Addis Ababa University
School of Graduate Studies College of Business and Economics

Assessment of Institutional Capacity in the implementation of Health policy: the case of Bishoftu City Health office/General Hospital

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DECLARATION

I, **Geleta Lemessa Dufera**, declare the thesis entitled: **Assessment of Institutional Capacity in the implementation of Health policy: the case of Bishoftu City Health office/General Hospital** is my original work, prepared under the guidance of Dr. Frehiwot G/Hiwot Araya (PhD). All sources of materials used for the thesis have been duly acknowledged. I further confirm that the thesis has not been submitted either in part or in full to any other higher learning institution for the purpose of earning any degree.

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Signature & Date

DEDICATION

This piece of work is dedicated to my parents for their selfless support, constant encouragement and inspiration toward in pursuit of my academic ambitions.

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Above all, my deepest thank goes to Almighty God for always he is with me in all my day to day undertakings and giving me strength to complete my study. I would also like to thank my advisor Dr.Frehiwot G/Hiwot Araya who oversaw my work from the inception to the end and was extremely supportive throughout.

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Acronyms

CDC	**Community Development Corporation**
CPD	**continuing professional development**
CRWRC	**Christian Reformed World Relief Committee**
CSA	**Central Statics Agency**
CSTS	**Child Survival Technical Support**
DH	**District Hospitals**
EPRDF	**Ethiopian People's Revolutionary Democratic Front**
GTP	**Growth and Transformation Plan**
HC	**Health Center**
HEW	**Health Extension Workers**
HMIS	**Health Management Information System**
HP	**Health Post**
HSDP	**Health Sector Development program**
IDF	**Institutional Development Framework**
ISA	**Institutional Strength Assessment**
ISR	**Institutional Self Reliance**
MSI	**Management Systems International**
NGO	**Non-governmental Organizations**
OCAT	**Organizational Assessment Capacity Tool**
OCI	**Organizational Capacity Indicator**
OGO	**Other Government Organizations**
PHCU	**Primary Health Care Units**
SH	**Specialized Hospitals**
TTAP	**Training and Technical Assistance Plan**
UNDP	**United Nation Development Program**
WHO	**World Health Organization**
ZH	**Zonal Hospitals**

Abstract

The objective of this paper is to investigate the institutional capacity of health in the implementing national policy of Ethiopian Health, in case of Bishoftu town. Survey questionnaire was administered for 133 sample respondents that were selected using multistage cluster sampling. In doing this, both qualitative and quantitative data were used in order to explore and describe the capacity of local government in Bishoftu town. The study found out that despite the commitment of the government to implement the policy in all tiers of health institution, the government failed to effectively institutionalize the national policy in the local government in the way that could respond to the users need. As such health institutions in the Town have failed to address the problem of health service delivery due to a number of capacity challenges and problems in their jurisdiction. The health institution in Bishoftu town suffer from limited institutional capacity such as shortage of human resource professionals and experts; lack of adequate material resource such as finance, office equipment's and building for permanent office; limited policy knowledge and understanding, lack of institutional experience are among the capacity problems faced by the governments in the town in discharging their responsibilities. This in turn resulted in poor quality service to the community in general. In order to improve the capacity of the actor in the town government must consider and reconsider the local levels in the national policy and establish strong institution at the grass root level to make the service more responsive to the community.

Key words: ***Institutional Capacity, Institution, Health Policy and Policy Implementation***

Chapter One: - Introduction

1.1. Background of the Paper

Different institutions are established and there existed in local level to implement the national policies formulated at center by the federal government. These institutions have their own structure and resources needed for the effective implementation of national policies. Particularly, while new policies are formulated, different institutional set up, which is responsible to handle these policies has to be established. These institutional set up have to be stretched from the point where policy is formulated to the point where policy is implemented. There has to be a link that integrates different institutions exists at different levels to implement policy (Willems and Baumert, et.al, 2003).

As such, overall organizational capacity is very important for both policy formulation and policy implementation of a given nation. For example, according to Grindle and Thomas (1990), the successful policy implementation will depend on the prevalence of institutional strength and political will. An excellent policy formulation with excellent policy tools may not be sufficient condition for the fulfillment of the policy objectives. There must be institutions that effectively implement the policy to bring an excellent policy outcome unless otherwise, the policy remains on the paper without bringing fruitful result for a target group. In short, the successful implementation of policy highly and critically depends on clarity of the policy, local capacity and the commitment of the policy implementers (Narendra Raj Paudel, 2009).

In Ethiopia, several policies have been formulated and developed both at national and sectoral levels to respond to the Health‟s issues particularly with coming of EPRDF to the power (since, 1991). The past policy frameworks that formulated in the past regimes were also amended and renewed to give greater consideration to the health‟s issues. The concern of this paper is the National Policy of Ethiopia Health which established in 1993 was developed following a critical examination of the nature, magnitude and root causes of the prevailing health problems of the country and awareness of newly emerging health problems and issued of its health policy in 1993, which emphasizes the importance of achieving access to a basic package of quality primary health care service by all segments of the population, using the decentralized state of governance. The health policy stipulates that the health services should include preventive, promotive and curative components. The new policy was founded on commitment to democracy,

the rights of the people and decentralization as the most appropriate system of government for the full exercise of these rights and powers in a pluralistic society *(Transitional Government of Ethiopia (TGE), 1993).*

In order to achieve the goals of the health policy, a twenty year health sector development strategy has been formulated, which is being implemented through divided in four series of five year HSDPs I to IV since 1997. The implementation of the first health sector development program (HSDP) was launched in 1997 and now the fifth HSDP is under way. Currently, the health sector is developing a long term strategy "visioning Ethiopia towards universal health coverage through primary health care" and medium term strategic plan for 2015/16-2019/20 "the health sector transformation plan". The main trust of the HSDP implementation is based on sector-wide approach, encompassing the following eight components. This includes: - service delivery and quality of care, health facility rehabilitation and expansion, human resource development, pharmaceutical services, information, education and communication, health sector management and management of information systems, monitoring and evaluation and health care financing (*Ethiopian Health Sector Transformation Plan*, 20015)

Particularly, while new policies are formulated, different institutional set up, which is responsible to handle these policies has to be established. These institution set up have to be stretched from the point where policy is formulated to the point where policy is implemented. There has to be a link that integrates different institutions exists at different levels to implement policy (Willems and Baumert, et.al, 2003).

The health service delivery in Ethiopia is restructured into three tier system: consisting of Primary Health Care Units (PHCU), General Hospital (GH) and Specialized Hospitals (SH). The health service of the country is decentralized and Woreda health institutions have the right and responsibility of managing the health services delivery and control their budget (*Ibid*).

This paper assess the institutional capacity of health in the implementation of national health policy on health institutional with a special reference to institutions, equipment‟s; human resources, resource allocation and utilization their ability to deliver service to realize the policy, the knowledge on the policy, accessibility to the society and the interactions among those actor in Bishoftu town. Bishoftu town is ranked as the first in its reform status among City/Town in Oromia Regional State and located at about 47 km east of Addis Ababa. It is a tourist center town surrounded by natural lakes and fast growing towns in the region. It was estimated that

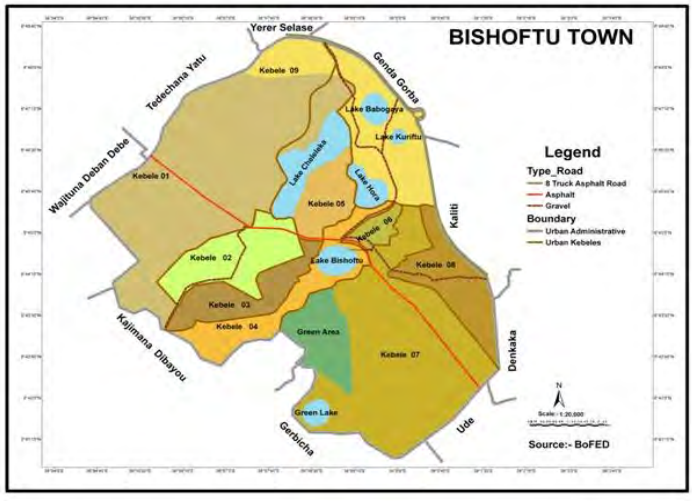
currently the number of population reached 147,100 according to (2015 Central statics Agency Website). Even if it is currently a fast growing and Tourist center Town, there are a numbers of social, economic and infrastructural problems in the Town.

1.2. Background of the Study Area

Bishoftu is located in Oromia National Regional State, East Shewa Zone at a distance of 47 Km from Addis Ababa. Its astronomical location is 8º 43‟- 8º 45‟ North Latitude & 38º 56‟- 39º 01‟ East Longitude. The town was founded in 1917GC. Bishoftu is one of the reform towns in the region and has a city administration, municipality and nine kebeles. The town has its own administration structure plan which was prepared in 2010 GC.

The area of the town is 15,273 hectare of land and it has a compact shape. Its altitude is 1900 - 1995 m above sea level; the Mean Annual Temperature is 27ºC and Mean annual rainfall is 746.6 mm. The prevailing wind direction is from East to West. According to the National Population and Housing Census carried out in 2007, the population of the town was 99,928. Out of these, 47,860 (47.8%) were males and 52,068 (52%) were females. Regarding age distribution 27,568 (27.58%) were within the age group of 0-15 years, 66,501(66.5%) 16-60 years, and 5,859 (5.86%) 60 years and above. The population growth rate of the town at medium variant is 2.9% while the average household size in the town is calculated to be 3.7%. It was estimated that currently the number of population reached 147,100 according to *(2015 Central statics Agency Website).*

Figer 1.1: Bishoftu city administration map



1.3. Statement of the problem

Health systems have to deal with many challenges. As the spectrum of ill-health changes, so health systems have to respond. Their capacity to do so is influenced by a variety of factors. Some operate at a national or sub-national level such as the availability of financial and human resources, overall government policies in relation to decentralization and the role of the private sector. Increasingly, however national health systems are subject to forces that affect performance such as migration and trade factors operating at an international level.

People seek to improve their health in many ways. Health seeking behavior is diversified based upon pragmatic and eclectic decisions not only influenced by physical financial and socio-cultural factors, but also by the accessibility, scope of service and the reputation of and trust in a provider or facility. This also involves self-referral and discontinuation of treatment. Mutual trust between health providers and the population and patient is a determinant as well as a consequence of the quality of care (Berlan and shiffman, 2011). Trust of patients is influenced by the perceived fairness and behavior and respect of individual providers, but likewise by the institutional set-up of care and by peoples experiences with public services in general (Gilson, 2005).

The differences lie in the relative severity of challenges being faced the way a particular health system has evolved and the economic, social and political context all of which determine the nature and effectiveness of the response. The lack of accompanying measures, such as financing systems to employ newly graduate doctors in the public system pushed them to the private sector in a non-regulated manner. Similarly, the unregulated increase of private facilities and the resulting increase of total supply do not improve access to qualitative and affordable care and may even lead to crowding out of public facilities and to increasingly provider induced demand.

One of the major objectives of national health policy of Ethiopia is capacitating health institutions engaged in the implementation of health policy particularly through the provision of services to improve the political and economic life of the society (TGE, 1993).

Then the local level of health providers should operate within an integrated health system where there are no gaps in access, where composing tiers operate complementarily rather than competing and where there is an optimal flow of patients and information so that the patient is helped at the most appropriate level(Unger, and Criel, 1995).The first-line health and social services are at the core of this system (World Health organization 2008), supported by an

effective second level including hospitals. Integrated systems require good coordination of all involved actors which, given the pluralistic nature of most systems is all the more essential (Bloom, and Standing, 2001).

