



***APPLICABILITY OF APPRECIATIVE INQUIRY AS
LEADERSHIP MODEL IN PUBLIC ORGANIZATIONS:
The Case of Bureau of Health, Addis Ababa City Government***

By: Haimanot Kagne Temteme

Advisor: Filmon Hadaro Hando (PhD)

***A Thesis Submitted to the Department of Public Administration and
Development Management of Addis Ababa University for the Partial
Fulfillment of the Requirement for Degree of Master of Arts in Public
Management and Policy, Specialization in Development Management***

**Addis Ababa University College of Business and Economics
Department of Public Administration and Development Management
Masters of Arts in Public Management and Policy**

**May 2015
Addis Ababa, Ethiopia**

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**

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BY: HAIMANOT KAGNEW TEMTEME

PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

APPROVED BY BOARD OF EXAMINERS:

**Dr. Filmon Hadaro Hando
Advisor**

Signature

Date

Internal Examiner

Signature

Date

External Examiner

Signature

Date

**Chair of Department of Graduate
Programs**

Signature

Date

Declaration of Originality

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 the thesis have been duly acknowledged.

Haimanot Kagnew Temteme

Signature _____

Date _____

Statement of Certification

This is to certify that Haimanot Kagnew Temteme has carried out her research work on the topic entitled **APPLICABILITY OF APPRECIATIVE INQUIRY AS LEADERSHIP MODEL IN PUBLIC AGENCIES: THE CASE OF BUREAU OF HEALTH, CITY GOVERNMENT OF ADDIS ABABA**. The work is original in nature and is suitable for the award of Master's Degree in Public Management and Policy.

Filmon Hadaro Hando (Phd)

Thesis Advisor

Signature _____

Date _____

ACKNOWLEDGEMENT

In the process of attending MA classes and preparing this final thesis, I have been indebted to many people who contributed in one way or another to its successful completion. First and for most myriad thanks for God as without HIM, it was impossible to complete this study.

I am deeply indebted to my advisor Dr. Filmon Hadaro for a key role he played in contributing valuable and constructive inputs. His guidance and keeping track of progresses were very encouraging and meaningful in the consecutive months devoted to conduct this research.

I appreciate and acknowledge the cooperation and support that I received from colleagues and classmates. To name few among all encouraging colleagues of mine, Selamawit Minker; Bilen Mekonnon; Yodit Yeminu; Ashenafi Tesfaye (my supervisor); Dereje Ketema; Tamiru Lega; and Nunu Bogale are some of them. From my classmates Hirut Assefa deserves much more appreciation and recognition since her part during the two years MA program was immense.

My friends Hanna Demissie; Yamirot Nigussie; Dawit Nigussu; Meron Abebe; Saba H/Giorgis; Hilina Kebede; Edigit Ayile; Ato Tizera Alene; Biletish Tadesse; Haileysus Agonafir; and Professor Woldamlake Bewiket your moral support and trusted friendship made today's Haimanot. I believe that you INVISIBLY are at the back of the production of this thesis, so it is worthy to acknowledge your contagious strength. The dialogues held in those years and lightly then after with Haileragual Tadess; Astawessegn Gellaw; Hirut G/Amlak; Fassika Kebede; Asfaw Fekadu; and the late Dr. Dereje W/Medihen have still space in me, cheers my dear friends everywhere in the world!!!

I have an enormous debt of gratitude in respect of all my family members' big bro Eyob Kagnew; Alemzewid Kagnew; Yared Metaferia; Fanaye Mekonnon; and Mahilet Kagnew (Kido). But I need to add a plus sign to my Father Kagnew Temteme and younger brother Dawit Kagnew (the diaspora) to their firm and productive honors both maintained all my way in life, words don't have enough power to state their contribution in this regard.

This MA program shared significant proportion of my time and energy from Bethelehem Surafel (Betika) and my little daughter Ruth Gaurave. You both are my reason to live and attain the best possible things; in that case I acknowledge your contribution is the MOST precious to this research paper preparation as well.

The last but not the least is Pact-my employer-in addition to the educational benefit package it offers to its employees it has been my supports in enumerable dimensions in all these years mean a lot-THANKS a lot!

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Annex I

ABBREVIATIONS

AABoH	Addis Ababa Bureau of Health
AAU	Addis Ababa University
AI	Appreciative Inquiry
BoFED	Bureau of Finance and Economic Development
BoH	Bureau of Health
BPR	Business Process Reengineering
BSC	Balanced Score Card
CSA	Central Statistics Agency
CPO	Core Process Owner
CV	Curriculum Vitae
EFY	Ethiopian Fiscal Year
FMoH	Federal Ministry of Health
HAPCO	Hive Aids Prevention and Control Office
HSDP	Health System Development Plan
KII	Key Informant Interview
MDG	Millennium Development Goal
NHE	National Health Expenditure
PO	Process Owner
RHBs	Regional Health Bureaus
SPO	Supportive Process Owner
WHO	World Health Organization

ABSTRACT

The quest for public service leadership practices are constantly changing in line with dynamics in resource scarcity and the growing demand for quality services. Theoretical lenses that are informed by transactional and transformational leadership practices are also revisited. More efficient and strength based approaches are recommended under resource constraints and growing service demand. More strength based approaches look for flexibility that accommodates diverse interests and possibilities, wider participation for consensus-building and using work place problems as learning opportunity. These aspects of leadership strengths are proposed from findings of empirical studies. These leadership strengths constitute the 4-D parameters and 8-assumptions of Appreciative Inquiry Model which are unique features of appreciative inquiry approach to leadership and are important in leadership development in public organizations. This study was aimed at analyzing the applicability of the Appreciative Inquiry Model in the Addis Ababa Health Bureau. The study employed qualitative research approach and conducted key informants interview with purposively selected top leaders and administered questionnaires for staffs. The result of the study showed that strength based approach is practiced within the bureau. The result also confirmed that staffs were not participating in major organizational decisions. Top leaders that participated in the key informant interview argued that the bureau has put in place bottom-up planning and evaluation system and “all” actors at all levels were participating. Flexibility in handling office matters and constructive learning opportunities from the problems and challenges of the bureau are found to be limited. The study concluded that the Addis Ababa bureau of health is practicing aspects of the Appreciative Inquiry Model as part of leadership development. This was evidenced by the efforts of the bureau in setting conducive working environment for staffs which will improve quality of health services to clients. The study thus recommends that the health bureau has to enhance participation of staff in key decisions and promote constructive learning opportunities from problems facing the sector. In order to make this happen the 4D-8-assumption appreciative inquiry practices should be implemented side by side with conventional transactional and transformational leadership practices.

Key Words: Appreciative inquiry model, leadership development, public organizations

Chapter One

1. Introduction

1.1 Background of the Study

1.1.1 Appreciative Inquiry Leadership Model

There is a broad consensus in the literature that leadership is essential to successful organizational performance. Scholars such as Pace and Faules (1994) have emphasized the role of leaders and followers as paramount to organizational success. Leadership involves at a minimum a leader, a collection of followers and context; yet most studies focus on the leaders themselves (Tosi, 1991) cited in Hart et. al. (2008). In this regard, new leadership models focus on the dualistic and dyadic nature of the relationship between leaders and followers as it is important for the success and improved performance of an organization. There have been repeated calls for consideration of change in the leadership fields. Osborn et al. (2002) cited in Hart, Conklin & Allen (2008) argued that leadership is depends on the context particularly when linked with change, change in context results in changes in leadership. The key aspects that is essential for making a strategic shift in the organizations applying contemporary findings that can fit with the changing demand of the leaders and their followers. Accordingly there are different leadership models that are critical for continuous organizational development.

Among others, Appreciative Inquiry model of leadership is the one. Appreciative Inquiry, (according to Cooperrider & Whitney, 2005; Clark, 2004; and Lewis, Passmore and Cantore, 2008), is a collaborative, strengths-based approach to both personal and organizational development that is proving to be highly effective. It deals with change that shares leadership and learning-as well as full engagement of everyone in the organization. The model focuses on organizational excellence of the previous period and inquires based on the given assumptions: deliberately quote success stories from the past, raise questions that lead to positive thinking, being confident in its internal capacity (both as individual staff and organizationally) create shared organizational vision, and promote teamwork.

Valuing what organizations have at hand from the past for the best interest of the future development is core element of Appreciative Inquiry (AI). As per the model particularly capacities or situations of one's previous performance when the organizational achievements excel results are good spring boards to reach to the next step; which is often related to organizational as well as leadership learning. The model involves collaborative inquiry, based on interviews and affirmative questioning, to collect and celebrate the good new stories of a community those enhance cultural identity, spirit and vision and inspires for more cooperation, relationship (teambuilding) and enhancing capability. As precisely stated by Hart, Conklin & Allen (2008) Appreciative Inquiry is predicated on narrating and reflecting on one's lived experience, one's contribution to, and the conditions surrounding that experience. This reflection provides the groundwork for creating images of possibility for transformation.

There is a 4-D and 5-D Models of Appreciative Inquiry Leadership where the Ds stand for Discovery, Dream, Design, Destiny with the 4-D whereas includes Define with the 5-D Model. In either of the cases exerting efforts to have affirmative topic is one of the fundamental responsibility of the Model and in the process each depicts a broad and abstract outlines of Appreciative Inquiry (Haar & Hosking, 2004).

Assumptions of Appreciative Inquiry

The foundation of Appreciative Inquiry Model lies in the EIGHT assumptions. The very essence of the model is governed by the principle of (i) in every society, organization or group, something works. It gives due emphasis that there is something valuable and important to the specified organization which should be identified and capitalized on it for the future direction. (ii) the act of asking questions of an organization, or group influences the respondent in some way, meaning the way of inspiring and envisioning matters what the group would focuses and proposes for its past performances and future plans. The question by itself may guide the way of thinking and looking for differently what is already existed. (iii) People have more confidence to the journey to the future when they carry forward parts of the past. To journey to the unknown tomorrow, it is good to build up on what is already crossed in the previous trip as it gives clue and be a base for the future. The fourth assumption glorifies what should be carried from the past: (iv) when carrying forward parts of the past, it should be what is best about the past. By

enumerating how the best was happened, the selection among the past needs to focus on what went well-the greatest happening of the past should be carried.

The (v) language used to create our reality is significantly affected by the means of communications. The sense of motivating, hoping the best and the successes wanted to set up determined by means of the language used for the entire process. Constructive and industrious languages geared the group to creative and productive thinking. Since individuals and groups might have different background and interest as they have different valuable inputs, (vi) valuing individual differences has taken as one of the guiding principle in the AI model of leadership. This is devised with the sense of team-building, team-work, participation, consensus and capacity building among the participating individuals and groups. (vii) What we focus on becomes our reality with the sense effort on core issue, and shared vision. Strength, success and shared values need to get appropriate attention so as to build on them and to redress those challenges on the road. Organizational and group reality should be focused and investing resources should be to the core organizational issues. The last but not the least guiding principles of this model are (viii) as reality is created in the moment, it is important to consider there are multiple realities. This has room for the impossibility of succeeding in numerous issues, looking for key competences and capabilities. It also amplified the human resource as the core organizational asset and the in-tangible assets are set of agreed inspirations and processes of influences.

These assumptions are uniquely defining the model. Appreciative Inquiry gives due emphasis to the internal capacity that led the organization in to its pick stage(s) during the previous performing period. The model creates space to accommodate the distinct organizational context and flexibly handle its case (Finegold, Holland & Lingham, 2002).

1.1.2 Bureau of Health, Addis Ababa City Government

As emphasis given in the National Health Service Program of the last 5th year health planning, Addis Ababa Health bureau continues being responsible for the delivery of promotive, preventive, curative and rehabilitative health services in the city. The number of Health experts

distributed in 15 professions, according to the 2012 data, is near to 12000. The profession is dominated by Nursing category where all Nurses 3980; Clinical Nurse, 2426; and BSc Nurse, 1138. This is followed by Urban Health Extension Workers, 1407. General Practitioners and Specialized Medical Doctors in different types are very lower in number, 201 and 314 respectively (for the details, please consult annex 5 of this study).

However as per the Mini Demographic and Health Survey by BoFED (2014) more and more efforts have to be executed by the concerned organizations to bring about an equitable distribution of health services in the city. The bureau further implied that the effectiveness of basic health care and supporting services as well as inter sectorial interventions largely rely on the extent of the entire stakeholders (the public sector, the private sector, the community, others) participation at all stages in realizing the aimed goal of equitable health distribution.

Enhancing effectiveness of health systems is proposed by WHO to mitigate the challenges the sector facing that includes Ethiopia. WHO estimated a global 20 to 40 percent inefficiency-related loss of resources in the health sector (MoH 2014), and it underlined that every country has room for improving efficiency in the health sector. Efficient use of resources is also an important case to make when arguing for increased investments in health from government, private sector, and development partners.

1.2 Statement of the Research

Appreciative Inquiry based leadership model for organizational development is the study of what gives life to human systems when they function at their best and encourages people working together to promote a more complete understanding of the human system, the heartbeat of the organization. Whitney & Trosten (2010) explains that in order to continuously succeed, organizations need more inquiry. Meaning people in the organization need less command and control by a few and more exploration of possibilities among many; need less certainty in their usual plans and strategies and a greater capacity to sense and adapt quickly as their world change.

As per Clark (2004) the shift in thinking begins with the person who raises the question. Followers in general and organizations in the change process need leaders who can acknowledge what they achieved before, actively participate in the creation of shared vision, enthusiastically asked provocative and inspiring questions. In such organizational development process center of excellence and joint efforts are strongly supported by innovation and client satisfaction. According to Rama, Conklin & Allen (2008) Appreciative Inquiry is grounded on describing and reproducing what was achieved and how was specific person or organization lived that experience.

UN-HABITAT (2008b) cited in Schmied (2010) acknowledged the positive role of cities as the cities of East Africa are, like elsewhere in the world, the national engines of the modernization, industrialization, economic growth and development. To play such kind of national roles the health condition of urban habitats is among the key issues.

According to the bulletin (MoH, 2014) inadequate capacity to implement a decentralized health system, weak referral network, poor quality of health information system, low effective coverage of high impact interventions, inadequate pharmaceutical supplies at health facilities, lack of human resource (HR) motivation and retention, shortage of highly skilled professionals, and low utilization of health services are listed among the main weaknesses of the sector. The 16 core goals designed by the Ministry of Health are the framework for the Addis Ababa Bureau of Health alike the other regions (Wamai, 2009). The bureau's coordination and facilitation power and functions are directly associated with these goals where the work processes and lower level structures draw their respective plans from this framework. The Addis Ababa Bureau of Health (AA-BoH) undertakes its daily activities of facilitation in light of assuring the goals are materialized at grass root level which resulted minimal room for innovation and creativity. Top and middle level managers are responsible in preparing the necessary list of activities and fulfilling the coordination and facilitation role of the core processes and supportive processes performance at all level. The list of activities prepared as per the change and measurement tools currently used by government agencies.

According to the publication of the Bureau of Finance and Economic Development, city Administration of Addis Ababa (2009), health related indicators are manifested in a number of ways. It notified that by and large, if equitable and sustainable development is to be achieved, an

initial step may be to give adequate emphasis for health as a means of identifying priorities in urban development endeavors. This would enable the urban development agenda to be guided by the long-term goal of human well-being rather than the short-term goal of economic wellbeing.

MOH, (2010) cited in Mini Demographic and Health Survey 2014 by Central Statistics Agency (CSA), HSDP IV is designed to provide massive training of health workers to improve the provision of quality health services and the development of a community health insurance strategy for the country. In line with the government's current five-year national plan, the health sector continues to emphasize primary health care and preventive services; with focus on extending services to those who have not yet been reached and on improving the effectiveness of services, especially addressing difficulties in staffing and the flow of drugs.

In order to use the relationships between employees to strengthen group and individual achievements; team work and motivation as sources for improving an organizational assets; probing inquiries by focusing on constructive questions with the intention of enhancing organizational excellence and successes of the bureau for future organizational development Appreciative Inquiry Leadership Model is proposed. In doing so, all the resource allocated and commitments of the Government of Ethiopia, the City Government of Addis Ababa and Addis Ababa Bureau of Health, the organization as a public agency can be functioning as a better place where innovation, learning and successful stories are experienced. More on that, the residents of Addis Ababa as clients of the Health Bureau will be able to get the health service as intended. On the backdrop of these outcomes, this thesis is aimed at assessing ways of using appreciative inquiry leadership model in the Addis Ababa Bureau of Health.

1.3. Objective of the Study

1.3.1 General Objectives

The main objective of this study is to understand whether appreciative inquiry leadership model can be applied in public institutions and if so in what ways is this model applied in public institutions of Addis Ababa City Government with what possible results, in specific focus to the Bureau of Health, in contrast to the mainstream leadership models practiced in Bureau.

1.3.2 Specific Objectives

The specific objectives of the study are to:

- Assess the leadership practices used by leaders of the bureau of Health of Addis Ababa City Administration (context description)
- Examine the inclination of employees for effectiveness and motivation in work place in relation to the leadership approach employed in the bureau of Health of Addis Ababa City Administration (context of existing results in the bureau)
- Analyze whether the health bureau applies appreciative inquiry leadership model focusing on what knowledge, skill and attitude change are needed to apply AI in the health bureau (application and results of using AI)
- Identify prospects and limitations of the application of the model with expected results in performance of health bureau of Addis Ababa (Policy advice)

1.4 Research questions

The research paper assessed the applicability of AI leadership model in public agencies with the theoretical perspective that entail organizations using the model benefit to excel. This is only happen when emphasis is given out to innovation, learning and use of successful stories that are experienced by the organization as opposed to blames and counter blames on problems. Hence organizational success and achievements continuously improves as the relationships, team work, motivation and sustained probing for excellence habitually become the culture of the organization. To this purpose the specific research questions will be:

1. What leadership practices are used by leaders of Health bureau of the city?
2. Do employees observe the leadership approach effective and motivating?
3. Is AI leadership model (knowledge, skill & attitude) applied in health bureau?
4. What opportunities are observed in applying AI for improving best practices, staff motivation and organizational learning?

1.5 Significance of the Study

Since Appreciative Inquiry as leadership model is a recent phenomenon and a number of success stories are spread in different countries, it is time to study its applicability and prospects in Ethiopia. Particularly in the public organizations where service delivery is mostly depends on the leadership practice. The Addis Ababa City Administration in general; and the Bureau of Health in particular will benefit from the analysis made in this perspective as both are the contagious government body to introduce and expand the best and new models emerged through time.

The bureau of Health can have the opportunity to see the existing leadership practice in line with Appreciative Inquiry model whereas the city administration in collaboration with the Bureau are advised to consider the recommendations as per the findings of this research work.

Meanwhile this study contributes the prospects of the leadership practice improvement in light of the Appreciative Inquiry Model in public agencies of Ethiopia. The existed potential to apply the Model, the areas need improvement to adjust the reality as per the requirements of the Model and potential challenges of the theory in Ethiopian public agencies context studied and is ready for referencing by other scholars. In the interim of all this process, the researcher learnt a lot from the research starting from its designing; gathering related literatures and data; and organizing this paper as per the required standards of the Addis Ababa University. Again the aim includes partially fulfilling of the Master of Arts in Public Management and Policy, concentrating on Development Management, has been achieved.

1.6 Scope of the Study

Appreciative Inquiry as leadership model includes an individual leader's understanding and ability as well as the nature, political and administrative features of a given organization. It has human aspect, an immediate focus on expediting the potentials of individual workers and groups of workers so as to mobilize for high performance.

- The institutional scope of this study is limited to Health Bureau of Addis Ababa City Administration, out of the public organizations.

- The thematic scope focuses on performance of and prospects/limitations of the organization selected.
- The respondents of the research include leaders and employees (followers).
- The analytic scope focuses on the leadership processes and its resultant perspectives in developing contexts for high performance in the health bureau of the city.

The gradients of analysis are established focusing on how appreciative inquiry is operationalized and practiced by the leadership for staffs' capacity building, motivation and relationship development. The interpretation is based on evidences of what has been achieved in the past in the work processes and look for rooms available for innovation.

The variables of operationalization and applicability are measured in terms of:

- Whether there is collaboration in registering performance (synergy),
- Appreciation of strengths of individual employees and groups in the work processes (motivation and strength based empowerment)
- Perspectives of lessons from previous achievements (whether best practices are documented, referred and used in planning and evaluation of results)
- Whether staffs are familiar and apply the processes in terms of seniority.
- Participation of employees (from top leadership to expert levels) in terms of frameworks, adherence to such frameworks in the work processes and the frameworks of learning and knowledge management in the organization selected

The applicability of the model in the health bureau studied by assessing the existing leadership practice in line with individual staff's preference as leader and follower; opportunity to know and practice the model; and the supportive environment for innovation and teamwork in the bureau of health. In the process, prospects and limitations of using this model for high performance are evidently identified and concluding remarks in the form of conclusion and recommendation are established.

1.7 Limitation of the Study

Key limitations include time and budget; consent of respondents, from the existed trend in government agencies, in telling the truth as it might be politicized. To resolve the doubt regarding politicizing the researcher has briefed respondents that the objective is purely academical and the confidentiality is fully respected before administering the questionnaires. To get full consents of respondents' informal networks helped to step up in the process along with the formal communication process.

1.8 Organization of the Thesis

This research paper hopes to critically observe and analyze the leadership practice of public agencies in Ethiopia with specific reference to the Addis Ababa Health Bureau that may help to complement the government of Ethiopia's efforts in inculcating greater awareness of and concern about the importance of health service as one of the key social services provided to its citizens. To this purpose the paper is structured in five inter-twined chapters.

It starts with the introductory part where research objectives, research questions, scopes and limitations are included. The second chapter is about theoretical and empirical related literature of the research framework. Appreciative Inquiry leadership as concept, model and grounded assumptions are concisely presented as appropriate followed by the analytical framework of this study. The next chapter covered the study area and research methodology used to study the Addis Ababa Health Bureau in the leans of Appreciative Inquiry Model of Leadership. Brief overview of the Addis Ababa Health Bureau; mandates, professional and institutional capabilities to deliver the health service to its clients are taken into consideration. The methodology aspect describes the design and method of study, sources of data, data collection instruments and the way data presented and analyzed as well as ethical consideration.

Fourth chapter, data presentation and analysis discuss the data in line with the theoretical framework of the study subject. In this chapter the existing leadership practice of Bureau of Health are reviewed in detail placing the research questions at the center of the discussion.

Responses of the questionnaires administered by the staffs are discussed and analyzed each other and also with and against the qualitative data gathered from the 4 key informants. Based on the presentation and analysis made in the earlier chapters, conclusion and recommendation along with further research areas are presented in the fifth chapter. With this chapter the concluding remarks of the researcher and possible policy recommendation(s) established as integral part of the study.

Chapter Two

2. Review of Related Literatures

2.1 Perspectives of Leadership

Like gardeners who nurture the growth of their plants, leaders nurture the growth of the people around them, according to Antonacopoulou & Bento (2011). In order to be organizationally successful the role of a leader is substantial. Knowing where the organization need to be by itself is one step which should be supported what type of resources are available and required to fulfill the vision of the organization. Understanding the internal reality is key purpose of every leader which includes the human capacity. As Hirsh (2011) stated effective career development is not just vital for growing good managers and leaders at all levels; it is a remarkable cheap and powerful way of motivating and retaining good people. More than anything else, effective career development really calls upon employees to understand the changing needs of the business, and seriously engages the organization with the people it employs. The engagement is what counts, and that is why career development is not responsive to a quick fix.

Leadership development should be a continuous process, not even a series of “episodes.” It is easy to lose sight of a development plan or career path. Learning should be ongoing so that it is constantly at the front of the leaders’ priorities and perhaps even incorporated into their work. This also ties in with variety: having a wide range of leadership development initiatives will likely allow practioners to design ongoing systems that avoid becoming redundant, as Giber et al. (2011) briefly indicated that the process in which the organization experiencing changes is mainly the responsibility of a leader. The ongoing system to handle the organizational development has to be designed and should set the leader to recurrently on means of improving the efforts of employees and in line with achieving organizational goals. This is possible when the leader and his/her followers capture, share and take advantage of the regular learning. According to Giber et al. (2009) leaders must understand and then communicate their own value systems if they are to be trusted and followed. Learnings from different perspectives support the leader to know what is available and needed in the future development of the organization. To

this purpose the interaction between employee and leaders at all level is interdependent as they stand for the common goal.

