water supply and electricity to HCs improved:** - Regular and continues supply of water and electricity is critical for provision of health service. 2 (33.3%) of HCs that did not have a water supply and or had an unpredictable or dysfunctional water system spent part of their retained revenue to establish or maintain the supply system. 1 (16.7%) of HC bought generators to ensure availability of electricity.

**Operational costs including paying utility bills covered:** - Before introduction of revenue retention and utilization, HCs reported that they did not have an adequate budget to cover operational expenses, including obtaining fuel for their vehicles, paying their bills, and buying essential medical and non-medical supplies. About 5% of retained revenue was used for improving the facilities health management information system.

**Health infrastructure improved:** - Some HCs renovated their building and constructed additional blocks. According to the study result 2 (33.6%) of HCs used about 20 % of retained revenue for renovation and maintenance of HC building.

##### **5.3 Systematizing fee waiver and exemption systems:-**

In the district, the new fee waiver system is fully implemented, an increasing number of poor households experienced better access to health services. A total of 573 indigents were selected

through social affairs and benefited from free health care services. The average number of fee waiver beneficiaries was 533 and the government budget allocation for waiver reimbursement per HC was not yet.

**Exempted health care services:-** In line with their regional legal frame works, health facilities were improvement exempted services that include immunization, ANC, PNC, Delivery, at primary health care unit, treatment of tuberculosis, and other public health services. HC were posted list of exempted services and this was helped to educate users about these services, included which ones were free.

According to the result, all HCs posted the list of exempted health services on their notice boards. The major problems encountered while providing exempted health services included shortage of drugs and medical supplies, absence of clear guidance on whether to fully or partially charge for service, additional costs incurred for the provision exempted health service and inadequate support from the government for the provision of these service.

### 5.5 Human Resource Management (HRM)

The information that has been used in this study in regards to the HC level human resource has also been collected from the director of PHCU. Therefore, based on this information the following situation has been presented about the health facility.

According to the following table, the percentage of human resource available in the facility is only 57 % of the standard required by the EFMHCA.

**Table 1 Available and Required Health Man Power for Health Centers**

S. No	Health Professionals Required	Minimum number required	Professionals Available											
			Kumbe HC		Natry HC		Gabjiro HC		Sokoru HC		Deneba HC		Basso HC	
			Avail	%	Ava.	%	Ava.	%	Ava.	%	Ava.	%	Ava.	%
1	Health Officer	2	2	100	2	100	1	50	3	150	2	100	1	50
2	General Practitioner (optional)	1	0	0	0	0	0	0	0	0	0	0	0	0
3	Midwife	3	2	66.7	2	66.7	1	33.3	3	100	3	100	2	66.7
4	Nurse	5	5	100	6	120	5	100	6	120	5	100	4	80
5	Ophthalmic nurse	1	0	0	0	0	0	0	0	0	0	0	0	0
6	Psychiatry nurse	1	0	0	0	0	0	0	0	0	0	0	0	0
7	Env. H. professional	1	0	0	0	0	0	0	1	100	0	0	0	0
8	Lab. technician or technologist	2	1	50	1	50	1	50	2	100	1	50	1	50
9	Pharmacist or Drug	3	0	0	0	0	0	0	2	66.7	1	33	0	0
10	Cleaners	5	3	60	2	40	1	20	5	100	4	80	1	0
11	Archive workers	6	5	83.3	5	83.3	4	66.7	6	66.7	5	83.3	4	66.7

12	Maintenance officer	1	0	0	0	0	0	0	0	0	0	0	0	0
13	Morgue attendant	1	0	0	0	0	0	0	1	100	0	0	0	0
		<b>32</b>	<b>18</b>	<b>56.25</b>	<b>18</b>	<b>56.25</b>	<b>12</b>	<b>37.5</b>	<b>29</b>	<b>90.6</b>	<b>21</b>	<b>65.6</b>	<b>13</b>	<b>40.6</b>

The information in the table tells that all of the health centers are not at good position in the availability of human resource. At the woreda level the average human resource is 57.8 %, meaning that 42.2 % of human resource shortage in the health center. The highest human resource shortage is observed in Gabjiro and Basso HCs. Shortage and uneven distribution of personnel was commonly reported in the sampled HCs especially pharmacist, lab technologist and Environmental health that leads to formation of weak HCGB and MT interims of service delivery.

