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Assessment of the effects of decentralization on urban service delivery: case study on education and health services deliverance at Debre Markos town, Amhara National Regional State

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List of Acronyms and Abbreviations

ANRS	*Amhara National Regional State*
BPR	*Business Process Re-engineering*
CSA	*Central Statistical Agency*
CBO	*community based organization*
DM	*Debre Markos*
DMHC	*Debremarkos health Center*
E.C	Ethiopian Calander
EPRDF	*Ethiopian People Revolutionary Democratic Front*
FAO	*Food and Agricultural Organization (UN)*
FDRE	*Federal Democratic Republic of Ethiopia*
GoE	*Government of Ethiopia*
KETB	*Kebele Education and Training Board*
KTPS	*King Teklehaimanot Primary School*
KTSS	*King Teklehaimanot Secondary School*
HHC	*Hidasie Health Center*
HSDP	*Health Sector Development Program*
LG	*Local Government*
MSS	*Menkorer Secondary School*
MoE	*Ministry of Education*
MoH	*Ministry of Health*
MWUD	*Ministry of Work and Urban Development (of Ethiopia)*
N or n	*Number*
PASDEP	*Plan for Accelerated and Sustained Development to End Poverty*
PTA	*Parent-Teacher Association*
SPSS	*Statistical Package for Social Scientists*
UN	United Nations
UNDP	*United Nations Development Program*
UNESCO	*United Nations Education, Scientific and Cultural Organization*
FFE	
HAPCO	
HIV/AIDS	
NGO	*Non governmental organizations*
OSSA	

Abstract

In Ethiopia rapid urbanization is the product of socio economic development. As a result urban populations have been growing in an alarming rate. This situation mainly aggravated by the two major features: rural-urban migration and natural increase of the population. Due to these demographic changes, pressure put on urban centers in which residents hardly get quality and efficient services. To tackle down such urban problems, the GoE has established decentralization policy that aimed to transfer powers, responsibilities and resources from the central government to regional, zonal, and Wereda levels of administration. This research has given emphasis on education and health service delivery in Debermarkos town case. In this town basic services provision intricate with social problems: inadequate and poor quality of services, less accountability and transparency, insignificant number of professionals, low institutional capacity and minimum public participation in planning, monitoring and decision making process. But these poor conditions of service providers of had not been assessed or studied (i.e. academically); it couldn't be identified, determined, evaluated and recognized the hindrance for effective implementation of decentralization at the district level. The research used qualitative and quantitative data. This study has assessed the local service providers' performance in line to quality indicators and the governance values indicators: accountability, transparency and community involvement in the improvement and provision of services. From the findings, it concluded that that decentralization obviously shown improvement in service delivery particularly in schools' and health centers' service delivery activities: service providers could perform their duties with autonomy, improve quality and efficient services delivery. However, administrative constraints: clarity of responsibility, accountability, open information flows, and participation have made the services provisions inadequate. The paper suggests that public service providers should be participatory, transparent (free access to information), empowered to decide administrative issues autonomously, accountable to the community, dynamic to identify community interest and should include community input in strategic planning and decision making process in the public service providers.

Key words: decentralization, autonomy, accountability, transparent, participation, social service: education service, health service,

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CHAPTER ONE
INTRODUCTION

1.1 Background of the Problem

Urban growth is a complex process which describes the phenomena in which different changes takes place in a certain location given that the society ways of living radically changed particularly in the size of the population, economic, environment, politics, social interaction and cultural sphere. Due to its positive correlation with development activities of cities, most countries have been involving in such phenomena with different magnitude. Nevertheless of this, as Becker states (2007:11), urbanization gives rise to uneven rather than smooth patterns of urban development: some cities grow rapidly, while others progress slowly. This is why today developing countries show fast urban growth rate (i.e. their rate of urbanization is 1.22 percent per year yet the base of the process is overpopulation of rural areas with inconsiderable urban social amenities such as education, health, employment) than to developed countries where their rate of urbanization is about 0.31 percent, albeit the base of the process accompanied by industrial development of the towns with considerable urban amenities: livelihood, social services, physical and infrastructure development (UN,2004).

Urbanization has been a leading characteristic of the development of the Third World in the twenty first century. Although rapid urbanization in the Third World has accompanied by an increase in urban poverty, poor quality social services delivery and unemployment, it is the product of economic development, which also reduces poverty and increases living standards. It improves the over-all economy of the Third World, but exacerbates urban inequalities. According to the UN 2007 revision report urban populations of developing countries have been growing considerably faster than that of the more developed regions. As a result, its share of the world urban population has been rising. This situation mainly aggravated by the two major features: rural-urban migration and natural increase of the population. In Africa these demographic change associated with fast urbanization rate which accelerate economic growth of the cities.

African cities are, thus, become center for socio-economic, politics, social services, cultural centers and commercial activities. Urban growth has been occurring as much in secondary towns and cities as in major administrative and commercial centers, the reproduction of agricultural oriented rural life is in question. Consequently, rural areas continues to experience substantial flows of out-migration often stirred by conflict, environmental degradation, the collapse of rural economies, or the urbanization of resource rich centers of extraction (UN-HABITAT,2002:65). Rural people, hence, migrate to urban centers for better life. As a result this high rate of rural-urban migration has caused many social, economic, political and environmental problems in the urban areas. Therefore, in Africa urbanization processes inexorably associated with many challenges and problems. Over crowding, corruption, poverty, environmental degradation, pollution, inadequate transportation system, poor quality of urban service delivery, mismanagement, insecurity i.e. high crime rate in the crowded cities, inequality are huge problems. It is also important to note that even though the process of urbanization correlates with economic development of the continent, similarly it affects the living conditions of urban residents. These urban residents, particularly the poor, have insignificant access to basic amenities and deprived of quality social services. To alleviate such social ills of urban areas, however, local governments of the continent have designed and implemented different development approaches and strategies. Good governance and decentralization, as a development strategy/policy, are considered to be a critical solution to fight major social ills of urban areas: inaccessibility of basic services, impoverished quality of amenities, inequalities, poverty, corruption and environmental degradation, among others.

Urban centers in Ethiopian are apparent places for socio-economic, administrative and religious practices. These areas play significant socio-economic and political roles. Ethiopia has been recorded for least urbanized country with fast urbanization rate. Such fast urbanization rate causes various social problems: environmental deterioration, poor urban service, slum areas, poverty, shortage of housing, unemployment, corruption, crime and the shocking growth of natural population. Urban centers, for instance, Bahir Dar, Dessie, Debre Birhan, Debre Markos (hereafter DM), and Gonder have affected by unprecedented rate of population growth to urban economic growth, social services delivery and infrastructure development. By considering these problems, the current government (EPRDF) has structured urban centers in a decentralization

principle so as local governments able to tackle down socioeconomic problems of their local areas to meet the millennium development goals. This program has enabled the local governments, civil society and other interest groups to recognize the diverse needs of the community. Such entities (units) have come together at common desk for meeting efficient, effective and quality education and health services.

The research focuses on the state of urban service delivery in the face of growing urbanization as well as the devolution of responsibility to the local government. By taking into account governance value of decentralization, the study makes an effort to assess whether decentralization brings improvement in education and health service delivery. It makes a brief conceptual and theoretical analysis on the link between the process of urbanization, decentralization program and service delivery. In the study the concept of decentralization will be considered as a mechanism or as an instrument to implement urban developmental goal particularly in education and health service.

This research, hence, briefly discusses the feature of decentralization in line to social service delivery. It discusses the conceptual linkage between decentralization and service delivery. It studies the institutional structure, mandate and implementation capacity of the local government of DM town (i.e. education center and health center) in providing efficient and quality services. Therefore by reviewing decentralization practice of DM town (local government) the researcher has tried to shed light on the feature of urban service delivery and developmental issues in local context. In light of this, it differentiates some major problems of service providers in implementing decentralization program. By assessing the effects of decentralization on education and health service delivery, the research analyzes the performance of these local service providers in delivering quality and efficient services to their customers and identifies some major positive outcomes of the local public centers under study.

1.2 Statement of the Problem

Ethiopia has been recorded to have 4 percent annual urban growth rate with a relatively rapid demographical change since the fall of socialist military government of the Derge Regime in May 1991 (CSA, 2010). This growth generates various problems which threaten the governance of urban centers. The diverse and complex problems facing towns and cities in the country, especially the problem posed by poor service delivery, inadequate urban infrastructures and constraint of resources demand local government to participate civil society and other interest group in governance issues to manage and to address urban crisis primarily through decentralization. As a result of this, the country experience new form of government i.e. the Federal System. Consequently the GoE has composed the country on regional ethnicity base so as to enable the local people to participate and carry out their economic, social, political, and development issues by themselves.

Following the Federal Constitutions of 1995 and ethnic based regionalization policy of the country, many cities (or towns) grow rapidly, gradually, or newly emerged as a result economic, political, social, and physical condition of the areas changed. This regionalization policy, as noted by Tegegne and Kassahun (2004), aimed to enable the local government to develop their own language, culture, socioeconomic development in their own respective areas, exercise self rule and bring about equitable share of national resources. However, at a ground level such decentralization process have been studied to have different rate of development progress within the regional states and *weredas* due to the presence of weak institutional capacity, *weredas* remained as marginalized or have insignificant responsibility and power to exercise (Tegegne and Kassahun, 2007:29). Basic social services for instance, education and health services are the main agenda of the GoE as these two services together determine the economic and social well being of country. By taking this into account the central government of Ethiopia transfers resources, responsibilities and power to the local level (regional state) with major share in resources and revenue /budget/ distribution. These conditions build momentum for decentralization that creates space necessary for autonomous policies at lower levels of government.

The local governments, thus, become prime responsible entities to plan and manage urban growth as well as provide basic social services through decentralization program. Decentralization at district level enables local governments to transfer resources and power to lower units to implement urban development policy (i.e. provision of quality services to urban residents) through community participation, empowerment and social inclusion. Nevertheless of these interventions and efforts, high population growth and poor governance put pressure on provision of quality and efficient services to local community. The local community has not been trouble-free access to receive such basic social services.

In DM town the provision of basic services (i.e. education and health services) have intricate with social (governance) problems: inadequate and poor quality of services, less accountability and transparency, insignificant number of professionals, low institutional capacity and minimum public participation in planning, monitoring and decision making process. These conditions negatively affect the performance of local public providers and the live of urban residents (as service beneficiaries).

Since the performance of public service providers of DM town (i.e. education and health service centers) have not been assessed or studied (i.e. academically), the change brought by decentralization couldn't be identified, determined, evaluated and recognized. Furthermore the impact of decentralization on service delivery mainly had been studied in line to quality and efficiency parameters. This research, however, has assessed the local service providers' performance not only in line to quality indicators but also the governance values: accountability, transparency and community involvement in the improvement and provision of services. To this effect, the current performances of the local centers (i.e. education institutions and health centers) need to be assessed so as to address the hindrance to implement decentralization effectively. To make the assessment more reliable and valid the research employed both qualitative and quantitative data. The study used indicators: national quality (i.e. policy) parameter and degree of decentralization as a reference points for the assessment. It, thus, bridges the existing information gap in attaining governance values on education and health services delivery by implementing effective decentralization.

1.3 Objective of the study

1.3.1 General objective

The general objective of the study is:

- To understand the relevance of decentralization for the improvement of service delivery (i.e. education and health services)

1.3.2 Specific objective

The specific objectives of this thesis are:

- To assess the extent the LG (education and health offices) devolve significant power (i.e. degree of autonomy) to lower service centers
- To evaluate accountability and transparency of service providers (i.e. education and health centers) to beneficiaries (community) in DM town
- To assess community and other stakeholders involvement in service (education and health) improvement and provision in DM town
- To identify major problems that hinder effective education and health services delivery in DM town
- To bridge the existing information gap on the implementation of decentralization in education and health services delivery
- To forward or recommend possible policy implication in implementation of decentralization for the improvement and development of education and health services

1.4 Research Questions

The researcher states the following research questions to identify the challenges and opportunities of decentralization program at the local level and its role in urban social development:

- Do service providers have significant power and resources to make decision?
- Do the local government units (service providers) involve community and civil society (NGOs) in the improvement of education and health service delivery?
- What are the major problems and opportunities of decentralization program in the improvement of education and health service delivery at DM town?
- Do education and health service improved after the implementation of decentralization program in the DM town?
- Do service providers serve the public in accountable and transparent way?
- Does decentralization bring positive changes in the performance of education and health service centers?

1.5 Significance of the Study

Even though many scholars have studied the impact of decentralization on urban service delivery, still there is a research gap which should be conducted at *Wereda* level in connection with urbanization, decentralization and basic services delivery particularly in DM town, Amhara National Regional State. It therefore discusses and assesses the impact of urban decentralization program on education and health services delivery. In addition to this, the research contributes academically different glance on the issues of decentralization by assessing the performance of lower government units (i.e. service providers) in improving and delivering quality education and health service in terms of governance values: accountability, transparency and community participation.

1.6 Scope of the Study

The research covers theoretical and empirical issues of decentralization and its impact on social service delivery particular emphasis given to education and health services. The concept of decentralization is multi dimensional and has multi faceted meaning: political, fiscal, administrative and economical. This research, however, focuses on the blending effects of administrative (deconcentration) and political (devolution) decentralization on education and health service deliverance in Debre Markos town case. It incorporated six lower governmental units (i.e. public service providers or centers) of the DM town: two primary schools, two secondary schools and two health centers. In light of this, the research has assessed the performance of these centers in implementing decentralization program by giving particular emphasis on accountability, transparency and community participation issues for the improvement of service delivery status.

1.7 Limitation of the Study

In this thesis the issue of decentralization was studied at local lower level in line with its implication toward social service delivery (i.e. education and health service centers) particularly at DM town. However, time scarcity and financial limitation hinder the researcher to study in depth by collecting enormous, reliable and exhaustive data from the local community, *Wereda* (town) government officers and other interest groups.

1.8 Organization of the Study

The researcher has organized this research in five chapters: chapter one is introduction which presents the background of the study, chapter two is reviews of related literature, chapter three is description of study area and methodology of the study, chapter four is data presentation, discussion and chapter five is conclusions and recommendations.

CHAPTER TWO
REVIEWS OF RELATED LITRATURE

This part deals with reviewing of various issues that are related to the basics of decentralization and service delivery. In addition, the underlying theoretical frameworks of this study are discussed.

2.1. Theoretical framework of decentralization

2.1.1. Definition of Decentralization

Webster New World Dictionary (1997) defines the term decentralization as break up a concentration of (governmental authority, industry, population, etc.) in a main center and distribute more widely. It refers to the transfer of authority on geographical bases. Central or local government transfer their power, resources, budget, etc to local level with different features and degree. A movement towards decentralization has featured prominently as part of the broader institutional transformation for engendering efficiency, accommodating pluralism and promoting democracy. Decentralization as a process has several variations in the approaches to developing legal and constitutional frameworks, promoting democratization and popular participation, as well as improving intergovernmental fiscal transfers and capacities. Africa seems to fit into the global pattern that shows the emergence of a new wave of decentralization directed mainly at streamlining relations, functions and authorities, and giving more powers to local authorities. According to Selee and Tulchin (2004:296), decentralization is widely though to improve democratic governance by bringing government closer to the people and thereby increasing state responsiveness and accountability. With authorities, functions and resources redistributed among the various levels of government, the central government then coordinated and regulates the activities of the various levels. This approach suggests that a strong state and strong civil society can and should be mutually reinforcing and that decentralization can strengthen the state by making it more responsive and accountable to citizens.

Decentralization in the continent (Africa) has focused on the existence and overall operation of institutions and structures of governance, administration and fiscal control at the local level. While moderate advances are revealed by these criteria, it is acknowledged, however, that as yet very few countries have attained a significant degree of devolution and empowerment of local communities. Some of the countries that have strived to elaborate constitutional frameworks that devolve power away from the centre have ended up giving significant authority to regions and not to local governments. A similar pattern is noted with administrative decentralization as observed through the clarity of roles for national and local governments provided by the law, the locus of responsibility for service delivery and the responsibility for managing civil servants. Decentralization policies refer to the interregional dispersion of population and economic activity, while de concentration refers to intraregional dispersion of activity. In practice, decentralization means the maintenance of significant population in remote areas of a country, either by inhibiting rural-to-urban and interregional migration of indigenous population (e.g., India) or by encouraging settlement in more sparsely populated areas (e.g., Brazil). In practice, de concentration means inhibiting the buildup of population agglomerations in a few core metro areas by deflecting migrants or existing residents to nearby satellite towns (Henderson, 1988:183).

A major objective of decentralization needs to be the fostering of subsidiary with the aim of maximizing the potential of inclusion of the citizenry and improving the responsiveness of policies and initiatives to the priorities and needs of citizens. Similarly, while attention has been given to gender issues in the various decentralization programs in the continent, more emphasis should be directed at ensuring that such initiatives lead to the empowerment of women in local decision-making and improvement of local government services for women. Where fiscal decentralization is concerned, efforts to improve financial management (namely, planning, budgeting and accounting) appear to have been more successful then others, but fundamental improvements are also needed in the generation and control of local governments' own resources as well as in promoting participatory financial management systems. Decentralization in many countries has focused attention on city government, but most city governments face severe constraints. Together with democratization, decentralizations of responsibilities and resources can bring benefits for the urban poor. Many city governments are rising to the challenge, but

others have severe constraints of capacity and vision about how to address the needs of those in poverty. There is evidence that, with decentralization and democratization, city governments do change, and that they can become more efficient and responsive. City governments should be strengthened, rather than assigning important functions to other agencies over which there is little or no democratic control, such as parastatal agencies, or higher level government agencies, where accountability is more remote. Where operational efficiency requires a separate agency, lines of accountability to democratically elected local representatives should be clear (Devas, 2004: 26).

A more profound lesson learned is that decentralization reforms in the continent, guided by the principle of subsidiary, need to transcend lower than local authorities and reach out to community and neighborhood empowerment and engagement. The relationship between local authorities and communities within them need to be realigned so as to ensure that devolved power, functions and resources are accordingly transferred to that level. The current local government reforms in the continent therefore have an important bearing on improving the governance of African cities and towns. Most countries have undertaken political, fiscal and administrative decentralization over the past decade in an effort to make government more responsive to citizens and to increase its efficiency. Decentralization has been most extensively implemented in Latin America and in the Transition economies, has made legislative advances in South Asia and Sub Saharan Africa, and is proceeding more slowly in East Asia and Mid East and North Africa. Implementation is inconsistent even within countries and greater legal autonomy for local governments has not necessarily meant greater local revenue or expenditure authority. Some countries are finding themselves with a very large number of small municipalities but with no mechanisms in place to foster coordination and economies of scale in management (World Bank, 2000).

2.1.2. Argument on decentralization

The issue of decentralization has become a common agenda in the development, management, economic and political literature. Many scholars has forward premises for the rationale of practicing decentralization in the development planning of a given country by stating

its many features of positive outcomes; whereas others strongly underlines its danger or threat in implementing decentralization in the local context by pointing out its negative impact for instance on accountability local government on expenditure issues.

2.1.3. For decentralization

There are certain themes that run through the arguments for decentralization. One of the most important ones is associated with democratization. It can be encapsulated in the idea that decentralization "brings government closer to the people". There are a number of connected strands within this line of argument. Firstly, it is argued that local government is more likely to be accountable to its constituency. Secondly, additional levels of government may increase the opportunities for people to become directly involved in government decision-making. Clearly regional and local government bodies do introduce additional layers of councilors and full-time politicians (Wittenberg, Martin, 2003:5). In liberal democracy it is often argue that decentralization can serve to balance different needs of different people and therefore it is more suitable than centrally determined social politics applied across different spectrum of the population.

Economists justify decentralization on the grounds of allocative efficiency. Their rationale is that decision about public expenditure that are made by a level of government that is closer and more responsive to a local constituency are more likely to reflect the demand for the local services than decision by a remote central government. As Wittenberg (2003) stated some of the major premises invoked in arguments around decentralization that addresses questions of the efficiency with which services are provided. These are: firstly, there may be significantly lower transaction costs involved with providing services locally. These transaction costs include the delays incurred in negotiating command chains which extend to the national head office; lower monitoring costs if the principals (elected officials) are based in the area and improved use of local knowledge. Secondly, there is likely to be a closer link between the preferences of local populations and the services rendered if the decisions are made locally. This would lead to a higher level of consumer surplus. In a worst case scenario, central governments might provide "white elephants" to local areas leading to the wastage of scarce resources. Thirdly, local

governments may be more effective at raising revenue. Bahl (1999) argues that the type of taxes typically collected by central governments (income taxes and VAT) have high thresholds associated with them. As a result a large portion of the economy in a developing country is outside the tax net. Since sub national government has better information about the tax base, this can be more effectively captured by such structures.

Another argument for decentralization is to improve the competitiveness of governments and enhance innovation and hence the likelihood that governments will act to satisfy the wishes of citizens. Another potential benefit for decentralization is that people are more willing to pay for services that respond to their priorities, especially if they have been involved in the decision making process for the delivery of these services (Ford,?, p.6).In addition, many proponents now see decentralization as an instrument for building institutional capacity within local governments and civil society organizations to achieve the UN's Millennium Development Goals and improve chances of successfully implementing policies for the poor that depend on local communities to take ownership of poverty-alleviation programs (Rondinelli A. et al, 1983:7).

2.1.4. Criticism on decentralization

As it has been seen in the above, a number of theoretical and empirical issues stand as a rationale (advocate) for decentralization practice. Contrary to these notions, some scholars noted some points as critics to against decentralization. Here it is worth to note Saito (2001) and Fallati (2004) works. Saito (2001:2) has pointed out some of these criticisms against decentralization by stating that decentralization may foster more local royalty to regional identities than the national identity and this may encourage more autonomy from the central government and even a territorial secession in multi ethnic and multi religious societies, particularly in Africa. This puts the national integrity itself at risk. Newly created autonomy may be manipulated by local elites for seeking their narrow personal benefits at the cost of general population who are in dare need of improved livelihood.

Decentralization may increase corruption at local level and thus this would not improve accountability. The increased efficiency and effectiveness of the public resources may not be

realized, since resources (capital, human and even social) available at local level in low income countries are very limited. These scarce resources are more effectively utilized when they are more concentrated at the national level. Decentralization may also jeopardize equity among different localities. Resourceful areas may take advantage of opportunities created by decentralization while relatively areas cannot. Falleti (2004:1) also noted the following critics of decentralization which leads to soft budget constraints, macroeconomic instability, clientelism and enlargement of bureaucracies.

2.2. Dimension of Decentralization

Decentralization covers a broad range of concepts. Each dimension has different characteristics, policy implications and conditions for success. It is useful to distinguish the following four dimensions separately yet they overlap conceptually: political, fiscal, administrative, and market decentralization.

2.2.1. Political Decentralization

Political decentralization is the transfer of political authority to sub national governments. This transfer takes place through constitutional amendments and electoral reforms that create new (or strengthen existing) spaces for the representation of sub national polities. Elections for important sub national offices are the hallmark of political decentralization and the shift from appointed to elected sub national officials is the most common form taken by decentralization in this dimension. In politically centralized systems, sub national officials are appointed by the national government and therefore can be held accountable by voters only indirectly (if at all). By giving sub national officials less cause to worry that their own careers will suffer if they fail to conform to central preferences, elections increase the potential autonomy of sub national governments. By giving sub national officials incentives to prioritize concerns of local constituents, elections increase the accountability of sub national governments to these constituents. In a decentralized polity, elections are held not just for sub national executive offices (such as mayors, governors, and chief ministers), but for representative positions as well (such as municipal councilors and provincial legislators). Elections can also be held for single-

purpose sub national governments (such as water districts and school boards) and not just multipurpose ones. While political decentralization changes the authority, autonomy, and accountability of sub national governments, it has a less direct impact on capacity.

Political decentralization can be understood to refer to either or both of the following: transferring the power of political leadership and representatives from central governments to local governments and transferring the power and authority for making socio-politico-economic decisions from central governments to local governments and communities. Understanding political decentralization only in the first sense would be limiting the meaning of "political" to the choice of political leadership through elections. Therefore the promotion of political decentralization in this sense would entail only putting in place structural arrangements that would facilitate local people to exercise their voting power with limited hindrance or intervention from central government. Here political decentralization would be referring to only electoral decentralization and participation would be understood only in terms of elections. On the other hand, promoting political decentralization in the second sense, would entail putting in place structural arrangements and practices that would empower and facilitate local governments and communities to exercise not only the voting power in the choice of their local leadership and representatives but also to have strong influence in the making, implementation, monitoring, and evaluation of decisions that concern their socio-politico economic wellbeing and to constantly demand accountability from their local leadership. The first sense of political decentralization refers to the vote while the second one refers to the voice. A combination of both enhances the influence of local people on the decisions that concern them. Political decentralization is best conceived within these two frameworks so that the power and authority to decide is not limited to electing leaders or representatives but includes the full range transfer of decision-making from central government to local governments / authorities / communities. This requires a structural arrangement that goes beyond putting in place local governments (USAID, 2009:10-5).

It requires a process that combines vertical and horizontal decentralization. While vertical decentralization transfers power and authority from central government to local government, horizontal decentralization empowers the local communities and enables them to receive and utilize the powers that are transferred to them especially in problem analysis, priority setting,

planning and constantly demanding accountability from their local and national leadership or any governance actor at the local level. Horizontal decentralization would require growth of civil society as well as structuring local governments in such a way that they are legally obliged to seek and promote the participation of the local communities in setting priorities, planning and making decisions that the local governments will implement in a whole range of socio politico-economic activities (Kauzya, 2007:2).

2.2.2. Fiscal Decentralization

Fiscal decentralization is the expansion of revenues and expenditures that are under the control of sub national governments and administrative units. Some define fiscal decentralization as occurring mainly on the revenue side, with respect to tax assignment and transfers of revenues between levels of government. But the definition used here, from the public finance literature, better captures the need to address the so-called "assignment problem"—matching functional responsibilities to financial proceeds across the various levels of government. Fiscal decentralization, as defined here, directly alters the authority of sub national officials when it expands their right to collect additional tax revenues or when it legislate a formal sub national role in expenditure policy. By letting sub national officials control more substantial revenue flows, fiscal decentralization enhances their capacity to actually perform the roles they have been formally authorized to play. Where sub national governments exist, fiscal decentralization gives these governments greater autonomy from the national government so that they can make their own governing choices and act independently of the national government.

It also affects accountability. When voters know that sub national officials have been given control over significant own-source revenues and expenditures, it becomes more important to hold them accountable for the important taxing and spending decisions they now make. On the expenditure side, fiscal decentralization refers to the transfer of additional responsibilities to sub national governments, often including responsibilities for some of the more important services governments can provide: healthcare, education, and infrastructure. Where citizen preferences for services are heterogeneous across sub national units, fiscal decentralization enables a more efficient matching between preferences and service provision. In contrast, services should be

assigned at a higher level in the presence of significant scale economies and externalities. Sub national governments should face a binding hard budget constraint in order to improve the quality and transparency of sub national spending decisions.