Different studies, reports and working papers have been written on national policy on Ethiopian health, but these studies do not incorporate the detail investigation of the capacity of the institution in the implementation of the policy. The capacities to formulate their own institutional policy and capacities to manage and control their institutional structure and resource are the most ignored aspects by scholars and government.

Another research that assesses the institutional capacity to influence public policy in local setup is undertaken by M. Tekleab, 2011 in Guraghe Zone. This paper made an in-depth assessment of the institutional capacities to influence public policy with a special emphasis on civil societies, council representatives, media and local government actor in Guraghe Zone. The paper made assessment on knowledge about policy context, how the actor influences the policy, how they link with other institutions and how they work with the community. However, the paper does not assess the specific policy and pays little emphasis to the implementation of policy. Furthermore, the paper was thematically delimited to the human aspect of the organizational capability and less emphasis on the physical capability such as financial capacity of the local actor. This was the knowledge gap that this research was trying to fill. So, in this study, the researcher has tried to assess the institutional capacity of in the implementation of health policy.

1.4. Research Question

In order to assess the institutional capacity and challenges in implementing the health policy in Bishoftu town health office with particular case study of public health institutions in Bishoftu town, the following research questions were formulated.

- Do the health institutional workers have both the national and local institutional policy knowledge?
- What are the main institutional capacities in the health sector to implement health policy effectively?
- What are the major factors affecting the institutional capacity of the health services?
- What are the overall challenges of health institutional capacity?

1.5. Objectives of the Research

1.5.1. General Objective

The general objective of this paper is to assess the institutional capacity of health institution in the implementation of health policy in Bishoftu town.

1.5.2. Specific objectives

- To assess the policy understanding of the actor/workers in health institutions,
- To assess various institutional capacities of health sector in effective implementation of the health policy,
- To identify and describe the factors affecting health institutional capacity in implementing the policy,
- To identify the overall challenges in health institutional capacity,

1.6. Significance of the Study

Up on its accomplishment, the paper has its own significances. It was also used for the concerned body to reconsider the contents of the policy to inculcate the role and responsibilities of the health institutions in detail in the policy content. Furthermore, it could serve as a stepping point for other interested bodies to conduct detailed analysis of the contents of the policy. It was also important to forward possible remedies for the policy and capacity problems of institutional capacity in the study area. The findings from this study may further aid governments in their policy formulation regarding adoption of continuous improvement methodologies.

Furthermore, the study helped for academia and others to conduct research on the implementation of Health policy in the future.

1.7. Scope of the Study

Bishoftu town has the main land of the town and Ada‟a woredas. But the study was delimited to the town and do not emphasize on the Ada‟a woredas. Furthermore, the study was conducted with the specific and special emphasis on the government health institutions which directly engaged in the implementation of health policies (providing health services for the community) and their capacities. In that, the study was not concerned with those private and non-

governmental health service providers‟ institutions and different government sectors which are indirectly engaged in the implementation of health policy. There are also different health sectors and organizations that are established at the grass root levels to promote health service in the town. But these organizations are not the scope of this paper. In time frame, the paper was limited from 2003C.C. to the current (during the year of 2008E.C.) capacity of the study unit.

1.8. Limitation of the study

This study had several limitations. Fist, the difficulties encountered in getting companies to respond to the questionnaires. The target respondents were operational managers or their equivalents and this cabinet/cadre of people take time to respond to questionnaires due to their busy work schedules. The second limitation of the study was that it purely depended on the individual questionnaire responses for data collection. It was thus not possible to have a time and to get in-depth information about service in these organizations, but would have been possible if other methods were used such as key informant interview. To this effect the results are only true to the extent of information provided by the respondents.

1.9. Organization of the Paper

These papers organized into five chapters. The first chapter contains the introductory part of the paper (background, statement of the problem, research questions, objective(s), and significance of the study, scope of the study, Conceptual Framework and limitations of the study). The second chapter presents different empirical and theoretical literatures on capacity issues and policy implementation roles of local government in policy implementation. The third chapter deals with the research methodology. The fourth chapter includes analysis and presentation of the data while the last chapter presents summary of major finding, conclusion and recommendation.

Chapter Two: - Review of Literature

In this chapter, both theoretical literatures, empirical literatures, Health System Dynamics Framework and Conceptual Framework related to the topic of the study are presented as follows.

2.1. Theoretical Literature

This chapter deals with review of different theoretical literatures on the concepts of institutional capacity and Policy Implementation. Different scholars contributions on the above issues as it is appropriate to the analysis of the topic are presented as follow in this chapter.

2.1.2. Concepts of Institutional Capacity

As one can understand from different literature, it is very difficult to provide single and universally accepted definition of the term capacity. This is because of the dynamic nature of the term and it is an evolving concept that changes through time. As stated in different literatures the term capacity interpreted and defined differently by different scholars and institution as they provide their interpretation based on their experience and specific point of view. While doing so they incorporate different concepts and components of the term capacity. Therefore, what one could generalize is that, none of the definition is universal and none of it is generally accepted. Peter Morgan, 2006; 19, in his report on the concepts of capacity, he summarizes that:

> *Every conception or definition of the concept of capacity is unsatisfactory in its way. Those that try to capture the full range of its various meanings tend to be too complex to use or too aggregated to have any operational value. Those, that focus more specifically on a few key aspects of capacity, end up with giving too little attention to issues that certain groups care about. One way to address this dilemma is to be conscious of the bias of a particular way of thinking about capacity and to help other participants to put it in context.*

In defining the term capacity, GlickMan and Servon (1990) provide and depend on five major components of capacity which includes:-

- **Resource capacity** (the capacity of the institution to generate and acquire resource for example from grant, contract, loan and other. How it attract, manage and maintain funding to meet its objectives),
- **Organizational capacity** (the capabilities of the internal operation of the institution which determine its ability to succeed and this is affected by different variables includes management style and skill of its staff, the size and experience of the institution and the organizational fiscal capacity),
- **Network capacity** (the ability to work and interact with other institution both within and outside the community. This represent the external relationship that institution tries to develop and maintain, and is very critical for its success),
- **Programmatic capacity** (this measures the types of service by the institution. the ability of the institutions to the core service and their ability to participate in other service such as technical supports, leadership development, cultural and educational activates), and
- **Political capacity** (institutional ability to respondent its reside credibly and advocate affectivity on the behalf of its residents in the larger political arena, institution must be able to mobilize supports and demonstrate the community‟s concern about issues and policies as well as negative for the benefits of the other), this contribution in the definition of the tern seems the be broader than the above, but the components used here could be categorized under the level of capacity used by the UNDP, and Willems and Baumert given bellow. And this definition does not consider the broader societal values, tradition and practices in the community as the components of the institutional capacity.

In defining the term Institutional capacity is an evolving concept as it is defined and interpreted by different scholars in different manners in different context and time. Therefore, it is impossible to provide universal definition of the concept in some in single word. But it is possible to view the term in specific context. Thus, the following are some of the definition of the term provided by different scholars in different time. The term institution of capacity, in its generality, is complex, vague or fuzzy concept. Therefore it is impossible to provide precise definition of the concept without identifying the contexts in which we are explain the term. It is

not a static term in that it is evolving through time. Therefore, it is not an easy task to provide the exact definition of the term Willems and Baumert et.al (2003). M.R. Bhagavan and I.Virgin (2004) provide the definition of „‟institutional capacity‟‟ as it encompasses, on the one hand, the functions (tasks) that institutions should have the competence (ability) to perform, and, on the other , the resources (human , technical and financial) and structures they need to that end. This deals with the internal operational capacity of the institution and the resource needed to this end. These definitions do not consider the external view and broader environmental perspectives such as polities, economic, social and regulatory issues that has to be considered in the capacity assessment.

Institutional Capacity is a broad concept that constitutes factors such as; technical ability, leadership, legitimacy of organizations, political support, supporting enabling environment e.g. legal frameworks and coordination arrangements etc. each of these constituent parts are interrelated and, if strengthened and can contribute to the overall strengthening of institutional capacity Wickham, Kinch and Lal (2009).

Broader definition of institutional capacity which is not exclusively different from the above but more in broader perspectives is the definition used by Wiliiems and Baumert et.al (2003). They provide that the concept of institutional capacity has evolved over the years; the concept of institutional capacity is a moving target since the field has evolved over the years from an initial focus on building and strengthening individual organization and providing technical and management training to support integrated planning and decision-making processes between institutions. Here they use the holistic view of the institutional capacity by which multilateral and bilateral development agencies have been used for capacity assessment. This framework distinguishes between ***three level*** institutional capacities:-

- **Micro-level** (it is individual level capacity which related to the individual performance and skill and it is very important for the success of any action and policy. It depends on different factors such as individual motivation, skill, training, and incentives)
- **Messo-level** (it is organizational level capacity or management capacity performance of the organization is also a key for the measure of institutional capacity) and
- **Macro-level** (broader organizational context or system level) they further distinguished the macro-level into three distinctive levels (network of organizations, public governance, and society, norm, values and practice) and put that there are five distinctive level of

capacity. This definition and level of capacity seems more inclusive than the contribution of the above former scholars and institution.

From the above literatures of the institutional capacity, we can understand that the concepts of the institutional capacity that given by the scholars and international development organizations are not exclusively independent as their explanation is, in one way or other, inter dependant. They have some common terminology and components in their interpretation. All the above are equally important for this research as they have at least one common component of institutional capacity used in the analysis of the paper. Therefore, different components of the institutional capacity were used selectively as their appropriateness to the paper.

2.1.3. Policy Implementation

Policy implementation, in every society, there exist some problems. These problems could be in the areas of politics, commerce, education, agriculture, communication, housing, transportation, health etc. In order to solve these problems as they might exist at given points in time, government is always seen formulating policies in response to them and in relation to the objectives of growth, national development and wellbeing of the citizens. The formulated policy has to be effectively implemented to provide solution to the problem for which they are formulated. Implementation literally means carrying out, accomplishing, fulfilling, producing or completing a given task.

Policy implementation is the next and most crucial stage after its formulation. It is, perhaps, for its importance that some scholars refer to the policy implementation stage as the hub of policy process. Fundamentally, policy implementation is the process of translating a policy into actions and presumptions into results through various projects and programs (Okoli and Onah, 2003; Ikelegbe, 2006).

In short, policy implementation is an integral and important stage and part of policy process rather than the separate and distinct from policy making process. It is all about the realization of the policy by using multiple policy instruments in a given policy context. For its realization, there must be policy and institutional capacity of those actors that takes parts in policy implantation. There must be effective institutional and policy mechanism by which policy implementation is enhanced.

2.2. Empirical Literatures

In the previous section we have stated the theoretical or conceptual literature that related with the topic under investigation. In this section, we are going to talk about the empirical literature which shows the real contribution of the sector Health system in different countries.

