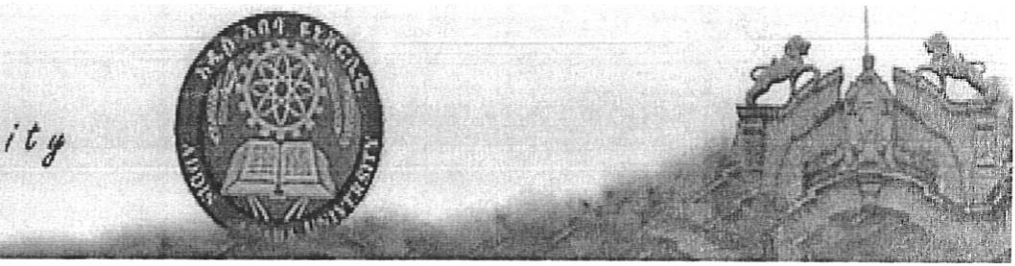

ADDIS ABABA UNIVERSITY

GE OF LAW AND GOVERNANCE STUDIES

CENTER FOR FEDERAL STUDIES

sment of decentralization on health care service delivery:

Gozamin Woreda- Amhara National Regional State

By

lene Agegnehu

An Impact Assessment of Decentralization on Health Care Service Delivery: The Case of Gozamin Woreda- Amhara National Regional State

A Thesis Submitted to the Center for Federal Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Masters of Arts in Federal Studies

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Acronyms and Abbreviations

ANRSC-	Amhara National Regional State Constitution
ANRS-	Amhara National Regional State
BOFED	Bureau of Finance and Economic Development
CSA-	Central Statistical Agency
EC-	Ethiopian Calendar
FDRE-	Federal Democratic Republic Ethiopia
EPRDF-	Ethiopian People's Revolutionary Democratic Front
HDG-	Health Development Group
HC	Health Center
HEP-	Health Extension Program
HEW-	Health Extension Worker
HH-	House holds
HSDP-	Health Sector Development Program
MDG-	Millennium Development Goals
MoH-	Ministry of Health
NGO-	Non Governmental Organization
OPD-	Out patient Disease
PDRE -	Peoples' Democratic Republic of Ethiopia
PFSA	Pharmaceutical Fund and Supply Agency
SNNPR-	Southern Nations Nationalities and Peoples Region
TM-	Traditional Medicine
UDA-	Urban Dwellers Associations
UNDP-	United Nation Development Program
UN-HABITAT-	United Nations Human Settlements Programme
UNICEF-	United Nations Children Fund
WA-	Woreda Administrative Council
WE-	World Bank
WHO-	World Health Organization
WPE-	Workers Party of Ethiopia

Abstract

This study, Impact Assessment of Decentralization on Health Care Service Delivery was done at Gozamin woreda of East Gojjam Zone Administration in Amhara National Regional state. The major objective of the study was to assess the impacts of decentralization on the health care service delivery. The current status of health care services, the responsibilities and functions of the woreda health office, the level of community participation and the major challenges of the woreda that hinder from providing quality health care services were reviewed. Methodologically, a descriptive research design with qualitative research technique/ method was employed to collect the data for the study. The instruments used to collect the data are interviews, focus group discussions and field observations. Primary and secondary data were collected from different Health institutions in the Woreda as well as from annual official health sector reports and documents. The analysis part was supported by legal and official documents. The findings of the study revealed the recruitment of health personnel, collection of user fee, management and supervision of health institutions, in-service training and career development of health workers are devolved to the woreda. The study also found that undertaking construction of health HCs and health posts is given to the woreda in a delegated form. Whereas, purchasing of drugs and other pharmaceutical equipments are highly centralized, controlled by the regional governments. The health care service accessibility and coverage of the woreda in terms of expansion of health care institutions has shown an improvement, it reach 100%. However, shortage of health personnel (midwifery, lab technician and pharmacy technician), shortage of finance for duty service and per-diem payment, and drugs shortage are the challenges of the woreda health care delivery system that affects the quality of the services. Moreover, according to the patients and households view, the costs of health care treatment is high as compared to the ability of most beneficiaries incomes, the free service scheme-which is very impressive were abused by kebele officials and weak one to five and one thirty network or groups were also the challenges of Gozamin woreda health care service delivery system.

CHAPTER ONE

1. INTRODUCTION

1.1.BACK GROUND OF THE STUDY

Decentralization can be defined as the "transfer of authority and responsibility for public functions from the central government to lower or quasi-independent government organizations or the private sector" (Rondinelli, 1989:5). The transfer of powers includes political, administrative or managerial and fiscal authority from the centre to lower levels of governments (WB, 2000:13). Currently, decentralization is seen as a fashion policy choice, where by every country is inclined towards decentralized government system in view of administering and providing services effectively and efficiently and ensuring good governance (Bernard, 2011:1). Regardless of difference in the levels of socio- economic and political development, both developed and developing countries have embarked on a dramatic change on the government system; from a very centralized to a decentralized one (OECD, 2004:8)..

Historically, Ethiopia in the previous two successive regimes was characterized by a tight centralization of all socio-economic, political and administrative spheres where the centre overwhelmingly control the authority, and decentralization was considered as a threat to the central administration (Dickovick and Tegegn, 2010:5). However, since 1991, the Ethiopian government has undergone decentralization process and adopted federal form of government and divided the country in to 9 self-governing regional states[1] and Addis Ababa city government. Settlement pattern, consent of the people concerned, language and identity criteria were used to demarcate regions (FDRE Constitution, 46 (2)). Considerable political, fiscal and administrative powers were devolved from the centre to the regions with the objectives to keep the country from disintegration via addressing a long standing nationalities question (Tegegne, 1998). Moreover, the 1995 FDRE constitution under Art.39 guaranteed to the Nation, Nationality and People of Ethiopia:

[1]Nine member states of the federation as stated under (Art.47) are: Tigray, Afar, Amhara, Oromo, Somali, Benishangul-Gumuz, SNNP, Harari, Gambella and Addis Ababa. The constitution remains silent about Dire Dawa city. But it established by Proclamation No.416/*2004*.

(1) to have unconditional rights to self-determination, including the right to secession, (2) to have the right to speak, to write and to develop its own language; to express, develop and promote its culture; and preserve its history; (3) to have the right to take full measure of self-government which includes the right to establish institutions of government in their respective territory that it inhabits and have equitable representation in state and Federal governments.

The FDRE constitution notes that, the *State government shall be established other administrative levels if they find necessary and adequate power shall be granted to them to enable the People to participate directly in the administration of such units' (Federal constitution Art.50/4). Accordingly,* the regional governments have established local governments in a way that fits their specific circumstances. Heterogeneous states have formed Zones or special woredas on ethnic bases. The relatively homogenous states established woreda governments. The powers and functions of Local Governments (Zonal, Woreda and kebele) therefore, derive from the states' functions and powers. The objective of woreda level decentralization was to improve service delivery, to have more participatory governance, and to promote economic development through empowering local communities by shifting decision-making powers down to the grass-root level (Hashim, 2010; Dickovick and Tegegn, 2010:5).

The Amhara national regional state as per the federal constitution, has established its own state structure to administer regional socio-economic development, manage ethnic diversity that exists there and to improve public service efficiency. Accordingly, the revised constitutions of the Amhara regional states provide that the administrations of the regional states are arranged by nationality administrations, Woreda and Kebele level. The Awi, Himra, and Oromo people are recognized as nationality Zonal administrations (Amhara proc. No 59/2001, Art. 45 (2)).There are 11 functional zonal administrations in the region. Argoba woreda has got special status. The Gozamin Woreda, which is located in East Gojjam Zone of ANRS, would be the target of the study. As per the ANRS constitution, the Woredas are supposed to perform a range of tasks.
Health service under decentralization system necessitates transferring certain functions to the local levels so as to meet the health needs of the citizens (Kwoyiga, 2010; Bossert, 1998). This is because the fact that decentralization promises for the betterment of local health service

provisions for a better quality of life (UNICEF, 2009: 20).In line with this sprite, health service responsibilities have been separated among the federal, state, Zone, and woreda. The present study, therefore, mainly focuses on decentralization in the primary health care service delivery system at Woreda or district level, at Gozamin woreda.

1.2. STATEMENT OF THE PROBLEM

As mentioned above, decentralization in Ethiopia involves the devolution of political, fiscal and administrative powers up to the woreda level. The woreda levels of governments are assigned to carry out socio-economic responsibilities within their jurisdictions. They are also assigned to provide basic social services such as education, health and water services. However, the performances of the woreda to discharge their responsibilities were constrained by interrelated factors.

Financial problems- inadequate funding for basic services provided to lower tiers of government is a major constraint. This can limits the abilities of woreda to empower themselves and improve service delivery. In order to meet the desired service provision, the Woreda administrations rely almost exclusively on unconditional block grants from regional governments. Even the majority of this grant is spent on salaries and operational costs, leaving little for other investments essential to improve. The other serious problem is lack of trained manpower. The technical and administrative positions of many woredas have not been fully filled or have been filled by untrained personnel with limited capacity (WB, 2008: 72).

According to Meheret (2007), inadequate institutional and administrative capacity and inefficient resource allocation and mobilizations are problems that the local government of Ethiopia has experienced. The limited resources made available to local government undermine decentralization policies and maintain weak local institutions. Inadequate infrastructure- lack of complementary infrastructure (water, electricity, phones or communication) and necessary equipment (vehicles, computers) hamper the abilities of woreda government to provide the desired services to the residents of the woreda.

The study area, Gozamin Wereda has faced similar problem. The health care service delivery system is hindered by the financial, lack of skilled manpower and poor infrastructure facilities. In addition, the majority of health budget is granted from the regional government instead of covering its expenditure by its own revenue at local level. According to MOH, 2010/11, inadequate capacity to implement decentralized health system, inefficient resource allocation and mobilization are some of the challenges observed at the woreda level government. Furthermore, according to the proclamation No. 117/97 EC of health care financing manual of Amhara National Regional State Health Bureau confirmed that, the majority of health centers in the region have constrained by inadequate budget to purchase adequate stock of drugs and pharmaceutical supplies.

1.3. OBJECTIVE OF THE STUDY

The general objective of the research is to assess the impact of decentralization on the health care service delivery at Gozamin Woreda, Amhara National Regional State.

The Specific objectives of the study include:

i. To identify powers entrusted to the study Woreda in relation with health service delivery.
ii. To describe the existing status of health care services delivery of the Woreda.
iii. To identify the main challenges or problems that the Woreda has encountered.
iv. To explore the extents or levels of community participation in woreda health care service delivery.
v. To assess the impacts of decentralization on the health care service provisions?

1.4. Research questions- in order to achieve the above state objectives, the researcher have tried to answer the following questions.

1. What are the powers and responsibilities assigned to the Woreda, concerning provision of health services?
2. What is the current status of health care service delivery at Gozamin woreda?
3. What are the major challenges or problems encountered the Gozamin woreda?
4. To what extent local people participate in the Woreda health care provision system?
5. What are the impacts of decentralization on the health care service provisions?

RESEARCH DESIGN AND METHODOLOGY

Research Design

alitative research technique with descriptive research design was employed. Qualitative rch helps to undertake in-depth study through exploring attitude, behaviors and experience sing data collection instruments as key informant, and focus group discussion. Qualitative oach uses the method of subjective assessment of opinions, behaviors, and attitudes of the le. It is concerned with qualitative phenomenon, involves quality or kind (Kothari, 1990:3). researcher also used descriptive research design because it enables the researcher to describe ature of general health care service in the Woreda, its performance and tribulations facing Woreda in relation with the health service decentralization.

. DATA COLLECTION APPROACHES

ces of data -in order to realize the intended objective of the study, both primary and ndary data source were collected and analyzed. The Primary data include:

nterviews- Woreda and kebele officials, the Woreda's health office manager, and health ers director were interviewed. The researcher assumed that they have knowledge about the ntralized health care system being practiced in the country in general and in the Amhara ional States in particular because of government position they have.

n-depth interviews- were conducted with beneficiaries of health care services households patients to understand their satisfaction or dissatisfaction with the existing health service vision. An in-depth interview was also administered with health extension workers.

Focus Group Discussion (FGD) - has been employed with the objective to capture feelings, eriences and diverse perspectives of the residents of the woreda through group interaction might not have been articulated in the one-to-one interview. The focus group discussion was anized in each selected health center with maximum of six participants involving both ders. The participants of the discussions included Nurses, mid-wifery, lab Technicians, rmacist and Health Officers. For the purpose of discussions; Semi-structured questions were pared to guide the discussion process.

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D) Field observation- is another important means of data collection method in qualitative research. According to Marshall and Rossman (2006), observation can be defined as "A systematic memorandum and recording of events, behavior and artifacts in the social setting chosen for a study."Observation enable the researcher to assess the physical or the visible apparatus or equipments of the health institutions. Besides to interview and focus group discussion, field observation by the researcher himself was also part of the primary data source.

Secondary data sources- various related literatures, federal and regional governments' health policy documents, proclamations were reviewed.

1.5.3. Sampling Design and Determination of Sample Population

The researcher in general had three categories of informants. The first category includes health workers-which include Nurses, Health officers (HO), midwifery, pharmacy technician, and Health Extension workers; the second is composed of households and patients; and the third category includes Woreda health office director, Health Center directors, kebele and woreda official) were considered as sources of primary information.

The Woreda under study, have the population of more than 148,191[2] stratified by 26 kebele administrations[3] with six health centers[4], and 26 health posts. The researcher, however, Cannot cover the whole Health Centers under studies. For the interest of time and financial constraint, out of the six HCs, three of them were selected[5], on the bases of their degree of urbanization and distance from the center were considered. Accordingly, the three health centers were selected

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[2] The woreda population figure varies considerably from office to office. For example, , according to the woreda government communication affair office, the total population size of the woreda is 170, 207, but I took the figure from the 2006 EC Gozamin woreda finance and planning office document148,191. Of these 73965 are males and 74226 are females.

[3] Chertekel, Wuger, wonka, Asab-abo, Libanos, Yenebrina, Giraram, Demba, My-angetam,Yebokela, Addis na Gulit, Balarif, Kebi, Yebokela Zuria, Chimet, Yebo-Argena, Deledel, Enerata, Yebokla Town, Gedemala Leklekita,Woynima-Geramo, Desa-Enesie,Yetijan Shebalima, kegn-Abo.

[4] The six health centers available at the woreda are: Chertekel, Aba Libanose, Fendeka, Yebokla, Giraram, Gozamin. Within these health centers, there are the numbers of kebeles with health posts in the form of cluster.

[5] The three sample health centers were; Chertekel, Gozamin and Giraram. Of these, Gozamin health center is relatively more urbanized than the others; while Chertekel is less urbanized than Gozamin but better urbanized and nearer to the center (in-between) as compared to Giraram-which is the most rural, very remote from the center and high land or dega HC.

both from a very rural and distant kebele, and from a relatively urbanized kebeles and in between. This type of combination in sampling method would enable the researcher to make simple comparisons between them and to see the impacts of decentralization on the nearer and remote kebeles (geographic location) with regard to health care service quality, and availability of health resources.

Determination of sample population-from the total of 69 health workers who are currently working at the selected health centers, 36 (25%) employees were selected for focus group discussion on the basis of their work experience- who have had five years and above. Of these 18 were nurses, 5 were midwifery, 4 were health officers (HO), 5 were pharmacy technician, and 4 Lab. technicians. The researcher also selected 4 key informants for in-depth interview purpose from Woreda health officials based on their position in government office, rich experience and knowledge they have. In addition, 6 health extension workers (two from each center), 12 households who previously visited and knew the health centre were also interviewed. Without biased to their background information, four households from each kebele/ health center/ were selected in order to have a representative sample. Concerning patients, the researcher randomly took out-patients[6]. First, the researcher registered the names of 96 patients who visit HC within a week in their alphabet order. Then starting from one, patients at every ten term were included and a total of 18 patients were selected. Patients were included as an informant only those who have not severe illness but those who had mild cases and the volunteer one so as to get appropriate response.

1.5.4. METHODS OF DATA PRESENTATION AND ANALYSIS

The necessary data were first collected through interview, focus group discussion and field observation. Then the data were compiled, expressed and analyzed qualitatively. Different means of interperating date such as percentage, figures, and tables were employed.

[6]**Out-patient-** According to MOH policy document, is patients who receive ambulatory care (examination and treatment) without being admitted or occupying a bed in the health institutions (MoH, 2007).

1.6. SIGNIFICANT OF THE STUDY

i. The finding helps the service givers and managers to see problems associated with decentralization and health care service delivery. And

ii. The result drawn from the study would help the officials and employees to create awareness for looking alternative policy options to provide adequate health service.

iii. It would make possible or serve as a road map for other scholars who have interests to carry out further research on related topic.

1.7. SCOPE OF THE STUDY

This research entitled as an assessment of decentralization in health care service was confined at Gozamin Woreda, Amhara National Regional state. Of the 6 health centers of the woreda, the study was delimited only on 3 HCs. Within this domain, the powers given to the Woreda, the nature of health service, the levels of community participation, financial source and its adequacy were discussed.

1.8. LIMITATION OF THE STUDY

During conducting the research, the researcher faced different obstacles that should hamper the quality of the research. Among others, financial and time constraint forced the researcher to limit the number of sample population. In addition to this, the researcher did not deal with the impact of decentralization in the whole kebele which are found in Gozamin Woreda, rather attempts to cover with impact of decentralization in health center in the three kebele due to research fund constraints so that the finding might not be representative enough.

1.9. ETHICAL CONSIDERATIONS:

Collecting information without the knowledge of the participant, and their expressed willingness and informed consent is considered as unethical, thus, the researcher first informed and explained the purposes of the research appropriately to them until their full consents were ensured in order to avoid unnecessary anxiety of the respondents and wastage of time by the researcher. Lists of patients included as a respondent is based on their consent. The researcher also tried to inform the respondents not to report in a way that changed or inclined to serve for

the researcher or someone else's own interest. For further personal and institutional security of the respondents, the researcher has tried to assure the anonymity or and the confidentiality of their response. The researcher also made an effort to avoid cheating and academic plagiarism since they are unethical and serious academic crime. As far as the citation is concerned, an appropriate in-text citation with foot note were used, and all necessary materials mentioned at the research body were duly acknowledged bibliographically placed at the end of the paper.

1.10. ORGANIZATION OF THE STUDY

This thesis is composed of five main chapters. The first chapter mainly deals with the proposal part of the research which consists of background of the research, statement of the problem, objectives of the study, significant, and the issues of research design and methodology. Chapter two discussed about review of related literature; while section three deals with the health policy context of Ethiopia. The three consecutive regimes health policy were discussed, though more emphasis was given to the present government's health policy. Chapter four discussed about data presentation and analysis part of the thesis. And finally the research was wind up with conclusion and possible recommendations.

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CHAPTER TWO
REVIEW OF RELATED LITERATURE

ODUCTION

ter attempts to deal with major issues such as conceptual definitions and meanings of zation forwarded by many scholars and institutions, its forms, rationales and potential s of decentralization in general and decentralization in the health sector in particular istorical overview of decentralization in Ethiopia.

nitions and Concepts of Decentralization

lization is frequently and commonly referred to as the shift of powers from centre to the its of government (Yuliani, 2004:1). In other words, decentralization involves the of transferring responsibilities, functions and tax power from a higher level of ent to a lower one. According to Rondinelli and World Bank decentralization is defined transfer of authority and responsibility for public functions purpose from the central ent to lesser or quasi-independent government organizations or the private sector" elli, 1999:2; WB, 2003). Economists, define decentralization in terms of resource e efficiency. For them, decisions about public expenditure that are made by lower levels rnment are more likely to reflect the demand for local services than decisions made by a central government (Treisman, 2002). According to the UNDP decentralization is the of the reshuffling or reorganization of authorities based on the principle of subsidiarity are the sources and the very basis of the legitimacy of all) and improving the authority acity of local governments so as to enhance the quality, co-responsibilities and efficiency government at different level (UNDP, 1999).

ralization is not an end by itself but it is a means for good governance as it increases 's opportunities to take part in the socio-economic and political affairs to enhance rency, responsiveness and accountability. By making the government much closer to the people, it meets diversity of social needs and priorities (UNDP, 1999). According to the source, decentralization is viewed as an important piece of democratization – the power of ople to determine their own form of government, representation, policies and services. In

designing decentralization strategies, it is important to ensure adequate processes of accountability, transparency and responsiveness by all societal actors.

For Blair (1996) decentralization means "overturning or reversing the accumulation of administrative power by a one centre and bestow powers to other local governments". His definition is further needs 'restructuring or reorganization of the hitherto institutions in a manner that enable local units to get adequate administrative authority'. These definitions given by the above mentioned scholars, however, are not welcomed by UNDP for the reason that a simple transfer of authority, responsibility and resources from the center to local units is not considered as decentralization; but instead decentralization will occur only when local governments: **i)** established by law so as to give them legal personality with the right to take legal action; **ii)** found in a recognized demarcated jurisdictional boundaries; **iii)** ruled by locally elected officials and representatives; **iv)** empowered to make and enforce local decree related to devolved public services; **v)** allowed to collect legally assigned taxes and revenues; and **vi)** have power to manage their budget, expenditure , and to employ their own employees (UNDP, 1999:5).

2.2. Dimensions of Decentralization

2.2.1 Political decentralization- It is the most far reaching type of decentralization as it takes the form of devolution in a genuine decentralization environment. Political decentralization entails the shifting of power to the citizenry and politically elected representatives to make them accountable to their constituencies through establishing viable community participation in the overall local development, and decision making processes in its recognized vicinity (Obsaa, 2010:13). Political decentralization enables local governments to have room for discretionary powers to make decisions and allow them to better identify the needs and desires of their citizens and implement policies within their jurisdiction (WB, 2000; Phillip, 2009). According to Muriu, Political decentralization is seen as the most favorable approach towards effective citizen participation in influencing local service delivery, and it is linked with increasing or giving more power for citizens and their elected representatives in public decision-making process. Moreover, Political decentralization often requires lawful or statutory reforms, pluralistic political parties, formation of local political units, and encouragement of effective public interest groups (WB, 2000).