On the revenue side, the most common types of fiscal decentralization include increasing the transparency and stability of transfers, endowing sub national governments with the power to collect their own taxes and to set the rates of these taxes, and giving sub national governments the right to borrow with greater independence from the national government. A number of principles should inform revenue decentralization: increasing revenue transfers and transferring tax authority are both important types of fiscal decentralization, but the latter has a more positive impact on accountability: paying more of their taxes at the sub national level may encourage taxpayers to hold sub national officials accountable for the spending of these revenues. At the same time, the assignment of some tax bases to sub national levels (for example, taxes with mobile bases and taxes structured for redistribution) can be inappropriate and potentially lead to great inefficiencies. The design of intergovernmental transfers should be based on a number of principles, including rule-based definitions of transfer fund pools, transparent and objective transfer allocation formulae, and incentives for sub national governments to raise local revenues. Local government borrowing should be based on an assessment of a sub national government's creditworthiness and the economic viability of specific development projects for which capital financing is being sought (USAID, 2009:10-5).

2.2.3. Administrative Decentralization

Administrative decentralization is the transfer of responsibility for the planning and management of one or more public functions from the national government and its centralized agencies to sub national governments and/or sub national administrative units. Administrative decentralization refers to the institutional architecture—structure, systems, and procedures—that support the implementation and management of those responsibilities under the formal control of sub national actors. It encompasses, among others things, sub national departmental structures and responsibilities; human resource requirements and management systems; and planning, monitoring and evaluation of service arrangements. Administrative decentralization may or may

not include improving capacities for budgeting, financial management and financial control, depending on the degree of fiscal decentralization in the country in question.

Administrative decentralization also includes mechanisms for working with higher, peer, and lower levels of government or administration, as well as mechanisms for working with key local nongovernmental actors, such as traditional authority structures and private sector partners. Administrative decentralization alters each of the four critical elements of decentralization. The impact on accountability is particularly important: under deconcentration, sub national bureaucrats remain accountable to national officials, whereas under devolution it is desirable that they become accountable to sub national elected officials for the quality of their performance. With respect to authority and autonomy, when control over personnel decisions is transferred from national to sub national officials, not only do the latter gain additional authority over government employees, but their autonomy from the national government is also enhanced. Administrative decentralization also directly influences the capacity of sub national governments and administrations by strengthening the systems and procedures that allow these units to perform their assigned tasks (USAID, 2009:10-5).

2.2.4. Market Decentralization

It is also termed as economic decentralization. The most complete dimension of decentralization from a government's perspectives are privatization and deregulation; they shift responsibility for functions from public to the private sector. They allow functions that had been primarily or exclusively the responsibility of government to be carried out by business, community groups, cooperatives, private voluntary association and other governmental organizations. Privatization and deregulation are usually accompanied by economic liberalization and market development policies (Ford, pp.4).

2.3. Forms of decentralization

Most authors are agreed that decentralization within a state involves a transfer of authority to perform some service to the public from an individual or an agency in central

government to some other individual or agency which is closer to the public to be served. The basis for the transfer are mostly territorial and functionally. Based on these, the following forms are recognized on which decentralization policies might pursue: devolution, deconcentration, and privatization (Turner, 1997:152-3). Bossert (2000) also stated the widely accepted terminology developed by Rondinelli (1981), who identifies three principal categories of decentralization: deconcentration, delegation, and devolution in his comparative analysis of decentralization in Latin America.

In the works of Oxhorn (2004:5) decentralization policies are characterized in terms of three discrete types that are distinguished by the degree of autonomy exercised sub national levels of government vis-à-vis the central state apparatus. These are de concentration, delegation and devolution. Deconcentration reflects the decentralization of policy administration and implementation while policy continues to be made at the central level. Delegation includes some transfer of decision making authority, although the central state still reserves control over key aspects of policy. Finally devolution entails maximum decision making authority for substantial governmental institutions. In addition to this Manor (1995), as quoted in Tesfaye (2006:16), states that privatization is also one form of decentralization in which the transfer of tasks formerly performed by the state agencies to the private sector.

2.3.1. Deconcentration

In the literature it is also termed as administrative decentralization. Deconcentration is one forms of decentralization in which authority and responsibility from one level of the central government to another while maintaining the same hierarchical level of the accountability from the local units to the central government to improve service delivery. Decision making and power are transfer from the central headquarter to an appointed official who is accountable to central government rather than to a representative of the local community who is accountable to the community (Turner, 1997:160-1). This form of decentralization is considered as the weakest one as decision making authority and financial management responsibilities rest on the hand of the central government. Nevertheless of this, Manor (1997) views deconcentration as a useful

first step in decentralization, because it brings government institutions and bureaucrats closer to dispersed people.

2.3.2. Devolution

Devolution is a political decentralization which refers to the transfer of political power and authority to the sub national units of government such as local governments, local authority, district councils and state government. This definition of political decentralization brings two important points into focus. First, it makes it clear that political decentralization is a necessary (though not sufficient) condition for devolution, which is the transfer of resources and responsibilities to sub national governments that are not under the direct, hierarchical control of the national government. Devolution cannot occur without political decentralization. Second, according to this definition, countries that have sub national administrative units but not sub national governments cannot experience political decentralization, which requires the use of elections to fill sub national governmental offices. The authorities of sub national elected officials in devolved governments tend to be (and in our view should be) broader than those granted to appointed sub national officials in sub national administrations. The exercise of core governance functions, such as deciding bases and rates of taxation, are generally reserved to elected officials in sub national governments (USAID, 2009:10-5).

In this case responsibility, decision making, resources and revenue generations are transferred to the local level of public authority in fully and as an independent legal entities and autonomous conditions. However even such decentralization allows the local government to act independently, the central government or authorities frequently exercise indirect, supervisory control over them. These authorities have corporate or statutory authority to raise revenues and make expenditures (Rondinelli, Nellis, Cheema 1983). Generally devolution has four key features: the body that exercises responsibility is legally separate from the central ministry; the body acts on its own, not under the hierarchical supervision of the central ministry; the body can exercise only the powers given to it by law; and the body can act only within the geographic limits set out in the law. Also such bodies are often supervised by a board of officials elected by the local population. Because the local body is legally separate from the ministry, it can enter

into contracts and conduct other transactions in its own name. The local body is fully responsible for its act; the central ministry has no responsibility unless the law specifies other arrangements (Florestal and Cooper, 1997:3).

2.3.3. Delegation

This refers to the delegation of government functions to parastatal units, private sector groups or non government organizations who now act as agents of the national government. In the works of Rondinelli (1983) the term delegation stated as the transfer of managerial responsibility for specifically designed functions to organizations that are outside the regular bureaucratic structure and that are only indirectly controlled by the central government. It is therefore the redistribution of authority and responsibility to local units of government or agencies that are not always necessarily branches or local offices of the delegate authority. In this form the accountability expressed in a vertical relationship i.e. top down approaches.

2.3.4. Privatization

Privatization is a term that has been associated with the transfer or sale from the public to the private sector of assets in terms of ownership, management, finance or control. The range of actions indicates that privatization increasingly defined broadly to include all efforts to encourage private sector participation in the delivery of public services. As Ford (? p.4) states privatization mean allowing private enterprises to perform functions that had previously been monopolized by government. It can mean contracting out the provision or management of public services or facilities to commercial enterprises. It includes financing public private institutional forms; it can also mean transferring responsibility for providing services from the public to the private sector through the divestiture of state owned enterprises.

2.4. Conceptual linkage of decentralization and urbanization

Many scholars considered urbanization as a continuous developmental process in which significant social, economic and environment change occurred. Because of this process

population number increased through natural increase and/or rural –urban migration, socioeconomic condition of the urban areas changed, different types of industrial plant manufactured and infrastructure construction expanded. As a result urban areas expected to deliver quality or at least a standard public service such as education, health, transportation, housing, water and sanitation, recreational center, food, electricity, modern telecommunication system and so on to the residents. As Sara Schuman stated urbanization and industrialization are the consequences of economic development because of a positive relationship between urbanization, manufacturing, and economic development. The manufacturing industries are beneficial for the following reasons. First industries benefit from the availability of infrastructure that rural areas lack i.e. urban areas have access to electricity, water, telecommunications, and airports. In addition, urban areas benefit from the availability of specialized business services, such as banks, financial offices, consulting services, professional schools. Because urban areas tend to have higher levels of education, urban areas also tend to have a larger number of skilled workers. The large-scale operation of one firm lowers costs and improves efficiency, which in turn reduces the cost inputs for other firms, creating a virtuous cycle. Finally, large metropolitan areas tend to be centers of the business, intellectual, and political elites that attract industry.

Because industry benefits from urbanization, many cities in the Third World generate a large proportion of the GDP and contribute significantly to overall economic growth. In Brazil in 1970, the population of Sao Paolo made up only 8 percent of the national population, but contributed 36 percent of GDP. The population of Mexico City made up only 14.2 percent of the national population in 1970, but contributed with 33.6 percent to the country's overall personal income. Finally, in China, the population of Shanghai accounts for about one percent of the total population but contributed to one-eighth of GDP in 1980. Therefore, the urban population is responsible for a larger proportion of economic growth and development. Initially, mega-cities benefit from economies of scale, but eventually the gains begin to diminish as the population of the city increases. The population growth in major cities in the developing world today is more a result of natural increase then of rural-urban migration. In the beginning stages of development, the urban population increase is attributed to large migrations from rural areas to urban areas. After World War II, rural-urban migration produced the urbanization of the developing countries today. Developing countries experienced high population growth as death rates fell, as a result of

medical advances, while fertility remained high. The rapid natural increase in the rural areas produced an excess supply of labor in agriculture. Due to the incentive to migrate to the cities for work, plus reduced possibilities of international migration, rural-urban migration increased rapidly. In the intermediate stage, where the developing world is today, an increase in the urban population results from high natural rates of increase from high fertility rates among urban dwellers. Finally, in the advanced stages of development, population increases once more is the consequence of migration. (Oberai 108, as quoted by Sara Schuman).

These progressive processes, on the other hand, are also reviewed in several academic literatures that, the limited carrying capacity of the natural resources and the ever increasing number of population become the two challenging issues to meet various needs of the population. Besides the incapability of the local government (i.e. financial and making political or administrative decisions), corruption, mismanagement and inadequate service delivery aggravate the problematic nature of urban management and development. The pressures on resource use have increased, accompanied by evidence of environmental deterioration that is potential environmental damage which implied the inability to sustain either the economy or the resource base on which it depends. In this case it is clearly shows that urbanization as processes have caused severe challenges to the urban environment and hence to the urban centers in which the local government or municipalities couldn't provide necessary social services and infrastructure facilities to urban residents; all these make the urban areas harsh to live in. Nevertheless of these, the local government has a prime responsible organ to tackle down these urban challenges by creating sound political, economic, administrative, and social arena. The local government, therefore, through the various kinds of decentralization programs can manage urban growth and response the need of the residents by delivering quality services in effective and efficient way among others.

According to Selee and Tulchin (2004:296) decentralization is widely though to improve democratic governance by bringing government closer to the people and thereby increasing state responsiveness and accountability. With authorities, functions and resources redistributed among the various levels of government, the central government then coordinated and regulates the activities of the various levels. This approach suggests that a strong state and strong civil society

can and should be mutually reinforcing and that decentralization can strengthen the state by making it more responsive and accountable to citizens. Decentralization forms: devolution, deconcentration and delegation the of power and the mechanism of delivery of services, undertaken separately or in some combination of all three, particularly in developing countries, has become the mantra of administrative, managerial and governance related interventions and reforms. Development theory and its practices are no longer conceived to be seen as the prerogative of a strong, centralized, and state but, rather, smaller more representative administrative and political units are presumed to be better at delivering and doing development. Not only have the structures and the role of the state changed in administrative terms, but there has also been a simultaneous realization that forms of democracy and participation are essential to make development work. Perhaps over the last half century, these two notions, of devolving power and delivery along with the greater participation by the people, have become the sine qua non of development (Zaidi, 2005:1).

The fact that decentralization is unfolding concurrently with urbanization in developing countries makes the need for local government development all the more pressing. This is a true feature in Africa countries because the continent is urbanizing or municipalizing and this movement is not likely to stop. Consequently, local authorities become places where the demographic and economic weight will become even greater in the future. Therefore, a response must be found to the emergence of the local entity as the appropriate place for the emergence of the new democracy as well as the provision of public services, according to the principle of subsidiarity. The other significant aspect was to ensure territorial balance and to give both rural and urban communities the means of offer necessary public services and become catalysts for development in general (UNCDF, 2006:14). Decentralized governance is increasingly being favored by many African countries as the most suitable mode of governance through which poverty reduction interventions can be conceived, planned, implemented, monitored and evaluated. Many hope that the process of decentralization will facilitate greater participation of communities in problem analysis, project identification, planning, implementation as well as oversight which in turn will increase ownership and the likelihood of sustainability of such initiatives (Kauzya, 2007).

In response to urbanization pressure, which is noted as an engine for local economic growth and development, for instance the Federal government of Ethiopia has initiated and implemented various developmental policy packages to facilitate the task of managing urban population growth, meeting the needs of the residents and extenuating urbanization's challenges. Urban areas will continued to grow at a rapid pace that are being faced by two central challenges. The first is the challenge of more effectively managing urban services, so that a minimum of efficiency could be assured for the continued functioning of the urban economy and the increasing numbers of urban poor would have access to clean water, health centers, education, public transport and other elements of public infrastructure. The second challenge, which in many ways subsumed the first, is to develop governance systems which provided access to local decisions by important groups in the community, while at the same time maintaining an institutional framework that is both legitimate in national terms and more appropriate to the nature of modern urban life.

The government has recently attempt to improve efficiency, equity, stability and quality of service through decentralization program wherein the burden of service delivery is shifted to Regional, Zonal and Wereda level. To be effective, yet, decentralization requires increased capability and administrative capacity on the part of local government. Local government via decentralization and good governance has responsibilities to manage and/or deliver effectively social services (education, health care), infrastructure (roads, water and irrigation, sewage), environment (natural resources), social safety nets and security to its citizens. Decentralization, hence, holds promise for improving the delivery of public services, as citizen input (participation) and oversight (accountability) tend to enhance the responsiveness of public policies, especially in the social arena. Under the devolved decentralization, it becomes possible to mobilize the local community at a grass root level in response to development issues, and improvement of social services. This system create great opportunities in generating financial capacities, efficiency and quality gains that promote effective delivery of services by shifting responsibilities of allocating scarce resources to lower level (Kumera, 2006).

The urban development policy, strategies and programs of Ethiopia have incorporated urban development, decentralization and service delivery issues as an agenda or a mechanism to

meet the PASDEP (i.e. Plan for Accelerated Sustained Development to End Poverty) among others (MWUD, pp 20-50). This research, therefore, by taking into account the critical role of political decentralization (that is devolution), in the *wereda* level development and in the issues of self rule, empowerment, fiscal autonomy, legal framework, decision making process, public participation and accountability of the local government; focus on the current performance of the local service providers that is education and health services delivery conditions of DM town in response to urbanization pressures.

The following diagram (figure) illustrated how these three variables (i.e. urbanization and decentralization and service delivery) related or affected each other and play vital role in meeting Millennium Developmental Goal (MDG) – end poverty.

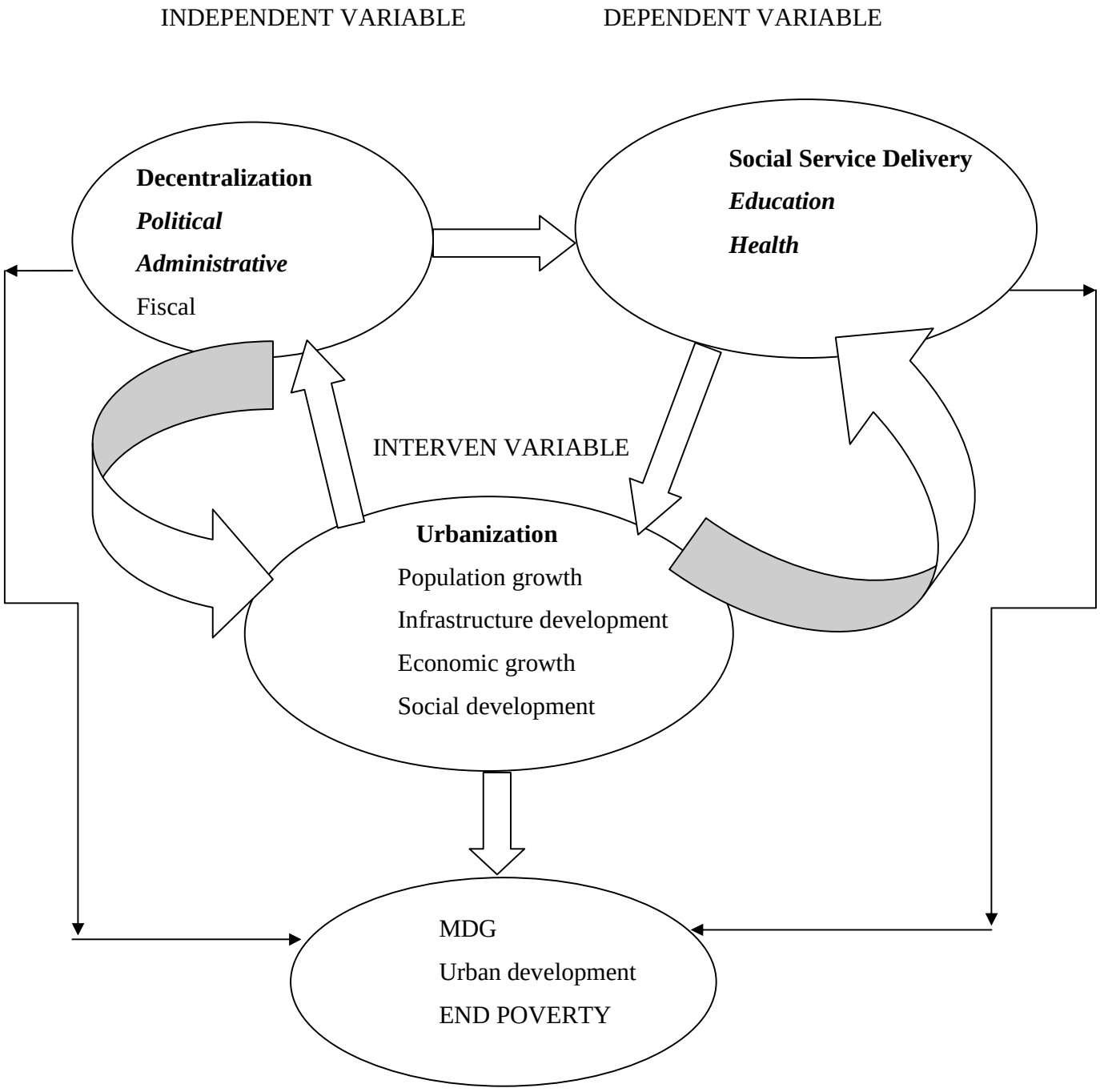

Fig.2.1 Analytical relationship among urbanization, decentralization and service delivery

(Sources Author's own construction)

2.5. Decentralization and Basic Service Delivery: Empirical Evidences

Decentralization has enhanced participation in decision-making, enabled local communities to determine their local leadership through democratic elections, provided institutionalized structural arrangements for participatory bottom-up development planning, and for involving special groups such as women, youth and the disabled in decision-making. It has also facilitated the mainstreaming of gender in development planning at local level (Kauzya, 2007: 25).

In the decentralization of governance and development Bardhan (2002) has described the experience of different countries empirically. In his work, he indicates two successful cases of decentralization in Latin America; there is some evidence available on the "before-after" comparison of service delivery outcomes. One is the widely noted case of participatory budgeting in municipal government in the city of Porto Alegre in Brazil; the other is the less well-known but quite dramatic success of the post-1994 decentralization initiative in Bolivia. In Porto Alegre, where assembly meetings of local citizens and neighborhood associations in different regions discuss investment priorities, review accounts and elect representatives to a citywide council that allocates available resources across wards, impressive results have followed: between 1989 and 1996, access to basic sanitation (water and sewage) as well as enrollment in elementary or secondary schools nearly doubled, while increasing revenue collection by 48 percent (Santos, 1998).

Although it is difficult from this study to isolate the impact of participatory budgeting reforms from those of other ongoing changes, it seems likely that there has been a substantial impact on the pattern of resource allocation across localities, particularly to poor ones, and in the lessening of the misappropriation of resources compared to the past and to other areas in Brazil. In Bolivia in 1994, the number of municipalities as well as the share of national tax revenue allocated to municipalities doubled, along with devolution to the municipalities of administrative authority, investment responsibility and title to local infrastructural facilities. This change has been associated with a massive shift of public resources in favor of the smaller and poorer municipalities and from large-scale production to social sectors. Faguet (2001) finds that public

investment in education, water and sanitation rose significantly in three-quarters of all municipalities, and investments responded to measures of local need; for example, the expansion in public education spending was larger on average in municipalities with a lower literacy rate or with fewer private schools. Faguet's analysis is in terms of levels of public spending, rather than outcome variables like school enrollments or school performance or access to water and sanitation services. In the studies of Porto Alegre or Bolivia, not much information is available on the allocation of resources within a community across households in different socioeconomic classes. This means that issues like cost-effectiveness of programs, targeting performance or the extent of capture of local governments cannot be addressed. Without household-level data on access to public services, these crucial aspects of the impact of decentralization cannot be properly assessed. There is hardly any household-level analysis in the literature of the comparative effects of centralized versus decentralized delivery.

One detailed study of targeting performance of a decentralized program using household-level information in a developing country is that of Galasso and Ravallion (2001) studying a decentralized food-for-education program in Bangladesh. In this central government program, in which two million children participated in 1995–1996, the identification of beneficiary households within a selected community was made typically by a local school management committee consisting of parents, teachers, education specialists and school donors. Galasso and Ravallion use data from a 1995–1996 Household Expenditure Survey to assess the targeting performance of the program. They find that the program was mildly pro-poor; that is, taking all villages, a somewhat larger fraction of the poor received benefits from the program than did the non poor. They also find some evidence of local capture. For example, within the set of participating villages, targeting performance was worse in communities with larger land inequality or in remote locations. But the targeting improved as the program expanded, suggesting that the program shifted the balance of power in favor of the poor. It is also clearly the case that the level of targeting within communities was superior to that achieved across communities by central allocation, thus offering little support for the view that the central government is more accountable to the poor than local communities. This finding is in some contrast to the experience of the widely acclaimed antipoverty transfer program of Progresa in Mexico. The program follows a two-stage targeting process. Coady (2001) finds that most of

Progresa's targeting effectiveness is achieved at the first stage when poor localities are selected, rather than in the second stage when households are selected within localities, not on the basis of identification of beneficiaries by local communities as in the food-for-education program in Bangladesh, but on the basis of information collected from a census undertaken for this purpose. In the 1990s, Nicaragua started a program of transferring key management tasks in public schools from central authorities to local councils involving parents. An evaluation of this program by King and Ozler (1998) on the basis of school and household surveys and student achievement tests suggests that de facto autonomy has not yet been given to many of the councils, but where it has been, there is a significant positive effect on student performance. A similar story on accountability can be told in the field of education and health, comparing north India with some authoritarian countries. Institutions of local accountability are rather weak in large parts of north India, and it is common to observe, for example, the serious problem of absenteeism of salaried teachers in village public schools and of doctors in rural public health clinics. The villagers are usually aware of the problem but do not have the institutional means of correcting it, as the state-funded teachers and doctors are not answerable to the villagers in the insufficiently decentralized system.

On the other hand, in non democratic China, the local Communist Party officials have sometimes been quite responsive to local needs (at least as long as they are not contradicting with the party's program), as the comparative study of two villages in China and India by Dre`ze and Saran (1995) show in the context of China's far better performance in the provision of primary education at the local level. Similar accounts are available of more effective public pressure in rural basic education and health services in Cuba compared with some of the more democratic regimes in Latin America. There are, of course, many authoritarian countries where local accountability is completely absent and the situation is much worse than in north India. Taken as a group, these studies suggest generally positive effects of decentralization, but it is hard to draw conclusive lessons. Many of the studies are largely descriptive, not analytical and often suggest correlations rather than causal processes. Educational decentralization, according to Hanson (1997), can be stated as a way to improve administrative services, increase the quality of education, share power with the local citizenry and advance the pace of national development. That shift coincided with a worldwide movement, spanning federal systems of government

(including those in Argentina, India, Nigeria, and the United States) as well as unitary systems (such as those in Colombia, Pakistan, and Papua New Guinea), in large countries (such as Australia, Canada, and Spain) as well as small (such as El Salvador, Malta, Nicaragua, and Zaire). In light of this, he identifies and explains the following fundamental issues, goals, processes, and strategies that shape educational decentralization initiatives in Latin America: accelerated economic development, increased management efficiency, redistribution of financial responsibility, increased democratization through the distribution of power, greater local control through deregulation, market-based education and neutralizing competing centers of power.

Different countries have various reasons for decentralized health sectors. In Uganda aimed to bring political power closer to the local communities, responding to local people needs and building local capacity; in Zimbabwe decentralization viewed as a means to enhance coverage, access and effective utilization of health care and prevention services. In Senegal to brings the government closer to the people. For Mexico, decentralization is an opportunity to revitalize democracy, facilitate community participation and encourage inter sectoral cooperation. It intended to share political power with the state governments, reduce the fiscal burden at the central level, rationalize the supply structure and improve management. In Kenya the rationale for decentralization is the desire to provide an enabling environment for improved health sector performance, increased responsiveness to local health needs, improved multi-stakeholder collaboration and increased potential to develop new funding mechanisms. In China the desire to increase quality of services, contain costs at the state level and increase local financial contributions. In Brazil is intended to improve the coverage of the key health interventions that influence the basic health outcomes of the population, reduce the inequality in distribution of publicly financed health care and improve the financial sustainability of the health sector through greater efficiency and through improved mechanisms for cost control (Hutchinson and Lafond, 2004:8-9).

In the preceding part we have seen the essences of decentralization have been the major agenda for countries to improve public services delivery by reducing the burgeoning social problems of urban dwellers through creating governance value such as responsiveness, equity, efficiency, effectiveness, accountability, access, resources allocation, coverage and participation

at the local level. The next section, however, briefly discusses the implication of decentralization on service delivery in Ethiopia context.

2.6. Overview of decentralization practice in Ethiopia

The foundation of modern local government had established during Emperor Haileslasie I by recognizing the provincial administration. According to Miheret (2007) this system was highly centralized as the government appointed governors to the provincial area to act as a representative of the Imperial throne in the periphery and hence the local government unit had no authority over their budgets and could not undertake development on their initiative. In this socialist military regime the form of government and its structure was highly centralized having less responsibility and authority to sub national levels of administration. The history of decentralization has been starting following the fall of Derge regime in 1991. After the fall of the Derge, the current government i.e. EPRDF (Ethiopian People Revolutionary Democracy Force) has changed the form government to the decentralization in the political context. As Tegegne and Kassahun (2004) described this phenomena this process involved in the reorganization of the Ethiopian state structure following the 1991 regime change, which is characterized by changes in the form of government (from unitary to the federal and governance (from the highly centralized to the decentralized variant) were highlighted so as to provide a clear background to the decentralization process.

Starting 1995 EPRDF established decentralization policy that aimed to transfer powers, responsibilities and resources from the central government to regional, zonal, Wereda and Kebele levels of administration. As per the 1995 federal constitution, regional governments enjoy a considerable degree of self-rule, including a constitution, a regional flag, the authority to prepare and administer budgets and the right to use regional languages of their choice in the courts, schools and public administration. It has been noted that to fulfill the specific objectives of district level decentralization programs eight possible intervention areas have been identified to address the capacity building needs at *wereda* and *kebele* level: institutional/organizational arrangement, staffing and training, fiscal transfer and revenue enhancement, local planning and

control, grass root participation system, minimum standard services, equipment support and strengthening institutions (Worku, 2005:30).

