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The Effect of Decentralization on Quality of Health Care Service Delivery at Local Level in Addis Ababa: The Case of Kirkos Sub-City.

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June, 2020

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A Thesis Submitted to the Department of Public Administration and Development Management of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Masters in Public Management and Policy (MPMP)

June, 2020
Addis Ababa, Ethiopia

Addis Ababa University
College of Business and Economics
Department of Public Administration and Development
Management

This is to certify that the thesis prepared by Bahlbi Brhane entitled “**The effect of decentralization on quality of health care service delivery at local level in Addis Ababa: the case of Kirkos sub-city**” which is submitted in partial fulfillment of the requirements for the Degree of Master in Public Management and Policy (MPMP), complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Declaration

I, Bahlbi Brhane declare that the thesis entitled “**The effect of decentralization on quality of health care service delivery at local level in Addis Ababa: the case of Kirkos sub-city**” is my original work. Moreover, I further confirm that the thesis has not been submitted either in part of or in full to any other higher learning institution for the purpose of earning any degree, and all sources of material used have been acknowledged accordingly.

Name of Researcher Bahlbi Brhane

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Date _____

Abstract

The main objective of this study was to examine the effect of Decentralization on Quality of Health Care Service Delivery in Kirkos Sub-city, Addis Ababa. The study used an explanatory research design and employed only quantitative data. Both primarily and secondary sources of data were applied. Data were collected from 189 respondents selected through convenience sampling technique. Descriptive statistical, correlation and multiple regressions are used in analyzing the data collected. The findings revealed that all the independent variables (institutional health care framework development, Financial health care framework development, accountability health care framework development, Health care Capacity Development Framework, Health care Communications and Coordination framework) have a statistically significant effect on the dependent variable (quality of health care service delivery). Based on the findings, the possible recommendations are Health centers should give much emphasis for essential capacity at health care frameworks required for efficient and effective decentralized health service delivery and budget allocation can be alleviated by allocation of budget based on office requirement and plan.

Key words: *Decentralization, Quality of health care, Institutional health care framework, financial health care framework and accountability framework.*

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Acronyms

- AHcFD Accountability Health Care Framework Development
- ASDM Alternative Service Delivery Model
- CIDA Canadian International Development Agency's
- CSOs Civil Society Organizations
- DSDM Direct Service Delivery Model
- DSDSM Decentralized Service Delivery Model
- EPRDF Ethiopia Peoples' Revolutionary Democratic Front
- FDRE Federal Democratic Republic of Ethiopia
- FHcFD Financial Health Care Framework Development
- HcC&CFW Health care Communications and Coordination Framework
- HcCDFW Health Care Capacity Development Framework
- HR Human Resource
- HSDP Health Sector Development Program
- IHcFD Institutional Health Care Framework Development
- M&E Monitoring and Evaluation
- MLR Multivariate linear regression
- MoH Ministry of health
- PSDM Privatization Service Delivery Model
- QHCSD Quality of Health Care Service Delivery
- RHBS Regional Health Bureaus
- SNNP Southern Nations Nationalities and Peoples
- SPSS Statistical Package for the Social Sciences
- UNDP United Nations Development Program
- UNESC United Nations Economic and Social Council
- USAID United States Agency for International Development
- WHO World Health organization

CHAPTER ONE

1. INTRODUCTION

1.1. Background of the Study

The term decentralization is defined as transfer of power and authority from the central government to regional or sub-national governments (Muriisa, 2008). The main motives for decentralization of the public sector include increase overall efficiency and effectiveness by allowing local governments to improve responsiveness, accountability, performance of the production and delivery services (Simon and William 2004,).

In other hand Mitullah (2012), assert that the notion of decentralization, has got due attention in the 1950s and 1960s while British and French colonial administrations ready colonies for independence by devolving responsibilities for certain agendas to local authorities. Nevertheless, it became well-known in the 1980s and 1990s when it featured as one of the World Bank's structural criteria (Muriisa, 2008 cited in Geberhmeden,2013). According to Gropello (2006), health sector decentralization was one element of a wide program for service delivery improvement. Presently decentralization is being practiced in most the developing countries of the world.

Yilmaz and Boex, (2010) stated many reasons why countries follow decentralization, among these the main rational which led to pursue decentralization was to improve public service delivery and strengthen poverty reduction as a result of central governments were unable to be more responsive, accountable, inefficient or ineffective at delivering public services. In line to this, Kumera, (2006) maintains that one of the factors that led to adopting decentralization has been the realization of the difficulty to manage a country's political, social and economic activities only from the center. This is frequent for most of the African countries that the center has already confirmed to take pleasure in neither the ability nor the time to deal with all matters nearby services and local development, which may be improved at the local level

According to the United Nations Economic and Social Council (2006), Decentralization is an extensive concept that can be both a means to improve the efficiency and effectiveness of public

services as well as an approach to endorse the broader values of pluralistic, participatory democracy. It implies transfer of political, financial, administrative and legal authority from central government to regional/sub national and local governments (Gebermedhin,2013).

According to Robinson (2003), while decentralization has improved public service management in other places, it has not led to any reforms in Africa. He blames this on the lack of political commitment, limited allocation of resources, lack of local units' capacity and lack of legal backing of decentralization changes. However, as World Bank (2014) puts it, Kenya decentralization is a unique case in Africa. It was implemented in 2013 with the full support of the political class, central ministries' bureaucrats, the public and a legal document. The county governments created by devolution are allocated at least 15% of all the national revenue collected every financial year (Constitution of Kenya, 2010). Kenya thus presents a unique case to study the impact of devolution. One of the most noticeable functions of the county governments is health.

As a result, decentralization reforms have come up with different promises counting local level democratization and perhaps improved service delivery for the poor (Tanzania Case Report, 2008). Ahmad, et, al., (2007), had identified some reasons as decentralization will have probability collapse to achieve its promise of improved service at the grassroots level. These include poor institutional design may weaken the links between information flows, service delivery and accountability as a result it may be a leading factor to poor service delivery outcomes. In addition, a poorly sequenced decentralization process may result in worsening of the service provision when local capacity is low.

Following this, there was the implementation of the other African country like; Uganda Health Policy Framework aimed at providing cheap, decent, reachable and quality health care for everyone. In other hand Uganda, develop institutional development framework and significantly affected the structure of the health sector which is the legal frame work to the Ministry of Health limits its functions to regulation, policy making and ownership of tertiary level facilities while county governments take over the function of provision of health services and managing health care funds (Barasa et al., 2017).

Like many other East Africa countries, Ethiopia has preoccupied in the process of decentralization by transferring responsibilities of the state to lower tiers of government. Such transfer of power is believed to bring not only political stability and contribute to democratic

governance, but also improve service delivery and attain equity (Tegegne, 2008). Besides, Ekpo (2007), also noted that decentralization in Ethiopia is a response to ethnic pressure and to agreement and collaboration between different groups and promote local self-rule. Having this fact, the government of Ethiopia has introduced the first and uneven seen decentralized governance since 1995 (Tegenge, 2008).

The decentralization process was implemented in two phases. The first phase was created in four states (Amahara, Oromia, Tigray and SNNP) soon followed by the other states, established a three tiered local administration through their constitutions. During this phase, the regional governments were given responsibility for delivering all education (except tertiary and secondary teacher training) and health service (Garcia and Sunil, 2008).

Following this, the second phase has been introduced since 2001. In this phase, the government decentralized four regions decided to move important sector departments (such as health, education, agriculture extension, and water supply and social sectors) from the zonal to the Woreda level (Yilmaz and Venugopal, 2008). Regional authorities have significant autonomy fiscal and personnel management, and also shoulder significant new responsibilities in terms of service delivery and governance.

Coming to the health sector, Wamai (2009) asserts that since 1993 the government has come up with the first country's health policy in 50 years setting the dream for the healthcare sector development for the next two decades having different programs. In this process on the National Health Policy and Strategy, the 20-year Health Sector Development Program (HSDP) was developed with a series of medium-term implementation plans and speculation programs.