## **CHAPTER SIX-DISCUSSION**

### **6.1 Organisational Structures**

It was clearly observed from results of this study that availability and functionality of organisational structures of HSD in study area was unsatisfactory mainly due to poor existence of these structures at PHC facilities level. At health center level, HCMC were still in the process of being established. At health post level, as being member of cabine of kebele VHC are found in ever kebele but not fully functional.

These findings are supported by many similar studies conducted in sub Saharan (east, central and South African countries). Among these, studies conducted in Kenya were found structural weaknesses between the HCMCs /VHCs and DHMTs and lack of clarity concerning the roles and functions of the DHMTs<sup>1</sup>. Other studies of Zambia and South Africa also support this finding<sup>1</sup>.

### **6.2 Health Center Governing Body**

The HCs have formal governing body, usually with seven to eight members, the woreda administrator or delegate cabine member's serves as the chairperson of the governing body, and have various sectoral delegate and community representatives are members. The HCs have management committees usually with five to seven members. The finding said that, the governing body needs to clarify and separate the powers of the DHMTs and HCGBs in order to reduce excessive influence of the former over the latter. Some operational challenges were observed in the governance of health facilities.

According to HSDA directive chairperson of governing body is woreda administrator or delegate cabine member from woreda but in all studded health center GB members leaded by kebele cabine these is against the regional regulation and HSDA directive. Most facilities noted that a high turnover of governing body members, due to a variety of reasons and because of the instability of local political situation.

Most of HCGBs were not aware about the correct frequency of their regular meetings. 4 out of 6 HCs have reported as they have conducted sufficient round of management meeting in the last six months of the year, these study was supported by Bishoftu hospital governing board assessment result<sup>31</sup>.

Boundary problems with the health center management and other respondents emphasized the boundary problems with the woreda health office. The ambiguity in authority was apparent in

statements about decisions concerning financial incentives for the staff, handling ethical issues, drug procurement, corrective action for employees, HC Director Supervision, and overall budgeting for the health center. This study was supported by study conducted in all Ethiopian hospitals<sup>33</sup>.

Poor communication and collaboration with Woreda health office, health center management and governing body were observed. In addition to ambiguity about the governing body versus the woreda health office roles, lack of communication and collaboration between the objects was also described as limiting governing body functioning. This study was supported by the study conducted in Debre birhan hospitals<sup>32</sup>.

Limited capacity of members of governing body and, the involvement of members in various government activities have constrained their effectiveness. As a result of their busy work schedules and insufficient incentive mechanisms as their major challenges or constraints. These finding strongly agree with the study conducted in Bishoftu hospital. In Bishoftu Hospital the mechanism they use to stay governing board<sup>31</sup>.

A programme of continuous capacity building for HCGB/MT on planning and priority setting, budgeting, administration and effective monitoring and supervision should be put in place at the district level to equip both the HCGB and HCMT members and other health personnel on pre requisite skill for effective administration and management of health care delivery at health facility level. This study was similar to the study conducted in Debre birhan hospital<sup>32</sup>

Majority of respondents said that lack of training and orientation on health service delivery administration directive was poor. Unmet training needs of governing body members a central concern for respondent was the lack of training and orientation on HSDA for governing body members. The findings were consistent with literature about governing boards in Ethiopian hospital to the finding that governing body activities are associated with Health center performance. This result was strongly dis-agree with the study conducted in Debre birhan hospital<sup>32</sup>.

### **6.3 Health facility based revenue retention, utilization and exempted health service**

Following ratification of the required legal frame work and adoption of operational guides, health facilities were able to retain and use their internally generated revenue as additive to their regular government budget. According to survey conducted in 2003 and 2004 revealed that in most health facilities, that drug budget was enough to cover only one quarter of the year, and health facilities were experiencing stock out of essential drugs for most of the year. Since then

stock out of essential drugs have been greatly reduced, and when they do occur, it is mainly because of shortages at PFSA and wholesaler level

In principles exempted health service like maternal health services are free but in some HCs charges for delivery-related services and supplies such as laboratory services, gloves and some drugs.