2.6.1. Decentralized governance in Ethiopia

In the developed countries the rural to urban migration was facilitated by large-scale industrialization and the need for labor. In the developing world particularly in Ethiopia this is not the case. Rather, population is placing a great deal of pressure on urban areas and without having the benefit of industrialization that is lack of employment opportunities for the mass of urban migrants is undermining the ability of cities to incorporate people. The consequences of this lack of employment opportunities are growing urban areas a large percent of whose population are unemployed and living in poverty and forced to live in unsanitary squatter settlements. These conditions create stress among the people which is aggravated by the ever increase demands of urban residents for better city service. But as a matter of fact this demand could not meet by the local, state, and federal government, the community or third party (such as private sectors, non profit organizations, and volunteer groups) since the limiting resources of the mother Earth and the fast rate of population growth. Due this pressure it is required to have an efficient urban management system which could deal with the situation and respond to it optimistically and resourcefully. With the growing demands of urbanization, urban management has developed as one discipline to facilitate a rapid change in cities. In this role, it has acquired new burdens, vision and opportunities (Minas, pp.164). The specific functions of an urban governance system and the mechanisms for decision-making and coordination in city service provisions and administration involve great effort and some what complex process to meet the needs of urban residents.

Decentralized governance may be more likely to adopt pro-poor policies, but this is not automatic, as local elites can be very successful in directing expenditure and taxation policies to their advantage and in gaining unduly from privatization. Sub-national governments have increasingly taken responsibility for providing and funding local public goods such as roads, water and sewerage systems, transit, power, and telecommunications networks, as well as other public infrastructure. Decentralized governance at the local level characterized by a set of

reforms such as intergovernmental transfer in the form of the untied block grants, redeployment of skilled and experienced personnel to Weredas and autonomy in terms of activity and budget planning and staff recruitment within limit of available and approved means have entailed the prevalence of a relatively enabling environment as compared to the previous state of affairs. Several improvements with regard to planning, budget allocation, priority setting and expenditure autonomy were experienced since then (Tegegne and Kassahun, 2004: 46).

2.6.2. Challenge and Problem of decentralization

As it is mentioned, the idea of decentralization is linked to subsidiarity (the lowest level of government that can perform functions efficiently and effectively). Economists justify decentralization on the grounds of allocative efficiency, enhancing the responsiveness of policymaking and the effectiveness of poverty reduction. Decisions taken closest to a local constituency are expected to better reflect the preferences of citizens, especially the poor. As a result, local governments are more likely to implement a poverty policy through community participation and social inclusion. The challenge is to maintain a poverty focus at central and local levels that is shrinking of political participation, especially given the risks of local governments being captured by local (Wereda) elites and interest-groups and of problems such as corruption, non responsive, less accountability, and non participatory. One-party monopoly of the political landscape at the local level will also have important implications on the autonomy of Wereda governments and generate risks of more upward accountability at the cost of reduced responsiveness and answerability to the community (Meheret,2007:94).

Moreover in Ethiopia urban management is often overlap with the political power with full of unrest nature creates severe problems in the city developmental activities. Because of poor democracy culture, poor urban governance and weak public participation in decision making, weak accountability, less decentralization of power to local (devolution), the urban management system of the country has become weak and unsystematic. In Ethiopian municipal services where new leadership has often induced shakeups, the past is often removed and the new takes so much additional resource and as long a time to put a new system in place. In the process, little or nothing is achieved. And when the dust begins to settle under the new system, misdoings usually

backfire, threatening and eventually undoing the new system. In this way, the cycle of constant rapture attains nothing but deterioration (Minas, 2003:128-9).

As it has been stated in many works, decentralization is not a panacea. Clearly, there are limits to what it can achieve. Not all government functions can or should be decentralized. Decentralizing weak Weredas may multifaceted problems. An appropriate balance of centralization and decentralization is essential and there needs to be complementary attention to central government. Through these two systems EPRDF transfer powers, responsibilities and resources from the central government to regional, zonal, Wereda and Kebele levels of administration. State function have been formally divided between the federal and regional governments whereby the central government is responsible for national issues of concerns, such as defence and national security, currency and foreign affairs, while regions are responsible for drawing and implementing budgets, providing public services such as primary and secondary education and health; carrying out socioeconomic and infrastructure development at regional and local levels (Miheret, 2007:76). Hence decentralization requires a strong central entity to regulate, to provide an overall framework to manage the re-allocation of responsibilities and resources in a predictable and transparent way and to assist local governments build capacity in the early stages. However in Ethiopian the decentralization process has faced with many problems and challenges, for instance, there is an unequal geographic distribution of resources (salaries, oil, water…), people and poverty, among local governments (Weredas) level.

> *…the block grants that Weredas received from regional governments and allocated among various budget items had on several occasions proved inadequate to meet the increasing service demands of the community (Miheret, 2007:95).*

There is also absence of legal frame work for implementation of Wereda decentralization policy. As a matter of fact, local governments must have adequate revenues –either raised locally through taxes or transferred from the centre – as well as the authority to decide on spending. Expenditure responsibilities of both central and local governments must be made legally explicit to enhance accountability and reduce overlap. As the revenue-raising capacities of local governments often are low, transfers remain the dominant source of revenues. Legal

framework/regulatory framework for implementation of the Wereda decentralization program were missing in many regions (Miheret, 2007: 96). The legal framework ought to clearly establish the formula for calculating transfers, to ensure predictability and avoid protracted, destabilizing political bargaining. Indeed, the tax-transfer system is one of the main instruments for achieving redistributive equity at the national level. To avoid financial destabilization, sub-national borrowing may be allowed under strict conditions.

2.7. Decentralization and Social Services Delivery

Local government via decentralization and good governance has responsibilities to manage and/or deliver effectively social services (education, health care), infrastructure (roads, water and irrigation, sewage), environment (natural resources), social safety nets and security to its citizens. Decentralization, hence, holds promise for improving the delivery of public services, as citizen input (participation) and oversight (accountability) tend to enhance the responsiveness of public policies, especially in the social arena. Responsibility for service provision should be allocated on the basis of the principle of subsidiarity, that is, at the closest appropriate level consistent with efficient and cost effective delivery of services (Tegegne and Kassahun 2007).

According to World Bank document (2001; 4), decentralization holds a lot of promise, but whether it improves public service delivery depends on the institutional arrangements governing its implementation. Several conditions must be met before the full benefits of decentralization can be reaped. First, for decentralization to increase allocative and productive efficiency, local governments need to have the authority to respond to local demand as well as adequate mechanisms for accountability. Because granting authority without accountability can lead to corruption and lower productive efficiency, decentralization needs to be accompanied by reforms that increase the transparency and accountability of local government. Second, functions need to be devolved to a low enough level of government for allocative efficiency to increase as a result of decentralization. Low-level governments are likely to be aware of local preferences and, if able to do so, are likely to adjust service delivery accordingly. Third, citizens should have channels to communicate their preferences and get their voices heard in local governments. But the existence of such channels is not enough. To effectively influence public policies and oversee

local governments, citizens need to have information about government policies and activities. The media play a crucial role in this area. In developing countries radio is especially important for disseminating information about government. The media, however, tend to focus on national events and politics. In a decentralized environment, adequate coverage of local events and politics is also important. However, recent evidence from education and health-care decentralization suggests that its impact is limited and its results mixed. Institutionalizing an adequate balance of power between the national and local government is a permanently evolving challenge. Decentralization is a complex multi-dimensional process of governance reform, with a multitude of entry points for civil society and donors.

Following the FDRE constitution of 1991, the county has practiced a devolved type of decentralization as new direction for the improvement of public service delivery which is expected to make better and develop socio economic development effort (Kumera, 2006; Mohammed (2006) as cited in Taye and Tegegne, 2007:34). By virtue of its constitutional power, the Federal Government is responsible for the formulation and declaration of social, economic and cultural policies. The policy of federal government in a way set objectives for the regional states. It affected orientation of the regional states as to how much effort they should devote to what kind of activities and emphasize in their services program (Tegaye, 2006:59).This measure has been taken because decentralized service provision is believed to attain equity, to bring political stability, develop democracy culture, and create accountable and responsive governance (Lijalem, 2008). It contributes the participation of local community in the development effort and also empowers the local administrative units to make decision without interference from the central. To realize these objectives the providing effective and efficient service, the government of Ethiopia has formulated education and health policies.

Education and Training Policy objective is to develop the coverage of education system through the country and to make more relevant to the present and future needs of the economy. The education and training policy addressed education from the kindergarten to university levels as well as non formal education. One of the policy's goals was to achieve universal enrolment in primary school by 2015 (Tegaye, 2006:62). The other one is the Health Sector Development Program I to III (HSDP I, II, III), which incorporates a 20 years health development strategy

through a series of five-year investment programs (MoH, 1999 as cited in Alemayehu 2009:2). Under the PASDEP, the government focuses on poverty related health conditions-communicable diseases such as malaria and diarrhea and health problems that affect mothers and children. Efforts are concentrated on rural areas and on extending services outwards from static facilities to reach villages and houseolds. In addition, and most importantly, gender is to be mainstreamed at all levels of the health system (MoH, 2007 cited in Lijalem 2008:57). Nevertheless of these efforts, it has been noted by Miheret (1998) that the practice of *wereda* decentralization in the area of service provision constrained with lots of problems: in budget allocation, the capacity of skilled manpower, institutional framework, revenue sources, public participation and financial dependency on Federal government.

2.7.1. Decentralization in Education Services

In the urbanized areas, residents demand various basic social services (such as education, health, and water). To meet these needs, which are expected to grow without stop in complex and multitude nature, become difficult and hard to government unless effective and efficient policy as an intervention measure is taken so as to reduce problems and then to eradicate poverty. Education is arguably one of the most important factors for full participation in the increasingly global society and success is often measured by technology-based metrics and further driven by knowledge. It is a fundamental element to sustainable development in the economic, political and social sphere (Asfaw et al, 2007:40).

The process of decentralization in education may considerably improve transparency, administrative efficiency and finance management, the quality and accessibility of services and the development of political responsibility in general. It is believed by many scholars that a decentralized education system would be more efficient, more compatible with the local priorities and more strongly encourage family participation, regarded as a factor of democratization (UNESCO, 2005:12). Similarly according to USAID (2005), educational decentralization involves transfer of decision making powers form the central Ministry of Education to intermediate government, local governments, communities and schools. The path, depth and ultimately the outcome of educational decentralization reforms depends on the

motivation of reforms, the initial country and sector conditions and interaction of various coalitions within the sector (as cited in Lijalem,2008:29). Educational decentralization raise question of how far decision making should be decentralized for each level or type of education (primary, secondary, and literacy training) and how responsibilities will be allocated for the development of curricula and teaching methods, evaluation, textbook production and distribution, recruitment and remuneration of teachers, school building and maintenance, the establishment of links between parents and teachers. Decentralization brings greater parental involvement, have positive effects on the pupil attendance, as has been observed in Brazil. It is important to note that decentralization of education, however, in the long run increase inequality between regions in terms of the financing and quality of education and the working condition of teachers. And for the majority of the researchers, local governance is potentially a source of social and territorial inequality (UNESCO, 2005:14-15).

A study undertaken in Gimbi wereda of Oromia National Regional State by Lijalem (2008) concluded that there has shown faster improvement on the access of primary education, the quality of education services in terms of percentage of qualified teachers, student section ratio, pupil-teacher ratio and student–text book ratio, albeit, none of these indicators have reached to national standard set for primary education. Moreover equity in terms of gender education services has shown improvement but efficiency of education service in terms of drop out and repetition rate did not improved. In this study it has been revealed that education sector is improved autonomy, community participation, and finance capacity.

Tesfaye (2006) has studied decentralization and service delivery in education: a case of Moretenna-Girru and Berhe Aleltu weredas of Amhara Region and Oromia Region respectively. In this study it has been shown that significant power is devolved to both *weredas* education level by which they could perform teacher recruitment, school construction, and education management. In addition to these, education coverage i.e. students enrollment in primary school is increased. Nevertheless of this, these two *weredas* have problems in manpower capacities which negatively affected the quality of education service. Similary Kumera (2006) has also studied decentralized governance and service delivery at two *weredas* i.e. Dieglu and Tijo of Oromia Region. He has shown that *wereda* is not efficient in public service delivery as predicted

to be during the post decentralization years. Various constraints such as financial, manpower, coordination and participation have basically contributed low performance of the *wereda*.

From the above research, decentralized education service, therefore, evidently has twofold outcomes. First it improves the quality of service delivery (i.e. interms of students-text-book ratio, students-section ratio, teacher-students ratio) particularly in primary and secondary schools. And in schools teaching learning activities are done with autonomy, gender gap is reduced and parents (community) involvement is increased. But various things such as manpower, financial capacity, mandate of local government (service providers) and sectors coordination could affect the quality of education service.

2.7.2. Decentralization in Health services

Health service refers to products or services, where some degree of public involvement is considered necessary within a particular health system context. Decisions regarding health services may relate to arranging health care services, management, production, distribution and/or financing of public services. The rationale of health decentralization are summarized in a Bankauskaite and Saltman (2007:16) as follows: to improve technical efficiency, increase allocative efficiency, empower local administration, increase the innovation o service delivery, increase accountability, increase quality of health services and increase equity (as quoted in Alemayehu, 2009:17-18). In a decentralized health service provision it is expected to be increased because it give freedom to the health service providers to arrange payment scheme according to ability with special assistances mechanisms for those who cannot afford to pay (Alemayehu,2009:4). According to Mills (1990) cited in Lijalem (2008) decentralizing health service include improved implementation of health programs, improved equity, greater community financing and involvement of local communities, grater integration of activities of different public and private agencies and improved inter sectoral coordination.

A study undertaken in district level decentralization program and service delivery of Gimbi *wereda* by Lijalem (2008) concluded that there has shown improvement in terms of number of health institutions and quality of health service particularly in prevention activities. In

addition to this immunization coverage has shown faster improvement. However the *wereda* health sector office has not efficiently executed its plan to immunization.

Alemayehu (2009) has assessed the notion of decentralization and health service delivery among health related personnel's and health beneficiaries. In the study it has been shown that health service providers have better awareness about decentralization of health service delivery than the beneficiaries. These beneficiaries, yet, affirmed that the health services provisions are improved when they compared the current service delivery system from the previous centralized system. Nevertheless of these, it has been shown that the existence of poor controlling mechanism, absence of working materials, financial constraints and in adequate number of skilled labor hinder the health providers to give quality service to the beneficiaries.

From the above research findings, decentralized health service, therefore, evidently improves the quality of service delivery particularly in prevention activities and establishment of health centers. Administrative constraints such as manpower and financial capacity could affect the quality of health service. It can be concluded that a mere decentralization does not have the guarantee in solving problems of public institutions.

CHAPTER THREE

STUDY AREA DESCRIPTION AND METHODOLOGY

This chapter deals with the study area description, methodology and procedures of the study, under which the methods, sampling techniques and sampling size, unit of analysis, as well as data analysis techniques are discussed.

3.1 Profile of the Study Area

3.1.1 Historical Foundation

In history, it has been noted that *Dejazmach* Tedla Gualu founded the area by the name *Menkorer* in 1843, the present Debre Markos town. He ruled *Menkorer* since 1853-1881. In 1881 church Saint Markos had been established and there after the area known as Debre Markos (Debere Markos City Service, 2005).

Debre Markos town /Wereda/ had been a center for commerce, culture, social and political administration of Gojjam for long period of time. The town */Wereda/* is a gradual urbanized area with 207,207 populations including the Gozamine Wereda (CSA, 2009:27). It has recently undergoing developmental activities particularly on infrastructure: mixed used buildings, road, education centers and health posts. These developmental progresses accelerate population growth of the town */Wereda/.*

3.1.2 Geographical location

Debre Markos town is found in Amhara National Regional State (i.e. Region three). It is found 300 killometers Norrth west of Addis Ababa, the capital city of Ethiopia and 265 kilo meters south east of Bahir Dar, capiatal city of the Amhara national Regional State.

The geographical coordinates of the town are $10^{0}21^{1}$ latitude north and $37^{0}43^{1}$ longitudes east. Its total municipal area is about 60 kilometers square; located at 2420 meters above sea level. The weather condition, in most of the time is *Weinadega*. The town enjoys a tropical climate with a mean annual rainfall of 1308 mm, temperature 16^{0}c, while the maximum and minimum recorded temperature being 24^{0}c and 4^{0}c respectively (planning and Economic Development of East Gojjam, 2004).

3.1.3 Demographical description

In Debre Markos town found in Amhara National Regional State (i.e. Region three).In the town there are twelve kebeles and one *wereda.* The town */Wereda/* is an area with 207,207 populations including the Gozamine *Wereda* (CSA, 2009:27). The total population includes the recently included Gozamine rural areas such as Wonka, Wutrin and Wuseta. From this total population 65,933 are urban dwellers, out of this 31,541 (i.e. 48%) are males and 34,392 (i.e. 52%) are females. The rest 141,274 are peripheral urban residents of which 70,542 (49.9%) are males and 70,732 (50.1%) are females.

3.1.4 Socio economic description

The majority of Debre Markos town settled by the Amhara people with ethnic composition of about 97% Amhara, 1.30 Tigre, 0.67 % Oromo, 0.56 % Agaw and 0.36 others. Religiously, 97% constitute Orthodox Christian, 1.88% Muslim, 0.81 % Protestant and 0.6 % others (Debre Markos City Service, 2005). The periphery urban residents mainly are engaged in agricultural production, commercial activities such as crop trade (for instance ‘Teff ‘, wheat, honey, etc). The urban residents mostly are civil workers, merchants and others.

3.2 Research Methodology

The study is a descriptive research in which quantitative and qualitative approaches utilized to analyze the data.

3.2.1 Instrument of data collection

3.2.1.1 Primary data sources

Primary data collected and utilized in the following methods:

- Survey questionnaires were prepared for education and health professionals. In addition to this questionnaires were prepared for services beneficiaries.

- Semi structured interviews were prepared for head person or process owner of public service providers: education centers and health centers.

- Field observation: check list was prepared to study the overall physical built condition and working environment of the service centers and the way how customers treated in the centers.

3.2.1.2 Secondary data source

Secondary sources such as: books, journal articles, thesis, proclamation, policy documents, reports and internet sources used.

3.2.2 Sampling Techniques

This research surveyed six public service providers, in which education and health services are delivered, of DM town. Education centers such as: KTSS, MSS, KTPS, and DPS, and health centers such as: DHC and HHC selected. The reasons for the choice of KTPS and DPS from the existing ten primary schools is that these centers have been relatively considered better performance in implementing decentralization to meet quality service delivery and also are the oldest in giving educational services when compared to others.

To meet the research objectives, data collected in both sampling methods: probability namely stratified random sampling method and non probability namely purposive sampling method. Using stratified random sampling method, the researcher divided the population into homogeneous subgroups i.e. non-overlapping groups (i.e., *strata*) and then taking a simple random sample in each subgroup. The researcher used this sampling method since it assures to represent not only the overall population, but also key subgroups of the population, and generally have more statistical precision than simple random sampling. Purposive sampling on the other hand used as it is very useful to reach a targeted sample quickly and where sampling for proportionality is not the primary concern (Trochim, 2006).

By using these two sampling methods the researcher collected data from 194 respondents. These respondents were selected from above four education centers and two health centers. The mechanism for selection of respondents could be described as:

*First group **102** respondents selected for Education Service Delivery (questionnaires and interview):*

- **50** respondents were selected randomly for questionnaires out of **235** teachers who work in the following four schools: Dil Betigil primary school (n=**5** out of 39), King Teklehaimanot Primary school (n=**8** out of 66), King Teklehaimanot secondary school (n= **22** out of 72), Menkorer secondary school (n=**15** out of 58)

- school directors were selected purposely for interview from the following four schools: Dil Betigil primary school, King Teklehaimanot Primary school, King Teklehaimanot secondary school and Menkorer secondary school

- From King Teklehaimanot secondary school (n= 26) and Menkorer secondary school (n=22), total **48** students were selected purposely from representative of students counsel of grade 9 and grade 10 students (for questionnaire).

*Second group **92** respondents for health service delivery (questionnaires and interview):*

- **35** health workers were selected randomly from DM health center out of 72 (for survey questionnaires).
- **15** health workers were selected randomly from Hidasie health center out of 36 (for survey questionnaires).
- **2** Health centers' directors (head) were selected purposely from DM health center and Hidasie health center (for interview).
- From these two health centers, **40** health service beneficiaries were selected randomly (for survey questionnaires).

3.2.3 Research design of the study

The researcher collected relevant data by utilizing cross sectional survey design. There are two rationales for selecting this survey design. First it is simple, quick to conduct, cheap and most commonly used design in social science. Second it is useful for collecting data, regarding service delivery, for a single time within a period the research conducted (Kumar, 1996, cited in Alemayehu, 2009:7).

3.2.4 Method of data analysis

The researcher analyzed data in qualitative and quantitative. The quantitative data analyzed using SPSS version 12 to find mean, percents, frequency and variance to reflect information. Graphs and tables employed to make the analysis simpler. The analysis of data conducted based on the research objectives, research questions and theoretical frameworks of the study.

CHAPTER FOUR

DATA PRESENTATION AND DISCUSSION

This chapter presents the data and the results obtained in the study along with discussion and interpretations of issues. The major findings of the study are presented using bar graphs, pie charts and tables. The logic behind is that tables, diagrams and graph give visual indications of magnitudes, trends and patterns in the data (Chandan, 1998:47). Data collected from document investigation and interview are blended and discussed in the next part qualitatively with underlying theoretical frameworks.

4.1 General Background of respondents

The research has incorporated 194 respondents from education and health centers. From these total samples size 28% (n=54) are teachers, 27% (n=52) are health personnel (nurse, medical laboratory, pharmacists), the rest 45% are education beneficiaries (i.e. 55% (n=48) students) and health beneficiaries (i.e. 45% (n=40) patients). The discussion has been blended with the data obtained from KI interview and the document investigated.

4.2 Background characteristics of respondents

The respondents are categorized in four categories: education personnel (teacher), students, health personnel and health service beneficiaries. Their distribution in terms of sex, age, education level and work experience are presented here under.

4.2.1 Distribution of background characteristics education worker (i.e. teacher)

From table 4.01 *(see appendix-B)* it has been learn that the study integrated different sex-age ratio to get relevant data. The total 50 teachers' respondents (i.e. 74%) are male whereas 26% are female. the study incorporated different age groups. Most of the respondents' age (i.e. 88%) lie

within 21 to 40 years. This shows that the research has included various aspects of the respondents by taking sex and age issue as relevant determinants.

As shown in the following table 4.02 *(see appendix-B)* educational level and work experience of the respondents are identified. As the research was conducted at primary and secondary school, 72 % of the respondents out of 50 are degree holders mainly consist from secondary school whereas 28% are diploma holders that are from primary school. In the study work experience of the respondents are also taken into consideration as it contribute its part in expressing their opinion. The majority of the respondents i.e. 44 % out of 50 stated that they have 5 to 9 year work experience, 30% of them claimed that they have 10 to 14 year work experience, 20% of the respondents said that they have below 4 year work experience and only 6% of the respondents claimed that their work experience is above 15 year. From this table it has been learnt the study has incorporated those senior education personnel i.e. teachers.

4.2.2 Distribution of background characteristics students

From table 4.03 *(see appendix-B)* it has been learn that the study integrated with different sex-age ratio of the students to get relevant data. From the total 48 students, the majority (i.e. 56.30%) are male whereas 43.7% are female. As shown from the table, from the total 48 respondent students, 72.9% are from 16 to 30 years old, 25% are below 15 years old and the rest 2.1% are above 31 years old. From these students 70.8% are from grade 9 to 10 whereas 29.20 % are from grade 5 to 8.

4.2.3 Distribution of background characteristics health personnel

As shown in the following table 4.04 *(see appendix-B),* from the total 50 respondents, 56% of are female and 44% are male. The majority of age distribution of health respondents is from 31 to 40 (48%, n=24), 34% of respondents are greater or equal to 41 years old, 16% are from 21 to 30 and the rest 1% is less than or equal to 20 year.

With regard to educational level and work experience of the respondents, as shown in the following table 4.5, 58 % out of 50 respondents are diploma holders, 32% out of 50 are degree holder

and 8% of these respondents are above degree level. This condition helps to get relevant information on the issue under consideration. It is generally assumed that educated person has better exposure and awareness on decentralization issues. The majority of the respondents i.e. 42 % out of 50 stated that their work experience is 5 to 9 year, 34% of them claimed that they have 10 to 14 year work experience, 14% of the respondents said that their work experience is above 15 year and only 10% of the respondents claimed that their work experience is below 4 year. From this table it has been learnt the study has incorporated those senior health personnel.

4.2.4 Distribution of background characteristics of health beneficiary

Samples of 40 health beneficiary were included in the study. From table 4.06 *(see appendix-B)*, 52.5% out of 40 are male whereas 47.5% are female (M=1.47, SD=0.50, V=0.25, Std Error=0.08). The age distribution of the majority (52.5%) of health beneficiaries are above 45 years old, and the minority 2.5% is below 15 years old. With regard to educational level and type of occupation of the respondents, as shown in the following table 4.6, 35 % out of 40 respondents are certificate level, 25% out of 40 are below certificate level, 22% out of 40 are diploma holder and 15% of these respondents are above degree level (M=3.56, SD=1.09, V=1.20, Std Error=0.17). According this table, 35% (n=14) of health beneficiaries are claimed that they work in the private company, 30% out of 40 are civil servant of the government, 15% of them are stated that their livelihood depend on agriculture (i.e. farmer) and the rest 17% out of 40 are classified their occupation as other type. The research incorporated various beneficiaries groups views on the study (M=2.55, SD=1.50, V=2.25).

4.3 The effect of decentralization on education and health service delivery

As mentioned in literature review, decentralization has significant impact on the service delivery. It improves service in terms of quality, accountability and responsiveness by developing community (citizen) participation [Devas (2004), Rondenellli (1983), Selee & Tulchin (2004), Wittenberg (2003), and World Bank (2000)]. Thus the research has tried to assess these issues particularly in education and health service delivery by taking into account the performance of service provider and opinion of service receiver.

4.3.1 Decentralized education service delivery

In this study the impact of decentralization on education service delivery has been assessed by taking into account the following variables: quality indicator, degree of autonomy, community involvement and accountability issues.

4.3.1.1 School effectiveness (quality indicators)

The efficiency and quality of education has been assessed based on the country education policy which has formulated as standard. According to MoE education policy (2010), for effective teaching learning process the number of students should be 1:40 in the second span of elementary school (i.e. from 5 to 8 grade) and in the first cycle of secondary school (i.e. from 9 to 10 grade) that focus on general education. Furthermore on MoE 2010 Progress Report, there has been an increase in the gross enrollment ratio from 2.2% in 2004/05 to 4.2% in 2008/09. The gross enrollment ratio in primary school has risen from 32% in 1990/91 to over 91% in 2006/07, giving a male to female proportion of 55.9% and 44.1%, respectively. This indicates that the improvement of the number of enrolment, proportion of male to female ratio and students per class room rate is determines as a critical element to deliver quality education service. From the national education policy document (MoE, 2010) the following elements are taken as determinant variables among others: pupil-teacher ratio, pupil-textbook ratio, student-class (i.e. number of students in a class), rate of drop out, rate of repetition, teacher training, student center approach and parent (community) involvement.