The first phase, HSDP I, enclosed the period 1997/98–2001/02 and was followed by the second phase, HSDP II (2002/03– 2004/05), and the third phase, HSDP III (2005/06–2009/10) (Saharty et al,2009) and now in HSDP IV. Decentralization is an effective method of managing service delivery which are inherently heterogeneous in nature, such as primary healthcare at local level governance (Asia-Pacific Leadership and Policy Dialogue for Women's and Children's Health, by unanimous author Note for Discussion 2012)

This is timely not only because of the 25 years of experience of implementing devolution in the Ethiopia especially main capital Addis Ababa. Because of current initiatives in the Health care decentralizations is changing the structure of government from HSDP II to HSDP III federal

government which is indeed a step even fundamental change that will significantly alter how health services will be governed in the country. But, there is no clear agenda has been stated what change is brought to public health.

According to Addis Ababa city Administrations health office report (2019) shows most of sub city health system is developed frame work to enhance effective management of decentralized health systems. Still there is upside down compline by heath care employees and consumers is existing during my live- in -work experience still need to evaluate what effect decentralization brought to quality of health care service delivery at local level in Addis Ababa focusing on Kirkos Sub-City.

1.2. Statement of the problem

Ethiopia has been characterized by a centralized administration until 1991. Since 1991, a series of reform measures were introduced in Ethiopia to effectively institute a multifaceted decentralized system (Kassa, A. 2015). With the adoption of a decentralized approach, it was expected that the system would create vibrant local governance systems, that can make public leaders become more accountable to their constituencies aimed at enhancing self-reliance, democratic decision-making, citizen participation and better service delivery (Kumera, 2006). Decentralization has been regarded as a viable alternative to centralized governance because, it improves peoples' participation in the decision-making processes and facilitates service delivery at local levels (Taye & Tegegne, 2007).

The Decentralization drive in Ethiopia has proceeded in two phases – first from the federal to regions and chartered cities (Addis Ababa and Dire Dawa) (1991-2001/02), and subsequently in to Woredas or sub-cities (2002/03) (Tegegne 1998). While the first wave of decentralization has registered significant achievements, it was not capable of bringing genuine self-rule and better service delivery particularly at lower levels of administration (Taye and Tegegne, 2007). This circumstance prompted the central government to take an initiative to further devolve powers and responsibilities to the woredas or sub-cities and kebeles in 2002/03 (Kassa Teshager 2011).

Health decentralization started in late 1993, the primary strategy used for improving health services in Ethiopia was the decentralization of authority and accountability of managing health services to sub-national levels (Wamai, 2009). This strategy was part of a broader government

decentralization policy across sectors. In this sector a lot of studies have been done on decentralization and service delivery in Ethiopia but not possibly identified in the effects of decentralized reform on health service delivery.

For example, some studies have revealed that inadequate local authority and autonomy over resources, poor accountability, and insufficient local participation have inhibited effective health delivery outcomes (Kassa & Shawel, 2013; Kassa, 2015; Kilewo & Frumence, 2015; Pundhi & Boke, 2015; Regmi et al., 2017). Majority of them were studied on an Assessment on Decentralized Service Delivery in the Health Sector. In relation to majority of study was finding were nearly the same focusing to the challenges in health service delivery; shortage of sufficient and competence human racecourses, inadequate pharmaceutical commodities, insufficient financial resources and weak leadership are identified as the major challenges.

The negative impact is generally seen in studies that have measured social perspectives. This excludes one qualitative study (Geberemdehen, 2013), whose findings showed a positive view of the impact of devolution on access to maternal healthcare by the users.

None of these has investigated the effect of decentralization on quality of health care service delivery and specifically access to health care services using quantitative methods. This research fills this gap by using secondary quantitative methods to establish if the results reflect the wider literature using the 19th effective management of decentralized health systems development frame work developed by WHO (2014) a such as; capacity development, accountability framework development, financial framework development, institutional framework development, communication and coordination framework development. The causes of these problems their impact on the quality of health care service delivery. The study substantiated the gaps in empirical analysis in terms of health service accessibility, accountability, institutional capacity, institutional coordination's and financing to the service delivery in health. In this respect, the study substantiated evidence that implies the improvements in health service delivery in terms of accessibility and quality to filling the gaps. The result from this analysis generated evidence to improve understanding about the factors that are affecting the sub city's health care service delivery in the specified public service areas. On the basis of these gaps, this study was to assess the effect of decentralization on quality of health care service delivery in Kirkos sub-city of Addis Ababa.

1.3. Objective of the study

1.3.1. General objective of the study

The general objective of this study was to examine the effect of decentralization on the quality of health care services delivery.

1.3.2. Specific objective of the study

- To examine the effect of institutional framework development on the quality of health care service delivery
- To determine the effect of financial framework development on the quality of health care service delivery
- To investigate the effect of accountability framework development on the quality of health care service delivery
- To examine the effect of capacity development on quality of health care service delivery
- To determine the effect of communication and coordination framework development on quality of health care service delivery

1.4 Hypothesis of the study

Ho1: Institutional framework development does not have a significant effect on the quality of health care service delivery

Ho2: Financial framework development does not have a significant effect on the quality of health care service delivery

Ho3: Accountability framework development does not have a significant effect on the quality of health care service delivery

Ho4: Capacity development does not have a significant effect on quality of health care service delivery

Ho5: Communication and coordination framework development do not have a significant effect on quality of health care service delivery

1.5 Significance of the study

This thesis makes a significant contribution to the knowledge effective management of decentralized health system. The study will contribute to the existing body of knowledge relating to decentralized health care services delivery in general and local level health service provision in particular. The value of this study is that it adds to assess of the quality of health care service provided to the community is also important. It is empirically providing the existing practices of decentralized service delivery in the health sector and there is little empirical evidence on the improvement of quality health care service delivery at the sub-city level. Again this study will contribute to develop the understanding how policies and programs are implementing and what factors are affecting the decentralization process of local health care service delivery. In addition this study will able evaluate the current statues of local governance in health care service delivery of the sub-city. It is important to study how to make the quality of health care service delivery effective and efficient through different decentralization reform measures. Therefore, it is important to study how decentralization improves the quality of health care services at the sub-city health administration and the federal government can significantly advantageous to rearrange the local health care service delivery system.

1.6 Scope of the study

This study was focused particularly on the effect of decentralization on the quality of health care service delivery at local level in Addis Ababa Kirkos sub-city public health sector. There are ten sub-cities in Addis Ababa city government from these the researcher selected Kirkos sub-city. The scope of the study was delimited to assess the effect of decentralized governance on the quality of health care services such capacity development, accountability framework development, financial framework development, institutional framework development, communication and coordination framework development .

The geographical scope of this study was due to resource constraint, it is difficult to cover all sub-cities and to keep the study manageable, however, the study was focused on the one sub-city located in Addis Ababa which is, Kirkos sub-city.

1.7 Limitations of the study

This study was limited in Addis Ababa only among the various regional states. it is also limited in Kirkos sub-city public health sector among 10 sub-cities, its due to the difficulties to cover all other regional states and other sub-cities regarding with limited time, costs and availability of information, the outbreak of pandemic disease and closure of libraries and lack of internet cafes following it have also contributed significant problem during the study. The researcher again faced the problem of the unwillingness of some staff of the selected health centers to answer questions on the questionnaires.

1.8. Organizations of the study

This study is structured in five chapters. The first chapter deals with background of the study, statement of the problem, objectives of the study, hypothesis of the study significance of the study, scope and limitation of the study, definition of terms and structure of the paper. The second chapter covers the review of literature, empirical study, and conceptual framework in the area of study. The third chapter discuss about the methodology employed by the study. The fourth chapter presents about data analysis and discussion of data collected. And finally chapter five contains summery of findings, conclusion and recommendation of the study.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Theoretical Concept of Decentralization

The concept of decentralization is a vague term because several understandings are being used for the same term. However, what should be noted is that none of the conceptions offer a comprehensive theoretical, methodological solution that will help us determine how decentralization should be carried out. But different approaches provided important concepts and guidelines for designing and implementing decentralization policy as a strategy for development in general and service delivery in particular (Fenta, 1998).