#### **6.4 Human Resource**

There availability of different health professional categories lowers than the already set standard by the EFMHACA in almost all the health centers. Regional health bureau has responsible for recruitment of most of the health workers, while the zonal health office is responsible to deploy them to woreda and woreda assign to the health centers.

The region is very vast, and also has poor transportation and communication systems in the study area, where the unreached part of the community with mix of primary health care service needs are found, and their makes the availability and sustainability of human resource problems.

As it has observed in this study, there is a problem of sustaining the existing health workers due to internal motivation to the urban areas, NGOs and Private sectors. There is a lack of managerial skills particularly in the zonal and woreda levels how to hire, manage and sustain the professional health worker.

There is poor recording and updating systems to keep properly the information of both health and other staff so as to trace efficiently and effectively the status of the health workers at health center and woreda health office. So, these poor recording and updating approach resulted in poor plan for proper human resource requirement, which is either training, off job short or long term training, without affecting the health care service provision.

Centralisation of human resource management tends to undermine local decision space. Since boards were established to allow community participation and ensure accountability and transparency in the use of public resources, they should be empowered to engage district health staff. Experience from countries like Uganda and Philippines show that improvements in delivery capacity of DHMBs were recorded where district systems have been accorded powers to hire and fire district personnel mainly because decisions pertaining to discipline and employment of the right personnel are quick and efficient.

## **CHAPTER SEVEN-CONCLUSION**

The study set out to assessing the operational capacity of Health center Management body and management teams using available literatures and primary data obtained from interviews with the health center governing body members and management teams. In general, decentralised health system was important than centralized system. Governing body members poorly responsible to their roles and responsibility in terms of planning implementing and evaluating health system in their catchment area.

Strengthening health center governing body to perform essential activities could result in improved health center performance, in a variety of areas including health service delivery and finance.

My findings indicate that newly established governing body members with limited resources and orientation on health service delivery administration directive best served by focusing efforts on key management activities.

On the other hand most of governing body lacks capacity to interpret health service delivery administration directive into the practice. Training status of governing body and health service managers at facility level was extremely low.

Insufficient number of community representatives delegates the community. It would be better more community representatives in the governing body members.

Results of this study can inform health managers at deferent level to implement strategies to support decentralization at the health center level.

## **CHAPTER EIGHT-RECOMMENDATION**

In order to improve the overall of existing organisational structures and management activities of governing body in study area, the following recommendations were made:

### **1 Health centers governing body**

- Terms of reference should be developed and give to health center governing body members.
- Training on HSDA directive should be given to governing body and health service managers
- Continues discussion and communication with woreda administration and woreda health office to address replacement or substitution of non-active members
- Scheduling meetings at more convenient times for governing body members

### **2 Human Resource**

- Recruit and motivate to sustain externally acquired health professionals
- Providing training on HR management to those at different levels process, particularly by focusing on HR planning and management.
- Properly and exhaustively map/inventory the available and required HRs for different health facilities, based on the standard set by EFHMACA.
- Identify the actual HR requirement that need to be acquired buy the region at all levels, and then formulate a strategy to look for alternatives and then get rid of the HR issues in the region.

### **3 Further study**

- I strongly recommend further study on the functionality of governing body at similar set-up which focused on assessing role of different stake holders in DHS.
- Further study is required to better understand the spectrum of responsibilities that can be delegated to health center governing body and how the varying levels of delegation can influence health center performance.