Asked a question “Is teacher–student ratio standard (or 1:25) in this school?”, as it is depicted in table 4.07 *(see appendix-B)* most of staff respondents 86% (n=43) claimed that teacher–student ratio in their school do not meet the standard. When asked these respondents what do they perceived the cause of this deficiency, the majority (47.5% of 43) indicated that unbalanced growth of number of students, 28.6% out of 43 respondents stated that turnover of teacher as a cause for not meeting the standard, unavailability of adequate classrooms in the school (i.e. 11.9%) and financial constraints to recruit appropriate number of teacher (i.e. 11.9%) *(See annexed table-A1).* From this it can be understood that school has insufficient number of

teacher when compare to the ever increasing number of students and hence students learn in crowding manner. With regard to the students-text book ratio, 80% out of 50 disagreed with the statement that the rate of distribution of text book per student is being 1 to 1; however 20% out of 50 claimed that the text book distribution is 1 to1.

When asked respondents "how many students are attending in given class?", the majority of the respondents i.e. 70% out of 50 claimed that the students-classroom ratio was 1:55 and the other 20% stated that the ratio was being 1:65. This fact has been also confirmed from the schools documents. For instance at King Teklehaimanot Secondary School (2011 academic calendar) the average population of students in grade 9 is 56, and in grade 10 is 54. Table 4.1 depicted the population of students who enrolled and attend class in two schools namely King Teklehaimanot Secondary School, and Dilbetigel Elementary school. From these tables it has been learnt that the student-section ratio for elementary school was 1:63 in 2002 E.C whereas in 2003 it has reached 1:65. Similarly in the King Teklehaimanot school student to class ratio was on average 1:66 in grade 9 and 1:54 in grade 10 (table 2).

From similar table it can be observed that female enrolment rate has been improved. From document investigation (in 2003 E.C academic calendar), the percentage distribution of female students has reached to 51% particularly in this elementary and secondary school. This condition indicates that the gender gap in education service delivery service has been reduced in significant way.

Table 4.1 student population distribution of Dilbetigel primary school (each grade has two sections)

Dilbetigel P S	**2002 E.C**			**2003 E.C**		
	male	female	total	Male	female	Total
Grade 5	44	73	**117**	66	54	**120**
Grade 6	62	43	**105**	44	67	**111**
Grade 7	54	65	**119**	68	42	**110**
Grade 8	76	89	**165**	78	100	**178**
Sub total	**236**	**270**		**256**	**263**	
Grand total	**506**			**519**		

Source: from the school's document, 2011

Table 4.2 Student distribution of King TS school (each grade has 19 sections) and Menkorer SS School

King T S S	**2000 E.C**			**2001 E.C**			**2002 E.C**			**2003 E.C**		
	male	female	total	male	female	total	male	female	total	male	female	total
Grade 9	690	829	**1519**	574	622	**1196**	607	616	**1223**	503	546	**1049**
Grade 10	478	391	**869**	531	645	**1176**	503	515	**1018**	513	520	**1033**
Sub total	**1168**	**1220**		**1105**	**1267**		**1110**	**1131**		**1016**	**1066**	
Grand total	**2388**			**2372**			**2241**			**2082**		
Menkorer School	**2000 E.C**			**2001 E.C**			**2002 E.C**			**2003 E.C**		
	male	female	total	male	female	total	male	female	total	male	female	total
Grade 9 and Grade 10	839	719	**1558**	899	893	**1196**	712	621	**1333**	744	726	**1470**

Source: from the schools' (KTSS & MSS) document, 2011

To assess whether the efficiency of education service in terms of student repetition and drop out rate is improved or not, inquiry were presented to 50 sample teachers. Accordingly, 54% (n=27 out of 50) claimed that repetition rate of students is high and 38% out of 50 also perceived the rate as very high (table 4.08). This result has been cross checked with the obtained school's documents.

From document examination, for instance, it has been learned that repetition rate of grade 9 student in King Teklehaimanot secondary school is high (table 4.3). As shown in the table, repetition rate of student increased from 62 to 105, this means that within two academic year students who repeat grade 9 were increased by 169 percent. From table 4.3 it could be observed that students' repetition rate increased in grade 9 from 1.5% in 2001 E.C to 8 % in 2002 E.C. as well as in grade 10 it increased from 0.8% in 2001 to 1.8 % in 2002. As depicted in table 4.08, student school drop out rate perceived as high rate by 54% of respondents and as very high by 24% of respondents. This condition also cross checked from the KTS School's document, as presented in table 4.3, school drop out rate was increased by more than 100% in grade 9 and grade 10. From this table (4.3) it can be understood that female students' repetition (i.e.53.23% in

2001 and was 61% in 2002) and drop out rate were relatively very high (i.e. 61% in 2002) when compared to male students.

Table 4.3 King Teklehaimanot secondary school student repetition and school drop out

No.	**indicator**	**School name**	**2001 E.C**			**2002 E.C**		
			male	female	total	male	female	Total
1	repetition number	King T S S Grade 9	29	33	**62**	41	64	**105**
2	drop out number	King T S S Grade 9	10	8	**18**	49	49	**98**
		King T S S Grade 10	5	5	**10**	7	11	**18**

Source: from the KTS school's document, 2011

The national education policy underlines six major packages for quality education service improvement: curriculum improvement, education management and organization, school improvement, teacher capacity development, employment of information communication technology and civics and ethics education (MoE, 2002). In light of this, the Amhara National Regional Education Bureau (Oct, 2010) has given emphasis for quality and efficient education service by working toward meeting the national policy standard. Therefore teaching learning process has to be student center and supported by continuous teacher training program as well as utilization of information communication technology, among others. In line with the above, questions were presented to assess whether continuous teacher training program and ICT workable or not at the school level. The majority of the respondents, 84% (n=42), claimed that continuous teacher training program is available in their school (fig 4.1). When asked how they perceived this training program in terms of quality, i.e. from these respondent population (i.e. n=42), 54.8% out of 42 rated that the training program as *good*, 19% out of 42 rated as *very good* and 26.2% rated as *poor*. When asked respondents why they perceived training program as poor, 36.4% of them stated that the training program could not be implemented effectively, 36.4% of these respondents felt that the school has no mandate to run its training program according to the plan, 18.2% claimed that the shortage of fund will hinder the training program to run effectively and the rest 9.1% stated that the training plan is not objectively developed *(see annexed table A2 & A3)*. Another question was presented to determine the participation of teacher in various

upgrading training program that are delivered by their school. The majority of respondents (82%) claimed that they participated in various training program whereas 18% out of 50 didn't participated in such teacher upgrading training program.

With regard to ICT employment in school activities, as shown in fig4.1, 86% out of 50 claimed that the inaccessibility of computer service in the school even for teaching learning process. Students also asked to if they have access to computer service, 64.6% (disagree) and 14.6% (strongly disagree) out of 48 denied the availability of computer service for instructional purpose. This condition asserted by the researcher when observation was conducted in four selected schools. In these schools the application of computer can be said insignificant. The number of computer and its related internet service are not worth mentioning. Concerning teaching learning approach of the schools question was presented to staffs and students to understand the existing system. Accordingly, 42% out of 50 staff respondents asserted that teaching learning process is students' center whereas 58% disproved the approach as students' center approach. Similarly 58.3% and 16.7% out of 48 students' respondents refuted that teaching learning process is not student center in the school *(see annexed table A4 & A5).*

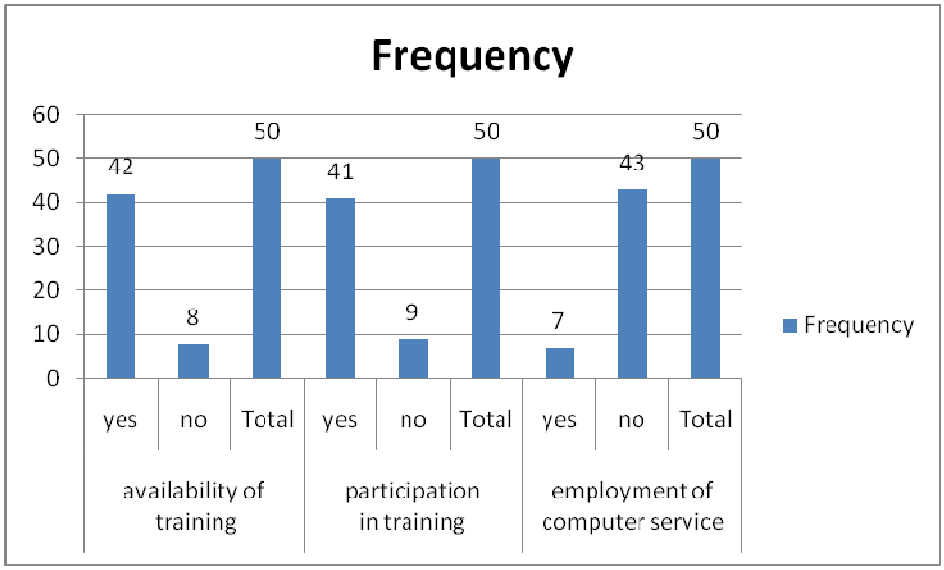

Fig 4.1 Respondents' view toward teacher training and employment of computer service
Source: own survey, 2011

4.3.1.2 Awareness on decentralization

To assess the awareness of respondents about good governance, 'do you define (know) the principle good governance?' was forwarded. The response was very encouraging. From table 4.13, 86% of the staff respondents stated that they have knowledge on (knowhow) principle of good governance. This indicates that the research participants had good awareness on governance elements: accountability, transparency and participation. But when asked these respondents (i.e. 86%) "Is there good governance practice in your school?" 66% of them stated absence good governance in their school. Their reasons were: lack of participatory approach (i.e. 45%), slight information flow (transparency) (i.e. 21.1%), no clear accountability of the officials (i.e. 18.2) and no public response (i.e. 15.2%) *(see annexed table A6).*

From table 4.4, as it has been observed, 90% of out of 50 staff respondents claimed that education service is decentralized in their school. This also supported by majority students (as service receivers), that is 77.1% out of 48 confirmed that education service being decentralized in their school *(see annexed table A8).* When asked question "Does decentralization improve education service delivery?" 70% of staff respondents asserted positive outcome of decentralization in the school performance. Some of the positive outcomes affirmed by respondents were: improve quality education and access to education (i.e. 45.7%), brings consensus on decision making process (i.e. 31.4%), make school activities transparent (open information flow) (i.e. 14.4%) and empower teacher on their activities. Contrary to this 30% out of 50 respondents refuted by underline the following: the presence of high level of interfere from the top management (i.e. 40%), the system is top down approach (i.e. 33.3%), the school has no power to decide (i.e. 13.3%) and the school has no adequate financial resources which made it incapable to decide (i.e. 13.3%) *(see annexed table A08 & A09).*

Table 4.4 Respondents awareness about decentralization

No.	**description**	**value**	**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
1	Define good governance principle	Yes	43	**86.0**	86.0	86.0
		No	7	**14.0**	14.0	100.0
		Total	**50**	**100.0**	100.0	
2	Education service is decentralized in school	Yes	45	**90.0**	90.0	90.0
		no	5	**10.0**	10.0	100.0
		Total	**50**	**100.0**	100.0	
3	Decentralization improve educa service delivery	yes	35	**70.0**	70.0	70.0
		no	15	**30.0**	30.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

4.3.1.3 Degree of decentralization in education service

Decentralization defined interms of the level of the system at which decisions are taken. This research has considered the two aspect of decision: administrative domain and level of decision making. From administrative domain of decision making personnel management and financial resources are taken in this study. The other aspect that is level of decision making also taken into consideration as it involves appointed school board, the school principal, the department head and the teachers (OECD, 2005). According to Tegegne and Kassahun (2007) statement, decentralization holds promise for improving the delivery of public services, as citizen input (participation) and supervision (accountability) tend to enhance the responsiveness of public policies, especially in the social arena.

The national education policy emphasizes decentralization for quality education service improvement. Therefore schools at regional level are organized in self directed manner to improve their service delivery. This condition create good opportunities for schools since the system enable them to involve different interest groups in service improvement process particularly in the planning, decision, implementing and monitoring activities.

In light of the above premise, this study has tried to assess the autonomy[1] of school in making decision. The following questions were presented to assess whether schools have autonomous in decision making, staff recruitment and financial allocation. When asked "Does school direct its day to day activities in autonomous[1] (self- direct) way?" The majority of the respondents, 54% (n=27), claimed that the school direct its activities in autonomous way. Contrary to this 46% out of 50 refuted to accept the school's independent action (table 4.18). The logic behind for such response were: high level of interference from the top hierarchical level (43.5% out of 23), the school has no power to decide on school issues (34.8%) and the system is top down approach (21.7%) *(see annexed table A10)*. As shown in table 4.6, 88% out of 50 claimed that the school management unit had no authority to recruit staff. This condition explains that schools had not significant authority to employ teacher by their own bureaucratic procedures. From the interview result it has been learnt that schools' directors had complained the staffing mechanism of the city education office of the DM which has the ultimate authority to place teachers at each school. As these school principals stated the placement of teachers are not transparent, objective, do not work on priority and are not merit based. As it is mentioned in the above, participation of public or community play positive role it the improvement education service.

As indicated in table 4.5, to examine whether decentralization improved schools' financial capacity or not, the next inquiry was presented. Accordingly, the majority respondents that is 84% (n=42 out of 50) claimed that the school generate its own income but 16% out of 50 confirmed that school did not generate its own income. From 84% respondents (n=42), the following major sources of revenue are listed: various sales income from sale of grass, tree, salvage office equipments (i.e. 57.1%), income education service cost (i.e. 21.1%) such as tuition fee and student identification card replacement fee, community aid-contribution (i.e. 16.7%) and only 4.8% out of 42 stated external donors such as NGOs as sources of income *(see annexed table A11).* This situation explain that schools' annual source revenue mainly depend on sale of some salvage goods or items, education service fee and community contribution. When the total annual budget of the schools compared to

[1] *The term* ***autonomy*** *in this context refers to mandate given to school to take decision (in administrative and academic issues) without the involvement of education office, Kebele or city counsel of the DM town*

the expected expenditure, they faced with short of finance. In line with this the researcher observed the financial management system of four schools: Teklehaimanot Primary School, Dilbetigel Primary School, Teklehaimanot Secondary School and Menkorer S School. As a result, from those who asked "which unit decides the financial (budget) allocation of the school?", 64% out of 50 confirmed that financial allocation of the school performed by 'Kebele' Education and Training Board (i.e. KETAB), 20% of respondents stated that school management unit determine expenditure of schools, 12% of respondents said education office of the city as well as 4% of out of 50 claimed that budget is determined via city council *(see annexed table A12).* This shows that school's expenditure assignments run in participatory approach but next to *Kebele* education office i.e. through KETAB relatively high authority has given to school management unit. According to the KI interview made with the Menkorer secondary school principal, the budgeting system of school highly determined by KETB decision. This unit has mandate to oversight the overall financial flow of school. Every educational material, stationary such as print paper, toner, pen, pencil, cleaning materials and other facilities can be procure only after the approval of the board. The board has six or seven members that chair by the local 'kebele' chairman and the school principal serve as secretary. The KETAB plays significant role in the fundraising activities for the school.

Table 4.5 Respondents attitude toward decision making process of school

No.	**description**	**value**	**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
1	school direct its day to day activities autonomous (self- direct) way	yes	27	**54.0**	54.0	54.0
		no	23	**46.0**	46.0	100.0
		Total	**50**	**100.0**	100.0	
2	school management unit have authority to rec teacher	yes	6	**12.0**	12.0	12.0
		no	44	**88.0**	88.0	100.0
		Total	**50**	**100.0**	100.0	
3	school generate its own revenue (income), o than annual budget grant	Yes	32	**64.0**	64.0	64.0
		no	18	**36.0**	36.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

The subsequent questions were offered to evaluate whether schools management unit participate teachers, local community and civil society in decision making process. As it is depicted in table 4.6, the majority of staff respondents, 64% (n=32), claimed that the management unit of the school participate teacher in the planning and decision making process. This situation also supported by student respondents as the majority that is 70.8% out of 48 claimed that the

school involves students in the planning and decision making process *(see annexed table 13).* During the study the research has observed existence of consultation program among school's management unit (principal, vice director), students counsel and parent- teacher association particularly at King Teklehaimanot Secondary School and Menkorer Secondary School. In this program various issues were raised for discussion, action and decision.

In light of the above, staff respondents were asked "Does school involve local community in decision making in process?"76% out of 50 also claimed that the school work together with the local community in the improvement of school activities. When asked why community being involved (participated) in the school decision making process, 63.2% out of 38 replied that for financial and labor contribution, 28.9% supposed for common understanding in education service improvement and the other 7.9% stated for developing sense of belongness (i.e. ownership) in the school service delivery. Contrary to this, i.e. 24% out of 50 refuted the involvement of community in the school decision making process; their main reasons were the presence of top down approach (58.3%) and school system is not participatory (41.7%) *(see annexed table A14 & A15).* In addition to this when we examine the involvement of civil societies, 78% of the respondents affirmed that participation of civil society (i.e. NGOs) in school improvement process was insignificant. The main reasons that provided by these 78% respondents were: the school system not participatory (41.5%), follows top down approach (36.5%), give little concern to contribution of NGOs (12.2%) and the school has constraints to involve NGOs in service improvement activities (9.8%) *(see annexed table A16).* This situation affect school performance negatively particularly in the availability of fund and educational facilities such as computer, academic reference books.

When staff respondents asked, "Does the school's management unit use community input in decision making process?" 70% out of 50 refuted to confirm role of community input in planning and decision making process of the school, while the rest 30% (n=15) asserted that management unit of the school consider community input in the planning and decision making process. The major reasons that were cited (i.e. by 70% respondents) as obstacles to use community input in decision making process: top down structure of school management system (54.3%), management unit want to control the agenda (28.6%), management unit of the school do not trust community local expertise or knowledge (14.3%) and also have no time to participate community in decision making process

(2.9%). Contrary to this 58.3% (agree) and 20.8% (strongly agree) out of 48 student respondents stated that the school use student input in decision making process *(see annexed table A17 & A18).*

Table 4.6 community involvement in school activities

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	Teacher participates in school planning decision making process	Yes	32	**64.0**	64.0	64.0
		no	18	**36.0**	36.0	100.0
		Total	**50**	**100.0**	100.0	
2	local community involve in school decision making in process	Yes	38	**76.0**	76.0	76.0
		no	12	**24.0**	24.0	100.0
		Total	**50**	**100.0**	100.0	
3	Management unit use community input in school's decision making	Yes	15	**30.0**	30.0	30.0
		no	35	**70.0**	70.0	100.0
		Total	50	**100.0**	100.0	
4	Civil societies (NGOs) participate in school service improvement process?	Yes	11	**22.0**	22.0	22.0
		no	39	**78.0**	78.0	100.0
		Total	50	**100.0**	100.0	

Source: own survey, 2011

4.3.1.4 Governance value: accountability

As mentioned in literature review, decentralization improve community involvement in agenda setting and decision making process and in so doing increasing local government supervision (accountability) and responsiveness (Selee and Tulchin, 2004; Tegegne and Kassahun, 2007). Accountability is the degree to decision makers in government, private sector and civil society organizations have to explain or justify what they have done or failed to do. To assess whether this premise hold true at school level or not, variables such as responsibility description, monitoring mechanism, audit practice, report system and information flow were used as determinant indicators for accountability and responsiveness respectively.

As indicated in the table 4.7, to evaluate whether accountability issues improved in schools environment or not, the next inquiries were presented to 50 school teachers. Consequently, the majority staff respondents that is 64% (n=32 out of 50) claimed that teachers have clear description of responsibility by which they do what the school expect from them, but 36% out of 50 confirmed that school did not provide them clear description of responsibility. From similar table, 74% respondents (n=37), affirmed that the school has controlling mechanism

to hold higher officials accountable for their responsibilities. From KI interview information, it has been learned that school management unit hold responsible for their actions by ANRS Education Bureau (2004) directive, KETAB and PTA working procedure.

In regard to auditing practice of schools, two questions were asked particularly to examine expenditure performance. Consequently, an interesting result discovered. The majority of respondents that is 84% (n=42), claimed that the financial statement of the school are audited internally by at end of fiscal year. However, when asked a question "Does financial statement of the school inspected by externally auditor in accordance with required schedules?" out of 50 respondents 86% claimed that financial system of school had not been inspected by external auditor. These two contradict result shows that the absence of clarity on financial management of schools. During physical observation of four schools, the researcher observed that financial documents were not keeping in accounting principle.

With regard to reporting system of schools, most respondents 72% out of 50 stated that they report to their immediate supervisor about their activities. When we examine the time interval for reporting 55.6% out of 36 respondents said that they report daily to their immediate boss, 33.3% out of 36 cited they report weekly and the rest 11.1% cited they report to their immediate supervisor monthly. Nevertheless of this, 28% out of 50 respondents confirmed that they didn't report to their immediate supervisor. Their reasons were absence of follow up (35.7%), absence of feedback from head (21.4%), lack of clear responsibility of staff (21.4%) and report has no value adding to their teaching activities *(see annexed table A19).*

Table 4.7 Respondents attitude toward school accountability issues

No.	description	value	Frequency	Percent	Valid Percent	Cumulativ Percent
1	school's activities discharge with a clear description of responsibility	yes	32	**64.0**	64.0	64.0
		no	18	**36.0**	36.0	100.0
		Total	**50**	**100.0**	100.0	
2	There is mechanism to monitor the responsibility of management unit (higher officials) of the school	yes	37	**74.0**	74.0	74.0
		no	13	**26.0**	26.0	100.0
		Total	**50**	**100.0**	100.0	
3	financial statement of school inspected by internal auditor in accordance with required schedules	Yes	42	**84.0**	84.0	84.0
		no	8	**16.0**	16.0	100.0
		Total	**50**	**100.0**	100.0	
4	financial statement of the school inspected by externally auditor in accordance with required schedules	Yes	7	**14.0**	14.0	14.0
		no	43	**86.0**	86.0	100.0
		Total	**50**	**100.0**	100.0	
5	teachers report about their actual performance to immediate supervisor	Yes	36	**72.0**	72.0	72.0
		no	14	**28.0**	28.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

Open information flows has significant role in the enhancement of public participation and hence improve accountability issues. It is believed that only if people know what is going on, both good or bad, could they hold their government accountable (Tsegaye,2006:265). By considering this premise into account, the research assessed the condition of information flow of the schools.

According to table 4.8, the majority of staff respondents claimed that school disseminates educational information to the local community (64%). But out of 50 staff respondents 64% stated that schools do not publicize plans and decisions to community. Only 36% out of 50 claimed that the schools publicize its plan and other related decision to the public in some events such as school holiday ceremony, parent-teacher association, at students counsel meeting and at community meeting (M=1.64, SD=0.48, Std Error of mean=0.06). Similarly when respondents asked, "Does school consult citizen to ascertain citizen interest?"74% out of 50 affirmed that schools management units do not consult community to ascertain their interest in the decision making process. This indicates that schools management units slightly consult community to determine or to consider their interest in the decision making process (M=1.74, SD=0.44).

Table 4.8 response on transparency and community involvement issues

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	school disseminate information to community	Yes	18	**36.0**	36.0	36.0
		no	32	**64.0**	64.0	100.0
		Total	**50**	**100.0**	100.0	
2	school publicize plans and decisions to community	Yes	18	**36.0**	36.0	36.0
		no	32	**64.0**	64.0	100.0
		Total	50	**100.0**	100.0	
3	school consult community to ascertain citizen interest	Yes	13	**26.0**	26.0	26.0
		no	37	**74.0**	74.0	100.0
		Total	50	**100.0**	100.0	

Source: own survey, 2011

4.3.2 Decentralized Health Service Delivery

As Bankauskaite and Saltman (2007:16) stated decentralization empowers local administration, increase accountability, increase quality of health services and increase equity (as quoted in Alemayehu, 2009:17-18). Decentralization gives freedom to the health service providers to arrange payment scheme according to ability with special assistances mechanisms for those who cannot afford to pay (Alemayehu, 2009:4).

According to Mills (1990) cited in Lijalem (2008) decentralizing health service include improved implementation of health programs, improved equity, greater community financing and involvement of local communities. In this study the impact of decentralization on health service delivery has been assessed by taking into account the following variables: quality indicator, degree of autonomy, community participation and accountability issues.

4.3.2.1 Health service effectiveness (quality indicators)

The efficiency and quality of health has been assessed based on the country health policy standard. From the transitional government health policy document, health service shall be provided based on democratization and decentralization system and for the development of the preventive and promotive components of health care. The policy underlines on the development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources. Thus the following are taken as indicator variables for standard service delivery among others: population to health center ratio, population to health station ratio, health officer to population, nurse to population ratio, health officer training, and utilization of ICT in health service and community involvement. These ratio is taken as standard in this research to assess the performance of DMHC and HHC. The national standard according to HSDP IV strategic document (2010) is: physician-population ratio (1:36,158), health officer –population ratio (1:48,451), Nurse-population ratio (1:3,870), Mid-wives –population ratio (1:56,427) and health extension worker –population ratio (1:2,301). This standard has been considered for effective health service treatment.

Asked a question “are there adequate health professionals in this center in this school?”, as it is depicted in table 4.9 most of the respondents 72% (n=36) claimed the prevalence of shortage of health worker in the center. These respondents reasoned out the following factors that were perceived as cause for manpower deficiency in the center: financial constraint of the center that hinder to hire health personnel in desired amount (41.7%), the presence of turnover for the sake of better salary (36.1%), unfavorable working environment of the center that discourage employee to work the center (19.4%) and scarcity of health workers in the local market to fill the vacant post as soon as possible (2.8%) *(see annexed table B1).*

This condition has confirmed from Debremarkos town statistical report (2010:42). According to this report health center to population ratio which is 1:64611, health station to population ratio (i.e. 1:900), nurse to population ratio (i.e. 1:2020), health officer to population ratio (i.e. 1:19,384), sanitarian to population ratio (i.e. 1:19384), medical laboratory technician to population ratio is 1:19384, pharmacy technician to population ratio (i.e. 1:7180) and health assistant to population ratio

(i.e. 1:16153). This is why most respondents that are 82% out of 50 claimed that they examine above 75 clients and 28% out of 50 said that they are visited on the average from 51 to 75 patients in a day. This state also affirmed by 52.5% (agree) and 30.0% (strongly agree) out 40 health service receivers by stating that many patients available in a day to get proper treatment in the health center. In line with this beneficiaries asked if they spent a lot of time in queue to get health services in centers. Accordingly most of them (75%) claimed that they spent a lot of time to get treatment from the centers. This why most health service beneficiaries that is 47.5% and 10% out of 40 denied that the health center do not provide better treatment to patients. But the rest that is out of 40, 35% (agree) and 7.5% (strongly agree) stated that the health centers provide better treatment to its clients.