2.2.1. Institutional Health Service Delivery Arrangement in Ethiopia

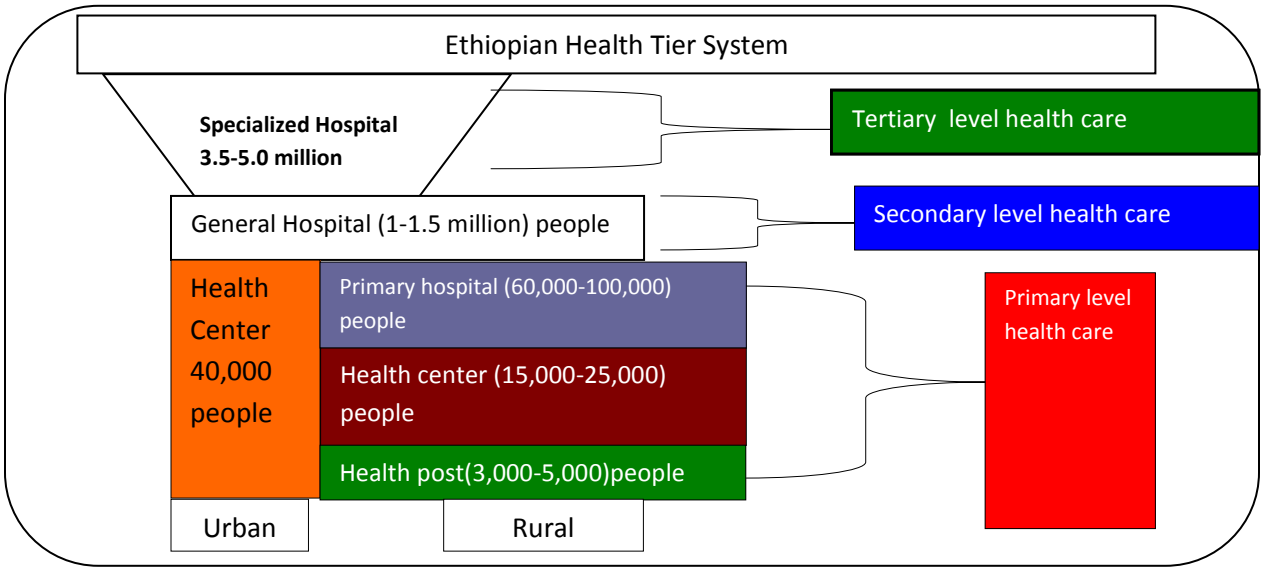
The Ethiopian health service is restructured into three tier system. These are the PHCU which is composed of a HC and five satellite HPs. These provide services to 25,000 population altogether. HP is staffed with two HEWs. The HEWs are expected to spend less than 20% of their time in health posts, and more than 80% of their time is spent on community outreach program visitation to households, especially mothers and children. They provide 96 hours of training to households on the selected packages of HEP and follow the practice before certification and graduation of the households. HEWs provide family planning, EPI, OTP, clean delivery and essential newborn care services, diagnosis and treatment of malaria, diagnose and treatment of pneumonia including dehydration using ORS. A HC is staffed with an average of 20staff. It provides both preventive and curative services. It serves as a referral center and practical training institution for HEWs. A HC has an impatient capacity of 5 beds.

A Primary Hospital provides inpatient and ambulatory services to an average population of 100,000. In addition to what a HC can provide, a primary hospital provides an emergency surgery service including Cesarean Section and gives access to blood transfusion service. It also serves as a referral center for HCs under its catchment areas, a practical training center for nurses and other paramedical health professionals. A primary hospital has an inpatient capacity of 25-50 beds. It is staffed by an average of 53 persons. It also serves as a referral center for HCs and a practical training center for nurses and other paramedics. A primary hospital has an inpatient capacity of 25-50 beds. General Hospital provides inpatient and ambulatory services to an average of 1,000,000 people. It is staffed by an average of 234 professionals. It serves as a referral center for primary hospitals. It has an inpatient capacity of beds and serves as a training center for health officers, nurses and emergency surgeons‟ categories of health workers. A specialized hospital serves an average of five million people. It is staffed by an average of 440 professionals. It serves as a referral general hospitals and has an inpatient capacity of beds.

The Ethiopian Health care System is augmented by the rapid expansion of the private for profit and NGOs sector playing significant role in boosting the health service coverage and utilization thus enhancing the public/private/NGOs partnership in the delivery of health care services in the country. Offices at different levels of the health sector from the Federal Ministry of Health to Regional Health Bureaus and Woreda Health Offices share decision making processes, decision powers, duties and responsibilities. The FMOH and the RHBs focus more on policy matters and technical support while Woreda Health Offices have basic roles of managing and coordinating the operation of a district health system under their jurisdiction.

Regions and districts have Regional Health Bureaus (RHB) and district health offices, respectively for the management of public health services at their levels. The devolution of power to regional governments has resulted in the shifting of decision making for public service deliveries from the center to largely under the authority of the regions and down to the district level (*Ethiopian Health Sector Transformation Plan*, 20015).

Figure 2.1: Ethiopian Health Tier System



Source: (*Ethiopian Health Sector Transformation Plan*, 20015)

2.2.2. Uganda Health system

This Health System Assessment (HSA) was carried out to identify strengths and challenges of the Ugandan health system, and to make recommendations for interventions to strengthen the system. It has three specific objectives: First, it provides a baseline for monitoring health system

performance throughout the period of the country‟s Health Sector Strategic and Investment Plan 2010/11–2014/15 (HSSIP). Second, it provides a snapshot, in a single document, of the status of Uganda‟s health system based on data collected from published documents and stakeholder interviews on different aspects of the system. Finally, it identifies the strengths and weaknesses of the system and provides recommendations, which can inform Government of Uganda (GoU) policymakers, development partners, and other stakeholders of potential areas for further strengthening, including ways to effectively implement the HSSIP (MOH, 2011).

The Ministry of Health (MoH) Supervision, Monitoring, Evaluation, and Research Technical Working Group steered the HSA process on behalf of the Ministry. Uganda‟s health development partners (HDPs) provided input to the process, from conception to the review of several drafts of the assessment report. The USAID-funded Health Systems 20/20 project conducted the HSA in conjunction with Uganda‟s Makerere University School of Public Health. Data collection for the HSA was conducted from January to April 2011, with additional interviews and data collection in November and December 2011(Ibid).

The HSA assesses key health system functions organized around the six technical building blocks defined by the World Health Organization: Governance; Health Financing; Service Delivery; Human Resources for Health (HRH); Medical Products, Vaccines, and Technologies; and Health Information Systems (HIS). The HSA team identified a number of strengths and opportunities in Uganda‟s health system as well as a number of constraints that cut across system components (Ibid).

2.2.3. Kenya Health System

In recent years, Kenya has been implementing important health sector reform measures, and health system strengthening has become a priority. The formation of the Grand Coalition Government in 2008 resulted in the Ministry of Health being split into two ministries: the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS). The MOMS administers secondary and tertiary hospitals (levels 4–6) of the health system, while the MOPHS oversees primary health care facilities (levels 1–3). The split adversely slowed down the sector partnership arrangement which was steadily gaining momentum. Kenya‟s second National Health plan (NHSSP II) underscores the importance of system strengthening with major efforts aimed at institutional strengthening, organizational

development, improving the availability of human resources for health, health financing, service delivery and information, medical commodity availability, and improved donor coordination (MOH 2005).

Continuing to strengthen Kenya‟s health system requires a thorough understanding of its unique strengths and weaknesses. The ministries of health used the HSA process to evaluate the state of the health system at the end of the current Annual Operational Plan (AOP), as input to the formation of the new AOP. The Health Systems Assessment (HSA) process allows countries to systematically and rapidly assess their national health system and provides policymakers and program managers with information on how to strengthen the health system. The approach provides a comprehensive assessment of key health systems functions, organized around six technical modules: governance, health financing, health service delivery, human resources, medical products management, and health information systems (Ibid).

2.3. The Health System Dynamics Framework

Much more than clinical medicine, the domain of public health and health policy and systems as a part of it - is shaped by dynamic alliances between actors from scientific, policy and operational backgrounds as well as the public in the form of patient groups, consumer associations and other interest groups and actors from the private sector. This strong influence of stakeholders from different backgrounds, each with their own logic and paradigms, contributes to the perceived lack of clarity.

A number of health systems frameworks have been published over the last decade. These have served different purposes, from describing or analyzing existing situations to being predictive or prescriptive. Comprehensive frameworks at the national level include the widely used World Health Organization (WHO) models (World Health Organization 2000;World Health Organization 2007;World Health Organization 2009), some of which were adapted for evaluation (World Health Organization 2008b). Other frameworks focus on specific “building blocks”, the interaction between actors or on the interface between different components (Atun 2009; World Health Organization 2008; World Health Organization 2010).11 (Shakarishvili, 2010) give a comprehensive and analytical overview of the differences in existing health system frameworks.

Many of the existing frameworks have a limited capacity to analyze the interactions and equilibriums between different elements of a health system. Most, moreover, do not focus on values as important steering mechanisms for the behavior of people and thus for choices and processes in a health system. In response to these shortfalls, we developed a framework for description and analysis of health systems dynamics, which consists of ten elements focusing on system interactions (van Olmen, 2010). While the health system dynamics framework incorporates elements of existing frameworks, such as WHO building blocks (World Health Organization 2007), it goes further than most. First, it emphasizes that a health system should be geared towards outcomes and goals, but jointly adds that they are and indeed should be, based on explicit choices of values and principles. Second, the framework considers some elements to be more important than others. We assert that the organization and delivery of health care services is the core of the central axis that includes leadership, governance as well as interaction with the population and other actors. This brings us to a framework consisting of ten elements and their dynamic interactions: 1) goals and outcomes; 2) values and principles; 3) service delivery; 4) the population; 5) the context; 6) leadership & governance; and 7-10) the organization of resources (finances; human resources; infrastructure and supplies; knowledge and information).

The dynamic dimension of this framework is essentially based upon the notion of complex adaptive systems (Paina, & Peters, 2011). Health systems are in essence social systems, composed of many actors and organizations that interact with each other. Given the central role of actors and their interrelations, processes of communication, coordination and regulation often result as responses that are non-linear and at best, hard to predict. Furthermore, interactions between elements take the shape of feedback loops and contribute to generative processes. These interactions lead to the emergence of temporary equilibriums. We would do well to note that health systems are also open systems, drawing and abstracting resources from their environment, but also responding to it.

2.4. Conceptual Framework

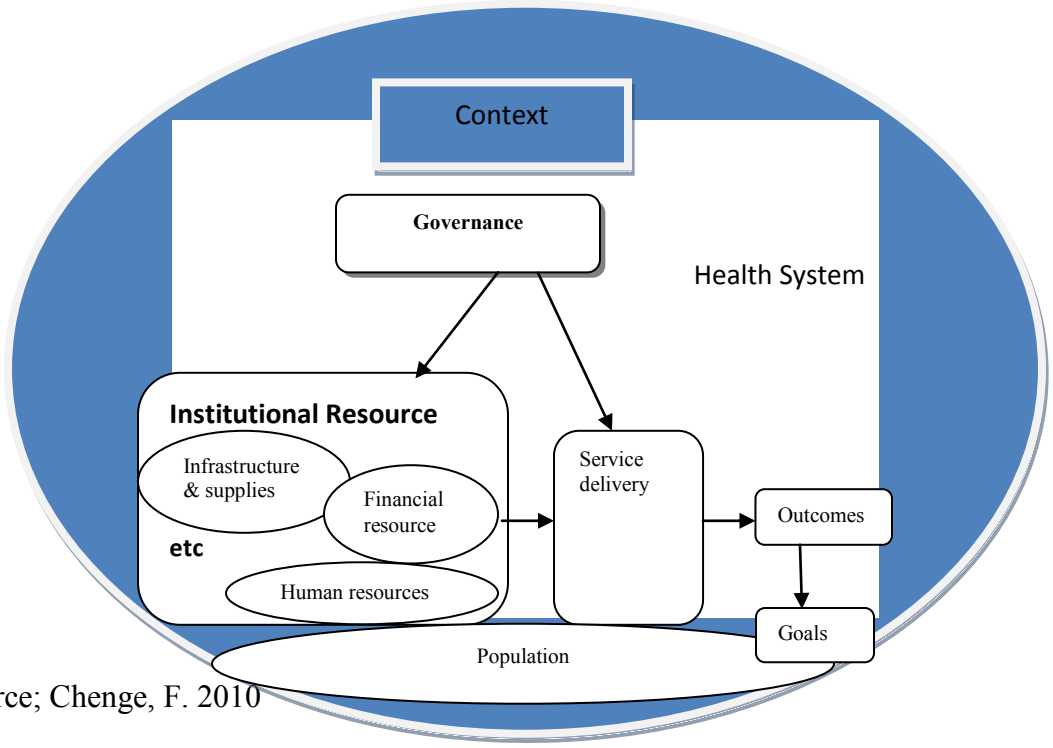
Numerous frameworks for describing or assessing the institutional capacity of development organizations are in development and use. Past history in measuring institutional capacity in the development arena reflects real conceptual and practical limitations (Jerry Vansant, Duke University, 2013).