Decentralization is often proposed as a way of reducing the role of the state, by fragmenting central authority and introducing more intergovernmental competition, in a way that doesn't loosen checks and balances at all (Pranab B, 2002). It is viewed as a way to make the government more responsive and efficient (ibid). For this reason, governments tend more and more towards its application (ibid). The main thing for this tendency as argued by many researchers is that, a decentralized system of government is more likely to result in enhanced efficiency and good governance than their centralized counterpart (Muruiu, 2013)

According to Rondinelli. (1999) decentralization is stated as the transfer of power and responsibility for public functions from the central government to the local government or quasi-independent government organizations or the benefit of private sector. In the classical sense, this concept, which refers to the transfer of authority, responsibility and resources from central government to local governments, has a decisive role in central government local government relations (Erylmaz, 2011).

Several definitions have been offered for decentralization. One of the most general defines it as the transfer of responsibilities and authority from higher to lower levels of government. Decentralization seeks to create relationships of accountability among citizens, service providers, and sub-national governments and between the local and central governments. This characteristic counteracts the perception that decentralization is simply shifting resources to local governments (World Bank, 2008).

Decentralization, in the modern sense, can be expressed as transferring administrative authority such as planning, decision making and the collection of public revenues from the central government to provincial institutions, local governments, federal units, semi-autonomous public institutions, professional organizations and voluntary organizations outside of the administration (Erylmaz, 2011).

Decentralization is a complex multifaceted system, which refers to the transfer of power, authority and accountability to local governments, semi-autonomous public institutions or regions. Decentralization is the most suitable mode of governance through which poverty reduction interventions can be conceived, planned, implemented, monitored, managed and evaluated (White, 2011). Besides, Turner and Hulme, (1997) cited in Thomas (2010/11) define decentralization insight of service delivery as a devolution of power to supply services to the public from central government to local government units, which are nearest to the public to be provided. Consequently, this definition demonstrates that decentralization refers to the transfer of power for decision-making, managing and provisioning of services to lower units of government.

In practice, decentralization entails the spread of power from a higher level to lower-level units, within a central government, from central to regional and local governments or from regional to local governments (Tegegne and Van Dijk, 2005; Jha and Mathure, 1999).

2.1.1 Decentralization Type

According to Olsen (2007), there are three forms of decentralization within the public sector: These are political decentralization, fiscal decentralization and administrative decentralization.

1) **Political Decentralization** -this refers to the process of giving citizens more power to influence public decision - making and the formulation and implementation of policies through elected leaders. This involves coming up with structures to improve people's participation in local political processes which provides mechanism of checks and balances (Sutiyo, 2014).

2) **Fiscal decentralization** - This is the process of transferring budgetary authority to the local authorities. It involves yearly allocation of resources to the devolved areas and authority to manage as per their priorities as it is necessary. The fiscal decentralization on policy would normally also address such issues assignment of local taxes and revenue sharing through local taxation and user and market fees (Olsen, 2007).

3) **Administrative Decentralization.** Refers transfer of responsibility for the planning, financing and managing of certain public functions from the central government to the local or regional government unites. On the other hand this means shifting responsibilities from central government officials in the capital city to those working in regions, provinces, and districts (Fritzen & Lim, 2006).

2.1.2 Forms of decentralization

There are different forms in which decentralization can be achieved, namely, de-concentration, delegation, devolution, privatization and de-regulation (J.D.Barkan 1998).According to Barkan these forms of government are discussed as follows.

- **Delegation** –Refers to share of responsibility for decision-making to organizations ultimately responsible to it.
- **De-concentration** –Refers to transfer of authority, financial and management responsibilities among different levels of government.
- **Devolution**– Refers to distribution of responsibility to local governments who elect their own functionaries and raise their own incomes.
- **Privatization** – Refers to shifting of responsibility for functions from public to private sector (for-profit and not-for-profit purposes).

2.1.3 Objectives of Decentralization

Many governments of the world use decentralization for various political, administrative, and economic purposes: “Increase people's participation in local development, planning, and management, coordinate administrative functions, political and administrative "penetration", creating social equity, more effective coordination, allowing local "experiments", lead to more flexible, innovative and creative administration, isolated or backward areas of development, integration of regional economies, macroeconomic stability, improve political stability, decentralizing public goods and services, participation planning, monitoring, and evaluation, delivery of goods and services, local-level financial management and administrative efficiency (Priyantha, 2019).

According to WHO report (2010) there are many objective of decentralization of health-care services is to improve efficiency of delivery and equity of outcomes. The potential benefits are many, including:

- Cater to local needs
- Decrease in duplication of services
- Innovation in service delivery through experimentation
- participative decision-making
- Increase in accountability and transparency of health services through user oversight
- Reduction of inequity between rural and urban areas
- Greater integration of activities of different public and private agencies
- Improved inter-sectorial coordination

2.2. Decentralization in Health Services

Decentralization of health-care services relates to the transfer of responsibility for planning, financing and management of health-care services from central or regional government and its agencies to local government, semi-autonomous public authorities or corporations (WHO, 2010).

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 (Saltman, 2007). 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, greater integration of activities of different public and private agencies and improved intersectional coordination.

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.

As cited in (Mahmud Muktar, 2011) 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.

2.3. Effective Management of Decentralized Health Systems

Effective management of decentralized health systems in the country developed by WHO (2014), in terms of delivering health care with equity, the prevalent legal and institutional frameworks, approach to fiscal decentralization, mechanisms to ensure accountability and available capacity at various levels. This assessment would need to be conducted in the context of the health system's design and inequities in coverage, access, utilization and outcomes. Decision space analysis has been effective in describing and improving decentralized health systems, and could be used for this work. It would also be useful to assess and evaluate the structure and functioning of decentralized health systems in other countries to learn from their experience United Nations Economic and Social Council, (2006 Cited in WHO, 2014).

- **Institutional framework development:** Refers to assigning functions, responsibilities and resources according to the intended objective for the respective level of government as well as a realistic assessment of the technical and financial capacity at each level. Certain issues in the health sector may be better retained with the center, e.g. epidemic control. Create/ re-design new administrative units/ centers of responsibility, as required. Assigning functions to avoid overlap and mismatch of responsibilities and decision-making authority. Monitoring & Evaluation frameworks should be developed alongside. Insulate the system from the influence of vested interests and powerful local groups, which may attempt to limit the intended objectives of the decentralization process.
- **Financial framework development:** Refers to analyses on how local governments finance health expenditures (through own revenues, transfers from central government, or shared revenues) and identify where local finances may need increase. Consider approaches to augment government funding where necessary, including through alternate sources of finance such as donors, private sector, CSOs and user charges. It also refers to hit these sources based on an assessment of requirement and potential to contribute, and the absorptive capacity at the local level. Work towards providing budgetary certainty to

local units of administration for health expenditure, e.g., by earmarking funds through the inclusion of a specific budgetary line item in the central government finances. An essential package of basic health services delivery or a new decentralized health service model, the crucial issue of financing the decentralized health system may be overlooked (World Bank group, 2001). A substantial financial gap between availability and plan can be agreed the health sector's ability to provide equitable, efficient and good quality services under decentralization (ibid).

- **Accountability framework developments:** Designed to introduce a monitoring framework to ensure accountability of the local government (World Bank group, 2001). Devise feedback mechanisms so that the local governments are not in a position to abuse their power. Engage civil society in an oversight role with regards to service delivery quality, accessibility and affordability (ibid). The links between the central government, local government, the private sector, and citizens must be designed to ensure that providers of infrastructure are accountable to those who pay for the services as well as those who benefit from the services (ibid). Participatory mechanisms should be structured so that the entire community can participate in infrastructure decisions, particularly regarding location and financing issues which have substantial distributive implications (ibid). Enhancing the availability of public information regarding budgetary and procurement decision making is important for community participation and accountability. The World Bank's Economic Development Institute is currently conducting workshops with local governments worldwide to enhance participatory budgeting and open procurement processes (World Bank group, 2001).
- **Capacity developments:** - Create/ enhance capacity at all levels to implement the various frameworks required for efficient and effective decentralization. Train government health care workers and civil servants in planning and managerial skills at the decentralized level, and the whole system administration at the central level. Recruit and train health workers to meet shortfalls compromising efficient health service delivery (World Bank group, 2001). Refusing capacity constraints at either central or local levels, or giving inadequate or delayed attention to training staff for their new roles are very serious omissions with predictable effects on health services(ibid). Decentralization places a considerable new management burden especially on the lower levels (ibid). Qualified health managers have lack of supply in many countries (ibid). Furthermore,

management training capacity may be insufficient to meet the rapidly expanding training needs (ibid).