A leader must understand the interests and objectives of the organization he or she is serving. Only with clear knowledge of these objectives he or she can set goals for the team that are high but achievable (Brown, 2007). As a consequence, the leader must know how to set goals and make decisions based on consultation with his or her team. Once the decisions are made, he or she must know how to implement them. Employees engagement in the situation is immense as experts on the activities planned and acquired the necessary steps as intended which need to be shared timely to the leaders from which leaders get learning from the implementation of what has been decided-the complimenting nature of leader-follower practiced.

Long-term leadership success does not come about through force of personality or character alone. Sensitivity to context is vital in understanding what works and what doesn't. The leadership context includes the legacies of past leadership actions, previous and present organizational arrangements, patterns and networks of relationships and host of other technological, social, cultural and political influences, (Pedlet et al., 2010). The legacy of the organization is highly depends up on previously achieved results and the context described in what situation the success records as well as noticing the internal capacity of the organization. Meanwhile building up on the past excellences taking the future into account and promote dialogue among employees to set the shared vision of the future organization.

Public agencies responsible for the provision of services to citizens at all level are in need of getting the right leaders to satisfy the public demand keeping all the known and unknown limitation behind. Alimo-Metcalf & Alban-Metcalf (2011) organizations across the public sector face enormous challenges in aiming to provide series of the highest standards to their clients and service users, while operating with strictly limited resources. The Metcalfes further argued that the way organizations approach leadership development can no longer be aimed purely at supporting the strengthening of 'human capital' by investing mainly in leadership programs for the few. This kind of programs must do far more, and also ensure that there are strategies in place for building leadership capacity within the organization by focusing on strengthening 'social capital' more widely. The concern of leadership sites far and is about the results of collective efforts exerted for common goal(s). It necessitates intentional investment to

reach the mass organizational community by aiming on what is availed abundantly that can be a foundation of the future organization.

In public sector, leaders' capacity to engage their staffs or followers in organizational matters is important. Alimo-Metcalfe & Alban-Metcalfe (2011) given the fact that public sector organizations will have to maximize the realization of the potential of all their staffs, it is not surprising that the phenomenon of 'engagement' has moved center-stage as a matter of serious consideration, and this in turn has enormous implications for the understanding of what constitutes effective leadership.

For the continuous organizational development various leadership models can be applied. Leaders need to focus on getting things done and motivating, developing, and communicating with people. David (2004) in certain instances, getting things done may require them to push people very hard, to demand more than they believe they can deliver and ignore their needs for the moment. In other circumstances, they may have to allow people room to fail and learn, sacrificing results for development retention, or commitment.

Under the leadership arena it is possible to get theories and models that have different purpose, approach and style. However some of the leadership perspectives are varied in degree of commitment in some aspects from the others and in other aspects they may stand in contrary directions. Among others only two called transactional and transformational leadership models are briefly described.

Transactional Leadership Model

The communication between transactional leaders and their followers are merely in 'exchange' relationship, (Burns, 1997). The relationship focuses on mutual benefits: rewards or recognition from the leader in response to the commitment or loyalty from the followers' side (Bolden et al., 2013). The role of the leader typically concentrates on each follower's performance; if necessary, taking corrective action when the follower fails to perform or nothing until problems arises (Bass & Bass, 2008). The hallmark of transactional leadership is the followers' recognition of the leader and acceptance of authority in exchange for valuable resources.

Rewards and positive reinforcement are provided by the leader. As a result transactional leadership is more practical in nature because of its emphasis on meeting specific targets or objectives (Aarons, 2006). An effective transactional leader is able to recognize and reward followers' accomplishments in a timely way. Nevertheless, subordinates of transactional leaders are not necessarily expected to think innovatively and may be monitored on the basis of predetermined criteria. Poor transactional leaders may be less likely to anticipate problems and to intervene before problems come to the fore, whereas more effective transactional leaders take appropriate action in a timely manner.

This is also supported by other researches such as Odumeru & Ifeanyi (2013), as transactional leaders are concerned with processes rather than forward-thinking ideas. These types of leaders focus on contingent reward (also known as contingent positive reinforcement) or contingent penalization (also known as contingent negative reinforcement). Contingent rewards (such as praise) are given when the set goals are accomplished on-time, ahead of time, or to keep subordinates working at a good pace at different times throughout completion. Contingent punishments (such as suspensions) are given when performance quality or quantity falls below production standards or goals and tasks are not met at all.

Transformational Leadership Model

Transformational leader works to transform individuals, groups, organizations and societies (Bass & Bass, 2008). By presenting goals to the followers as a compelling vision, leaders inspire followers to put aside their self-interest for the sake of the organization and can have a lasting impact on their value systems and ambition levels leading to intrinsically sustained behavior change among followers. Bass & Rigo (2006) leadership is not just the extent of people at the top. It can occur at all levels and by any individual as long as it is important for leaders to develop leadership in those below them. This notion is at the heart of paradigm of transformational leadership. The principles derived from this are fundamental to effective leadership and are widely applicable to many segments of life, ranging from work to family and classroom and, importantly, to issues of social change. This is because for this model, the capacity to transform or act as a change agent seems to be a key requirement to lead the staffs during the unstable organizational environment.

The truly transformational leader according to Waldaman et al. (1990) manifests individualized consideration and converts crises into developmental challenges. He/she uses intellectual stimulation to foster followers' thoughtful, creative, adaptive solutions to stress rather than hasty, defensive, maladaptive ones. True transformational leadership does not replace the transactional that has provided the necessary structure for readiness. Rather, transformational leadership adds to transactional leadership (Waldaman et al., 1990) because without the transformational components the transactional leadership may prove inadequate.

In general as Cameron (2006) stated most leaders pay almost exclusive attention to the gap between what is going wrong, mistakes, poor performance, or illness and the middle point on the continuum, represented by an absence of illness, effective performance, or problem resolution.

However this research paper would go concentrate on the other extreme which looks the gaps as possibility of improvement in addition to the emphasis given for strength based leadership practice known as Appreciative Inquiry Model of Leadership. This is because as Ridgeway (2003) leadership is inherently a group rather than individual phenomenon. As a result the process of the social influence Chemers (2001) cited in Ridgeway (2003) a group members solicits and mobilized the aid of others in the attainment of a collective goal. This paper advocates since members jointly stand for the accomplishment of some agreed goal or objective, their participation need to be voluntary, respected and mutual where their journey should be based on individual and group past-strengths, purposely inquired constructively to the next high point and accept valued deference among the participation of all of its members.

Given the fact that public sector organizations will have to maximize the realization of the potential of all their staffs according to Alimo-Metcalfe & Alban-Metcalfe (2011), the active participation and empowerment of these followers has no option than being moved at the core value of the sector. During this practice therefore, leadership development goes beyond individual leader and refers to the development of collective leadership process and social capital, (Iles & Preece (2006) cited in the Metcalfes (2011).

2.2 Leadership in Political Context

According to Blondel, 1987; Wildavsky, 2006; Wildavsky,1989; Klenke, 1996 cited in Mascuillie et al. (<http://www.ashgate.com>, accessed January 12, 2015) the concept of political leadership is difficult to define essentially. They agreed on the difficulties because the political leadership is dependent on institutional, cultural, historical, contexts and situations in specific terms as well as in general framework. For Mascuillie et al., however ‘Political leadership’ overlaps significantly with the higher levels of military, legal, organizational, and religious and ideological leadership, and is a special part of ‘social leadership’ in general where the latter includes parental, business, educational, scientific, technological, religious and other forms of leadership.

According to Hartley (2011) formal political systems are those organizations and institutions which are governed by elected representatives with public accountability. Some political institutions are about law-making and policy-making, while others plan and provide public services such as education, healthcare and prisons, and some carry out both functions. Public organizations derive most of their funding from the state and their policies, their budgets and their practices are governed through boards, committees, councils or cabinets consisting wholly, manly or partly of elected politicians.

People search for real achievements, not for promises, among public agencies under normal circumstances. Apart from the elected political members “voice” which expresses the community’s needs and aspirations, (Masciulli et al.) citizens need to touch and feel achievements in life. More fundamentally, it is clear that many people are losing faith in political parties. As a result some local politicians these days are openly voicing their doubt about political parties

According to Aaron (2006) leading in the public sector brings special challenges for organizations implementing evidence-based practices. For example, the need for obtaining or renewing contracts and securing funding is an ongoing concern. At the local level, implementing evidence-based practices within an existing contract may mean renegotiating statements of work

and defining what services can be reimbursed. National reimbursement policies may not be aligned with the provision of some evidence-based practices. These and other related concerns can lead to challenges for leaders in communicating how a vision of improved or changed services fits, or does not fit, with the day-to-day roles, duties, and tasks fulfilled by providers.

In political context (Masciulli et al.) successful leaders are those who have demonstrated their ability to move their society tangibly in the direction that seemed clearly supportive of their suggested 'grand design'. Unsuccessful leaders are those whose efforts to move their society in the direction of their choosing have backfired or brought about results clearly destructive of their propagated strategic vision. Stronger leadership should help to mitigate some of the stresses of day-to-day operation of services and improve leaders' ability to handle change.

The study conducted on the British National Health Service system (Walshe & Chambers, 2010) as one of the public agency loaded with one of the necessary and complex social services indicated that too piecemeal and very low investment in health sector leadership development make the system to unable to meet the existed demand. In view of its enormous size, scale, political sensitivity, public scrutiny and complexity of the health sector it is important to install appropriate responsive leadership system. The study also discussed in the sense that there is no coherent approach to managing and development talent as a result a more comprehensive and integrated approach is required. However Walshe & Chambers (2010) implied that in addition to high regard of competitiveness for the best talent in the graduate marketplace and producing many future leaders due attention should be given to other parts of leadership development landscape. The other leadership development landscape includes, but not limited, the needs of much wider and less elite-focused cadre of managers, the needs of clinician managers, the development of future board level leaders and chief executives, and the needs of non-executive members of the health system boards. Walshe & Chambers (2010) concluded that the leadership practice in the health system entails a more distributed, devolved and networked model of governance.

To Turnbull (2010) government agencies and departments have been the subject of capability in reviewing the strategy, leadership and delivery as their key areas. Among others the key

leadership activity at the most senior level of public leadership as Turnbull described (a) encouraging innovation through entrepreneurial leadership within the public agency main duties; (b) with the aim of supporting the assessment and management of risks, government agency should develop framework that control the implementation; (c) should set strategic aim clear to all, meaningful throughout the public sector and is achievable; (d) extend supports to achieve the strategy and ensure provision of appropriate financial and human resources; (e) regular performance review as a means of important organizational learning; (f) engaging of people at all levels during the setup of organizational values and stands; and (g) ensuring that its obligations to internal and external stakeholders are both understood and met.

These key leadership roles in public agencies are closely interconnected with the approach and assumption of appreciative Inquiry leadership model. If we understood the listed key leadership activities as inspiring stakeholders including staffs for innovation; determining attainable strategies; escalating attainments; acquiring knowledge from performed whereabouts; and in placing shared organizational visions. Turnbull (2010) also backing up that all public organizations have stories, and the other important role of every leader is in developing stories of success-it is about building reputation and reputation is an important aspect of public leadership.

2.3. Concept of Appreciative Inquiry as Leadership Model

Appreciative Inquiry as leadership model is new in practice (Lewis, Passmore & Cantore 2008; Cooperrider & Whitney, 2008; Cooperrider & Godwin, 2010). It is a relatively new asset-based line of attack from the field of organizational development that has been garnering attention for its successful application in facilitating organizational change. In the National Academy of Management Conference in August 1999, one of the founders of the Appreciative Inquiry- Richard Beckhard, presented how the model is advanced in promoting change and innovation at its early stage. He said that Appreciative Inquiry is an exciting breakthrough as it is a revolution in the way we think about change. For the reason that the model brought something substantive, conceptually strong, and emerging rapidly professionals of the field and him-self are fascinated. As a result specialists of the Appreciative Inquiry Leadership model are looking at something important that enduring consequences and energizing innovation for leadership development, (Watkins & Mohr, 2001).

The term AI can be looked at as two separate words, each with its own meaning: Appreciate: valuing; recognizing the best in people and organizations; Inquiry: the act of discovery, exploration, examination, looking at, investigation, and study Taken together, then, AI is a way of looking at a person, an organization, and the world and saying, “Let’s look at the best that there is. Let’s define and study that, and then use the data to build on what is working.” AI is a change process as Martinetz (2002) explained. As a process, that inquiries into, identifies, and further develops the best of what is in organizations in order to create a better future also supported by Coghlan & Preskill, (2003). Valuing what we have at hand from the past for the best interest of the future development is core element of Appreciative Inquiry (AI). As per the model particularly capacities or situations of one’s previous performance when the organizational achievements excel results are good spring boards to reach to the next step; which is often related to organizational as well as leadership learning.

Cooperrider and Whitney (2005) argue that in everything it does, appreciative inquiry deliberately seeks to work from accounts of the positive core. This is mainly because human kind wanted to focus on its quality so as to reach the ultimate goal. Joint efforts, commitment and constructive ways of looking matters those can lead to the next footstep. The central point is that due emphasis given for the best achievement of everybody and contributing factors for the success can motivate the person to be energized for the future. Cooperrider and Whitney put this view as the time to dig out the shortfall of human being should be replaced by its excellence. The swiftness and largely informal spread of the ideas suggests is believed a growing sense of dissatisfaction with exhausted theories of change, especially those wedded to vocabularies of human deficit, and a corresponding urge to work with people, groups, and organizations in more constructive, positive, life-affirming, even spiritual ways (Cooperrider and Whitney, 2008)

The Model in the eyes of its expertise also describes as a collaborative, strengths-based approach to both personal and organizational development that is proving to be highly effective. It deals with change that shares leadership and learning, full engagement of everyone in the organization. **Here** organizations are understood as places where people come together and collaborate for the intended results. This is directly related with what Lewis, Passmore, & Cantore, (2008) briefly coined organizations in terms of living-human-things having three attributes: alive and inert, made of people; and systems composed of related elements.

In order to benefit most from the existed resources and future possibilities in any organization, Appreciative Inquiry model prefers to act collectively with greatest energy which employs synergy rather than desegregation. For this purpose the model involves collaborative inquiry, based on interviews and affirmative questioning, to collect and celebrate the good best stories of a community, group or organization those enhance cultural identity, spirit, vision and inspires for more cooperation, relationship (teambuilding) and enhancing capability. Appreciative inquiry is a way of seeing that is selectively attentive to—and affirming of—the best and highest qualities in a system, as agreed by a group working to achieve certain goals; in the case of this research study, health and institutional capacity building, a situation in which human capability flourishes and transpires. It involves an appreciation for the mystery of being and a reverence for life. According to Clark (2004) Appreciative Inquiry is a great way to begin the change process. It is an affirmative line of attacking to human and organizational development. Appreciative Inquiry winds from possibilities and hopes; and installing these possibilities and hopes to the existing capabilities of individuals and competences of the organization (its existence or purpose).

In the process of inquiry into its positive core, an organization enhances its collective wisdom, builds energy and resiliency to change, and extends its capacity to achieve extraordinary results. Such results are products of leaders' interaction both parallely and horizontally in organizations. According to Clark (2004), Appreciative Inquiry helps us to discover what works, so that we can do more of it. This emanates from organizational learning at one hand and knowledge management on the other hand. These both processes are linked the organization vision and mission – linking the past lessons, present high performance and future improvements in thinking, practice and application. It is an inquiry approach based on positive questions and propositions of success. In Appreciative Inquiry, a clear, concise topic is chosen; often on core vision-mission driven works of the organization; from which positive questions are developed and visionary and inspiring plans of action are initiated. To Clark individuals recall and tap into positive achievements and stories that strengthen and inspire furthest and plan over to initiate high performance and expediting individual capabilities.

Appreciative Inquiry (A facilitator Guide by Catholic Relief Service, 2005) in other words is perceived as a form of learning that selectively seeks to locate, highlight and illuminate the life-giving forces of an organization, group or partnership. Cooperrider & Whitney (2005) appeal the

process of mapping what is working internally as the positive core of an organization. Dulye *et.al.* (2007) also indicated that appreciative inquiry preconditions successful change work-whatever it's focused on-to shift the focus of conversation and dialogue. In this respect, way from malfunction, pathology and problems towards images of health, vitality and energy. According to Whitney & Trosten-Bloom (2010) appreciative inquiry insists that desirable changes in an organization can be better achieved by focusing on a relational process of inquiry, grounded in affirmation and appreciation.

A working environment where organizational excellence and strength-based approach is preferred because, Jackson & McKergow (2002) cited in Peelle (2006) efforts to define, clarify, and articulate the problem when addressing issues associated with human relationships foster a climate of hopelessness and despair while being irrelevant to solution discovery. Head *et. al* (2001) cited in Peelle (2006) suggest that culture change interventions focused on organizational failure increase resistance to change by casting negative aspersions on personal competencies. More on that the power of the model according to Coghlan *et al* (2003) is the way in which participants become engaged and inspired by focusing on their own positive experiences.

Appreciative Inquiry accepts every reality for what it is-areas in need of conversations and transformation (Coghlan, Preskill & Catsambas 2003). Appreciative Inquiry focused action learning process would incorporate critical reflection by seeking to learn from failures as well as successes in terms of the problem (Getha-Taylor, 2011). More on that for Elliott (1999) cited in Miller (2011) the model is important to note that AI does not ignore problems. Instead, Appreciative Inquiry addresses problems within an organization by focusing on doing more of what works and what will work even better tomorrow. Other experts of the Model including Clark are also considering potential challenges of the past and the future blames in the route of the model, practically they prefer to approach the matter from other side. Here the other side (Clark 2004) refers problems or limitations are accessed in the sense of 'what IS working' instead of 'what is NOT working'. This implicitly raises and addresses problems, limitations and obstacles those negatively affecting the development of the organization.

To conclude, appreciative Inquiry deals changes, both planned and unplanned, with respect to valuing the best of what is; envisioning what might be; dialoging what should be and realizing what needs to be (Cooperrider and Whitney 2005). These processes require participation and

dialogue schedules; as well as frameworks of learning. The ultimate assumption undergirded here is that an organization has to “embrace solution to underperformance” rather than focus on a “problem” (Cooperrider, Whitney and Stavros, 2008) and a process and a result are equally important for success of organizations. Constructing on the positive core and the excellence of the organization supports valuing the internal capacity and get space for them to participate as well as share in the organizational development. Engaging the appropriate employees timely and lead them to reach the shared vision as per the model is the key responsibility of a great leader. At this time only, path way to organizational development is acceptable and the result is a fruit of the contribution of all employees who are actively involved and in turn motivated for the next round of a continuous development. As per Cooperrider, Whitney & Stavros (2008) this process is the most effective one in leadership practice: Appreciative inquiry model backs if change in a given organization is inevitable; it should be handled on capitalizing with the organization’s center of excellence in the previous period and build on to the envisioned future state of being.

2.3.1 Appreciative Inquiry Model

Appreciative Inquiry (AI) is a method for studying and changing social systems (groups, organizations, communities) that advocates collective inquiry into the best of what is in order to imagine what could be, followed by collective desired future that compelling and thus, doesn’t require the use of incentives, coercion or persuasion for planned change to occur (Kessler 2013).

Appreciative Inquiry model is presented in sequences. The sequence indicates that learning and getting improvement in the lives of the organization better works in such a step by step manner. Appreciative Inquiry (Bellinger & Elliott 2011) is characterized by four circular rather than linear processes that are alternatively known as the four-D or 4-D model. The 4-D model renowned by experts of Appreciative Inquiry Watkins & Mohr, (2001) as cited in Peele (2013) comprises Discover, Dream, Design, and Destiny in its circle as depicted in the diagram follows.



figure 2.1: Appreciative Inquiry, 4-D Cycle (Hart et. al, 2008)

As depicted in the diagram above the process starts with selecting a topic: affirmative or positive topic choice which will be a central theme of the dialogue process all time. What follows are Discovery (appreciating and valuing), Dream (envisioning), Design (co-constructing the future), and Destiny (learning, empowering, and improvising to sustain the future). These are the essence of dialogue woven through each step of the process briefly (Cooperrider, Whitney & Stavros, 2008)

Discovery Stage: The central aim during this phase is that leaders need to find out and appreciate what gives life and energy to people, their work and their organization, Haar and Hosking (2002). In this stage for Bushe & Kassam (2005) the process of inquiry that perhaps most defines Appreciative Inquiry practice is the collection of “stories” from system members and other stakeholders about their best experiences. The focus is on constructive stories that reflect peak experiences “choose the positive as a focus of inquiry”. Relevant issues to be incorporated in the first stage of the 4-D Model (Coghlan, Preskill & Catsambas, 2003) are:-

- Describe a high-point experience (lessons) in a given organization - a knowledge documented about the time when it was most alive and engaged;
- Without being modest, what is it that the staff valued most about the organization, the work, and its employees in the past and help the existing?
- What are the core factors that give life to the organization, without which the organization would cease to exist and unable to live for its purpose?

As per the understanding of Bushe (2011) habitually considered as to be a key innovation of the model participants are interviewed about their “best of” experience. Another important

innovation for Carter & Johnson (1999) cited in Bushe (2011) has been to have organizational stakeholders act as both interviewers and interviewees. The purpose of all this is that to engage all members in the act of inquiry itself from which shared visions in placed and sense of ownership ensured.

Dream Stage: the question is what might be, it is the envisioning stage of AI. The team members engage in brainstorming to find out what the world is calling their organization to be. The important aspect of this phase (Akdere, 2005) is that while sharing common images of an ideal future, provocative propositions are welcomed to stretch the imagination. “What might be?” is at the center of the dialogue to find out the result or impact of envisioning intensely discussed. Based on the information gathered in the Discovery Stage, eyes try to draw worth valuing things towards the life of the organization. Cooperrider & Whitney stated this stage as people are brought together to reflect carefully to the innovations and moments of organizational “life”. The dialogue sometimes can be in storytelling modes, sometimes in interpretive and analytic modes.

The amount of preparation and the degree to which clarity about that common dream is ought vary widely by application and according to Bushe (2011) often results in something more symbolic like a graphical representation, that a mission statement.

From this mix, a concrete consensus on plan is met and used to inspire high-quality performance. A convergence zone is created where the future begins to be discerned in the form of visible patterns interwoven into the texture of the actual and the past. The second stage, (Rama, Conklin & Allen 2008), is an unconstrained look at the ideal. Participants in the specific dialogue are encouraged to use the affirmative images described during the discovery phase to help them envision how they might want to see their organization in the future. In this stage participant’s dialogue about their respective organizational wishes which includes possibilities of success, avoiding unnecessary issues in the organization and addressing unfriendly matters in the future.

Design Stage: The main purpose is to create a shared image of a preferred future. With a common dream in place, employees are asked to develop concrete proposals for the new organizational state. (FINEGOLD et al, 2002) It is to create design principles that will inform the system’s structures and policies that can move them toward the realization of the dream. They are principles that are known as provocative propositions statements that stretch the system from

where it is to where it wants to be. Where possible (Bushe, 2011) social architecture processes are employed where a model of design elements is used to identify categories for participants to organize around and create change proposals, often called possibility statements or design statements.

It is a time for sustained dialogue so that people arrive at a level of depth, commitment and trust as they design together principles that they are prepared to live by. Because the provocative propositions are rooted in the dream and the discovery of best past experience, they inspire confidence to reach beyond one's grasp (Finegold, Holland & Lingham 2002). The ultimate goal here is to create or design organizational structures, processes and relationships that support the dream as articulated in the previous phase. Haar & Hosking (2004) said that emphasis shifts from dreaming about what might be to co-constructing what should be. These principles are known as provocative propositions statements that stretch the system from where it is (AS-IS in BPR) to where it wants to be (TO-BE in BPR).