Fortunately there is a great deal of similarity in these new frameworks, reflecting the fact that there is a well-developed emerging consensus on the attributes that make for effective and sustainable institutions. Where frameworks differ is in emphasis, semantics and in the way certain attributes are defined or clustered. "Governance," for example, can refer to the relatively narrow issue of an organizations legal (governing) structure or it can be a category encompassing the organization‟s culture, mission and values. "Management" can be used to refer rather narrowly to management systems and procedures or be used in the much broader sense of strategy and leadership. "Strategic Management" can include factors of governance and a sense of vision or mission (Ibid).

This summary does not do justice to the richness of these frameworks, most of which provide sub-categories and/or indicators to give substance and meaning to the attributes. Another point worth noting is that many of these frameworks come with highly participatory suggestions as to how they are to be used. That is, the purpose often is not simply to judge an organization‟s capacity but rather to provide a learning tool for institutional self-understanding and a launching pad for capacity enhancement. In this approach, assessment teams play a facilitating role and participants rather than external assessors take the lead in determining the relative capacity of their own organization (Ibid).

Most frameworks use perception scales or indices as the measuring device along various continuums of organizational development (usually tied to a specific organizational unit of analysis) (Ibid). The paper reviewed available literature using a conceptual framework that was adapted from different existing models. In our conceptual framework, major consisting of six elements and their dynamic interactions: 1) the context; 2) governance, 3) the institutional resources (finances; human resources; infrastructure and supplies and etc.), 4) Service delivery; 5) outcomes and goals; and 6) the population (Chenge, F. 2010).

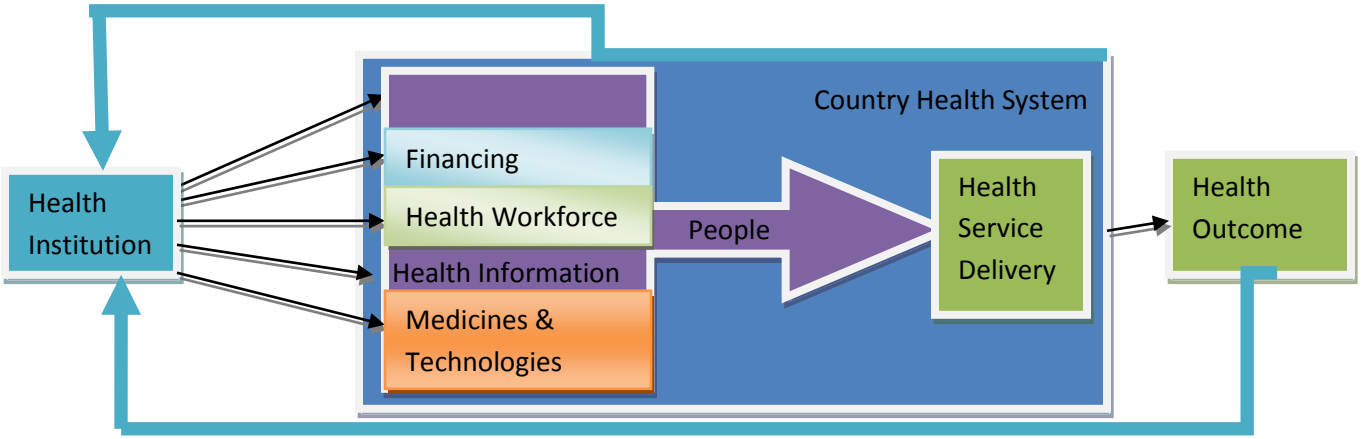
Figure 2.2: The health system dynamics framework



Source; Chenge, F. 2010

The explored how these five points interlink and contribute toward the sixth point of interaction, namely, the delivery of health services. The proposed framework is represented in Fig. 1. The central role of people is recognized in our model. Also, all aspects of the six points of interaction take place within a general context that includes economic, social, political, environmental, and other factors that are not included in our analysis. The conceptual framework data and analysis have limitations that arise because health systems are „complex adaptive systems"

Fig.2.3. Conceptual framework of the health institution system



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Using the Health System Dynamics framework to describe and analyze a health system calls for such elements to be taken into account as a logical necessity.

i. Context

Because health systems are essentially open systems, they are shaped and influenced by wider societal change. This means that every country has a health system that reflects its political decision-making and historical evolution (Riley, J. 2008). It also implies a constant need for response to new developments and transitions, such as an ever-evolving disease burden composition; new technologies; changing expectations of patients and providers; increased availability of information and the changing roles of the state in the health and social sectors.

An analysis of the national context encompasses a governance analysis covering recent evolutions in the domestic political regime (including regulatory system); institutional arrangement (relations state, private sector and civil society organizations); the organization of the public sector (public sector reform including decentralization) and public financial management. The policy context of a health system at each level cannot be analyzed in isolation local, national, regional and global as each of these levels dovetails others through power configurations and dynamics. Global financial and economic regimes and policies have an important influence on national policies in LIC (Low Income Country). Many global and national actors interact directly with local health service and program managers, politicians and other stakeholders.

ii. Governance

Governance entails policy guidance to the whole health system, coordination of actors and regulation of different functions, levels and actors in the system, optimal allocation of resources and ensuring accountability towards the population and all stakeholders.

Government actors have a central role in the steering of the health system, since they have a public mandate. Ensuring the protection of citizens against ill health and its social and financial consequences is an important element of their legitimacy as public servant. Government should play a mediating role between all stakeholders to promote equity, efficiency and sustainability and to ensure the public finality of the health system. In practice, however, the state‟s power is often undercut by forces at multiple levels (Reich, M. 2002). Agreements with international

organizations and donors, for instance, curb the state‟s autonomy to decide on macro-economic policies and this may subsequently impose limits on its role in the delivery of health services.

Decentralization processes within states devolve responsibilities for the delivery of health services from central to local government structures. As a result, a variety of players, including market and civil society actor, politicians, professional organizations and cooperative structures, have an influence on governance. The increased role of stakeholders at all levels and in different functions demands strong capacity in the ministry of health, it‟s decentralized structures and local governments to take leadership and to steer pluralistic and fragmented systems into a satisfactory balance. It entails strategic vision, technical knowledge and information, consensus building and negotiation skills, as well as the capacity to consider values and principles, but also the ability to ensure effective participation and involvement of multiple stakeholders through transparent and fair processes. Furthermore, such involvement and linkage between different levels within the state and the health system is essential to facilitate the bottom- up influencing of policy- making and the implementation of policies.

iii. Institutional Resources

a. Infrastructure and supply Goods

Developing the infrastructure of a health system means assuring that there are enough health facilities within proper reach of the population, which are equipped, maintained and adapted to the specifics needs of those making use of it.

Ensuring quality throughout the whole supply chain requires the identification of reliable producers, procures and suppliers. In practice, this is often not case. Currently the WHO pre-qualification system only includes very few categories of drugs (Cauldron et al. 2008). Drug regulating authorities in most LIC (Low Income Country) have too few resources to execute the necessary regulatory oversight to ensure quality, (Laing et al. 2001; World health organization, Regional office for Africa 2009).

In many countries, the central supply systems aggregating orders at different levels are vulnerable for hick-ups at different levels, affecting the functioning of the total chain. Ensuring financial access to quality essential medicines entails adequate information on quality and prices, comprehension of international trade agreements and the capacity to negotiate prices and mark-ups in the national distribution system. Essential medicines list and treatment guidelines are

important steps in promoting the rational prescription and use of medicines, which should be complemented by systems of control and support of provider behavior and increasing awareness on both the correct use and risk of irrational use.

b. Financing

Financing involves the acquisition, pooling and allocation of financial resources in such a way that it effectively contributes to attaining the desired goals and outcomes. In essence, health financing needs to ensure access to services while protecting people against catastrophic health expenditure (world health organization 2008b). Health care financing modalities have a direct bearing on equity, efficiency and sustainability. The commission on macroeconomics and Health estimates the cost of a core package of activates at around US$40 per person per year, although analysis of health system performance shows that a number of countries are able to perform well with less (Riley, J. et.al 2008). Since health financing always involves rationing the decisions on priority setting and allocation of resources have great implications, especially when resource run scarce (Palmer, N. 2004; Roberts, M. 2004).

The prime responsibility for revenue collection is located at the national level, because this is linked with government accountability to the population. There is, however, a strong plea for global social responsibility and for longstanding commitment of the international community to contribute to the health financing of the basic package for those countries too poor to raise sufficient funds internally (Ooms, & Hammonds, 2009).

c. Human Resources

The transaction intensity of many health services makes professional staff one of the scarcest resources in many health systems. The health workforce can only meaningfully contribute to the performance of the HS if health workers are available, competent and performing up to standard.

Comprehensive healthy workforce policy integrates planning and organization of training, recruitment, remuneration and deployment adjusted to the evolving models of health care delivery, workloads and the evolution of the work force (Marchal, B.2003; Narasimhan, 2004).

To create an enabling environmental human resource management ideally consists of a package of practices and strategies that balance financial and non- financial incentives with control measures and regulation and maintain public-oriented values and ethics (Marchal, 2010) The wide array of health service organization, each with different staff incentive structures, leads to

big differences in staff availability, skill mix and capacities across sub- system and between rural and urban areas. It is one of the functions of governance to regulate incentives, so as to reduce imbalances and tension (Kalk, 2011; Meessen, 2011c; Unger, 2008).

iv. Service Delivery

Health service delivery is the process through which providers, health facilities, programs and policies are coordinated and implemented so as to reach the goals of the health system. It relates to services ad activities with the primary purpose to improve health and includes primary prevention; secondary prevention; curative care and rehabilitation (Marchal, B. et al. 2011). This means that a wide set of activities needs to be organized, form focused activities to general services. There are several ways to classify the delivery of this wide range of activities and services criteria include: the focus on individuals/ families or the total population (Boussery, G. 2011): the need for permanent availability or the possibility for intermittent scheduling (Van Damme et al. 2011a) or the extent to which services are transaction-intensive, discretionary and subject to information asymmetry (World Bank 2004). Scarcity of resource and the respective need for rationing requires prioritization of interventions. In practice, heath delivery intervention are often `bundled`.

v. Outcomes and Goals

Similarly to the WHO (World Health Organization 2000), we define outcomes as the direct results of the organization of health care delivery (e.g. Universal coverage, quality of care and responsiveness), and goals as the expected impact in terms of improved health and social and financial protection. Attainment of such goals is not dependent on the health system alone, hence their place in the framework sooner orbit the health system.