- **Communication and Coordination:** - Implement efficient coordination and information sharing mechanisms among the various levels of administration and decision-making to ensure information asymmetry does not hamper the effective delivery of health services. (World Bank group, 2001).

2.4 Quality of health care service delivery

Quality of health care service delivery is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (WHO, 2018). It implies that quality of care can be measured ultimately aimed at health improvements rather than simply increasing service inputs or refining system processes, and should reflect the desires of key stakeholders, including service users and communities.

As cited in (Tirunesh Bazezew, 2013) “There is no single, universally accepted definition of health care quality. It is because; health care quality involves descriptions of many different, complex aspects of care from several different perspectives (ibid). Quality may be measured in terms of outcomes, the end results of care and treatment, or it may be evaluated in terms of process, the way in which the care is delivered. Researchers, health care providers, government, and consumers may all assess health care quality differently” (Barbara, 2002).

According to (Jeanmarie, 2005), quality as it relates to healthcare, represents the overall satisfaction with life during and following an individual’s encounter with the healthcare system its organizations and providers. Quality acts an indicator of satisfaction based upon an individual’s experience while receiving medical care. As cited in (Jeanmarie, 2005) “comfort factors, dignity, privacy, security, degree of independence, decision-making autonomy, and attention to personal preferences” (Shi & Singh, 2005, p.27) are all significant attributes of healthcare that are important to most people. These essential factors influence healthcare consumers in making decisions about specific providers and facilities.

Generally quality has been defined at a clinical level, and it involves offering technically competent, effective, safe care that can be described and measured differently (WHO, 2004).

There are about three categories of quality. The first one is client quality, what consumers want from the service, individually and as population; this can be ensured by consumer, satisfaction. The second one is professional quality, which deals to meet consumers need, focus on about service delivery system ensured by standard setting and the process of clinical professional or organizational audit. The third one is management quality; focuses on efficient and productive use of resources to meet consumer need (J. mark, 1994)

By including health services in general, this definition of quality of care spans both curative and preventive care, and facility and community-based care for individuals and populations (WHO, 2018). This scope is particularly important in countries facing an increasing burden of non-communicable disease and whose health systems must provide services across the life course, including risk reduction, screening, disease management, rehabilitation and palliative care (ibid). As there is a steadily growing evidence base on the effectiveness of various modalities for disease prevention and control, this definition of quality of care also acknowledges the need for methods to incorporate new evidence into service delivery systematically(ibid).

The quality of health service delivery in health facilities is growing recognition as a strategy for monitoring and evaluating primary health service plan in developing countries (Roemer et al, 1998). Under a simple inspection-based system, quality of service delivery is a process of ensuring that conforming service is delivered to the customer, or activities are assessed and then compared with the specified requirement to assess conformity (Barrie et al, 1994). Quality as conformance to the requirement is frequently misunderstood to mean purely conformance to specification. Crosby believes that conformance with the requirement is conformance to both specification and customer needs (Peter and Debram, 1993).

Quality as perceived by the recipient is critical to the complete definition of quality of service delivery. Quality of service delivery consists of two interdependent parts; quality in fact and quality in perception. The first involves meeting one's own specification (conformance to standards), and the second part is meeting the expectation of one's customer. Clients often evaluate qualities of service delivery in health service in terms of factors such as staff courtesy, degree of concern, cleanliness, promptness or timeliness in getting service (Vincent, 1991).

There are two elements in the performance of the service providers: technical skill and interpersonal skills. Technical skill depends on the knowledge and is judged in comparison with the best in practice (standard). The interpersonal skill is the use in which service provider

communicates information necessary for effective service, but this skill should meet social and individual expectations and standards. Those standards, if applied, are generally expected to lead to desired results (Donabedian, A.1988).

Availability, accessibility, and utilization are essential elements of the quality of service. The argument is if area services are not available, accessible and not utilized by the people the quality is related as a zero. Poor quality of service, with its resulting consumer dissatisfaction, increases dropout rates underutilization (Kincey, 1995).

According to the (WHO, 2014) strategies, quality of health service delivery involves the right care, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste . Quality health care increases the likelihood of desired health outcomes and is consistent with seven measurable characteristics: effectiveness, safety, people-centeredness, timeliness, equity, integration of care and efficiency (ibid).

2.5 Models of Service Delivery

According to UNDP, (1999 as cited in Alemu Teferi 2018) service delivery is a place of institutional arrangements approved by the government to offer public goods and services to its citizens. Based on this, the institutional arrangements that significantly affect the most important thing of public service delivery in different systems of services can be divided in to four fundamental forms of public service delivery preparations that governments applied in all place (ibid).

2.5.1. Decentralized Service Delivery Model (DSDSM)

This model refers to the most popular model in most countries through devolution of power to sub national units. Decentralization is based on complementary principles of governance; regulations anywhere provision and deliverance of services are to be devolved to the local governmental level, local units, subject to economies of scale and capacity. Although desirable quality is positive, local units are improved located to game supply of a specified service to citizens 'demands, transforming citizens from service receiver to customer, as well as ensuring citizens better accountability for service quality (UNDP, (1999 as cited in Alemu Teferi 2018)

2.5.2. Privatization Service Delivery Model (PSDM)

Administration moves the public services to private delivery enterprises for achievement of effective service. For that matter, the government has no accountability except supervising the

business companies' based on the lawful systems. In addition to that, Transportation and communication services are privatized in various nations. And also, the essential reason of privatization is to increase benefit of allocate efficiency of the market mechanism and to meet supply gaps through assembling private sector speculation in the public service sector. UNDP, (1999 as cited in Alemu Teferi 2018)

2.5.3. Direct Service Delivery Model (DSDM)

The central government carry out legislation, put into effect it, appoint employees, spends, generates and allocate services, mobilize resources, either straightly in service from the center or through de-concentrated line agencies, presuppose complete accountability, and is responsible not only for provisioning but also for delivering services effectively. UNDP, (1999 as cited in Alemu Teferi 2018)

2.5.4. Alternative Service Delivery Model (ASDM)

Alternative service slivery simulates the relationship between the government and private sector with different contractual arrangements. Though, the authoritative ownership is generally vested in the hand of government, and it maintains the power to provide public services, while the private parties produce the genuine service delivery. UNDP, (1999 as cited in Alemu Teferi 2018) With regard to the relevance of the above forms of service delivery, decentralization Service Delivery Model is more related with the study. Based on this understanding this research assessed the effect of decentralization on primary health service delivery

2.6. The relationship between decentralization and service quality

Decentralization on quality and how the changes in the primary health organization affected the quality of primary health care. These approaches are made on the understanding that changes in health system organizational structure directly or indirectly affect the delivery of health services (Wakida, 2005).

The relationship between decentralization and service quality is achieving a high level of customer satisfaction. Most researchers suggest that level of service quality and decentralization should be delivered by the service provider as service quality is normally considered an antecedent of customer satisfaction (Cronin, et al 2000).

Henceforth, the exact relationship between decentralization and service quality has been described as a complex issue, characterized by debate regarding the difference between the two constructs and the casual direction of their relationship (Brady, et.al, 2002).

According to Tesfaye, (2006) Service Delivery fundamentally refers to the methodical arrangement of activities in service giving institutions with the purpose of fulfilling the needs and expectations of service users and other stakeholders with the optimal use of resources. Service delivery improvement contributes to the establishment of administrative machinery that can face the challenges of the 21st century. For doing so; Mitullah (2012) reveals that most of the African metropolises have been accepting different forms of administration for effective service delivery, since the 1990s.

Decentralizing service delivery has been a fashionable approach since 2002 when UN-Habitat launched the Global Campaign on local and urban Governance. In favoring the advantage of decentralization Tesfaye, (2006) reveals as it raises the efficiency and responsiveness of government, locally elected leaders know their constituents better than authorities at the national level and so should be well-positioned to provide the public services delivery local residents want (ibid). Forcibly nearness makes it easier for citizens to hold local officials accountable for their performance. Even though the reason for decentralized governance is to create financial, efficiency and quality gains by devolving financial resources and executive powers to local governments for the delivery of services. It is financially costly to national governments since part of a load of financing services can be transferred to sub-national units and private providers which can produce these at a lesser cost (Robinson, 2007).