Delivery Stage: - At this final stage innovative and improvised ways to create that it comes to action in the future. The delivery stage is also known as Destiny. After people moved through discovery, dream, and design, at delivery they begin to read the organization or community in a new way. This is to mean having a way that invites possibility, forges new networks of relationships, and ultimately effects the direction and meaning of one's actions (Finegold, Holland & Lingham 2002).

Exactly what ought to happen in this phase has provoked the most confusion and the least consensus amongst Appreciative Inquiry theorists who recognize that using the outcomes of Design to create new targets, gaps to fill, and objectives to achieve may be counter to the very philosophy of Appreciative Inquiry (Kessler, 2013). Because the model is a recursive process, people within the system continue to value their successes, inquire into what is working well, and continue to seek ways to get more of their success. According to Haar & Hosking (2004) delivery is about sustaining the developments and innovations of the inquiry process and to nurture a collective sense of destiny. Here the role of the leaders Bushe (2009, 2011) at this stage needs to be more concrete in "tracking and fanning" in order to acquiring and amplifying those innovations of participants want to nurture and creating events and processes to energize self-organizing momentum.

However to illustrate the routine in a systematic and interlinked way the 5-D Model of Appreciative Inquiry is also referred in some case. The case happened when the 5th D- representing the ‘Definition’ stage added at the beginning of the process. It separately deals in the dialogue (Rama, Conklin & Allen 2008) with what to learn about, who to involve guiding forward and how to involve them. Whereas defining these key components of the inquiry is re-distributed among the various stages in the 4-D Model process as appropriate. In either of the cases exerting efforts to have affirmative topic is one of the fundamental responsibility of the Model and in the process each depicts a broad and abstract outlines of Appreciative Inquiry (Haar Hosking 2004). The inquiry and analysis of this paper therefore, would follow the 4-D Model.

2.3.2 The EIGHT Assumptions of Appreciative Inquiry Model

There are eight assumptions in the Appreciative Inquiry model in which the new ways of looking for organizations are grounded. These assumptions uniquely define the model. The overall point in this regard is that the organizational internal capacity is the key factor that led the organization in to its pick stage(s). It wanted to give wider space to its past performance and its employees. According to Finegold, Holland & lingham (2002), the existed organizational context matter based on which its future steps will be managed.

The purpose of these assumptions is that as per Cooperrider and Whitney to accelerate the nonlinear interaction of organization breakthroughs, putting them together with historic, positive traditions and strengths to create a “convergence zone” facilitating the collective re-patterning of human systems. The foundation of Appreciative Inquiry Model lies in the EIGHT assumptions as discussed separately as follows.

2.3.2.1 Brief Overview of the EIGHT Assumptions of Appreciative Inquiry

(a) In every society, organization or group, something works

To Cooperrider, Whitney & Stavros, (2008), the simplest assumption that every organization has something that works well and those strengths can be the starting point for creating positive change governs AI. This in short tells about the positive core of the organization. It can be identified by inviting people to participate in dialogues and share stories about their past and present achievements, assets, unexplored potentials, innovations, strengths, elevated thoughts, opportunities, benchmarks, high-point moments, lived values, traditions, core and distinctive competencies, expressions of wisdom, insights into the deeper corporate spirit and soul, and visions of valued and possible futures. According to Rama, Conklin and Allen (2008) it is predicated on narrating and reflecting on one's lived experience, one's contribution to, and the conditions surrounding that experience. This reflection provides the groundwork for creating images of possibility for transformation.

(b) The act of asking questions of an organization, or group influences the group in some way.

As per Clark (2004) the shift in thinking begins with the person who raises the question. The questionnaire needs to move beyond the traditional which Clark determines as ineffective problem-solving approach where emphasis is on what works, so can do more of it. The problems won't disappear but will be smaller as what works gets larger and greater in importance. He further noted that the most innocent affirmative question evokes change.

According to Cooperider & Godwin (2010) in the model in a very artful and disciplined way involves the craft of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. It centrally involves the mobilization of whole system strengths-based discovery through the crafting of the "unconditional positive question" often-involving hundreds or sometimes thousands of people in mutual collaboration.

Appreciative Inquiry involves making very conscious and deliberate choices about the kinds of questions we ask when initiating change in organizations or communities. A booklet titled

Changes in the Neighborhood (2003) further designated that inquiry and change occur simultaneously; the case is not in the way that ‘first we do the analysis and then we decide on change.’ The very process of inquiry/analysis creates its own changes.

(c) People have more confidence to journey to the future (the unknown) when they carry forward parts of the past (the known)

By focusing on people’s experiences of ‘the best’, Appreciative Inquiry brings life to our pursuit of positive change. According to a booklet titled Changes in the Neighborhood (2003) being cautious about the unknown is often a very healthy and natural human reaction. To this purpose nonetheless people wanted to move confidently into the unknown by recognizing elements of their past experience that have prepared them for that future. Furthermore, the booklet acquaints that recognition that we did something successfully in the past generates confidence in our ability to do similar things in the future.

(d) If we carry forward parts of the past, they should be what are best about the past.

Appreciative Inquiry encourages participants to contain many more success stories and achievements by sharing their best experiences, tell those stories, and use them as themes for the future. Best stories of the organization have powers to move faster than that of stories of failures (Changes in the Neighborhood, 2003). As per Cooperrieder et al. (2008) it is important that the inquiry focus on the desired attributes that one wishes to bring into the future. A series of questions are posed to pairs of people including prompts about times when the best has occurred with whatever is the topic of discovery, what people value about themselves and their work, and what wishes they have for the future

(e) The language we use creates our reality

Appreciative Inquiry promotes that we use language and knowledge to create the world as we know and understand it. According to Changes in the Neighborhood, (2003) the way we see the world and think about it is a product of our many conversations about it. The language we use creates our reality mainly provokes the sense of motivating, hoping the best, and success to step up among the team and members of the organization. Clark (2004) glorifies that the use of

affirmative language changes the way we think; changing the way we think will change the way we work. Scholars in the Appreciative Inquiry area asserted that the power of language and its relational use actually creates the world; we see what we believe.

(f) It is important to value differences

It is important to think of an organization with people from different social, economic, educational as well as personal interests. So in order to bring their skill and interest for the shared vision and goal they should seat together with the sense of team-building, team-work, participation, consensus and capacity building. The goal of collaborative processes is not to create a single mindset. Changes in the Neighborhood (2003) recommends to this purpose creative collaborative processes which can discover ways in which difference is accommodated and even honored. Some of the most productive Appreciative Inquiry process with a wide spectrum of people was involved, and people from extremely divergent backgrounds found themselves connected with one another. If a process does not value those differences, the people who feel excluded will become non-participants, and potential critics of the entire process.

(g) What we focus on becomes our reality (with the sense effort on core issue, and shared vision).

If strengths and achievements are the core issue of the organization then that is what everybody in the organization understands the working place. The shared vision among employees becomes positive core which even derives them to the next high level of organizational success. People who spend their time trading stories of what doesn't work, as a Booklet (www.mycommunityinformation.com accessed on August 23, 2014) titled as "Changes in the Neighborhood", and all the terrible things that happened to them or their organization in the past, will inevitably end up with a mindset that focuses on those negatives and impossibility of everything. Individually and collectively, we are all capable of focusing our intellectual and emotional energies on one matter to the exclusion of many (or all) others. In fact, our reality is based on what we experience, and where we direct our attention.

(h) Reality is created in the moment, and there are multiple realities

The impossibility of succeeding in multiple issues, looking for key competences and capabilities, putting the human resource is the core and the intangible assets are set of agreed inspirations and processes of influence. According to a booklet “Changes in the Neighborhood” (www.mycommunityinformation.com, accessed on August 23, 2014) individuals and groups hold differing perceptions, based on the reality of their experiences. Because we are changed by experience, our ‘reality’ changes over time. Anyone who has ever been privileged with an organization or group knows that things look very different on the inside than they do from the outside. Organizations involved in a change proposal are well served to recognize that there is no one set of ‘facts’ that will be universally true to all participants.

Further Haar & Hosking also noted that an act/text may/may not get supplemented; an act may receive many different supplements and so may differently contribute to multiple, simultaneous, ongoing construction processes. In this way of thinking we presume multiple, ongoing realities and processes rather than a singular, fixed, state of things that can be more or less well known. Here it is not viewed as a singular, fixed, ‘something’-which might be a useful view for certain purposes, but as multiple ongoing local constructions (Haar & Hosking, 2004).

2.4 Unique features of Appreciative Inquiry as Leadership Model

As **one** of the unique characteristics of the model, problems hindering the development of the organization are appreciated. This happened as the way it is looking for the obstacle has changed. According to Coghlan et al., problems are addressed, but not denied or ignored, from a different and often more constructive perspective: it reframes problem statements into a focus on strengths and successes. At the middle of Appreciative Inquiry process participants are essentially asked to state their specific wishes for the organization, at the Dream stage.

The founders of the Model Cooperrider and Whitney (2000) confirms that Appreciative Inquiry can get everybody much better results than seeking out and solving problems. They said if anyone combines a negative culture with all the challenges we face today, it could be easy to convince ourselves that we have too many problems to overcome—to slip into a paralyzing sense

of helplessness. Both asked not to be misunderstood in this regard by thinking they are advocating mindless happy talk. They probed Appreciative Inquiry as a complex science designed to make things better. We can't ignore problems—we just need to approach them from the other side—from the constructive and learning side.

The analysis of positive core imparted leaders to focus on doable energies and possibilities of the organization rather than focusing which process or which employee caused the problem. In this respect, planning for high performance emanates from consensus and confidence that the human resource at all levels as well as other resources are participated and motivated productively.

The flexibility nature of Appreciative Inquiry in leadership practice to be applied in different situation with its full benefit is the **other unique** element of the model. The model can be used informally, such as in a conversation or in a formal context, such as at a strategic planning conference or retreat. These are partly characteristics of transformational leadership; in which a transforming leader influences and inspires using various circumstances – leadership as art and science. However the Appreciative Inquiry can enable leaders to influence a person or two persons or in thousands using similar process of the model (either the 4-D or 5-D model) . There is no formula for using Appreciative Inquiry; each application is designed to address the specific requirements of the user system. That being said, there is a model that serves as a guide for designing the inquiry process to elicit the system's most positive image for a better future and the will to move toward its realization (Finegold, Holland & Lingham, 2002).

Third point that describes Appreciative Inquiry uniquely is that it has room to hear every member of the community (whatever population size it might have) or every staff of the organization (even too large). If designed correctly, all involved have the opportunity to co-create change and transform their organization. Everyone gets to be heard! It brings out the best of each individual. In organizational setting where competencies are categorized into job classifications and processes, influence and inspiration can be analyzed in the categories. Such processes dictate the methodology of observation, participation of individuals working in the categories and establish evidence on gradients of variation.

Fourth, the model wanted to distinguish success from failure in leadership practice. It is totally strength-based attitude. Cooperrider & Godwin (2010) processing a systematic appreciative

inquiry with the concept of constructive verb called ‘appreciate’ that probes treasuring as well as increasing in values into strengths, successes, and positive deviations from the norm. Cooperrider & Godwin induced that failure and success are not opposites and are merely different as such they must be studied separately and learnt in ways of improving performance. Among the two, the model deliberately focuses on the success so as to improve its future enactments in the same spirit. As a result, the model stands against the traditional problem solving approach that focuses on what is not working, who fails in what reason, and what lacks from human system (Finegold, Holland & Lingham 2002).

Haar & Hosking are among others to acknowledge the importance and share the outlook of the model’s founders. Further they compared Appreciative Inquiry with conventional action research, Haar & Hosking (2004), where the finding designated as AI takes a more positive stance, is more collaborative and participative, and is more capable of generating innovative change.

2.5 Leadership versus Appreciative Inquiry Model

(Pace & Faules, 1984) a leader is one who helps others to achieve desired outcomes results. Leaders behave in ways that facilitate productivity, high moral, energetic responses, quality workmanship, commitment, efficiency, few defects, satisfaction, attendance, and continuation in the organization. For Pace and Faules a leader needs to focus on the positive side of people and process in the organizational development. They promoted organizational development is a career area that may be for a leader if he or she has the ability to interact with organization members at all levels, an interest in helping others develop, and the talent to conceptualize, design, and implement programs that integrate people, technology, and systems both vertically and horizontally within the organization.

Likewise, leader can teach people to analyze work systems, identify areas that need improvement, and assist them in acquiring the skills to refine their work systems. Pace and Faules (1984) observes and if leader can take a broad “system view” of organization processes in learning and developing problem solving, decision making, leadership and management skills so as to apply them to real work situations. Involvement of employees; empowering them based on

their interest and capacity; and jointly designing and implementing organizational vision are the common values in the literature of leadership as well as appreciative Inquiry.

Leadership development and Appreciative Inquiry mutually are believed in building up on the internal capacities of the organization in terms of knowledge management and learning respectively. For leadership (Ahmed et al., 2002) the knowledge management which consists of a set of cross-disciplinary organizational processes is a key element. The knowledge management pursues the ongoing and continuous creation of new knowledge by leveraging the synergy of combining information technology, and the creative and innovative capacity of human beings. Managing knowledge creation requires getting individuals and teams to share information. With Appreciative Inquiry model learnings from previous experiences is a bench mark for future journey. Employees and organizational profiles observed as assets from which participatory and innovative ideas generated. Equally with the leadership perspective, Appreciative Inquiry Model emphasizes on the importance of empowering employees and routine nature of learning in organizational development.

A leader to be successful in modern organizational leadership environment according to Ahmed et al. (2002) requires the qualities of innovation, learning and quality. All three are closely intertwined-each one reinforcing the occurrence of the other. Where the first two are boldly emphasized in Appreciative Inquiry and the issue of quality is described in different directions such as in terms of best achievements, joint success and organizational excellence. Learnings and participation of everybody is stimulated with the intention of ensuring sustainable organizational development in the competitive world using innovative ideas in the Appreciative Inquiry Model of leadership.

Although innovation and learning may not be the sum of what was needed to be successful, certainly they formed the basis of success (Ahmed et al. 2002). Creating an exhilarating environment brings out the best in people and successful companies are those that do this, and are able to capitalize on their people's strengths. Organizational learning therefore seeks to describe a process of increasing the overall performance of an organization by encouraging knowledge creation and use in each of its value chain functions, in order to render each a source of competitive advantage or core competence. Ahmed et al. seek to do this by arriving at a wider view of each area, such that it can question the existing paradigms that reinforce current

operation and seek better solutions to the everyday problems. This kind of leadership development concepts qualify at least four major assumptions of Appreciative Inquiry Model (i) in every community, organization something works; (ii) What we focus on becomes our reality; (iii) people have more confidence to journey to the future (the unknown) when they carry forward parts of the past (the known) and (iv) If we carry forward parts of the past, they should be what is best about the past

2.6 Empirical Literature Review

In the capacity and knowledge of the researcher, Appreciative Inquiry in the Ethiopian context is not studied, yet in the continent of Africa as well. As a result the researcher has looked for other countries experience, mainly in the public organizations where resources are limited and the services are given to citizens in lower or zero costs. Accordingly, the following three empirical literatures are reviewed.

Figone (2010) among others in public agencies struggling with a variety of barriers to success and efficiency are employee attitude and performance. Progressive discipline has traditionally been the method for trying to change employee behavior. Figone studied the AI concepts as they apply to public administration, and to offer a case study of its application in a Bay Area city. One of the city's local principal departments with employee attitude, efficiency, and inter-relationships, as well as the lack of communication, teamwork, and individual leadership demonstrated by the support staff group was adversely impacting the core services of the department. This environment offered an opportunity for the conduct of an application of AI techniques, and a chance to evaluate changes that came about as a result of this application.

As per Figone, AI can be a powerful tool in both professional and personal lives, but it takes a deep personal commitment and persistence to attain the desired goals. Also, if AI were applied in the whole organization it could be especially effective due to the interactions amongst the various sections of the organization, not just an extremely small subset of the organization participating in this change effort. AI is a powerful, positive paradigm shift that can have remarkable results as long as the participants are open to making this change.

The researcher concluded that the aim of the study, enhancing the effectiveness of the manager and also to make a significant difference in work environment to the participants, were partially achieved in this round of AI research process. It will take additional months to further enhance the effectiveness of the manager and to significantly make a difference in the work environment (Figone, 2010).

The other study on eighteen secondary schools (grade 8-12), 88 elementary schools, and seven adult learning centers were invited to apply to be part of the learning inquiry, (Bushe, 2007A). Members of the District Management Team, the elementary and secondary school teachers' unions, and the Internal AI staff choose eight out of 20 applicants. At the District level, the Associate Superintendent responsible for the site was the District Sponsor, and a principal at the site was made the Site Sponsor.

Five key themes about “what do we know about learning” emerged from all the inquiries are create caring, supportive relationships; demonstrate passion in teaching; offer experiential and out of classroom learning opportunity; address diverse learning styles; and provide flexibility and choice.

Bushe (2007) implied in his conclusion that vital interviewing strategy accomplished the objectives where it was competently executed. The stories were extremely powerful in capturing people's attention and in generating positive dialogue among and between various stakeholders. He further learnt that it was possible to create a climate that led to positive, energized, design statements without beginning the AI process with appreciative interviews.

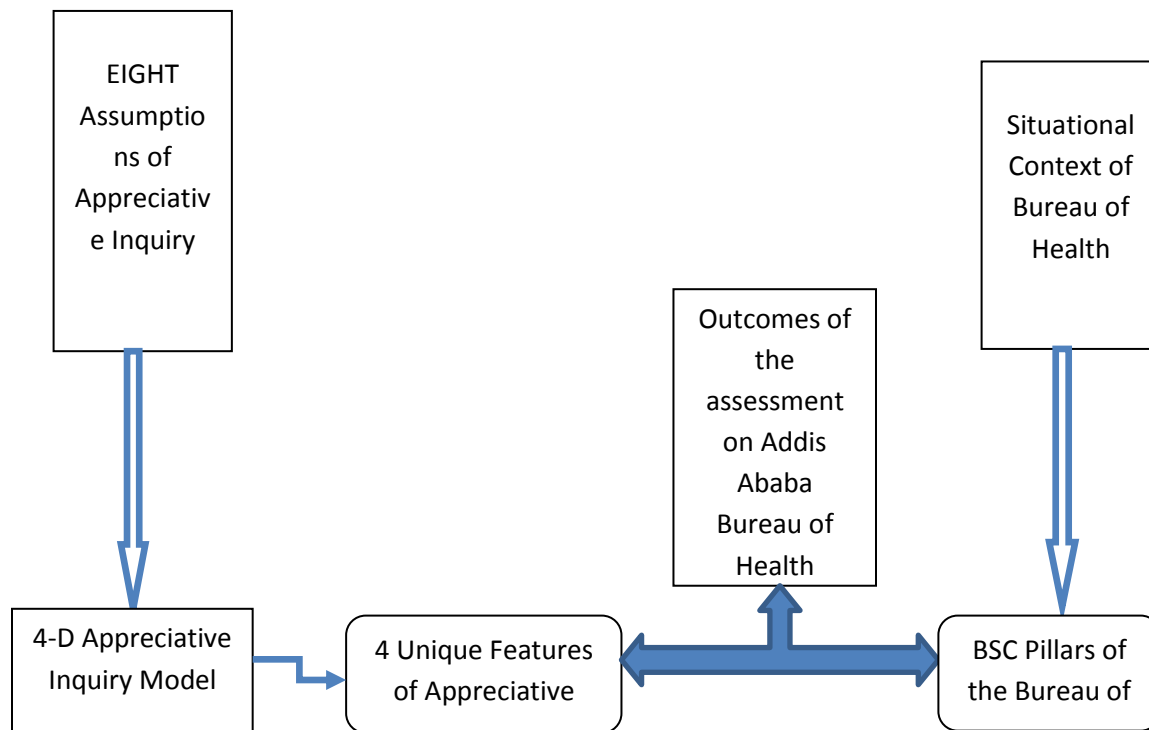
The third empirical study is also conducted by Bushe (2010). The study covered eight different sites in a large, Canadian urban school district engaged in an appreciative inquiry into “what do we know about learning”. The paper describes the AI intervention in detail and then explores differences in each site that may explain differences in level of change. The level of positive effect and ratings of success of the AI Summits at each site showed no meaningful relationship to change outcomes. Level of change did appear to be related to how generative the inquiries were, how well the Discovery phase was managed and the quality of Design statements that came out of the summits. Other factors exogenous to the design of the AI also appeared to play a role.

These included relations between teachers and principals, credibility of local change agents, passionate and engaged leadership, and linkage to pre-existing, shared concerns.

The study finally concluded that perhaps the strongest reason the incremental sites did not experience transformational change was because stakeholders were pretty happy with their leaders and with their schools. By contrast, at each of the transformational sites there were widely acknowledged “problems” that the AI addressed. The results suggest that it is inaccurate to say that AI is not concerned with solving problems. If problems aren’t solved, how much energy will organizational leaders and members really have to put into the change process? Instead, the study recommends that AI is transformational when it addresses problems that are important to organizational members not through problem-solving, but through generatively, (Bushe, 2010).

2.7 Analytical Framework of the Study

The Analytical Framework of the Applicability of Appreciative Inquiry as Leadership Model in Public Agencies specific to Addis Ababa Health Bureau



Source: Developed by the researcher, December 2014

The situational context of the Addis Ababa Bureau of Health demonstrates its readiness to improve its services and systems at all level regarding quality, access and timeliness. This is to efficiently utilize the allocated resources to fulfil the bureau's vision with the ultimate goal of client satisfaction. The four Balanced Score Card (BSC) pillars: Internal Process; Finance; growth and empowerment; and client satisfaction. Following the Business Reengineering Process (BPR) tool adaptation and utilization in the bureau of Health to swift the desired change, to measure the intended the BSC tool is customized. All these entail that the bureau aspires to improve the quality and accessibility of health services to clients in the city of Addis Ababa.

In the Analytical framework of this study the 4-D Appreciative Inquiry Leadership Model founded in 8 assumptions bases in organizational strength and achievement of the past. Among others, looking the learning perspectives of challenges and problems; with intent constructively probing staffs to the future; successes and asset based approach; and wider participation of staffs are characteristics of the model. If the Bureau of Health applies this model for its leadership practice within both the change (BPR) and measurement tools (BSC) the outcomes listed at the right corner of the table will be happened.

The expected outcomes to the bureau of health in the application of the Appreciative Inquiry Leadership are leadership practice improved; organizational strengths identified, shared and scaled up; staffs participation, commitment and satisfaction enhanced; in the bureau's environment team work, innovation and creative appreciated; the knowledge and capacity to apply the model existed; organizational learning valued, documented, shared and future developments built up on it. Above all the client satisfaction, organizational efficiency; employees' empowerment and growth; and appreciative inquiry leadership model as system installed in the Addis Ababa Bureau of Health.

Chapter Three

3. Description of the Study Area and Methodology

3.1 Description of the Study Area

3.1.1 Health Sector in Ethiopia

The national health policy issued in 1993 by the Government of Ethiopia underlines the importance of achieving access to a basic package of quality primary health care services by all segments of the population, using the decentralized state of governance. The policy insists that the health services should consist of preventive, curative and rehabilitative components. With the aim of achieving the goals of the health policy, a twenty-year Health Sector Development Plan (HSDP) has been formulated. The strategy is being implemented through a series of five-year plans, so-called Health Sector Development Plans/Programs, (MoH, 2013 cited in revised strategy plan of Addis Ababa Health Bureau, Dec 2014).

The revised HSDP document implies that Ethiopia has been implementing HSDP since 1997/8 (1990 EFY). The first phase of HSDP (HSDP-I) was completed in 2000 (1993 EFY). The second phase was shortened to three years to allow its harmonization with the countries development plan. The third phase of HSDP was completed during the period July 2005 to June 2010. HSDP IV is being implemented and it covers the period from 2010/11 – 2014/15. The health service system in Ethiopia (Wamai, 2009) is federally decentralized along the nine regions and two city administrations. The HSDP is a key component of the GTP and its primary objective is to improve the health of the population through the promotion of preventive, curative and rehabilitative health services by (a) improving access to affordable health services; and (b) improving the quality of health services, CSA 2014.