The integrated framework thus acknowledges that social, economic, political and other factors are major determinants of health and the well-being of people. Improved health and wellbeing is the first goal of any health system. The holistic definition of health as „Physical mental and social well-being" (Alma Ata .1978; World Health Organization 1946) has been widely accepted although in reality the definition is often narrowed down to the mere „absence of disease" as both measure and gauge. The increasing number of people with life-long conditions has led to advocacy for a broader definition, which again would take into account people"s resilience or

capability to cope with, maintain or restore one‟s integrity, equilibrium and sense of wellbeing (Huber, 2011).

vi. Population

The population is involved in the health system as patients or customers, but also as citizens having rights and obligations and as funders or even suppliers of care (Frenk, J. 2010). There has been increasing attention for people as producers of health and health care, with attention for the (spontaneous) activities of individuals and the collective action of groups in the community such as self-help groups; patient organizations; peer-groups and informal caregivers.

The concept of participation includes a wide variety of approaches on a scale of increasing empowerment, from mobilizing people to contribute inputs, over common decision-making processes, to increased capacity and to autonomously recognizing and acting upon situations (Rifkin. 2003). Empowerment at the individual and community level is widely recognized as an important goal, because it contributes to reducing inequities and bringing about desired social change (Gilson, L. 2007). At the community level, a strong community voice in relation with other actors in the health system, especially when priorities are set, is important.

Generally, from the above literatures of the institutional capacity, we can understand that the concepts of the institutional capacity that given by the scholars and international development organizations are not exclusively independent as their explanation is in one way or other, inter-dependent. They have some common terminology and components in their interpretation. The entire above are equally important for this research as they have at least one common component of institutional capacity use in the analysis of the paper. Therefore, different components of the institutional capacity were used selectively (Organization of Resources: - Infrastructure, Financial and Human resource) will be as their appropriateness to the paper.

Chapter Three: - Research Methodology

3.1. Research Approach

In conducting this study, both qualitative and quantitative approach was applied. Qualitative approach was used when there is a need to explore the characteristics of a situation, group, or population, to evaluate programs, and to develop policies. It enables the researcher to develop a level of detail about the individual or place and to be highly involved in actual experiences of the participants. Qualitative research is characterized by its aims, which relate to understanding some aspect of social life and its methods which (in general) generate words, rather than numbers, as data for analysis N. Brikci and J. Green. (2007). In this paper, qualitative research approach was used to identify and investigate institutional capacity of Health institutions in Bishoftu town to implement the national policy of Ethiopian Health particularly policy understanding of the actor, existence of both policy in the institution, how the actor understand and interpret the policy, network among the actor and between the actor and other sectors, resource of the actor.

Quantitative approach was used to investigate and asses the perception of the actors on the quality and sufficiency of the service of the Bishoftu town Governmental Health Institutions. It was also used to make some assessment of capacity issues of the actor.

In order to achieve the above objectives, the process of assessing institutional capacity in the implementation of health policy will be done after passing through a number of steps, so the methodology for this research is both qualitative and quantitative approach based on intensive fieldwork data collected through different techniques namely, questionnaires (open and close ended), observation and review of documents through content analysis.

This research has attempted to identify institutional capacity of the local government in implementing the policy in Bishoftu town. Therefore, descriptive and exploratory methods of research were applied in the paper. In the paper, descriptive research method was used to describe the capacity of the government health institution in the Bishoftu town and analyzed the actor‟s/workers position and responsibilities in the national policy. The paper was also interpreting the perception of the actors who are the worker and user of the institution after identifying through the exploratory method. Exploratory method is important to identify or explore the policy knowledge and capacity of the governmental health institutional levels in Bishoftu town.

3.2. Sampling Techniques and Sample Size

Bishoftu town have two governmental health institutions: one General Hospital and Health office, there exist 3 health centers. General Hospital is serving 1.2 million people living in three towns and five districts. In this institution, currently have 196 professional staffs‟ workers. In addition 200 persons from supportive working process (Human Resource Administration, Finance, sanitary workers, guard and etc) were also contacted. The Health office, there exist 3 health centers (Chalalaka, Bishoftu and Katta Health center), each health center averagely serving 3 kebeles (9 *kebeles* totally) and each HC is averagely serving 60,098 people (180,293 peoples totally). In general, 2 government health institutions (Hospital and Health office) in Bishoftu town were selected as participants of the research. Here, the general assessment method and judgmental method was used to elicit information from all government health institutions staffs. Besides, the samples are taken from managers of health office, employees of health office who are permanently or temporarily employed and head of different sections. For the study, purposive (judgmental) sampling technique has been used. The researcher used purposive sampling technique because the employees of the institutions were nearly the same understanding about the situation in health institutions, other the employees work by shift day and night, then when the questioner distribute the night workers missed, so the researches focused on day workers purposive distribute questioners. At health institutions, each case team above three sections of own process is taken. These are organizational resources (Infrastructures, Financial and Human resource). This is for the purpose of comparison between different section in their contribution to service and others.

Table 3.1: The details of sample design summarized

Target Group	**Institutions**	**No of Respondent**	**Sampling method**	**Purpose**
Government Health Institutions	General Hospitals	70	Purposive (judgmental)	Questionnaires
	Health office:- 3HC (Chalalaka, Bishoftu & Kata)	63 (21 for each)	Purposive(judgmental)	Questionnaires
Total		**133**	**Purposive(judgmental)**	**Questionnaires**

3.3. Source of the Data and Methods of Data Collection

Data was collected from both primary and secondary sources. The primary data sources were questionnaires and observation and the secondary data source was documents of the institutions. To collect primary and secondary data, particularly in this descriptive research, the researcher employed the following techniques: i) observation method, ii) Through questionnaires.

- **Primary data:-**

- **Questionnaire:** In this method a questionnaire is sent to the sample persons of employer concerned with a request to answer the questions and return the questionnaire. Most questions in the questionnaire were closed-ended questions and contain different parts like demographic characteristics of the respondents and Health offices contribution to good service. However, opportunities are given to the respondents to say more through open ended questions if it is necessary.
- **Observation Method:** Under the observation method, the information is sought by way of investigator‟s own direct observation without asking health office and selected health institutions. This data collection instrument is used to see the real situation of the health office. Using this method, the researcher had exposure to see different issues like the nature of their working premises, the appropriateness of their working place, the working conditions, the nature of the interaction between members and other related issues are observed.

- **Secondary Data –** such as documents, periodicals, publications and etc. relevant to the study were collected from different government institutions like Central Statistical Agency (CSA), Ministry of Health, Oromia Health Bureaus, Bishoftu city Administration, Bishoftu city Health Institutions and different stockholders.

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3.4. Method of Data Analysis and Presentation

Analysis began along with data collection through the well documentation of the data. The analysis of qualitative research notes begins in the field, at the time of observation, distributing questionnaires or both, as the researcher identifies problems and concepts that appear likely to help in understanding the situation. The data that were collected through these techniques was immediately rephrased and re-documented immediately after the researcher separate from

respondents because effective transcription and good analysis depends on documentation. The documented data was conceptualized and categorized into different themes based on the natures of the data while it was analyzed. Then the data was thematically described. Quantitative data was computed manually and analyzed by using tables to show percentages and average of responses. In doing this, both qualitative and quantitative data was used in a mixed way that each supports one another.

Quantitative data was captured electronically using Microsoft Excel software. The responses on the questionnaire were scored using a 5-point response scale with "strongly disagree" scoring a 1 and "strongly agree" scoring a 5. An average score was calculated for each response for each school using the weighted average formula:

Average score= ({ax1} + {bx2} + {cx3} + {dx4} + {ex5}/ {a+b+c+d+e}

Whereby:

a = number of respondents who strongly disagreed

b = number of respondents who disagreed

c = number of respondents who neither agreed nor disagreed

d = number of respondents who agreed

e = number of respondents who strongly agreed.

Content analysis was used to manually analyze qualitative responses and categorize them into emerging themes and subthemes. The themes evolved around the existence of organizational resources (human resource policy, infrastructures, service delivery and the existence of both policy for financing and sources of funds).

4. Chapter Four: - Data Presentation, Analysis and Interpretation

4.1. Introduction

This chapter deals with the presentation, analysis and interpretation of the data collected from the sample health institution and health offices and secondary data. It constitutes the background of the study area, the responsibilities of the local government in the policy, institutional capacity (the roles, how roles are assigned, how the staff understand the responsibility, the resource and its sufficiency and how it is utilized in the institution), policy capacity (the policy knowledge of the actor, how the actor identify their roles and responsibilities in the policy, existence of the institutional plan), the network between the government health institutions and the perception of the actor on the health institution in the Bishoftu Town.

Generally, 133 questionnaires on the institutional capacity of health policy implementation developed and were distributed to two governmental health institutions employees in Bishoftu town and 125 questionnaires were collected, as a result the overall response rate was 94%, in addition to this the researcher pre-test the questionnaires by distributing for 40 employees.

4.2 Analysis of Institutional and respondent's bio-data

The government is the main health provider in Ethiopia but the coverage and distribution of its health facilities among regions remains uneven. The institution has well-organized (General Hospital, City Health Office, Health Center and Health Post) profiles that show the overall roles and responsibilities of the office in general and individual workers in particular.

Bishoftu health offices were established since 1986 and responsible for District health administration office for the regulation/administrate the all health institutions in the districts. Now, the health institution has operated its duties averagely with 196 professional and 200 supportive staff workers in Preventive and curative services, Inpatient and ambulatory services, Emergency surgery service including Cesarean Section and gives access to blood transfusion service and using appropriate technology to enhance service delivery. There are totally 9 governmental health institutions in the town with three health centers, two Hospitals and four health posts.

The town health office regulate/implement the positions need professional and expert personnel which had been planned and approved by the Regional Government to be recruited and hired by the town health office for each kebele*s* of the three HC in the towns (Calalaqa, Katta and Bishoftu), implemented. Both Health institutions have made contact with each other health institution (General Hospital and private health center) and interaction with other institutions regarding the issues of the community in the town is existent.

The ideas of employees of the Bishoftu town health institutions are collected through questionnaires that filled by the researcher and oral discussion that made with numbers of employers that came to the organization for service and manually analyzed as follow by using table and percentage. This part contains the sex, age and educational background of the respondents, their participation in decision making/working of the institutions.

The following table 4.1, shows the personal information of the respondents to the scheduled which shown sex, age and educational background of the respondents. Accordingly, 64.8% of the respondents are female, while the rest is male and 87.2% of the respondents are age 26-44, 8.8% 18-25 while the rest is above 45. Regarding their educational background, the majority (55.2%) of the respondents are BA/BSc or MA/MSc holder while 40.8%, 3.2% and 0.8% enjoyed college diploma, 10-12th and Medical director or above respectively.

Table 4.1: Socio demographic distribution of Bishoftu public health institutions, 2016

Variables	Choices	Frequency	Percentage
Gender	Male	44	35.2
	Female	81	64.8
	Total	**125**	**10**
Age	18-25 years	11	8.8
	26-44 years	109	87.2
	45-55 years	5	4
	56-60	-	-
	Above 61 years	-	-
	Total	**125**	**100**
Level of Education	Under 10	-	-
	10-12 completed	4	3.2
	Diploma	51	40.8
	Degree	69	55.2
	M.A/M.SC.	-	-
	MD/Specialist and above	1	0.8
	Total	**125**	**100**

Source: - developed from the response of the questionnaire

4.2. Health policy and Capacity of the Institution

To realize the objectives of the health policy, the government established the Health Sector Development Program (HSDP), which is a 20-year health development strategy implemented through a series of four consecutive 5-year investment program (MOH, 2010). The core elements of the HSDP include: democratization and decentralization of the health care system; development of the preventive and curative components of health care; ensuring accessibility of health care for all segments of the population and promotion of private sector and NGO participation in the health sector. The HSDP prioritizes maternal and newborn care and child health and aims to halt and reverse the spread of major communicable disease such as HIV/AIDS, TB, and malaria.