Decentralization policies and programmers' appropriately planned, decentralized governance can have a positive effect on the performance of local governance institutions, service delivery agencies. So, it is mandatory that the policies and programs have to consider local governments' capacity based on the following instruments (Bertuci, 2001).

2.7. The effect of decentralization on services quality

The effects of decentralization anchor on the details of its design. Decentralization varies along several dimensions: (1) the specific functional responsibilities being developed to sub-national levels of government; (2) the recipient level of government, that is, local, municipal or provincial; (3) the amount and nature of changes in sub-national financing (tax assignment,

conditions for intergovernmental transfers, borrowing rules); and (4) the changes in the mechanism for sub-national political accountability (election versus appointment of mayors, for example) (World Bank, 1998). In Sub-Saharan African countries, these various aspects of decentralization have occurred to different degrees and not simultaneously. Thus, it would be important to understand the effects of different decentralization designs.

Effective decentralization needs adequate financial and staff resources. Sub-national governments must have the legal authority to raise revenue to support its expenditure requirements. Thus, the fiscal relationship between the center and lower-levels of government must be clearly worked out on the basis of equity, fairness and justice (Azfar, et al (2005)

Decentralization improving the quality of service delivery in lower levels of government can deliver services such as water, education, sanitation, health etc effectively. Also, at the lower levels of government, politicians and civil servants are more aware of the needs of their community that will be more responsive to providing such services. Preferences of local populations are better known at lower levels of government (World Bank, 2001).

Decentralization reforms are bound to have varying levels of success in achieving their intended effects on health systems, such as equity in population health outcomes, health system efficiency and health system resilience, including how community engagement influences these effects. But it is also possible that one or more of these measures of impact may improve at the expense of others. Given that decentralization reforms are often implemented independent of considerations for their impact on the health system, in some settings, decentralization reforms may interact with previously centralized health systems, and in other settings they may interact with existing forms of decentralization in the health system. It is therefore important that health sector stakeholders understand and are equipped with strategies to maximize the positive and minimize the negative impacts of decentralization reforms (and of these interactions) on a range of measures in different settings (Seye Abimbola, 2019).

Decentralization health service quality is as a significant dimension of health care which may be understood at two different levels: first as a whole including the resources, the activities, the management and the outcomes of health care - this would imply that quality is the merit or excellence of the system in all its aspects second at a more restricted level it may be considered to be one of the features of the health care resources and activities Panda and Thakur (2016).

2.8. An Overview of Decentralization and Public service delivery in Ethiopia

According to Abraham, (2011) before 1991, like many other African countries; Ethiopia has been a passed through a multifaceted problem of ethnic groups with a diverse religious and cultural backgrounds. The country has a strong centralized system of governance for many years. As a result, the question of decentralized governance started during the last decade of Emperor Haile Selassie regime (Fenta, 1998) cited in Abrham, 2011).

Having this the imperial was governments to attempt decentralize to the local units the so called Awraja administration. The most important intent of woreda administration at the time was enforcement of commandment and collection of levy and only few agencies like police, finance and justice were devolved at wereda level (Kumera, 2006). These services were centrally financed and prohibited.

During that time the self-administration proclamation as a pilot project 50 to make 50 Awrajas self-administering units with substantial independence, the first uneven tried to decentralize local and regional government in the history of Ethiopia was made in 1966 by the Haile Selassie government (Meheret, 1998). The first comprehensive administrative decree No. 1 of 1942 defined the power and role of the Ministry of interior as the principal central government department to supervise local government throughout the country (Abrham, 2011).

However, the effort for decentralization beneath the imperial government and dictatorial regime commonly recognized as it was stayed inappropriate owing to severe control of public services in a centralized approach (Kumera, 2006). After the collapse of Imperial rule, the Derg government controlled the political power in 1974. Though, it did not also have a better achievement in decentralizing power from the center to the grassroots level more than the Imperial regime (Meheret, 2007) cited in Abraham (2011). Then, the attempts of Derg decentralization policy was futile due to the fact that it is not basically designed to grant self-administration, secure the preservation of place and stability of the country (Fenta, 1998).

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.

With the failure of the halfhearted decentralization reform effort under the most authoritarian regime, the country was thrown into further turmoil that precipitated the collapse of the regime and its replacement by the EPRDF forces in May 1991 (Meheret, 1998 cited in Gebermedihine, 2013). Capacity must exist at the sub-national government level. The sub-national government must have sufficient professional and well-trained staff. Where shortages of qualified and experienced persons exist, the training and re-training should be put in place in order to develop professional and technical expertise that will provide public services efficiently. Capacity connotes the ability, competency, efficiency of sub-national governments to plan, implement, manage and evaluate policies and strategies on how to improve the service quality (Daniel, 2002).

Following this Ethiopia has been decentralizing functions, resources, and authority to the local level. A more decentralized health care system has been part of this movement. The first wave of decentralization resulted in the MoH, regional Health Bureaus (rHBs), and Woreda health offices sharing the decision-making about the design, development, and implementation of the health system (USAID, 2019).

To this end the government had developed four consecutive strategic plans with a strong devolution of power to the local authorities starting since 1993. These are; first phase, HSDP I, enclosed the period 1997/98–2001/02 and was followed by the second phase, HSDP II (2002/03–2004/05), and the third phase, HSDP III (2005/06–2009/10) (Saharty et al, 2009). Thus, the government has practicing these planned development programs cited in Gobermedihin, 2013).

For the implementation of all these health sector programs the government of Ethiopia has adopted a strategy of integrated health services centered on primary health care. The six-tier system encompassing health posts, health stations, health centers, rural hospitals and referral hospitals were replaced by four-tier system. The four-tier system consists of primary health care units (a health center with five satellite health posts), primary hospitals, general hospitals, and specialized referral hospitals with catchment population of 25 000, 100 000, 1million and 5million respectively (World Health Organization and Global Health Workforce Alliance,2019).

2.9. Empirical Evidences

Many empirical studies have revealed that an effective decentralization process as part of the reform makes a difference to achieve goals of the organization. The existing theories of decentralization in developing countries offer a variety hints on the impact of the implementation of this system itself. Those impacts are still debatable as to whether or not this system was bringing benefit to citizens. There is much empirical evidence to suggest that in some cases, decentralization have positive impacts to service delivery, government performance, economic growth or reducing corruption. In the other hand, there are also some results, which show that decentralization creates higher perceived corruption and poorer service delivery performance. Therefore, this section reviews some previous empirical findings about decentralization and public health service delivery.

The overall assessment of the federal decentralization system of Ethiopia as presented by a World Bank working paper looks like a progressive fiscal federalism. However this progressive fiscal federalism as described in the report is not accompanied by similar political arrangements. Ethiopian local governments have a high degree of upward accountability mechanisms without the accompanying discretion and downward accountability mechanisms. Ethiopia's complex decentralization arrangements highlight horizontal political accountability of federal, regional and local level executives to their respective regional parties and EPRDF. The design of local government finances and administrative arrangements, which establishes hierarchical controls, rules out opportunities for real political competition. Local government structures in theory may be in line with the expectations of donors and multi-lateral institutions but the party structures seem to keep a tight control over the so called democratic institutions. The lack of separation of executive and legislature coupled with the lack of political competition ensures weak discretion and accountability at the local level (Yilmaz and Venugopal, 2008).

A study conducted in Nigeria by Okoji there are some encouraging results in some aspects; the overall assessment of decentralization is not encouraging. According to him this discouragement is attributed to: first, there is the over-concentration of political and financial power as well as human resources at the federal level to the detriment of state and local governments. Second, there are inadequate finance and insufficient tax power on local governments. Third, decentralization in Nigeria has limited the powers of local government on budgeting and staffing. Fourth, there is no set minimum standard for quality, quantity, and access from central government to local government. Fifth, there is a lack of human resources in local governments, Hence, his overall assessment is expressed in his words as: service delivery in the country has been largely characterized by waste, inefficiency, and deteriorating quality over time (Okojie, 2009).