As per the FMoH (2014), Ethiopia has made remarkable progress in improving access to health services and quality of health care. Wamai (2009) despite all those improvements and with a rapidly increasing population, Ethiopia faces major health concerns. Constraints in the delivery of services include: the low number of health care facilities which are ill-equipped, mal-

distributed and in a state of disrepair; an ineffective health care delivery system which is inefficient and biased towards the curative service; high-handed health care delivery system and management which although decentralized at the regional level still relies on centralized policy making and budgets; an acute shortage of human and material resources; and inefficient utilization of the available while little involvement and participation of the private and NGO sectors as well as the beneficiary communities.

Similar to other low-income countries (FMoH, 2014) the health sector in Ethiopia lacks the level of financial resources needed to buy good health care for all its citizens. Its per capita health spending of US\$16.10 in 2007/08 showed the extent to which health care is underfinanced, as this amount is well below the \$34 per capita that the World Health Organization (WHO) Commission on Macroeconomics and Health recommended should be spent in low-income countries to deliver essential health care services in 2001, an amount that has been revised upward to US\$60 by 2015.

Still National Health Expenditure (NHE) of the country for the year 2010/11 was over Birr 26.5 billion (US\$1.6 billion). Per capita national health expenditure increased from US\$16.09 per capita in 2007/08 to US\$20.77 in 2010/11. This figure is far below the HSDP-IV per capita spending target of US\$32. Thus, health is still under financed and there is strong need for making more resources available to the sector to improve health service delivery and ultimately the health status of the population.

Health Infrastructure in Ethiopia consists of hospitals, health centers, health stations, general hospitals, referral hospitals, private clinic not for profit, and private clinic for profit, health posts, pharmacies, drug shop, and rural drug venders, (Kidist, 2009). In the context of Addis Ababa, the capital city of Ethiopia, all health infrastructures are available, except health stations, health posts and rural drug venders. This study concentrated on the leadership practice of Health Bureau in the City Government Addis Ababa.

3.1.2 Political & Administrative Structure of the Addis Ababa City Government

According to the amended Addis Ababa City Government Charter Proclamation No. 35/2012 and 21/2010 the structure of the organs of power of the City include the City Government; 10 Sub-Cities; & 116 Woredas. The organs of power of the City Government are the City Council, Mayor, City Cabinet, City Judicial Organs, & Office of the Chief Auditor of the City. The organs of power of a Sub-City are the Sub-City Council, Sub-City Chief Executive, & Sub-City Standing Committee; and that of Woredas have Woreda Council, Woreda Chief Executive, Woreda Standing Committee, and Woreda Social Court.

The sources of revenue for the city are direct tax, indirect tax and non-tax revenue. By 2004 E.C (2011/12) the city generated 8373.46 million ETB total Revenue and spend the total of 8323.88 million ETB for various developmental programs implemented in the Addis Ababa city.

The UN-HABITAT, 2008a, 2008c cited in Schmied, (2010) revealed that the capital of Ethiopia, Addis Ababa, is thought to have over four million inhabitants and the next ten largest cities altogether host less than 1.5 million of people. These figures don't suggest that urbanization should be an issue in Ethiopia, however, closer insight into the current trends in population growth show a different perspective.

3.2 Bureau of Health, City Government of Addis Ababa

Powers and Functions of the Bureau of Health, City Government of Addis Ababa

The city government of Addis Ababa is restructured and has got amended proclamations numerous times during the post 1991 period with the purpose of improving the living standards of urban residents and building the country's image in a range of ways. Cabinet members of the city government of Addis Ababa are 22 where 2 are the Meyers; 14 are at Bureau level and the remaining are officials of the government organ (6) selected by the Mayor, Addis Negari Gazeta 2012.

According to the recently revised Addis Ababa City Government Executive and Municipal Service Organs Re-establishment Proclamation No 35/2012, powers and functions of the Health Bureau and Organs it coordinates are listed: (Addis Negari Gazeta, 2012).

1. Establish health service standards and ensure its implementation in accordance with the National Health Policy and Standards; provide or cause to be provide health awareness raising education to the residents of the City;
2. Control, conduct surveillance, supervise, prevent and collect information concerning communicable disease upon conducting survey and investigation; prevent epidemic diseases in collaboration with appropriate organs;
3. Provide or cause the provision of mothers & children health care service &supervise the same;
4. Administer, in accordance with the law, hospitals and health care training institutions owned by the City Government; distribute medicens and medical equipment that are provided by the Federal Government and donor organizations for the implementation of different programs;
6. Develop strategies for the application of traditional medicens and treatment together with modern/contemporary medicine;
7. Conclude agreements and contracts and sign agreements with Non-Governmental charity organizations that conduct programs of medical services and follow up the implementation of same;
8. Organize data on the activities undertaken to control and prevent H.I.V/AIDS and other diseases in the City, submit the results of the analysis of the data to the appropriate organs;
9. Organize and provide health care counseling and information services.
10. Ensure medical information given by government health institutions, follow up, and take measures where necessary.

The proclamation further implied in its Article 6/2012 under accountability of Other Executive Organs and Higher Education and Training Institutions, 8 different health institutions and Addis Ababa HAPCO are assigned to be held responsible for the Bureau of Health. These executive organs are Kotebe Primary Level Hospital; Office for Control and Prevention of HIV/AIDS; Hospitals (6); Menelik II Health Science College; and Kenema Pharmacies Enterprise; as mentioned under sub-article (17) to (25) of Article 5 shall be accountable to the Bureau of Health.

Comparing the powers and functions of the Addis Ababa Bureau of Health with what Turnbull (2010) has described as key roles of leadership in public context such as reviewing strategy, leadership and service delivery it is open to learn that fits well. Each of the ten listed above are linked with either one or more than one power and functions of the bureau.

Organizational Structure of Bureau of health, Addis Ababa City Government

As a result of the re-organization and decentralization process of the Addis Ababa City Administration in 1995 EFY (2003) a new structure has been put in place for the Bureau having 3 core processes: Curative Health Service Core Process; Health Promoting and Disease Prevention Core Process; and Supportive Process where the first two positions are held by the two Deputy Bureau Heads. The Advisor for the Bureau Head administratively categorized under Supportive Process, the Health Science College and the Addis Ababa HAPCO are also the key organs of the Health Bureau sharing the immediate line under the Head of the Bureau. As can be seen the diagram above, the Bureau head is also supervising and closely working with Hospitals (6); Sub-City level health Offices and Kenema Pharmacies (all with white background in the diagram).

The Addis Ababa bureau of health base in Cherkos Sub-city plays the coordination and facilitation role in line with the health service delivery and city level health related policy making based on its legal mandate. To handle duties and responsibilities mainly associated at head office level, the bureau has 160 staffs including the 4 Bureau Heads.

Table 3.1 Addis Ababa Bureau of Health

No	Category	Female	Male	Total
1	Bureau of Heads	0	2	2
2	Curative Health Service Core Process (including deputy head)	17	23	40
3	Health Promoting and Disease Prevention Core Process (including deputy head)	13	14	27
4	Supportive Process	38	53	91
	Total	68	92	160

Source:-Human Resource Manual, Addis Ababa Bureau Health Revised Dec 2014

The 10 Sub-city level Health offices that manage health centers- where health services are primarily provided to the resident of Addis Ababa- in their respective Woredas are administratively accountable to their own sub-city administrations, keeping the reporting and joint efforts with the Bureau Head as it is. Number of Health Centers under the supervision of the 10 Sub-city are 103, average 10 health centers per Sub-City where the highest 11 is found in the Yeka Sub-city. Each health center is accountable for a Board which comprises the Woreda Administrator (chairperson), Medical Director of the Health Center; Head of Woreda Health Office; Woreda Finance and Economic Office; Employee representative; and Community representative. The 6 Hospitals are also administered by Board which comprises similar board structure but at Sub-City level. These organs of the Health Bureau are geographically dispersed within the City, while their work relationship and affiliation is still strong and intertwined along with the Bureau of Health (for the details, please consult annex 6 of this study)

3.3 Situational Context of the Health Bureau, Addis Ababa City Government

Addis Ababa Bureau of Health introduced a balanced Score Card which is applied in the Bureau since 2009. As stated in the Ministry of Health website decision making processes in the development and implementation of the health system are shared between the Federal Ministry of Health (FMoH), the Regional Health Bureaus (RHBs) such as Addis Ababa Bureau of Health and its lower level structures, Sub-City and Woreda Health Offices. Furthermore as a result of recent policy measures taken by the Government of Ethiopia, the FMoH and the RHBs are made to function more on policy matters and technical support, while the Woreda health offices have been made to play the pivotal roles of managing and coordinating the operation of the primary health care services.

As briefly described in the Addis Ababa Health Bureau's revised strategic plan for 2012/13-2016/17 (2006-2010 Ethiopian Calendar) the bureau evaluates it-self as it is fully in line with the national health directions and systems: joint responsibility of achieving health targets and goals. Accordingly providing essential health services to its clients both residing in Addis Ababa and coming from other parts of the country are the major emphasis of the health bureau system. The essential health service package consists of five major components which are (a) family health services; (b) communicable disease prevention and control service; (c) hygiene and

environmental services; (d) health education and communication services; and (e) basic curative care and treatment of major chronic conditions (revised 5 years plan of the AA-BoH, 2012).

Service provision at all level is realized in the Bureau's plan where units, lower level structures such as Woreda Health offices and health centers are drawing their plan from the Addis Ababa Bureau of Health which is drawn from the Ministry of Health as well. As per the Bureau's Strategic Plan, revised Dec 2014, the overall plan is divided in to 16 goals where each goal is supported with list of activities need to be done so as to ensure the framework and minimum standard are maintained at all level. Regular monthly, quarterly and annual meetings, 1 to 5 learning group discussion and staff performance evaluation are conducted against the specific organizational and individual plan which derived from the overall plan, according to the Performance Assessment tool revised on June 2014. The process of reviewing of delivery of tasks tracked in the health system focused on what is missed, who didn't perform well, not deliberately selected constructive languages instead it emphasizes what is overlooked as per the traditional problem solving methodology.

Because Addis Ababa is a political, administrative and economic center for a variety of reasons, health facilities owned by Federal government, other government bodies and private sector are located in different parts of Addis Ababa. As a result the residents and visitors of the city are also getting health facilities from other health service providers than institutions' under the direct administration of the Addis Ababa Bureau of Health as well. For instance, among the Hospitals located in the city only 12% (6 out of 50) are under the Bureau of Health where 70% (35 out of 50) are privately owned. In the meantime 98% (40 out of 41) of Medical Colleges are privately possessed. On the other hand health centers providing basic essential health facilities for the public are fully owned (103 out of 103) by the Bureau. All types of clinics such as higher and medium level are totally out sourced from the Bureau's effort are owned by Private and NGOs comprising 96% (692 out of 723) and 4% (31 out of 723) respectively. In general the private sector role in most of the health facilities involved is dominant as can be observed in the table below (for the detailed information, please consult annex 5 and 6 of this study).

3.4 Research Methodology

By drawing the facts and figures from public institutions and members of the city council, the target population of the study is employees of the bureau and the analysis will be made at institutional level.

Descriptive data about the leadership practices in the Bureau of Health, City Government of Addis Ababa will be collected using different tools and methods. The inter-relationship between horizontal and vertical work units in the bureau and its next level offices will be assessed against the theoretical framework of the appreciative Inquiry leadership model. Descriptive method is selected to relate and compare the process and applicability of the model in public organization in a better way.

Among the 14 bureaus encompassed in the council of the city government, Bureau of Health is selected for this study. Purposive sampling was used to take the bureau and its lower level structure:

- i) The Addis Ababa Bureau of Health was selected for piloting to adopt the BSC as management tool, under the Ministry of Health, at national level
- ii) The piloting of the BSC recorded as successful in the health sector and the scaling up of the BSC implementation are carried out nationwide
- iii) Keeping the degree of variation, the health sector has got recognition from both the Government of Ethiopia and the international community for best achievements of health related components of the Millennium Development Goal (MDG)
- iv) Though records shown that significant achievements in the health service delivery, still there are areas need improvement
- v) For the achievement of the MDGs, the leadership practice in the sector is considered as one of the contributing factor
- vi) Health is vital service to the national development of the country in varied aspect

3.4.1 Variables, Indicators and Measurements of the study

The 4-D appreciative Inquiry Model is applied for the data collection, presentation and analysis of this paper. Accordingly what gives life to the Addis Ababa Bureau of Health and what is happening when the bureau is at its best in the Discovery stage of the model; what might be and what is the world calling the Addis Ababa health bureau to be in Dream; how can its employees create the ideal as articulated by the data sources of this research in Design stage; and how can the bureau continue to learn, adjust, and innovate in Destiny stage will be the theoretical frame of this thesis.

In this process, the EIGHT assumptions of the AI model are the assessment factor where the FOUR unique features of the model as leadership development are key influencing factors, called indicators. These features are observing problems from the other-side; Inquiring different ways and solutions (flexibility); dealing with greater participation of members; and committed for strength based approach. With regard to the Addis Ababa Health Bureau, the research questions of this study have measured in line with the expected outcomes as variables are inter-related in the table below.

The EIGHT Assumptions are indicators whereas the four unique features of the appreciative inquiry model are specific variables for this research paper. To analyze the results measurements are drawn in line with the Research Question of the Paper.

Table 3.2 Variables and Indicators applied for the Study

Independent Variables	Dependent Variables	Indicators
1) In the bureau of health there is something that works 2) The act of asking question in the Addis Ababa Bureau of Health, influence the staff in someway 3) What the staff of the bureau focuses become their reality 4) There is multiple reality in the Bureau of health	Problems observed from the other side	a) Documented and shared learnings from the past success and failure b) Peoples attitude on getting or learning that something doesn't work c) The emphasis given to failures, not performed tasks
1) Staff of the bureau of health have more confidence to journey to the future when they carry forward parts of their past; when they carry, 2) The bureau picks what is best about the past 3) Differences are valued as one of the important factor of the bureau	Flexibility nature of leadership practice	a) Readiness to carry something best from past performance b) Peoples observation on other's idea, c) Availability of spaces to entertain new ideas, innovation and creativity d) Team works and joint efforts used
1) There is multiple reality in the Bureau of health 2) In the bureau of health there is something that works 3) What the staff of the bureau focuses become their reality	The leadership is participatory in nature	a) Staffs participation in organizational matters b) Sharing decisions made by management c) Consultations made before decisions affecting staffs life made
1) In the bureau of health there is something that works 2) The act of asking question in the Addis Ababa Bureau of Health, influence the staffs in someway 3) The bureau picks what is best about the past 4) The language staff of the Bureau of Health use creates their reality 5) What the staff of the bureau focuses become their reality	Strength based leadership practice is applied	a) Identified strength of staffs and process units b) Success stories continued on the previous successes c) Interests to look for constructive ideas/thinking

Source: Developed by the researcher, December 2014

3.5 Research Design

Research Design: the research employed case study design; it focuses on Bureau of Health of Addis Ababa City Government. A case study (Baxter and Jack, 2008) is an approach to facilitate exploration of a phenomenon within its context using a variety of data sources. It ensures in substantiating the issue in a variety of lenses which allows for multiple facets of the phenomenon

to be revealed and understood. More on that the case study design better fits to assess whether the Appreciative Inquiry Model of leadership is applicable to the public agencies in Ethiopia, particularly learning a lessons from the Bureau of Health of the Addis Ababa City Government.

3.6 Methods and Instruments of Data Collection

The study uses qualitative and quantitative data collection instruments. For the purpose of serving the objectives of this thesis, both primary and secondary data sources are used.

Primary data sources for this study are key informants, respondents of questionnaires distributed and documents originally reviewed by the researcher. Except the documents, all primary sources are identified from the study organizations. This is mainly because Addis Ababa Health Bureaus (RHBs) is major actor for the city government's health related policy decisions as well as coordinating the day to day operations of health care series at grassroots level.

Respondents are selected randomly for questionnaire administration whereas purposive sampling is deployed for the key informant interview based on staffs' leadership position, level of participation in the organizational matters and educational background in the respective rank of the bureau. In the process, the researcher did observation purposefully as some of the elements of the model can be noticed during the times spent in the organization as well as with people.

In order to thicken and substantiate the analysis and interpretation of primary data, the researcher has been able to gather secondary data from secondary sources. Appropriate sources referred were published and E-books, journals, reports by the bureau of Health of Addis Ababa City Administration and research papers conducted by other users.

Data Collection Instrument: Data collection instruments for primary sources are prepared in a semi-structured way. Self-administered questionnaires have structured such as yes/no; list of alternatives; and specific figures such as age category and years of service and unstructured question in which respondents were asked to put their opinions. The key informant interview comprised discussion points in the form of unstructured questions from which facts, opinions and perceptions can be drawn systematically.

The unstructured questions for key informants interview consist of their competency to lead, the use of best practices of the past, their freedom and interest in the process of handling the city's health care units such as reviewing institutional learning, knowledge management and conduct regular meetings (document and share learnings and best practices, existed trend and policy) were discussed. Furthermore the existing practice to engage staffs in organizational development issues (setting shared vision, believe in internal capacity); to facilitate and coordinate for success (team work, communication process, value differences) and maintaining supportive supervision (identify individual strengths and assists to lift up) and potentials to build up the leadership practice in the bureau structure.

The staff working at various level in the bureau of health was asked what inspired most in their work, what their role and how that situation(s) is recognized by their supervisor or organizationally, the influence of office communication on their day to day activity, level of satisfaction on team spirit and shared vision, benefit package, viability and accessibility of professional development opportunities, understanding on regular performance measurement processes and trends on documenting their learnings.

Data collected through questionnaire are analyzed and triangulated with the qualitatively gathered data and captured from secondary data. The unit of analysis includes the leadership practice existed; flexibility of system to empower and utilize staff capacity; means applied to ensure staff participation; staff motivation and understanding and applicability of strength based leadership practice. These further supported by context description, existed human resource development, relationship and team work; availability of room for innovation and creativity, and applicability of AI model and its results.

With regard to the secondary technique library research conducted. Primary sources such as regulations, minutes of different meetings, human resource manuals and posted directives in the office surrounding were considered. Library research also includes books (published and electronically accessed), internets, journals (both published and electronically accessed), and relevant research papers pertinent for the subject matter under discussion were reviewed.

3.7 Study Population

The study population selected for this research paper is public organization employees. Since public organizations do have facilitation and service provision role, it is important to study the working environment in which they operate and deal with facilitation and service provision functions.

The reason for selecting the Addis Ababa city government for this study is that the city has soundly good exposure for the developmental issues and changes happening in the world. And the recently introduced model for leadership development i.e. Appreciative Inquiry can be recognized and practiced as well as having good prospects in the city government of Addis Ababa in general and in the health sector as public organization, taking the previous experience of introducing the BSC to national level into consideration.

To deal with the prospects and limitations of the model in Ethiopian context, Health Bureau of the City Administration has been selected as the bureau is responsible for majority of the population category. In addition to the population size the sensitivity, dynamics and the diversity of the citizens served under the Bureau (and its lower level structure) is the key reason for being selected as a study organization. As a result the working environment of the Bureau of Health focusing on the leadership practice among staffs at all level is the study population.

3.8 Sample

The staffs of Health Bureau of Addis Ababa City Government are respondents for questionnaires. The staff members closer to the leadership approach and health experts are selected. The respondent categories are two: who participated in key informant interview (4) and who administrate the questionnaire (41). The key informants for the study are; head of the Health bureau; BSC adaptation committee representative; major donor; and Health Adviser of the Bureau.

- 1) The other category of primary respondent using questionnaire are health experts in the two core processes of the bureau (32); the supporting process (10)

2) Further observation has done by the researcher in all the communication process gone through out the research period. Out of the 43 total numbers of questionnaires distributed 42 were returned. As one was not fully completed, the only 41 (97%) of the returned questionnaires were used for analysis.

Table 3.3 Data sources from the Bureau of Health

No	Tools to be used	Category	Number of participant
1	Key Informant Interview	Bureau Head	1
		Health Advisor of the Bureau	
		Major Donor	1
		BSC adaptation team leader	1
2	Questionnaire administration	Health experts under the 2 core process section of the Bureau	32
		Supportive Process	10
TOTAL			42
Key Informant Interview			4 (100%)
Questionnaire fully administered and utilized			41 (97%)

Source: Own Survey, November 2014

Before the actual data collected, both tools were tested with the suitable category of respondents. The data collected during the pilot test were not included in the analysis of this research paper, but it is only to take necessary corrections to make the tool as clear and as per the need of the research as possible. Including General Practitioner in the educational categories listed for options; and need of classifying years of services in the health sector between in the Addis Ababa Bureau of Health and other institutions are major improvements done based on the learning of the pilot testing.

3.9 Data Presentation and Analysis

Data collected from primary and secondary sources are interpreted mainly in descriptively style. Using in SPSS Software, qualitative data were categorized and summarized. Mainly the level of Health Bureau’s organizational performance with respect to its achievement, relationship among

work units, and documentation of learning against the basic Appreciative Inquiry Assumptions. The data results are presented in tabular and graphic forms; from which interpretation and analysis as well as discussion of findings is presented. The general framework for analyzing the results is directed in line with the conceptual and analytical frameworks designed for this research purpose.

3.10 Ethical Consideration

All requirements of the Bureau of Health and the research procedures of the Addis Ababa University are properly adhered. Which includes formal request for cooperation written by the AAU, College of Business and Economics, the researcher's full CV, final draft proposal approved by the advisor and application letter as per the Addis Ababa Bureau of Health requirement are submitted to the bureau. The documents submitted were reviewed by the committee assigned by the bureau and get acceptance as it fulfills the criteria set. More on that, every respondent were asked for individual consents before the data collection proceeds all the time. Regarding to the research ethical issues, all scientific evidences and supporting documents were consulted and properly acknowledged.

Chapter Four

4. Results and Discussion

4.1 Introduction

This chapter presents the results of the data under study and interpretation of the findings. It starts with presentation of the respondents demographic data as background characteristic such as sex composition; highest educational attainment; age category; years of services in the health sector and supervisory role. Then the study variables are discussed in line with the respondents understanding and knowledge in the questionnaire. Apparently qualitative data gathered through key informant interviews used to substantiate and triangulate results and discussions. Empirical evidences are also considered to support arguments as appropriate.

4.2 Demographic Characteristics of Respondents

The number of questionnaires distributed, returned and considered for analysis is 43, 42 and 41 respectively. The 97% and 95% rate is calculated for return and full return that are used for analysis and discussion in this research paper as equated to the distributed number of questionnaires. The sex disaggregation of the 41 respondents is 1:2 meaning 14 are female and 27 are male employees of the bureau of health

The key informant interview conducted with 4 vital position holders in the Addis Ababa Bureau of Health. They are Head of the Health Bureau; Advisor for the Health Bureau; BPR adaptation case team leader; and a representative of Center for Disease Control as major donor of the Addis Ababa Bureau of Health. 75% (3) of the key informant interviewees were male and 25% (1) was female.

Age and Years of Service in current position

The characteristics of the respondents further disaggregated with age category and their educational status taking the highest achievement as sort of dialogue.