When staff respondents asked, "Is health service treatment delivered with reasonable cost in this center?" only 42% out of 50 claimed that the center's treatment cost as reasonable while the majority 58% (n=29) refuted this reasonable fee. The respondents' (i.e.58%) reasons were: the fee is cheap when compare to private clinics (48.3%), health service treatment delivered with low cost (34.5), it makes health center's financial budget inadequate (10.3%) and the health center makes no recovery from their cost (6.9%). On the other hand the majority (that is 60% who agree and 7.5% who strongly agree) of health service beneficiaries perceived the treatment cost (fee) as reasonable, the rest refuted to consider the fee as reasonable *(see annexed table B2 & B3)*

With regard to facilities of health service, the condition of medical laboratory and pharmacy center were assessed. Accordingly 84% out of 50 confirmed that the health center has equipped with adequate laboratory kits. Contrary to this 90% of the staff respondents claimed that clients (or health service beneficiaries) do not get prescribed drugs in the health center's pharmacy. Health service beneficiaries were also asked if they get prescribed medicine (drugs) from the health centers or not, the majority that is 55% and 7.5% out of 40 confirmed the unavailability of medicine in the health centers' pharmacy *(see annexed table B4).*

Table. 4.9 Indicators for quality health service delivery

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	there is adequate health professionals in the center	yes	14	**28.0**	28.0	28.0
		no	36	**72.0**	72.0	100.0
		Total	**50**	**100.0**	100.0	
2	Number of clients (customers) you serve in a given day (in number)	from 51 to 75	9	**18.0**	18.0	18.0
		above 75	41	**82.0**	82.0	100.0
		Total	**50**	**100.0**	100.0	
3	there are medical equipments such as medical laboratory kits in the health center	yes	42	**84.0**	84.0	84.0
		no	8	**16.0**	16.0	100.0
		Total	**50**	**100.0**	100.0	
4	beneficiary get medication (drug) in the health center's pharmacy	Yes	5	**10.0**	10.0	10.0
		no	45	**90.0**	90.0	100.0
		Total	**50**	**100.0**	100.0	
5	health service treatment is delivered in reasonable cost?	Yes	21	**42.0**	42.0	42.0
		no	29	**58.0**	58.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

Staff respondents were asked question “does the health center utilize information communication technology (computer) in its daily services delivery?” in order to assess whether health centers utilize information communication technology in health service delivery. As indicated in figure 4.2 the majority of the respondents, 70% (n=35), claimed that the inaccessibility of computer service in the health center. This is asserted by the researcher when observation had conducted in two selected health centers. In these health centers the application of computer not worth mentioning. The number of computer and its related internet service are not worth mentioning.

When asked “Is there various training program for upgrading health worker in the health center?” 84% out of 50 asserted that availability of various upgrading training program for health worker as well as most of the respondents (84% out of 50) affirmed that they participated various training programs. To assess the relevance of such upgrading training programs to health workers, respondents were asked to rate it’s significant to their career development. Accordingly 45.2% out of 42 rated training programs as *good*, 2.4% out of 42 rated as *very good* and 52.4% rated as *poor*. When asked respondents why they perceived the training program as *poor*, 48.1% of them stated that the training programs were not their professional interest, 29.6% out of 27 claimed that

the training programs were not significant to their career development, 18.5% of these respondents felt that the not prepared well and the rest 3.7% claimed that the programs were not clearly stated *(see annexed table B5, B6 & B7).*

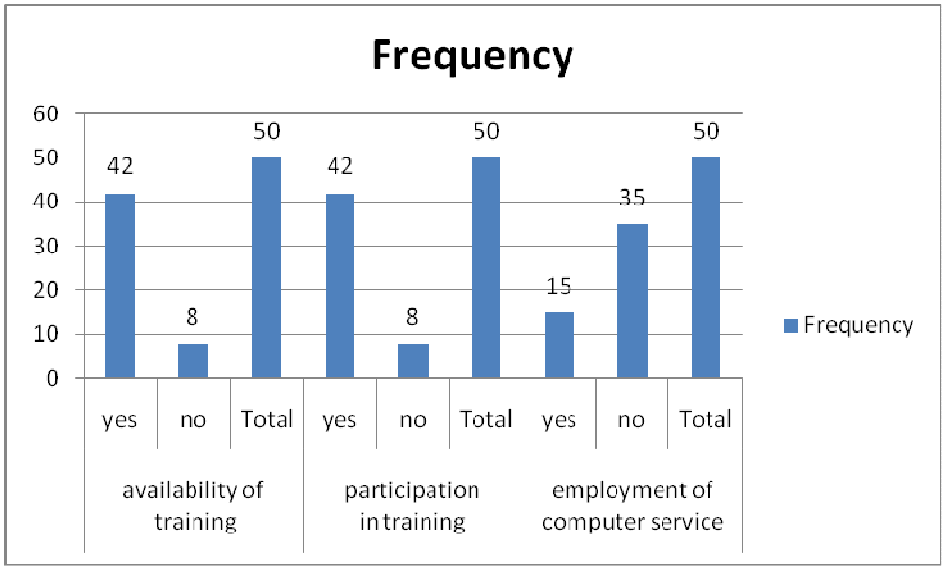

Fig. 4.2 responses on staff development and ICT issues

Source: own survey, 2011

Number of respondents

Description

4.3.2.2 Awareness of decentralization

To assess the awareness of respondents about good governance, "do you define (know) the principle good governance?" was forwarded. The response was very encouraging. From table 4.10, 72% out of 50 respondents stated that they have knowledge on (knowhow) principle of good governance. This result indicates that the research participants relatively had good awareness on governance principles: accountability, transparency and participation (M=1.28, SD=0.45, V=0.20). But when asked these respondents (i.e. 72%) "Do you think the health center work as according governance principles?" 69.4% of them stated that governance principle nonexistence in their health center. Their reasons are: lack of participatory approach (i.e. 64%), no open information flow (transparency) (i.e. 20%), no public response (i.e. 12%) and no clear accountability of the officials (i.e. 4%) *(see annexed table B8).*

From similar table, as it has been observed, 86% of out of 50 claimed that health service is decentralized in their center. To assess whether health service beneficiaries understood service delivery is decentralized or not, the majority (60%=disagree and 10%= strongly disagree) out of 40 responded health service did not decentralized. This statistics report shows that staff respondents have slight low variation on the awareness of decentralization (M=1.14, SD=0.35, V=0.12) than health service beneficiaries that showed relatively high variation (M=3.22, SD=1.05, V=0.12) *(see annexed table B9).* And when staff respondents asked about their attitude toward empowerment of worker to make decision in health service delivery, 79.1% out of 43 refuted that decentralization do not improve health workers' decision making activities whereas 20.9% (n=9) of the respondents, on the other hand, claimed the positive role of decentralization on empowerment of worker to make decision. When asked a question, "Does decentralization improve health service delivery?" 84% out of 50 respondents asserted positive change of decentralization in the health service delivery. The major reasons that were perceived the role of decentralization positively were: improve quality and access to health service (45%), develop common understanding on decision making process (23.8%), makes the health center's activities transparent or open (21.4%) and empower health personnel (9.5%). Contrary to this 16% out of 50 respondents refuted that positive role of decentralization in health service delivery. These respondents (16%) reasoning out the following: interference from higher government body (i.e. 62.5%), the health center management follows top down approach (i.e. 25%) and the health center has no power to make decision on its day to day activities (i.e. 12.5%) *(see annexed table B10 & B11).*

Table 4.10 Staff awareness on decentralization

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	Define good governance principles	yes	36	**72.0**	72.0	72.0
		no	14	**28.0**	28.0	100.0
		Total	50	**100.0**	100.0	
2	Health service is decentralized in the center	yes	45	**90.0**	90.0	90.0
		no	5	**10.0**	10.0	100.0
		Total	50	**100.0**	100.0	
3	Decentralization improve health service delivery	yes	42	**84.0**	84.0	84.0
		no	8	**16.0**	16.0	100.0
		Total	50	**100.0**	100.0	

Source: own survey, 2011

4.3.2.3 Degree of decentralization in health service

The following questions were presented to assess whether health centers have autonomous in decision making, staff recruitment and financial allocation. When respondents asked, "Does health center direct its day to day activities in autonomous[2] way?" The majority of the respondents, 58% (n=29), stated that the health center do not direct its day to day activities in autonomous way. Contrary to this 42% out of 50 claimed that the health center performs its activities independently (table 4.11). The logic behind for such response were: high level of interference from the top hierarchical level (44.5% out of 29), the system is top down approach (41.4%), the health center has no power to decide (6.9%) and the health center has no adequate financial resources (6.9%) *(see annexed table B12).*

As shown in table 4.11, 76% out of 50 claimed that the health center management unit has authority to recruit staff. This condition explains that health center has significant authority to employ health worker by their own bureaucratic procedures. From similar table 4.15, to examine whether decentralization improved health center financial capacity or not, the next inquiry was presented "Does health center generate its own revenue (income), other than annual budget [2]subsidy/grant?" Accordingly, the majority respondents that is 86% (n=44 out of 50) claimed that the health center generate its own income but 14% out of 50 confirmed that health center has no its own income. From 86% respondents (n=44), the following major sources of revenue were listed: health service fee (i.e. 58.1%), external donor (i.e. 32.6%), community aid (contributions) (i.e. 4.7%) and only 4.7% out of 44 stated that sources of revenue from sale of various materials *(see annexed table B13).*

When asked "which unit decides the financial (budget) allocation of the health center?", 48% out of 50 staff respondents confirmed that financial allocation of the center performed by management unit, 24% of respondents stated that health office of the city determine financial allocation, 20% of respondents said city council decide the allocation of annual budget as well as

[2] *The term **autonomy** in this context refers to mandate given to health center to take decision (in administrative issues) without the involvement of health office, Kebele or city counsel of the DM town*

8% of out of 50 claimed that the health center budget is determined by community *(see annexed table B14).*This shows that the financial allocation of the health center determined by the management unit and DM health office. According to the KI interview made with the Debremarkos health center head, the budgeting system of center highly determined by management unit decision. This unit has mandate to oversight the overall financial flow of the center. Every medical material, stationary such as print paper, toner, pen, pencil, cleaning materials and other facilities can be procure only after the approval of the management unit.

Table 4.11 Respondents attitude toward decision making process

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	health center direct its day to day activities autonomous (self- direct) way	yes	21	**42.0**	42.0	42.0
		no	29	**58.0**	58.0	100.0
		Total	**50**	**100.0**	100.0	
2	health center management unit have authority recruit health personnel	yes	38	**76.0**	76.0	76.0
		no	12	**24.0**	24.0	100.0
		Total	**50**	**100.0**	100.0	
3	health worker participate in planning and decis making process	Yes	13	**26.0**	26.0	26.0
		no	37	**74.0**	74.0	100.0
		Total	**50**	**100.0**	100.0	
4	health center generate its own revenue (income)	Yes	43	**86.0**	86.0	86.0
		no	7	**14.0**	14.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

As mentioned in the above, participation of public or community play positive role it the improvement health service. Therefore the subsequent questions were presented to evaluate whether health center management unit participate health worker, local community and civil society in decision making process.

As it is depicted in table 4.12, the majority of the respondents, 76% out of 50 stated that health workers do not participate in decision making process. 72% out of 50 respondents also claimed that the health center does not involve local community in the planning and decision making process. This situation was also confirmed from health service beneficiaries responses' (n=40), since the majority 52.5% (disagree) and 12.5% (strongly disagree) stated that health center did not participate community in the planning and decision making process. The other 35%

out of 40 perceived that the center decision making process done with the community involvement *(see annexed table B15).*

When respondents asked, "Does health center management unit use community input in decision making process?" 74% out of 50 refuted to confirm use of community input for decision making process in the health center, while the rest 26% asserted that management unit of the health center consider community input in the decision making process. The major reasons that were cited (i.e. by 74% respondents) as hindrance to use community input in decision making process: top down structure of health center (28.6%), management unit want to control the agenda (31%), management unit do not trust community local expertise or knowledge (11.9%), have no time to participate community in decision making process (21.4%) and also community has no time to participate (7.1%). This result was confirmed from 40 beneficiaries' responses. From these 40 respondents 47.5% were disagreed, 15% were strongly disagreed on the proposition the use of community input in the decision making process of the center. This statistical result explains that the management unit hardly use community input in the planning and decision making process. On the other hand when we examined the involvement of civil societies in the health center, 70% out of 50 respondents affirmed that the health center participate civil society (i.e. NGOs) in considerable manner for its service improvement activities.

Table 4.12 community involvement in health service center

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	health center involve local community in planning and decision making in process	Yes	14	**28.0**	28.0	28.0
		no	36	**72.0**	72.0	100.0
		Total	**50**	**100.0**	100.0	
2	health center's management unit use community input in decision making	Yes	8	**16.0**	26.0	26.0
		no	42	**84.0**	74.0	100.0
		Total	**50**	**100.0**	100.0	
3	health center participate civil society (NGOs) in service improvement process	Yes	35	**70.0**	70.0	70.0
		no	15	**30.0**	30.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

4.3.2.4 Governance value: accountability

Decentralization improve local government supervision (accountability) and responsiveness (Selee and Tulchin, 2004; Tegegne and Kassahun, 2007). To assess whether this premise hold true in health centers or not, variables such as responsibility description, monitoring mechanism, audit practice, report system and information flow were used as determinant indicators for accountability. As indicated in the table 4.13, to evaluate whether accountability issues improved in the health center or not, the next inquiries were presented to 50 health personnel. Consequently, the majority respondents that is 58% (n=29 out of 50) claimed that health professionals have clear description of responsibility by which they do what the health center expect from them, but 42% out of 50 confirmed that center do not provide them clear description of responsibility.

From similar table, 68% respondents (n=34), affirmed that the center has controlling mechanism to hold higher officials accountable for their responsibilities. According to staff respondents 52.9% claimed that management unit hold responsible for their actions by health center's directive that is working procedure, 'gimgema' (self critics program) (29.4%) and by reporting to higher level official. In regard to auditing practice, two questions were asked. Consequently, an interesting result discovered. The majority of respondents that is 82% (n=41), claimed that the financial statement of the centers are audited internally at end of fiscal year. However, when asked a question "Does financial statement of the school inspected by externally auditor in accordance with required schedules?" out of 50 respondents, 66% claimed that financial system of center were not been inspected by external auditor. These two contradict result shows that the absence of clarity on financial management of schools. During physical observation of the two health centers, the researcher observed that their financial documents were not kept in accordance to accounting principle. With regard to reporting system of center, 50% out of 50 respondents stated that they report to their immediate supervisor about their activities. The other 50% out of 50 respondents confirmed that they do not report to their immediate supervisor. Their reasons were absence of follow up (32%), absence of feedback from head (36%), lack of clear responsibility of staff (12%) and report has no value adding to their health service delivery activities (20%) *(see annexed table B16).*

Table 4.13 Respondents attitude toward health center accountability issues

No.	description	value	Frequer	Percent	Valid Percent	Cumulative Percent
1	Health center's activities discharge with a clear description of responsibility for its professional	yes	21	**42.0**	42.0	42.0
		no	29	**58.0**	58.0	100.0
		Total	50	**100.0**	100.0	
2	There is mechanism to monitor the responsibility of management unit (higher officials) of the health center	yes	34	**68.0**	68.0	68.0
		no	16	**32.0**	32.0	100.0
		Total	50	**100.0**	100.0	
3	financial statement of the health center inspected by internal auditor in accordance with required schedules	Yes	41	**82.0**	82.0	82.0
		no	9	**18.0**	18.0	100.0
		Total	50	**100.0**	100.0	
4	financial statement of the health center inspected by externally auditor in accordance with required schedules	Yes	17	**34.0**	34.0	34.0
		no	33	**66.0**	66.0	100.0
		Total	50	**100.0**	100.0	
5	health professionals report about their actual performance to their immediate supervisor	Yes	25	**50.0**	50.0	50.0
		no	25	**50.0**	50.0	100.0
		Total	50	**100.0**	100.0	

Source: own survey, 2011

According to table 4.14 it has been learned that health centers disseminate health related information to local community (80%). In addition to this out of 50 respondents 80% stated those health centers do not publicize plans and decisions to public. Only 20% out of 50 claimed that the health centers publicize its plan and other related decision to the public. In the same way when respondents asked, "Does health center consult citizen to ascertain citizen interest?" 70% out of 50 affirmed that health center do not consult citizen in decision making process. This indicates that health activities performed with minimum citizen involvement or participation.

Table 4.14 Respondents attitude toward transparency issues

No.	description	value	Frequency	Percent	Valid Percent	Cumulative Percent
1	Health center disseminate information to public	Yes	40	**80.0**	80.0	80.0
		no	10	**20.0**	20.0	100.0
		Total	50	**100.0**	100.0	
2	Health center publicize plans and decisions to public	Yes	10	**20.0**	20.0	20.0
		no	40	**80.0**	80.0	100.0
		Total	50	**100.0**	100.0	
3	Health center consult community to ascertain citizen interest	Yes	15	**30.0**	30.0	30.0
		no	35	**70.0**	70.0	100.0
		Total	50	**100.0**	100.0	

Source: own survey, 2011

4.3.3 Major problems identified in education and health service delivery

Theoretically, as mentioned in literature reviews, decentralization improves the provision of basic services by creating effective and efficient mechanisms for the involvement of community and other stakeholders in the planning, monitoring and decision making process. And the involvement of community in the local government decision making process is believed to develop governance values: accountability and transparency among others. However in reality, as decentralization is not a panacea for all poor service delivery, various constraints occurred in service delivery. Thus under the study, decentralization practice of six local governmental institutions studied to determine its impact on service delivery. The research has identified some major problems of these institutions that hinder effective service delivery. From the physical observation, document examination and interviews result of six government institutions the following problems are identified and presented here under.

4.3.3.1 Problems identified in education service delivery

Decentralized education services improve transparency, accountability, participation, the quality and accessibility of services and hence delivered efficient services (UNESCO, 2005). Educational decentralization involves transfer of decision making powers form the central ministry of education to intermediate government, local governments, communities and schools (USAID, 2005). Decision making process of educational institutions should be transferred to lower layers such as primary and secondary schools by sharing responsibilities with community.

- **<u>Poor physical conditions of the schools</u>**

In teaching learning process several factors should be considered to create conducive environment. To list some of these: availability of school facilities (such as communication, electricity, water, first aid, toilet, teacher and student lounge), conditions of the physical building of classrooms, presence of teaching learning materials such as teaching aids, administrative materials such as toner, paper, and other stationary materials. These factors determine the general conditions of schools.

- ✓ According to observation conducted in four educational institutions: Dilbetigel Primary School, King Teklehaimanot Primary school, King Teklehaimanot Secondary School and Menkorer Secondary School, only the last one has favorable building to carry on teaching learning process. The physical conditions of the rest three (i.e. DPS, KTPS and KTSS) are not conducive for teaching learning process. The schools' sections are too old that threat for dilapidation. And hence this condition may threat the life of students and teachers who prime become possible victims for accidents. By considering this into account the researcher made discussion with teachers, students, parents and school principals particularly at KTPS and KTSS. As a result the researcher documented the school community perception (teachers, students, principals and parents) toward the dilapidated condition of their schools. Most of the school community especially teachers hold the school principal as liable for not taking active actions in solving this conditions. Some students who worked in students counsel as member said that the school management as accountable for not considering this case as a serious problems. In this regard important lesson have been learnt from KTSS principals interview conducted. The interview result with KTSS principal presented in the following box 1.

Interview made with Ato Ayesheshum Ayenew (principal of KTSS)

Q1- How do you express the physical condition of your school?

Ans: Well! The school (KTSS) has involved in teaching learning process for above 50 years. As you observe, the physical condition of our school is very terrible to carry on teaching learning activities. Currently the classrooms are not only too old but also narrow ones (that is below 6.2mx7.26m=50.25m^2) which makes teaching learning activities to be carrying out in harsh situation. We, therefore, have threat for unexpected accident that may hurt members of the school community.

Q2- If so, what proactive measures does the school management has taken to avoid such threat?

Ans: Indeed the school management had made various efforts to renovate the building. To name some of these: since the situation is above the financial capacity of the school, we report to education office of the town, city counsel of DM, to PTA, to KETAB, to the community and even to students counsel. In addition to this to make the renovation real, the school prepared various events to collect money from the community and other interest group. Nevertheless of these efforts, the school still couldn't get adequate financial resources to make construction activities. However, currently new classrooms are being constructed by education office of DM town. This office controls the overall activities of the construction. Unfortunately due to various reasons, this construction could not be completed with specified time. Generally when we come to the issue, we only have notified those active actors (teachers and students) to be aware of the situation to take precaution and in this year we have budgeted 100, 00.00 ET Birr to maintain minor damages such as doors, windows, electricity line, water line, ruined the floor and ceiling of sections, broken chairs and tables.

Box -1. Physical built conditions of school

- ✓ These educational institutions: Dilbetigel Primary school, King Teklehaimanot Primary school, and King Teklehaimanot Secondary School have no office for department heads and teachers. Furthermore these schools do not provide adequate library service, computer

service and science laboratory demonstration effectively. This condition makes teaching learning process conducted within unfavorable environment.

- **<u>Lack of efficiency and quality schools service delivery</u>**

In the study the effectiveness of the four schools (i.e. KTSS, KTPS, DPS and MSS) in education service delivery were assessed using the following variables: student-teacher ratio, student-textbook ratio, student-class (i.e. number of students in a class), rate of drop out, rate of repetition, teacher training, student center approach and parent (community) involvement in the education service. Consequently the following problems are identified:

- ✓ **poor quality student-teacher ratio, student-textbook ratio and student-class ratio**

According to MoE (2010) policy, teacher to student ratio should be in 1:25 ratio. However, in the selected four schools, the study has identified the inadequate number of teachers when compare to student population. Because of this constraint, teacher load become on average 24 periods. Even students-text book ratio shows improvement still the distribution is not one to one. The study has identified that student text book ratio was beyond the standard; it has been recorded as one to four. Similarly the number of students per section determines quality education service. Accordingly the research identified that students-section ratio of the schools were beyond the national standard (i.e. 1:40).

- ✓ **High student drop out rate and repetition rate**

The study assessed whether the efficiency of schools performance in terms of student repetition and drop out rate improved or not. As a result repetition rate of students were high. The repetition rate of student increased 1.5% in 2001 E.C to 8 % in 2002 E.C in grade 9 and from 0.8% in 2001 to 1.8 % in 2002 grade 10. Similarly student school drop out rate was increased by more than 100% in grade 9 and grade 10.

- ✓ **Inaccessibility of information technology (IT)**

The national education policy of Ethiopia has taken emphasis on the employment of information communication technology for service improvement (MoE, 2002). Nevertheless of this, when observation was conducted in four schools, the researcher observed that the absence of meaningful employment of computer service in teaching learning process. At In these four schools, the number of computer is very low (i.e. one or two) that limited for administrative clerical activities and internet service are not acknowledged at all. This situation may hinder teaching learning process of schools as teachers are expected to upgrading their knowledge and skills by acquainting themselves with new technology application.

- ✓ **Teaching learning process is hardly student center**

From questionnaires responses and KI interview result, it has been learned that the schools teaching learning processes difficult to define as students center.

- ➢ **<u>Degree of decentralization</u>**

The national education policy of the country emphasized decentralized education service to improve service by recognizing the diverse culture, needs of its citizens, the importance of local resources mobilization, and effective implementation of the central policy. In this regard the study assessed the performance of the four schools interms of schools' autonomy in decision making, staff recruitment, community involvement and financial allocation. Consequently the following problems identified:

- ✓ **school has no authority to recruit teacher**

According to KI information (Ato Aschale Adamu), the schools have no authority to recruit teachers by their own. He said that such mandate has been given to DM education office by higher governmental organ namely education bureau of the region. This office performs administrative task such as promotion, demotion, salary scale and transferring. In these activities schools roles are only limited to report the manpower demand to the office. As the DM education

office does not act promptly for administrative routines, some constraints have created on schools performances especially in filling the vacant post. In our school (KTSS), for instance, we requested the office to employ two science teachers but still no action taken. This in turn has made teachers to be overloaded or burden in covering the courses. Furthermore the placement of teachers is not transparent, objective, do not work on priority and are not merit based.

- ✓ **The school do not use community input in decision making process**

In principle within decentralization framework power and resources transfer to school to make decisions and work with community, civil society (NGOs) and other interest groups. In the study it has been identified that the local community involvement in education services activities has been improved. But according to staff respondents' views dues to the existence of top down approach in education service delivery schools do not use community input in the decision making processes. The education office of DM forwards its agenda and controls the implementation.

- ✓ **Little involvement of civil society (NGOs)**

The participation of non governmental organizations for the improvement education service should not be understated. Such organizations, for instance: FFE, HAPCO could play positive roles in the empowerment, in the assistance (financial or materials), on awareness creation for voluntary counseling and testing of HIV/AIDS and teacher training program. According to KTPS v/principal information, some NGOs such as FFE, OSSA, Global Fund, World/EMSP, HAPCO, work with schools to help vulnerable students/ children/, create awareness on HIV/AIDS and family planning issues, support students who score low academic performance and empower female students. Nevertheless of this, the participation and inter relationship of such organizations with these four schools have been found poor. According to staff respondents' views the schools have made passive movement to involve and work together with such NGOs in the improvement process.

- ✓ **Inadequate financial capacity**

According to MSS Principal Information, the financial capacity of the school is inadequate. The school collect its revenue from various sources: mainly from government grant budget, community contributions, student ID fee, student certificate issuance fee and some from sale of grass, tree and salvage goods. However these sources couldn't cover the total expenditure of the school.

- **Low governance value: accountability**

Accountability is one of the governance values in which local government officials shall explain or justify what they have done or failed to do. When the research assessed description of responsibilities, audit practice, reporting system, information flows and public consultation programs of the four schools, the following problems were indentified:

- ✓ **Lack of clear description of responsibility for its professional**

Although the majority staff respondents claimed that teachers have clear description of responsibility by which they do what the school community expect from them, some stated that the absence of clear description of responsibility. This shows that the schools' performance being positive on organization of description of responsibility for its professional. But as the managerial practice of the schools expressed as top down approach, discharging of teachers are expected from the higher layer. This situation may discourage effective and active participation of teacher in various school tasks.

- ✓ **Poor financial management system**

In the research financial management of the schools were assessed in line with expenditure assignment and auditing practice in order to determine the condition of accountability. Consequently, based on the staff respondents' statement even if the financial statement of the school being annually audited internally, it had not been inspected by external auditor annually for long time. In addition to this from physical observation of the four schools, it has been found that their financial management method was out of date, not harmonized with

modern accounting principle. When the annual revenue (income) and expense conditions of the schools studied, the following problems were identified: lack of clarity on financial record to explain how much earned in the last four years, nonexistence of annual statistical report that indicate percentage growth or reduction and absence of documents that indicate sources income. This condition makes the financial expenditure of the school lack clarity and risk for petty corruption.

- ✓ **Schools slightly publicize plans and decisions to community**

In principle decentralization recognizes the diverse needs of community and makes possible active involvement of citizen on various developmental issues. In a decentralization framework, community participation in planning, monitoring and decision making process has to be taken as a critical factor for effective and quality service delivery as well as for service improvement. Thus education institution i.e. school has to make its plan and decision known to the community. However the research revealed (i.e. according to the majority response) that those schools slightly publicize their plans and decisions to community.