2.2.2 Fiscal Decentralization- can be defined as powers related to taxation; revenue generation and expenditure decision making for public function are detached from the center and then transferred to lower units of government. In other words, it determine the duties of *who determine tax base, sets tax rate and collects what type of taxes, who makes what expenditures, and how (if any) vertical imbalance is corrected* (UNDP, 1999). In order local governments to have capacity to discharge their functions effectively, it is a must to have adequate means revenue that could be raised either locally or granted from the central government, and have freedom to make expenditure decisions. As a result, it considered as a core elements of decentralization because it is fiscal decentralization that determine degree of autonomy of local governments to carry out various economic and social tasks (WB, 2000).

2.2.3 Administrative Decentralization- according to World Bank, 2000 document, administrative decentralization can be defined as the transfer of responsibility for planning and managing and administering certain public functions from the central government and its agencies to field units of government agencies, subordinate units or levels of government, quasi-autonomous public authorities or companies, regional, or functional authorities. The rationale for administrative decentralization is to shift decision-making power and responsibilities in order to deliver services by lower level government agencies, field offices, or line agencies (Matinussen 1997:210-211; Meheret 1998:2).

2.3. Forms of decentralization

White (2011) in his study on government of decentralization in the 21st century, he indicated three forms of decentralization and their characteristic features:

- **Deconcentration-** is the shifting of the administrative workload from centrally located officials to offices outside the national capital or headquarters without transferring adequate authority. Under deconcentration, local governments are fully controlled by the center and thereby it serve as the administrative arms of the center. In other words, it can create strong field administration or local administrative capacity under the supervision of central government ministries (Olsen, 2007:5). As far as health sector is concerned, deconcentration explained as establishing health agencies at lower levels of government. The established

an arrangement in which there are mutually beneficial and coordinate relationships between central and local governments. It also needs to have local institutions recognized by local citizenry as service provider institutions in accordance to their preferences (UNDP, 1999:6).

As far as health service is concerned, devolution can be explained as the transfer of decision making, planning, financing, and collect user fee powers to sub national governments. Sub national health institutions are not subordinate to the MoH but carry out on behalf the people. Even though, the aforementioned categorization is still use frequently, it is subject to criticism. For example, it is hardly to find countries in conformity with any single classification of decentralization, but have manifold elements of different forms of decentralization at the same time. For example, deconcentration to the district level will combined with delegation to for instance, hospital administrative boards, and the promotion of private providers (Omar, 2005).

2.4. Rationale of Decentralization

Contemporarily, across the glob there is a wide-range of movement towards greater decentralization. The common rationale for decentralization is to increasing the efficiency of local public services provisions and resources mobilization and allocation. Furthermore, decentralization helps to have more participatory and democratic governance, reduced poverty, promote economic development, enhance equitable access to public services, and improved government accountability and responsiveness, are among others the reason behind the demand (Prud'home, 2005:2; Litvack, and Ahmed. R. Bird, 1998; UNDP, 1999:16). Moreover, decentralization enables people to have saying in their own internal local socio-economic and political affairs; through active participation they can evaluate the performance of their representative government. Boex (2001) as cited by Negalegn, 2011; WB, 2000:6) summarized the rationales of decentralization as follow:

1) The service provided by local governments will easily address the demands of the local population because of proximity and information advantage.
2) Government administrators will appear to be accountable to their electorate for the quality of the service they provide.

3) Since decentralization has capacity to realize the preference and priority of local residents', as a result, people will show willingness to pay for public service they used.
4) It may increase revenue mobilization because of the fact that it is easier for local governments to levy and collect land use taxes and user fees,
5) Decentralization allow for policy experimentation and innovation through the sprite of competitiveness so that the government will act to satisfy the needs of the people.

Furthermore, Kassahun and Tegegne (2004) noted that, decentralization give room for checks and balances in the different echelons of government; it make possible for the participation of non-governmental actors, provides options for citizens to take part in local development activities, and by increasing local resource mobilization and utilization, it enables local administrators to provide better efficient and effective service to their constituents. Beside to these, according to UNDP, local governments are found in a better position to respond for local difference in circumstances, choice, tastes, standards, and location requirements for services delivery and infrastructure (UNDP, 1999).In order to realize the above mentioned rationales, according to WB, the following conditions are important:

1) Local financial resources and fiscal authority should equivalent with their functions and responsibilities assigned to them to provide local public services, so that local politicians can act on the bases of their promises and bear the costs of their decisions.
2) There must be a mechanism that enables community to express their desires in a meaningful way, so that there is a realistic encouragement for people to participate.
3) Local government's activities must be accountable and transparent so that local communities can react with, monitor and evaluate the performance of local government activities,
4) The legal and institutional system, the organizations of service delivery responsibilities, and the intergovernmental fiscal system should be designed in such a way to support the political objectives (WB, 2000:8).

2.5. The Challenges of Decentralization

Although, decentralization has a multitudes of advantages as discussed above, it is not something panacea, it has its own disadvantages, it may not always brings efficient service delivery due to interrelated factors such as inefficient institutional capacity, scarcity of resources and its uneven distribution among local units may affect equity in service provisions, and shortage of trained man powers etc (WB, 2000). Scholars like Prud'home and Tanzi stood against giving fiscal decentralization to sub national governments. For instance, Prud'home (1995) tried to list out a range of problems that might arise due to decentralization: macroeconomic instability because of difficulty in coordinating and harmonization of sub-national stabilization policy with national policy and have little or no incentives to undertake stabilization policy through monetary policy; affect efficiency of local public service delivery because of the fact that some public services are beyond the economic scale of local governments, it call for nationwide supply than the local one. The center in this case is more efficient in terms of technical production and economic of scales than what sub national governments does. Furthermore, decentralization may open the way for the development of tight bureaucracy, widening of regional disparity and create interpersonal inequality. In addition, it poses considerable tension in relation with sharing of power between different echelons of government. The 'losers'- i.e. the central government is often hesitant to surrender power to those who needs to gain power i.e. to the periphery (Mills, et al, 1990).
Moreover, the World Bank, 2000 in the briefing notes of decentralization also noticeably verify the challenges of decentralization as follow:

> It can result in the loss of economies of scale and of control over scarce financial resources by the central government. Weak administrative or technical capacity at local levels may result in services being delivered less efficiently and effectively in some areas of the country. Administrative responsibilities may be transferred to local levels without adequate financial resources, making equitable distribution or provision of services more difficult. Decentralization can sometimes make coordination of national policies more complex and may allow functions to be captured by local elites. Also, distrust between public and private sectors may undermine cooperation at the local level (WB, 2000:5).

In addition to these, the World Bank also underlines other related challenges in relation with transferring more power and responsibilities to the local governments. Although, it has an advantage of enabling local officials to be more responsive to local needs, it is not without problem. That is local officials frequently change and may therefore be ignorant about key national policies; and sometimes local leaders may resist national policies to accept and implement in their district. Conflicts may arise because of lack of harmonization in organizational management, and clear division of power and responsibilities among different echelons of governments and even within line agencies, and lack of political commitment or willingness to decentralize power, are also the challenges of decentralization (Aas, 1997; Olsen, 2007).

2.6. Decentralization in the Health Sector

Most developing countries in Africa and elsewhere face severe challenges in relation with access, efficiency and quality in improving health sector performance. These problems call for an immediate system reforms in the macro-organization, distribution and financing of health sector. Consequently, decentralization considered as a means for way out from such challenges (Wamai, 2004). Through devolving power to local government, it can bring in internal competitions with regard to the provision of quality and efficient provision of goods and services and enable the government to improve its responsiveness to the public and enhance the quality of service provision (UNDP, 1999). Decentralization in the health sector is therefore, encouraged by national and international organization. For instance, World Health Organization encourages health service decentralization with the hope that decentralization has potential advantages to empower communities to develop sense of ownership and control of their own health and to enhance efficiency in public sector performance. Health care service provisions quality and coverage will badly improve through a viable community participation in the management and delivery of health care services (WHO, 1978). Assuring the quality of health care service is dependent on the degree of accountability of the service providers, the more the national and local leaders are accountable to their electorates, the more likely that decentralization will brings to better and more responsive services (WB, 2000).

Decentralizing health care service provision has multifold theoretical reward. Acçording to Mills, 1994 cited in WB, 2000), point outs the some of the following advantages gain from decentralization in the health sector:

1) Enable to furnish a unified and rational health care services to local preferences,
2) Yields better ways for the realization of health program and policies,
3) Since the target populations are more visible and clearly identified by local officials, there is little or no duplication of services
4) Lessening or narrow down of the disparities between rural and urban areas,
5) Increase local community financing and participations in the community health system,
6) Better amalgamation of activities of different public and private agencies, and
7) Develop inter-sectoral coordination etc.,

In addition, decentralization can cherish dynamism in the health service provision since it permits private and public service providers; enhances pluralism through allowing and opening the room for civil society to involve in the decision-making process and consequently improves governance and accountability; and improves local based innovation and adjustments for local resource mobilization in order to curb local health problems are also some of the central objectives and merits of decentralization within the healthcare sector (Mills, 994).

However, there are also arguments against decentralization of health service system. For example, Collins (1989) point outs some of the possible difficulties of decentralization in the health care service delivery. He attempted to verify that decentralization by itself is not a guarantee for the service delivery to be more responsive to local health needs; because local elites just like central level officials and politicians, need to pursue their own interests. If local governments are dependent on once locally generated revenue, the advantages gain from improved health care through decentralization will be questionable. This is because the fact that local units are considerably differ in resource endowment so that the benefit will depends on where peoples are actually live. People who reside relatively in resource well-off regions by far can enjoy better health care service than those who live in resource scant areas (Collins, 1989).

Decentralization in the health sector also involves the issues of deciding who does what? i. e. Which functions and programs vis-à-vis health services are assigned and transferred to sub national government and which remain under central control? According to Kolehmainen-Aitken and Newbrander (1997), the central government has the responsibilities to perform those functions which has national outlook and to realize national health goals. For example, standardization of health service must be executed by the center because unlike the sub national government, the center has the capacity to perform it well. If a task is so significant for the realization of central-level goal that has nationwide implications, it should not be decentralized, instead keep under the shoulder of the center. Some of the general guideline for assigning responsibilities to central and local level of governments are:

Table 1. Assignment of health responsibilities among different levels of government

Tasks/functions	**Federal /center/**	**state**	**LG**	**Rationale**
Policy Design (Family planning and vaccination policy)	✓			Spillover effect. But the implementation task done concurrently by the center, state and Local Government,
Standards Setting	✓			Requires minimum national standard, Spillover effect(to control the free movements of drugs with poor quality from one regions to the other),
Health research	✓	✓		To improve the quality of health service delivery,
Health treatment		✓	✓	To make health services closer to the user
Training health personnel	✓	✓		To address the shortage of man power, i.e. to meet the needy trained health man power at the center and state level. .

Source: World Bank, 2000

2.8. The Historical Background of Decentralization in Ethiopia: An Overview

Introduction

In this sub topic attempts were made to assess the trajectory of decentralization system during the imperial regime, the military dictator (Dergue regime) and the post 1990 federal state (which brought a paradigm shift in the history of Ethiopian state). In order to have deep insight about the Ethiopian state structure, a short and brief overview of the past two successive regimes' decentralization feature were discussed. A detailed discussion was made in the current state structure so as to understand the shift in state structure and to see the current status of local government, and their powers and responsibilities assigned to them. A special emphasis was given in dealing with the structure, power and duties assigned to sub national governments particularly at Woreda and kebele administrations units in Amhara regional state since it is part of the area where the researcher is going to deal with.

2.8.1. Decentralization during the Imperial regime

For many centuries Ethiopia had a unitary system of government where the emperor assumed at the apex of the state. The emperor appointed regional leaders who have close allegiance to the emperor in order to handle local issues provided that they paid tributes (Tesfay, 2007:18).Following Emperor Haile Selassie I came to the throne in 1930, he continued to centralized power in his hand using written constitution as an instrument. He had put into operation the most ambitious centralization policy as compared with his antecedent. To that end, the 1931 first written constitution and the 1955 revised constitution serve as a strong weapon for his power consolidation and centralization program (Asmelash, 2000 cited in Tesfay, 2007).

In spite of this fact, as Ethiopian scholars investigate that the emperor attempted three sequences of decentralization. The first decentralization effort was the establishment of municipal governance which was held in 1945. The management roles of municipality were rested on mayor or (*kentiba-* in *Amharic)* with the following responsibilities and functions: delivery of public health, hygiene, water supply and sewerage services, electricity and street lighting, properties such as land, building, weapons registration, and provision of public services. Moreover, construction of intra-town roads, bridges and squares; slaughter houses; supervision of animal and vehicle traffics; issue of driving and small business licenses; delineation of market

areas; provision of welfare services like poor relief, hospitals, asylums, and schools; and approval of plans for private constructions. Concerning the financial powers, the municipality were empowered to fix and collect revenue from licenses on trade and professions, use of market place, vehicles and driving license, sanitary charges, land survey and registration fees, advertising, cattle registration); collect rental income tax etc are some of the revenue assignment of municipality councils (Ghebrehiwot, 2014: 16). Of course, these powers were subject to the approval of ministry of interior.

Ghebrehiwot (2014) further mentioned the failure of the municipality from realizing the stated goals. He pointed out that, the municipalities were not recognized as a distinct level of government, the appointments of Mayors were on the hands of the Emperor which had made the municipal governance undemocratic. The lack of power to determine municipal budget made the municipal government not to meet the intended objectives.

The second decentralization attempt was'Local Education Board' issued by the Proclamation No 94/1947. In doing so, education tax was delegated to the provinces. Through Local Education Board, the Provinces were empowered to determine the establishment of elementary school.

The third decentralization attempted was made by Order No. 43/1966 at Awraja or sub province level in the form of 'Awraja self-administration' in 50 selected provinces.An economic criterion was considered during the selection of Awraja to become self- sufficient administrative.

The Order allowed the Awraja to have elected council in order to perform some socio economic activities at local level. For instance, the elected council has the power to manage, build, maintain and identify the areas where primary schools, road and health centres are constructed; and conduct economic activities such as trade and agriculture. The Awraja self- administration project however, remained on paper because of failed to pass the bill (Tegegne, 1998; Meheret, 2002; Ghebrehiwot, 2014).

2.8.2. Decentralization during the Dergue regime (1974-1991)

Immediately after the Dergue regime assumed power in 1974, it took serious of major policy initiatives. The introduction of the policy of nationalization of rural and urban land and extra urban houses was put in place by issuing proclamation No. 47/1975.

The first attempt of decentralization was the establishment of Peasant association (PA) in rural kebele and Urban Dwellers Associations (UDA) in urban areas as lowest local administrative units. Peasant association had the responsibilities to administer local land redistribution, construction of primary school and clinics; provide social justice. The UDA also had similar responsibilities with exception to engaged in land redistribution.Although the officials or administrators were elected by the people, they did not act on behalf of the interest of the people but serve as the political arms of the government (Ghebrehiwot, 2014; Meheret, 2002; UN-HABITAT, 2002: 88).

The other unsuccessful decentralization attempts were made in 1987 following the foundation of the Peoples' Democratic Republic of Ethiopia (PDRE) in order to address the then nationality questions. The regime tried to curtailed and cool down the political pressure through awarding some kind of autonomy to those areas which resist the regime ferociously. Consequently, the Asseb, Eritrea, Ogaden, Dire Dawa and Tigrai areas, which were characterized as politically unstable areas waging arm struggle either for genuine autonomy or secession were preferred to be autonomous regions (PDRE constitution, 1987).Principally, although, these regions were assumed autonomous, in practice, however, were subordinate to the central government. And they were expected to realize the implementation of centrally draft laws and directives in its respective jurisdiction (Meheret, 2000; Ghebrehiwot, 2014: 22).

It was therefore, clear that decentralization was not the regime's policy priority to devolve power down to the regions, but instead it was the reaction for the then political pressure (the problems of ethnic uprising and political instability). As a result, the Dergue regime was failed to established genuine decentralized government, and was not able to address important issues such as fiscal decentralization and people's power to decide their own social and economic affairs. In addition, the regions were compelled to implement the centrally designed policies and directives but had no power to legislate their own law and policies for their own jurisdiction without the

permission of the center. Again they are also directly accountable to the center than the people they administer. Moreover, the regime prefer a monolithic authoritarian centralized government with single party- worker party of Ethiopia (WPE), shows lack of political commitment to give space for popular participation and to have authentic self-governments, failure to grant significant powers to the regions selected in the one hand and increasing demand of autonomy on the other hand, together intensified nationality grievances and finally it succumb for the demise of the regime from power in 1991(Meheret, 2000; Negalegn, 2010).

2.8.3. Decentralization of Post 1991

Unlike the two preceded regimes which were characterized as highly centralized government, where the center overwhelmingly control every aspect of government, Ethiopia registered a new lesson and change the old history of the country since 1990s. EPRDF[7], a coalition political force, defeated the Military regime in May 1991; and organized a National Conference for Peace, Reconciliation and Democracy, where about 24 political forces were participated. The Participants ratified a Charter which serves as an interim constitution that laid a base for the foundation of the present federal state structure. The charter is the first document in its nature in recognizing decentralization as a prerequisite policy alternative for the transition from military dictator to voter based rule.

The Ethiopia decentralization process since the 1991, in general encompass two waves. The first wave or phase of decentralization (1991-1994), was the devolution of power from the center to the state. The 1995 FDRE constitution divided the country in to nine self-administrative regions and Addis Ababa City Government. The regions were demarcated on the basis of settlement pattern, consent of the people concerned, and language and identity as criteria (Federal Constitution, 1995, Art.46). Accordingly, Tigray, Afar, Amhara, Oromia, Somale, Southern Nations, Nationalities and Peoples (SNNP), Benishangul-Gumuz, Gambella and Harrari national regional states; Addis Ababa and Dire Dawa city governance (FDRE, 1995, Art.46; proclamation No. 416/2004).

[7]Lists of the four coalition parties of EPRDF are: the Tigray people Liberation Front (TPLF), the Amhara National Democratic Movement (ANDM), the Oromo People's Democratic Organizations (OPDO), and the Southern People's Democratic Organizations (SPDO).

UN-HABITAT (2002) and Tegegn (1998) noted that, each regional government has substantial powers and authority, including regional constitution, an elected regional assembly, and the right to use and choose its own working language. In addition, every regional state empowered to prepare its own socio-economic development plans, mobilize resources for local and regional development and prepare and implement their own regional budget. A clear division of powers and responsibilities between federal and regional governments are made by the constitution under Article 51 and 52 respectively. Beyond that residual powers (none exhaustive listed powers) are reserved for the states.

The second wave of decentralization, commonly known as '*Woreda or District level* decentralization'[8], was put in practice since 2002. Regional governments have devolved powers from the region to Zonal (though it has no constitutional base in all regions), Woreda and Kebele levels of governments. The objective of this wave of decentralization is to make the government closer to the people so as to improve service delivery, to have more participatory governance, and to promote economic development at grass root level (UN-HABITAT, 2002:89).

The pace of Woreda decentralization however, was took place in two steps based on wait and see approach. The four regions which are the most populous and relatively developed regions, namely Tigray, Amhara, Oromo and SNNP, as compared to the newly emerged regions, have conducted Woreda level decentralization earlier than the remaining regions aimed at enabling Woredas to take primary responsibility for the delivery of basic services with block grants being given directly to them (Wamai, 2004). And the remaining state and the two urban municipalities (Addis Ababa and Dire Dawa) then followed such decentralization process in the succeeding years (Dickovick and Tegegne, 2010).

Zonal levels of government is found below regional and federal government and above Woreda and kebele administration, in most regional governments are assumed to be an intermediate level of government acting as channels of communication between regional and Woreda and kebele level of governments.

[8]The term '***Woreda*** and ***District***' use interchangeably throughout this thesis.

4) Preparation and approval of the Woreda budget;
5) Construction and maintenance of lower grade rural roads;
6) Manage agricultural development activities, administering and protecting the natural resources of the Woreda.
7) Administer primary education and health care institutions.
8) Enforce the policy, legislation, directives, plans and programms of the federal and the regional governments within its jurisdiction.
9) Coordinate and supervise the different executive offices in the Woreda.
10) Collect rural land use fees, agricultural income taxes and other revenues.
11) Uphold peace and security of the people resides in the Woreda, direct its security and police organs as well as follow up and supervise their activities; and
12) Facilitate rural development, protect, develop and provide care for natural resources" (ANRS constitution, 2001, Art. 86 & 91).

Kebele Administration- it is the lowest administrative units in the hierarchy of regional government, with elected council empowered to represent citizens at local levels. It has the same structure to the Woreda administration, consists of three principal organs: the Kebele Council, Kebele Administrative Council and the Social Court (Art.96).

The Kebele Council- is the highest organ of the government as far as the Kebele inhabitants is concerned. Members of the council are directly elected by the kebele inhabitances and accountable to the electorate (Art 97).

The Kebele Administrative Council- is the lowest executive body, whose members are comprised from the Kebele's Chief and Deputy Administrators as well as public employees. It entrusted to implement laws, regulations and directives issued by its superior Administrative Organs (Art, 101 and 102).

The Kebele Social Court- is a judicial organ empowered to deal with cases that are social in nature. Judges are appointed by kebele council among from those candidates proposed by kebele administrator (Art. 107 of ANRSC).

CHAPTER THREE

HEALTH POLICY IN ETHIOPIA

INTRODUCTION

This chapter discusses a brief review of health policies in Ethiopia. The historical review of health policies in Ethiopia under three consecutive regimes– the imperial regime, the Dergue regime and the current federal government. But a detailed discussion has made on the current health policy priorities, institutions that are being under operation and the structures of the overall health system of the country.