The process of decentralization in Uganda the conventional conception of decentralization which comprises a national project, transmitted outward from the capital through the establishment of a set of formal structures and procedures (Francis & James, 2003). In order to reach on these conclusions these two authors developed two modes of operation that could accommodate the existing contradiction between the center government interference and local participation. This study conclude that the benefits of decentralization are considered to include improved efficiency of public service provision, more appropriate services, better governance, and the empowerment of local citizens.

The Economic Policy Research Centre, (2010) noted that health service system the accountability framework has a variety of stakeholders with varying degrees of responsibilities and voice. These include the patients or service-users (who may be citizens); policymakers (e.g. politicians and technocrats at central and local governances); the service providers (e.g. medical superintendents); and finally, frontline staff (doctors and nurses). Generally from this points of view one can conclude that accountability in public service delivery is the main ingredient of its practices if not there may be a failure of local government system in its service delivery.

Bandara (2011), in his research reveals that one of the major critical factor of efficiency and effectiveness of services provided by decentralized local governance institutions is the human resource or staff which it has. In this way adequacy and capability of that staff is very important. As a local government institution, a one of the major challenges faced in service delivery is deficiency of sufficient staff and incompetence of such staff to deliver the services efficiency and

effectiveness manner. Lack of capacity and financial management capacity and may therefore not positively impact local governance. In this case local governance system often lacks fund raising capacity, the educational background of councilors is also often too low, relations with the central government are also not often clear. Local councilors lack the required human resources and financial resources to effectively meet public service requirements (M. M. Daemane,2011).

Consistent with the result of this study prior empirical evidence found significant relationship between institutional health care framework development and quality of health care service delivery (Muriisa, 2008) maintains that the targeted institutional health care framework development dealing with people's desires at the grassroots positively.

Sasaoka, (2005), in this study the institutional capacity of woreda governments is near to the ground, and there are no sufficient skilled personnel and administrative resources available. Regional governments are supporting wereda governments in budget management. Decentralization has been criticized since of inadequate training of woreda governments; its proponents, however, claim that institutional capacity building is impracticable to achieve without actual transfer of funds. As a result the federal government has introduced different reforms to improve the local service delivery among this fiscal or public financial management is one of the components in decentralized and health service delivery in the local administrative units, though it need a further investigation how much the local government institutions are capable of implementing their duties.

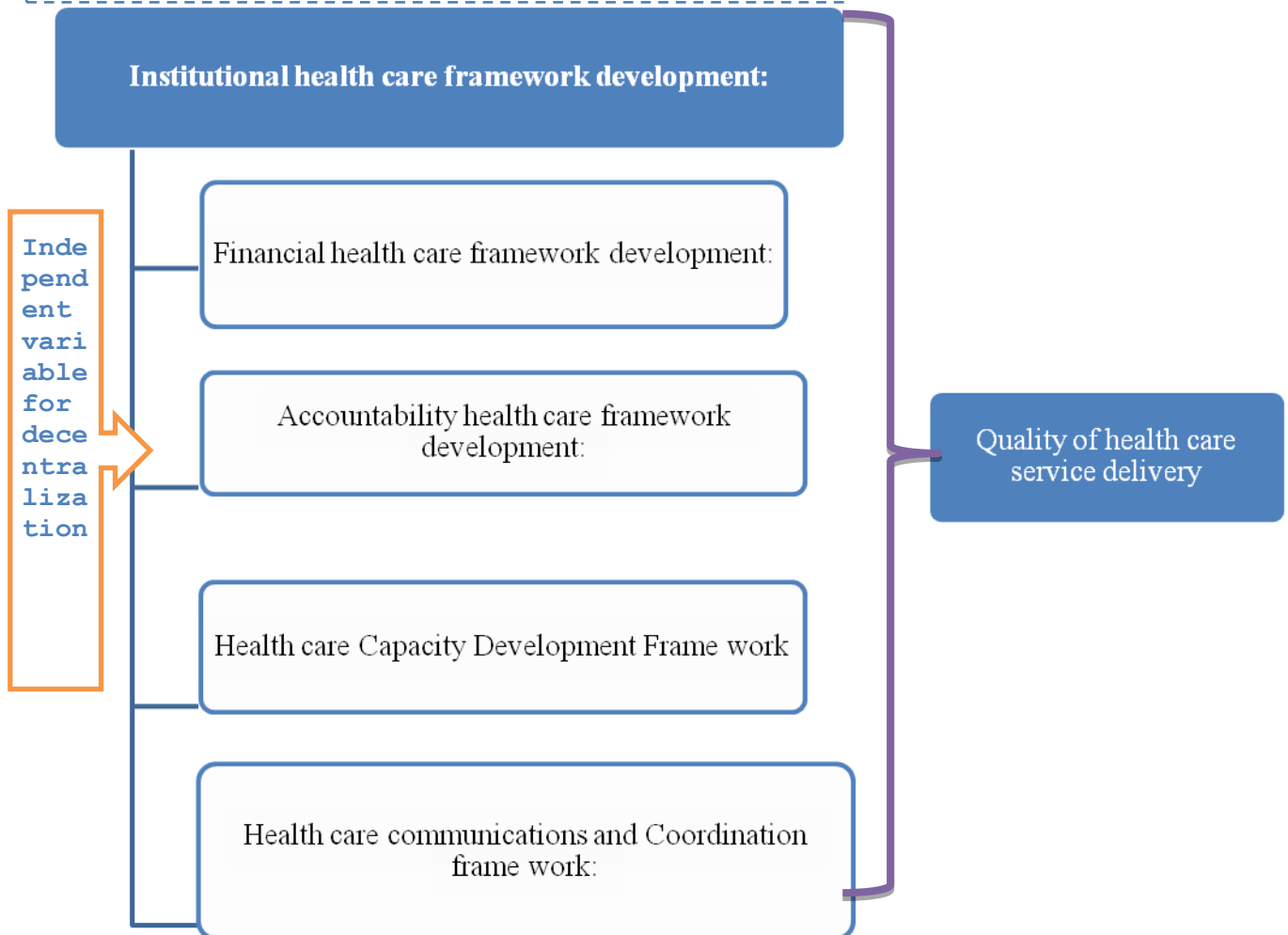
Social Protection Committee (2013) adds that financial health care framework development is measured by the number of health workforce with the correct skill mix to match people's needs and the supply of medicine and equipment as well as access to pharmacies.

Contemporary research studies by Shrestha (2010) argues that there may in adequate supply of facilities and staff close to the people but they may not be utilized the capacity development. In such scenarios, people tend to move to other areas in search of affordable services. Therefore, it is important to take account of the capacity development aspect. Similarly, to Gulliford et al (2002), adds that bed capacity is an important indicator raised concern that financial health care development is not enough to measure access because of financial or organizational obstacles, which could hinder one from accessing available services. Gulliford et al. (2002) posit that access largely depends on physical accessibility and affordability.

To summarize, most of these empirical studies have revealed existence of a relationship between decentralization and quality of health care service delivery. In addition it is important that organizations link decentralized practice to quality of health care service delivery.

2.10. Conceptual Frame Work

Fig 1: conceptual frame work



Source: Adopted from Who,2014 by Author adopted in,2020

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1. Research Design

According to Rajendra K, (2008) a research design is the arrangement of events and conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. Therefore, it is the conceptual structure within which a research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data (Kothari 2004).

Explanatory research is useful for studying relations between causes and effects (Kothari, 2004). In this study, as explanatory research, this study was to examine the effect of decentralization on quality of health care service delivery. Accordingly, this study was employed explanatory research. The main purpose of explanatory research studies is to formulate a problem for more precise investigation or to develop the working hypotheses from an operational point of (Kothari 2004). This type of research also helps to identify the causal links between the independent and dependent variables.

3.2. Research Approach

The research approach used in this study was only quantitative approach. Quantitative research focuses on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon. Quantitative research approach used to show and represent questionnaires response. The quantitative approach was employed to grasp the attitude of respondents regarding the health service quality, health service accountability, financial framework development, institutional framework development, health care capacity development, health care communication and coordination framework in the study area. Theses data's was collected from respondents using questionnaires. To this end the Quantitative research chosen to obtain quantitative view point of analysis and inference techniques on the effect of decentralization on quality of health care service delivery.