## Reference

1. An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya, *IPAR publications please visit our website-www.ipar.or.ke*
2. Health Systems 20/20, 2012. The Health System Assessment Approach: A How-To Manual. Version 2.0. [www.healthsystemassessment.org](http://www.healthsystemassessment.org)
3. Health sector development plan, MOH HSDP IV, 2011, Ethiopia
4. Oromia Health service delivery administrative directive 2015, Ethiopia
5. Health Sector Transformation Plan, 2015, Addis Ababa, Ethiopia
6. Bureau of Finance and economic development Audit report 2015, on misuse of funds in
7. Islam, M., ed. 2007. *Health Systems Assessment Approach: a How-to Manual*. Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management
8. Luboga, S. and A. Hagopian. 2011. Satisfaction, motivation, and intent to stay among Ugandan physicians: a survey from 18 national Health centers. *International Journal of Health Planning and Management*.
9. Management Sciences for Health. 2011. *Securing Ugandans' Right for Essential Medicines (Uganda SURE)*. Cambridge, MA: <http://www.msh.org/global-presence/uganda-sure.cfm> Accessed Mar. 16, 2011.
10. Bossert, T. and Beauvais, J. (2002). *Decentralisation of Health Systems in Ghana, Zambia, Uganda and the Philippines: A Comparative*
11. Madison, D. L, C. Combs. "Location Patterns of Recent Physician Settlers in Rural America." *Journal of Community Health* 6, no.4, 1981):267-74.
12. Institute of Development Studies. Financing primary health care. id21 insights health 12. May 2008
13. De Friese G.H, Ricketts T.C. Primary Health Care in Rural Areas: An Agenda for Research. *Health Services Research* 23:6 (February 1989)
14. Rohde, J., et al.30 years after Alma-Ata: has primary health care worked in countries? *The Lancet* Vol. 372 September 13, 2008
15. Analysis of Decision Space. Harvard School of Public Health, Boston, MA, USA and New York University of Law, New York, NY, USA.
16. Bossert, T., Mukosha, Bona C. and Bowser Diana (2003). .Decentralization in
17. Zambia: Resource Allocation and District Performance.. *Journal of Health Policy and Planning*; 18(4): 357-369.
18. Brinkerhoff, Derick W. and Markus D. Ingle (1989). .Between Blueprint and
19. Process: A Structured Flexibility Approach to Development and Management. *Journal of Public Administration*, Vol. 9, No.5.
20. Cassels, A. (1995). .Health Sector Reform: Key Issues in Less Developed Countries.. *Journal of International Development*, 7 (3), 329-67.
21. Health care financing system, ministry of health, Ethiopia 1999
22. World Health Organization report 2010, Addis Ababa, Ethiopia
23. Health facility governance in the Ethiopian health system, 2014
24. Evaluation report of Ethiopian health sector financing reform Midterm Project evaluation
25. Ministry of health Supervision Report, 2011, Addis Ababa, Ethiopia
26. Synthesis Report of Quarterly Supportive Supervision Conducted in Oromia Region in 2014
27. An Assessment of the Service Delivery Capacity of the District Health Systems in Kenya IPAR Discussion Paper Series 7
28. What do District Health Planners in Tanzania think about improving priority setting using 'Accountability for Reasonableness'? <http://www.biomedcentral.com/472-696317/180>
29. Monitoring the referral system through benchmarking in rural Niger: an evaluation of the functional relation between health centers and the district hospital-<http://www.biomedcentral.com/472-6963/6/51>
30. Community voice and role in district health systems in east and Southern Africa: A literature review
31. Innovation and performance improvement: sharing experiences from four hospitals in oromia region
32. Ethiopian Hospital Management Initiative, Clinton Health Access Initiative, Addis Ababa
33. Clinical Governance and Risk Management: Achieving safe, effective, patient-focused care and services. NHS Quality Improvement Scotland, October 2005