3.1. Health Policy during the Imperial Period (1930 - 1974)

At the end of 19th century, during the reign of emperor Menelik's, modern vaccination, modern health care facilities including the first hospital, leprosarium, and pharmacies in Ethiopia were established (Zein, 1988).These health facilities continued to expand during the imperial regime until the Italian invasion in 1935. During the occupation period (1935-1944), Italian brought new medical organization and about 2000 doctors to Ethiopia aimed at protecting Italian national army against infection. Later, the existed limited hospitals and clinics were converted in to army medical clinics for use of the military instead of providing service to the people. Consequently, at that time the health institution could not brought significant change on health of the people (Abebaw, Nd)[9]. Immediately after the liberation of Ethiopia in 1941, a *"Public Health Directorate"* was established under the Ministry of Interior. Following that, the first health legislation was established in 1947. In 1948 the formal autonomous health care called Ministry of Public Health was established.

The Regime formulated four successive five years health development plan in the health care system from 1958 to 1979. In the first five year plan (1958-1962) 3, 48 and 100 new hospitals, health centres and government health stations respectively were established.While in the second five year development plan (1963-1967) gave more emphasis on: preventive measures, Expansion of basic health services, and proposed that one health centre should serve 50,000 people and supposed to manage ten health station under its scope, and one health station

[9] The abbreviation '*Nd-* implies '*No date'* that is, unavailability of date of publishes of an article, and I use '*Nd'* for similar article (if any) that has author/s but lack date, throughout the thesis.

established in such a manner to serve 5000 people. Whereas, the third Five Year Development Plan (1968-1973) stressed on: Malaria Eradication service, more emphasised on training of health professionals and expansion of health services, to established provincial health departments in order to improve preventive tasks. The fourth health development plan (1974-1979) was however, interrupted by the popular revolution of the 1974. During the health development plan, achievements were done on the area of establishing centralized services for example, anti-Epidemic service; trachoma, TB and malaria control; and smallpox eradication programs; and regional health departments were established. The public health college and training center at Gonder was established in 1957 jointly by the government of Ethiopia, World Health Organization and UNICEF. The purpose of the college was to train HOs, sanitarians, and community nurse to staff HCs. Until 1987, more than 1000 health personnel had trained by the college (Zein, 1988:3).

Besides to modern health institutions, the regime also recognized traditional medicine as part of the health development plan. Legally, formal recognition to Traditional Medicine was given by the imperial proclamation No.27 of 1942, where the legitimacy of the practice is recognized as long as it does not have negative impact on health of the people, but registration and licensing was introduced in 1950 (Alemayehu and et al, 2006).

3.2. Health Policy during the Dergue Regime (1974-1991)

At the end of emperor Haile Selassie's regime and the beginning of Dergue regime, because of the influence of World Health Organization, through *'Alma Ata Declaration-1978'*[10], to have a more substantial policy for health service provision, in the 1970's and 1980s, Ethiopia adopted

[10] ***Alma-Ata declaration'*** is an international conference centered on 'primary health care' which was held in September, 1978 in Alma-Ata, USSR (now Almaty, Kazakhstan). The declaration was sponsored by the WHO and is the 1st international organization which declared the importance of primary health care and outline the world governments' role and responsibilities to the health of the world citizens. The drafter of the declaration hoped that it would be the first step towards achieving health for all by the year 2000. The document also expresses "the need for urgent action by all government's, all health and development workers, and the world community to protect and promote the health of all the people of the world." Moreover, although, the stated goals were not realized, the documents still serve as fundamental tenets that guide the work of the WHO today and the future of international health care (*http://www.cliffsnotes.com/cliffsnotes/history/what-is-the-almaata-declaration*.

Primary Health Care (PHC) as the national strategy to achieve equitable access to health services and to ensure preventive care alongside curative treatment.

Consequently, the Dergue regime was tried to establish a Ten year health development plan with the following intents: encourage full and active community involvement in all health activities; ensure multi-sectoral collaboration and coordination in health actions among the concerned governmental and mass organizations; expand health services to where the broad masses live and work; control of all major contagious or communicable diseases; provide all-inclusive health services for mothers, children, students, under-privileged nationalities, workers etc; and Craft a healthy living, working and recreational environment (Abebaw, Nd; Zein, 1988:5).

For implementation purpose, the ten-year plan was divided in to three periods. The first phase covered (1984-86), phase II (1986-89) and phase three covered the period (1990-1994). For this purpose, 52% of the capital budget and 71% of annual recurrent budget was financed from government sources; 21% and 27% of capital and recurrent annual budget were expected from the community sources. In the late 1970s and 1980s the ministry of health total spending as a share of government expenditure declined from more than 4% to 2.8% (Wamai, 2009:282). The Per capita spending has remained below the sub-Saharan Africa average of US$12.8. But, since the revolution there has been growth of capital and recurrent health budget allocations. The nominal recurrent health budget has increased from 35 million birr in 1974 to 100 million birr in 1984. And the nominal capital budget has also increased from 16 to 48.6 million. The health care service coverage in 1974 was estimated to be 15-20% (Zein, 1988:63).

However, as nutritional deficiency, inadequate environmental health, epidemics of communicable disease, and the concentration of most health institutions in the major cities could not address the health needs of rural people were some of the challenges of the plan. For instance, in 1981 infant mortality and child rate was 155/1000 and 147/1000 respectively. The percentage of death in all type was reached to 60% and the life expectancy at birth was reduced to 43 (Zein, 1988:57).

As far as traditional medicine is concerned, the Dergue regime gave attentions for the promotion and development of traditional medicine, particularly after the adoption of the Primary Health Care Strategy in 1979 and 1980. By 1979, 6,000 traditional practitioners were registered. Meetings and workshops were organized that brought together traditional and modern medical practitioners (Alemayehu and et al, 2006: 128).

3.3. Health policy in Post 1991

Legal framework

Following the change of regime in 1991, the Transitional government articulated the country's first health policy in 1993.The general health program of the country was derived from the constitutional provision of Art 51 (2) of FDER constitution. This article of the constitution granted the federal government to have the following powers and responsibilities with regard to public services provisions: (1) to formulate and implement the country's policies, strategies and plans in respect to overall economic, social and development matters; (2) to establish and implement national standards and basic policy criteria for public health, education, science and technology; and (3) to administer and expand all federally funded institutions that provide services to two or more States (FDRE Constitution, 1995, Art. 51/(2, 3 and 13)). Similarly, at state level, the states have power to formulate and execute economic, social and development poiicies, strategies and plans of the State (Art. 52/2(c)).

Based on these general legal frame works, the government articulated the country's health policy and different health sector development programs as well as traditional medicine. Accordingly, traditional Medicine was incorporated as part and parcel of the Health policy (Alemayehu and et al, 2006: 128). Laws and regulations concerning traditional medicine were issued under the Drug Administration and Control Proclamation No. 176/99. The general strategies adopted include identifying and encouraging the utilization of its beneficial components, coordinating and encouraging research including its linkage with modern medicine and developing appropriate regulation and registration of practitioners (Alemayehu and et al, 2006: 131).Since my major focus is not traditional medicine, detailed emphasize is not given.

The current health policy has recognized the objectives of health delivery system to contributing positively for the overall socio-economic development effort of the country[11].The policy has derived from the commitment of the government to democracy and gives strong emphasis to the fulfilment of the needs of the less privileged rural population that constitutes about 85% of the total population in Ethiopia (MOH, 2010). Expanding the primary health care system, and encouraging partnerships and the participation of nongovernmental actors, disease prevention and promotion, ensuring accessibility of health care for all are the focus of the policy (Wamai, 2009:279).It also focuses on enhancing inter-sectoral collaboration between MoH with Ministry of Education, in training health workers and school health promotion; Ministry of Water Resources to ensure availability of adequate and clean water supply; with Ministry of Agriculture on nutrition, prevention and control of communicable diseases; with Ministry of Finance on improving resource allocation to the health sector; with the media in public health awareness creation and dissemination of health messages and information to the general public; Collaborate with Ministry of Women Affairs to ensure gender equality and maternal and child health services; and Collaborate with Ministry of Transport on the reduction and prevention of road traffic accidents and improvement in efficient referrals of the injured etc. The collaboration of MoH is also extends with private sectors, professional associations in order to expand health facilities, training of health professionals and mobilization of resources for the health sector and to advance quality of health services and reduce professional misconducts (MoH , 2010/11).

To realize the policy objectives, the Health Sector Development Programme was drafted in 1997/98 with the period of 20 years with a rolling five-year programme period. It provided a long-term plan framework with the major goals to (a) build of basic infrastructure, (b) provide standard facilities and supplies and (c) develop and deploy appropriate health manpower for realistic and equitable primary health care delivery at the grass root level. The total budget was estimated at 20 Billion Birr for the 20 years period, the first five years required 5 Billion Birr (MoH, 2003:20).The program has comprised of eight components with separate objectives.

[11]Federal Democratic Republic of Ethiopia (FDRE).Sustainable Development and Poverty Reduction Program. Addis Ababa: Ministry of Finance and Economic; 2002.

Table 2: The eight stated components of HSDP and its respective objective.

No.	Components	Objectives
1	Health service delivery & quality of care	✓ To increase the quality and coverage of promotion, prevention, and curative services,
2.	Health facility rehabilitation and expansions	✓ To increase the access to and improve the quality of health services via rehabilitating the existing facilities &by constructing the new one,
3.	Human resource development	✓ To increase the supply of manpower; and ✓ to improve the productivity of the staff,
4.	Strengthening pharmaceutical services	✓ To ensure a regular and adequate provision of effective, safe and affordable drugs of high quality both at the public and private sectors,
5.	Information, Education and communication	✓ improve health Knowledge, Attitude &Practice about personal & environmental hygiene & common illnesses and their causes; ✓ To increase the collaboration of different stakeholders (policy maker, manager, etc).
6	Health management and information system	✓ To improve knowledge and skills of policy formulation, planning and budgeting, financial management, programme implementation, and monitoring, ✓ To increase community involvement in the management of health facilities and community-based health interventions.
7.	Health care financing	✓ To improve public health sector efficiency, and ✓ To generate additional and new sources of revenue besides government based sources, ✓ Increased resources mobilization to the health sector, ✓ Promote efficient allocation of resources, ✓ Develop a sustainable health care financing system.
8.	Monitoring and evaluation	✓ To monitor progress and achievements of HSDP components and the improvements of service delivery, quality and financial performance, ✓ Evaluate the impact, & effectiveness of HSDP's components

***Source**: MoH, 2002 from HSDP-II manual.*

The Health Sector Development Program is divided into the following four successive five years of implementation plans period.

HSDP-I (1997/98–2001/02)-due attentions were given for disease prevention and restructured the health services delivery system under decentralization. Out of the 5 Billion birr required to it, 60% was assigned for recurrent expenditure (including salaries), 30% for capital expenditure and the remaining 10% for contingencies (MoH, 2003).

Table 3: The intended objectives and achievements of HSDP I

Program	Targets/objectives	Achievements
HSDP I	To increase coverage of Primary Health Care Units (PHCU) by 60%	❖ Reached the PHCU Coverage to 55-61%
	Construct 1147 new HPs	❖ 1193 HPs were built (104%)
	Build 459 new HCs	❖ 384 HC were built (84%)
	Build 66 new Hospital	❖ 68 hospital were built (103%)
	Contraceptive prevalence rate 20%	❖ 14.6% only achieved
	Ante natal care (ANC) service	❖ Increased from 30% to 30.2%
	Delivery by trained health workers	❖ Decrease from 10% in 1998 to 9.7% in 2002
	Postnatal controls coverage	❖ Covered 10.1%

***Source**: Manual of evaluation of the performance of HSDP I (MoH, 2003).*

HSDP I has achieved the objectives in the construction of health posts (HPs) and hospitals shown above, it however, shown weakness and meet below the target in some objectives due to Serious shortage of skilled human resou.ces; poor communications between peripheral health facilities and referral hospitals; poor infrastructure and the difficult topography of many rural areas; and Weak management capacity etc.

HSDP II (2002-2005) - has the objectives to: A) enhance access and coverage to health care, along with utilization; B) Improve service quality through training and an improved supply of necessary inputs; and C) reinforce management of health services at Federal and Regional levels.

In order to achieve these objectives, encourage the participation of the private sector and NGOs, through creating conducive environment is among the strategies that were employed.

The major achievements of HSDP II was: among others, HEP was introduced first and 2,800 HEWs were trained and deployed in 2004/5; the contraceptive coverage grew dramatically from 4% in 1996/97 to 25% in 2004/05; and access to toilet facilities was increased from 10 % to 29 % etc. However, inaccessibility of Service and transportation problem; weak diagnostic laboratory services, low health seeking behavior and insufficient resources; shortage, high turnover, & insufficient skills of midwives and delivery service at HEW due to poor quality of training; shortage of drugs, and medical supplies, and slow career development for HEWs etc were some of the challenges of the program (MoH, 2010/11).

HSDP-III (2005/06- 2009/10)- during this program, more emphasis was given on the role of NGOs in the planning and implementing health care service delivery especially at district level, increase national health spending and the need to strengthen government-NGOs partnership (FMOH, 2005; Wamai, 2009:280). There were a remarkable increment of in the expansions and rehabilitations of health facilities constrictions at the end of HSDP-III.

Table 4. The objectives and achievements of HSDP III.

Program	**Targets/ objectives**	**Achievements**
HSDP III	• PHCU Coverage 100% • family planning service 60% • Ante natal care • Post natal care • Clean and safe delivery • Delivery by skilled delivery	• Meet 90.0% • Reached 56.2% • reached 68%, • Reached 34% • Has increased to 10.8%; & • deliveries assisted by skilled health personnel reaches to 18.4 %;

***Source**: MoH, 2010/11.*

NB: PHCU- implies primary health care unit

The program highlights factors that hindered from realizing of some of the objectives. For example, shortage and attrition of highly skilled professionals, inadequate coordination mechanism for public private partnership in health, and weak regulatory system of pharmaceuticals and medical Supplies also the challenge of the program (MoH, 2010/11:37).

HSDP-IV (2010/11 -2014/2015) - the design and content of HSDP-IV was influenced and shaped by many international health declarations' inputs such as MDGs, the African Health Strategy (2007-2015), Paris Declaration on Aid Harmonization 2005, Accra Accord on Aid Effectiveness (2008) and Abuja Declaration on Health Care Financing in Africa were considered. The strategies employed to meet its objective are: ensuring demand driven production of human resources; improved responsiveness to community health needs; improving inter-sectoral collaboration and increase the involvement of private sector in human resource development; improve the quality in the training of health professionals; improve quality and efficiency of medical education; and Enhancing cost-effectiveness in staff retention and motivation schemes (MoH, 2010/11).The achievements of HSDP as per the target of the plan are summarized below:

Table 5. The 2004 Performance and target Indicators HSDP IV.

Indicators	EFY 2004 Baseline	EFY 2004 Performance	EFY 2004 Target	HSDP IV Target (2007EC.)
Ante natal care	82.2%	89.1%	85.1%	90%
Delivery by skilled health personnel	16.6%	20.4 %	37.7%	62.0%
Postnatal care coverage	42.1%	44.5 %	60.1%	78.0%
Contraceptive acceptance rate	61.7%	60.4%	76.5%	82.0%
Pentavalent 3 Vaccine Coverage	84.7%	84.9%	89.0%	96.0%
Measles Vaccine Coverage	81.5%	79.5%	88.0%	90.0%
Full Immunization Coverage	74.5%	71.4%	85.0%	90.0%

Source: *From MoH, 2013 quarterly Health Bulletin.*

NB. *Unlike the other previous three programs, the HSDP IV is not a completed one but is a program on going. The indicators in the table therefore, taken from the two year performance evaluation of HSDP IV done by MoH since 2004 EC.*

As the table above indicates, the two year performance of HSDP IV is low or below the target. The contributing factor to this is that health institutions (especially health posts & HCs) were not adequately equipped with necessary materials, inadequate access to PMTCT services as well as their insufficient integration with maternal services, laboratory capacity and availability of trained laboratory staff, especially in peripheral health facilities, to perform sputum-smear examination during treatment.

The Table 6. *The trends of the health institutions constrictions by the four consecutive HSDP.*

Name of health Facilities	Prior to HSDP I	HSDP-I (1997/8)	HSDP- II (2003/2004)	HSDP- III (2010)	HSDP- IV (since 2012)
Health posts	76	1193	6,191	14,416	15,668
Health centers	241	384	519	2689	2, 999
Hospitals	49	87	126	195	254 (129 ongoing construction)

Source: *FMoH,(2010/11:22) in HSDP-IV manual; FMOH (2013:18) Quarterly Health Bulletin | May 2013,*

As far as the financial issue is concerned, at the beginning of 1990s, the share of government budget spent to the health sector was only 1% of the GDP. But later, the share of health expenditure has increased slightly from 2.7% in 1996 to 5% in 2004/05 (Wamai, 2009:282). Again, the national health expenditures have grown significantly from 4.5 Billion Birr (US$ 522 million) by 2004/05 to Birr 11.1 billion (US$ 1.2 billion) in 2007/08. For instance, In 2008/09, the national health budget that has been allocated was 10.1% of the national GDP. In the same, period, the per capita health expenditure has increased from US$ 7.14 by 2004/05 to US$ 16.09 in 2007/8 (MoH, 2010/11).

3.4. Division of mandates among different levels of governments

Ethiopian following the establishment of HSDP, attempted has made to specify the major tasks performed by each level of government. According to Proclamation No. 475/1995 of the Federal Democratic Republic of Ethiopia has specified the Powers and duties of the Federal Ministry of Health, Regional Health Bureau and Woreda Health Office. Accordingly, the federal ministry of health has the following duties and responsibilities:

- ✓ *"Cause the expansion of health services;*
- ✓ *establish and administer referral hospitals as well as study and research centers;*
- ✓ *Determine standards to be maintained by health services;*
- ✓ *Issue licenses to and supervise hospitals and health services established by foreign organizations and investors;*
- ✓ *Determine required qualifications of professionals engaged in public health services at various levels, and provide certificates of competence for same; c*
- ✓ *Cause the study of traditional medicines, organize research and experimental centers for same;*
- ✓ *Devise strategies, means and ways for implementing prevention, control and eradication of communicable diseases;*
- ✓ *Undertake studies with a view .ɔ determine the nutritional value of food".*

According to the same proclamation, the mandates or the responsibilities of the Regional Health Bureaus (RHB) are listed as follow:

- ➢ *"Prepare, based on national health policy, health care plan and programme for people of the region, and to implement when approved;*
- ➢ *Ensure adherence to health laws, regulations and directives related to public health in the region;*
- ➢ *Organize and administer hospitals, health centers, health Posts, research and training institutions that are established by the regional government;*
- ➢ *Issue license to health centers, clinics, laboratories and pharmacies to be established by NGOs, and private investors;*
- ➢ *Supervise to ensure that they maintain the national standards;*
- ➢ *Ensure that professionals engaged in public health services in the region operate within the prescribed standards and supervise same;*

- *Ensure adequate and regular supply of effective, safe and affordable essential drugs, medical supplies and equipment in the region;*
- *Cause the application, together with modern medicine, of traditional medicines and treatment methods whose efficiency are ascertained;*
- *Cause the provision of vaccinations, and take other measures, to prevent and eradicate communicable diseases; and ascertain the nutritional value of foods.*

Woreda Health Offices - have duties to administer and organize the operation of primary health care services at Woreda levels. They are also responsible for planning, financing, monitoring and evaluating of all health programmes and service deliveries in the Woreda. More specifically, Woreda Health Offices are responsible for primary health care services namely, primary hospital, Health Centers and Health Posts (MoH, 2010/11: 35).

3.5. Health Service Delivery Institutional Arrangement

The first HSDP I introduced a four tier system for health service delivery comprised of primary health care unit (comprising health center and health posts); the district hospital; Zonal hospital and specialized referral hospital. A Primary Health Care Unit has been designed to serve 25,000 people, while a district and a Zonal hospital are each expected to serve 250,000 and 1,000,000 people respectively. However, the recent health sector development program HSDP-IV in 2010 has been reduced and restructured it from four to three tiers of health service delivery. According to the 2010 MoH policy draft, the three levels or tiers of health care system are the following:

Fig-7. The current Ethiopian health tier system

No.	**Level or tires of health care service**	**Supposed to deliver services to:**
1.	**The primary health or Woreda health care level**	
	a. **Health posts**	❖ Responsible to serve a population of 3,000-5,000 staffed with two HEW. ❖ HEW are expected to spend less than 20% of their time in health posts, and more than 80% of their time should be spent with community ❖ provide environmental health services, such as family planning, clean delivery and essential newborn care services, diagnosis and treatment of malaria, pneumonia, and diarrhea etc.
	b. **Health Centers (HCs)**	❖ Serve a population of 25,000 in rural HCs and 40,000 for urban HCs. ❖ Staffed with an average of 20 health workers and holds at least five satellite HPs, ❖ Serve as a referral centre HPs and practical training institution for HEW, ❖ Provide both preventive and curative services. ❖ Have an in-patient capacity of five beds.
	c. Primary Hospitals	• Have 53 staffs, and provide inpatient & ambulatory services for an average population of 100,000. • Provide emergency surgical services, including Caesarean Section and gives access to blood transfusion service. • Serve as a referral centre for HCs, and is a practical training centre for nurses and other paramedical health

		professionals. • Has an inpatient capacity of 25-50 beds.
2.	**The 2ndry health care level or General hospital**	✓ Delivered inpatient & ambulatory services to an average of 1-1.5million people. ✓ Has an average of 234 professionals and serves as a referral centre for primary hospitals. ✓ It serves as a training centre for health officers, nurses and emergency surgeons. ✓ have an inpatient capacity of 50 beds
3.	**The Regional referral and Specialized (Federal) Hospitals**	✓ Is expected to provide services with a range of 3.5-5 million people. ✓ Staffed with an averagely 440 professionals. ✓ Serves as a referral center for General Hospitals. ✓ Has an inpatient capacity of 110 beds.