Table 4.1 Age category and highest Educational attainment of respondents

Age	No	Percent	Educational status	No	Percent
20-25	4	9.76	Phd	1	2.38
26-30	12	29.27	MA/MSC	11	26.19
31-35	6	14.63	MD/GP*	16	38.10
36-40	5	12.20	BA/BSC	12	28.57
41-50	10	24.39	Certificate	2	4.76
51-60	4	9.76	Total	42	100.00
Total	41	100.00	* Medical Doctor/General Practitioner		

Source: Own Survey, January 2015

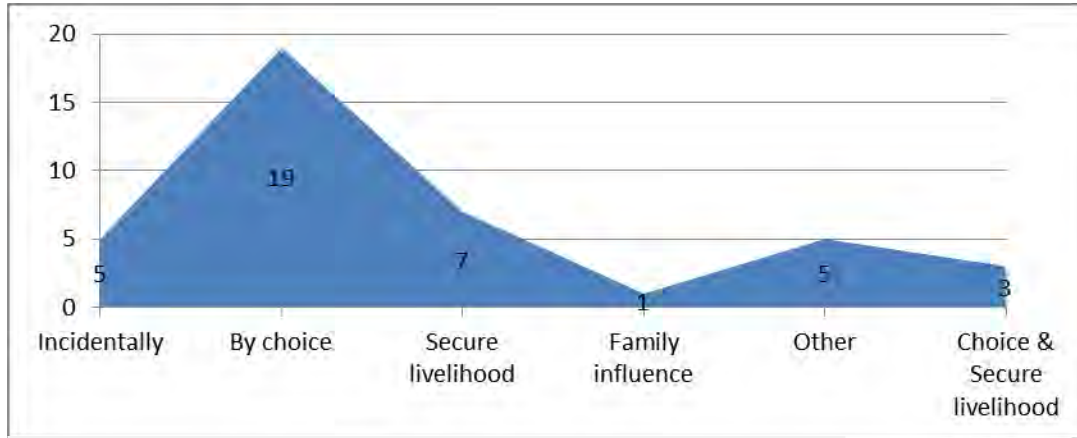
Most of the staffs based on table 4.1 above are at the age range of 26-30 and 41-50 respectively, the sum contains about 50% of the total respondents. The first and the last age group encompassed the most junior and the most experienced staffs, each had 4 respondents and out of the total respondents about 20% (9% each category) belongs to these two categories. The remaining active and stable working groups aged 31-40 years have represented with about 26% of the respondents (31-35, 14% and 36-40, 12%). This representation of age category can show the perspectives and experiences of the new blood, the experienced and also the middle age that helps this research analysis more realistic and illustrative.

Experts of the bureau of health with different profession at head office are participated. Respondents with medical doctorate and first degree were about 67%; each comprises (16, 38%), and (12, 29%) respectively. Staffs with second degree are also fairly represented 26% (11) whereas 1 staff at Phd level (2%) is responded for the questionnaire among the current employees of the Addis Ababa Health Bureau. This summarizes more than 95% of staffs of the bureau of health were with and above the first degree level in educational background.

Respondents' exposure to first join the health system for career development and working environment is strongly by choice followed by considering the health profession as a decent means of securing livelihood. Respondents who could join the sector as of their own preference were 45% (19) and others 17% (7) believed that it is the better way out for safeguarding livelihood. 7% (3) of respondent had two major influencing reasons when they first joined the

health system, partly their choice for professional development and at the same time it is considered as decent means for source of revenue.

Figure 4.1 How Respondents First Joined the Sector



Source: Own Survey, January 2015

Still about 12% (5) of respondents confirmed in the figure 4.1 above that they joined the health sector without prior knowledge or incidentally inclined to the health system. One respondent (2%) drew to the system as a result of optimistic family influence. The diagram above reflects the reality of the bureau of health staffs', in a range of 45% to 2% variation, for all professions participated in this research study.

Therefore, it is good clue that the staffs of the bureau of health are at the mix of all age categories as experienced and new blood employees are bridged by those at the middle. The implication also mirrored that there is possibility of acceptable transfer of organizational culture through generations in the Bureau of Health

4.3 Substantive Data

Table of 4.2 summarizes the result from respondents who wrote their current position are limited to 33, 80% of the returned questionnaires. Age disaggregation over the current position showed that about 30% (10) are with the age of 26-30 group while 60% (6 out of the 10) of them were working at the officer position. In the officer position respondents of non-health professionals such as finance, human resource management and planning are partaken.

Table 4.2 Summary of Age cross tabulated with current position

Age	Manager	MD/GP	PO	SPO	Nurse	Officer	Other	Total
20-25	0	1	0	0	3	0	0	4
26-30	1	0	0	1	0	6	2	10
31-35	0	0	0	0	0	4	0	4
36-40	0	0	0	1	0	0	3	4
41-50	3	0	1	0	0	4	0	8
51-60	0	1	0	0	0	1	1	3
Total	4	2	1	2	3	15	6	33

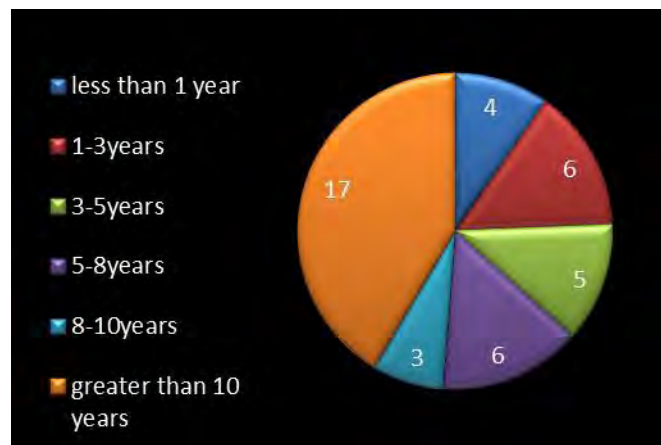
Source: Own Survey, January 2015

The process owner position which is among the key decision making positions within the health profession, next to the deputy bureau heads as depicted in the bureau’s structure. For this research purpose one process owner responded and the age category was belonging to the 41-50 group. The 2 sub-process owners were fall in the 26-30 and 36-40 age groups. The Medical Doctors/General Practitioners were at the early and late working age, 20-25 and 51-60 groups. All 3 respondents with nursing profession were in the young working age group, 20-25.

Years of Service in Health System and How first joined the Sector

About 40% of respondents (17) based on the figure 4.2 have more than ten years of experience in the health system. The next highest categories were 5-8 years and 1-3 years, each had 14% (6) respondents.

Figure 4.2 Years of Services in the health system



Source: Own Survey, January 2015

Meanwhile 61% of respondents have been working to the system a minimum of 5 years. About 10% (4) are staffs newly joined the health sector in less than one year period.

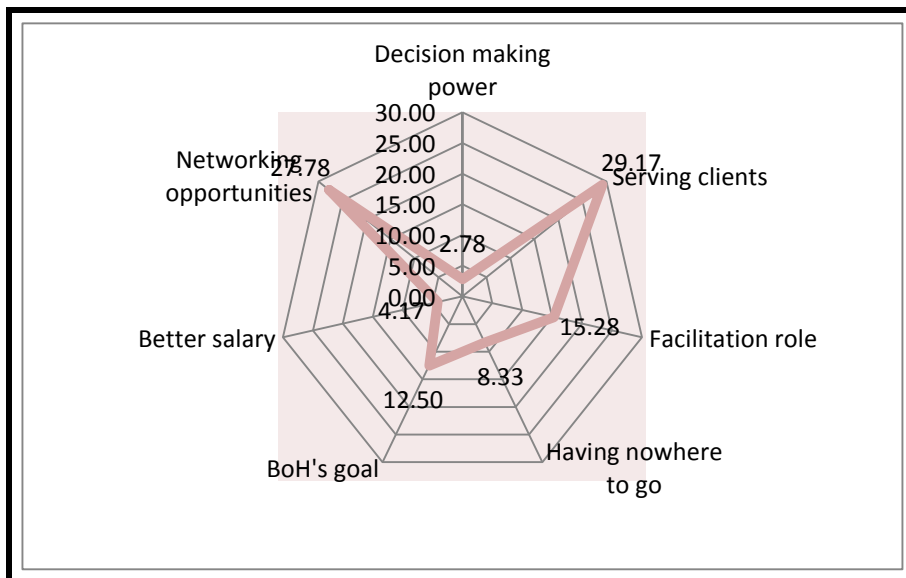
4.4 Results and Discussion of Survey Questions

4.4.1 Staffs Attachment with the Bureau of Health

Respondents were asked to provide the reason for staying in the health service for their career using multiple responses options.

The result of the data collected for this survey purpose shows in figure 4.3 below that the highest percentage i.e. 29% reflected their level of satisfaction in serving clients of the health service reinforced them to stay longer in the city health bureau. The next most preferred options are networking opportunities created and facilitation role created in the health system as selected by 28% and 15% of respondents respectively. The facilitation role at the bureau leave mean is that providing supports and coordinating different tasks for common purpose at all level including hospitals, health centers and health colleges are helped in increasing attachment resulting more years of service in the system.

Figure 4.3 Reason to stay longer in the Addis Ababa Bureau of Health



Source: Own Survey, January 2015

12% of respondents justified their reason to stay in the health system as their commitment to materialize the goals of the health bureau which they shared with. 8% are responded for this question in a way that they don't think they have other options to work and that led them continuing working what has been salaried before.

Five options were presented to get staffs' understanding on the significant organizational values of the Bureau of Health. As per the table 4.3 below shared vision and trust in internal capacity have selected by 28% and 21% of respondents which are the top two most preferred significant values.

Table 4.3 Summary of Significant Organizational Values

List of values	Percent
Shared vision	28.30
Trust in internal capacity	20.75
Learning from previous successes	18.87
Valuing differences among staffs	16.98
Constructively probing for the future	15.09
Total	100.00

Source: Own Survey, January 2015

Learning from previous successes (19%) and valuing individual difference (17%) are the next best preferred values with two percent of differences among them. The least preferred value under the multiple choices presented for respondents is constructive way of probing for the future (15%) that is less than by near to half comparing to the first top choice of the same group.

This result reflected that the vision of the Addis Ababa bureau of health got acceptance by about one third of the respondents as organizational value. Data from key informant interview heightened that shared vision is critical value of the bureau of health as well. The CDC representative as major donor to the bureau confirmed that “because CDC is sharing the vision of the bureau, it becomes one of its allies to realize the common effort.” This result implied that the health bureau’s vision is well understood and shared by its internal and external stakeholders.

Table 4.4 Summary of Staffs contributions to the achievements of Health Bureau

Staffs contribution to the achievements	Percent
Actively participated in different tasks	30.88
Connect efforts to next plans	10.29
Creating spaces for professional carrier	7.35
Influence the process gone positively	11.76
Opportunity used for staffs' GE*	1.47
Overall contribution to the achievement	38.24
Total	100

Source: Own Survey, January 2015

To get the staffs attitude regarding their level of efforts and feeling about the staffs contribution for the achievements recorded by the Addis Ababa bureau of Health, questions were presented in multiple responses (See Table 4.4). About 38% believed that the overall contribution they made to the achievements of the bureau’s goal was immense. This is supported by the next highest category, 31% of the respondents rated, for the individual staff’s active participation in different tasks for the accomplishment of organizational objectives. Influencing the process gone through positively during the previous performance periods and link this effort to the next strategic and annual planning time are rated as 12% and 10% respectively.

However valuing differences and communicating staffs in a way that can lead each to think constructively are selected in lower rate 17% and 15% respectively. The least chosen option was using the success of the bureau to the growth and empowerment of staffs intentionally as only one respondent (1%) chosen for it. As a result these 3 important and necessary factors as value of the Addis Ababa Bureau of Health are neglected to some extent.

It seems that both staffs and the bureau of health were given higher attention to the operational planning period and what is desired to achieve instead of strengthening the lively interaction of non-material assets and the human devolvement aspects. More on that, the commitment to connect the achievements over serious of periods and using such kind of opportunities for growth and empowerment of staff are overlooked. It also has implication in the realization of the core components of change and its measurement tools, the BPR and BSC tools. The tools are about crafting changes, persistently make changes over time and applying learning to the growth and empowerment of staffs from which the organization benefited further.

4.4.2 Strength Based Approach

Seventeen percent of respondents (7) strongly agreed that the strengths of the bureau of health has been identified and used for future organizational development purpose. The cumulative response including those went for neutral and above it are about 86% (36).

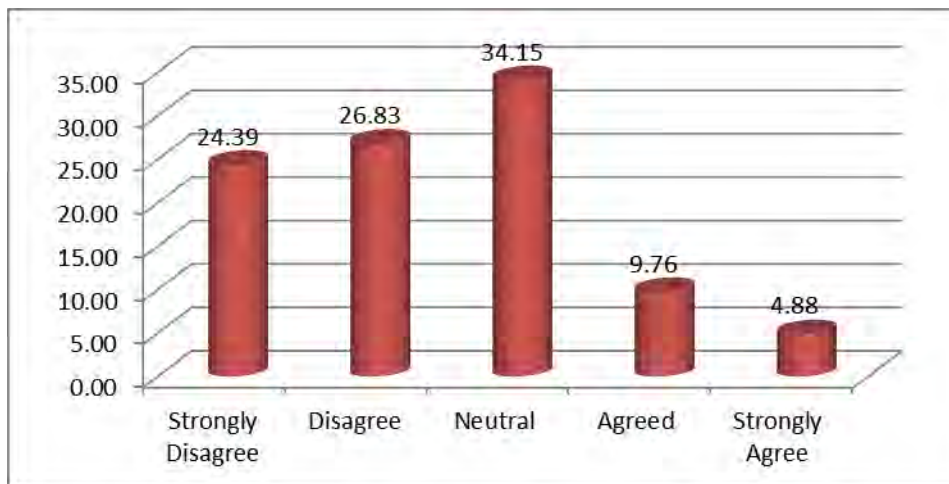
Table 4.5 Bureau's strength identified and used for future development

Level of agreement	No	Percent
Strongly Disagree	1	2.44
Disagree	4	9.76
Neutral	16	39.02
Agree	13	31.71
Strongly Agree	7	17.07
Total	41	100.00

Source: Own Survey, January 2015

Most of the respondents had agreed at least moderately identified and used for organizational development interventions, as 32% (13) agreed and 39% (16) opted for neutral. About 12% (5) of the respondents were disagreed on the identification and application of organizational strengths for next implementation period. Overall picture shows that the bureau of health's strengths is identified and the identified strengths are deliberately applied for the future organizational development purpose.

Figure 4.4 Individual staff's strength identified and used for development



Source: Own Survey, January 2015

However according to the cumulative percentage in the figure above, more than half of the respondents (51%, 21) don't agree that individual strengths are identified and used for appropriate staff developmental interventions. Out of them, about 24% (10) strongly disagreed and 27% (11) disagreed in this regard.

Those who were in between, but at least clearly reflected that they don't agree individual strengths are not identified and used for development, comprises more than one-third of the respondents, 34%. As a result the total proportion of respondents who are not in favor of recognizing strengths of individual staffs identifying and exerting appropriate capacity development efforts with the intention of enhancing quality of works is meaningful high as it reached about 85% (35). One can notice that the so far achievements and successes of the bureau might not be analyzed in terms of staffs contribution as well as those achieved are not yet used for motivating staffs. Only about 5% and 10% of respondents rated the identification and utilization of staff's capacity practice with strongly agreed and agreed respectively.

The key informants however said the bureau of health is intensely concerned about its staffs. Staffs as internal resources treasured and the bureau arranged empowerment options including the 1:5-learning group as one way of transferring skills mechanism'. The other means described during the key informant interview is that the bureau arranged monitoring and technical assistance provision by the skilled and with higher experienced specialists to staffs at the next lower level position both in the bureau and other institutions under the bureau's supervision with the aim of strengthening individual staffs' capacity at level. The performance assessment tool, according to the documents reviewed has also components of self-empowerment efforts exerted by the employee him/herself.

Sharing of previous success and achievement of the bureau was asked for the same group. With minimal variation the overall picture of the answer mirrored what is happening with mistakes and problems at different level. It specifically reflected that about 68% (28) were not openly agreed about there is a trend of proudly sharing the achievements and success of the Addis Ababa bureau of health as organizational culture. To the extent of cumulative percentage result of 32% prefers to disagree, 10%, 4 with strongly disagree and 22%, 9 with disagreed. But minor variation is observed in the strongly agreed respondents as 17% (7) preferred that it is a bit pleasant than what is reflected in disagreement i.e. 12%, 5 respondents in looking problems and

challenges from the learning and constructive perspective trends of the bureau of health. Organizational success such as the urban extension workers program and accessibility of health institutions to the residents of Addis Ababa are proudly shared by most of the key informants.

Table 4.6 The Bureau’s achievements shared proudly and repeatedly

Level of agreement	No	Percent	Cumulative Percent
Strongly Disagree	4	9.76	9.76
Disagree	9	21.95	31.71
Neutral	15	36.59	68.29
Agree	6	14.63	82.93
Strongly Agree	7	17.07	100.00
Total	41	100.00	

Source: Own Survey, January 2015

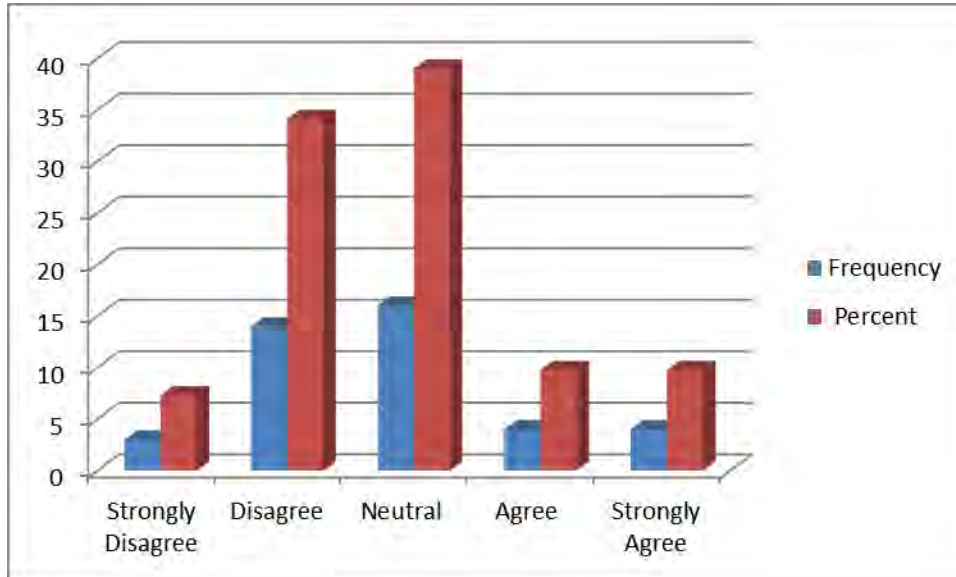
From the past performance of the bureau of health, each key informant has at least one success story. The stories are varied for instance. To the advisor, bureau head, and BPR adaptation team leader (i) the urban health extension program (ii) the accessibility of health facilities and (iii) fine-tuning the bureau’s BPR and BSC tools is top success story to each of the key informants respectively. The bureau head supports the urban health extension program while the BPR adaptation team leader also mentioned the accessibility of health institutions for their next best success story of the Addis Ababa health bureau. This implies that the success stories the bureau has and the potential to use them as spring board for other interventions are supported with excessive evidences.

Qualitative data further justified that the bureau continuously reflected its achievements which international and national community correspondingly acknowledged. Awarding model households and urban health extension workers are designed to acknowledge their respective strengths and motivate their peers to meet the standards.

Documenting the organizational learning of the health bureau was also asked for respondents to rate in a Likert Scale measurement. Less than 20% (8) were agreed that documentation is one of the health bureau’s cultures. Most of them 38% (16) stayed neutral as depicted in the diagram

below, figure 4.5. Respondents who disagreed in cumulative are a bit higher than 40% as strongly disagreed were 7% (3) and disagreed also counted as 33% (14).

Figure 4.5 Documenting Organizational Learning in the Bureau of Health



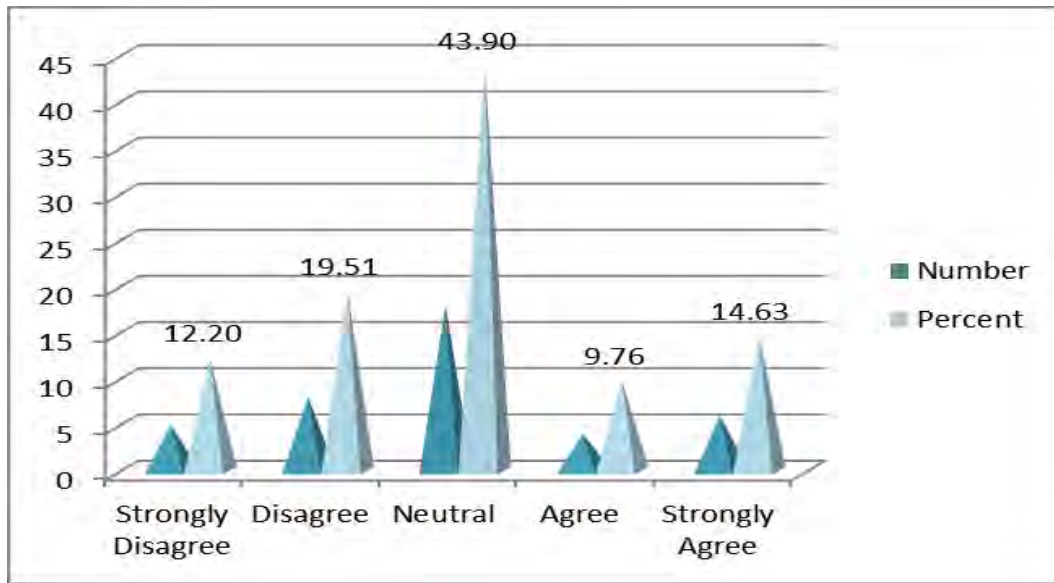
Source: Own Survey, January 2015

It is obvious that to learn from previous performance individuals, units and organization are in need of knowing what has happened and how was it went at any given time in the past. In this regard the practice in the Addis Ababa Bureau of Health is not promising as recording the processes and results of every program is insufficient. Since coordinating and leading the health sector performances of the city is at the hand of the Addis Ababa bureau of health documenting learning (both successful and unsuccessful) affects the decision made in the sector. More on that by doing so, the internal and external stakeholders of the bureau of health can get the opportunity to use these documents and make evidence based decisions. Decisions supported by precise evidences will have value on well-grounded plan, implementation and evaluation that results more successes stories to the health service provision in the city administration of Addis Ababa. The quantitative data however implies that more than 40% of respondents are not satisfied with the documentation trend in the health bureau.

As one the key informant distinguished previous efforts along with internal and external stakeholders were ended worthless as the commitment of the top management of the bureau of health was minimal. The head of the health bureau in his interview also confirmed that it is only

a recent phenomenon in the history of the health sector, including his bureau, to introduce the Communication Affairs as a separate work unit. The Communication Affairs case team is assigned for documenting the performance of health service in the city administration’s health issues.

Figure 4.6 Utilization of Documented Learning for Future Planning



Source: Own Survey, January 2015

With the aim of getting respondents attitude on the utilization culture of documented learning by the bureau a follow up question presented in the questionnaire distributed. The result found out that even from the documented learning, the trend in consulting the previous period practices to generate necessary data and acquaintance has meager feature. The utilization of documented learning from previous performances ranked as poor, total of 32% (13) rated with strongly disagree and disagree; on top of that 44% (18) respondents favored for neutral ranking.

Qualitative data from key informants enlightened that higher level achievements and decisions are intensely reviewed and used for future organizational development. The BPR adaptation team has well organized documentation regarding the processes gone through since its inception. The case team kept all evidences to support the decisions to award and/or to referrer for further inquiries in hard copies. The process and results found in the change tools adaptation dealings are precisely documented and ready for reference as per the documents reviewed by the

researcher. As a result except top level achievements of the bureau such as shared by the key informants of this paper, other achievements and processes by individual staffs, work units, core processes/departments, hospitals and other lower level health institutions might not be documented and shared to stakeholders for learning purpose.

Up to this data was collected (January 2015) documenting the regular reports produced at the bureau level to stakeholders is part of the responsibilities of the budget and planning case team under Supportive Process (SP). Data from the key informants argued that Communication Affairs work unit will hold the documentation and utilization of learning from the entire bureau's structure as its main duties.