The health service system tiers; PHCU which is composed of a HC & five satellites HPs, Primary Hospital, General Hospital and specialized hospital. Accordingly, the Health Extension Program (HEP) serves as the primary vehicle for prevention, health promotion, behavioral change communication and basic curative care. The program is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in the rural and urban community.

HP is not self- contained or independent health institutions. They are rather structured under the Health office and they are directly accountable to the City Administration Health Office as they are depends on and perform by the budget given to them by the City Administration health Office. The main mandate of this health office is control/regulate (monitor and evaluate implementation of health institutions according to policy) the health sectors in all government and private sectors.

The others are Hospital, there are two hospitals in this town, that is Defense hospital and General Hospital; Defense hospitals do not give the health service for the community; it gives only for the military. The General Hospital was previously a district hospital which has been upgraded to zonal hospital. It is serving 1.2 million people living in three towns and five districts. The hospital has medical, pediatric and surgical wards, 2 operation theatres, a pharmacy, a radiography unit, a delivery room and an emergency unit. Outpatient department (OPD) services cover general medicine, maternal and child health care, HIV/AIDS and TB, ophthalmology, dental service, physiotherapy and mental health.

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 addition to the above capacity problems which can also be categorized as the components of the policy capacity, the actor in Bishoftu town lack policy understanding for the effective implementation of the policy.

Effective policy implementation depends on the availability of sufficient resources, policy understanding, policy knowledge and the commitment of the policy implementers. Without knowing the national policy it is difficult to concretize the policy into different program, project, guidelines, specific action plan and implementation plan and to prepare different organizational activities in localized manner. In doing this it is mandatory to have policy paper on national policy.

In this case, all selected actor in this research do not have knowledge on the national policy on Ethiopian health even they do not know the existence of the policy. They said that they conduct and implement the plan provided to them and the awareness raising program given to them by the higher levels of Ministry of health while they receive the plan and occasional training given to them.

Generally, the health development army is a group of persons or workers organized based on department or social proximity to participate, teach and learn each other and take practical actions for the betterment of institutional and community health. The name army denotes a group of committed, enthusiastic persons who are prepared to achieve a certain task or objective. HDAs are organized by their proximity/neighborhood of staff with smallest organized group commonly called one-to-five networks. Health Development Army (HDA) implementation has started in EFY 2003, with progress being made in the organization and network formation over the past five years.

4.3. Institutional Capacity of Bishoftu Health sector

This part concerned with presenting and analyzing the institutional capacity of the health sector in Bishoftu town which includes the town‟s health institutions. Based on the response obtained from each instruments, the results were organized as follow in the way that support each other. This title covers the Institutional resource (Infrastructure & supply goods, Human resource and Finances) and Service delivery.

4.3.1. Institutional Resources

Institutional Resources considers that the organization and delivery of health care services is the core of the central axis that includes leadership, governance as well as interaction with the population and other actors. This brings us to a framework consisting more than four elements and their dynamic interactions: the institutional resources (finances; human resources; infrastructure and supplies and etc.).

I. Infrastructure and supply Goods

Availability, accessibility, equity, efficiency and quality of health services depend on the distribution, functionality and quality of infrastructure. According to respondent says during interview, in improving this area the health sector attained some successes which include the health facility construction has created access to care to many people that was never reached with any type of service before, the health center expansion has enabled the sector to enhance access to services for programs. While access to services has improved, because of the issues around functionality, health facilities are not able to provide some of the priority services such as deliveries in a method that attracts patients.

Moreover, problems arise when patients use facilities that lie outside the immediate catchment area, which could be due to number of reasons including the logistics of travel, sociocultural preferences and perceptions of quality. Urban areas present a particular challenge because although physical proximity may pose less of a problem, issues of affordability and acceptability become more important obstacles to access.

Table 4.2:- Means of patient transport used by health institutions

Issues	Response		
		No.	%
The means of patient transport used by health institutions to give service for community is satisfied?	Yes	105	84
	No	20	16
	Total	125	100

Source: - developed from the response of the questionnaire

According to respondent, in the above table 4.2 the means of patient transport used by health institutions to give service as institutional revealed that the satisfaction of the respondents with the service they received from the institutions. The major 105 (84%) of the respondents respond the provide the service for the health institutions are satisfied, while 20(16%), of the respondents responds not satisfied by supplying of means of transport, because the distance from their house the health institutions and lack of capacity to pay. The transport used by health institutions to give service for community Ambulance and communities used private vehicles like; Buses; minibuses & vans, Motorcycles and Bajaj and etc. with the service of the sector respectively.

Table 4.3:-Frequency of Supply of Medicine

Issues	Response	No.	%
Frequency of Supply of Medicine is enough?	Yes	87	69.6
	No	38	30.4
	Total	125	100

Source: - developed from the response of the questionnaire

Regarding the quality of the supply medicine received by the respondents from the institution as it is evaluated by time took to the have supply‟s. Based on these measurements, in the above table 4.3, the majority 87(69.6%) of the respondents replied that the service frequency of supply of medicine is enough in Very fast fair quality, while 38 (30.4%) of the respondents replied that the service is slow respectively. Furthermore, the respondents said that there are mechanisms to provide suggestion to the office regarding their activities and service.

Table 4.4:- Presence of Supplies Procurement System represents

Issues	Response	No.	%
Does the health facility have a system in place for procurement of supplies in health institutions?	Yes	69	55.2
	No	56	44.8
	Total	125	100

Source: - developed from the response of the questionnaire

Presence of Supplies Procurement System represents the idea of the respondents on the health institutions has a system in place for procurement of supplies for institutions. As such in the above table 4.4, the majority 69(55.2%) respondents feels good with the procurement of supplies in health institutions, the rest 56(44.8%) respondents were feels no good with the procurement of supplies in health institutions. In the words of the respondent‟s majority satisfied with the procurement of supplies in health institutions.

Table 4.5:- Adequacy of facility and equipment

Issues	Response	No.	%
There are adequate facilities and equipment‟s including offices in the institutions?	Yes	86	68.8
	No	39	31.2
	Total	125	100

Source: - developed from the response of the questionnaire

In those institutions, the adequate facilities and equipment‟s including offices or staff provide in the institutions. As such in the above table 4.5, the majority 86(68.8%) agree with the adequate facilities and equipment‟s including offices in the institutions, the rest 39(31.2%) respondents were feels no good with the adequate facilities and equipment‟s including offices in the institutions. In the words of the respondent‟s majority agreed with the supplies of the institutions.

Table 4.6:-Sufficiency of the service received

Issues	Response	No.	%
1. Do you think that the service of the health institution is sufficient?	Yes	73	58.4
	No	52	41.6
	Total	125	100

Source: - developed from the response of the questionnaire

According to above table 4.6 represents, the idea of the respondents on the providing of the service of the health institution. The table shows that majority 73(58.4%) of the respondents

responds, the health institutions provide good service, while the rest 52(41.6%) of the respondents believes that no sufficient/enough service provide this health institutions. This shows that in the words of the respondents they are satisfied because of the commitment of institutions.

Table 4.7:- Proper and efficient Utilization of Resources

Issues	Response	No.	%
This health institution is utilizing its resource properly and efficiently?	Yes	56	44.8
	No	69	55.2
	Total	125	100

Source: - developed from the response of the questionnaire

The above table 4.7 represents the idea of the respondents on the proper and efficient utilization of resources the health institutions. The table shows that only 56(44.8%) of the respondents respond the health institution are used/managed the resources proper and efficient utilization, while the majority 69(55.2%) of the respondents believes that the health institution are no used/managed the resources proper and efficient utilization for providing service. This shows that the health institution could not provide or used its resource properly and efficiently. As it was previously indicated under the institutional capacity of the office, the office lack professional and financial resources in provide sufficient service to the users in the town. For instance the respondents from workers in the health institutions said that "the offices do not provide necessary and sufficient training equally treated workers supportive workers and technical staffs. But the sufficiency of the institution fully accessible by water, electricity, road, medical equipment and etc. to give service for community.

Table 4.8: Barriers in Providing Adequate Health Service

No	Barriers	strongly disagree	Somewhat disagree	no opinion	somewhat agree	strongly agree	Weighted Average
1	Lack of good governance		11	2	59	53	4.232
2	Lack of office/staff	5		11	29	80	4.432
3	Inadequate budget	5	9	15	32	64	4.128
4	Lack of man power	5		7	52	61	4.312
5	Geographical location	7	14	17	67	20	3.632
6	Lack Infrastructures	6	2	1	59	57	4.272

Source: - developed from the response of the questionnaire

As indicated in the above table 4.8, based on the response of the respondents, the main barriers in providing adequate and effective health service to the community, lack of staff averagely by 4.43 and lack of man power averagely by 4.31 than the others, while the response of the respondents averagely said geographical location 3.63 and the rest 4.23, 4.27, 4.13 averagely represented lack of good governance, lack of infrastructures and inadequate budget respectively. In the words of the respondents they are not satisfied because of the lack of providing adequate and effective health service to the community in the institutions.

Generally, as the respondents give their suggestion, the office has to work more to effectively respond to the need and interests of the community in general and health‟s institutions in particular. The institutions has a suggestion box and suggestion pad (document) in the offices to put their ideas on the quality and sufficiency of the institutions. As such the service of the institution is responsive in terms of the time, accessibility and quality. According to the respondents, the institutions has to be visible to the community as the respondents use the office with great facilitate and continuously provide service while the institutions clearly announce and stipulated their service availability to the community.

II. Human Resource

One of the dimension or components of institutional capacity is the availability of sufficient and skilled manpower (which include effective leadership, professionals and experts). Which means Effective health system is a function of multiple factors which adequate numbers and mix of motivated and skilled human resources are essential at all levels of the health system. Human Resources for Health management is an integrated use of systems, policies and management and leadership practices to recruit, maintain and develop employees to create access to quality health care to all people. Effective human resources management requires governance structures with adequate number of well qualified human resources management and leadership professionals who have capacity and motivation to assess HRH needs, develop and implement relevant policies, strategies and operational guidelines to ensure health workforce planning, development, recruitment and equitable distribution, career development, motivation, retention and performance.

According to Ethiopian health service restructured, the HC is staffed with an average of 20/staff, Primary Hospital is staffed by an average of 53 persons, General Hospital is staffed by an

average of 234 professionals and specialized hospital is staffed by an average of 440 professionals. Accordingly, the health service institutions structures in Bishoftu town, Health center and General Hospital. The following table 4.9 shows the last five years available and required human resources Professional of each year of the Bishoftu town health institutions.

Table 4.9: Staff workers institutions for last five years

Institutions	Staffs	Required Professionals/year	Years				
			2003	2004	2005	2006	2007
General Hospital	Professional	234	83	95	99	99	105
	Supportive	-	-	-	-	157	163
Health Office(3HC)	Professional	60	26	28	36	37	41
	Supportive	-	35	35	36	36	37
Health Extension Workers			46	46	48	48	50

Source: - developed from the response of the questionnaire

The table 4.9, shows that the total number of existing Professional personnel of the Health Center is in 2003E.C was 26 and increased to 41 in 2007 E.C. while the required personnel was 60. This is to mean that the offices fulfill in 2007 E.C only (41 out of 60) 68.33% and the other in the General Hospital the total number of existing Professional personnel in 2003E.C was 83 and increased to 105 in 2007 E.C. while the required personnel was 234. This is to mean that the office fulfill in 2007E.C. only (105 out of 234) 44.87% of its human resource requirement, while the respondents believes that even if the total required personnel are in place, because of the bulkiness and multiplicity of the work of the institution, it would have not been sufficient for the effective operation of the institution. Each working process and officials and required abilities and educational backgrounds of the officials in the working process is decided by the regional government with little consideration of the internal capacity of the institutions in particular and the Town administration office in general. As such there is lack of professional in the institution. The following table 4.10 shows the last five years available human resources of each year of the Bishoftu town health institutions.