Source: *Federal Ministry of health, 2010/11*

3.6. Free Health Care Service Delivery

Its legal framework

Ethiopia institutionalized mechanisms for providing services to the poor free of charge through a fee-waiver system, as well as through free provision of selected public health services (through exemption) such as treatment of tuberculosis patients, immunization of children under the age of five) (USAID, 2012: 4).It becomes much systematized following the implementation of health care finance reform in 1998. Through fee waiver, the poor section of the societies will enjoy equal service to that of higher income individual. Similarly the Amhara National Regional State also institutionalizes free health care services by proclamation no. 117/97.The proclamation set specific standard to identify who are the beneficiaries of the free services and who are not. The following groups of people are eligible to use free health services:

i. Regional residences whose household income are unable to cover their basic living costs and it has to be proved by popularly elected officials up on the recommendation of local

or kebele population and must have certificate cards, Have no adequate and permanent source of livelihoods, Elders who have no assistance. In addition, those whose average monthly income is below the minimum scale of government salary and if they do not have other alternative source of income are qualified to use free health services.

ii. Street dwellers with no house, who are able to bring evidences from labors and social affairs bureau,

iii. Displaced people (either by manmade or natural calamities and henceforth unable to pay for their own medication) who able to bring evidences from kebele administration,

iv. Individuals who are beneficiary of a 24 Hrs emergency medical service at the health institutions, and has failed to pay for or no other body to cover the cost resulting there from are the standards employ to include people in free service scheme.

The proclamation further, mention additional specific criteria to identify the most certified beneficiaries of free service by clustering them in to rural and urban. However, since the numbers of population live in urban area are insignificant in the study Woreda, I only deal with criteria set to identify rural beneficiaries. Hence, the following points should be considered: The size of land, its productivity and irregability (water based land); Number of domestic animal (Hen, Sheep, Got, Cow and others); total annual crop and animal productivity yields; health status, ability to work and earn income; Other source of income (example, from trade, rent and handcrafts) if any; number of dependents in the household; and aid from third party, if any etc. Finally, after exhaustively passes these steps, the screened beneficiaries of the services have access certificate card which identify them they are users of the services, and must be renewed if the permission dates are terminated.

In this case, all People of the gott are responsible to identify who are poor incapable to cover medical treatment costs, and who are excluded from the scheme through mass meeting. Once the eligible beneficiaries are identifying, the people sent lists of beneficiaries to kebele administration. Then the kebele administrator brings lists of candidate beneficiaries to the kebele council for further approval. After the selected beneficiaries are evaluated and get acceptance by the kebele council, lists of the beneficiaries (with full information such as households' name, sex, occupation, numbers of families, average annual income and their history whether he/she

was the beneficiaries of the same program so far etc) must transfer to Woreda administration. Finally, the Woreda administrator approves and announces the final accepted lists of beneficiaries to the program (Proc. No. 117/1997 EC of ANRS health care finance).

In the process of free service provision, the Gott or sub- kebele people as a whole, the kebele administration and or kebele council, Woreda administration, labors and social affairs bureau (aimed at identifying street children), and emergency prevention and preparedness office (aimed at identifying displaced free medical users) are the major actors and concerned bodies both in the identification and delivery process of free health service (Proc. No. 117/1997 EC of ANRS).

3.7. Health Extension program or Package (HEP)

HEP is an innovative community- centered health service delivery program intended to increase access and quality to prevent essential health interventions through community/kebele based health services with strong focus on preventive and promotional health measures, behavioral change, and community organization and mobilization, and increased health awareness. In other words, HEP aimed at contributing to the improvement of the health status of the families, with their full participation, using local technology and the skill and knowledge of the communities. HEP is therefore, the result of the introduced in recognition of failure of essential services to reach the people at the grassroots level (MoH, 2013: 3). The Health Extension Service provision is mainly focusing on preventive health measures targeting households particularly women at the kebele level. For this purpose, two women health workers trained for at least a year and deploy at every kebele. That is each kebele with an average of 5000 population has two health extension workers (MoH, 2002). HEP assumes that health behavior can be enhanced in communities by creating model families that others will appreciate and copy (Hailom, 2011:46).

The Health Extension Program was introduced with 16 innovative packages. These packages along with implementation guidelines were made available to implementers as well as to technical and vocational training institutions. Those packages are incorporated under four health care sub programs which are listed below.

Table 8.The health extension packages of the health extension program

No.	The four sub program	Lists of packages
1.	***Disease prevention and control***	Prevention & control of: **i)** HIV/ AIDS; **ii)** TB; **iii)** Malaria; and **iv)** provide first aid and emergency measures.
2.	***Family health***	Has 5 packages: **i)** maternal and child health; **ii)** family planning; **iii)** immunization; **iv)** adolescent reproductive health; and **v)** nutrition.
3.	***Environmental hygiene and sanitation:***	Has 7 packages: **i)**proper & safe excreta disposal system; **ii)** proper and safe solid and liquid waste management; **iii)** water supply safety measures; **iv)** healthy home environment; **v)** food hygiene & safety measures;**vi)**arthropods and rodent control; and **vii)** Personal hygiene.
4.	***Health education and communication***	i) Information dissemination and awareness creation purpose

Source: *MoH, 2002.*

The central philosophy of HEP is that if the proper knowledge and skill is transferred to households they can take responsibility for producing and maintaining their own health. The program was anticipated to help accelerate the country's progress in meeting Millennium Development Goals (MDG) particularly emphasis on (reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases). The HEP is therefore the most important approach for bringing key maternal, neonatal and child health interventions to the community (MoH, 2002; MoH, 2013).There are over 35,000 Health Extension Workers who were trained and deployment of who are post in rural communities to provide primary health care at health post and household levels. By the end of 2012 over 15, 668 health posts were built, and 2,999 health centers and an extra 449 are under construction so as to achieve universal Primary Health Care coverage (FMoH, 2012). Currently, the regional government in collaboration with woreda health office undertakes the training responsibility of Health extension workers.

3.8. Health Development Group (HDG)

Health Development Group is a newly emerged institution established in 2010/11. It can be defined as an organized movement of the community through participatory learning and action meetings aimed at to encourage healthy life, to improve the performance capacity of the health sector. It provides an unprecedented opportunity to participate the community in the identification of local challenges, policy to deal with them, and evaluate the performance of Health Extension Program. The HDG in general has four key responsibilities intended to realize. These are: 1) find out local obstacles that discourage families from utilizing key services and implementing the HEP and prioritize those that they want to address as a team; 2) Come up with practical strategies to tackle these problems; 3) put into practice the strategies; and 4) assess or evaluate their activities (Hailom, 2013: 4).

To realize these comprehensive objectives, a health development team which comprised of up to 30 households inhabited in the same area was organized. To make it more workable, the team of 30 households further divided into smaller group consists of at least five households in each group, what the policy documents refer it as 'one-to-five' association or network of female. The HDG in general and 'one-to-five' network in particular are further facilitated by health extension workers and the kebele administration. Once the team or the group organized, the members of a group are expected to select their leaders from among the members in order to guide five households. The leaders are supposed to be a model family in the societies and able to mobilize the communities. The one-to-five networks are expected to have meeting every week, while the one-to-thirty team meets once every two week. During meeting session, they evaluate their performance as per their plan and give ranks to identify the strong and poor performers. A performance report including the grades has to be collated at the health development team level and sent to the Health Extension Workers (Hailom, 2013: 4).

There are two different approaches were used to organize the community: **i)** women-centered Health Development team (focused mainly on female households) and, **ii)** a mixed group HDG (is an association of male and female heads of households). Women- centered team is mainly focus on health related issues that enable women to create awareness to bring birth at health

institutions, and to inform each other the importance of vaccination for child and how to care them.

In Amhara region, the organizations of HDG follow mixed-group approach (MoH, 2013). Both men and women, besides to health related issue, engaged on the other socio-economic activities such as protecting natural resources through terracing and planting trees to protect soil erosion. As far as health matter is concerned, women center groups were organized. Every household are organized in to one-to-five and one-thirty networks. The leader of the group write down the lists of group member and every one of the group members has a copy of paper so that they know and remember each other.

CHAPTER FOUR

Description of Study Area, Data Presentation, Analysis and Discussion

Introduction

Under this chapter there are two sub sections that would be discussed. The first section describes the general overview about the Gozamin woreda's geographical location, topographic and climate condition, road link, the socio- economic conditions of the Woreda with the objective to familiarize the reader with the woreda as well as to identify the factors that determine the health status of the woreda. The second section presents the findings of the study.

4. Description of Study Area

Gozamin Woreda is located in East Gojjam of Amhara National Regional State. It is one of the 18 woredas[12] found in the East Gojjam Administrative Zone. It is found 300 Km and 265 km away from Addis Ababa and Bahir Dar city respectively. And bordered by Senan Woreda in the North, Basso-liben Woreda and Oromia Region in the South; Debaye Telatgin and Aneded Woredas in the East; and Machakel and Debre Alias Woredas in the West. According to the Agriculture and rural development office of the Woreda, the total area of the Woreda is 1217.8 square KM. Woreda's land form is characterized by plains (74%), highlands (16%), mountains (9%), and valley (1%)[13]. The altitude ranges from 900m to 2640 meter above Sea level. There are about 23 main rivers that have potential importance for irrigation. Of these Chemoga river is the longest one which covers 45 KM length and has potential to generate 2.31 Mega Watt electric powers. There are also a number of small streams in the Woreda namely: Shegeza, Kullech, Degelle, Atemena and Wutren rivers are there (Agricultural and rural development office of Gozamin Woreda, 2005 EC).

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[12] Gozamin, Debre Alias, Machakil, Sinan,Debay tilatgin, Enargenawga, Bassoliben, Dejen, Aneded, Lumama, Awobel, Hulteju Enesi, Enemay, Sheble Berenta, motta urban Woreda, Enbssia Sar meder, Bibugn, Debre Markos town and Goncha Siso Enessia.

[13] The figure varies from report to report, but the researcher took the 2005 EC annual statistic report of the woreda.

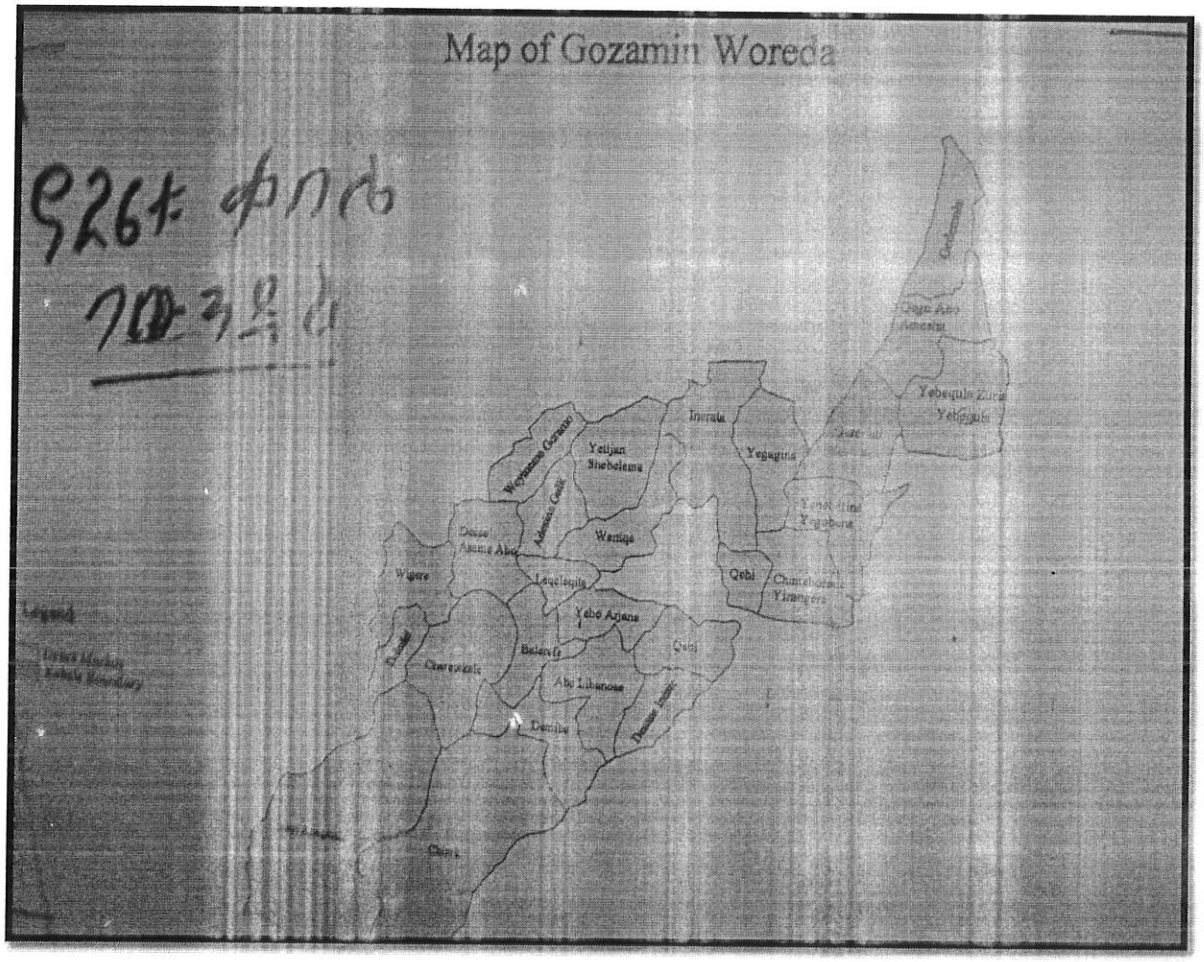

Fig.1. *Administrative Division Map of Gozamin Woreda*

Climate condition

There are four agro-ecological categories of weather condition in the Gozamin *Woreda*. Of these, Wirch (alpine) covers 1 percent, *dega* (highland) covers 9 percent, Weyna dega(medium altitude) covers 74 percent, and *Kolla* (lowland) covers 16 percent. The Average temperature level of the Woreda varies from 11.4°C-25 °C, and the average rainfall ranges from 1448mm-1888mm. Regarding soil type Verti-soil (47%), Nitosoil (31%), Randiziance (7%), Luvisoil (5%), Lit soil (4%), acrisole (1%) and Cambisoil (4%) are the most common and predominant soil type.

Economic condition

Economically, Subsistence mixed Agriculture (crop and animal production) is the major source of people livelihoods. The varieties of cereal crops, such as Teff, Barley and Wheat, are the most produced crops type. Bean, Nug, Maize and Engdo (Barley like crops) are also cultivated in these different ecological zones (Gozamin *Woreda* Annual statistical data, 2005 EFY)[14].Moreover, animal rearing is also additional source of income. Cow, Sheep, Goat, Donkey, and Horse are some of the most commonly rearing animals' type in the Woreda. Peasants/farmers use oxen to plough their farm lands and sell to cover their immediate consumption needs.

Socio- demographic conditions

Table-9. *The distribution of people in to urban and rural areas.*

Area of residence	Population number			
	Male	**Female**	**Total sum**	**Percent %**
Rural	71,933	72,750	144,683	97.81%
Urban	1273	1935	3808	2.19 %
Total	73206	74685	148,191	100%

Source: *Gozamin Woreda government information and communication office, 2006 EC.*

As shown in the table 9, the majority of the population resides in rural kebeles and only (2%) of the population live in a relative urban areas. numerically, it was found in an equal proportion of male and female populations.

In order to have clear picture about the woreda and to see the disparity (if any) of the woreda in relation with the regional standards, the Amhara national regional state's socio-economic and demographic indicators are included.

[14]**EFY**- denote an abbreviation for '***Ethiopian fiscal year***'. And I used such abbreviation to show the time of an activity performed by Ethiopian calendar. NB. Any stated year without the word EFY or EC is Gregorian calendar (GC).

Table 10. The socio- demographic conditions of Gozamin woreda, 2012/13.

Variables	**Gozamin Woreda**	**ANRS Regional**
Population No.	148,191	19,219,999
Population growth rate	1.5%	2.17%
Health coverage	100%	98%
• Antenatal	59.5%	85%
• Delivery	10%	25%
• Post natal	37.2%	59%
Life expectancy		Averagely 54
Male	53	55.9
Female	56	58.5
Education service		91.6%
• 1st (1-8) education.	91.17%.	{7,327 1st school}; coverage % NA
• 2nd (9-10) education	94.36%	2nd {G 9-10} is School 278
Road	155 Km total length,	Total 8578* km. Of this,
• Asphalt	37 Km	1725Km
• Gravel	118 Km	6853
• Feeder road	52 Km	NA
Clean water supply	60% (33,627 people.)	61.85 %(60.79%-R, 70.65%-U)
Religion		
✓ Orthodox	99.9 %.	82.5%
✓ Muslim	0.02	17.2%
✓ Protestant	—	0.2%
✓ Other faiths	—	0.1%
Total Fertility rate	---	4.2%
Infant mortality (0-1 yrs)	NA	94/1,000 live births &154/1000 under five MR[a]
Child mortality rate	NA	154/1000 live birth[b]
Maternal Mortality R.	NA	676/100,000 live birth[c]

Source: Gozamin *woreda health sector office 2005 EC report;*

Development Indicators of Amhara Region Computed by BoFED, 2004/05 EC.

* *a,b,c-Sources derived from CSA(central statistic agency)2012/13*
* *The road length at regional level includes road controlled by ERA (Ethiopian Road authority, which covers 5154KM-(60.08%), and the remaining 3424Km (39.95%) are found under the jurisdiction of regional road authority.*

NA- not available.

4.1. Data Presentation, Analysis and Discussion

Under this section, attempts were made to show the main findings of the research on the bases of data collected through interview and from woreda's health office documents. For discussion purpose, I have rearranged the sequence of research question in the following way:

1) *What is the existing status of health care service delivery system at Gozamin woreda?*
2) *What are the powers entrusted to the Woreda health office?*
3) *What impact does decentralization brought on health care delivery system?*
4) *To what extent does community participate in the process of health care service provision?*
5) *What are the challenges of decentralization in the health care delivery system?*

4.2. The existing status of health care services at Gozamin Woreda

In order to have clear picture, it seems imperative first to assess the general health conditions of the woreda. The study Woreda health policy mainly gives priority for disease prevention and promotion like what Federal Ministry of health does. Most of the preventive activities can be undertaken through health extension workers by implementing 16 packages (see chapter three) at household level. Medium curative service also provide at health center level. According to woreda health office, there is no hospital services in the district but there are 26 health posts and HCs. The types of health services provided by the district health institutions are: emergency and out-patient treatment, immunization, family planning, and child welfare services, antenatal, and delivery and post natal services, laboratory treatment. According to 2005 EC annual statistical report of the woreda health office, the current health care service coverage of the woreda is 100%, which is found better than the regional health care coverage, 98%. This implies that the health institutions in the woreda are found on averagely stated kebele (one HC for five kebeles).

In order to understand the general nature of health care service at Gozamin woreda, it is important to see the number of health workers and health institutions and their ratio to the population in comparison with regional standards and the national one. This could enable the researcher to see the gap (if any) of the woreda to that of the region and the national standards.

Table 11. *Comparison of health personnel and health institutions situation in Gozamin, Amhara region and at national level.*

	Gozamin Woreda [1]		**Amhara Region[2]**		
Health personnel and institutions	No. of health personnel	Health personnel Ratio to population	No. of health personnel	Ratio of health personnel to population	National standards[3]
HEW	56	1:3039	7,471	1:2,383	1:2500
Nurse	51	1:3767	6537	1:2889	1: 4725
Pharmacy technici.	13	1:3092	NA	NA	NA
Medical special.	—	None.	NA	NA	NA
Medical doctor	—	None	188	1:187,554	NA
Health Officer	9	1:18,966	1029	1:18352	1:63,785
Lab Technician	11	1:15,473	1011	1:18679	NA
Health post	26	1:6828	3267	1: 5780	1:5,000
Health centers	6	1:28,448	796	1:23,724	1:25,000
Woreda Hospital	None	NA	17	1:1,819,279	1:250,000

Source: [1] *Gozamin woreda health office, 2005EC;*

[2] *ANRS Health Bureau Annual Reports (2004/05) and CSA, 2010/11;*

[3] MoH, 2010/11.

NA- No Data Available.

Regarding the ratio of health institutions to the population (1:6828 for HP and 1:28,448 for HC), as one can see from table 11, show that the woreda is found below the minimum national standards (1:5000 and 1:25,000) and regional status 1: 5780 and 1:23724) for health posts and HCs respectively. The ratio of HCs to the population at regional level by far is found better than the woreda and even from the national one. Also, it is better than the woreda in the ratio of health posts to the population but not at national level. The ratio of health posts to the population at Gozamin woreda exceed from minimum national and regional standard by 1828 and 1048 people respectively. This ratio however, shows the average one not the individual health post and center. For example let's take Chertekel health center to make it clear. The total population encompassed by Chertekel HC is 35,000 which are beyond the national standard. And health posts are now serving a population of 13,070. Every health post is fulfilled by two health extensions workers in order to provide service not more than 5000 people. Chertekel kebele however, has three health extension workers to serve the stated population. Even though, the number of health extension workers is exceeded from the national standard, still it is not adequate as compared with the population size.

With regard to this, an interview with health extension workers shows that, though they are three in number, still it is too much difficult to them to visit households. There are gotts or villages that they could not yet visit as a result of size of the people and the kebele itself. Moreover, the settlement patterns of the people are very scattered; they could not visit more than eight or ten households per days. The nature of their works however, requires a day to day contact with people in order to guide or give direction on how to perform for example, toilet, wood saver fire, educating moms about family planning and how to use malaria protective nets (interview with Chertekel health extension workers, January 17, 2014).