3.3. Selection of the Study Area

The study was conducted in Kirkos sub-city to investigate the effect of decentralization on quality of health care service delivery. Kirkos sub-city is found in the center of the capital city Addis Ababa with a diverse socio-economic characteristics community and the easy access of service delivery, it is appropriate as well as timely to investigate the effect of decentralization on quality of health care service delivery in the health sector in particular. In the sub-city, it has 11 woredas and 8 governmental health centers. The main purpose to select Kirkos sub-city in health service delivery are basically inadequate and aggravated by poor socio-economic. In addition, the proximity of the researcher to health services in this sub-city and the preliminary assessment made has revealed the prevalence of various problems related to service delivery in the area. Moreover, conducting a study on more sub-cities requires more time and resources and these limits making thorough analysis of the subject. Therefore, in line with the above reasons, Kirkos Sub-city was purposively chosen as area of study to investigate the effect of decentralization on quality of health care service delivery.

3.4 population and sampling Procedures

3.4.1 Population

A population can be defined as all people or items (unit of analysis) with the characteristics that one wishes to study (Kothari, 2004). The target population of this study was professional employees of the health center and customers of health center. In the sub-city, there are eight (8) governmental health centers. Among eight public health centers four public health centers were selected by convenience sampling method. Due to resource constraint, it is difficult to cover all these public health centers, and to keep the study manageable, however, the study was focused on the four health center which are, Kirkos health center, Felegehiwot health center, Meshulekia health center and Gotera mesalecha health center. From the selected public health centers the total population was 740 professional employees according to 2020 report. Having this total population, the sample size of the study was determined sample size from total population. With regard to sampling frames participants were selected from all professionals.

3.4.2. Sample size

As Mike Slovin (2007), developed a means of determining sample size from large population and becomes representative possible sample size. By using the Mike Slovin formula with

confidence level: 95%, degree of variability: 50% (Maximum Variability), sample error: $\pm 7\%$ and makes easy to determine middle representative sample size from large population.

The total number of employees from four public health center was obtained comprised 740. To determine the appropriate sample size for the study the researcher deals with three possible options which can provide different sample sizes (emphasis added).

The basis for determining the sample size in each option is the level of precision or sampling error, the confidence level and the degree of variability in the attributes being measured. In this regard, the researcher used option to determine sample size. Since the population is large the following simplified formula was applied in this research:

$$n = N / (1 + N (e)^2)$$

Where: N = Population Size n = Sample

Size e = Precision (Sampling Error): 7%

In this option the sampling error was decreased from $\pm 10\%$, $\pm 7\%$ to $\pm 5\%$ so as to get the middle sample size options 2 is more appropriate.

Confidence Level = 95%

Degree of Variability = 50% (Maximum Variability)

Sampling Error = $\pm 5\%$ Total Population =

The sample size is computed as follows:

$$n = N / (1 + N (e)^2) \quad n = 740 / (1 + 740(0.07)^2)$$

$$\underline{\underline{n = 159.965 = 160}}$$

Table 3.1: Illustration for the Sampling Design for Quantitative Data

Sample Unit	Total Population	Sample Size	Sampling technique
Communities respondents	Unknown	96	convenience
Employees	740	160	convenience

Source: Kirkos Sub-City Administration, HR department manual, 2020

Based on the Mike Slovin (2007) sample size determination formula 160 employees and 96 customers were taken as a representative sample. 96 health customers were conveniently selected from four public health centers. To obtain the sample from the population the researcher used convenience sampling method from four public health center. For 160 professional employees the researcher used proportional method based on their population size.

Table 3.2 Sample Size

No	Name of health center	Population	Sample
1	Kirkos health center	195	$(195/740)*160 = 42$
2	Felegehiwot health center	170	$(170/740) *160 =37$
3	Meshulekia health center	184	$(184/740)*160 = 40$
4	Gotera mesalecha health center	191	$(191/740)*160 = 41$
Total		740	160

Source: From field survey data,2020.

3.5. Sampling Technique

Sampling is a process of selecting a few (a sample) from a bigger group (population) to become the starting point for estimating or predicting the frequency of an unknown piece of information, or outcome regarding the bigger group (Kumar, 2011). This process of selecting a sample from the total population has advantages and disadvantages (ibid). The advantages are that it saves time as well as financial and human resources. However, the disadvantage is the possibility of an error in the estimation exists (ibid).

Due to the COVID 19 pandemic, it was hard to get the employees in their office. Consequently, the researcher used a convenience sampling technique to select the target employees in the health centers. Moreover, a convenience sampling techniques were also employed by the researcher to select a sample of customers.

3.6. Source of Data

The information/data required for the study was collected from both primary and secondary sources. The primary source of data is the collection of first-hand information using questioners

that appropriately suit the study based on the researcher assumed perceptions. Secondary data was used in order to determine the conceptual farm work of the study like books and internet sources, record files, research outputs, etc. Secondary data were collected from other additional annual reports of community consumer and staffs from selected health care provider, reviews, previous research, and other relevant literature.

3.7. Methods of Data Collection

In order to studying the role of community participation in local economic development, it was necessary to collect the data as follows; multiple data gathering techniques have been employed for triangulation reason. As a result, questionnaires were prepared and employed to collect data. The researcher selects to use questionnaire as one of important tool to collect the necessary data from the local communities. Questionnaires were distributed to the customer in health center and employees. In this study, quantitative data was collected by a questionnaire. The questionnaire was prepared by using closed ended questions which designed on a Likert type-scale with a 5-point scale from 1 – “Strongly Disagree” to 5 - “Strongly Agree”. A main advantage of a 5-point Likert scale is that, it is easy to interpret the data gathered and assigned in number to each option.

Important details regarding participation, relationship between the sub-city health center and the community, the work activity of different committees including their appointment process, the development activities undertaken, community participations, empowerment, sustainability of community participation in local economic development and the challenges of the community was obtained using questionnaire.

3.7.1. Questionnaire

As indicated above, the study utilized questionnaire as data gathering tool. Based on the basic research questions and the review of related literature, closed ended questionnaire was prepared and administered by the researcher for employees and health center customers. The questionnaire had two main parts. The first part of the questionnaire was focused on the demographic of the respondents and the second part of the questionnaire was emphasized the main parts of the research objective. Out of 160 and 96 questionnaires distributed to the employees and health center customers respectively, 95 and 94 of the questioners were properly filled and returned. The questionnaire was formerly prepared in English but, for customer’s is has translated into Amharic that is local language that can be easily understood by the respondents.

3.8. Description of variables and model specification

In this study decentralization is considered as an independent variable. Whereas, quality of health care service delivery is treated as a dependent variable. Linear Regression Model

$$Y = \beta_0 + \beta_1 X + \varepsilon$$

Y = Quality of Health Care Service Delivery

β_0 = Constant

β_1 = Regression of Coefficient

X = Decentralization (Independent variable)

ε = Error

$Y = \beta_0 + \beta_1 \text{IHcFD} + \beta_2 \text{FHcFD} + \beta_3 \text{AHcFD} + \beta_4 \text{HcCDFW} + \beta_5 \text{HcC\&CFW} + \sum$

Where:

β_0 is the intercept term- it gives the mean or average effect on Y of all the variables excluded from the equation, although its mechanical interpretation is the average value of Y when the stated independent variables are set equal to zero.

β_1 , β_2 , β_3 , β_4 , and β_5 refers to the coefficient of their respective independent variable which measures the change in the mean value of Y, per unit change in their respective independent variables.

IHcFD: Institutional Health Care Framework Development

FHcFD: Financial Health Care Framework Development

AHcFD: Accountability Health Care Framework Development

HcCDFW: Health Care Capacity Development Framework

HcC&CFW: Health care Communications and Coordination Framework

\sum : error term

3.9. Methods of Data Analysis

Statistical Package for Social Science (SPSS) software version 20.0 was employed to analyze and present the data through the statistical tools, descriptive statistics used to summarize data and an inferential analysis. General information of the respondents was analyzed by using descriptive statistics such as percentages and frequency. Pearson's correlation coefficient was used to determine the relationships between decentralization practice and quality of health care service delivery. Regression analysis was used to investigate the effect of decentralization (independent variable) on quality of health care service delivery (dependent variable).