To determine strength based approach applied in the bureau of health, there is a good trend in sharing success stories of urban health extension programs and improved accessibility of health institution. Steps taken to have Communication Affairs as work unit in the bureau of health can be considered as promising ladders. However echoing only higher level achievements is not enough in the bureau which comprises health centers, hospitals and other health service providing institutions. What makes the organization excellent in any given time and or in any given program could be the fundamental area that determines its life in the remaining period. When the existed situation for that success defined it would be easy to focus on those required elements to design the next period contextually. And strengths of staffs in clear guidance and participation of individuals need to be identified and to bridge gaps observed joint planning and efforts should be put forth. Proposed necessary interventions may have resource implications such as finance and time.

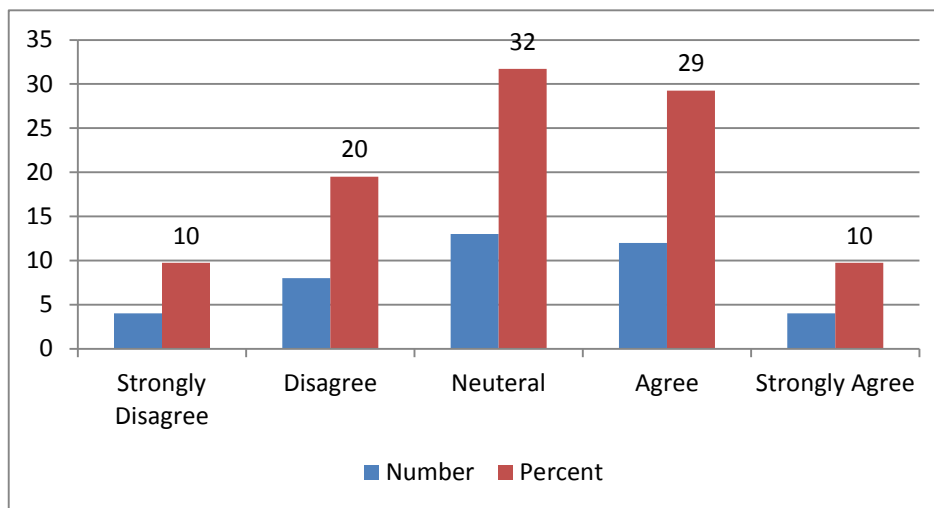
Thus far there is no variation between quantitative and qualitative data sources that documenting full organizational learning and its utilization for decision making is not at its substantial stage. Both groups agreed on the necessity of documenting all learning from previous performance and utilizing them as deemed at time of strategic planning and operational planning preparation. As the documented learning shared timely to health actors considering the sensitivity and necessity of health service to citizens as basic social services, it contributed meaningfully to the nation's development.

4.4.3 Participatory Nature of Leadership Practice

The Addis Ababa bureau of health in its head office has 160 staffs including the bureau heads. The staffs are working under three work units classified in core processes (2) and supportive process (1). The experience and understanding of these experts is vital to fulfill the bureau’s objective. Participation of staffs in the development of strategic documents, operational plan and in the implementation of what is planned at all level is crucial.

About 40% of the respondents shared the feeling of something works in the bureau that emerged from its experience, legal mandate, human resource and management team. However about one-third of them (32%) were remain silent whereas the other 30% of respondents reflected their disagreement. In terms of helping to achieve the goal of the Addis Ababa health bureau, its history can be source of confidence to believe in the bureau has something valuable and important inputs. As an authorized public agency with power the spirit of having capacity on delivering quality health services to clients and empowering the health institutions and health systems, the Addis Ababa health bureau can be regarded as an agency with something necessary and workable public agency.

Figure 4.7 Staffs understanding about there is something that works in the bureau of health



Source: Own Survey, January 2015

Above all the human resource, both health and non-health professionals is among the most valuable wealth of the bureau that can be merged with other backups. The achievements documented and non-documented are also assets that booming the feeling of numerous “something” in the bureau of health. Recognition by 40% of the respondents is not minimal though potentially it can be far reaching.

Table 4.7 Summary of Participatory leadership practice Against Sex

Sex	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Female	0	0	2	0.29	6	0.30	2	0.67	3	0.50	13	0.32
Male	5	1.00	5	0.71	14	0.70	1	0.33	3	0.50	28	0.68
Total	5	0.12	7	0.17	20	0.49	3	0.07	6	0.15	41	1.00

Source: Own Survey, January 2015

The leadership practice of the bureau of health was rated by its staff and the result showed that about 49% (20 respondents) were selected for neutral. From the positive and negative margined the negative side weighted by 29% (12) whereas the other extreme side is ranked for 21% (9) with agreement.

The level of agreement and disagreement reviewed in line with sex. The result found that among the female respondents 46% (6) were neutral and 38% (5) of them are believed that there is respectable and excellent participatory leadership practice in the bureau of Health. Those female respondents who are not agree cover 15% and none of these female respondents strongly disagreed in the existence of participatory leadership practice in the bureau of health.

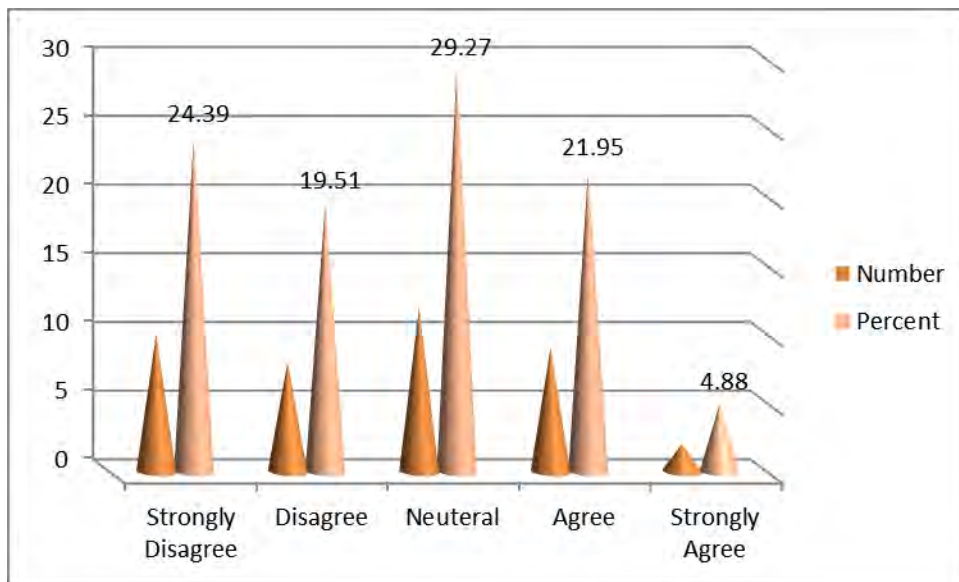
However 50% (14) of male respondents preferred for neutral answer. Contrary to the female respondents 36% from the male group are not agreed in the availability of participatory leadership practice in the same office. More on that half of these unsatisfied respondents are opted for strongly disagreed choices. Male respondents who have agreed are 14% (4). Therefore male staffs of the Addis Ababa bureau of health as compared to their female colleagues missed the participatory leadership practice.

Nonetheless, data from the qualitative source argued since the bureau is using Woreda-Based planning and evaluation procedure in the health system and bureau always collected such

practices and reports from lower level structures including core processes in the bureau level the room for staff and stakeholders’ participation is warranted. Additional evidence quoted by the key informants is that the office of the bureau head is open once per week there internal and external stakeholders can share concerns and participate in areas good for staffs as well by communicating the bureau head directly. More on that every staffs participation in a 1:5 group learning discussion, monthly processes level meetings and report sharing about planning and accomplishment are means intentionally designed to increase staffs participation at all level.

Regarding level of staffs’ consultation at least in major organizational decisions that affect the lives and working condition of the bureau and/or the staffs, 44% (18) were not agreed: as 20% (8) disagreed and 24% (10) were strongly disagreed. Those who agreed about the management of the bureau consulted staffs in key organizational decision were about 27% (11); where 23% (9) and 5% (2) replied as agreed and strongly agreed respectively. If the neutral group are not with the agreed one, the respondents total that aren’t confident on participation in major organizational decision exceed to 63%.

Figure 4.8 Summary about Staff consultation on major management decisions



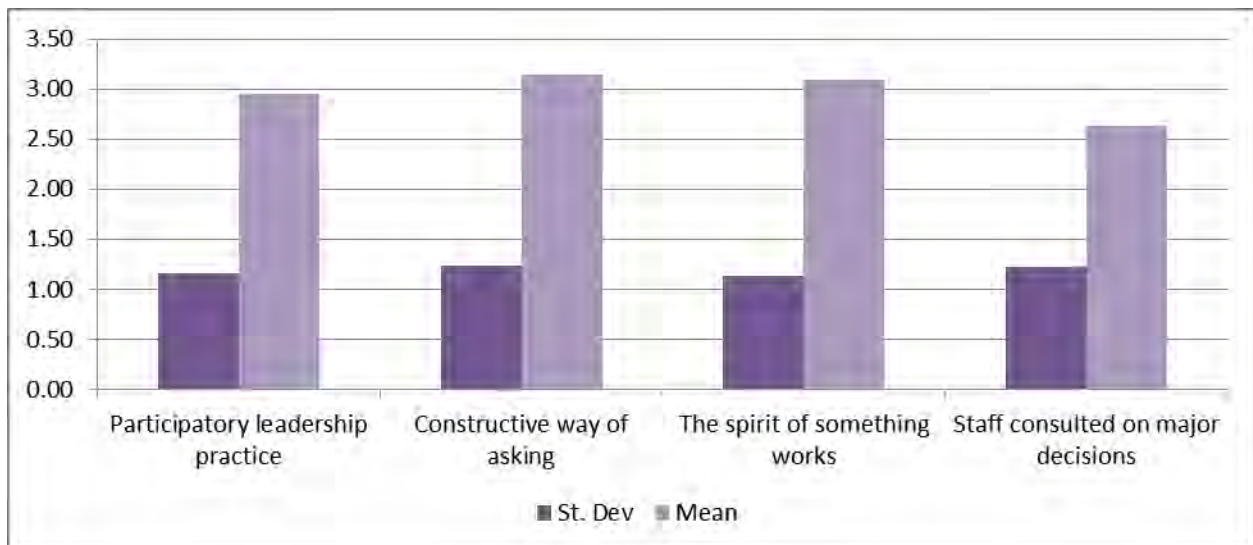
Source: Own Survey, January 2015

This may imply that major decisions of the Addis Ababa Bureau of health are mostly missing the inputs and consents of its staffs. More on that, the existed capacity and experiences of staffs of the bureau of health is not fully underlined by bureau.

Key informants claimed that planned regular meetings conducted at process and work unit levels are major source of inputs for the top level management team through the corresponding representative. The decision making process includes consulting representatives of stakeholders including staffs as appropriate directly or by reviewing their reports and other necessary documents. For instance, the BPR case team leader notified that change tools applied in the bureau are continued as per the recommendation of what is happening at the ground. And yet he alike to other key informants has reservation on the consistencies and full participation of staffs due to resource limitation including budget.

The standard deviation results that reflected the staffs’ participation in different mechanisms also supports as this is a missed opportunity to both the bureau and the staffs. The result of 1.16, 1.24, 1.14 and 1.22 are standard deviation with the participatory leadership practice, constructive way of asking questions, the essence of something works in the bureau, and staff consultation for key decisions made by the management team of the health bureau respectively. All above 1 results indicated that the distance of each response given by respondents is far each other from the center value. The aggregate result of the four parameters are indicative of there is limitation in leadership trend with regard to having spaces for the participation of staffs at all level.

Figure 4.9 Standard Deviation and Mean on 4 key parameters on participation



Source: Own Survey, January 2015

The mean value of these parameters also support the limitation in staffs participation. The results fall between 2.95 and 3.15 are reflecting the respondents unsatisfactory feeling on this regard. This may infer that most of the staff is working under unpleasent environment which directly can affect the the success and acheivments of the bureau of health in the future if not treated timely.

However qualitative data obtained from key informants that given the framework of the health priorities to the City Administration of Addis Ababa by the bureau, staff at all level participated in diverse ways including work plan preparation, providing or taking technical supports, implementing what is planned, evaluating in weekly, monthly, quarter, semiannual and annual performances.

Further, as per the understanding of one of the key informants regarding the intervention of the CDC program, the Addis Ababa bureau of health allowed the program staffs to involve in all aspects. The CDC program represented in a management meeting when decisions related to its intervention is the agenda. The management of the bureau of health equally treated the CDC program and thoroughly reinforced the implementing team of the bureau at lower level to do the same. Once the program gets buy-in of the bureau's tom management, considerable amount of space for participation is available for technical matters.

The bureau head pointed out that all successes declared by the bureau are the results of these actors. Likewise the Addis Ababa Health Bureau's experience and successes are fed to the national records. In general, he reinforced in a way that the participation of staffs in the overall implementation and evaluation of the health service programs is robust. Meanwhile the contribution of his bureau to the country-wide health planning course under progress such as the 2nd national Growth and Transformation Plan (GTP), the next 20 years HSDP and the first 5 year plan of the second 20 years HSDP is based on the agreed upon successes of the health service by each and every health actor within the city of Addis Ababa health bureau, the Bureau Head confirmed.

4.4.4 Perceiving challenges and Motivation in the Bureau of Health

Quite the corresponding to proudly and repeatedly sharing out about what has achieved at bureau level in the previous period, about 46% of the respondents (19) disagreed with repeating past

mistakes with its destructive message. This is reasonably good trend and observation of staffs as it helps to reduce unnecessary stresses and wastage of resources. This percentage could be a base to treat mistakes of an individual's, group's and bureau's from its learning perspective with the aim of capitalizing upon it.

Table 4.8 Previous Mistakes and Problems Repetitively Revealed

Level of agreement	No	Percent	Cumulative Percent
Strongly Disagree	5	12.20	12.20
Disagree	14	34.15	46.34
Neutral	9	21.95	68.29
Agree	8	19.51	87.80
Strongly Agree	5	12.20	100.00
Total	41	100.00	

Source: Own Survey, January 2015

The remaining cumulative percent, 32% (13), of respondents confirmed that mistakes in the past period are stated over and over again. However as those at the middle (22%, 9) didn't yet disprove, the probability of those who agreed with the point under discussion might increase up until 52% (22). This 52% implies that about half of the staffs of the bureau of health are challenged with the previous mistakes and problems for longer period that might contribute for affecting the current working environment and efforts to be exerted for success.

What the bureau head wanted to give emphasis in this regard seems supporting the result from quantitative data. His clarification offers due emphasis that before gaps are taking place the bureau arranged supporting mechanisms to redress diversified matters. Regular reports and monitoring visits are best ways of identifying unaccomplished plans and if the reason is somehow acceptable (i.e. because of ambitious plan or lack of inputs) it will be considered for next period. However problems or gaps identified at any given time and place is subjected for appropriate measures including disciplinary measures, if indispensable.

Nevertheless none of the key informants are sure that problems could be opportunities to strengthen the trend and capacity of the bureau and its staffs. In general, the practice of the bureau of health revealed that the system is working to set problems free environment and if it happened the system is not designed to consider it as a good opportunity to learn and grow.

Need for investing in Leadership Capacity Building

Leadership skill development intervention of the bureau of health has got responses in multiple response options summarized in table 4.9. About 22% of respondents selected the bureau should invest in leadership skill development because the challenges in the health sector are sensitive by its nature. It is noted by 16% of respondents that health bureau should invest to empower health professionals with leadership skill as one of its key responsibilities. Other competitively reasoned out justifications selected by respondents implied that government’s attention to the sector is high, leadership skill is one of the required skill by health professionals and, professionals in the health system should understand the existing leadership challenge in the sector, each got near to 14%. This 14% showed that three important matters met as per the understanding and knowledge of respondents: the national interest, the interest of the health professionals, and the importance of the leadership concept to the sector.

Table 4.9 Best reason of the health bureau to invest in building staffs leadership capacity

Reason to invest in leadership capacity building	Percent
Sensitivity of challenges in the sector	22.45
Government’s special attention for the sector	14.29
Needed by the health professionals	14.29
Donors have budget	7.14
Health professionals should know the leadership challenge	14.29
Health professionals should be empowered in leadership	15.31
The health sector should be led by health professionals	12.24
Total	100.00

Source: Own Survey, January 2015

Twelve percent of respondents reflected that the bureau should invest in leadership skill development of its staff because the sector needs to be led by health professionals. Taking these respondents into account reasonable numbers of staffs are in need of getting leaders in the health bureau who exclusively are from the health profession. The least selected option is budget allocated by donor organization rated by 7% of the respondents in the multiple response questions.

Positions most needed Leadership Development Skill

The importance of leadership development training equally to all staffs of bureau of health got support by 25% of respondents as reflected in table 4.10. The highest importance of leadership skill development was proposed for medical professionals, near to 31% respondents chosen it. 20 percent’s implied that top level managers should be incorporated in the leadership skill development opportunities as priority groups. The lowest cases are middle level managers, administrative staffs and lower level managers as percentages to these category were 13, 9, and 2 respectively. The understanding of respondents seems that leadership practice is existed and needed in medical professionals and at the top where improvement in this skill specifically should align with to the two groups.

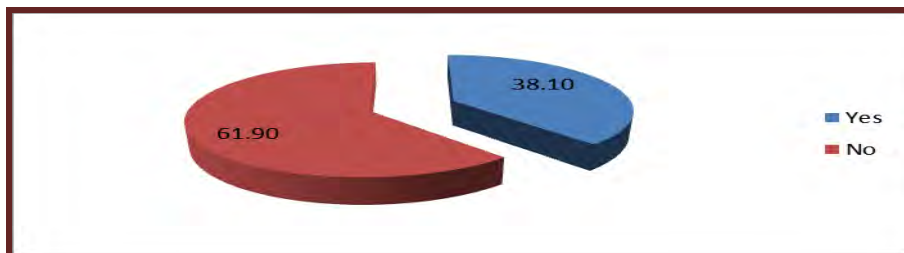
Table 4.10 Summary of most important position for Leadership skill development intervention

Responsibility/position	Percent
Medical professionals	30.91
Administration staffs	9.09
Top level managers	20.00
Middle level managers	12.73
lower level managers	1.82
Equally to all	25.45
Total	100.00

Source: Own Survey, January 2015

However the opportunity of getting leadership training to staffs of the bureau of health seems limited. Only 38% (16 respondents) got leadership development related training in the period they worked for the bureau of health system in professional service provision.

Figure 4.10 Summary of Leadership Skill Development trainings attended

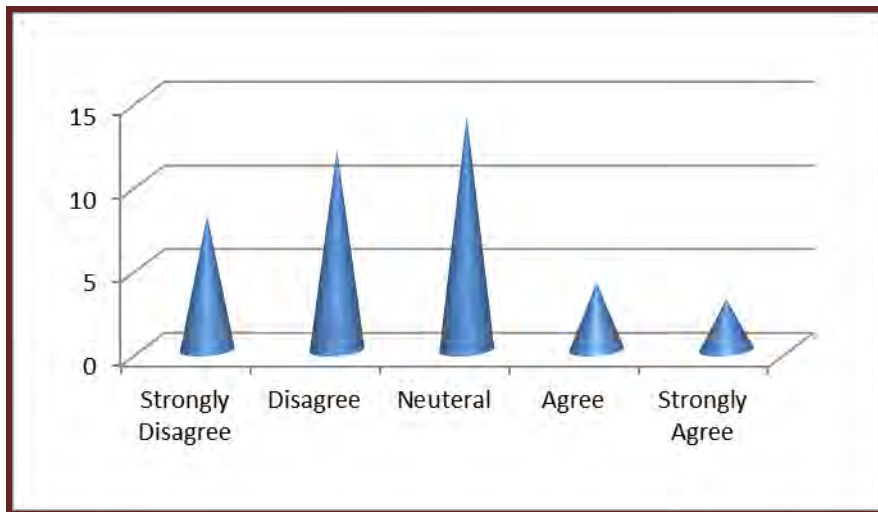


Source: Own Survey, January 2015

The remaining 62% (26 respondents) as per the figure 4.10 confirmed that they never got such skill development opportunity.

Using Likert Scale measurement respondents asked to reflect their understanding on the distribution of staffs’ development opportunities which includes short term trainings and full time schooling for next higher level education. More than 80% (35 respondents) are rated for less than agreed options for fair distribution of such developmental opportunities. Strongly disagreed, Disagreed and Neutral responses are given by 8, 12 and 14 respondents containing about 19%, 29% and 33% respectively.

Figure 4.11 Fair Distributions of Professional Development Opportunities



Source: Own Survey, January 2015

From the positive extreme absolutely agreed and agreed number of respondents are 3 and 4 containing 7% and 10% respectively. The middling respondents preferred to select neutral regarding the fair distribution of developmental opportunities hold 33% (14). More on this the unsatisfied respondents are 20 near to 50% as reflected in the table 4.11 below. The overall result showed that more than three-fourth of the respondents couldn’t confirm the developmental opportunities are fairly distributed among staffs of the bureau of health.

In association with the reactions given by staffs of the bureau health about the spreading nature of staff developmental opportunities against male and female respondents, the reflection had the following summary. The dissatisfaction level of male was stronger than that of female staffs: as

64% (18) of male were fall in the disagreed and strongly disagreed choice options whereas only 15% of female respondents (2) fall in the same options. 25% (7) and 54% (7) of male and female respondents respectively opted for the neutral choices. 87% (7) and 92% (11) respondents who strongly disagreed and disagreed were male staffs of the health bureau respectively.

Table 4.11 Summary of Fair Distribution of Staff Development Opportunity Disaggregated by Sex

Level of agreement	Sex		Total
	Female	Male	
Strongly Disagree	1	7	8
Disagree	1	11	12
Neutral	7	7	14
Agree	2	2	4
Strongly Agree	2	1	3
Total	13	28	41

Source: Own Survey, January 2015

The trend reversed at the aggregate levels of agreed while 10% (3) and 30% (4) replied with agreed and strongly agreed regarding the fair distribution of staff developmental opportunities in the bureau of health. Correspondingly 67% (2) and 50%, (2) were female respondents who went for strongly agree and agree to the point under discussion.

The maximum rate given for the availability of motivating benefit package is agreed, no one went for the strongly agreed option. This ‘agreed’ option was also selected by 30% (12) of the respondents. With regard to the acceptability of benefit packages the largest category of

Table 4.12 Summary of responses about Motivating Benefit Package Existed

Level of agreement	No	Percent
Strongly Disagree	3	7.50
Disagree	10	25.00
Neutral	15	37.50
Agree	12	30.00
Strongly Agree	0	00.00
Total	40	100.00

Source: Own Survey, January 2015

respondents preferred to remain neutral 37.5% (15) whereas those who went for disagreed in cumulative were 32.5% (13) respondents with 25% (10) disagreed and 7.5% (3) with strongly disagree. The worst of this had shown as no-single respondent could strongly agree about being motivated in the existed benefit package availed by the Addis Ababa bureau of health.

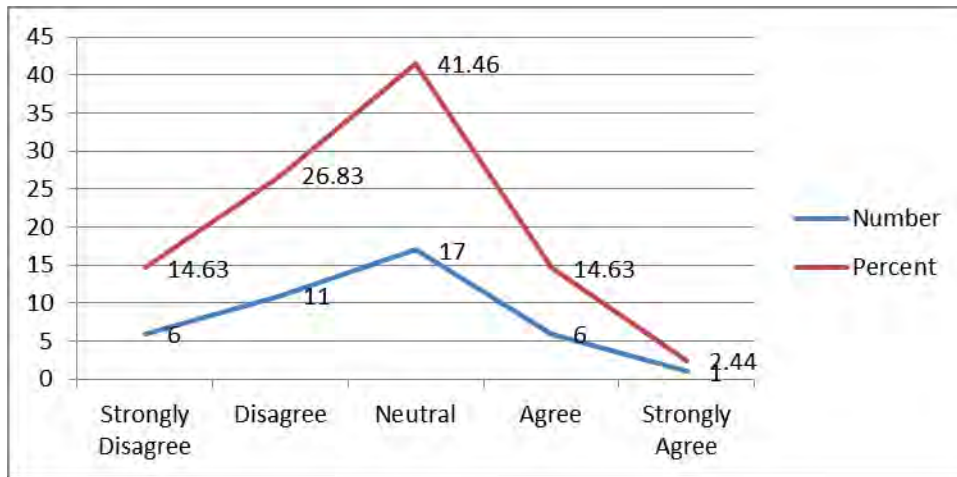
Representative of major donor agency for the Addis Ababa Health Bureau appreciated the recognition mechanisms arranged in a weekly base nomination of best performing staff, “Best performing staff of the week”. Awarding Model Urban Health Extension Workers and Model Households in practicing services given through the 16+health package by Urban Health Extension Workers are also among the most appreciated motivational approach applied by the health bureau as well.