The status of Health workers

Regarding the number of health workers, according to Woreda health sector office, though not adequate, that there is an increasing trends in the number of health workers over the years. There are a total of 196 staffs, of which 153 are health personnel and 43 are administrative workers). Of the 196 staffs, 25 are first degree holder, 97 are diploma holders, 51 are certificate (10^{+3}), 18 are 12 grades completed and 5 of them are below 12 grade. Out of 153 health workers, 56 are health

extension workers, 97 other health workers. As far as educational level is concerned, the majority of the health workers are diploma and certificate holders, but a very few workers are first degree holders.

According to the national standard, one health center without including administrative staffs, is organized with the following professional capacity. Two health officers (HOs), eight Nurses, two Laboratory technicians, two Pharmacy technicians and three midwifery. The current status of health personnel of the woreda can be summarized as follow:

Table 12.*Number of health personnel distribution by profession and sex in the Gozamin Woreda.*

No.	Types of professions	Total number		
		M	F	Sum
1.	Health officer	6	3	9
2.	BSC Nurse	-	1	1
3.	Clinical nurse (Dip.)	28	22	50
4.	Midwife (dip)	6	2	8
5.	Lab technologist (degree)	2	2	4
6.	Lab technician (diploma)	4	3	7
7.	Pharmacy Technician	7	6	13
8	Sanitary technicians (Bsc)	1	-	1
9.	Sanitary technicians(dip)	4	-	4
10.	Health extension	-	56	56

Source: *compiled from Woreda health sector office, 2006 EC.*

As can see from the table 12 above, the proportion of male and female health personnel in the woreda, excluding HEWs, reflects the male-domination over female. Out of 97 health personnels, only 39 are female and the remaining 58 of health personnel are male. The domination of midwifery by male profession would affect the interest of pregnant women to give birth at health institution level.

Documents show that there is an improvement in the number of health personnel. To make it more clear, let see the trends of some selected health personnel from the year 2001 EC – 2006 EC by the table 13 below.

Table 13. *The health personnel improvement trends at Gozamin* Woreda.

Year E.C		***Types of professions***				
		Lab. Technician	Pharmacy technician	Nurse	HO	Health extension
2001	No. of health workers	6	8	35	3	44
2002	No. of health workers	9	6	43	3	49
2006	No. of health workers	11	13	51	9	56

Source: *compiled from Woreda's health sector office (2001-2006 EC).*

NB: *the 2003, 2004 and 2005 EC data regarding ratio of health workers to the people were inaccessible. For this reason, I used the available data to see the change in improvement.*

As can see from the table 13 there is an increasing trend in the number of health workers. For instance, the number of nurse has increase from 36 in 2001 EC to 51 in 2006 EC, and the number of pharmacy technician also increase from 8 to 13 in the same year. The number of HEW has increase to 56 by the year 2006 EC, which were only 15 since 1995 EC. The number of pharmacy technician, it shows a fluctuation trends. It was 8 in 2001 EC and 6 in 2002 EC but increase to 13 by 2003 EC. The reason to this is due to migration to private clinic and public health in urban area. The turnover of health personnel affects the quality of service provision. Moreover, though there is an improvement in the number of health personnels, still there is shortage of health workers in some professions. Pharmacy technician and lab technician workers are among others the major problems in all most all health centers. For instance, there is only one Pharmacy technician and lab technician at Gozamin health center. Nurses are forced to act as a pharmacy technician using bag (*pestal*) to hold or carry drugs at a time when a technician is either absent, or duty off. Under this occasion, nurses are forced to give, determine dosage of and time interval of drug intake. In doing so problems related with dosage or quantity and time interval are there. For example, a pharmacy technician at Gozamin health center expressed the problem as follow:

They give 5 ml amoxicillin instead of giving 10 ml, and ordered them to take drug prior to meal or after meal for other drugs. For those drug which must be taken meal to food might prescribed to be taken after meal and the vice verse is true.

She further added, I always inform and ask the concerned body of the Woreda, Zonal and even the Regional official while we have meeting. Nevertheless, their routine answer is that shortage of pharmacy technicians is not only at regional level but even at national level, so that the only option they have is to run the tasks by the existing personnel and by nurse until additional pharmacy technicians will be hired.

The health problems of the woreda

Although, the health care service coverage of the woreda has improved as stated above, but there are problems in relation with; first, some HCs and HPs are not well furnished. They have the problems of access to medical equipments such as drug, lab re-agents, and staff shortages. Second, the prevalence of deadly diseases. For example, Malaria, TB, Trauma, Upper respiratory diseases are some of the common disease that lead high death in Gozamin Woreda. Currently, there are top ten identified leading causes of morbidity disease that records high rates of death.

Table: 14.*The top ten diseases and its prevalence rate 2012/13.*

	Top ten Disease at Gozamin Woreda			Top ten Disease at Regional level	
No	**Name of diseases**	%	No	**Name of diseases**	(%)
1.	Diarrhea (non bloody)	53.23	1.	Malaria	25.9
2.	Pneumonia	19.18	2.	Diarrhea	13.2
3.	Malaria- (confirmed with lab.)	6.52	3.	Pneumonia	11.2
4.	Diarrhea(with dehydration)	5.19	4.	Acute Febrile Illness (AFI)	10.3
5.	Diarrhea (with bloody)	3.39	5.	Helminthiasis	9.2
6.	Malaria (clinical without lab.)	3.26	6.	AUR Infection	9.2
7.	Other/ un specified eye disease	2.93	7.	Dyspepsia	6.9
8.	Infection of the skin	2.19	8.	Trauma (Injury)	4.9
9.	Otitis	2.06	9.	Muscular skeleton & connectivity tissues disease	4.7
10	Moderate acute malnutrition	1.99	10.	Other/unspecified diseases	4.4

Source: *Gozamin Woreda health sector office data, 2005 EC and CSA 2012/ 2013 Report.*

As shown from the table 14 above, Diarrhea, Pneumonia, and Malaria are the three most top prevalent morbidity leading disease that accounts more than 78% at Gozamin woreda. According to Woreda health sector office, 2005 EC, inadequate accessibility of pure drinking water and poor personal and environmental hygiene are responsible for the outbreak of high Diarrhea disease. At regional level however, Malaria is number one leading morbidity disease followed by Diarrhea and Pneumonia which jointly accounts 50% of the total causes of death in the region.

4.3. Power and Responsibilities bestowed to the Woreda Health Office

Following the second phase of decentralization, health care service delivery responsibilities were decentralized from the regional health bureau to the woreda health office. The Woreda Health Offices are empowered to manage, plan, coordinate, finance, monitor and evaluate the function of primary health care services at Woreda levels (MoH, 2010/11).

According to the constitution of ANRS, 2001, Woreda level of governments have the powers to prepare and decide annual economic development and, social service plan within its jurisdiction. Thus, the tasks of administering primary health care institutions are the responsibilities of Woreda administration (Art. 83 &86 of ANRSC). Hierarchically, health centers that existed within the Woreda jurisdiction are responsible to Woreda health office, and health posts are accountable to the nearby health centers. See the figure two below.

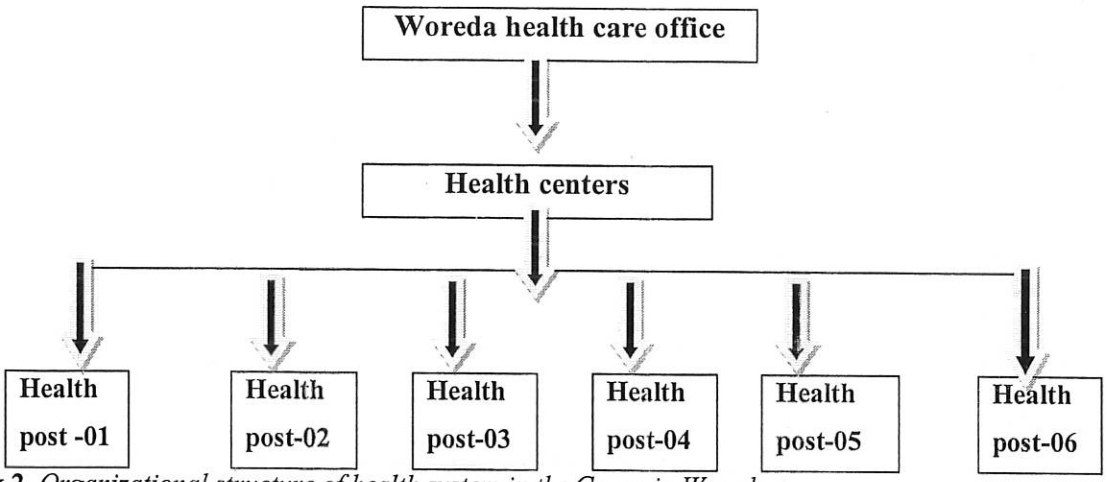

Fig.2. *Organizational structure of health system in the Gozamin Woreda.*

On the bases of this general legal provision given to the woreda, Gozamin Woreda health office has the following powers and responsibilities:

A) Undertake Building of HCs and health posts- building primary health institutions is delegated to the woreda authority. In fact, the constructions costs are financed by the regional and or federal government budget. Minimum standards for construction of health posts, health centers and district hospitals are available for use by woreda health offices. Hence, what is expected from the Woreda health office is to identify the area (kebele) where the health centers are established on the bases of the standards given to them. In the process of selecting sites where health institutions (HCs) is established, the number of population size and administrative centrality are the criteria. Also, it has duties to maintain and rehabilitate or recover old health centers buildings, furniture and other medical equipments as well as administer the construction of HCs' and health posts' toilet via mobilize and organizing the community

B) Administrative autonomy/ power

i. Health workers Recruitment-the woreda has the duties to ensure that the Woreda's health institutions have adequate man power. The mandate of health personnels recruitment and hiring is devolved to woreda level. According to woreda health office director, surveillance was first made by the woreda health office in collaboration with HCs regarding how many personnel are needed, the number of vacant place and unfulfilled profession exist at each Health Center, and

then the proposal is submitted to the woreda council for approval in order to determine the annual budget. HCs identify their vacant positions and then inform to the woreda health office to fill the vacant professions. Based on the proposed plan collected from HCs, the woreda health office can post vacancy notice in order to hire the required health workers. But at a time when there is no available candidate apply to the woreda, the woreda can formally ask the zonal health department to fill the gap through increasing posts to searching the required numbers of staffs. In addition, because of in availability of qualified candidate on health sectors, the regional governments directly hire health personnel graduated from higher institutions so as to minimize shortages of staffs. Furthermore, the woreda health office in accordance with quota given by the zone health department, can recruit eligible health workers for further professional development. It also makes available in-service training in order to scale up staffs' skills and awareness on their field of specialization. Hiring of health personnel is therefore, a devolved power of the woreda health office.

ii. Provide in-service training and promotion to the health workers- in this regard, the woreda has the responsibilities to provide in service training to health personnel in order to develop their skills. Moreover, by creating good sprite of competition among health extension worker and health institutions, it gives incentive to those who have better performance in their work. The HCs have the power to fill the performance evaluation of the staffs. The promotional reward (give education opportunity, money incentive) is done based on this evaluation.

iii. Management and Supervision of health institutions- the woreda health office has a responsibility to supervise health institutions established within the woreda jurisdiction. In addition, the woreda health officer is required to share its experience to health centers and provide technical support to health centers and posts; and shall develop the capacity of health workers through in-service training and professional development by organizing or arranging experience sharing forum, and manage the health extension program by organizing health development team and people participation and mobilization.

In addition, the Woreda has also the responsibilities to distribute health equipments offered by the zone health department to health centers. By organizing people in to development team, it

can strengthen disease preventive role of health extension tasks, monitor, evaluate and give remedial actions or decisions; Forecast and prevent the occurrences of epidemic disease; if once it appears the Woreda attempt to make it under control.

C) Generating internal revenue

i. Collect user fee and finance health institutions

Legal frame work-according to proclamation No. 117/1997 EC of the ANRS health service provision and administration, the woreda health office is empowered to collect user fees and finance health institutions. The proclamation declared that, health institutions, besides to the government budget allocated to them, can collect and use internal revenue as an additional budget aimed at improving the quality of health service provisions, and to improve their economic capacity. Improving the quality[15] of services is the central and the ultimate objectives of health centers while utilizing their internal revenue. The proclamation under article 4, further lists down the following sources of internal revenue of Woreda health institutions.

- ✓ From varieties of health treatment services, and bed service from in-patients,
- ✓ Services that has direct relation with medical services,
- ✓ From drugs sale and laboratory treatment , finite – terminated medical equipment sell,
- ✓ Revenue generated from free service and from sale of non-clinical equipments, for example, house rent, sale of grass, and from contract income,
- ✓ Revenue directly donated by partner organizations in the form of cash or in kind etc.

Once the money is collected from the above sources, it must be kept in a special bank account opened in the name of health institution in collaboration with the Woreda economy and finance office. HCs can put in use all revenues that they generate from service provision. The procedure of opening an account requires three person whose names are announce to the bank and have an *'And'* account' by the joint name of the two representative. Accordingly, the medical director of the health center, purchasing and finance administration officer, and a case team leader who is

[15]The term ***'quality service'***- is difficult to find one common definition. But according to the revised proclamation no. 117/97 EC of health care financing implementation manual of ANRS, it could be defined as *'providing an indispensable or necessary health service at the right time, in the right way for the right beneficiary so as to get the desired result'*. Hence, in this research the term quality service was used and defined as in such manner *(taken from the Amharic version of the proclamation).*

appointed by the medical director of the health center is the three persons responsible to sign and open health center bank account by their name on behalf of health center.

The purpose of using internal revenue is to realize the following aims: first, to provide standardized, quality, prompt and sustainable health services; second, to enhance the culture of people to use health institutions and to develop sense of ownership by improving the quality of health service provision; third, to organize health institutions by necessary drug and medical equipments; and lastly, to enhance work motivation and develop sense of ownership through building the capacity of health institution's manpower (Proc. 117/1997 EC).

Table 16. *Internal revenue generated by the Woreda at the health centers level.*

No	Name of health center	From drug selling	From medical treatment	From varieties source	Total sum
1.	***Gozamin ****	***19254.95***	***15977.15***	***3127.77***	***38359.87***
2.	Fendeka	11522.30	4119	191	15832.30
3.	Aba-libanos	11206.02	4147	2168	16521.02
4.	***Chertekel****	***25527.95***	***9370***	***30***	***34927.95***
5.	Yebokla	33951.05	5320	2350	41621.05
6.	***Giraram****	***7008***	***4448***	***0***	***11456***
	Total sum	108,470.27	42,381.15	7866.77	158,718.19

Source: *compiled from Gozamin Woreda health office, 2006EC.*

* *Signify to identify sample health centers from none sample.*

As one see from the table 16, within the last six months the Woreda has collected 158,718.19 birr from different source. However, there are wide variations among health centers in generating internal revenue. For example, the difference in income collected between Gozamin and Giraram is ranging 38359 and 11456. As far as the autonomy of HCs over their internal finance is concerned, they have the right to use the whole collected money for the following specific tasks listed by ranks based on its necessity to the health centers as it was stated under Article 4 (9) of proc. No.117/1997 EC .

Rank-1- Internal source spent for activities that are considered by first rank are the following:

To purchase drugs and re-agents and to cover transport costs, to purchase medical equipment that fit with the level of health institutions, for infrastructural facility construction(such as water, electric light, for sewerage and fence building), to improve the clean and safety environment of the health institutions, and to cover the costs of non-medical service (food, security and hygienic) transfer to third party.

Rank-2- Activities done by the 2nd level priority at the expense of internal source are:

To improve health system information or evidence, for building additional rooms constructions and rehabilitation, for training purpose (for laboratory, pharmacy and counseling) etc that enable to improve health service provision, and to make health institution's finance and drug holding system computerized.

Rank-3 -Due attentions given to be perform by the 3rd level are:

Purchasing the necessary bureau materials (pen, paper, etc.); transport cost; for supplementary building construction and rehabilitation purpose; to cover the cost of those workers who are employed not more than 3 month contract; to cover other recurrent costs related to improving the quality of health institutions; and for various non-medical training (computer, purchasing, bureau administration and management) expenses.

However, there are tasks which are not covered by internal sources of health institutions. For every scholarship training and its transport cost, domestic training that takes more than a month, every payments in the form of gift for third party, employing and pay salary for advisors (including research work), and any activities outside the aims planned to perform by own internal source and priority given etc are some of costs that are not covered by internal sources.

As far as financial matter is concerned, the Woreda health office has no direct contact with the nearby zonal health department but has a direct relation with regional health bureau. The regional government directly finances its subsidy to Woreda without the need for intermediary body (zone). The only relation the Woreda has with zonal health department however, is in the sphere of reporting (prior to the submission of reports to regional health bureau, whatever it may be, shall reported first to the zone), training to upgrade the capacity of Woreda organized either by the zone or by the region.

ii. Other sources of Woreda Health Financing

In addition to health treatment fees, like other woredas, Gozamin woreda's health institutions get finance from 1) woreda block grant transferred by the regional government, 2) external loans and assistances in kind and or cash from donor organization, 3) other sources.

A) From woreda block grant

Table-17. *Budget allocation of Gozamin Woreda health care office by each year.*

Years (EC)	*Total Annual health sectorbudget*	*Growth rate*
2003	3,076725	1.1%
2004	3,385 715	1.3%
2005	4,428,817	1.08%
2006	4,794,766	-

Source*: Own compilation from Woreda economic & finance office (from 2003-2006 EFY).*

Although the amount of budget assigned to the health sector show a linear increment, but when we compared it with the existing inflation rate (two digits, for example this year), it has a nominal increment or growth rate. In the current budget year, the Gozamin Woreda approved a total budget of 54,396,269. Of these 11, 330,000 birr were collected from internal sources, 42,740,744 birr were from regional grant, and the remaining 325,525 birr is promised foreign donors. Table 4.7 depicts the share of health sector in comparison with other sector offices.

Table 18.*Total Annual budget and its allotment to different sector offices by 2006 EC.*

No	Sectoral offices	Budget	% share to the total
1.	Education	24,667,391	56.43
2.	***Health****	***4,294, 766***	***9.82***
3.	Rural dev't	3,949,361	9.03
4.	Water supply	541154	1.24
5.	Other sectors	10,267,794	23.48
	Total sum	43,714,466	100

Source*-Own compilation from Woreda economic & finance office (2006 EC).*

As shown in the table 18 above, comparatively speaking, education sector is the highest receiver of budget than the other sectors. Numerically, education sector alone accounts more than 56 of the total annual budget. This is so because the sector has the highest manpower in take than others. The health sector, however, receives six times less than what education sector has received. Its total share from the gross Woreda budget is not more than 10%. Even the majority share of the budget however goes to the workers' wages and salaries. The share of capital budget by 2006 EC is 500,000 Birr. This inadequate capital budget has an impact on the improvement of health service infrastructure.

B) From donors

Besides to government budget, health budget is also financed through foreign aids directly given to the woreda. For example, in 2003 EC, 166,324 birr were promised by donors and by 2006 EC, 325,525 birr was again promised by the donors. However, the promised money was not yet given the woreda. The amount of money offered directly to the woreda by donors is as such not significant. Unfortunately, because of absence of data, I was not discussed here in detailed.

4.4. Impacts of decentralization on health care service delivery in the Woreda

Literatures point out that decentralizing health care service will bring health institutions closer to the beneficiaries. Local officials have information advantages in identifying health priorities needs of the local people (Omar, 2005). As a result, decentralization will improve the access, quality and affordability of health care service delivery at local level (Conn, C, and et al, 1996). The next sub topic discusses about the impacts of decentralization regarding such issues.

4.4.1. Accessibility of health institutions

'Access'- is the term that frequently used but difficult to come up with conventional definition. However, according to Kwoyiga (2010:42), *accessibility* refers to both the physical location of health institutions as well as patient mobility. In this thesis, for analysis purpose, the researcher concerns accessibility in terms of the geographic location (its closeness and remoteness) of health institutions to the beneficiaries.

Access to minimum standard of public service (such as health, education, clean water, food and social security) is the rights of citizens as it is stipulated by the Ethiopian Federal Constitution under Article 90 (FDRE, Art. 90/1). These public services actually are the concurrent power of the center, the region and woreda governments. To realize this rights, increasing the number of health institution and make it more closer to the people are the prior tasks of the government. To that end, decentralization of health care system to lower echelons of government was a one step forward to achieve that goal.

The table below shows the responses of households and patients with regard to accessibilities of health institutions. The majority of patients and households in the three HCs replied that there is accessibility of health care services.

Table 19. *The responses of patients and households regarding accessibility of health services.*

Name of HCs	Types of respondents	Total sample population	**Accessibility of the services**			
			Yes	%	**No**	%
Gozamin	Patients	6	2	33	4	67
	HHs	4	1	25	3	75
Chertekel	Patients	6	4	67	2	33
	HHs	4	3	75	1	25
Giraram	Patients	6	5	83	1	17
	HHs	4	3	75	1	25

Source: *Survey data, 2014* HH- denotes house holds

The above table 19 depicts that (67%) of patients and (75%) HHs at Chertekel HC, and 83% of patients and 75% of HHs at Giraram HC respond that the health care service system is accessible. Whereas, 33% of patients and 25% of HHs at Chertekel HCs were disagree on it. Similarly, 17% of patients and 25% of HHs at Giraram woreda responded that the health care service system is not accessible. In contrast to this, the majority of patients (67%) and HHs (75%) at Gozamin HC were asserted that the health care service system is not accessible. Together, the majority of respondents in all HCs agreed that the health care service system is accessible. A statement made by Gozamin woreda health office director has reinforces the responses of the patients and HHs made at Chertekel and Giraram HCs. He said that, by now, the

woreda health institutions become closer to the people. The average distance of kebeles from HCs is not more than 7Km. The table below depicts the lists of kebele encompassed by respective HCs and their distance from the HCs.