Table 4.10: Trends of staff workers in health institutions for last five years

No	Description	Years				
		2003	2004	2005	2006	2007
1	Physicians	10	14	15	17	17
2	Health Officers	16	16	19	21	21
3	Nurses(Clinical, MW, lab & etc.	83	93	101	98	108
4	Health Extension Workers	46	46	48	48	50
5	Supportive staff	35	35	36	193	200
	Total	**190**	**204**	**219**	**377**	**396**

Source: - developed from the response of the questionnaire

In 2007E.C, there were 17 physicians, 21 Health Officers, 108 Nurses, 50 Health Extension Workers (HEW) working in the town and 200 Supportive staff. In the words of the respondents, the institution is in shortage of professional workforce.

Given the shortage of human resource (HR) the existing staff has got necessary training and educational opportunity to enhance their capacity. Regarding the availability of sufficient training to the technical staff and but the supportive staff are not that much invited to training and further educational opportunity to enhance their capacity. This in turn resulted in limited individual capacity in the sector in one way and limited capacity of the office in other (as institutional capacity is the product of the individuals capacity) to provide sufficient and quality service to the users in particular and the community in general.

III. Financials

Financial resource is a crucial input for provision of adequate and optimum quality health services. However, the ever increasing cost of health care and multiple competing priorities in resource poor countries makes financial resources insufficient to make substantial improvements in access and quality of health care. The capacity of the institution to generate and acquire resource from different source, and how the institution attract, manage and maintain funding to meet its objectives in effective manner is also one of the capacity indicator.

The capacity to manage financial resources is fundamental to success within the enabling environment and at the organizational level; this applies to the management of both internal

resources (national budgets) as well as external resources (development funding). A concept key to external resources is Direct Budget Support (DBS), which is broadly defined as joint government/donor mechanisms to permit external resources to be channeled directly through national budgets, using national allocation, procurement and accounting systems, to supplement public expenditure on nationally agreed priorities.

The following table 4.11, the governmental health expenditure has increased substantially. Between 2003 E.C and 2007 E.C, government financing grew from 8,890,861 to 13,907,135 of total health finance budget in Bishoftu health institution.

Table 4.11: Allocation of Budget for the last five years in each Health institutions

Institution	2003	2004	2005	2006	2007
G/Hospital	5,252,325	7,214,700	7,879,700	8,850,000	8,942,600
H/Office	3,638,536	4,125,354	4,364,127	4,772,595	4,964,535
Total	8,890,861	11,340,054	12,243,827	13,622,595	13,907,135

Source: - developed from the response of the questionnaire

Regarding the financial and other resources such as office equipment and supplies of the health institution, almost all of it is covered by the Regional health bureau and City Administration government budget. In addition to the government grant to the institutions, the institution has a right to addressing collection and use of revenues by health institutions. Regarding the adequacy of the budget appropriation and allocation is arbitrarily assigned to the office by the government and by the office respectively. Above 75% of the respondents said that the budget assigned to the health institution based on population of the catchment and 25% through Block Grant. In addition to the government grant to the institutions, respondent says the institutions have a right to collect and use of revenues by different methods according to the following table 4.12.

Table 4.12: Sources of internal revenue

What are the sources of internal revenue?	No	%
• Collection of Tax	-	-
• Sale of drug	63	50.4
• Service charge	46	36.8
• Others (Lab cost, preventive clinic)	16	12.8
Total	125	100

Source: - developed from the response of the questionnaire

The amount of retained revenue generated in health facilities varies from facility to facility and from institution to institution. On average health centers generate 30% of their total budget while hospitals generate 23% from retained revenue. Bishoftu health institutions on average retained ETB 3.1 million per year, while HCs retained ETB 1.93 million. According to respondent, in the table 4.12, the retained collected from sale of drug 63%, from service charge 36.8% and from others like; (inpatient service, outpatient service, ART service, EOPD service, Lab cost, preventive clinic and others) 12.6% collected. The retained revenue has improved availability of essential medicines, diagnostic equipment and medical supplies. It is also used for renovation and expansions of rooms and staff housing.

In addition to this, the role of non-governmental organizations (NGO"s) has also been expanding. This NGO that works on Bishoftu health institutions; such as center for diseases Control, Tulam University on HIMS, World food program on preventive and WHO on training. This is a meaningful achievement both for health Institutions improving harmonization in financing of the health sector.

4.4. Challenges to implementation of health service

As indicated in table 3.13, based on the response of the respondents, the main challenges in in the health institutions for providing adequate and effective health service to the community according to health policy, Inadequate Supply of Equipment"s (Drug 3.83 & Medical equipment 3.89) averagely by 3.86 and Lack of Working place (Location place 3.69 & Infrastructure 4.02) averagely by 4.08 than that of Lack of Capacity (Financial capacity, Human capacity & Technical capacity) and Procedures Rules and Regulations. This shows that the institution has face more problems due to implementing health policies in the town. In the words of the respondents respond, the city Administration in general and the health institutions in particular in the town, are looking for solving this problems by taking by a soon action focusing on the tables 4.13;

Table 4.13: Challenges to implementation of health service

No	**Challenges**	strongly disagree	Somewhat disagree	No opinion	somewhat agree	strongly agree	Weighted average
A	Lack of Capacity	8	22	3	70	22	3.60
	· Financial capacity	13	33	-	62	17	3.30
	· Human capacity	3	12	5	78	27	3.91
	· Technical capacity	9	20	4	71	21	3.60
B	Lack of Working place	9	12	9	58	39	3.85
	· Location place	6	17	15	59	28	3.69
	· Infrastructure	11	6	2	57	49	4.02
C	Inadequate Supply of Equipment‟s	7	12	10	61	36	3.86
	· Drug	9	11	9	59	37	3.83
	· Medical equipment	4	13	11	62	35	3.89
D	Procedures Rules and Regulations	7	17	15	55	31	3.69

Source: - developed from the response of the questionnaire

Based on the observations, and the responses given to the questionnaires administered to a sample of the employees of these pilot Institutions, the operations performance measure that was least influenced by implementation of institutional practices was increased environmental sustainability health had negatively human resource outcomes in employee attitude in all. The main four items that characterize Inadequate Supply of Equipment‟s (Drug & Medical equipment) 3.86%, Lack of Working place (Location place & Infrastructure) by 3.85%, Lack of Capacity (Financial capacity, Human capacity & Technical capacity) by 3.60% and Procedures Rules and Regulations by 3.69% framework that was used in the study. The greatest impact on attitude was on employees‟ preference to be part of health activities in the institution. This implies that participating in health activities has a negatively impact on employee attitudes and institutions could greatly improve their workers‟ attitudes by having them participate in health activities. In addition to hiring experienced executives and furnishing incentives to employees, the employees of the health need to be given intensive training so that they become committed to the professional standards that will enable their institution to optimize operations.

Chapter Five: - Summary of Major Finding, Conclusion and Recommendation

5.1. Summary of Major Finding

Based on the data analyzed and presented above major findings of the paper is summarized as follow.

1. **At all levels of government structures in the town there is lack of sufficient human resource.** There are acute shortages of professional workforce particularly at the *health centers* and general hospital level shows in the table 4.9.

- Lack of professional work force and the total required personnel are not in place, because of the bulkiness and multiplicity of the work of the institution, it would have not been sufficient for the effective operation of the institution. Regarding the availability of sufficient training to the technical staff they are in a better position getting chance while the supportive staffs are not that much invited to training and further educational opportunity to enhance their capacity. This in turn resulted in limited individual capacity in the sector in one way and limited capacity of the office in other to provide sufficient and quality service to the patients/customers in particular and the community in general.
- Given the multiple and overlapping responsibilities and lack of human resource, there is also other hurdle for the government officials starting from *health center* up to the town"s general hospital in Bishoftu town.
- The HR policies and procedures are not accessible to all staff and as a result, not consistently implemented. In-service training needs are not systematically reviewed to link with individuals/teams and organizational performance and there is little or no in-service training opportunities to develop HRH leadership and management skills.

2. ***Limited Financial Resource.*** Concerning financial resource, general hospital and health centers have a right to mobilize resource in addition to government budget, but they lack experience/commitment to do so because of lack of professional to prepare vary income generating program for this purpose. As such the institutions came across financial shortage as the government budget is not sufficient for their effective operation.
3. ***Lack of sufficient supply facilities***: Institutional capacity to coordinate multiple stakeholders, research and development, the synthesis and dissemination of pharmaceutical information and pharmaceutical services are satisfied. The facility systems in place for procurement of supplies are enough, but, the market for pharmaceuticals is still limited given the size of

Bishoftu‟s population. With the aim of increasing the availability of health commodities at an affordable price in usable conditions, the sector procured pharmaceuticals, medical supplies and equipment through the Revolving Drug Fund (RDF) and the various programs is increasing over time. But, the availability of key medicines in the hospital requests is below satisfactory.

4. In addition to the above capacity problem, the institutions have ***lack necessary policy capacity that supports the effective implementation of the policy and their plan.*** The actor has no understanding about the health policy and the officials of the actor do not even know the existence of such policy. They further lack policy professionals and health experts for effective realization of the objectives of the sector and the national policy.

5.2. Conclusion

The paper made an analysis of policy and institutional capacity of the health institutions in implementing the national policy of Ethiopian health in Bishoftu town. The study found out that despite the commitment of the government to implement the policy in all tiers of health institution, the service is restructured in such a way that the PHCU is composed of one HC and five satellite HPs, these provide services to about 25,000 beneficiaries and staffed with an average 20 personnel‟s. It provides both preventive and curative services. It serves as a referral center and practical training institution for HEWs. A HC has an impatient capacity of 5 beds. General Hospital provides inpatient and ambulatory services to an average of 1,000,000 people. It is staffed by an average of 234 professionals. It serves as a referral center for primary hospitals. It has an inpatient capacity of beds and serves as a training center for health officers, nurses and emergency surgeon‟s categories of health workers.

Accordingly, it was observed that the three health centers in Bishoftu town provide services averagely to about 60,097 beneficiaries, which is more than double of the standard set by the policy. This showed that the institutions are delivering service more than capacity in terms of the number of beneficiaries, at the same time the member of personnel delivering service at each health center is averagely 14 personnel‟s which is blow the standard by 30% averagely.

The General Hospital was previously a district hospital which has been upgraded to zonal hospital. It is serving 1.2 million people living in three towns and five districts. The total number of existing Professional personnel in 2007E.C was 105. This is to mean that the office fulfill in

only 44.87% of its human resource requirement. This showed that the institutions are delivering service more than capacity in terms of the number of beneficiaries, at the same time the member of personnel delivering service at this institution blow standard by 55.13%.

Concerning financial resource, general hospital and health centers have a right to mobilize resource in addition to government budget, but they lack experience/commitment to do so because of lack of professional to prepare income generating program for this purpose. As such the institutions came across financial shortage as the government budget is not sufficient for their effective operation.

As such governmental health institutions in the Town, suffer from limited institutional capacity such as shortage of human resource professionals and experts; lack of adequate material resource such as finance, office equipment‟s and building for permanent office; limited policy knowledge and understanding, lack of institutional experience are among the capacity problems faced by the governments in the town in discharging their responsibilities. This in turn resulted in poor quality service to the community in general. In order to improve the capacity of the actor in the town government must consider and reconsider the local levels in the national policy and establish strong institution at the grass root level to make the service more responsive to the community.