- ✓ **Schools do not consult community to ascertain their interest**

In those four schools, according to staff respondents' perception the management unit does not consult community to ascertain their interest. According to KI discussion, as the structure of education institution is top down approach, the management unit of the school remains undecided to consult community by its own initiative. As KI quoted ‘’the school management unit will act only if the ‘agenda’ forwarded by education office”. This may be the main reason why this unit has refrained to consult community since it lack adequate power or resources to answer or to address their interest. This situation makes difficult to mobilize community voluntarily.

4.3.3.2 Problems identified in health service delivery

As mentioned in literature review, decentralization empowers local administration, increase accountability and participation, increase quality and hence improve efficient health services delivery (Bankauskaite and Saltman, 2007:16, Mills, 1990). In the study, the efficiency and quality of health service delivery were assessed based on the country health policy indicators: population to health center ratio, population to health station ratio, health officer to population, nurse to population ratio, health officer training and governance value: community involvement in decision making, level of decentralization, accountability and transparency. Accordingly in this research the following major problems were identified, among others. These are:

- **<u>Lack of efficiency and quality health service delivery</u>**

In the study the effectiveness of the two health centers (i.e. DMHC, and HHC) in health service delivery were assessed using the following variables: population to health center ratio, population to health station ratio, health officer to population, nurse to population ratio, health officer training and community involvement. Consequently the following problems are identified:

- ✓ **Inadequate number of health professional to health beneficiary ratio**

In two health centers (i.e. DMHC and HHC), the study assessed population to health center ratio and health worker to population ratio. Based on the information found in DM town statistical report (2010) and KI interview, the two health center has to serve high number of beneficiaries (patients) with minimum number of health professionals. To aggravate this condition, health workers resign for the sake of better salary and good working environment. This is why most staff respondents claimed that they examine high number of patients that ranges from 51 to 75 on average. This is why most patients have to spend a lot of time to get treatment from the centers.

- ✓ **Inadequate medication (drug) in the health center's pharmacy**

According to staff respondents' statement, clients (or health service beneficiaries) do not get prescribed drugs in the health center's pharmacy. This is also was confirmed from health service beneficiaries whether they get prescribed medicine (drugs) from the health centers or not, the majority confirmed that the unavailability of medicine in the health centers' pharmacy. Thus health service receivers forced to find drugs from private pharmacy centers by which they incurred for higher cost.

- ✓ **Inadequate financial capacity and low health treatment cost**

In principle decentralized health service delivery promote health center to design various payment scheme according to the ability of patient. In line to this the study assessed the financial conditions of the two centers. Accordingly as most staff respondents stated the health center designed special cost for poor, HIV/AIDS counseling and testing and mother –child treatment services. These services have been delivered with insignificant cost. Health service receivers confirmed that such payment scheme as reasonable cost that help them in getting health services. This situation, however, according to staff respondents' perception such payment scheme are not reasonable since reduce the center's financial budget and hence affect recovery from their cost.

- ✓ **Inaccessibility of information technology (IT)**

The employment of information communication technology for health service improvement is worth mentioning in this study. Some of the benefits of ICT in health services delivery are: for identification of patient case, financial management, planning and budgeting activities, handling staff and health beneficiary profile and preparing accurate report. Nevertheless of this, when observation was conducted in two health centers, the researcher observed that the absence of meaningful employment of computer service in health service delivery. At In these two centers, the number of computer is very low (i.e. one or two) that limited for administrative clerical activities and internet service are not acknowledged at all. This situation may hinder health service delivery as health personnel are expected to upgrading their knowledge and skills by acquainting themselves with new technology application.

- ✓ **Poor quality of training program**

According to staff respondents, who participated, the training program were not their professional interest, significant to their career development, not prepared well and clearly stated.

- ➢ **<u>Degree of decentralization</u>**

Decentralized health service delivery recognizes diverse culture and needs of its citizens as well as the importance of local resources mobilization. In this regard the study assessed the performance of the two health centers interms of health center autonomy in decision making, staff recruitment, community involvement and financial allocation. Consequently the following problems identified:

- ✓ **Little autonomous (self- direct) of the health centers**

According to KI information, the health centers have little autonomous to direct their administrative issues particularly in the procurement activities. Some of the reasons the KI quoted were: high level of interference from the top and usually decision made on top down approach. She said that although the health centers have mandate to propose what to be procured, decision made only from the DM health office or the health centers management board. As these units do not act promptly for such administrative routines, some constraints have created on health service performances especially in getting medicine and other related materials at the right time to the right person. This condition has also intricate with long bureaucratic chain which ultimately makes the health centers to provide inefficient service. In this regard important lesson have been learnt from DMHC head interview conducted. The interview result with DMHC head presented in the following box 2.

Interview made with W/ro Mastewal Sinshaw
(Administrative and finance process owner of DHC)

Q1- Is health service delivery decentralized at your center?

Ans: Yes! Health service at DM is decentralized.

Q2- If so, does the center run its activities in autonomous way? What outcome brings to health services?

Ans: The health center has partial mandate (fifty- fifty percent) in running its activities; meaning that the condition of health service delivery of the center equally affected by DM health office. The health center has mandate to perform procurement and staff recruitment activities without the health office interference. Because of decentralization, the health center able to generate its own income (revenue). This revenue collected from various sources: health service cost, government budget and donation. The DM health office, however, has power in the allocation of governmental budget. This office informs us by sending an internal memo to act accordingly. Nevertheless of this, in DM town financial flows controlled and regulated by economic and development office using a 'pooling system'.

Q3- Does the health center involves health personnel, local community and civil society (NGOs) in planning and decision making process?

Ans: There is, of course, little involvement of health personnel, local community and civil society in planning and decision making process. The health center has limited mandate to involve or consult the stake holders in the improvement of service delivery. The center has been working with local residents through the coordination of 'kebele' office and the health stations.

Box -2. Decentralized health service delivery in DMHC

- ✓ **Insignificant participation of health personnel, health service beneficiary and community in decision making process**

In decentralization framework, the participation of community for effective service delivery and for the improvement service considered as pillar. By taking this point into account, the study

assessed the participation of community in decision making process. Accordingly, as the majority of the respondents stated there is slight involvement of health personnel, health service beneficiaries and local community in the planning and decision making process.

- ✓ **The health center do not use community input in decision making process**

In the study effort has been done to assess whether the management unit of the health centers use community input in decision making process or not. From the response it has been learnt that the management unit hardly use community input for decision making process in their health center.

The major reasons that were cited as hindrance to use community input in decision making process: top down structure of health center, management unit want to control the agenda, management unit do not trust community local expertise or knowledge, have no time to participate community in decision making process and also community has no time to participate. This situation explains that in the top management unit hardly use community input in the planning and decision making process.

- ✓ **Little power to make decision on financial capacity**

According to the majority staff respondents' information, the health center budget is highly determined by management unit decision and DM health office. This unit has mandate to oversight the overall financial flow of the center.

- ➢ **<u>Low governance value: accountability</u>**

In the study accountability issue were assessed in clarity of description of responsibility, audit practice, reporting system, information flows and public consultation programs of the two centers, the following problems were indentified:

- ✓ **Health centers do not publicize plans and decisions to community**

In the study the majority respondents revealed that health centers slightly publicize their plans and decisions to community.

- ✓ **Schools do not consult community to ascertain their interest**

According to KI discussion, as the structure of health center expressed in top down approach, the management unit hardly consults community to ascertain their interest.

- ➢ **<u>Opportunity of decentralization in education and health service delivery</u>**

The research has identified some major opportunities of decentralization in effective education and health service delivery at DM town. These are:

- ▪ **<u>In education institutions (primary school and secondary school)</u>**

  - ✓ Teaching-learning activities are done with great autonomous that is in self direct manner

  - ✓ Female enrolment rate has been improved. The percentage distribution of female students has reached to 51% particularly in this elementary and secondary school.

  - ✓ Many teachers have been participating in continuous teacher training program to upgrade their capacity and skill.

  - ✓ The management unit participate teacher in planning and decision making process as well as involve local community in decision making in process

✓ The management unit has high autonomous mandate to run its financial resources

✓ Students as service receivers involve in decision making process

- **In health institutions**

✓ Involvement of civil societies in the health center (i.e. NGOs) increased particularly in service improvement activities.

✓ Special payment mechanism is designed for poor who especially can not afford the treatment cost as well as free of charge for mother-child treatment.

✓ Health related information highly disseminated to local community

✓ The number of health worker who have been participating in various upgrading training program increased

✓ Management unit has significant authority to recruit health worker by their own bureaucratic procedures.

✓ Health professionals have clear description of responsibility. In addition to this the center has controlling mechanism to hold higher officials accountable for their responsibilities.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusions and recommendations of the study. The chapter has three sections. These are discussion of the major findings, the conclusion part and recommendations. The study is assumed to be useful for understanding of the implication of decentralization on education and health service delivery.

5.1 Summary of findings of the study

The study has assessed various aspect of decentralization in the provision of quality service in the DM town. Under the study six different governmental institutions were incorporated. These were from education institutions MSS, KTSS, KTPS and DPS and from health institutions DHC and HHC. The major aim of the study was to understand the relevance of decentralization for the improvement of service delivery (i.e. education and health services). When awareness (know how) of the education and health service providers to service receivers were compared, it was recognized that the former has better awareness on the essence of decentralization and affirmation of its positive outcomes than latest.

The study revealed that under decentralization framework the involvement of higher local government (that is education office and health office) become very limited in education and health services delivery. The research has identified that the variation of degree of interference in education and health service. According to the findings the level of decentralization in education institutions (schools) are higher than that of health service. In school the management unit could to some extent decide on its financial resources, runs teaching learning process independently whereas health center has not such mandate. Contrary to this the health center has relatively higher power in the recruitment process of health workers to fill the vacant position but school has slightly mandate to employ teachers and other staff member.

One of the arguments for decentralization is brings government closer to the people; community and other stakeholders involvement may be, therefore, a determinant factor that play vital role in the implementation of decentralization for effective education and health service delivery. Under the study the extent of community involvement in education and health service provision were assessed. The majority of the staffs and service beneficiaries respondents perceived that the

community participation in the decision making process improved in the decentralization framework. Nevertheless of this, because of the top down approach of the service centers management unit hardly use community input in the decision making process. With regard to civil society (NGOs) involvement in the service provision and coverage, health center has showed better improvement and became relatively inclusive than education institutions.

In a decentralization expenditure assignment are made by a level of government that is closer and more responsive to a local constituency are more likely to reflect the demand for the local services than decision by a remote central government. In light of this premise, the financial capacity and management condition of the service institutions were evaluated along with degree of freedom on expenditure assignment. According to schools principals and health centers directors discussion, it has been recognized that the institutions have massive financial constraints. The unavailability of adequate financial resources hinders the centers (i.e. service providers) to deliver efficient and effective services for beneficiaries. In addition to this, the study has identified that education centers have relatively higher autonomous in expenditure decision making process than health centers.

5.2 Conclusions

The following section presents conclusion remarks of the study. In the study, six governmental institutions were included to evaluate the impact of decentralization on education and health services delivery based on the following variables: effective and efficient service provision, degree of autonomy, community involvement and accountability issues. The out comes are summarized as follows:

- **In education centers (KTSS, MSS, KTPS and DPS)**

According to the findings, school effectiveness interms of quality indicators was not significant. Student repetition rate, student drop out rate, teacher to student ratio, students to section ratio, and student to text book ratio, the employment of information technology were in

poor standard that slightly met the national standard for quality indicators. Hence we can conclude schools that are found at DM town have to do so many things to meet the national quality standards.

According to statistical report of schools, female enrolment rate has been improved. The percentage distribution of female students has reached to 51%. From this, it can be conclude that gender gap on access to education service has been reduced to a significant way.

The management unit of school develops the participation teachers and students as well as the involvement of local community in planning and decision making process. However, because of the top down structure of education system school management unit slightly use community input in the decision making process. School Furth more, the involvement of civil society particularly NGOs in the service improvement and coverage were inconsiderable. This condition indicates that school management unit was passively involving such organizations in the school activities.

Teaching learning process of school was not student centered. This condition affects quality of instruction and achievement of students negatively. Contrary to this teachers have taken continuous training program to upgrade their qualification, academic capacity and teaching skill. This indicates that the performance of school in teacher capacity development was positive but not in its teaching learning approach.

In decentralized education service, school act independently but the accountability of management unit and staffs were poor. This expresses that school lack clear description of responsibility, poor financial management system, slightly publicize plans and decisions to community and hardly consult local community to ascertain their interest. From this we conclude that in school education service was delivered with low governance value.

- **In health centers (DHC and HHC)**

Health centers disseminate health related information to educate the people or beneficiaries about the preventive and curative actions. These centers have clear description of responsibility by

which the officials hold accountable for what they have done. In the health center there few number of health professionals and little medicine (drugs). This indicates that high number of beneficiaries (patients) have got insufficient health service treatment. From This condition it can be conclude that the efficiency and quality health service delivery is poor.

Health service treatments of the centers are customer oriented. This condition improves the condition of service provision. In addition to this, health personnel have taken continuous training program to upgrade their qualification and skill. This indicates that the performance of health center in treatment was positive. Special payment mechanism is also designed for poor who especially could not afford the treatment cost as well as there is free of charge service delivered for maternal treatment. Sector coordination made possible particularly with 'kebele' office to screen, to identify and to approve the target groups. From this we can conclude that decentralization can serve to balance different needs of diverse people and therefore it is more suitable than centrally determined payment scheme.

However, in the health centers there were relatively little autonomous (self- direct), insignificant participation of health personnel, health service beneficiary and local community in strategic planning and decision making process, hardly use community input in decision making process and insignificant power to make decision on financial capacity. From these we can conclude that in these health centers level of decentralization have not achieved a remarkable performance. In health center the accountability of management unit and staffs were poor. This shows that health center slightly publicize plans and decisions to community and hardly consult local community to ascertain their interest. From this we, again, conclude that in health center service was provided with low governance value.

Generally, it can be concluded that decentralization evidently shown improvement in service delivery particularly in schools' and health centers' activities. To mention some of these positive outcomes: it enabled the local service providers (education and health centers) to perform their duties with autonomy, to provide quality and efficient service (i.e. interms of access and coverage) to their clients. However it is also important to note that administrative

constraints such as manpower, clarity of responsibility, open information flows and financial management system has made the services provisions inadequate.

From the research findings, it can be said that the local service providers particularly in DM town has several limitation to implement decentralization in its full context. Therefore the following recommendations are drawn to improve the education and health services delivery by alleviating some of those identified troubles.

5.3 Recommendations of the study

Despite decentralization improve the condition of education and health service delivery, several determinant factors hinders for full attainment of its objective. Accordingly different intervention strategies should be considered to alleviate some constraints that impede effective implementation of decentralization. Hence the following recommendations are drawn in the intention to address major problems identified in the study.

1. In the public service centers management system should be participatory in service provision so as to include various views of internal and external customers (i.e. workers, stakeholders and service beneficiaries)
2. Service delivery should be transparent and hence the customer (i.e. service beneficiary) should have free access to information and also public service centers should be audited equally by internal and external auditor on a regular time schedule.
3. Public service provider should be more empowered and authorized to decide in the overall administrative issues autonomously: budget allocation, procurement and staffing activities. In addition to this there should be clear description of responsibility in public service center in order to hold or to develop its management unit and worker accountable
4. There should be a system to identify community interest or preference to recognize their rights to get proper service and access to basic (i.e. education and health) services as well as there should be a workable framework to include community and other interest groups (i.e. NGOs) input in the improvement, strategic planning and decision making process

List of References

Amhara Nation Regional State (2010); *Primary School Education Standard Performance Mesurement;* volume two; Bahir Dar.

Amhara Nation Regional State Education Bureau(2004) ; *School organization, community involvement and financial management***;** Bahir Dar

Asfaw Kumsa et al (2007); *Poverty alleviation and regional development policy and practice in Sub Saharan Africa in Regional Development Dialogue (2007);* Regional development policy and practice in Africa; United Nations Center for Regional Development, Nagoya, Japan;Vol.28, No. 1, Spring 2007

Assefa Damte, (1993); *Urbanization in Ethiopia: Pre and post Revolutionary experience*, university of Winconsin, Milwaukee.

Bardhan, Pranab (2002); *Decentralization of Governance and Development*, *Journal of* Economic Perspectives—Volume 16, Number 4—Fall 2002—Pages 185–205 (http://people.bu.edu/dilipm/ec722/papers/28-s05bardhan.pdf)

Becker, Charles M; *Urbanization and Rural-Urban Migration, International Handbook of Development Economics*, chapter 35; Durham April 2007, pp11-13.

Barry, Brian J.L,(1976); *Urbanization and counter urbanization*, Volume II, urban Affairs annual reviews, Sage Publication, Beverly Hills, London

Bossert, Thomas J.(2000);*Decentralization of Health Systems in Latin America: A Comparative Study of Chile, Colombia, and Bolivia*; Harvard School of Public Health;pp.3-4

Central Statistical Agency (2010)**;** *Statistical Abstract 2009-Ethiopia***;** FDRE, Addis Ababa, Ethiopia.

Chandan, Jit S (1998); *Statistics for business and economics*; Vikas publishing house Pvt Ltd, New Delhi.

Decentralized Governance for Democracy, Peace, Development and Effective Service Delivery; United Nations Department of Economic and Social Affairs,ST/ESA/PADSER.E/88, New York, USA; 2004

*The Impact of Decentralization and Privatization on Municipal Services (2001***)**; report for discussion at the joint meeting on the impact of decentralization and privatization on municipal services, JMM/2001; International Labour Organization, Geneva, 15-19 October 2001

Devas, Nick; *Urban Governance and Poverty: Lessons from a study of Ten Cities*; Manila, Philiphinese ; February 2004; pp 23-27

Dunleavy, Patrick (1981); *urban change and conflict, perspective on urban studies*; Open University, Harper & Row, London.

Falleti, Tulia G (2004); *A sequential theory of decentralization and its effects on the intergovernmental balance of power: Latin American cases in comparative perspective*; working paper #314 July 2004; pp.1-10

Federal Democratic Republic of Ethiopia Ministry of Health; *Health Policy of the transitional government of Ethiopia,* Addis Ababa

Federal Democratic Republic of Ethiopia Ministry of Health; *Health Sector Development Program IV, 2010/11 – 2014/15*; October 2010, Addis Ababa

Florestal, Ketleen and Copper, Robb (1997); *Decentralization of education, legal issue; Direction in Development*; World Bank, Wahington, D.C,pp.3

Ford, James (?); *Rationale for decentralization*; in Decentralization Briefing Notes; Litvack,Jennies and Seddon, Jessica (ed.); World Bank Institute, working paper; pp.6

Garcia, Marito and Rajkumar, Andrew Sunil (2008); *Achieving better service delivery through decentralization in Ethiopia***;** Africa Region Human Development Department, World Bank Working paper No. 131, World Bank, Washington D.C., USA

Gugler, Josef (1988); *The urbanization of the Third World*; Oxford University press, USA

Gilbert, Alan (1992); *Cities, poverty and development, Urbanization in the third World*, Josef Gugler (ed.),2nded;Oxford University Press, USA

Hanson, E. Mark (1997); *Educational Decentralization: Issues and Challenges (http://www.thedialogue.org/PublicationFiles/PREAL%209-English.pdf*)

Henderson, J Venon (1988); *Urban Development, theory fact and illusion*; Oxford University Press, Inc, New York.

Hutchinson, Paul L and Lafond, Anne K (2004), *Monitoring and Evaluation of decentralization reforms in developing country health sectors*; The Partners for Health Reformplus project,abt Association inc,Betheseda, Maryland

Kassahun Berhanu and Tegegne Gebre-Egziabher, (2004) *Citizen participation in the decentralization process in Ethiopia***,** **a** consultancy report submitted to the Ministry of Capacity Building, GoE, Addis Ababa;pp 32-33.

Kauzya, John-Mary (2007); *Political decentralization in Africa: Experience of Uganda, Rwanda, and South Africa*; United Nations, New York
(http://unpan1.un.org/intradoc/groups/public/documents/un/unpan028411.pdf)

Kojima, Reeitsu (1996); *Introduction: population migration and Urbanization in developing countries: the developing economies*, vxxiv-4 December 1996.

Kumera, Kanea Tucho (2006); *Decentralized governance and service delivery: a case study of Dieglu and Tijo Wereda os Arsi Zone in Oromia Region*; MA Thesis, Institute of Regional and Local Development, Addis Ababa University

Litvack, Jennie (?), *Decentralization Briefing Notes*; Litvack,Jennies and Seddon, Jessica (ed.); World Bank Institute, working paper

Lijalem, Wakgari (2008); *District level decentralization program and service delivery: A case study of Gimbi Wereda, Oromia National Regional State*, Ethiopia; thesis, RLDS, Addis Ababa University,pp.86-90.

Manor, James (1997); *The political Economy of Decentralization;* The world Bank

Medina, Moneyba González,(?); *Urban governance and management in the European union: case studies of Santiago de Compostela (Spain) and Konstanz (Germany);* Rúa de Madrid, Santiago de Compostela, Spain

Miheret Ayenew (?); *A rapid Assessment of Wereda Decentralization in Ethiopia*;pp.73-76

Minas Hiruy (2003); *Urban management and Development; the role of urbanization in the socio-economic development process*, Berhanu Nega and Befekadu Degfe (ed); EEA/Ethiopian Economic Association, Addis Ababa, Ethiopia

Ministry of Education (2002); *The education and training policy and its implementation*, Addis Ababa, Ethiopia; pp. 9-14

Ministry of Works and Urban Development; *Plan for Accelerated and Sustained development to end poverty (2005/6-2009/10),* Addis Ababa, Ethiopia; pp 2-4.

Montgomery, Mark R (ed.) (2004); *Cities Transformed, demographic change and its implication in the developing world*; Earthscan, London

Organization for economic cooperation and development (2005); *School factors related to quality and equity result from PISA 2000,* OECD; www.oecd.org/dataoecd/15/20/34668095.pdf

Oxhorn, Philip (et al, 2004); *Decentralization, Democratic governance and civil society in comparative perspective: Africa, Asia and Latin America*; Philip Oxhorn, Joseph S.Tulchin and Andrew D. Salee (ed.); Woodrow Wilson Center Press, Washington, D.C.

The Political Economy of Decentralization: http://www.fao.org/docrep/006/ad697e/ad697e04.htm

Queiroz, Luiz Cesard (2001); *Challenges of Urban Reform, Urban Political Monitoring and Urban Management,(?)*

Quigley, John M (2008); *Urbanization, Agglomeration and Economic Development*; pp 128.

Rakodi, Carole (1997), *The urban challenge in Africa: Growth and management of its large cities*; united Nations University Press, New York

Regional Development Dialogue (2007); *Regional development policy and practice in Africa*; United Nations Center for Regional Development, Nagoya, Japan;Vol.28, No. 1, Spring 2007

Rondinelli A., Nellis R. John, Cheema, Shabbir G.(1983); *Decentralization in Developing countries, a review of recent experience;* The International bank for Reconstruction Development; World Bank

Salee, Andrew D and Tulchin, Joseph S (2004); *Decentralization, Democratic governance and civil society in comparative perspective: Africa, Asia and Latin America*; Philip Oxhorn; Woodrow Wilson Center Press, Washington, D.C.

Saito, fumihiko (2001), *Decentralization theories revisted: the lesson from Uganda*; Ryukoku University, Japan; Ryukoku RISS Bulletin. No. 31 March 2001, pp. 2-3.

Saltman,Richard B.,Bankauskaite, Vaida and Vrangbaek, Karsten(ed.)(2007); *Decentralization in health care, strategies and outcomes*; European observatory on health systems and policies series, Open University Press, England

Singh, Ranvinder Sandhu (2003); *Urbanization in India, Sociological contribution*; Sage publications, New Delhi, London.

Shewaye Tesfaye (2003); *The challenge of urban management in Ethiopia: the case of Amhara Municipal Reform; the role of urbanization in the socio- economic development process,* Berhanu Nega and Befekadu Degfe (ed); EEA/Ethiopian Economic Association, Addis Ababa, Ethiopia

Simone,Abdou Malik (2002); *Principles and Realities of urban governance in Africa*; UN-HABITA, Kenya; pp 13.

Stevenson, Deborah (2003); *Cities and Urban cultures*; Open University press, maidenhead Philadelphia.

Tegegne Gebre Egziabher (2000); *Perspectives and issues of urban development in Ethiopia,* working paper No. 10, September 2000; Regional and Local development studies, Addis Ababa University

Tegegne Gebre Egziabher and Kasahun Berhanu (2004); *the role of decentralized governance in building local institutions, diffusing ethnic conflicts and alleviating poverty in Ethiopia,* Regional Development Dialogue, vol.25,No.1.

Tegegne Gebre Egziabher and Van Dijik, Meine Pieter (ed.) (2005); *Issue and Challenges in local regional development; Decentralization, urban service delivery and Rural-urban linkages and inequality in developing countries;* RLDS, Addis Ababa University.

Tesfaye Tadesse (2006); *Decentralization and service delivery in education: A case of Moretenna-Girru and Berehe Aleltuu Weredas In Amhara and Oromiya Region respectively;* MA Thesis, RLDS, Addis Ababa university

Turner, Mark and David Hulme (1997); *Governance, Administration and Development, making the state work;* Macmillan press ltd, London.

UN (2004), *World Urbanization Prospects*: The 2003 Revision, New York

UN-HABITAT**;** *Principles and Realities of urban governance in Africa,The Global Campaign for Good Urban Governance,* UN-HABITAT,2002 pp.65-66.

UNCDF (2006); *Local Development Practices and Instruments in West Africa, and their link with the millennium development goals: A synthesis of case study from UNCDF in Benin, Burkina Faso, Guinea, Mali, Niger and Senegal;* UN, New York, USA, pp. 13-44

UNDP (1999); *Human Development Report*: United Nations Development Program, 1999.

UNESCO (2005), *Decentralization in Education: National Policies and Practices*: United Nations educational, Scientific and Cultural Organization, France; pp.12-15

USAID (2009); *Democratic Decentralization Programming Handbook*, USAID/Office of Democracy and Governance,1300 Pennsylvania Avenue, NW Washington, DC 20523;pp.10-15

Wittenberg, Martin (2003); *Decentralization in South Africa;* School of Economic and Business Sciences and ERSA, University of the Witwatersrand, Johannesburg, South Africa; pp.5-8

Worku Yehualeshet (2005); *District Level Decentralization in Ethiopia: Expenditure Assignments and Fiscal Transfer* in (2005); Issue and Challenges in local regional development; Decentralization, urban service delivery and Rural-urban linkages and inequality in developing countries; Tegegne Gebre Egziabher and Van Dijik, Meine Pieter (ed.) RLDS, Addis Ababa University, pp.29-47

World Bank (2001); *Decentralization and governance: does decentralization improve public service delivery?,* PREM Note, Number 55, June 2001,pp.4

World Bank (2000); *Urban and local Government Strategy: Cities In transition*, Washington, D.C. USA

World Urbanization Prospects: *The 2007 Revision Population Database (http://esa.un.org/unup/p2k0data.asp)*

Zewdie Serbarro (1998), *Urban Field Development in Ethiopia and other related issues,* Zeleke Zewdie; FDRE, Ministry of works and Urban Development, Addis Ababa.