### Conceptual frame work for health center governing body

Health Service Function → Health System Performance → Impact

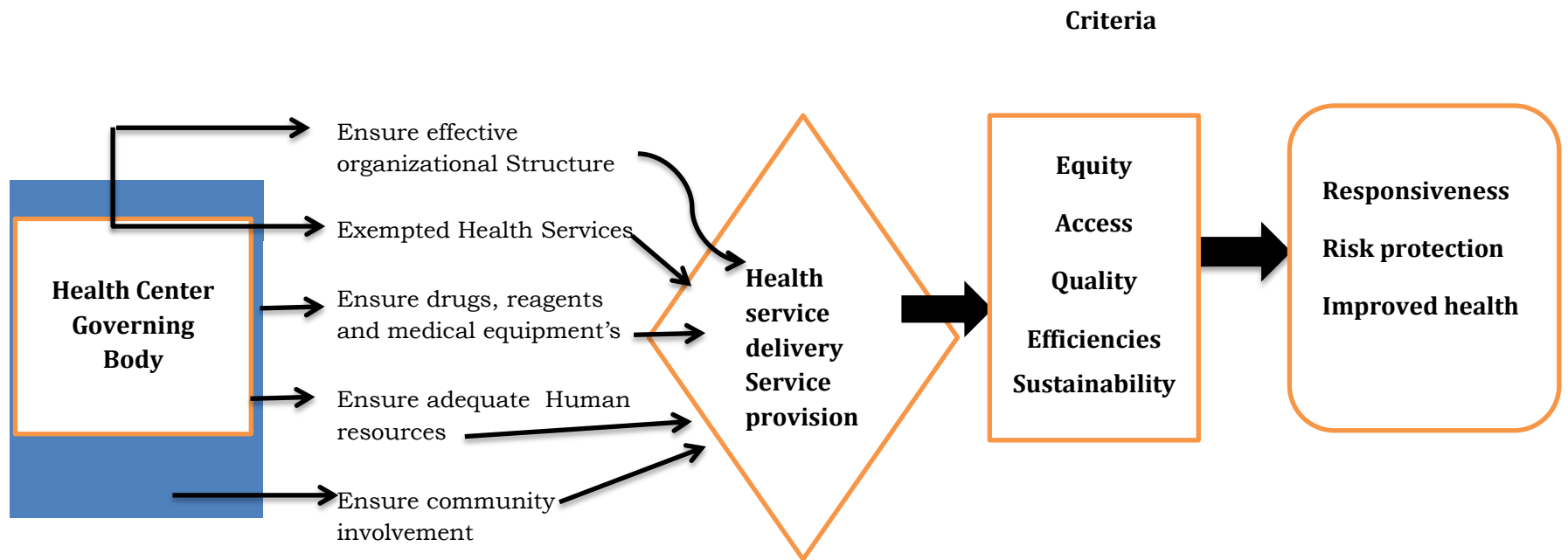


Fig.1 Conceptual frame work

**Addis Ababa University, College of Health Sciences  
School of Public Health**

**Assessment of the operational capacity of health center  
management team and governing body**

**I. Background Characteristics**

1. Region \_\_\_\_\_ 2. Zone \_\_\_\_\_ 3. Woreda \_\_\_\_\_  
4. Name of health center \_\_\_\_\_ 5. Catchment Population \_\_\_\_  
6. Name of respondent \_\_\_\_\_ 7. Sex \_\_\_\_\_ Age \_\_\_\_\_  
8. Responsibility \_\_\_\_\_ 9. Profession \_\_\_\_\_ 10. Educational  
Background \_\_\_\_\_ 11. Telephone Office \_\_\_\_\_

**II. Management Structures**

- |       |   |     |    |
|-------|---|-----|----|
| 1     | Is the health center management structure in place                    | Yes | No |
| 2     | Does it have guidelines on its functions and responsibilities?        | Yes | No |
| 3     | Have meetings been held according to guideline?                       | Yes | No |
|       | 3.1 If Yes how many _____ How often _____                             |     |    |
| 4     | Are there records of these meetings?                                  | Yes | No |
| 5     | Does the structure have authority to make decisions on                |     |    |
|       | 5.1 Health center Plans   | Yes | No |
|       | 5.2 Health center Budget  | Yes | No |
|       | 5.3 Purchase of drugs and other medical supplies?                     | Yes | No |
| 6     | What are the functions of health center management teams?             |     |    |
| <hr/> |   |     |    |
| 7     | Do the members of the health center management have job descriptions? | Yes | No |