Finally the actor has no understanding about the health policy and the officials of the actor do not even know the existence of such policy. They further lack policy professionals and health experts for effective realization of the objectives of the sector and the national policy. Then the government failed to effectively institutionalize the national policy in the local government in the way that could respond to the users need and problem in a localized manner.

5.3. Recommendation

Based on above finding and conclusion of the paper, the following recommendations were forwarded as a policy implication for the improvements of the actor.

- Sufficient and competent work force has to be recruited to the sector to enable them to provide their service in sustainable manner. Effective human resources management requires governance structures with adequate number of well qualified human resources management and leadership professionals who have capacity and motivation to assess HRH needs, develop and implement relevant policies, strategies and operational guidelines to ensure health workforce planning, development, recruitment and equitable distribution, career

development, motivation, retention and performance. Regarding the financial governments assign sufficient budget to the health institutions to enhance their operational capacity.

- There must be continuous and sustainable training program and educational opportunity to the officials in order to improve their capacity both in the policy areas and institutional perspectives. This enables the actor to handle the purpose of the sector in effective manner as individual abilities and skill is very important for the fulfillment of the organizational objectives. Health Institution must have sufficient information and understanding of the national policy.
- Resource is very important to the effective discharge of the institutional plan in every types of organization. As such, the sector in the town must have sufficient resource to discharge their responsibilities. Sufficient financial and other resource must be assigned to the actor. The actor itself should effectively utilize the existing resource and by using their right, they must prepare project and program to raise funds from different institutions to enhance their financial capacity.
- There must be formal and informal mechanism by which the institutions in the town share their experience with others particularly among the health institutions. As a general there should be strong partnership and network both among the actor and between actor and other sectors.

An excellent policy formulation with excellent policy tools may not be sufficient condition for the fulfillment of the policy objectives. There must be institutions that effectively implement the policy to bring an excellent policy outcome unless otherwise, the policy remains on the paper without bringing fruitful result for a target group. In short, the successful implementation of policy highly and critically depends on clarity of the policy, local capacity and the commitment of the policy implementers

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7. Appendix

Appendix One

Addis Ababa University

School of Graduate Studies

Department of Public Administration and Management

Scheduled questionnaire to be answered by the City Administration Health Office workers

Dear respondent, this semi-structured interview is prepared for collecting data in conducting thesis entitled **Assessment of Institutional Capacity in the Implementation of Health Policy: the Case of Bishoftu Town** in the partial fulfillment of the requirement of Masters‟ of Art in Public Management and Policy, specialization in policy. Therefore, I strongly appreciate and thank you in advance for your positive collaboration in my work. Then it is strongly confidential that all information that you provide will not be exposed to the third party and it is only applied for the academic and research purpose. In that, your genuine information has a greater credit for the successful completion of the research.

This questionnaire is filled and responded by Bishoftu town health office.

Part I: Demographic characteristics of the respondents

1. Name of the Institution on which you works _____
2. Sex A. Male B. Female
3. Age: A. 18-25 B. 26-44 C. 45-55 D. 56-60
4. Educational Level: A. Below Grade 10 B. 10-12th C. College Diploma E. BA/BSc F. MA/MSc G. MD/Specialist and above
5. Occupation _____

II. Health Institutions and Personnel:

6. Please indicate number of health Institutions in Bishoftu town by type
   a) Health post _____ c). Clinic _____
   b) Health center _____ d). Hospital/General Hospital _____
   e). Others _____

7. Occupied positions of health institutions in your town by type of profession **(%)**

No	Description	2003	2004	2005	2006	2007
1	Physicians					
2	Health Officers					
3	Nurses					
4	Health Extension Workers					
5	Clinical nurse					
6	Other (If any)					

III. Provision of service;

1. The Ethiopian health service is restructured into three tier system. These provide services to 25,000 population altogether and staffed with an average of 20 staff. A Primary Hospital provides inpatient and ambulatory services to an average population of 100,000 and has an inpatient capacity of 25-50 beds with staffed by an average of 53 persons. General Hospital provides inpatient and ambulatory services to an average of 1,000,000 people and it is staffed by an average of 234 professionals. A specialized hospital serves an average of five million people and it is staffed by an average of 440 professionals. I hope all health institutions in Bishoftu town accordingly give the service sufficient for the community.
   a) strongly agree ☐ b) somewhat agree ☐ c) No opinion ☐
   d) Somewhat disagree ☐ e) strongly disagree ☐
2. If your answer for is No. 3 (e) state your reasons?

   _____
3. The means of patient transport used by health institutions to give service for community is satisfied? Yes ☐ No ☐
4. Frequency of Supply of Medicine is enough?
   Yes ☐ No ☐
5. Does the health facility have a system in place for procurement of supplies in health institutions? Yes ☐ No ☐
   If your answer for is yes state what the means of patient transport are used by the institutions.

   _____
6. There are adequate facilities and equipment"s including offices in the institutions?
   Yes ☐ No ☐

If your answer for is yes state what the means of patient transport are used by the institutions.

_____

7. Do you think that the service of the health institution is sufficient?

   Yes ☐ No ☐

8. This health institution is utilizing its resource properly and efficiently?

   Yes ☐ No ☐

9. Depend on the following table tick **(✓) as** the main barriers in providing adequate and effective health service to the community.

No	Barriers	strongly agree	somewhat agree	No opinion	Somewhat disagree	strongly disagree
1	Lack of good governance					
2	Lack of staff/office					
3	Inadequate budget					
4	Lack of mane power					
5	Geographical location					
6	Lack Infrastructures					

   Other (if any) _____

10. What do you suggest for improvement: _____

_____

III. Supply and Utilization of Resources

1. How financial resource is allocated to health institutes in your town (hospitals, health center, health post, etc.)

   a) Based on population of the catchment b) block grant c) Unit cost method(cost per head)

   d) If any specify:_____

2. Health institutions are using their resource properly and efficiently.

   a) Strongly agree ☐ b) somewhat agree ☐ c) No opinion ☐

   d) Somewhat disagree ☐ e) strongly disagree ☐

3. If your answer for question No 2 is (b) what are the sources of resources mainly for your health institutions? _____

4. Please indicate the total budget allocated health institutions in your town for the last five years?

   1. 2003 _____ 4. 2006 _____

   2. 2004 _____ 5. 2007 _____

   3. 2005 _____

V. Constraints

1. Depend on the following table tick **(✓)** the major challenges of your institutions in human resource development, financial resource and infrastructure development in order to implement health policy at your local.

No	**Challenges**	strongly agree	somewhat agree	No opinion	Somewhat disagree	strongly disagree
A	Lack of Capacity					
	• Financial capacity					
	• Human capacity					
	• Technical capacity					
B	Lack of Working place					
	• Location place					
	• Infrastructure					
C	Inadequate Supply of Equipment‟s					
	• Drug					
	• Medical equipment					
D	Procedures Rules and Regulations					

Appendix Two
Addis Ababa University

School of Graduate Studies

Department of Public Administration and Management

Scheduled questionnaire to be answered by the Health Institutions workers

Dear respondent, this semi-structured interview is prepared for collecting data in conducting thesis entitled **Assessment of Institutional Capacity in the Implementation of Health Policy: the Case of Bishoftu Town** in the partial fulfillment of the requirement of Masters‟ of Art in Public Management and Policy, specialization in policy. Therefore, I strongly appreciate and thank you in advance for your positive collaboration in my work. Then it is strongly confidential that all information that you provide will not be exposed to the third party and it is only applied for the academic and research purpose. In that, your genuine information has a greater credit for the successful completion of the research.

This questionnaire is filled and responded by Bishoftu town health institution workers.

Part I: Demographic characteristics of the respondents

1. Name of the Institution on which you works _____
2. Sex:- A. Male B. Female
3. Age: A. 18-25 B. 26-44 C. 45-55 D. 56-60
4. Educational Level: A. Below Grade 10 B. 10-12th C. College Diploma E. BA/BSc F. MA/MSc G. MD/Specialist and above
5. Occupation _____

II. Health Institutions and Personnel:

6. Type of health institution

a) Health post
b) Health center
c). Clinic
d). Hospital/General Hospital
e). Others

7. Number of staff workers in your health institution for last five years.

No	Description	2003	2004	2005	2006	2007
1	Physicians					
2	Health Officers					
3	Nurses					
4	Health Extension Workers					
5	Clinical nurse					
6	Other (If any)					

III. Provision of service;

7. The Ethiopian health service is restructured into three tier system. These provide services to 25,000 population altogether and staffed with an average of 20 staff. A Primary Hospital provides inpatient and ambulatory services to an average population of 100,000 and has an inpatient capacity of 25-50 beds with staffed by an average of 53 persons. General Hospital provides inpatient and ambulatory services to an average of 1,000,000 people and it is staffed by an average of 234 professionals. A specialized hospital serves an average of five million people and it is staffed by an average of 440 professionals. I hope all health institutions in Bishoftu town accordingly give the service sufficient for the community.

   b) strongly agree ☐ b) somewhat agree ☐ c) No opinion ☐

   d) Somewhat disagree ☐ e) strongly disagree ☐

8. If your answer for is No. 3 (e) state your reasons?

   _____

9. The means of patient transport used by health institutions to give service for community is satisfied? Yes ☐ No ☐

10. Frequency of Supply of Medicine is enough?

    Yes ☐ No ☐

11. Does the health facility have a system in place for procurement of supplies in health institutions? Yes ☐ No ☐

    If your answer for is yes state what the means of patient transport are used by the institutions.

    _____

12. There are adequate facilities and equipment"s including offices in the institutions?

    Yes ☐ No ☐

If your answer for is yes state what the means of patient transport are used by the institutions.

_____

13. Do you think that the service of the health institution is sufficient?

Yes ☐ No ☐

14. This health institution is utilizing its resource properly and efficiently?

Yes ☐ No ☐

15. Depend on the following table tick **(✓) as** the main barriers in providing adequate and effective health service to the community.

No	Barriers	strongly agree	somewhat agree	No opinion	Somewhat disagree	strongly disagree
1	Lack of good governance					
2	Lack of staff/office					
3	Inadequate budget					
4	Lack of mane power					
5	Geographical location					
6	Lack Infrastructures					

Other (if any) _____

16. What do you suggest for improvement: _____

_____

III. Supply and Utilization of Resources

17. How financial resource is allocated to health institutes in your town (hospitals, health center, health post, etc.)

b) Based on population of the catchment b) block grant c) Unit cost method(cost per head)

d) If any specify:_____

18. Health institutions are using their resource properly and efficiently.

a) Strongly agree ☐ b) somewhat agree ☐ c) No opinion ☐

d) Somewhat disagree ☐ e) strongly disagree ☐

19. If your answer for question No 2 is (b) what are the sources of resources mainly for your health institutions? _____

20. Please indicate the total budget allocated health institutions in your town for the last five years?

1. 2003 _____ 4. 2006 _____

2. 2004 _____ 5. 2007 _____

3. 2005 _____

V. Constraints

21. Depend on the following table tick **(✓)** the major challenges of your institutions in human resource development, financial resource and infrastructure development in order to implement health policy at your local.

No	**Challenges**	strongly agree	somewhat agree	No opinion	Somewhat disagree	strongly disagree
A	Lack of Capacity					
	• Financial capacity					
	• Human capacity					
	• Technical capacity					
B	Lack of Working place					
	• Location place					
	• Infrastructure					
C	Inadequate Supply of Equipment‟s					
	• Drug					
	• Medical equipment					
D	Procedures Rules and Regulations					