Conflicting views are found on the subject of recognizing best performing staffs from each work units. Best performing staff of the week is selected and the name of the winner posted on the bureau’s Notice Board regularly to share the recognition to wider bureau’s community. This is among the best ways of organizationally motivating staffs as described but some have doubt about the transparency and reliability of the process that also affects the end result. The doubt is supported with complaints from the staffs. The doubt is justified as there are cases where the selected winner is not accepted by majority of staffs and the reason given out to this is unsatisfactory as it says ‘the selected staff is not qualified but designated just to motivate that employee to the future’. This also supports the subjectivity nature of motivational packages that lacks trusts from the staff side.

4.4.5 Flexibility to Maximize Accommodating Different Prospects

According to the figure below, about 17% (7) were agreed to the open space left out for innovation and creativity in doing their day to day activities. Among them again 15% (1, 7) only was strongly agreed and the 85% (6, 7) opted for the agreed choice out of the lists under Liker Scale measurement. About 42% of respondents (17) were fully intensely disagreed where 35% (6, 17) strongly disagreed supported by 65% (11, 17) categorized in the disagreed option. Those respondents designated in between option were also significant as they contained 41% (17) out of the total respondents.

Figure 4.12 Availability of Room for Innovation and Creativity



Source: Own Survey, January 2015

Those who were unable to confirm the availability of room for innovation and creativity in broad-spectrum are reached 83% (35) as these respondents either disagreed at different level or unwanted to inform their specific understanding. This implied that the staffs’ interest to be motivated for innovation and creativity was not yet getting conducive environment in the bureau of health.

However the advisor for the Bureau head differed slightly as he believes that there are rooms left for innovation and creativity on handling the planned activities by implementers. To the advisor, implementers can decide how to materialize the uniform goals and activities as per the specific context of the health institution or work unit; “the progression to deliver the listed activities-‘the how part’ is the place were innovative and creativity of actors can be reflected; once more this needs to be done without affecting the framework designed at the top.” He self-confessed conversely that everything should be accomplished in line with the direction and framework given by the bureau and no guarantee for resource allocation if then innovation and creativity might have cost implication.

About 40% (16) have agreed that team work among staffs of the bureau of health is appreciated; as 10% and 6% went for agreed and strongly agreed respectively. This figure is the evidence that significant number of respondents is comfortable in team working practice of the bureau of health.

Table 4.13 Summary about if team work is appreciated

Level of Agreement	Number	Percent	cumulative %
Strongly Disagree	1	2.44	2
Disagree	9	21.95	24
Neutral	15	36.59	61
Agree	10	24.39	85
Strongly Agree	6	14.63	100.0
Total	41	100.00	

Source: Own Survey, January 2015

The next highest category of response for measuring the existed trend of team work preferred to agree in average 37% (15) that shows these percent of respondents were not sure about the point under discussion. Still those who disagreed were not insignificant as it contains near to one-quarter (24%) of respondents as can be grasped in the table above.

Since there is a 1:5 group learning approach and the BPR tool that encourages team work to realize objectives of the bureau of health, it doesn't seem normal that near to 60% respondents were unable to recognize the availability of team work organizationally. More on that sharing experience, plan and review group as well as individual assignments regularly are conducted in a 1:5 group learning approach in the bureau of health according to the health bureau's strategic documents and key informants.

The bureau head debated that the system in place in the health sector in general is flexible and ready for accommodating changes. Bureau's performances evaluated as successful with the agreed criteria set jointly with Ministry of Health, the activity or the task either will be transferred to the appropriate body or to the next step. The bureau head supported his explanation with evidence "the 16-package basic health service program will be transferred to the model households and the current urban health extension workers will join health centers for professional health service provision with adequate additional training and coaching". He further stated that pro-active planning about the non-communicable diseases by the Addis Ababa Bureau of Health for instance is that the accessibility of health institution ensured at Addis Ababa city level, the minimum requirement one health center to the 40,000 population already met.

The bureau is rigorously following the BPR change tool and BSC for measuring changes since 2010. However most of non-health professionals didn't get guidance and tools to use both tools within their profession and the bureau's context in January 2015 yet. More on that both adopted tools are distributed to all staffs of the bureau of health concurrently, and challenges in operationalizing them at health centers and hospital levels reported frequently to the bureau. After 4 years of recurrent complaining, the bureau has initiated to change the way professionals in health institutions could better perform their duties using a revised tool of BPR and BSC compatible to each. The tool adaptation team leader confirmed that the proposed changes are ready to be submitted in late January 2015 to the Addis Ababa Bureau of Finance and Economic Development (BoFED) for approval. If the document can get approval by the BoFED, procedural measures will continue as the proposed changes will have budgetary implication and that might lead in missing the next fiscal period as well which will start as of July 8, 2015.

Existed trend shows that tools and frames are directly shared from the top to health actors under the direct supervision of the bureau. When there are inconveniences for applying fully or partly, reporting the case to the bureau along with supporting evidence usually takes extended time which affects the moral of the affected body or group and resource negatively. More on that if the case requires additional involvement of other government agencies over the higher level management of the bureau of health such as Addis Ababa BoFED, dealing with multiple realities got distresses. As a result experiencing the opportunity of reality created in a moment and there are multiple realities in the bureau of health at all level is tough. The advisor of the bureau contended that realities in the health bureau are created in frequent moments but the bureau doesn't perceive any curious measures to identify valuable inputs and purposefully applied from such diversified reality. This is expressive of facing the challenges of different reality and flexibility of handling the bureau's subject matter efficiently

Handling Matters arising from Performance Assessment Results

As per the human resource manual Performance Assessment of employees of the bureau of health conducted with two major components: organizational goal and employees' behavior. 80% of the evaluation component is made based on the individual performance directly measured against the 16 goals. All are defined permanently in line with quality, quantity and timeliness. Individual employee's contribution to the specific institution, process or case

evaluated using the format developed by the bureau of health. The cumulative result of each generate the employee’s performance status and finally the summation of all staffs, processes and units calculated as aggregate of the whole. The bureau of health’s level of performance against the 16 major objectives set then would be drawn up based on its part’s results.

The remaining 20% is fully committed to the behavioral characteristics of employees. It is also sub-divided in to 4, out of which 2 are self-evaluation by the employee her/himself and the rest are by immediate supervisor (1) and the work unit (1) where that employee belongs. The two self-evaluation components directly measure own empowerment plan (10%) and behavioral characteristics (5%). The case team or the process as a work unit also assesses every individual as its member (7%) and the immediate supervisor rate (out of 8%) the performance of his followers against the listed characteristics. As some the respondents wrote in the open ended questions what is written in the manual is perfect but unrealistic. Still others believed that the performance assessment is necessary and important but it is open for biasedness.

The performance assessment result is one of the key documents incorporated in the employees’ file. The employees have concerns as it is all about their employment and performance history in the bureau of health, consulted for promotion and other organizational benefits as well as for their future career development.

Within the framework of the performance assessment process in which about 15% is directly completed by the employee and the rest is done either by the team or by external bodies there might be some variation. To further explore the source of variation and mediate the dissatisfaction of employee, compliant procedure needs to be in place.

Table 4.14 Possibility of Complaints on Performance Assessment Grades

Level of Agreement	Number	Percent	Cumulative %
Strongly Disagree	4	9.76	10
Disagree	7	17.07	27
Neutral	12	29.27	56
Agree	13	31.71	89
Strongly Agree	5	12.20	100
Total	41	100.00	

Source: Own Survey, January 2015

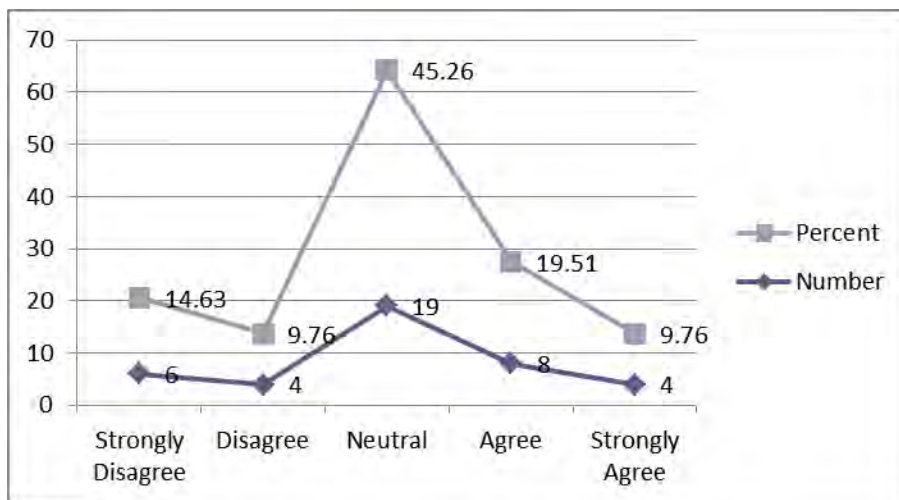
To get respondents understanding and experience in this regard a question was raised about the possibility of reporting complaints on performance assessment grade. 44% (18) were agreed in the availability of chances to inquire on the gaps they feel incorrect. Near to 30% (12) of respondents were neutral. On the other hand, a total of 27% (11) were not agree in the possibilities ready to be heard of any complaints staffs might have in relation to performance assessment grades, with 10% (4) and 17% (7) strongly disagreed and disagreed respectively.

The 27%, 29% and 44% disagreement, neutrality and agreement in general terms respectively implied that the environment in the bureau of health has room to comply deceptive issues materialized in association with performance assessment. This doesn't mean however that, respondents opted strongly differed and stayed in middle-of-the-road are unimportant since the percentage of these groups is above 50% as reflected in table 4.14 above.

4.4.6 Satisfaction in Existed Leadership Practice

It is clearly reflected that staffs of the bureau of health understand the leadership practice existed. All respondents, except one (2.4%), were confident enough to demonstrate their level of satisfaction in this leadership trend. Those who set average to decide their level of satisfaction were 45% (19) as portrayed in the diagram below. It implies that all most half of the respondents weren't ready to determine their frame of mind in relation to the availability of satisfactory leadership practice in their organization.

Figure 4.13 Summary of staff's satisfaction on existed leadership practice

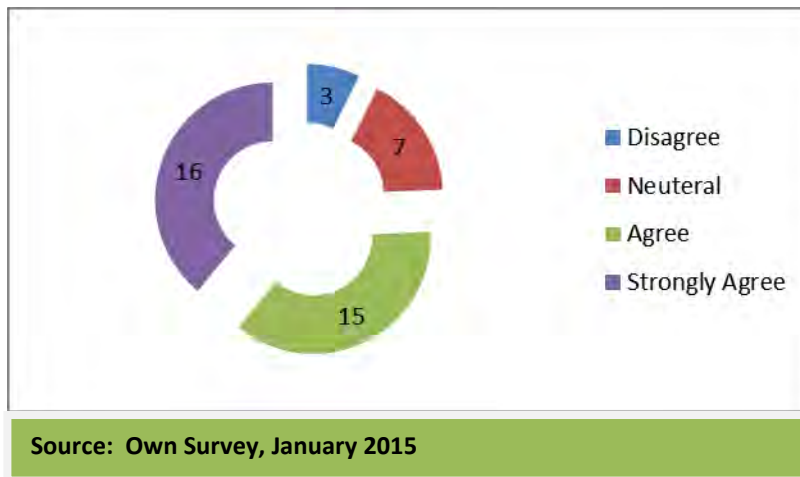


Source: Own Survey, January 2015

Whereas about 30% (12) were satisfied and 25% (10) were dissatisfied with the current leadership trend in the bureau of health. It is difficult to say that employees with low satisfaction will prefer to stay in the organization longer that might include those selected neutral in the Likert Scale measurement. This may result missing staffs with abundant experiences in which the bureau of health invested a lot over time if any corrective measures are not taken before long.

Following this, it might not be a coincidence that the improvement in leadership practice needed by staffs rated with agreed strongly and with just agreed were 39% (16) and 37% (15) respectively. While about the other 17% (7) were interested neither to propose it nor to disagree with the need of improvement in leadership trend.

Figure 4.14 Summary of response about the Need for Improvement in Leadership Practice



Only 7% (3) respondents are disagreed for the proposed idea of changes in current leadership practice is required. On top of this, none of the respondents were strongly disagreed with regard to point under discussion. the proposed idea regarding the need of improvement in leadership practice of the bureau of health.

The distribution in age category of respondents showed that those who disagreed 7% (3) were equally spread in the 26-30, the 36-40 and the 51-60 age categories. The strongly agreed and agreed groups are dominated by the 41-50 age category with 5 respondents to each. Nearly 24% of the respondents are from this category and none of them were selected different from the last two options that reflected leadership trend improvement is strongly required.

Table 1.15 Staff Response about Need of Leadership Trend Improvement against Age

Age category	Disagree	Neutral	Agree	Strongly Agree	Total
20-25	0	1	1	2	4
26-30	1	3	4	4	12
31-35	0	2	1	3	6
36-40	1	1	1	2	5
41-50	0	0	5	5	10
51-60	1	0	3	0	4
Total	3	7	15	16	41

Source: Own Survey, January 2015

It is also possible to observe that the 26-30 age category was opted for the need of leadership trend improvement as among the total 12 respondents of the same age category, 8 (67%) of them were selected the agreed and strongly agreed options.

Table 4.16 Staff Response about Need of Leadership Trend Improvement against Current position

Current Position	Disagree	Neutral	Agree	Strongly Agree	Total
Manager	0	0	0	4	4
MD/GP	0	0	2	0	2
PO	0	0	0	1	1
SPO	0	2	0	0	2
Nurse	0	1	0	2	3
Officer	0	3	9	3	15
Other	1	1	2	2	6
Total	1	7	13	12	33

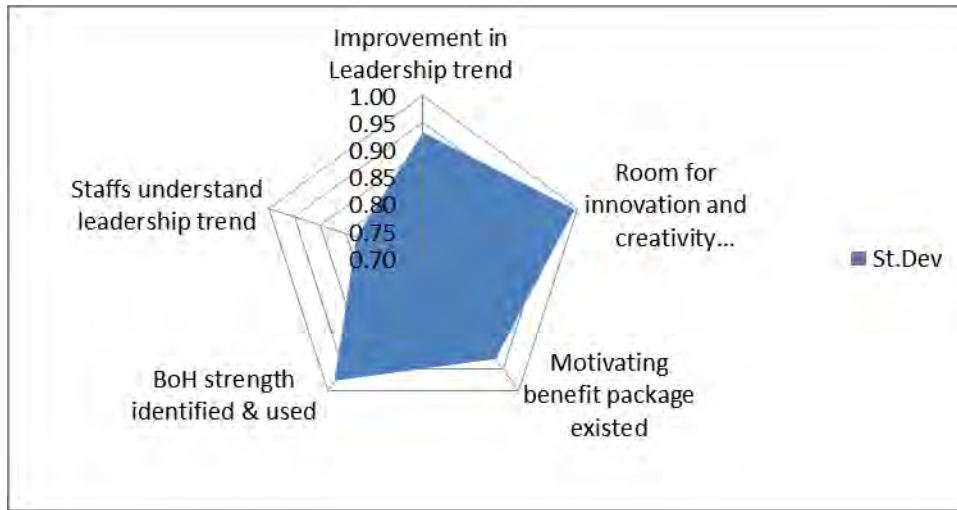
Source: Own Survey, January 2015

Among the 33 respondents who were willing to share their current position, those who needed the improvement regarding the current leadership trend of the bureau were officers as 80% (12 out of 15 respondents) of them replied for this question with agree (9) and strongly agree (3). The remaining 3 out of 15 opted for neutral. All Managers (4) and the process owner (1) were also strongly supporting the proposed leadership practice improvement. It is still possible to note that 76% (25) replied that they are in need of working environment in the bureau of health with improved leadership practice is far from moderate level.

Standard Deviation

Out of the 19 parameters presented in the Likert scale measurement type of question to respondents 5 of them are rated with below 1 standard deviation. In relative term the lowest deviation between alternatives implied that there is better agreement on the situation among respondents. The smallest gap observed with St. Dev of 0.83 in staffs understanding about the existed leadership trend. However the result is not that much far from the remaining parameters having lower results such as 0.93 (2), 0.98 and 0.99 all are still closer to 1 again as depicted in the diagram below.

Figure 4.15 Parameters with Lowest Standard Deviation

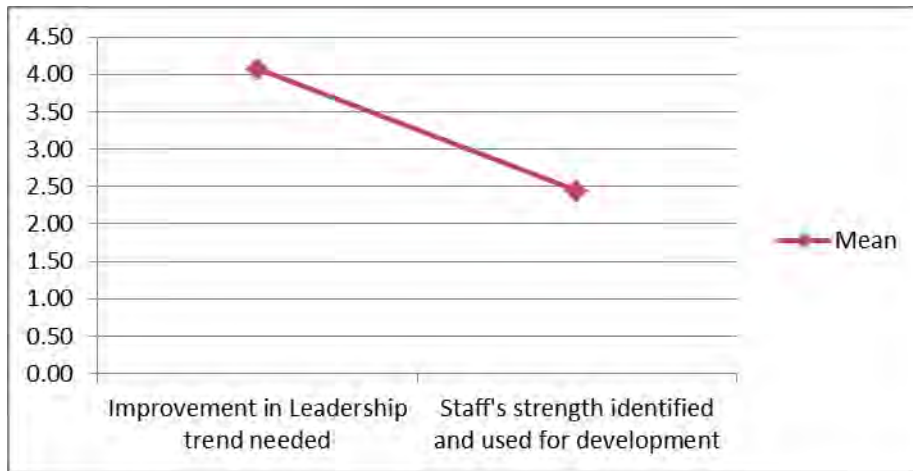


Source: Own Survey, January 2015

Mean Comparison

Mean results are reflecting between 4.07 and 2.44 the highest and the lowest among the Likert Scale type of questions. The highest 4.07 is associated with the importance of leadership practice improvement. This result implied that staffs are inquiring changes that can enhance the trend of existed leadership practice. On the contrary minimum mean is recorded with the identification and application of individual staffs strength for future development. This 2.44 mean also showed that near to 50% of respondents were waiting for the staff capacity development intervention.

Figure 4.13 the Lowest and the Highest Mean Results



Source: Own Survey, January 2015

Both results indicated the management of the bureau of health should give attention in the leadership practice and in investing staff development areas. Otherwise the success stories shared and the planned activities for future periods might not be realized.

Individual differences among staffs of the bureau of health are expected to be a reality due to many reasons. Valuing and using these differences for improving the quality of health service provision to the city of Addis Ababa and to fulfill the organizational objectives. However as three of key respondents confirmed there is no space to utilize the differences of individual staffs. The advisor put this case in a way that every supervisor and staff is likely to deliver any specified and obligatory tasks within the agreed distance among themselves. He added the feeling currently available is much of maintaining reasonable distances while no problem for meeting with limited and obligatory situations.

Similarly key stakeholders noted that biasedness between groups and individuals existed nonetheless efforts to deal with major differences of these bodies are not yet operationalized. This implies that the Addis Ababa bureau of health is unaware of valuing individual differences of staffs as well as work units and it is possible to note that the bureau is missing important and valuable benefits as a result of disregarding value differences. The value difference among staffs could potentially be motivating and inspiring their daily performance that affects the strong and long standing individual and group energy in realizing the bureau's objective.

The legal framework as depicted in the strategic document of the bureau of health as well as clearly stated in different versions of the Addis Negari Gazeta the Bureau of Health, Addis Ababa City Government is fully in line with the expectation of scholars in the public administration including Turnbull. Powers and functions of the Addis Ababa Bureau of Health in the governance perspective include reviewing strategy, leadership and service delivery (Turnbull, 2010). For instance the ten listed by Turnbull are linked with either one or more than one power and functions of the bureau stated in the Addis Negari Gazeta.

Chapter 5

5. Conclusion and Recommendation

5.1 Conclusion

Appreciative Inquiry as leadership model is defined as strength based where its previous success stories are leading future developmental direction the group, community and organization in a better way. The model gives emphasis on in-depth looking for the situation when the organization's performance excel and then capitalize on those key contributing factors. Valuing differences and internal capacity, constrictive way of probing for the future, willing to pick the best out of the past performance, curiosity on the language used and looking the other side of problems for learning are fundamentals of the AI model.

According to the descriptive analysis, among the recognized organizational values the shared vision of the Addis Ababa Bureau of Health is weighed more. About one-third of respondents believed that there is shared organizational value which is very important and crucial as the Addis Ababa Bureau of Health can use it for strengthening staffs and other stakeholders' commitment to the future organizational development. The other values confirmed its existence though picked by the least proportion of respondents are constructively probing for the future and valuing individual difference for the best interest of the organization and its employees. These values can boost the human asset of the bureau of health that is among the fundamental resources for improving the Addis Ababa Bureau of Health future advancement.

There are plentiful success stories shared by the bureau. The stories comprise diversified types such as households, individual staffs like Urban Health Extension Workers and accessibility of health service to the community at grass root level. More on that there are still auxiliary un-tolled success stories and best practices at hospital, health centers, colleges and laboratories under the Addis Ababa Health Bureau supervision that can increase the type and number of achievements from the bureau's performance. To craft the strength based working environment, there are more than enough stories from the past performances of the bureau of health as a public agency working in Ethiopia, Addis Ababa.

The bureau understands the add-up values on specific areas when the role modeling approach is functional. It is possible to fully extend this trend for acknowledging best performing

individuals, work units, institutions and the bureau itself. Such an action endorses the capacity of the bureau of health to realize the assumption about the organization has more confidence to its future journey when it carries forward parts of what was best in the past.

There is strong limitation in both documenting the bureau's learning at all level as well as utilizing what is documented for informed and evidence based decision making in the bureau of health. To get the existed practice capturing and sharing learning emanated from performances is practiced in a limited way. Above all the study found out that the bureau is unable to utilize all documented learning for informed decision.

The bureau showed its interest to install "Woreda-Based" system to foster extraordinary participation including community. However, it doesn't seem that the interest is materialized as quantitative finding implied that about 50% of respondents are not happy with their participation in organizational matters. And yet the bureau can use the remaining half percent of the respondents' participation experience and identifying those contributing factors for those positive feeling to build up on the trend with the aim of addressing the gaps noted by the unsatisfied respondents. Otherwise this might entail the decisions of the bureau is missing valuable inputs and concerns from those feel unhappy about their level of participation as experienced and skilled staffs of the bureau of health. Male staffs as compared to their female counterparts are mostly dissatisfied as per the result of the quantitative data collected for this research paper.

The qualitative data articulated further about participatory nature leadership practice respecting the framework given from the top level management in two ways. The first one is that the regional bureau's has mandate to prioritize their activities within the objective and framework presented by the Ministry of Health. For this the bureau put its experience in shifting with some of the objectives such as entering into the health extension program after 7 years when the Ministry introduced. The other justification for participatory nature of leadership is that the sector is using Woreda-Based planning approach. This is with the aim of ensuring the participation of all actors including those at grass root level. According to the qualitative data the sum total of all these actors planning and evaluation yield the bureau level performance results. This is to mean that the bureau can't reject their participation though the qualitative data and the secondary data such as the strategic documents are significantly go-far beyond supporting the availability of such practices in the bureau of health.

The availability of spaces for innovation and creativity is minimal as the left out room in this regard is to determine how to implement the listed objectives and activities as per the national framework. Though each activity are shared from the bureau level, health institutions such as hospitals, health centers and Pharmacia agencies are allowed to apply a different methodology if believed that is appropriate the specific context. Since there is resource constraint including budget and staff time to initiate different methodology the left out space to creativity and innovation is restrictive by itself.