Table 20. *The distance of kebele from health center.*

Name of HCs	Kebele(HPs) included under HCs	Distance from HC (Km)	Estimated Walking time consume (Hr)[a]
Gozamin	Yebo-Argena	7	1
	Wonka	8	1:25
	Desa Enesi	15	2
	Kebi	5	40 minute
	Enerata	8	1:30
Chertekel	May Angetam	12	1:50
	Chertekel	0	0
	Weger	10	1:45
	Deledel	9	1:30
Giraram	Giraram	0	0
	Yenebrina	1	15 minute
	Chembord	8	1:25
	Yegagna	9	1:30

Source: *compiled from Gozamin woreda health office, 2006 EC.*

a- researcher's own estimation work

As one can understand from the table 20 relatively speaking health posts or kebeles encompassed under Gozamin HC is located far from the center than kebele found at Chertekel and Giraram HCs. For example, Desa Enesi Health Posts are the most farthest (15Km) than any other kebele found at Chertekel and Giraram.

In the study woreda based on the above assertion made by respondents, show an improvement in the accessibility of health services. A separate interview with households also reaffirms that the

service system is accessible. For example, household admit that there is an improvement in the accessibility of health institutions in their surroundings. Both health workers and households acknowledged this fact. For instance, another household from Giraram HC provided the following statement with regard to change in the accessibility of health institutions.

> Now, we have health center closer to us. No more going to Debre Markos in search of medical treatment. We simply access health institution around us without the need for travelling long distance as we did so far. The maximum distance of the health center from my house is not more than 7 KM. We would like to thank God and our government (household informants from Giraram health centre, January, 2014).

This shows that local people can easily access health institutions around their vicinity, which was not the case in the near past decades. Similar expressions were found from focus group discussion at Chertekel and Gozamin health centers respondents. Currently, there is no problem of accessibility of health center or health post. In each kebele there is at least one health post with two health extension experts.

According to the Woreda administrator, this achievement was gained after decentralization was come in to being. He further compares the current decentralized health service provision to that of the centralized era. There were only one health center till 2001; there is however a gradual progresses in the numbers of health institutions and its services even at Kebele level. There are about five or four health posts in a clustered kebele encompassed by one health center. In contrast to this, according to focus group respondents at Giraram health center, due to the geographical set up of the kebele which contribute for high scattered or dispersed settlement of the people highly affect them to enjoy equal health service at all Gotts within the Kebele.

Health extension workers views– similar views were observed from Desa-Enesi kebele, which is clustered under Gozamin HC. The kebele has a distance of 15 KM away from Gozamin health center. Besides its remoteness from the HC, it also has a very difficulty topographic landscape characterized by mountainous, gorge and valley land forms. For this reason, the kebele is not the beneficiary of ambulance service. This in fact challenge them to get HC easily especially for sever patients. They also added that, they always claim to have own HC in their kebele, and repeatedly ask the woreda. However, the woreda remain silent to their voices. Having this

response, I forwarded question to the woreda health office directors why it could be and his response was the following:

> In fact the problem that they raised is true and is a justified question. But the reason why the woreda silent to their claim is due to few population numbers inhabited there. Establishing HC is a standard based with a population of about 25,000. But the numbers of population at Desa-Enesi kebele (3,919) is below to the national standard that justifies having HC.

The accessibility of health institution to the people improves the health of women. In fact this improvement could be so accessibility of health institutions accompanied with traditions of the people has brought an impact on the delivery of women at health center. The closeness of institutions to the people, it encourages women to give birth at HC.

4.4.2. The impacts of decentralization on quality of health care services

Providing quality service, among others, is an inherent aim of decentralization in the health sectors (Wamai, 2004). Through devolving power to local government, it can brought internal competitions with regard to the provision of quality and efficient provision of goods and services and improve the responsiveness of the government to the public and enhance the quality of service provision (UNDP, 1999). As mentioned earlier, quality of service is about providing necessary health care services at the right time, in the right way for the right beneficiary. Is this so, the immediate beneficiaries of the service are households and patients, I have administered questioners and interview to them in order to know whether they are satisfy or not. Accordingly, the results in the table 21 show that, there is difference of quality service at HC level. For example, at Gozamin health center, the majority of the respondents agree that there is quality of health care services. In contrast, respondents at Chertekel and Giraram HCs answered that there is no quality service (see table 21).

Table 21. Patients and HHs response on quality of health care services

Name of HC	Types of respondents	No. of respondents	quality of health care services			
			Yes	%	**No**	%
Gozamin	Patients	6	5	83	1	17
	HHs	4	3	75	1	25
Chertekel	Patients	6	2	33.3	4	66.6
	HHs	4	1	25	3	75
Giraram	Patients	6	1	16.6	5	83.3
	HHs	4	1	25	3	75

Source: Survey data, 2014

As can be shown from the table 21, 83% of patients and 75% of HHs at Gozamin HCs responded that the there is quality of health care service provision. While 17%% patients' and 25% HHs were respond that there is no quality of services. At Chertekel HC, 33.3% of patients and 25% of HHs asserted that they could get quality of health service in their health centre. But the majority of respondents asserted that there is no quality of services. 16.6 % patients and 25% of HHs at Giraram HC were affirmed that there is quality health service. However, the majority of patients (83.3%) and HHs (75%) disagree with the presence of quality health service at Giraram HC, but only 16.6% of the patients and 25% of HHs were confirmed that there is a quality health care service. In general from the table above, one can see that the majority of respondents (HHs and patients) assert the absence of quality health care service provisions. Having this information, I have triangulate theses idea through interview. Hence, similar response was observed while I interviewed patients. For example, an interview with Patients at Chertekel kebele added:

> The approaches health workers have are discouraging to visit health center. Problems like insulting and absenteeism, waiting lengthy time for once return are there in the health center. Postponing our treatment for another day, lack of welcoming face and even disrespect of us jointly encourage us to leave health center, and go to traditional medicine.

The household view- problems related with ability of health workers in diagnosing patients, unavailability of them at health center (most health works, perhaps not all, leave the center even

at regular working time) and give unrelated drugs with the disease are the common problems. Moreover, they dislike patients while they appear before them and insult both patients and their attendants are some of the problems mentioned by the households.

Health personnel associate the low quality services with the level of infrastructure exist at HCs. A focus group discussion with health workers expressed the situation as follow: 'in our HCs as you see there is no water, electric light, and the building of class room for office is still not finished. They further mentioned that, there is no adequate supply of drug'. Correspondingly, the woreda health office director reinforce in that: though we have improved the coverage of health HCs and HPs in the woreda, the established institutions are not equipped with health personnel and constrained by financial problem. Creating a good working environment for the health workers is important elements of assuring quality services. However because of budget problem, we could not offer incentive payment for health workers.

4.4.2. Affordability of health care Service at Gozamin Woreda

The term '*Affordability*' can be defined as the ability of people to pay the direct cost for example, for drug, card fee, and the indirect cost, for instance transportation fees of the health services. It is decentralization that create good environment in such a manner that the service delivery system is affordable to the local people. Otherwise, it may pose a challenge for people owing to lack of income-inability to pay for health related fees (Kwoyiga, 2010:91). The ability of beneficiaries to pay the cost of the service is therefore, the determinant factors for affording health care services. With the aim to make the health care services affordable to all sections of the people, the government of Ethiopia in general and the Amhara regional state (in line with the federal policy) in particular, established free health service scheme[16] for the poor people and exempt some selective public health services from service charge.

[16] ***'Free health service'***- means a service in which the costs of the services are covered by the government in order to have opportunity for the poor individuals or households (who cannot able to afford cost of services) to get medical services without any payment. On other words, it is the rights of the poor people to get free health service from health institutions. When we say free service, by no means, the costs of free services are not covered by health institutions but instead by the government or other third party on behalf of the beneficiary. Therefore, free health service does not mean that it is without payment, but, it needs payment however, the payment system did not lay on the part of the beneficiary (Proclamation no. 117/1997 EC).

i. Free health services- the introduction of free service delivery enables poor people to afford and enjoy free health care services. This has contributed a lot for saving the lives of the poor. The major objectives of free health service provision is, to ensure just or reasonable distribution of health services to all people through making health services afford to all including the poor. Once the poor identified by the kebele residents, the eligible poor have the right to access identification card. It can be realized by providing free health services (see chapter three). As mentioned earlier, the kebele residents are the responsible body in identifying the eligible poor through mass meeting or forum.

The reality according to the majority of respondents, the kebele people do not involve in the process of identifying who are the poor and who are rich (though it is relative, but for this research rich- those who able to pay for the service costs. Until now, we have yet not seen forums or mass meeting organized to select the poor to make them part of the program. The issue of identifying the poor is however dominated by, and left to the kebele chairman in collaboration with local militia (*mengistawi buden- in Amharic*). The only thing that the chairman did is to ask few residents of the kebele questions like, who are the poor, do they have land and how many families do they have etc separately. No doubt, people who asked by the chairman are biased to their relatives and close friends. For example, there are poor people to the extent of incapable to get their daily meal, but cannot be part of the program simply because they have land regardless of taking the productivities of the land in to consideration.

Table 22. The number of free service beneficiaries and its cost of service.

No	Name health center	Number of free service beneficiary	Total expenses	Provided money from Woreda council to cover the cost
1	Gozamin	34	1270.70	1270.70
2.	Fendeka	28	859.10	859.10
3.	Aba- Libanos	15	216.60	216.60
4.	Chertekel	198	6685.35	6685.35
5.	Yebokla	142	3886.50	3886.50
6.	Giraram	21	390.75	390.75
	Total sum	438	12,469	12,469

Source- *Woreda health sector office document, 2005 EC.*

The presence of free health service for the poor is valued by the people. For example, according to Giraram health center household respondents, the free health service program is very interesting one that it enable the poor to get medical treatment from health institutions as what the rich people did. However, what makes the people dissatisfied is the procedure that employed. It lacks fairness, transparency and abused by kebele officials. There is a possibility of exclusion of target poor and an inclusion of wealthy group. This incident is happen due to the result of misuse of power by kebele officials. One household (female) at Giraram health center expressed here resentment as follow:

> I am one of poorest of the poor in our village. My husband died three years ago and I am a single parent with three children. However, as a result of being not close relation with chairman of and his yes men, I excluded from free service scheme (interview with female households at Giraram HC, January, 2014).

The testimony of the above household view proved that the process of identifying the eligible poor is subjective to a couple of problem including corruption, discrimination or bias treatment by the local officials.

ii. Exempted service[17]-people due to lack of income, they find it difficult to get treatment services when they feel ill. But exempted service is another mechanism to make the health services affordable to all. Legally speaking, the ANRS under chapter six of the proc.No.117/1997 EC list down public services such as immunization, antenatal care, delivery at primary health care unit, postnatal care and family planning services, treatment of tuberculosis and its follow up, supply of TB drugs and sputum diagnosis, leprosy, fistula, Epidemic, voluntary testing and counseling of HIV/AIDS, and prevention services of HIV/AIDS

[17]'***Exempted service***- is meant that a kind of medical services provided by the health center for all beneficiaries of the kebele residents free of charge. The difference between free health service and exempted service is that, under free service scheme- there is discrimination between the poor and the rich people. In other words, free health service is not available for all, instead it is merely poor and risky centered. Rich people (who able to afford medical services they used) are not entitled to use free services. Whereas, exempted service is available to all (rich + poor). In both cases however, the costs of the service are covered by the government. In the case of free services, besides to the government, other third parties –who enter an agreement with health institutions on behalf of the poor in order to cover the costs of the services, might be involved. ***NB:*** A free service does not mean that the costs of the services that the health institutions incur are not compensate or covered at all. It is free because the services are offered to the poor by health institutions without the need for direct payment from the service recipients but by the government expenses, not by the health institutions.

transmission from mother to child etc as exempted public services. Unlike free medical services-which are available only to the poor people, exempted services is however provided for all people regardless of the levels of economic differences. Currently, Gozamin Woreda has providing exempted services for about 1240 people. The following table depicts the number of exempted service recipients across health centers with total cost that the service has taken.

Table 23. Number of exempted health service beneficiaries in the Woreda

No.	*Name of health centers*	*Number of Exempted Service recipients*	*Total costs/ expenses*
1.	*Gozamin*	142	5346.85
2.	*Fendeka*	121	3069.55
3.	*Aba- Libanos*	95	2216.10
4.	*Chertekel*	390	16,709.15
5.	*Yebokla*	390	13,483.30
6.	*Giraram*	102	2687.90
	Total sum	***1240***	***43,512.85***

Source- *Gozamin Woreda health sector office data, 2006 EC.*

According to the research result done by USAID in Ethiopia, scarcity of drugs, absence of clear guidance on whether to fully or partially charge for services, and extra costs incurred for the provision of exempted health services, and inadequate support both from the government and NGOs for the provision of these services are some of the problem encountered in the process of providing exempted services (USAID, 2012). There is confusion on how the charge of exempted services is imposed. For example, for TB treatment HCs at Gozamin woreda impose card fee as for other disease does.

No matter how this effort has done, divergent views were observed from households and patients regarding affordability of the services. For example, 67% of patients and 50% of HHs at Gozamin HC respond that the service is affordable. See the table below

Table 24. *The response of patients and HHs regarding affordability of health care services in terms of ability to pay direct and indirect cost.*

Name of HC	Types of respondents	Total no. of respondents	**Affordability of health care services**			
			Yes	%	**No**	%
Gozamin	Patients	6	4	66.6	2	33.6
	HH	4	2	50	2	50
Chertekel	Patients	6	1	17	5	83
	HH	4	3	75	1	25
Giraram	Patients	6	1	16.6	5	83.3
	HH	4	1	25	3	75

Source: Survey data, 2014

The table 24 shown that, the majority of patients and HHs at Chertekel HC expressed that the health care service delivery is affordable. In contrast, 83% of patients and 75 % of HHs at Giraram HC respond that the service is not affordable. 50% Households at Gozamin Health Center asserted that the service is affordable. Further, an interview was conducted with male patients on what regard the service is not affordable. He expressed as follow:

> I do not know whether health centers are private for profit institutions or business organization or public health institution. If a person going to the health center, first he/she expected to pay 7 birr per single card directly. And this card is valid for 15 days only. If the same patient visits the health center after 15 days, he /she required to pay 7 birr again. It showed a dramatic increment of the cost of card fee as compared to the previous one. For instance, before three or four years ago, it was only 4 birr, imagine how it is inflated. We are suffering more; we need some urgent modification on cost of treatment *(male patients at Giraram health center Jan, 20, 2014).*

The same result was observed at Chertekel HC. Patients complain that the card fee is now increased and for treatment too. For example a man appears at health center with trauma, he is expected to pay not less than 100 birr.

Although the majority of the above respondents claimed the affordability of health service is low, a male Household informant from Gozamin HC responds that, by no means, health service payment is expensive because there is nothing else beyond health. Everything will cease if the health of a person is at risk, so whatever the costs of treatment is, I can pay. He further compares the cost of HCs with private clinics. But, the only objection that he has was, HCs cannot provide quality service as private clinic. So comparatively speaking, the cost of public health institutions is affordable than the private one. Opposite to this, another household stated that *'it is difficult for me to pay for the service because my total wealth is only two oxen with four timade (in Amharic) land. Even the land is not productive enough. And I lead three children (households at Giraram HC, 2014).* From those informants, one can understand that the economic status of the people have an impact on their health cost decision. There are people who have no enough money to pay for and not included in the free service scheme and there are also people who can pay the health costs within a kebele. People in the study woreda have assets like livestock (cow, Goat, sheep and hectares of land) that when sold it can enable them to pay treatment fees. But without any thorough investigation of peoples' wealth, it is difficult for the researcher to say that people can afford the service or not. This issue is not addressed by this thesis and so the researcher recommends the need for further research to reach at a right conclusion whether the health care service delivery system is affordable or not.

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Directors HCs views: the directors of the Chertekel health center acknowledged that they hear complain here and there from the people. At every forum, people ask me to tell what is the reason for such increment? And need some reduction in the cost of card. However, the directors of the three HCs respond that the increment of such cost on card and 25% added on each drug is not to make HCs merchants but it is for the sack of them to provide quality services (health center director of Chertekel, Jan 19, 2014).

Politician views- according to woreda council, in order to provide quality services, HCs are empowered to increase internal revenue through card fee and drug sell and from other services. He further stated that the amount of cost for treatment is done based on the abilities of the people of the woreda. If it is believed that the cost is beyond the abilities of the people, it will be modified.

Contrary to this, health personnel during FGD revealed the inabilities of the patients to afford the costs of the service asked by health center based on their years of surveillance at health center:

> Some patients (who are not included under free service scheme) return back to home without getting treatment if the cost of the service is higher than what they have. If we know that the degree of illness is severing, we, health workers contribute money out of pocket for a patient to get treatment, so as to save the life of the patient *(FGD at Gozamin health center January, 2014).*

Even though, the health care service system is highly subsidized by the government, still there are people who are neither afford the required costs nor include under the free service scheme. . In this regard, a research on the practice of traditional medicine in Ethiopia done by Alemayehu and et al (2006) has proved that more than 35% of the patients did not get the prescribed drugs because of lack of money. The free service program encompasses the whole people who unable to afford the costs but limited to the poorest of the poor. Besides, the program is abused by kebele officials so that some poor people may not include in the scheme but instead those who able to pay the cost may included.

Patients' view- under this scenario, patients who are economically incapable search alternative means of treating illness, like self medicating and use traditional medicine. One patient responds its alternative measure for treatment as follow:

> If the requested birr for treatment needed is beyond my pocket, there has no option other than using traditional medicine. I and my family prefer to go to holy water (*'Tsebel'- in Amharic*) and church to pry towards God in order the patient to receive forgiveness and sanctity from God to the disease affected. Most of the time, people would like to go St. Georg Holy water[18] since it cures many patients especially patients with evil sprite, mental disorder, crazy or mad *(patients at Giraram health center January, 2014).*

Why and when traditional medicine is?

Traditional medicine has a role in the access and affordability of health care services. The type of disease patients suffer determines the area where the treatment or therapy is get.According to my

[18] ***"St. Georg Holy water"***- is located in close proximity to Giraram kebele, at a specific locality name called ***Engcha***. It is a Well-known Holy water with St. Georg church and many spiritual priests. Patients not only the nearby kebele residents but also from a very remote village come to there in order to get therapy.

informants, disease like mental disorder cause by evil spirit, evil eye or buda are typically best cured by traditional medicine than the modern one.

Table 25.The response of patients and HHs about TM -Vs- modern health institutions.

Where did you go for treatment while you feel ill?				
	Types of respondents			
Types of treatment area	Households		Patients	
	No. of respondents	(%)	No. of respondents	(%)
Modern health institutions	6	50	7	39
Traditional Medicine	6	50	11	61
Total	12	100	18	100

Source: *Survey data, 2014*

As shown from the table 25, the majority of patients (61%) prefer to go to traditional medicine when they feel sick and the remaining 39% prefer modern medicine. Whereas, in case of households, there is no majority number in preferring either traditional medicine or modern health institutions, but (50%) of households prefer traditional medicine and the rest 50% prefer modern medicine. The reason why majority of patients prefer traditional medicine and practitioners is that, unlike modern health workers, traditional medicine practitioners show good faces, respect, and always present in their work place, low cost and exist just around the people so that one can access them at every time (patients at Giraram HC, 2014).

Health personnel views- a nurse at Giraram health center acknowledged the role of traditional medicine in general and holy water and prayer in particular. He emphasis its role as: 1) the location of TM is closer to the people has an advantage of save time, 2) It provide healing free of charge (particularly holy water) so that it is more affordable especially for the poor and 3) its inherent nature of therapy has no side effects as what modern medicine does. In spite of this fact, therapy accessed by traditional medicine is not accepted by at least health personnel level in his HCs. Most of the time, health workers and traditional medicine practitioners could not do

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intimately. The practitioners are accused of lack scientific knowledge but they have ample indigenous knowledge accumulated over century from their forefather (ancestor).

Health Center directors' views- the responses of all the three health centers reaffirm the health personnel views. They respond that, they advice traditional medicine practitioners in order to abandon their work than offering training for them. According to Gozamin HC director, by this year the HC organized a forum with traditional medicine practitioners. The aim of the forum is to forward message not to do in the future. By this forum, many (number not mentioned) practitioners leave their activities. In contrast to this, the national health policy recognized traditional medicine and make as part of the health policy in 1993, but what is done here is in contrat with the policy.

4.5. Community Participation

Currently, community participation in the administration of health services is considered as an essential aspect of health systems. This is due to the fact that, the direct beneficiary of the health service provision is the people themselves. If it is the case, their active engagements in the operational discourse of health service provision are so imperative in order to attain the accessibility and quality of health services at community level. Moreover, it has also improved the performance of health institutions by strengthening the accountability of health service providers to the patrons and by scaling up of sense ownership (World Bank, 1994). Having this, it is important to see the trends and the extents of people participation in the process of health service delivery system at the study Woreda.

In order to create sense of ownership and improve peoples' participation, health centers through kebele health extension workers organize the *'one-to-five'* and *'one–to-thirty'* health development team network system. The task of organizing people in to this team is left to health extension works in collaboration with kebele administration. Each development team has one chairperson with power and responsibility to follow up members of the group whether or not they are in a right track to implement health packages. There is a regular meeting every week to evaluate their performance. During meeting session the kebele health extension worker must present there in order to disseminate to the group and the leader, health education to them about new packages, and the meeting is wind up with division of assignment that will be done in the

coming week. There is coffee and tea ceremony prepared by the group member at a meeting session so as to attract participants. Sometimes the team leaders meet with Woreda experts and then he/she come back to the team to teach them or disseminate to them what he/she was learned. A women one- to-five team in collaboration with health extension workers, play an important role in the protection of personal and environmental sanitation. There are exchanges of knowledge among women how to hold house and meal utensils clean and caring for children. Moreover, they also advise pregnant women to give birth at health institutions so that no members of the group are give birth at home.