## Annex 2 Health Center Leadership and Governance Checklist

		Yes	No
1.	A Governing Body has been established		
2.	Terms of Reference for the Body are defined		
3.	The Body meets at a minimum every quarter		
4.	There is a planned orientation programme for new Body members		
5.	The Health Center has a Statement of Vision, Mission and Values that has been approved by the Governing Body		
6.	All staff have been oriented to the Health Center Vision, Mission and Values		
7.	A Health Center manager has been appointed		
8.	The manager has signed a job description that outlines his/her duties to lead the Health Center		
9.	The Health Center Manager is evaluated quarterly		
10.	A Management Committee has been established. Membership of the Management Committee has been approved by the Governing Body		
11.	Terms of Reference for the Management Committee are defined		
12.	The Management Committee meets as a minimum every two weeks		
13.	The Health Center has a strategic plan that has been approved by the Governing Body		
14.	The Health Center has an annual plan that has been approved by the Governing Body		
15.	All staff have been oriented to the Health Center strategic and annual plans		

## Annex 3 In-depth interview guideline

### Governing Body members

1. Age
2. Year of service
3. Educational status
4. Marital status
5. Average monthly income
6. Are you happy with being a management member?
7. Where does your family live \_\_\_\_\_
8. Where do you live? Home rented \_\_\_\_\_ government provided family
9. How was the health centre governing body welcomed by health workers and management members?  
\_\_\_\_\_  
\_\_\_\_\_
10. What are the changes, observed in the organization of services which are due to governing body?  
\_\_\_\_\_  
\_\_\_\_\_
11. Are there changes in the quality of care offered such as Drugs, medical equipment, water supply and electricity?  
\_\_\_\_\_  
\_\_\_\_\_
12. Do you get all the necessary support from governing body/  
I. Yes                      II. No                      III. do not know
- 12.1 if No, please fill the following
- 12.1.1 Drugs/vaccines    I. Yes                      II. No                      III. I do not know  
If no, why? \_\_\_\_\_
- 12.1.2 Medical Equipment    I. Yes                      II. No                      III. I don't know  
If no why? \_\_\_\_\_
- 12.1.3 Water supplies                      I. Yes                      II. No                      III. I don't know  
If no, why? \_\_\_\_\_
- 12.1.4 Electricity                      I. Yes                      II. No                      III. I don't know  
If no why? \_\_\_\_\_
- 12.1.5 Finance/benefits/ allowance..    I. Yes                      II. No                      III. I don't know

If yes why? \_\_\_\_\_

12.1.6 Other resources I. yes II. No III. I don't know  
If no, why? \_\_\_\_\_

13. Do you get supervision support I. yes: II. No III. I don't know  
13.1 If yes, please write by which level and how frequents is by which level

13.2 How frequent \_\_\_\_\_

---

**Changes observed in your facility**

1. Material resources (facilities, equipment)
2. Human resources (number of personnel and their qualifications)
3. Organizational structure (staff organization, level of reimbursement)
4. Transportation.
5. Adequacy of staff supply and training
6. Status of recording and utilization of information
7. Systems for monitoring and evaluating services
8. Mechanism for community representation
9. How many model how hold are there in your catchment area
10. Of these how many are during your stay(by You)

**For health center Governing Body/Management teams interview**

Questions must include

1. Qualifications including training, experience, continued education
2. Frequency and type of supervision they have received
3. Degree of management and administrative support
4. Technical knowledge
5. Availability and adequacy of health commodities and equipment and presence of systems for maintaining adequate availability of supplies.
6. Presence of protocols and standards of practice
7. Interpersonal skills
8. Governing body perceptions of the service delivery environment
9. Changes or success due to Governing body
10. Challenges

## **Annex 4 Focus Group Discussion Guideline**

### **Management team of HCs**

Instruction to be included

1. How was the governing body welcomed by health workers and management members?
2. What are the advantages of governing body?
3. What are the disadvantages of governing body?
4. What is your opinion about governing body compared to the old approach? Why?
5. Do you think the reform (availability of governing body) useful? Probe: - If yes why? If no why?
6. What should be done (organization, approach..) if the service is no to be properly utilized by the community
7. What are the problems or constraints related to quality health service? \_
8. What are the changes, observed in the organization of services which are due to governing body
9. What is the opinion about the quality of service provided by health Center workers and why? Are there changes in the quality of care offered by facility? What are the changes observed?

**THANK YOU SO MUCH**