Zaidi ,S. Akbar (2005); *The Political Economy of Decentralisation in Pakistan,Transversal Theme "Decentralisation and Social Movements"* Working Paper No. 1,University of Zurich Irchel, Winterthurerstr. 190, CH-8057 Zurich, Switzerland

http://www.unu.edu/unupress/unupbooks/80918e/80918E0f.htm

www.socialreaserachmethods.net/kb/order.php (Last Revised: 10/20/2006 ; 2006, Trochim, William M.K)

http://www.cia.gov/library/publication/the-world-factbook/fileds/2212.html ***(CIA World Fact book, 2010)***

http://f01.middlebury.edu/EC428A/Conferences/Urbanization/2001/Schuman.htm ***(Sara Schuman: Is Urbanization the Cause of Third World Unemployment and Poverty?)***

Table 4.01 Percentage distribution of STAFF respondents by sex and age (TEACHER)

Sex of Respondents		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	male	37	**74.0**	74.0	74.0
	female	13	**26.0**	26.0	100.0
	Total	50	**100.0**	100.0	
Age of respondents		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	21 to 30 years	22	**44.0**	44.0	44.0
	31 to 40 years	22	**44.0**	44.0	88.0
	above 41 years	6	**12.0**	12.0	100.0
	Total	50	**100.0**	100.0	

Table 4.02 Percentage distributions of TEACHER respondents by education level and work experience

Education level of respondents		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	degree level	36	**72.0**	72.0	72.0
	diploma level	14	**28.0**	28.0	100.0
	Total	50	**100.0**	100.0	
Work experience of respondents		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	below 4 years	10	**20.0**	20.0	20.0
	5 to 9 years	22	**44.0**	44.0	64.0
	10 to 14 years	15	**30.0**	30.0	94.0
	above 15 years	3	**6.0**	6.0	100.0
	Total	50	**100.0**	100.0	

Table 4.03 Percentage distributions of students by sex, age and grade level

sex of the respondent		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	male	27	**56.3**	56.3	56.3
	female	21	**43.7**	43.8	100.0
	Total	48	**100.0**	100.0	
Age of the respondent		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	below 15 years of age	12	**25.0**	25.0	25.0
	from 16 to 30 years of age	35	**72.9**	72.9	97.9
	above 31 years of age	1	**2.1**	2.1	100.0
	Total	48	**100.0**	100.0	
Education (i.e. grade) level of the respondent		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	5 or 8	14	**29.2**	29.2	29.2
	9 or 10	34	**70.8**	70.8	100.0
	Total	48	**100.0**	100.0	

Source: own survey data, 2011

Table 4.04 Percentage distributions of health professional by sex and age

Sex of respondent		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	22	44.0	44.0	44.0
	Female	28	56.0	56.0	100.0
	Total	50	100.0	100.0	
Age of respondent		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than or equal to 20 year	1	2.0	2.0	2.0
	21 to 30 year	8	16.0	16.0	18.0
	31 to 40 year	24	48.0	48.0	66.0
	Greater than or equal to 41 year	17	34.0	34.0	100.0
	Total	50	100.0	100.0	

Source: own survey data, 2011

Table 4.05 Percentage distributions of health professional by education level and work experience

Educational level of respondent		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	above degree level (postgraduate0	4	8.0	8.0	8.0
	Degree level	16	32.0	32.0	40.0
	Diploma level	29	58.0	58.0	98.0
	certificate level	1	2.0	2.0	100.0
	Below certificate level	0	0	0	
	Total	50	100.0	100.0	
Work experience of respondent		Frequency	**Percent**	Valid Percent	Cumulative Percent
Valid	below 4 years	5	**10.0**	10.0	10.0
	From 4 to 9 year	21	**42.0**	42.0	52.0
	From 9 to 14 year	17	**34.0**	34.0	86.0
	above 15 year	7	**14.0**	14.0	100.0
	Total	50	**100.0**	100.0	

Source: own survey data, 2011

Table 4.06 Percentage distributions of health beneficiary by age, sex, education status and occupation type

variable		**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
Age of the respondents	below 15 years of age	1	**2.5**	2.5	2.5
	from 15 to 30 years	5	**12.5**	12.5	15.0
	from 30 to 45 years of age	13	**32.5**	32.5	47.5
	above 45 years of age	21	**52.5**	52.5	100.0
	Total	40	**100.0**	100.0	
		Frequency	**Percent**	Valid Percent	Cumulative Percent
Sex of respondents	male	21	**52.5**	52.5	52.5
	female	19	**47.5**	47.5	100.0
	Total	40	**100.0**	100.0	
		Frequency	**Percent**	Valid Percent	Cumulative Percent
Education status of respondents	above degree i.e. postgraduate level	1	**2.5**	2.5	2.5
	degree level	6	**15.0**	15.0	17.5
	diploma level	9	**22.5**	22.5	40.0
	certificate level	14	**35.0**	35.0	75.0
	below certificate level	10	**25.0**	25.0	100.0
	Total	40	**100.0**	100.0	
		Frequency	Percent	Valid Percent	Cumulative Percent
Types of occupation	government (civil servant)	12	**30.0**	30.0	30.0
	private company	14	**35.0**	35.0	65.0
	Non governmental organization	1	**2.5**	2.5	67.5
	agriculture (farmer)	6	**15.0**	15.0	82.5
	other type	7	**17.5**	17.5	100.0
	Total	40	**100.0**	100.0	

Source: own survey data, 2011

Table 4.07Percentage distributions of student-teacher and student-text book ratio

No.	indicator	Response (value)	frequency	percent	Valid percent	Cumulative percent
1	Student-teacher ratio	Yes	8	**16**	16	16
		No	42	**84**	84	100
		Total	50	**100**	100	-
2	Student-text book ratio	Yes	10	**20**	20	20
		No	40	**80**	80	100
		Total	**50**	**100**	100	-
3	Student-class ratio	26 to 40 (i.e.1:40)	5	**10.0**	10.0	10.0
		41 to 60 (i.e.1:55)	35	**70.0**	70.0	80.0
		above 61 (i.e.1:65)	10	**20.0**	20.0	100.0
		Total	**50**	**100.0**	100.0	

Source: own survey, 2011

Table 4.08 Repetition and drop out rate of student

No.	Indicator	Response (value)	frequency	percent	Valid percent	Cumulative percent
1	Repetition rate of student	very high	19	**38.0**	38.0	38.0
		high	27	**54.0**	54.0	92.0
		very low	1	**2.0**	2.0	94.0
		low	3	**6.0**	6.0	100.0
		Total	**50**	**100.0**	100.0	
2	Drop out rate of student	very high	12	**24.0**	24.0	24.0
		high	27	**54.0**	54.0	78.0
		very low	5	**10.0**	10.0	88.0
		low	6	**12.0**	12.0	100.0
		Total	100	**100.0**	100.0	

Source: own survey, 2011

Table-A1 staff reason for teacher deficiency

Why teacher numbers become inadequate?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	increasing number of students	20	40.0	47.6	47.6
	turnover of the teacher	12	24.0	28.6	76.2
	unavailability of adequate classroom	5	10.0	11.9	88.1
	financial constraints to employee teacher	5	10.0	11.9	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-A2 staff response on training

If your response to question 10 is yes

is there teacher training program in the education center?, if yes		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	good	23	46.0	54.8	54.8
	poor	11	22.0	26.2	81.0
	very good	8	16.0	19.0	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-A3 staff reason for poor training program

If your response to question table A2 is poor, why?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not objective	1	2.0	9.1	9.1
	plan not implemented	4	8.0	36.4	45.5
	center has no mandate to run	4	8.0	36.4	81.8
	shortage of fund to cover training cost	2	4.0	18.2	100.0
	Total	11	22.0	100.0	
Missing	System	39	78.0		
Total		50	100.0		

Table-A4 staff response on teaching approach

is teaching learning process active (student centered) in the school		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	24	48.0	48.0	48.0
	no	26	52.0	52.0	100.0
	Total	50	100.0	100.0	

Table-A6 staff response good governance

If no governance why?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no transparency (information flow)	7	14.0	21.2	21.2
	lack of participatory approach	15	30.0	45.5	66.7
	no public responsiveness	5	10.0	15.2	81.8
	no clear accountability of the officials	6	12.0	18.2	100.0
	Total	33	66.0	100.0	
Missing	System	17	34.0		
Total		50	100.0		

Table-A10 staff response on decentralization

if there is no decentralization, why		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	high level interference	10	20.0	43.5	43.5
	the system is top down approach	5	10.0	21.7	65.2
	the center has no power to decide	8	16.0	34.8	100.0
	Total	23	46.0	100.0	
Missing	System	27	54.0		
Total		50	100.0		

Table-A11 staff response regarding sources of revenue

Source of revenue (income)		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	service fee	9	18.0	21.4	21.4
	external donor	2	4.0	4.8	26.2
	community aid - contribution	7	14.0	16.7	42.9
	various sale income	24	48.0	57.1	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-A12 staff response on budgeting system

which unit decide the financial (budget) allocation of the center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	education office of the city	6	12.0	12.0	12.0
	the school management unit	10	20.0	20.0	32.0
	the community (via kebele unit)	32	64.0	64.0	96.0
	the city council	2	4.0	4.0	100.0
	Total	50	100.0	100.0	

Table-A08 staff attitude on the role of decentralization

Positive role of decentralization on service delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	improve quality and access	16	32.0	45.7	45.7
	brings consensus on decision making process	11	22.0	31.4	77.1
	makes the school's activities transparent	4	8.0	11.4	88.6
	empower teachers on their activities	4	8.0	11.4	100.0
	Total	35	70.0	100.0	
Missing	System	15	30.0		
Total		50	100.0		

Table-A09 staff attitude on hindrance of decentralization

Decentralization slightly practiced in school, because		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	high level of interference	6	12.0	40.0	40.0
	the system is top down approach	5	10.0	33.3	73.3
	the center has no power to decide	2	4.0	13.3	86.7
	the center has no adequate financial resources	2	4.0	13.3	100.0
	Total	15	30.0	100.0	
Missing	System	35	70.0		
Total		50	100.0		

Table-A14 staff attitude on community participation

Reason for community involvement		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	they contribute financial and labor	24	48.0	63.2	63.2
	common understanding in development goal	11	22.0	28.9	92.1
	to develop sense of commonness in service delivery	3	6.0	7.9	100.0
	Total	38	76.0	100.0	
Missing	System	12	24.0		
Total		50	100.0		

Table-A15 staff attitude on problems of community involvement

why the management unit slightly participate community		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not participatory	5	10.0	41.7	41.7
	follows top down approach	7	14.0	58.3	100.0
	Total	12	24.0	100.0	
Missing	System	38	76.0		
Total		50	100.0		

Table-A16 staff attitude on NGOs involvement

Why NGOs being to little		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not participatory	17	34.0	41.5	41.5
	follows top down approach	15	30.0	36.6	78.0
	give little concern to NGOs support	5	10.0	12.2	90.2
	has constraints to work with NGOs	4	8.0	9.8	100.0
	Total	41	82.0	100.0	
Missing	System	9	18.0		
Total		50	100.0		

Table-C staff attitude on monitoring mechanism

mechanism to monitor responsibility of management unit (higher officials) of the center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	administrative manual	18	36.0	48.6	48.6
	teacher parents association	12	24.0	32.4	81.1
	'gimigema' program of the center	4	8.0	10.8	91.9
	education office of the city	3	6.0	8.1	100.0
	Total	37	74.0	100.0	
Missing	System	13	26.0		
Total		50	100.0		

Table-D staff attitude on reporting practice

Reason for not reporting system		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	lack of clear responsibility of the staffs	3	6.0	21.4	21.4
	absence of follow up	5	10.0	35.7	57.1
	absence of feedback	3	6.0	21.4	78.6
	report has no value adding	3	6.0	21.4	100.0
	Total	14	28.0	100.0	
Missing	System	36	72.0		
Total		50	100.0		

Table-A17 staff attitude on use of community input

Why management don't use community input		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	don't trust community knowledge or expertise	5	10.0	14.3	14.3
	have no time to participate community in decision making	1	2.0	2.9	17.1
	want to control the agenda	10	20.0	28.6	45.7
	structured in top down approach	19	38.0	54.3	100.0
	Total	35	70.0	100.0	
Missing	System	15	30.0		
Total		50	100.0		

Table-A7 student response attitude on teaching approach

teaching learning process of the school is student center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	8	16.7	16.7	16.7
	disagree	28	58.3	58.3	75.0
	strongly agree	2	4.2	4.2	79.2
	agree	10	20.8	20.8	100.0
	Total	48	100.0	100.0	

Table-A8 student response on decentralized education

education service is decentralized in the school		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	1	2.1	2.1	2.1
	disagree	5	10.4	10.4	12.5
	strongly agree	5	10.4	10.4	22.9
	agree	37	77.1	77.1	100.0
	Total	48	100.0	100.0	

Table-A13 student response on school participation

the school participate students in planning and decision making process		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	5	10.4	10.4	10.4
	disagree	7	14.6	14.6	25.0
	strongly agree	2	4.2	4.2	29.2
	agree	34	70.8	70.8	100.0
	Total	48	100.0	100.0	

Table-A18 student response on participation in decision making

the school use students input in decision making process		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	3	6.3	6.3	6.3
	disagree	7	14.6	14.6	20.8
	strongly agree	10	20.8	20.8	41.7
	agree	28	58.3	58.3	100.0
	Total	48	100.0	100.0	

Table-E student response on decentralization

Decentralization improve education service delivery of the school		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly disagree	6	12.5	12.5	12.5
	disagree	21	43.8	43.8	56.3
	strongly agree	2	4.2	4.2	60.4
	agree	19	39.6	39.6	100.0
	Total	48	100.0	100.0	

Table-B1 health worker response on problem of center

are there adequate health professional in the center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	financial problem to hire worker	15	30.0	41.7	41.7
	the presence of turn over	13	26.0	36.1	77.8
	the health center is not conducive for work	7	14.0	19.4	97.2
	unavailability of health professionals in the market	1	2.0	2.8	100.0
	Total	36	72.0	100.0	
Missing	System	14	28.0		
Total		50	100.0		

Table-B5 health worker response on training assessment

Why the need assessment is poor? because		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not include your training interest	2	4.0	20.0	20.0
	not represent your subject area	2	4.0	20.0	40.0
	not clearly stated	2	4.0	20.0	60.0
	not significant to your career development	4	8.0	40.0	100.0
	Total	10	20.0	100.0	
Missing	System	40	80.0		
Total		50	100.0		

Table-B6 health worker response on relevance of training program

Training program was		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	good	19	38.0	45.2	45.2
	poor	22	44.0	52.4	97.6
	very good	1	2.0	2.4	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-B7 health worker response training program

If your response to table B6 is POOR, why?		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not prepared well	5	10.0	18.5	18.5
	not your professional interest	13	26.0	48.1	66.7
	not clearly stated	1	2.0	3.7	70.4
	not significant to your career development	8	16.0	29.6	100.0
	Total	27	54.0	100.0	
Missing	System	23	46.0		
Total		50	100.0		

Table-B8 health worker response on governance issues of center

there is little governance in your health center in the service delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	there is no transparency	5	10.0	20.0	20.0
	there is lack of participatory approach	16	32.0	64.0	84.0
	there is no public responsiveness	3	6.0	12.0	96.0
	there is no clear accountability of the officials	1	2.0	4.0	100.0
	Total	25	50.0	100.0	
Missing	System	25	50.0		
Total		50	100.0		

Table-B2 health worker response on decentralization

does decentralization enable health worker to make decision		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	there is top down approach	2	4.0	28.6	28.6
	there is no participatory approach	4	8.0	57.1	85.7
	there is no empowerment	1	2.0	14.3	100.0
	Total	7	14.0	100.0	
Missing	System	43	86.0		
Total		50	100.0		

Table-B13 health worker response on sources of revenue

sources of revenue (income)		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	health service fee	25	50.0	58.1	58.1
	external donor like civil society	14	28.0	32.6	90.7
	community aid (contribution)	2	4.0	4.7	95.3
	from various internal sale	2	4.0	4.7	100.0
	Total	43	86.0	100.0	
Missing	System	7	14.0		
Total		50	100.0		

Table-B14 health worker response on financial allocation

financial allocation of the health center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	health office of the city	12	24.0	24.0	24.0
	the center management unit	24	48.0	48.0	72.0
	community	4	8.0	8.0	80.0
	city council (mayor office)	10	20.0	20.0	100.0
	Total	50	100.0	100.0	

Table-B12 health worker response on autonomous action

health center perform its day to day activities in autonomous (self-directed) manner		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	presence of high level of interference	13	26.0	44.8	44.8
	existing system is top down approach	12	24.0	41.4	86.2
	health center has not power to decide	2	4.0	6.9	93.1
	center has no adequate financial resources	2	4.0	6.9	100.0
	Total	29	58.0	100.0	
Missing	System	21	42.0		
Total		50	100.0		

Table-B10 health worker response on role of decentralization

decentralization brings positive change in health services delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	improve quality and access of health service	19	38.0	45.2	45.2
	develop common understanding on decision making process and	10	20.0	23.8	69.0
	makes the center's activities transparent	9	18.0	21.4	90.5
	empower health personnel	4	8.0	9.5	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-B11 health worker response on problems of decentralization

Problem of decentralization		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	presence of high level of interference	5	10.0	62.5	62.5
	existing system is top down approach	2	4.0	25.0	87.5
	The health center has not power to decide	1	2.0	12.5	100.0
	Total	8	16.0	100.0	
Missing	System	42	84.0		
Total		50	100.0		

Table-F health worker response on why the community is being involved in the center program? because

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	they could contribute financial and labor	7	14.0	53.8	53.8
	to create common understanding in development goal	3	6.0	23.1	76.9
	to develop a sense of commonness in health service delivery	2	4.0	15.4	92.3
	to develop responsiveness and accountability	1	2.0	7.7	100.0
	Total	13	26.0	100.0	
Missing	System	37	74.0		
Total		50	100.0		

Table-G health worker response on community involvement

Community not involved in decision making		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	top down structure of the health center	14	28.0	46.7	46.7
	the management want to control the agenda	13	26.0	43.3	90.0
	the management unit do not trust local expertise or knowledge	3	6.0	10.0	100.0
	Total	30	60.0	100.0	
Missing	System	20	40.0		
Total		50	100.0		

Table-H health worker response on civil society involvement

Problems on the involvement of civil society (NGOs) in the improvement processes of health service delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	is not participatory	8	16.0	53.3	53.3
	follows top down approach	3	6.0	20.0	73.3
	give little concern to NGOs support	2	4.0	13.3	86.7
	has constrain to work with NGO	2	4.0	13.3	100.0
	Total	15	30.0	100.0	
Missing	System	35	70.0		
Total		50	100.0		

Table-I health worker response on community involvement

mechanisms to monitor the responsibility of management unit (higher officials)		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	working procedures (administrative manual) of the center	18	36.0	52.9	52.9
	Evaluative (i.e. critics) action of the center or 'gimgema'	10	20.0	29.4	82.4
	health office of the city (By reporting to higher official)	6	12.0	17.6	100.0
	Total	34	68.0	100.0	
Missing	System	16	32.0		
Total		50	100.0		

Table-B16 health worker response on reporting practice

health professionals reporting system		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	The lack of clear responsibility of the staffs	3	6.0	12.0	12.0
	The absence of follow up	8	16.0	32.0	44.0
	The absence of feed back	9	18.0	36.0	80.0
	report has no value adding to health service delivery	5	10.0	20.0	100.0
	Total	25	50.0	100.0	
Missing	System	25	50.0		
Total		50	100.0		

Table-17 health worker response on use of community input in decision making

management unit slightly use community input in decision making process		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	the management unit follows top down approach	12	24.0	28.6	28.6
	the management unit want to control the agenda	13	26.0	31.0	59.5
	the management unit do not have time to participate community	9	18.0	21.4	81.0
	the community do not have time to participate	3	6.0	7.1	88.1
	the management unit do not trust local expertise	5	10.0	11.9	100.0
	Total	42	84.0	100.0	
Missing	System	8	16.0		
Total		50	100.0		

Table-B2 health worker response on service cost

health service treatment delivered with unreasonable cost		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	health service treatment delivered with low cost	10	20.0	34.5	34.5
	the fee is cheap when compare to private clinics	14	28.0	48.3	82.8
	it makes health center's financial budget inadequate	3	6.0	10.3	93.1
	the health center makes no recovery from their cost	2	4.0	6.9	100.0
	Total	29	58.0	100.0	
Missing	System	21	42.0		
Total		50	100.0		

Table-B4 health receiver response on pharmacy service

Customer get prescribed drugs (medicine) in the center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	4	10.0	10.0	10.0
	agree	11	27.5	27.5	37.5
	strongly disagree	3	7.5	7.5	45.0
	disagree	22	55.0	55.0	100.0
	Total	40	100.0	100.0	

Table-B9 health receiver response on service delivery is decentralized

Decentralized health service delivery		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	3	7.5	7.5	7.5
	agree	9	22.5	22.5	30.0
	strongly disagree	4	10.0	10.0	40.0
	disagree	24	60.0	60.0	100.0
	Total	40	100.0	100.0	

Table-B3 health receiver response on payment system

Health service beneficiary pay reasonable cost for treatment		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	3	7.5	7.5	7.5
	agree	24	60.0	60.0	67.5
	strongly disagree	1	2.5	2.5	70.0
	disagree	12	30.0	30.0	100.0
	Total	40	100.0	100.0	

Table-B18 **Customer spent a lot of time in queue to get health services**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	5	12.5	12.5	12.5
	agree	25	62.5	62.5	75.0
	strongly disagree	1	2.5	2.5	77.5
	disagree	9	22.5	22.5	100.0
	Total	40	100.0	100.0	

Table-B19 **Customer has received feedback when they complain in the health center**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	1	2.5	2.5	2.5
	agree	8	20.0	20.0	22.5
	strongly disagree	4	10.0	10.0	32.5
	disagree	27	67.5	67.5	100.0
	Total	40	100.0	100.0	

Table-B20 **The center report to the public about its performance or achievement**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	2	5.0	5.0	5.0
	agree	23	57.5	57.5	62.5
	strongly disagree	2	5.0	5.0	67.5
	disagree	13	32.5	32.5	100.0
	Total	40	100.0	100.0	

Table-B21 **The center participate the local community in decision making process**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	2	5.0	5.0	5.0
	agree	12	30.0	30.0	35.0
	strongly disagree	5	12.5	12.5	47.5
	disagree	21	52.5	52.5	100.0
	Total	40	100.0	100.0	

Table-B22 **The management use community input in decision making process (participatory approach)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	strongly agree	5	12.5	12.5	12.5
	agree	10	25.0	25.0	37.5
	strongly disagree	6	15.0	15.0	52.5
	disagree	19	47.5	47.5	100.0
	Total	40	100.0	100.0	

Table-B23 **After decentralization, health service delivery has been improved**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	3	7.5	7.5	7.5
	agree	27	67.5	67.5	75.0
	strongly disagree	2	5.0	5.0	80.0
	disagree	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Addis Ababa University
School of Graduate Program
Institute of Regional and Local Development Studies
Urban Development and Management center

Questionnaire I

Prepared by: Mahmud Muktar

Respondent: Education personnel -teacher

Dear Respondent,

The purpose of this research questionnaire is for academic reasons. The research studies Debre Markos town's education services delivery condition within a decentralization framework. The data collected will be employed for the partial fulfillment of the Master of Arts Degree in Urban Development and Management Studies Program of Addis Ababa University. Therefore you, the respondent, kindly requested to give the right information and responses for the questions.

The format contain TWO SECTIONS: the first part dealt on your personal information, the second section dealt about education center (i.e. school) performance in line with decentralization program.

To this end, to make this research real and objective, your answers are indispensable. I would like to express my deepest gratitude for your sincere cooperation in advance.

Definition of term

- ***Decentralization*** in this context is devolution of government power from the higher to lower level unit, in this case to Debre Markos education office to schools
- ***Education Center*** in this context refers to **primary school** or **secondary school**
- ***The term ***standard**** in this context refers to the number of teacher per students in a given class (i.e. 1:40)
- **The term ***standard**** in this context refers the ratio of student per text book (i.e. 1 to 1)

SECTION I-1

Personal Information

Instruction: Please selects and writes the letter that represents your personal information in the box provided.

1. Age----------

A= below 20 yr B= 21-30 yr C= 31-40 yr D= above 41 yr

2. Sex----------

A= Male B= Female

3. Educational level----------

A = above degree B = Degree level C = Diploma level

D= below diploma level

4. Work experience----------

A= below 4 yr B= 5-9yr C= 10-14 yr D= above 15 yr

SECTION I-2

Instruction

The following questions are presented in multiple choice and open end type. Please select (circle) your best choice(s) as per the nature of the questions.