Participation in the protection of personal and environmental hygiene

It is a must to have a toilet at household level. It is up to the men to dig a deep hole. The preparation of the toilet can be made either by grass or steel house depending on the capacity of the individual households. Those economically capable household can build toilet through steel and cement, while those who unable to buy steel and cement will build grass houses. The task of keeping the hygiene of the toilet is rest on household. This can be done through the health extension workers. Special rewards will goes to those households who make the toilet in accordance with the standard directed by health extension worker.

As far as common toilet is concerned, the whole community members have responsibility to do it in an area where central for all. The place where common toilet established must be located near the main road and in a place where many people resides. The whole community bear the cost of the constructing toilet including provide labor force; contribute money to buy steel and wood. Every one of the community and other people come elsewhere are eligible to use it. However, no one take the responsibility of cleaning and washing it. As a result, the hygiene of common toilet is not keep tidy.

According to health directors, currently there is at least one common toilet at every kebele established in at central place where most people access it, and every household have a toilet. People prepare toilet by steel but the problem is the issue of using these toilet. Even in some kebele the quality of common toilet is poor, once they used it nobody is responsible to clean it. This show that much remain to do in creating awareness to the people regarding the importance

of using toilet for their personal and the environment health. Having toilet by itself is not an end, but it call for an appropriately usage.

Participation on the sphere of building health institutions

Moreover, people participation also extends to the extent of building health posts (they offer physical force). Both male and female engage in building health institutions. According to my informant's view from male households, community members provide free labor for any labor-intensive or physical work and such as in the construction of health institutions, clear up and arrangement of the health facilities, providing necessary material such as land and tree and collect stone from remote area. They further stated that, the people of their kebele perform any tasks identified and ordered by kebele officials through campaign. No hesitation is there at all. Health posts are established by the peoples' force. For example, mudding the wall and covering the roof by steel, and fencing the boundary by wood was performed through the cooperation of kebele residents within not more than a day. Women also involve by fetching water for mudding purpose.

Hcwever, regarding to their participation in the management of health center is still low. They considered such tasks as a mere responsibilities of health workers. Their rationale to say this is that they are not literate enough that enables them to engage in the management process. And assumed that the only responsibility they have is to do what tasks imposed by the kebele administration.

Politician views: according to kebele council chairman, the Practice and or culture.of people involvement in the process of identifying their health problems and overall planning activities is almost inexistent. We as kebele officials call for meeting in order to discuss about the socio-economic and health related issues with them but almost all people considered it as irrelevant and miss the meeting time.

Health personnel view: Another interview with health extension workers (January, 2014) proved the existence of little involvement of people as follow:

> Because of we always lived near to them and they repeatedly seen us for lengthy years, people gradually become reluctant to accept and perform what we told. Currently, people other than enter promise to do health packages (for example, prepare and use toilet including common toilet, use family planning etc) while we visit their home, we hardly

observe anyone who discharge once promise. Sometimes, at a time when we visit them, they hide themselves not to see by us and in order not to do the above mentioned packages. Main you how much they are ignorant for their own affairs!

This evidence shows that people lack adequate awareness and necessary health education regarding the importance of maintaining personal and environmental hygiene. Even though, people have for example, toilet they are unwilling to use or excrete by. For instance, according to Chertekel HC document, there are 1914, 2898, 2215 households who have toilet, malaria protective net, and dry garbage sewerage respectively but still they did not want to use it.

Participation in giving priority

The kebele official, a direct representative of the people, participate at the woreda council in the process to identify target kebeles where HCs are located by presenting the reality of their kebele to the council. They also give priority which social service give priority than other by assessing the needs of the kebele people through kebele meeting. In this regard, a Chertekel kebele chairman responded that, in 2002 EC our kebele has decided to have high school so as to overcome the problem of our children, and now we have high school here. For this purpose, people contribute both in kind and in cash in addition to budget given by the woreda.

Participation in the Health institutions management

With regard to management tasks, as discussed earlier, the Woreda has the responsibility to manage and administer the whole health institutions that established under the jurisdiction of the Woreda. Its mandate also extends to the extent of planning, financing, evaluating, and monitoring and ensures the human source of health institutions are adequate (MOH, 2010/11). Moreover, the ANRS allows health centers to have some discretion power to run by themselves. Currently, health centers in the study area are managed and control the overall activities of the center through organized body called board (Article, 19 of proc. No. 117/97 EC ANRS Health service provision management). The combination of the board is consists of 5 members, namely, director of health center and one chairperson of a case team appointed by the director, civil servants from other government sector office, and lastly, three persons elected from the community can form the board of the center. The director of the health center is assigned to act as a secretary of the board. The three elected personnels among the community will represent the

entire community on issues that have to do with health and work intimately with health workers towards the realization of the objectives of community health. Via three people, the communities are supposed to actively participate in the administration and management of health institution. The chairman of the board is a political nominee-directly nominated by the Woreda administrative council and accountable to the Woreda health office and the board. The chairman of the board in particular has power to manage and control members of the board, and call them for regular meeting, and in collaboration with the secretary of the board, prepare regular meeting agendas (Proc. 117/1997 EC, Article, 11).

The same proclamation further state that members of the board are expected to exert unreserved endeavor to improve the health sector, must be residence of the kebele and have acceptance by the people, have interest and commitment to be a member of the board. Moreover, the members must be free from conflict of interest and as much as possible balanced composition of profession and sex must be there. The board in general has the following powers and responsibilities:

(a) Administer and follow up the overall activities of health center;(b) Prepare short and long term plan and strategies of health center and then bring to the Woreda health office; (c) Approve annual budget of health center and regularly follow up its utilization;(d) Approve the health center's quarter, half year and annual report and forward decisions; (e) Ensure the health service provision based on standards, impartial and in a transparent manner; (f) Follow up the provision of free health service at HC and suggest possible solution for the problems in collaboration with Woreda health care office, (g) On the bases of health care finance implementation manual, try to identify and give non-clinical services to third party; (h) Make sure that rules and principle established by the Woreda health office are appropriately implemented; (i) Discuss with the people and other bodies regarding health care service provision; (j) make sure the national health policy principles or standards are implemented at HC; and (k) Perform other tasks assigned by the Woreda health office.

Providing prompt, fruitful and sustainable health services, through improving the administration and leadership skills of health centers, and to develop the culture of people to be beneficiary of health institutions by improving peoples' sense of ownership up on health centers are some of

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the aims of establishing board. The board has three terms of years. They must have a meeting at least once a month, and members have a duty to present at every meeting session. They have also both individual and collective responsibilities with regard to problems occur at HC due to failure in discharging their tasks properly.

In order to make the board more effective, there is a mechanism of motivational or incentive payment from government budgets. If the health center collects more than 400,000 birr annually from internal revenue, 125 and 100 birr will be payed to the chairman of the board and other members respectively. If the health center collects below 400,000 birr annually, only 75 and 50 birr will be payed to them respectively. This payment however, is practicable only to those members who discharge their respective duties effectively through attending regular meeting of the board. In other words, motivational fee is hardly paid to those members who miss at monthly meeting.

Even though, powers given to the board and the existence of incentive payment for them seems more attractive structure, but practically it encountered by the number of intricate problems in discharging of their intended responsibilities. According to the statement made by the directors of HCs, the boards have the following limitations: little or no commitment to improve HC, frequent absenteeism (no available at regular meetings of boards) at monthly meeting; members are very busy in their private life than devoting little time in dealing with issues concerning on HC, lack of experience and capacity to effectively perform, dominated by few members, ignorant of their duties as a board member especially those elected from the community because of illiteracy related problems and lack of skill development training opportunity to the members etc are some of the problem that the board experienced. In addition, there are also board members who are accused of showing disinterest for different reasons. This confirms that there is a problem in the screening or election process of board members.

4.6. The Challenges of decentralized health care service delivery of Gozamin Woreda

It is the last objective of the research attempted to dealing with challenges that happening under a decentralized health service delivery system. Some of the challenges are list down on the bases of information collected through interview and personal observation.

and degree respectively, which is a discouragable one. And even this skimpy birr is paying to them only when their duty lays on the two selected holy days within a week i.e. Saturday and Sunday. However, in the remaining day, instead of paying money, the values of duties are changed in to a six hrs brake. The same response was observed from another FGD at Giraram Health Center.

The directors of all health centers accept these problem mentions by the focus group discussants. We really have a big budget problem, particularly budget assigned for duty and per-diem. Only a few birr was assigned for this purpose. What makes the problem worse is that, as they expressed, they are not entitled to use their internal revenue for this purpose because like salary of the staffs, duty and per-diem budgets are budgeted directly by the Woreda. In my opinion, the problem will be addressed if health centers have discretion to use their internal revenue to supplement regular budget in order to have comparable duty and promotional payment for staffs. In order to overcome the problem of abusing the money by the officers, the woreda government has to established strong auditing and regular reporting system. In this regard, the proclamation however, does not permit health centers to do so.

In addition, druggist at Gozamin health center viewed her work overload as follow: she is the only one pharmacist (druggist) engaged there. And she carries lots of responsibilities such as requesting drug to purchase, make specification to the require drug, check the number of drug entered in the drug store, selling drug, reporting, etc are tasks rest on her shoulder alone. There are times where she was missing her lunch time in order to serve the coming patients. She added that, it is immoral for her to close drug room while there are many patients. As I can understand from the respondents, overwork load to health workers is due to the result of shortage of manpower on the field. Those health workers with few in number affected much by overburden whereas; health workers with enough (though enough is relatively) in their number enjoy relative modest working environment.

3) Weak Referral System as a challenge

According to the statement made by Woreda health office director, it is true that there is weak referral system of patients in the Woreda. He explained the reason why it could be in the

following statement: "Lack of transport availability and road facility, the perception of patients themselves who perceive modern health care as a last alternative for their treatment etc in combination are responsible for delay in referral of patients" (health office director of the Woreda January, 2014). Even though, ambulatory service for emergency cases is there, because of its limited in number (only one in the Woreda) in the one hand and a very large size of the woreda on the other hand are incomparable, and road related problem, jointly hamper the expected outcome from being realized. As compared to the size of the Woreda and the number of ambulance, it is insignificant. Patients therefore bear the task of getting means of transports to reach at referral health institution (which is mostly Debre Markos, for severe cases). In this regard, patients expressed the service of ambulance car as:

> There is only one ambulance that gives free service only for pregnant women. For other patients other than child and pregnant women, ambulance provides service with payment i.e. 300 birr per single trip. Imagine! It is beyond my capacity to afford ambulance fee and other related medical services. As a result, I prefer to use traditional ambulance[19] for referral cases (male patient from Chertekel health center, January, 2014).

According to the director of health center, sometimes, due to delaying of ambulance car, severely ill patients and pregnant women were died before they reach at referral hospital. Besides to this, as patient attendants has elucidated, the problem of delay in reference is not a mere problem of patient and traditional medicine practitioners', the health worker themselves take lengthy time in giving immediate referral letter as soon as they know that they could not cure the patients. In other words, in most cases, they are not volunteer to refer patients but rather give appointment time to patients for another day through giving a dozen of drugs. If the patients are not rehabilitating by the drug offered at the first time, they change another drug in the second time. Through these circumstances, at the middle of the time, the patient will affected severely and or die if things are worse. Any attempts of asking them to give refer letter by the patient themselves or by their attendants considered it as undermining their profession or ability of curing or rehabilitating patients from their illness.

[19] '***Traditional ambulance***'-is a product of indigenous knowledge made from local wood. Local people (in most cases youth who have strong energy) are assigned to carry patients to bring at health institutions. These can be done voluntarily by the sense of humanity and due to strong culture of cooperation of people.

4) Insufficient space (***for Bureau, OPD, Card room and Drug storage and dispense***)- is another challenges facing the Woreda health institutions. While I was visited the selected health centers, I have observed that there is serious problem of class room shortage especially for OPD room and bureau. The director of all selected health center agreed with this problem. A focus group discussion was proved this problem by the following statement.

> You can see the shelf in the drug room how much it is concentrated and disorder allocation of drug. Drug store and dispensary class are merging together in to one class, we are forced to diagnosing patients by one room which leads too much delay in service, and merging two or three bureaus in to a single room is mandatory (FGD at Chertekel health centers, 2014).

They further explained that there is a long delay in accessing drug from the Woreda; it takes at least more than a month. This is happen because of the tight procedure it has at the Woreda level. In line with this, Prud'home asserted that decentralization may open the way for the development of tight bureaucracy and delay in service provision (Prud'home,1995). HCs first expected to send specification paper with lists of drug types, brand name and dosage, time of arrival. However, sometimes the woreda sent to the HCs unspecified drugs (drugs other than what they mentioned in the specification paper/ letter) or unnecessary drug, some time they sent beyond HCs' demand. These in fact, yield unnecessary accumulations and expirations or decay of drugs in the one hand and lack of or un-availability of immediate necessary drug in the health center. Consequently, HCs are obliged to purchase critically desired drugs in their respective HC from a nearby private or Red Cross pharmacy (though the policy did not allow to do so) by the health center's internal birr from Debre Markos. After HCs have purchased, the Woreda send the same type of drugs. As a result, this brought unnecessary expense and concentration of unwanted drug in a very narrow drug store room.

Having this information in mind, I have further tried to provide question to the woreda's health equipment supply and distribution director why it could be happened. He partially agreed with the aforementioned problem. There is lack of human power to do it. He was the only one that

was assigned to do these tasks and hence it a challenging task to read lists of specified drug, packing and distributing it to the six health centers. It could not perform by a single man. It is unlikely true to say no delay in the provision of drug. Sometimes when he was too tired and busy, he could not read and identify each and every specific drug of all health centers on time and in a right way. For this reason, there will be a case where unspecified or unnecessary drug (what they do not mentioned in the specification letter) were make available to them. Notwithstanding this fact, health centers themselves are not without problem, they could not mention the type of drug, the dosage, and the brand's name appropriately. Consequently, in combination with these intricate reasons, the above indicated problems would undoubtedly occur.

5) Little training and education opportunity

Concerning the training opportunity available there (both in-service training and professional development), more than 98% of health workers responded that there has no or too little opportunity of professional development to upgrade their knowledge and skill. In addition, lack of transparency and impartial treatment problems are there. The training opportunity is not openly provided to us; instead those who have close relation with the directors will easily got the opportunity than the other (FGD at Giraram HC January, 2014). In this regard FGD at Chertekel and Giraram HCs asserted the same voice with the above statements.

The problem becomes very serious for health extension workers. There are health workers who have eight and above years of service, but still they do not get chance to upgrade their career. According to Chertekel's health extension workers response, they are not happy with the types of training given. After training program is wind up within four months[20], no change appears on their level of profession. The training program is not considered as professional development because those who accomplished the training program, still they are health extension workers (not aimed at transferring them to other higher profession, for example, towards nurse). The total

[20] The total time the training program takes is four month only within two subsequent years. It was always held at summer seasons. To be specific, two summer months (June and July) in the first year and the same will be happened in the second year. The nature of training given by itself is aimed at not to upgrade health extension workers in to nurse.

annual quota given to the Woreda by the zonal health department is not more than four health extension workers and other health workers.

Furthermore, even the dedicated in-service training being provided is not adequate. A nurse respondents at Gozamin health center viewed that it was only a two months training offered to equip nurses to druggist (her prior profession is nurse but because of shortage of pharmacist at the HC, she act as a pharmacist by the help of such in-service training). She further emphasis the problem encountered, she always inclined to her original profession and even now she wants to work by her profession i.e. nurse.

Moreover, according to focus group discussants, though there is little in-service training, the required personnel will not be sent to attend the training. Most of the time, the top officials hide letters (that send either from the Woreda, region or from the federal) which asked them to recruited and send based on the specific criteria set by the letter. However, what is being done here in the Woreda is not in accordance with what the letter needs. For example, if the training requires pharmacy technician, contrary to this, they recruits from other unrelated professions say for instance from nurses, HO (FGD at Gozamin HC, 2014). In spite of this fact, by 2005 EC the following in-service training were embarking on at Gozamin woreda.

Table 26. In-service training offered by Gozamin woreda to health workers

No.	*Professionof the trainee*	*Types of training*	*Dates assigned for training*	*Training offered by*
1.	clinical nurse	Family planning	4 days	Regional Health Bureau
2.	Clinical nurse	Mentorship	6 days	MSH
3.	Bsc Envi. Health	Mentorship	6 days	MSH
4.	HO	Mentorship	6 days	MSH
5.	Clinical nurse	TB	10 days	MSH
6.	Clinical nurse	TB/HIV	6 days	Heal TB
7.	Clinical nurse	TB	10 days	Regional health bureau

Source: *Gozamin Woreda health sector office, 2006 EC.*

6) Inadequate infrastructure as a challenge for decentralized health service delivery

Although, the mere establishments of health institutions close to the people is not sufficient condition for ensuring quality services but it could be a necessary condition. In other words, quality service delivery besides increasing the number of health institutions, it further requires infrastructure such as access to clean drink water, Drug, efficient transportation system, toilet availability etc. In these regard, the Woreda in many kebele face problem as my respondents explained. ***Households and patients view-*** both households and patients cited that same words while expressing their dissatisfaction as follow:

> We are curtailed by lack of clean water. We get our drinking water from river, pond, rain water (at summer season) which is contaminated by animal. There is no separate place for human and animal as a result people around us are at risk of water born diseases. Furthermore, the problem is not simply inaccessibility of pure drink water, but also its distance matter a lot. Women are always going a long distance away from their home to fetch water (interview with Giraram kebele households January, 2014).

Contrary to this, World Health Organization at Alma Ata Declaration, recommended that clean drink water should be available to the people at home or the distance covered to get clean drink water should not be more than 15 minute distance (WHO, 1978).In this regard, much remains to be done by the woreda so as to make it available around the beneficiary with necessary quality. Supplementary to this, a focus group discussion at Chertekel kebele disclosed the prevalence of poor availability of clean drink water causes for the outbreaks of disease such as Ameba, Cholera, typhoid and worm. Similarly, focus group discussants at Giraram health center viewed lack of electric light as a serious problem being faced their health center in order to provide laboratory service. In addition, it contributes a lot for the outflow of health worker towards relatively urban centers. Moreover, lack of clean toilet and water even at health center level are exacerbating the challenge. However, comparatively speaking, among the three health center, Gozamin by far has better toilet and pure water service. This is because the fact Gozamin HC geographically, located at Debre Markos town and hence, it can easily access such services.

Regarding financial source, Woreda health office gets its finance from woreda block grants transferred by the regional government, external loan and assistance (either in kind or cash), and from internal revenue generated from treatment services provided by health institutions. Of these, the majority share of the budget of health institutions is comes from government grant which accounts more than 79%. In contrast, own resource of Woreda health office has a share only 20% and the remaining 1% of the budget were covered by foreign aid. As I have observed from majority of the respondents, the Woreda health office face acute budget shortages, especially, recurrent budget (for duty and per-diem fee to the service providers, budget assigned for training (professional development), and for motor cycle and other vehicle fuel gas. What makes the problem worse is that internal revenues of health institutions are not allowed to use for the aforementioned activities as it is clearly described by the health care finance proclamation 117/97 of ANRS health bureau. But according to the proclamation, internal revenue of HCs serves as a complementary or additional source of health institutions besides to the government budget. Its purpose is to improve the quality of health care services provided by the HCs other than expending for the above mentioned purpose.

Concerning to the impacts of decentralization on health care service delivery, as the findings of the research revealed both positive and negative impacts was observed. Of the positive impacts of decentralization, it improves the accessibilities of health care institutions to the beneficiaries and the numbers of health centers and posts increase significantly, facilities like setting chair for sick, TV(except Giraram HC), telephone service(at Gozamin HC) are available. The HCs and health posts were established closer to the people so that it relatively reduced transport and time cost incurred by the patients. Moreover, the number of health personnel also increase in the last ten years. The ratio of both health institutions to the people and health workers to the people has also improved. However, still there are pitfalls. Based on the responses made by the patients and households, the quality of health care service is poor. For example, inadequate supply of drugs and budget at the various health centers, shortage of human resources including health workers and administrative staffs (lab and pharmacy technician, midwifery, porter), poor allowance and per-diem fees are some of the challenges of health institutions. With regard to the affordability of the health care services in the woreda, the finding shown that there is divergence of responses between patients and HHs within and among HCs. Hence, it needs further research.

The research also found that traditional medicines and practitioners in the disease prevention and curative, in ensuring accessibility and affordability of health services provision has credible importance, though, they lack recognition and integration with modern health institutions. People at Gozamin Woreda have optimistic attitude to traditional medicine, particularly to holy water and praying because of their age old cultural beliefs, low cost and religious influences. There is lack of the culture of working intimately and cooperatively between modern health personnels and traditional medicine practitioners. They look as enemy for one another. Health workers condemn traditional medicine practitioners as lack of profession skills and scientific knowledge about how to prescribe drugs.

The finding finally point out that, high workload and inadequate payment, shortage of room for bureau, OPD and drug and dispensary class, weak referral system (from lower health units to the higher one) at different level of health institutions, little training and education opportunity, and absence of inter sectoral collaboration are the critical challenges that the Woreda health office experienced. Moreover, weak net work organization of *one–to-five* and *one-to-thirty* health team, lack of vehicles for supervision and inadequate infrastructures such as road, water and electric light etc are also problems that hinder the woreda to provide quality health care service.