Role modeling and recognizing best performers are well acknowledged by both qualitative and quantitative sources though there are identified gaps. The limited staffs' developmental opportunities are not fairly distributed between employees of the bureau of health as per the qualitative data findings. Designing intervention to create staff developmental opportunities along with attractive benefit packages as part of staffs' motivation is partly missed.

Staffs understand the current leadership trend under operation in which most are less satisfied. Only 30% of respondents showed that they are satisfied with the existed leadership practice. This has the potential to lead unsatisfied staffs to look other options as means of ensuring livelihood and developing their professional career. And most of them confirmed that the leadership practice needs improvement so as to increase staffs participation, increase the accessibility and impartiality of staff development opportunities and using the bureau's achievement to the growth and development of its staff.

Staffs have good understanding on the inevitability of the bureau to invest in leadership capacity building to professionals working in the health bureau. It is indicated by the respondents that leadership capacity building efforts have got acceptance. The government attention, the health professionals' interest and the sector's alertness in this regard met as per the understanding and knowledge of respondents. Nonetheless the leadership related capacity building opportunities are marginalized as those trained in leadership development area at least for once are only 38% of the respondents.

It seems that the team work approach currently applied in the bureau of health required revision as more than 60% of respondents were not comfortably answered that it is appreciated by the working environment of the bureau. As long as the 1:5 learning group and similar team work

approach is used to exert joint effort, it needs to be with the good understanding and interest of the staffs. Furthermore the study found out that the written document of employees' performance assessment in light of its purpose and procedures are appreciated. However respondents indicated that what is written is not fully applied during performance assessment which creates dissatisfaction and distrust among the respondents as they witnessed the application is open for subjectivity and biasedness.

Keeping the differences in being familiar with and practicing with or without knowing the theoretical perspective of the model, most fundamental assumptions of Appreciative Inquiry Leadership Model is available.

To strengthen the existed trend and to help the Addis Ababa Bureau of Health in benefiting more the Appreciative Inquiry Leadership Model is applicable in general.

Specifically to strengthen the following valuable and important practices in the bureau the Appreciative Inquiry is the best Model:

- To bridge the gaps noted such as limitation in collecting success stories, documenting them and referring them for future organizational development;
- To enhance the participation of staffs working at all levels in major decisions such as preparation of strategic plans and evaluating annual operational plans so as to get their expertise and observation about health service delivery of the Addis Ababa Health Bureau;
- To enhance the benefit from the existed role modeling practice in the health bureau;
- To enhance the motivation, creativity and innovation capacity of staffs for future organizational development;
- To secure the staffs understanding on the efforts of the management of the bureau of health apart from the shared organizational vision;
- To raise the rehearsal of constructive way of probing the future, deliberate use of selected language, and valuing individual differences to dispose conducive working environment;

- To build the bureau that is preferred as the topmost organization by staffs, to excel health clients' satisfaction in quality service delivery, and as role model by other public agencies;

5.2 Recommendation

The Addis Ababa Bureau of Health should capture, document and use all success stories from each of its stakeholders (both internal and external) for future planning as these are basic foundation for the Appreciative Inquiry leadership Model.

Since the bureau is responsible to guide, control and provide technical support to health actors performing in the City of Addis Ababa, the bureau's planning, execution and results of interventions need to be fully documented. These documents need to be distributed timely to appropriate bodies, consulted for next period planning and do subsequent tracking to ensure the built-up on what goes well as suitable.

The bureau should deliberately work to reinforce the strength base approach to encourage the performance of every individual, work unit and the bureau of itself. The role modeling of urban extension health workers and the households these health extension workers are supporting should be replicated in other regular duties of the bureau of health at all level. Acknowledging the best capacity and trying to capitalize on this capacity to discharge the undesired weakness of the performance must be accepted as major value of the bureau of health.

The bureau should give special emphasis to enhance the deliberate action on major appreciative inquiry elements such as there is something in the bureau that makes the performances of the bureau successful; valuing individual differences; and realities are created in a moment & there are multiple realities in the bureau of health. These elements are among the least acknowledged once among the 8 assumptions of Appreciative Inquiry Leadership Model.

The bureau of health should take strategic steps in applying the Appreciative Inquiry Leadership Model as it helps for creative and innovative way of handling assignments. It also addresses the gaps noted on participatory nature of the existed leadership practice. Opportunities should be created to its staff about the concept of the model, internalizing it and contextually designing to the bureau of health must be among the priority agenda of the bureau.

The bureau should be aware of that there is visible demand on the leadership practice change by the staff. Apart measuring the objectives achieved and the additional efforts required to reach the bureau's vision, the human element as critical asset to the sector should be heard and necessary assistances should be taken to mutual satisfaction.

As organization being familiar with the process of Appreciative Inquiry Model as it has ways to address most of the necessary improvements keeping the achievements so far recorded.

The government commitment to the health sector and the staffs' interest on skilled man power on leadership should be used as a good opportunity to invest in the concept. The bureau has potential to influence the appropriate stakeholders both state and not state actors to get resources to apply the Appreciative Inquiry Model.

5.2.1 Future Research Area

- Further study needs to be conducted to found the substantial reason for gender discrepancy regarding the existed leadership practice of the city administration of Addis Ababa, Bureau of health. This is due to results found out male staffs more than the female, are very sensitive for the unavailability of participatory leadership practice and unfair distribution of staff capacity development opportunities among staffs of the bureau of health.
- Though it is not one of the set objective by the researcher, the result found out that reasonable percent of respondents confirmed that the Addis Ababa Bureau of Health need to be led exclusively by health professionals. It is commendable to dig out their justifiable reason and identify the pros and consequences of leading the sector by health professionals only
- The study found out that significant numbers of respondents are pro-change in current leadership practice. The leadership change required need to be further studied: to identify the justification to change, the type of change demanded and the desired outcome after the leadership practice change.

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Annex

Annex 1: Questionnaire Administered by health experts and support staffs of Addis Ababa Bureau of Health, at Bureau level

Addis Ababa University-School of Graduate Study

Faculty of Business and Economics

Department of Public Administration and Development Management

Dear Respondent;

My name is Haimanot Kagnew, Candidate for Master of Public Policy and Management (MPMP). My research topic is on “The Applicability of Appreciative Inquiry as Leadership Model in Public Agencies: The Case of Health Bureau of Addis Ababa City Administration”. In that context, I have identified the need to collect data on the leadership practice of the Addis Ababa Bureau of Health from knowledgeable practitioners interested in the subject matter. I have designed twelve questions related to the topic of my study in the leadership practice of Addis Ababa Health Bureau. I am confident that your contribution to this research thesis is great and the opinions you share regarding the topic of study is essential for the findings.

This questionnaire administration may take about 25 minutes to complete. Please note that writing your name is not essential. I assure you that the information to be shared by you will be used only for academic purpose and shall be kept confidential and private.

As you are the appropriate informant representing staffs of the Addis Ababa Health Bureau in one of its structure, I would like to ask you kindly to get your consent for your thoughtful cooperation. Will you agree to reply to the questionnaire items?

a) Yes

b) No

If your choice is “Yes”, please proceed to the next part of the questionnaire,

If your choice is ”No”, we appreciate the time you commit so far with us, please return this paper to us. Thank you very much

For your consent, I thank you very much!

II-Survey Questions

For some questions, response choices have been provided. You may kindly circle the in the letter having your response; whereas for some others you may need to provide your response using your own words. If you need additional space please use the back of the questionnaire and include the question number as appropriate.

2.1 What do you like most about your current position that encouraged you to stay?

(You can give multiple answers)

- a) The decision making power
- b) The service provision role to clients
- c) the facilitation role
- d) Because I have nowhere to go
- e) Serving my organization according to its goal
- f) Having better salary
- g) The networking access with a variety of people

If other, please specify _____

2.2 As you engaged experts in the health system, what stands out for you as a high point when you were part of an outstanding organizational effort in the health system? (You can give multiple answers)

- a) My active participation for outstanding effort
- b) The contribution of this outstanding effort for our next period performance
- c) The space I get for my professional career
- d) The process we gone through itself
- e) The growth and empowerment opportunities then after
- f) Its contribution for the achievement of our organization's goal

If other Please specify _____

2.3 What do you consider some of the most significant value trends, events, and developments shaping the future of your organization? (You can give multiple answers)

- a) Shared vision
- b) Trust in staffs capacity
- c) Learning from organizational success
- d) Value individual differences

e) Constrictively probing for the future

If other, please write it _____

2.4 What do you feel are the most promising areas in order of importance in which to expand the collaboration between supervisors and supervisees in your organization (rank from 1-7 in front of each choice; note that 1 represents your first best choice)

- a) Timely sharing of information _____
 - b) Regular supervision and feedback provision _____
 - c) Incentive system _____
 - d) Acknowledge what has been achieved by different mechanisms _____
 - e) Organize social events/committee _____
 - f) Arrange career development options _____
 - g) Improve group works, team building and shared responsibilities _____
- (Please write your justification for marking the number one rank you have made)

5.5 What do you consider is the best reason the health bureau should invest in building staffs leadership capacity? (You can give multiple answers)

- a) The challenges in the sector are sensitive
- b) Government has special interest in the sector
- c) The staff needs it
- d) There is donor budget for this purpose
- e) Everybody should see leadership challenges
- f) It empowers health professionals in leading
- g) Sector should be led by health professional

If you have any other reasons please write:

2.6 To whom is the capacity building in the leadership case MOST productively made?

- a) Medical professionals
- b) Administrative staffs
- c) Top level managers
- d) Middle level managers
- e) lower level experts
- f) Equally important to all

2.11 Please indicate the existing leadership practice in each of the four categorized points by placing a tick mark in one of the boxes in front of it. Note that 1= Strongly disagree; 2=Disagree; 3= Neutral; 4=Agree; and 5= Strongly Agree

Measuring leadership practice as experienced by Staffs of BoH

No	Noticed factors	Likert Scales				
		1	2	3	4	5
1	Existed leadership practice in the bureau of health is participatory in nature					
2	The way of asking each other is very constructive that led to some possibilities and achievements					
3	In daily routines, staffs are sharing the feeling of there is something that works all the time					
4	Differences in attitude and choices are always valued at most effort					
5	Past achievements of the bureau are shared proudly by many staffs					
6	Past problems and mistakes of the bureau are shared repeatedly by many staffs					
7	Individual staffs' strengths are always identified and considered for recognition and staff development					
8	The bureau's strength is always identified and considered for future organizational development					
9	Staff understands the leadership trend well					
10	Staff are consulted in major decisions made by management committee					
11	Staff development opportunities are distributed fairly within the bureau					
12	If staff is not satisfied with the result of performance assessment, it is possible to complain to the next level					
13	Staff satisfied with the leadership practice in the bureau of health					
14	Staffs need to propose improvements on leadership practice in the bureau of health					
15	Team work is appreciated in the bureau					
16	There is room for Innovation and creativity in the bureau					
17	Existed benefit package is motivating staffs					
18	Organizational learning is always documented					
19	Are these organizational learning used for planning for next physical period					

Thank you very much for committing your time to share your honest understanding and knowledge.

Annex 2: Part B- Key Informant Interview

Addis Ababa University

School of Graduate Study

Faculty of Business and Economics

Department of Public Administration and Development Management

Dear Interviewee;

My name is Haimanot Kagnew, Candidate for Master of Public Policy and Management (MPMP). My research topic is on “The Applicability of Appreciative Inquiry as Leadership Model in Public Agencies: The Case of Health Bureau of Addis Ababa City Administration”. In that context, I have identified the need to collect data on the leadership practice of the Addis Ababa Bureau of Health from knowledgeable practitioners interested in the subject matter. I have designed ten questions related to the topic of my study in the leadership practice of Addis Ababa Health Bureau. I am confident that your contribution to this research thesis is great and the opinions you share regarding the topic of study is essential for the findings.

This key informant interview process may take about an hour or less. I assure you that the information to be shared by you will be used only for academic purpose and shall be kept strictly confidential and private.

You are chosen as appropriate informant and the information you share will be analyzed at the level of the Bureau of Health of Addis Ababa City Administration. I would like to ask you kindly to proceed for your thoughtful cooperation. If you have any information you forgot to tell me during the interview, please feel free to call me by 09-11-66-09-11 including issues of clarity, if, in any case, you will have after the conclusion of our sessions.

For your consent, I thank you very much!

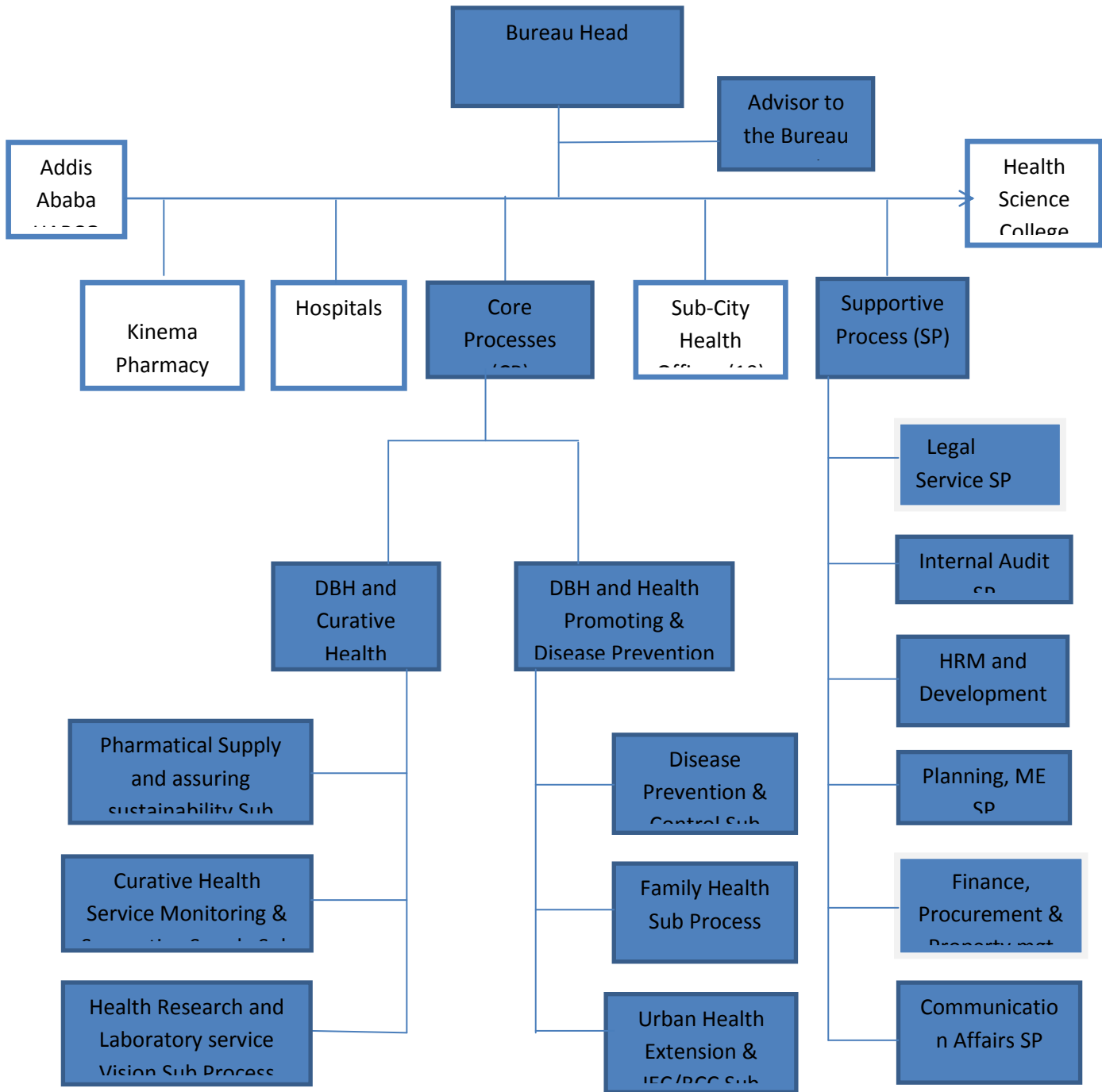
Content of interview

1. Experience of inspiration: Tell me about the best times that you have had with Addis Ababa Bureau of Health. Looking at your entire experience in the health sector, recall a time when you felt most alive, most involved, or most excited about your involvement. What made it an exciting experience? Who was involved? Describe the event in detail.
 - Any of the processes or story documented,
 - If so is it shared to anyone, how did you do it, what was the feedback from the other side?
2. Values: What are the things you value deeply -- specifically, the things you value about yourself, your work, and your team/group in your current working place?
 - Your observation in language usage during office (both formal, informal) level communication
 - The way ask staffs and you are asked by staffs; for accomplished, unaccomplished stuffs/performance; to take absence of leave; vehicle service
3. Core Life-Giving Factor: What do you think is the core life-giving factor of the environment you are working in? What is it that, if it did not exist, would make your team/organization totally different than it currently is?
 - How do you manage/see obstacles, problems, mistakes happened
 - Is there any different perspective than you had at that time
4. Wishes: If you had three wishes for your organization), what would they be?
5. Competence: Your competency to lead your team: the use of best practices of the past in the leadership practice, your freedom and interest in the process of handling your leadership assignment such as reviewing institutional learning, knowledge management and conduct regular meetings. Tell me about a time when you felt decisions were made in a participatory way. What was happening? How did this make people feel?
6. Participation: Existing practice to engage staffs in organizational development issues (setting/revising shared vision, believe in internal capacity);
 - How do you get the ideas of the lower level staffs and the team working physically far from your area, bureau such as HEW

7. Role modeling: Your role in facilitating and coordinating for organizational success (team work, communication process, value differences)
 - AMOL (assist, model, organize, leave): How the supportive supervision trend looks in your leadership role (identify individual strengths and assists to lift up) and
8. Imagine a time in the future when people look to Addis Ababa Health Bureau as an exceptional example of a thriving, attractive public agency where all staffs engage as leaders and see themselves as owners of the health system of the city.
 - In this exciting future, how will you imagine the staffs are engaged in the organization's vision setting?
 - What is true of the bureau's leaders at all level? What is sustaining their dedication?
 - What kinds of systems and structures are most encouraging staffs' engagements?
 - What are you most proud of having helped your organization to accomplish this success

Thank you again,

Annex 3 Overall Structure of Bureau of health, Addis Ababa City Government



Source: Addis Ababa Bureau of Health, 2014

Annex 4:-The Analysis Framework of the Applicability of Appreciative Inquiry as Leadership Model in Public Agencies specific to Addis Ababa Health Bureau

<p>Situational Context of Bureau of Health</p>	<p>The leadership practice of the Bureau of health is directly influenced by the Government of Ethiopia and Ministry of Health; goals are shared; leadership approach is given nationally designed; currently the bureau of health is starting to use BSC as measurement tool; the existed leadership trend in general shows that task oriented instead of putting staffs at the center; performance assessment focused on what is missed instead of what is achieved; delivery of tasks as requirement where there is no attention given for innovation and creativity</p>			
<p>4 Research questions</p>	<p>Factor of Analysis: the 4D-AI Model using the 8 Assumptions of Appreciative Inquiry</p>	<p>4 Unique Features of AI</p>	<p>BSC Pillars of the BoH</p>	<p>Outcomes of the Assessment</p>
<p>- What leadership practices are habituated by leaders of Health bureau of the city?</p>	<p>1) In the bureau of health there is something that works 2) The act of asking question in the Addis Ababa Bureau of Health, influence the staffs in someway 3) Staffs of the bureau of health have more confidence to journey to the future when they carry forward parts of their past; 4) The bureau picks what is best about the past 5) Differences are valued as one of the important factor of the bureau</p>	<p>- Capacities and contexts flexibility considered - Higher participatory nature - Strength and asset based leadership</p>	<p>- Internal Process - Growth and Empowerment - Finance</p>	<p>- Leadership practice improved - Participatory nature of leadership practice enhanced - Organizational strengths identified</p>
<p>- Do employees observe the leadership approach effective and motivating?</p>	<p>1) The act of asking question in the Addis Ababa Bureau of Health, influence the staffs in someway 2) Staffs of the bureau of health have more confidence to journey to the future when they carry forward parts of their past; when they carry, 3) The bureau picks what is best about the past 4) Differences are valued as one of the important factor of the bureau 5) The language staffs of the Bureau of Health use creates their reality 6) There is multiple reality in the Bureau of health</p>	<p>- Problems are observed from other-side - Higher participatory nature - Based on strength and assets</p>	<p>- Internal Process - Growth and Empowerment</p>	<p>-Staffs satisfaction in the leadership approach understood - Staffs willingness to understand AI Model observed - Spaces given to staffs by the organization perceived - Staffs commitment to the health service provision increased</p>
<p>- Is AI leadership model (knowledge, skill & attitude) applied in health bureau?</p>	<p>1) In the bureau of health there is something that works 2) The act of asking question in the Addis Ababa Bureau of Health, influence the staffs in someway 3) The bureau picks what is best about the past 4) The language staffs of the Bureau of Health use creates their reality 5) What the staffs of the bureau focuses become their reality 6) There is multiple reality in the Bureau of health</p>	<p>- Problems are observed from other-side - Capacities and contexts flexibility considered - Higher participatory nature - Based on strength and assets</p>	<p>- Internal Process - Finance - Growth and Empowerment</p>	<p>- The existed leadership practice against the AI model studied - The knowledge, skill and attitude of health bureau's staffs participated in the research process</p>

				enhanced - Possibilities to AI model interventions introduced
- What opportunities are observed in applying AI for improving service provision, staff motivation and organizational learning?	<ol style="list-style-type: none"> 1) In the bureau of health there is something that works 2) The act of asking question in the Addis Ababa Bureau of Health, influence the staffs in someway 3) Staffs of the bureau of health have more confidence to journey to the future when they carry forward parts of their past; when they carry, 4) The bureau picks what is best about the past 5) Differences are valued as one of the important factor of the bureau 6) The language staffs of the Bureau of Health use creates their reality 7) What the staffs of the bureau focuses become their reality 8) There is multiple reality in the Bureau of health 	<ul style="list-style-type: none"> - Observing problems from other-side - In considering capacities and contexts flexibility - The highest level of staffs participation in organizational issue - Building working environment based on strength and assets 	<ul style="list-style-type: none"> - Internal Process - Finance - Growth and Empowerment 	<p>What opportunities are observed in</p> <ul style="list-style-type: none"> - In documenting and sharing success stories and building up on them - In Staff team work, innovation, motivation and - Organizational learning and development improved

Source: Developed by the Researcher, October 2014

Annex 5: Distribution of health professionals in public sector in the city Administration of Addis Ababa, Bureau of Health 2012/2013 (2005 EFY)

No	Profession	Number
1	Specialists of all type	314
2	General practitioner	201
3	Health officer	606
4	Pharmacist	231
5	Pharmacy technician	360
6	Nurse(Bsc)	1138
7	Clinical Nurse(Dip)	2426
8	Midwife(Dip + Bsc)	416
9	All Nurses	3980
10	Lab Technologist	220
11	Lab Technician	358
12	Radiologist	30
13	Radiology Technician(X-ray)	26
14	Environmental Health(Dip+ BSc)	137
15	Health Extension Workers	1407
Total		11850

Source: Addis Ababa Bureau of Health, Dec 2014

Annex 6:- Type and number of health and educational facilities in the city by ownership, Addis Ababa City Administration 2014/15 (2007 EFY)

Type of HF	AACAHB	Federal	Army	Police	Private	NGO	Total
Hospital	6	5	1	1	35	2	50
Health Center	103	0	0	0	0	0	103
Clinics all type	-	0	0	0	692	31	723
Pharmacies and Drug stores	17	-	-	-	756	-	773
Public health Lab	1	-	-	-	-	-	1
Health science college	1	-	-	-	-	-	1
Medical college	1	-	-	-	40	-	41

Source: Addis Ababa Bureau of Health, Dec 2014