I. Regarding school service delivery (i.e. teaching-learning activities)

1. Does teacher to student ratio is standard* at this school?

   a) Yes b) No c) I do not know

2. If your response to question 1 is **no**, what do you think the cause of this to happen? (Hint:-you can select at least one options, if necessary)
   a. The increasing number of students
   b. turn over of teachers
   c. The unavailability of additional class rooms
   d. Financial constraint to employee teacher
   e. if other, please specify_____

3. Does student to text book ratio is standard** at this education center?
   a) Yes b) No c) I do not know

4. If your response to question 3 is **no**, what do you think the reason behind? Because (Hint:-you can select at least one options, if necessary)
   a. deficiency of text book in the store
   b. Financial constraint to acquire text book on time
   c. The increasing number of students
   d. The unbalanced nature of demand-supply of text book
   e. If other, please specify_____

5. Does the education center employ information technology (computer) service (i.e. internet service) in its teaching-learning activities?
   a) Yes b) No c) I do not know

6. Is teaching learning process active (student centered) in the school?
   a) Yes b) No c) I do not know

7. Which area has problem in your education center service delivery? (Hint:-you can select at least one options, if necessary)
   a) Finance and procurement
   b) Teaching experience (skills)
   c) Human resources administration
   d) Physical built and facilities
   e) If there is other, please specify_____

8. How many students are there in a given class (i.e. students-class ratio)?

   a) Below 25 (1:25) b) 26-40 (1:40) c) 41-60 (1:50) d) above 61 (1:60)

9. The repetition rate of students in this school is?

a) very high b) high c) very low d) low

10. The drop out rate of students in this school is

a) very high b) high c) very low d) low

11. Is there teacher training program in the education center?

a) Yes b) No c) I do not know

11.1 If your response to question 11 is **yes**, how do you rate the program? (i.e. in terms of quality)

a) Good b) poor c) very good

11.2 If your response to question 11.1 is **poor**, your reason is (Hint: here you can select more than one, if it is necessary)

a) the training program is not objectively developed
a) The training plan could not be implemented
b) the center has not mandate to run its training program
c) shortage of fund to cover the training cost
d) if other, please specify_____

12. Have you ever participated training program prepared by the school or education office (for your professional development)?

a) Yes b) No c) I do not know

12.1 If your response to question 12 is **yes**, how do you rate the relevance of training program? (i.e. in terms of quality)

a) Good b) poor c) very good

12.2 If your response to question 12.1 is **poor**, why? Because the training program (Hint: here you can select more than one, if it is necessary)

a. is not prepared well
b. is not your professional interest
c. is not clearly stated
d. is not significant to your career development
e. if other, please specify_____

II. Concerning Degree (level) of decentralization

13. Do you know (define) the principle of good governance (i.e. for instance, accountability, responsiveness, participative)?

a) Yes b) No c) I do not know

13.1 If your response to question 13 is **yes**, do you think (believe) that there is good governance in your education center in the service delivery?

a) Yes b) No c) I do not know

13.2 If your response to question 13.1 is **no**, what is your reason? Because in the education center (Hint:-you can select at least one option, if necessary)

a. there is no transparency
b. there is lack of participatory approach
c. there is no public responsiveness
d. there is no clear accountability of the officials
e. if other, please specify_____

14. Is education service decentralized in your school?
a) Yes b) No c) I do not know

14.1 If your response to question 14 is **yes**, does decentralization enable teacher to make decision in teaching learning activities?

a) Yes b) No c) I do not know

14.2 If your response to question 14 is **no**, why? Because in the school (Hint:-you can select at least one option, if necessary)

a. there is top down approach
b. there is no participatory approach
c. there is no empowerment
d. there is no clear accountability
e. if other, please specify_____

15. Does the education center has authority to recruit professional (teachers) in the school level?
a) Yes b) No c) I do not know

16. Does the education center generate its own revenue (income) sources?
a) Yes b) No c) I do not know

17. If your response to question 16 is **yes**, the sources of revenue (income) are from (Hint: here you can select more than one, if it is necessary)

a) the education center services fee
b) external donor like civil society
c) community aid (contribution)
d) from various sale income such as tree, grass, old (damaged) office equipments
e) if other, please specify_____

18. Which units decide the financial allocation of the education center?

a) The education office of the city b) The center management board

c) The community (via kebele unit) d) The town (city) council

e) if other, please specify_____

19. Does the education center perform its day to day activities in autonomous (self-directed) manner?

a) Yes b) No c) I do not know

20. If your response to question 19 is **no**, the reasons behind is (Hint:-you can select at least one option, if necessary)

a. The presence of high level of interference
b. The existing system is top down approach
c. The education center has not power to decide
d. The center has no adequate financial resources
e. if other, please specify_____

21. Does decentralization improves or brings positive change in education services delivery of the school?

a) Yes b) No c) I do not know

21.1 If your response to question 21 is **yes**, why? Because decentralization (Hint:-you can select at least one option, if necessary)

a. improve quality and access of education
b. develop common understanding on decision making process and accountability
c. makes the school's activities transparent
e. empower teachers
d. if other reasons, please specify_____

21.2 If your response to question 21 is **no**, the reason behind is

a) The presence of high level of interference
b) The existing system is top down approach
c) The education center has not power to decide
d) The center has no adequate financial resources
e) if other, please specify_____

22. Does school management unit participate teacher in decision making process?

a) Yes b) No

22.1 if your response to question 22 is **no,** your reason is

a) School management is top down approach
b) The management system is not participatory
c) Because teachers are not empowered
d) if other, please specify_____

23. Does school participate the local community (i.e. through kebele office) in decision making process?

a) Yes b) No

23.1 If your response to question 23 is **yes**, why the community is being involved in the center program? Because (Hint: here you can select more than one, if it is necessary)

a) they could contribute financial and labor
b) to create common understanding in development goal
c) to develop a sense of commonness in education service delivery
d) to develop responsiveness and accountability
e) if other, please specify_____

23.2 If your response to question 23 is **no**, why because the school management system

e) Is not participatory
f) follows top down approach
g) give little concerns to community contribution
h) work to accomplish the politic mission
i) if other, please specify_____

24. Does management unit of the school participate civil society (NGOs) in the improvement processes of education service delivery?

a) Yes b) No

24.1 If your response to question 24 is **no**, why? Because the management unit (Hint: here you can select more than one, if it is necessary)

a. Is not participatory
b. follows top down approach
c. give little concern to NGOs support
d. has constrain to work with NGOs
e. if other, please specify_____

III. Concerning accountability and transparency issue

25. Does the education center discharge activities with a clear description of responsibility for its professional?

a) Yes b) No c) I do not know

26. Is there a mechanism to monitor the responsibility of management unit (higher officials) of the center?

a) Yes b) No

27. If your response to question 26 is **yes**, the mechanism to supervise the responsibility of management unit of the school is through (Hint:-you can select at least one options, if necessary)

a) Working procedures (administrative manual) of the school
b) Teacher parents association
c) Evaluative (i.e. critics) action of the school community (teacher, student, staff, parents and director) or 'gimgema' program
d) education office of the city (By reporting to higher official)
e) If other please specify,_____

28. Is there internal auditing action on financial statement of the school to community or other stakeholders in accordance with required schedules?

a) Yes b) No

29. Is there external auditing action (i.e. by education office or 'kebele' audit unit) on financial statement of the school to community or other stakeholders in accordance with required schedules?

a) Yes b) No

30. Do teachers report (i.e. to immediate supervisor) about their actual performance in this education center?

a) Yes b) No

30.1 If your response to question 30 is **no**, the reason behind is

a. The lack of clear responsibility of the staffs
b. The absence of follow up
c. The absence of feed back
d. report has no value adding to education service delivery
e. if other, please specify_____

30.2 If your response to question 30 is **yes**, how often do you report?
(Hint:-you can select at least one option, if necessary)

a. daily b. weekly c. monthly
d. quarterly e. if other, please specify_____

31. Does the education center disseminate information (i.e. through mass media, in annual school events, magazines or booklet) regarding its teaching learning performances to the community?

a) Yes b) No

32. Do customers (i.e. students or parents) present complain freely on the condition of service delivery?

a) Yes b) No

33. If your response to question 32 is **yes**, do customers get timely response?

a) Yes b) No

33.1 If your response to question 33 is **yes**, how long official take to settle the complain (problems)?

a) below 1 hour b) from 1 to 4 hour c) from 4 to 7 hour d) above 7 hour

33.2 How do you rate the response provided by the concerned (higher) official (referring to question 35.1)?

a) Very good b) good c) poor

34. If your response to question 32 is **no**, why? Because (Hint:-you can select at least one options, if necessary)

a. Lack of awareness in handling customer's complain
b. lack of professionalism
c. there is no public responsiveness
d. there is no clear responsibilities of the officials
e. if other, please specify_____

Thank you!

SECTION I-3

Attitude questions

Prepared for Student /education service beneficiary/

Please read the following statements and select only one which indicate your best choice by using a symbol x or √ under each row and column.

N$^{o.}$	**Description**	**Strongly disagree**	**Disagree**	**Strongly agree**	**Agree**
		A	**B**	**C**	**D**
1	In this school teacher to students ratio is standard (i.e. one to forty)				
2	In this school textbook are delivered in one to one ratio				
3	Teaching learning process is carrying in smooth manner within a specified academic calendar				
4	Teaching learning process of the school is student center (i.e. active learning process)				
5	students are empowered to present their problem to the school				
6	The school management unit consult students in decision making process regarding school academic issues				
7	The school teachers are responsive for their clients (students)				
8	The school has autonomous mandate to make decision				
9	Teachers help students to meet standard academic performance				
10	In this school teaching learning process is supported by library service				
11	In this school teaching learning process is supported by computer service				
12	In this school teaching learning process is supported by science laboratory service				
13	The school has adequate classroom resources: chair, tables				
14	There is a open system to check the accountability of the teacher				
15	The building of the school is conducive for teaching learning process				

16	The local community (i.e. kebele, the parents) participate in the school service improvement activities				
17	The student has easy access to education services				
18	students has received proper education assessment (i.e. grading system) in the school				
19	Decentralization enable the students to participate in the improvement of teaching learning process				
20	Decentralization brings improvement in education service delivery of the school				

Thank you!

SECTION I-4

Semi- structured Interview Guideline

Prepared for school officer (principal)

- Name of the interviewee_____
- Age_____
- Sex _____
- Place of work_____
- Your position title? _____

1. In Ethiopia decentralization has been implemented to accelerate urban development and hence to meet the millennium development goal i.e. End Poverty. So what do you say the impact of decentralization toward education services? _____
2. Does the education sector work in line with decentralization principle? If No why? _____
3. Does the health sector have adequate mandate and power to make decision on the improvement and development of the education services? If No why? _____
4. Does the health sector decentralize its power and mandate to education centers like school, and college? ----------
5. Does the education sector work in accountability and transparent manner? If no why?

---

6. Do you believe that decentralized education service delivery improve the performance of school? If no, why?
7. Does the education sector prepare capacity building (upgrading) training program? If No, why? _____
8. Is there interference from higher organs like regional education offices?
   Yes ☐ No ☐ I do not know ☐
9. If yes, at what area do these governmental organs interference become high?
10. Is the current education service delivery condition adequate when you compare to the growing number of urban population? If no, why? If yes, how?
11. Does the education center wok together with local community in improving service delivery? If no why? If yes how?
12. Does the education center wok together with non governmental organization in improving service delivery? If no why? If yes how?
13. What problems hinder the education sector in performing its tasks successfully?
14. What mechanism do you suppose to improve the local education service delivery status?
15. Do you believe that the current civil service reform program (BPR) brings positive changes in customer satisfaction?

Thank you!

SECTION I-3

Attitude questions
Prepared for health beneficiary

- **A- Personal Information**

Instruction: Please selects and circle the letter that represents your personal information in the space provided.

- Age_____
  i. Below 15 years ii. 16 to 30 years iii. 31 to 40 years
  ii. iv. Above 41

- Sex _____
  i. Male ii. Female

- Educational level_____
  i. Above degree (MA, PhD) ii. Degree level iii. Diploma level
  iv. Certificate level (high school completed) v. below certificate level

- Work in _____
  i. Government ii. Private company iii. Non governmental organization (NGO) iv. Agriculture (farming) v. other type

- **B- Attitudinal question**

Please read the following statements and select only one which indicate your best choice by using a symbol **x** or √ under each row and column

N^{o.}	**Description**	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
		A	**B**	**C**	**D**
1	in this school teacher to students ratio is 1 to 25				
2	in this school textbook are delivered in 1 to 1 ratio				
3	student to section size is 1 to 40				
4	teaching learning process of the school is student center				

5	students are empowered to present their problem to the school				
6	In this school teaching learning process is supported by computer service				
7	education service is decentralized in the school				
8	teachers are evaluated by students in the semester				
9	the school participate students in planning and decision making process				
10	the school use students input in decision making process				
11	The physical built (i.e. building) of the school is conducive for teaching learning process				
12	the school disseminate information freely to community				
13	Decentralization enable the education center to work together with the community				
14	Decentralization improve education service delivery of the school				

Thank you

SECTION I-6

Check list Guideline

The following check list intend to conduct observation of the whole environment of the education center (i.e. primary and secondary schools)

No.	Observed functions/activities/things	value		condition	
		Yes	No	good	poor
1	Is teaching learning process run in conducive buildings or are the classrooms in good conditions?				
2	Does the education center have adequate teaching aids?				
3	Is there internet service for teaching learning activities in school?				
4	Is there adequate number of computer for teaching learning activities in school?				
5	Is the center has delivery library service to clients?				
6	Is the center has science laboratory?				
7	Is there sport field in the school?				
8	Is there staff lounge in the education center?				
9	Is there customers complain handling system in the center?				
10	Does the education center have adequate space to serve its clients in a proper way?				
	Does education worker (teacher) serve their clients in responsive and accountable manner?				

Addis Ababa University
College of Development Studies
Urban Development and Management Center

Questionnaire - II

Prepared By: Mahmud Muktar
Prepared for health personnel
Dear Respondent,

The purpose of this research questionnaire is for academic reasons. The research focus on health services delivery of Debre Markos town within a decentralization framework. The data collected will be employed for the partial fulfillment of the Master of Arts in Urban Development and Management Study Program in Addis Ababa University. Therefore you, the respondent, kindly requested to give the right information and responses for the questions.

The format contain TWO SECTIONS: the first part dealt on your personal information, and the second section dealt about health center (i.e. DMHC or HHC) service delivery performance in line with decentralization program.

To this end, to make this research real and objective, your answers are indispensable. I would like to express my deepest gratitude for your sincere cooperation in advance.

Definition of term

- ***Decentralization*** in this context is devolution of government authority and responsibility from the center to lower level unit, in this case from Debre Markos city health office to health centers
- ***Health Center*** in this context refers to **DM health center** or **Hidasie health center**
- ***Service delivery*** in this context refers to **health service delivery**
- The term ***Adequate*** in this context refers to the number of health professionals (Medical doctors or Nurses or health officers) per the number of beneficiaries in your respective health center
- *****The term Adequate*** in this context refers to the number of health professionals (Medical doctors or Nurses or health officers) per the number of beneficiaries in your respective health center

SECTION I-a

Personal Information

Instruction: Please selects and writes the letter that represents your personal information in the box provided.

Key: yr = year

1. Age----------

   A= below 20 yr B= 21-30 yr C= 31-40 yr D= above 41 yr

2. Sex----------

   A= Male B= Female

3. Educational level----------

   A= above degree level i.e. postgraduate level (or Medical Doctor)
   B= Degree level C= Diploma level D= Certificate level
   E= below certificate level

4. Occupation type (work in)----------

   A= governmental (civil servant) B= private company worker
   C= non governmental organization worker D= Agriculture (i.e. farmer)
   E= other type

SECTION I-b

Instruction

*The following questions are presented in multiple choice and open end type. You, the respondent, **circle** your best choice(s) as per the nature of the questions.*

Regarding general condition of health service delivery

2. Are there adequate** health professionals in the health center?

   a) Yes b) No

3. If your response to question 1 is **no**, what do you think the cause of the deficiency?
   a) financial problem to hire worker
   b) the presence of turn over
   c) the health center is not conducive for work
   d) The unavailability of health professionals in the market
   e) if other, please specify_____

4. Are there medical equipments such as laboratory kits in the health center?
   a) Yes b) No

5. Does the health center utilize information communication technology (computer) in its daily services delivery activities?

   a) Yes b) No

6. Does the management unit participate health professional in service improvement planning program?

   a) Yes b) No

7. How many clients (customers) do you serve in a given day (in number)?

   a) Below 25 b) 25-50 c) 50-75 d) above 75

8. Does a beneficiary or customer get medication in the health center's pharmacy?
   a) Yes b) No

9. Does the health center disseminate health concern information (health) to the public?
   a) Yes b) No

10. Which area has problem in your health center service delivery? (Hint:-you can select at least one options, if necessary)

    a) Finance and procurement
    b) Professional experience (skills)
    c) Human resources administration
    d) Physical built and facilities
    e) If there is other, please specify_____

11. Is there training program in the health center?

a) Yes b) No

11.1 If your response to question 11 is **yes**, how do you rate the program? (i.e. in terms of quality)

a) Good b) poor c) very good

11.2 If your response to question 11.1 is **poor**, your reason is (Hint: here you can select more than one, if it is necessary)

a) the training program is not objectively developed
b. The training plan could not be implemented
c. the center has not mandate to run its training program
d. shortage of fund to cover the training cost
e. if other, please specify_____

12. Does the center study your training needs (i.e. need assessment study)?

a) Yes b) No

12.1 If your response to question 12 is **yes**, how do you rate the need assessment (i.e. in terms of quality)?

a)Good b) poor c) very good

12.2 If your response to question 12.1 is **poor**, why? Because the need assessment

a) not include your training interest
b) is not represent your subject area
c) is not clearly stated
d) is not significant to your career development
e) if other, please specify_____

13. Have you ever participated training program prepared by health office (for your professional development)?

a) Yes b) No

13.1 If your response to question 13 is **yes**, how do you rate the relevance of training program? (i.e. in terms of quality)

a) Good b) poor c) very good

13.2 If your response to question 13.1 is **poor**, why? Because the training program (Hint: here you can select more than one, if it is necessary)

a. is not prepared well
b. is not your professional interest
c. is not clearly stated
d. is not significant to your career development
e. if other, please specify_____

Concerning degree (level) of decentralization

14. Do you know (define) the principle of good governance (i.e. transparent, accountability, responsiveness, participative)?

a) Yes b) No

14.1 If your response to question 14 is **yes**, do you think (believe) that there is good governance in your health center in the service delivery?

a) Yes b) No

14.2 If your response to question 14.1 is **no**, what is your reason? Because in the health center (Hint:-you can select at least one option, if necessary)

a. there is no transparency
b. there is lack of participatory approach
c. there is no public responsiveness
d. there is no clear accountability of the officials
e. if other, please specify_____

15. Is health service delivery decentralized in your center?
a) Yes b) No

15.1 If your response to question 15 is **yes**, does decentralization enable health personnel to make decision in the center?

a) Yes b) No

15.2 If your response to question 15 is **no**, why? Because in the center (Hint:-you can select at least one option, if necessary)

a) there is top down approach
b) there is no participatory approach
c) there is no empowerment
d) there is no clear accountability
e) if other, please specify_____

16. Do you think (believe) that the decentralization program improve the health service delivery?

a) Yes b) No

17. Does the health center has authority to recruit professional in the center level?
a) Yes b) No

18. Does the health center generate its own revenue (income) sources?
a) Yes b) No

19. If your response to question 18 is **yes**, the sources of revenue (income) are from (Hint: here you can select more than one, if it is necessary)
    a) the health center services fee
    b) external donor like civil society
    c) community aid (contribution)
    d) from various sale income such as tree, grass, old (damaged) office equipments
    e) if other, please specify_____

20. Which units decide the financial allocation of the health center?

    a) The health office of the city b) The center management unit

    c) The community (via kebele unit) d) The town (city) council (mayor office)

    e) if other, please specify_____

21. Does the health center perform its day to day activities in autonomous (self-directed) manner?
    a) Yes b) No

22. If your response to question 21 is **no**, the reasons behind is (Hint:-you can select at least one option, if necessary)

    a. The presence of high level of interference
    b. The existing system is top down approach
    c. The health center has not power to decide
    d. The center has no adequate financial resources
    e. if other, please specify_____

23. Do you think that decentralization brings positive change in health services delivery?

    a) Yes b) No

    23.1 If your response to question 23 is **yes**, why? Because decentralization (Hint:-you can select at least one option, if necessary)

    a. improve quality and access of health service
    b. develop common understanding on decision making process and accountability
    c. makes the center's activities transparent
    d. empower health personnel
    e. if other reasons, please specify_____

    23.2 If your response to question 23 is **no**, the reason behind is

    a. The presence of high level of interference
    b.The existing system is top down approach
    c.The health center has not power to decide
    d.The center has no adequate financial resources
    e.if other, please specify_____

24. Does the health center participate the local community (i.e. through kebele office) in decision making process?

a) Yes b) No

24.1 If your response to question 24 is **yes**, why the community is being involved in the center program? because (Hint: here you can select more than one, if it is necessary)

a) they could contribute financial and labor
b) to create common understanding in development goal
c) to develop a sense of commonness in health service delivery
d) to develop responsiveness and accountability
e) if other, please specify_____

24.2 If your response to question 24 is **no**, why because the center management system

a) Is not participatory
b) follows top down approach
c) give little concerns to community contribution
d) work to accomplish the politic mission
e) if other, please specify_____

25. Does management unit of the center participate civil society (NGOs) in the improvement processes of health service delivery?

a) Yes b) No

25.1 If your response to question 25 is **no**, why? Because the management unit (Hint: here you can select more than one, if it is necessary)

a. Is not participatory
b. follows top down approach
c. give little concern to NGOs support
d. has constrain to work with NGOs
e. if other, please specify_____

<u>Concerning accountability and transparency issue</u>

26. Does the health center discharge activities with a clear description of responsibility for its professional?

a) Yes b) No

27. Are there mechanisms to monitor the responsibility of management unit (higher officials) of the center?

a) Yes b) No

28. If your response to question 27 is **yes**, the mechanism to supervise the responsibility of management unit of the school is through (Hint:-you can select at least one options, if necessary)

    a) Working procedures (administrative manual) of the center
    b) Evaluative (i.e. critics) action of the center or 'gimgema' program
    c) health office of the city (By reporting to higher official)
    d) If other please specify,_____

29. Is there internal auditing action on financial statement of the center to community or other stakeholders in accordance with required schedules?

    a) Yes b) No

30. Is there external auditing action (i.e. by health or 'kebele' audit unit) on financial statement of the center to community or other stakeholders in accordance with required schedules?

    a) Yes b) No

31. Do health professionals report (i.e. to immediate supervisor) about their actual performance in this health center?

    a) Yes b) No

    31.1 If your response to question 31 is **no**, the reason behind is

    a. The lack of clear responsibility of the staffs
    b. The absence of follow up
    c. The absence of feed back
    d. report has no value adding to health service delivery
    e. if other, please specify_____

    31.2 If your response to question 31 is **yes**, how often do you report?
    (Hint:-you can select at least one option, if necessary)
    a. daily b. weekly c. monthly
    d. quarterly e. if other, please specify_____

32. Does the health center disseminate information (i.e. through mass media, in annual events, magazines or booklet) regarding its performances to the community?

    a) Yes b) No

33. Do customers present complain freely on the condition of service delivery?
    a) Yes b) No

34. If your response to question 33 is **yes**, do customers get timely response?
    a) Yes b) No

34.1 If your response to question 34 is **yes**, how long official take to settle the complain (problems)?

a) below 1 hour b) from 1 to 4 hour c) from 4 to 7 hour d) above 7 hour

34.2 How do you rate the response provided by the concerned (higher) official (referring to question 33.1)?

a) good b) poor c) very good

35. If your response to question 33 is **no**, why? Because (Hint:-you can select at least one options, if necessary)

a. Lack of awareness in handling customer's complain
b. lack of professionalism
c. there is no public responsiveness
d. there is no clear responsibilities of the officials
e. if other, please specify_____

Thank you!

SECTION I-c

Interview guideline: semi-Structured Interview Questions

Prepared for health center office head

- Name of the interviewee_____
- Sex _____
- Work Experience_____
- Educational level(your grade and profession trained)_____
- Your current work position (title)? _____

1. In Ethiopia decentralization has been implemented to accelerate urban development and hence to meet the millennium development goal i.e. End Poverty. So what do you say the impact of decentralization toward health services? _____
2. Does the health sector work in line with decentralization principle? If No why? _____
3. Does the health sector have adequate mandate and power to make decision on the improvement and development of the health services? If No why? _____
4. Does the health sector work in accountability and transparent manner? If no why?
5. Does the health office decentralize its power and mandate to health centers?

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6. Do you believe that decentralized health service delivery improve the performance of the centers? If no, why? If yes, what are the positive changes?

7. Is there interference from higher organs like health bureau or regional health offices?
   Yes ☐ No ☐ I do not know ☐
8. If yes, at what area do these governmental organs interference become high?
9. Does the health center wok together with local community in improving service delivery? If no why? If yes how?
10. Does the health center wok together with non governmental organization in improving service delivery? If no why? If yes how?
11. Do you believe that the current health service delivery system is adequate when you compare to the growing number of urban population? If no, why? If yes, how?
12. What problems hinder the health center in performing its tasks successfully?
13. What mechanism do you suppose to improve the local health service delivery status?

Thank you

SECTION I-d

Attitude questions
Prepared for health beneficiary

- **A- Personal Information**

Instruction: Please selects and circle the letter that represents your personal information in the space provided.

- Age_____
  i. Below 15 years ii. 16 to 30 years iii. 31 to 40 years
  ii. iv. Above 41

- Sex _____
  i. Male ii. Female

- Educational level_____
  i. Above degree (MA, PhD) ii. Degree level iii. Diploma level
  iv. Certificate level (high school completed) v. below certificate level

- Work in _____
  i. Government ii. Private company iii. Non governmental organization (NGO) iv. Agriculture (farming) v. other type

- **B- Attitudinal question**

Please read the following statements and select only one which indicate your best choice by using a symbol **x** or √ under each row and column

N$^{o.}$	**Description**	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
		A	**B**	**C**	**D**
1	The health center has medical materials such as x-ray, laboratory kits, etc				
2	In this health center services are delivered in transparent way				
3	Customer get prescribed drugs (medicine) in the center				
4	There is adequate health professionals in the center				

5	Health professionals are empowered to make decision at their respective expertise				
6	The health center's professionals are responsive for their clients				
7	the center disseminate information to its client through media				
8	the health center service delivery is decentralized				
9	Health service beneficiary pay reasonable cost for treatment				
10	The number of clients increased at the center				
11	There is a system to check the accountability of the management officials				
12	This health center provide better health service treatment to its client				
13	This health center has adequate space (bed room) to meet its growing clients needs				
14	customer spent a lot of time in queue to get health services				
15	customer has received feedback when they complain in the health center				
16	The center report to the public about its performance or achievement				
18	The center participate the local community in decision making process				
19	The management use community input in decision making process (participatory approach)				
20	After decentralization, health service delivery has been improved				

Thank you

SECTION I-6

Check list for field observation

The following check list intend to conduct observation to study health center's service delivery (i.e. DHC, HHC) conditions

No.	Observed functions/activities/things	value		If **yes,** condition	
		Yes	No	good	poor
1	Is there modern technology application in the health service delivery at the center?				
2	Does the health center have well equipped medical laboratory unit?				
3	Does the health center have adequate medicine in stock or pharmacy unit?				
4	Do clients serve in equal term by the health center?				
5	Is there adequate nurse or medical doctors in the health center?				
6	Is there a system to handle client's complaint in the center?				
7	Is there daily public health care health (lesson) in the center?				
8	Are there high queue of clients for receiving proper health services at the center?				
9	Do clients spend difficult time to get health treatment in the center?				
10	Does the health center bring positive changes in client handling and serving?				
11	Is the cost of health center service affordable?				
12	Is there physical built favorable for health service delivery?				
13	Does the health center have adequate space to serve its clients in a proper way?				
14	Does health worker serve their clients in responsive and accountable manner?				

List of participant

From education center

- Key informant…….Mulugeta Adamu (Teacher….KTSS)

Name of participant for interview	school	Position
• Ato Yihunie Melese	KTPS	Director
• Ato Lamesgine Adamu Tegegne	KTPS	V/Director of
• Ato Aysheshum Ayenewu	KTSS	Director
• Ato Asnake Wasie	KTSS	V/Director
• W/ro Tsigie Habtamu	KTSS	Purchaser and cashier
• W/ro Ejigayehu Mola	KTSS	Accountant
• Ato Aschale Adamu Hailie	MSS	Director
• Ato Aemiro Manaye Alamineh	MSS	V/Director
• W/t Messeret Getachewu	MSS	Book Store
• W/t Tiruwerk Amsalu	MSS	Accountant
• Ato Melak Asefa	DPS	Director
• Ato Alem Kere Asefa	DPS	Record Officer

From Health center

- Key informant……. Zemzem Seid (Nurse)

Name of participant for interview	Health center	Position
• W/ro Mastewal Shinshaw	DMHC	Head
• Ato Fiseha Belay	DMH office	Planning and evaluation head
• W/ro Kidaniemiheret	DMHC	Nurse

From DM town city counsel office

- Key informant……. Melsachewu Demelash ……Mayor-Secretary

Name of participant for interview	school	Position
• Nebyu Minale Mebratie	City counsel office	Mayor
• Kefale Adinewu	City counsel office	V/mayor
• Ato Humniesa Bekele Gemechu	Economic development office	Chief Auditor
• W/ro Belaynesh Lulie	City counsel office	Office secretary
• W/ro Atakltie Abebe	City counsel office	Office secretary

From other organization (civil society-NGO)

- Yitayal Teshome (from Global Fund-World/EMSP)

DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented in any university and that all the source materials used for the thesis have been duly acknowledge.

Name:_____

Signature:_____

Date:_____

This thesis has been submitted for Examination with my approval as a university advisor.

Name: _____

Signature:_____

Date:_____