5.2. RECOMMENDATIONS

On the bases of the abovementioned discussions and findings the following recommendations are suggested to the regional health bureau in general and the Gozamin Woreda health office in particular:

i. The fee waiver program has enabled poor people to get health care services. However, still there are many very poor people who are under covered by the fee waiver schemes. Therefore, the government officials (kebele and woreda) and health personnel should take these very poor sections of the society in to consideration during annual health and budget planning.

ii. Active engagement of people in the planning, running and evaluation of local service delivery is among others, the rationale of decentralization. This can be realized through a continuous awareness creation done to the local people. However, the level of people participation especially in the management of health institutions was found to be low. Hence,

there must be strong users' involvement in the process of health services provision and management.

iii. The proclamation of health care financing has a good step forward for capacitating health institutions so as to generate additional money and permit them to decide on their expenditure matters. It in fact enables HCs to improve the quality of health care service delivery. However, the proclamation needs certain future revision concerning on the autonomy of HCs in use of their internal revenue. It is more preferable for Woreda health institutions to have discretion over their internal revenue to use in accordance with their current problems, instead of limiting or restricting them to specified ranked tasks mentioned above (chapter four). If HCs are allowed to use internal revenue for example, to pay for duty, per-diem and promotional fee to the health workers is significantly increase the commitment and inspiration of health workers and enables HCs to cover budget gap related to this.

iv. The regional government should empower HCs to purchase their own drugs. Empowering HCs to buy drugs from PFSA directly by their pharmacy technician enable them to provide necessary drugs on time, and keep them from unnecessary wastages, delay and decay of drugs. This is due to the fact that they know when and how many, it's type and frequently need and sells drugs in their HC, so that they can bring the required drug promptly.

v. The Woreda health office shall ensure the presence of educational opportunity to the service providers in order to scale up them to provide quality services. At the same time, the existing educational and training opportunities in the Woreda should be available to all health workers impartially. There must be transparent, open, efficient or competent based and fair procedures and rules for recruiting the candidate beneficiaries. It is also worth to inform that the Woreda must increase budgets assigned to this purposes.

vi. There must be ethical code of conduct to the health workers so that patients will be attracted to follow up their illness at the health institutions. It is convincing to take at least administrative measures for those who insult patients and show unfriendly approaches.

vii. Concerning free services provision, caution has to be made in the process of identifying target poor who are eligible to the services from the non target one. So, there must be strong cross checking mechanism while the beneficiaries of free services are chosen.

viii. The Woreda health office shall give recognition to traditional medicine and integrate it into the modern health institution. Health institutions at each level should provide training and

organize workshop to traditional medicine practitioners so as to develop their skills and to synchronize their indigenous skill with scientific knowledge.

ix. Additional health personnel and Administrative workers must be hired so as to overcome the problem of overburden and necessary budget should be there.

x. The woreda health office must have strong cooperation with other sector offices in order to provide inclusive and to ensure lasting disease prevention. For instance, in order to overcome water born disease, there must be a close collaboration with the Woreda water sector so as to provide pure drinking water to the people.

xi. Finally, the one-to-five and one- to-thirty health development team or networks play important role in improving the health care service provision. Hence, HEWs in collaboration with the kebele officials has to do to create strong health development team. And adequate training and supervisions should be provided to them. The members of the team and the leaders of the group shall make ready themselves to discharge their responsibilities through attending Weakley meetings.

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Appendix I

ADDIS ABABA UNIVERSITY

COLLEGE OF LAW AND GOVERNANCE STUDIES

CENTER FOR FEDERAL STUDIES

Interview Guide Questions

Dear respondents,

I am Alene Agegnehu, MA student in Addis Ababa University at the center of Federal Studies. Now I am conducting MA thesis on the topic: *'Impact Assessment of Decentralization on Health Service Delivery at Gozamin Woreda.'* Hence, I kindly ask you to respond to the questions provided below. Your genuine ideas will therefore, contribute a lot to the accomplishment of the thesis in particular and in the process of improving the quality of decentralized health care service delivery in general and ANRS in particular. The study is conducted mainly for academic purpose, nothing else. I assure that, any information you provide will be kept with greatest secrecy.

I thank you very much for your cooperation.

Yours sincerely,

Alene Agegnehu

Interview Guide for households (HHs)

Read the following items and respond to each question by putting a tick mark (✓) to your choice and/or providing a short answer where necessary. No need of mention your name.

a) Sex---------- b) Name of health center you settle_____

1. In time of illness, where do you go for treatment?

   A) Modern health institutions B) Traditional medicine

2. If your answer is *'traditional medicine*, why you prefer it?

   A) Less cost B) accessibility C) their good approach D) list any other

3. For what types of diseases do traditional medicine is best fit?

4. Is there community based 'common toilet' in your locality? A)Yes B) No

5. If your answer is yes, what is its quality?

   A) Very high B) High C) Moderate D) Low E) Very low

3. Do you feel satisfied about the health services provided at the health centers? A. yes B. No

8. Are there improvements on the health service delivery system? If so, in terms of what?

   A) Bed B) drug availability C) patients treatment D) accessibility of health institutions

9. Can you participate in your health centers' services delivery process?

10. Can you suggest the means for further improvement of the service?

Interview guide for the Patients

a) Sex----------.

b) The type of disease you have ----------.

c) Name of health center----------.

1. Where do you give birth or follow up your illness?

   A) At home B) at health center

2. If your answer is '*At home'*, please state the reason why it could be?

   a).....b).....c).....d).....

1. Do traditional medicines are helpful to you in curing and rehabilitate your illness?

   A) Yes B) No

2. If so, for what type of disease do you think that traditional medicines are best fit?

   1) ----------. 3) ----------.

   2) ----------. 4) ----------.

3. If you answer for Q-2 is at home, by what means of transportation you go to the health center? A. Horse Car B. Ambulance C. Other means----------.

4. How far did you travel to the health center in order to get service?

   A) Less than one KM B) Less than two KM C) Greater than two KM

5. How many time it take to get the health center (approximately)?

A) Less than 1 hrs B) less than 2 hrs C) 2 hrs D) Greater than 2hrs

6. How do you get the health services being delivered in your health center?

   A) Excellent B) Very good C) Good D) Satisfactory E) Unsatisfactory

7. What is the level of infrastructures (road, toilet, drug, bed, and water etc) in the health center look likes? A) Excellent B) Very good. C) Good D) Satisfactory E) Unsatisfactory

8. How do you feel about health workers? Do they treat you in a manner you think or like?

9. Are you satisfied for the service given to you? If so, on what area?

10. Are you capable of paying for the service you received? If no what alternative you use?

11. Which piece of health services would you need to be changed? Why?

7. What will be your recommendation for further improvement of health service provision in your locality?

Interview Question for health extension workers (HEWs)

a) Name of health center/post----------.

b) Years of experience----------.

1. What the settlement patterns of the people in your kebele looks likes?

   A) Very scattered B) fairly scattered C) densely populated

2. How the settlement pattern affects in addressing the health need of the people?

   1. ----------3. ----------

   2. ---------- 4. ----------

3. How many households can you visit within a day? A. 100 B. 80 C. 50 D.

4. In what ways do you help the community to protect their personal and environmental hygiene? 1. ---------- 3.----------

   2. ---------- 4. ----------

5. Do people are keen to accept and implement the policy packages in their home? Yes No

6. What measures will you take if your answer for Q-5 is ***No***, please explain)

7. Do you think that the people have adequate know-how about how to lead a healthy life?

   1) Yes 2) No

8. If the answer for Q-7 is *No*, what do you do to change such condition?

   1. ---------- 3. ----------

   2. ---------- 4. ----------

9. Is there any form of training opportunity? 1. Yes 2. No

10. If your answer for Q-9 is ***yes***, what types of training is delivered to you?

    1. ---------- 2. ---------- 3. ----------

11. How often does the training is being held?

1. Once a year 2. Quarterly 3. Per month 4. Randomly 5. Write other if any?

12. What problems do you faced? Suggest means of overcoming these challenges?

Interview Guide for Woreda's Health Office director

a) Sex----------.

b) Years of stay in office----------.

1. What is the role of your office for the management of health centers and posts?
2. How many health workers are employed in the Woreda?
3. Who is responsible to hire health workers? Are you empowered to hire?
4. Who are the responsible bodies empowered to supervise and evaluate the activities of the health centers?
5. What sort of health facilities are being provided by the Woreda health units?
6. Who determine the amount of local user fees charge at the health centers and post?
7. Are you involved in the process of setting or determining user fees?
8. Do you believe that the existing user fee is set based on the ability of the beneficiaries?
9. How the health care service delivery centers are accessible to the communities?
10. What changes does decentralization brought in the health care service delivery?
11. In your own opinion, do you think decentralization is a best policy for meeting the health needs of the people?
12. What are the main challenges that make health care service delivery sub- optimal in Gozamin Woreda following decentralization?
13. Are there people participations in the process of their health care service system?
14. In what ways does the community contributes for the running of the health center?
15. What circumstances do you think improves community participation? And
16. What conditions do you think deters community participation?
17. What should be done to handle these problems or hindrances?

Focus Group Discussion for health workers

a) Name of health center----------

b) Number of participants----------

1. As a health worker, what is your role in the protection of communities' health care?
2. In what ways your health center useful to the community?
3. Are the health centers capable enough to address the health needs of the people? What are the challenges they encountered?

4. In your experience, which functions of health services are decentralized?

   1.---------- 3.----------

   2.---------- 4. ----------

5. In your health center, how does decentralization influenced health care delivery in terms of diagnosis, drug availability, Lab equipment, level of providing care of patients,
6. Is there improvement on the health care system after decentralization was implemented?
7. What are the hindrances or challenges (if any) for the successful implementation of decentralized health care services delivery in your health centers?
8. Do you believe Traditional medicines are essential for improving peoples' health conditions? If so,
9. Do you work in collaboration with them? A. yes B. No
10. If you say ***yes***, what good lesson do they have that you like?

    a. ---------- b. ---------- c. ---------- d. ----------

11. Can you describe some of the weaknesses of them----------?
12. Could you suggest some realistic solutions for improving the decentralized health care services?

Interview guide for woreda and kebele council

1) Does the Woreda or Kebele administration have a capacity to mobilize human and financial resource in order to improve the provision of health service delivery?

   A) Very high B) High C) Moderate D) Low E) Very low

2) Do you believe that, the woreda or Kebele administration has a capacity to implement the health plans independently?

(a) Very high (b) High (c) Moderate (d) Low (e) Very low

3) In what way can you help health center in order to provide quality health services?
4) Do you believe that, decentralization has brought a change for better health services?

A) Very high B) High C) Moderate D) Low E) Very low

5) In your opinion what is the contribution of decentralization for better health service delivery?

APPENDIEX II

በአዲስ አበባ ዩኒቨርስቲ

ሕግና አስተዳደር ኮሌጅ

የፌደራሊዝም ጥናት ማዕከል

<u>ቃለ መጠይቅ መምሪያ</u>

የተከበራችሁ ተጠያቂዎች፣

እኔ **አለነ አገኘሁ** በአዲስ አበባዩኒበርስቲ **በፌደራሊዝም ጥናት ማዕከል** የማስተርስ ተማሪ ስሆን በዓሁኑ ሰዓት የመመረቂያ ጽሑፌን ዲሴንትራላይዜሽን በጤና አገልግሎት ያለዉን ተጽዕኖ በ ጎዛምን ወረዳ መገምገም- በሚል ርዕስ ስለምሰራ ይሕንን ጥሑፍ ከዳር ለማድረስ የዕናንተው መልካም ተሳትፎ በከፊልና የጤና አገልግሎት አሰጣጥ ጥራቱን ለማሻሻል በአጠቃላይ ስለሚጠቅም ከዚህ በታች ያሉትን መጠይቆች እንድትሞሉልኝ ስል በአክብሮት እጠይቃለሁ:: ጥናቱ ለትምሕርታዊአላማ ብቻ ስለሆነ የሚስጡት ምላሽ በጥብቅ ምስጢር እንደምይዘዉ ላረጋግጥላችሁ እወዳለሁ::

በቅድሚይ ስለትብብራችሁ በጣም አመሰግናለሁ

አለነ አገኘሁ

<u>1. ለየጤና አገልግሎት ተጠቃሚ አባ ወራዎች የተዘጋጀ ቃለ መጠይቅ</u>

1. የህመምስሜትሲሰማዎትህከምናለማግኘትየትነዉየሚሂዱት?

ሀ/ ዘመናዊጤናተቃምለ/ባህላዊመድሄኒት ቤት

2. መልሶ<u>*ባህላዊ ምድሃኒትቤት*</u> ከሆነለምንእንደመረጡትባጭሩይገለጡልን?

ሀ/ ዝቅተኝ ገንዘብስለሚጠይቅ ለ/በቅርቡ ስለማገኘዉሐ/ ጥሩ አቀራረብስለሚያሳዩኝ

3. በአቅራቢያዎ ጤናጣቢያ አለን? ሀ/ አዎ ለ/ የለም

4.ለጥያቄ ቁጥር 3 መልስዎ *አዎ* ከሆነ፡ ወደጤናጣቢያዉለመድረስምንያህልጊዜይወስዳልብለዉይገምታሉ?

ሀ/ 1 -2ሰዓት ለ/3-4 ሰዓት ሐ/4-6 ሰዓት መ) ካልሆነ እርስዎ ቢጠቅሱ ----------

5. በአካባቢይችሁየጋራመጠቀሚያሽንትቤትአለን? ሀ/ አዎ ለ/ የለም

6. መለሶ <u>*አዎ*</u>ከሆነጥራቱምነይመስላል?

ሀ)በጣምከፍተኛለ) ከፍተኛሐ)ተመጣጣኝመ) ዝቅተኛሠ) በጣምዝቅተኛ

7. በጤናተቀመጠበሚሰጡትግልጋሎትእረክቻለሁበለዉያስባሉ? ሀ) አዎ ለ) አይደለም

8. የአገልግሎቱ ከፍያ ተመጣጣኝ ነዉ ብለዉ ያስባሉን? ሀ) አዎ ለ) አይደለም

9.በጤናአገልግሎትአሰጣጡ ላይመሻሻል አለበት የሚሉት ካለ ቢዘረዝረ----------?

1. ከቀበሌያችሁ ህዝብ አሰፋፈር ምን ይመስላል?

ሀ/ በጣም የተበታተነ ለ/ በመጠኑ የተበታተነ መ/ ጥቅጥቅ ያለ

2. የሰዎች የአሰፋፈር ሁኔታ እንዴ ነዉ የህዝቡን የጤና ፍላጎት ለማሻሻል እንቅፋት የሚሆ ነዉ?

1. ----------2.----------3. ---------- 4.----------

3. በቀን ዉስጥ ምን ያህል አባዎራዎ ችትጎበኝላችሁ? ሀ/10 ለ/ 20 ሐ/ 30 መ/-------

4. በምን መልኩ ነዉ የህብረተሰቡን የግልና የአካባቢ ንጽህና ለመጠበቅ አስተዋጸ የምታደረጉት?

1. ----------2.---------- 3. ----------4. ----------

5. ህብረተሰቡ የጤና ፓኬጅ ፖሊሲዎችን በቤቱ ለመቀበልና ለመተግበር ፋቃደኛ ናቸዉን?

ሀ/ አዎ ለ/ አይደለም

6. በተራ ቁጥር4ለተጠቀሰዉጥያቄመልሶ**<u>አይደለም</u>**ከሆነችግሩንለመቅረፍምንአይነትአርምጃእንደሚዎሰዱባጭሩይግለጡልን-

----------?

7.ህብረተሰቡ በጤናቸዉ ዙሪያ በቂ የሆነ ዕዉቀት ወይም ግንዛቤ አላቸዉ ብለዉ ያስባሉን?

ሀ/ አዎ ለ/ የላቸውም

8. መልሶዎ**<u>የላቸውም</u>**ከሆነ ይህን ሁኔታ ለመቀየር ምን ታደርጋላችሁ?

1. ---------- 2. ----------3. ---------- 4. ----------

9. የስልጠና እድል አለ በለዉያስባሉ? 1.አዎ 2.አይደለመ

10. ቁጥር 9 ለተጠቀሰዉ ጥያቄመልሶ**<u>አዎ</u>**ከሆነ ምን አይነት ስልጠና ነዉ የሚሰጣችሁ?

1. ----------2---------- 3. ---------- 4. ----------

11/ ስልጠናዉ የሚሰጣችሁ በየስንትጊዜ ነዉ?

1. በዓመት አንድ ጊዜ 3. በየወሩ

2. በየሩብዓመቱ 4. በዓመት ሁለት ጊዜ 5.ሌላ ካለ ይጠቀስ--------

12. የሚገጥማችሁ ችግሮች ምንድ ናቸዉ? የሚገጥማችሁን ተግዳሮቶች ለመፍታት የሚያስችሉ መፍተሄዎች ምንምን ሊሆኑይችላሉ ብለዉያስባሉ----------?

<u>ለወረዳ ጤና ቢሮ ሃላፊ የተዘጋጀ ቃለ መጠይቅ</u>

ጾታ----------

በቢሮ የቆዩበት ግዜ----------.

1) ጤና ጣቢያዎችን ከማሰትዳድር አንጻር የወረዳዉ ሚናምንድነዉ?
2) በወረዳዉ ዉስጥ ምን ያህል የጤና ሰራትኞች ይገኝሉ የተሰጣቸዉን ሃላፊነት ለመወጣት በቂ ናቸዉ ብለዉ ያስባሉ?
3) የወረዳዉን የጤና ባለሙያዎችን የመቅጠርና ከስራ የማሰናበት ሃላፊነት ያለዉ የማን ነዉ?
4) በርስዎ አስተያየት ዲሴንትራላዜሽን የሰዎችን የጤን ፍላጎት ከማማላት አንጻር ጥሩ ፖሊሲ ነዉ ብለዉ ያምናሉ?
5) በወረዳዎ ውስት ዋና የጤና ተግዳሮቶች ምን ምን ናቸው?

6) እነዚህን ችግሮች (ተግዳሮቶች) ለመፍታት ምን እየሰራችሁ ነዉ?

<u>ለጤና ሰራተኞች የቡድን ዉይይት (FGD) የቀረበ ጥያቄ</u>

ሀ) ተሳታፊዎች ያሉበት ጤና ጣቢያ ስም----------

ለ)የተሳታፊዉ ብዛት----------

1. በጤና ጣቢያችሁ በብዛት ተሰራጭቶ የሚገኙ በሽታዎች ምን ምን ናቸዉ?

ሀ/---------- ለ/---------- ሐ/----------መ/----------

2. የእነዚህ በሽታዎች ምክንያት ምንድን ነዉ ብለዉ ያስባሉ?----------

3. እንደ ጤና ባለሙያ ኅብረተሰቡን ከእነዚህ በሽታዎች ለመጠበቅ ምን እየሰራችሁ ነዉ?

4. በአላችሁ የስራ ቆይታ፣ የትኞቹ የተጤና አገልግሎቶች ዲሴንትራላዝድ(ያልተማከሉ) ሁነዋል

1.----------2. ---------- 3.----------4. ----------

5. ዲሴንትራላዜሽን (ያልተማከለ) አሰራር ከመጣ በሃላ በጤና የአገልግሎት አሰጣጥ ላይ መሻሻሎች አሉ ወይ?

ሀ/ አለ ለ/ የለም

6. መልስዎ <u>**አለ**</u> ካሉ፣ ምንምን የአገልግሎቶች ዘርፎች ተሻሽለዋል? ሀ/ የመድሃኒት አቅርቦት ለ/ የላብ. አቅርቦት መ/

7. በጤና ጣቢያችሁ ዲሴንትራላዝድ የጤና አገልግሎት በትክክል እንዳይተገበር የሚያደርጉ ተግዳሮቶች ምንምን ናቸዉ?

8. የህዝቡን የጤና ሁኔታ ለማሻሻል፣ ባህላዊ መድሀኒቶችና አዋቂዎች ጠቃሚ ናቸዉ ብለዉ ያምናሉ?

9. መልስዎ <u>**አዎ**</u> ከሆነ በህብረት አብራችሁ ትሰራችሁ? ሀ/ አዎ ለ/ አንሰራን

10. ለጥያቄ ቁ 8 መልስዎ <u>**አዎ**</u>ከሆነ፣ ምን ምን በጎ (መልካም)ነገሮች አላቸዉ?

ሀ/ ---------- ለ/ ---------- ሐ/ ---------- መ/ ----------

11. ደካማ ጎን ካላቸዉ ቢገልጡልን?

12. በስራችሁ የሚያጋጥሙ ችግሮች ምን ምን ናቸዉ ቢዘረዝሩልን?

13. ያልማከለ የጤና አገልግሎትን ከማሻሻል አንጻር ተጨባጭ መፍጽኄ ናቸዉ የሚትላቸዉን ብትዘረዝሩ?----------

<u>ለወረዳዉ ና ለቀበሌ ምክር ቤት የተዘጋጀ ቃለ መጠይቅጥያቄ</u>

1. የወረዳዉ (የቀበሌዉ) አስተዳደር የጤና አገልግሎት አሰጣጥን ለማሻሻል ወረዳዉ (በቀበሌዉ)ያለዉን የገንዘብና የሰዉ ሃብት አቅርቦቶችን የመጠቀም (የማንቀሳቀስ)አቅም አለዉ ወይ?

2. የወረዳዉ (የቀበሌዉ) አስተዳደር የጤና አቅዶችን የማስፈጸም ሀቅም አለዉ ብለዉ ያምናሉ?

3. ዲሴንትራላየዛሽን በጤና አገልግሎት ዙሪያ ለዉጥ አምጥታልብለዉ ያምናሉ? ሀ/ አዎ ለ/ የለም

4. ለጥያቄ ቁ 4 መልሶ <u>**አዎ**</u>ከሆነያመጣዉን ተጨባጭ ለዉጥ ቢዘረዝሩልን?

ስለትብብርዎ አመሰግናለሁ

አለነ አገኘሁ **ጥር, 2006 አ.ም**

DECLARATION

I, the undersigned declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used for the thesis has been duly acknowledged.

Name: Alene Agegnehu

Signature 

Date: June, 2014

This thesis has been submitted for examination with my approval as university advisor

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Gebrehiwot T.