3.10. Ethical Consideration

Ethical consideration in research should uphold fairness, honesty, openness, disclosure of methods and the purpose for which the research is being carried out. In this case, Primary information gathered from sub-city community customers and staffs from selected health care provider respondents is kept until the reasonable period of time. Confidential files and issues regarding employees' personal data, policies and strategies of the organization and other highly classified information that need to be kept confidential are given value and kept confidential.

3.11. Validity and Reliability of the Research

3.11.1. Validity

Validity is the most critical criterion and indicates the degree to which an instrument measures what it is supposed to measure (Kothari, 2004). The literature review was conducted and thoroughly examined to make sure that the content of measuring is relevant to the study. A questionnaire paper was modified according to literatures within the topic and review by professionals and academicians.

To ensure the validity of the instruments the comment of woreda 02 community customers and staff from selected health care provider were included. For the clarity of the instrument and to avoid contradiction of the instruments, the English version was translated in to Amharic and checked for alignment. As a result, some questions found to be similar were removed.

In order to ensure the validness of this study the instruments were checked and evaluated by professionals in the subject matter area. Moreover my advisor had evaluated and commented on the instruments before they are distributed to the respondents.

3.11.2. Reliability

As Ayman, (2011), Cronbach Alpha is one of the commonly used indicators of the scales internal consistency. Reliability statistics was used to confirm the reliability of the instrument. Preferably, the Cronbach Alpha coefficients of a scale should be above 0.7. Based on this, a pilot test with 15 questionnaires was made in the study area (with Kirkos sub-city community customers and staffs from selected health care provider) before the actual distribution of the instrument starts.

A reliability analyses was conducted to each variable of the instrument. The reliability of the measures was examined through the calculation of Cronbach’s alpha coefficients. For scale acceptability, Hair et al. (1998) suggested that, Cronbach’s alpha coefficient to construct is 0.6. If each domain obtains the value 0.6, this means, the items in each domain are understood by most of the respondents participated in the questionnaire. On the other hand, if the findings are far from the expected value of 0.6, this might be caused by respondents’ different perception toward each item of the domain.

Table 3.3: Reliability Test measures indicator	No. items	Cronbach Alpha α
Institutional health care framework development	5	0.950
Financial health care framework development	5	0.946
Accountability health care framework development	6	0.917
Health care Capacity Development Frame work	6	0.965
Health care communications and Coordination frame work	6	0.950
Quality of Health Care Service Delivery α	8	0.895

Source: from field survey data, 2020

The Cronbach’s alpha values are reported as follow. Institutional health care framework development yield Cronbach’s alpha = 0.950, Financial health care framework development Cronbach’s alpha = 0.946, Accountability health care framework development Cronbach’s alpha = 0.917, the Cronbach’s alpha for Health care Capacity Development Frame work was at 0.965, Cronbach’s alpha for Health care communications and Coordination frame workwas at 0.950 and

Cronbach's alpha for Quality of Health Care Service Delivery is 0.895. The Cronbach's alpha values are greater than 0.6 and this indicates the items in each of the domains are well understood by the respondents.

The reliability of the questionnaire was evaluated through Cronbach's Alpha which measures the internal consistency. The Alpha measures internal consistency by establishing if certain item measures the same construct. Cronbach's Alpha was established for every objective in order to determine if each scale (objective) would produce consistent results should the research be done later on. The findings of the pilot study shows that all the seven scales were reliable as their reliability values exceeded the prescribed threshold of 0.7 (Pallant, 2005).

CHAPTER FOUR

4. Data Analysis, Presentation and Interpretation

4.1. Introduction

This chapter deals with analysis, presentation and discussion of the data gathered through questioners. First descriptive statistics are presented. Then it follows with the results of inferential statistics of data analysis and discussed the relationship between the independent and dependent variables. The chapter presents an analysis of the information designed to respond to the research objectives as outlined in the study. There are two sections presented in the questionnaire. The first is a general section which addresses the respondents' demographic characteristics. The second sections address specific research objectives and they include the extent to which the five decentralization system predicator effects on quality of health care service delivery.

In this study total of 160 questionnaires were distributed to the employees and 96 questionnaires were distributed to the customers of health center. Out of 160 and 96 questionnaires distributed to the employees and health center customers 95 and 94 respectively of the questioners were properly filled and returned. This shows that total 73.8 percent response rate. According to (Pallant, 2005) a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent; therefore, this response rate is excellent for analysis and reporting and non-response shows it does not materially bias the sample.

4.2. Socio-Demographic Characteristics of Employee Respondents

The study analysed the demographic characteristics of respondents involved in the study. In this section the respondents profile is presented. It includes gender, age, level of educational, and length of service in the current position. Analysing these variables was meant to provide any evidence of association between these variables and the various responses.

4.2.1 Demographic information of respondents in Kirkos sub-city health center employees

Table 4.1: Gender and Age of Respondents

Gender		Frequency	Percent
	Male	54	56.8
	Female	41	43.2
	Total	95	100.0
Age			
	Below 25Years	16	16.8
	26-30Years	33	34.7
	31-35Years	23	24.2
	36-40 Years	16	16.8
	Above 40 Years	7	7.4
	Total	95	100.0

Source: from field survey data 2020

The above table 4.1, shows that, from a total of 95 respondents, 54(56.8%) respondents are male While, 41(43.2%) of the respondents are female. This explains that the number of male respondents were greater than female respondents who were participated in the study.

With regard to respondents` age category, 16 respondents were below 25 years representing 16.8%. 33 respondents were between 26-30 years representing the majority which is 34.7% and the next higher groups were between the age of 31-35 years representing 24.2% and they were 23 in number. 16(16.8%) respondents were within the age group of 36-40 years. The rest 7(7.4%) were more than the age of 40 and above. Therefore, this implies that the majority groups of respondents are less than 35 years of age and this implies that the employees` of Kirkos sub-city health center are young.

Table 4.2: Education and Experience of Employee Respondents

Education		Frequency	Percent
	Diploma	18	18.9
	First degree	56	58.9
	Master's Degree & above	21	22.10
	Total	95	100.0
Years of Experience			
	Below 5Years	18	18.9
	6-10 Years	33	34.7
	11-15Years	34	35.8
	Above 15Years	10	10.5
	Total	95	100.0

Source: from field survey data 2020

From above table 4.2, demography background regarding to educational level respondent indicates that, out of the 95 respondents captured in the research work, 56 respondents representing 58.9% of the total population were BA/BSC holder in other words they were first degree and 21 respondents representing 22.1% were masters and above degree holder. While the remaining 18 (18.9%) of the respondents were diploma holders. This shows that majority of the respondents are educated to a level of Bachelor's Degree or have first degree.

With regard to the respondent working experience, the majority 34(35.8%) of the respondents have been working in the health center for 11-15years. Similarly 33 (34.7%), 18(18.9%) and 10 (10.5%) of them served the health center between 6-10, for less than 5years, and above 15 years respectively. This shows that most of the respondents have a lot of working 11-15 & 6-10 years' experience and implies that the composition of work experience of the representative samples may have a positive effect on the quality of the finding of the study because the majority of the respondents has experienced.

4.2.2. Demographic information of customer respondents in Kirkos sub-city health center

Table 4.3: Gender and Age of Customers

Gender		Frequency	Percent
	Male	52	55.3
	Female	42	44.7
	Total	94	100.0
Age			
	18-20 Years	9	9.6
	21-30 Years	14	14.9
	31-40 Years	22	23.4
	41-50 Years	31	33.0
	Above 50 Years	18	19.1
	Total	94	100.0

Source: from field survey data 2020

From above table 4.3: demographics of respondents, Kirkos sub-city health center customer was asked their gender there were significantly more men 52(55.3%) than women 42(44.7%). This shows that males were dominant than females from the total respondents. Other distribution was age of respondents which shows that the age factor of the respondent's profile was 9 respondents representing 9.6%(18-20 Years); 14 respondents representing 14.9% (21-30 Years); 22 respondents representing 23.4%(31-40 Years); 31 respondents representing 33%(41-50 Years); and 18 respondents representing 19.1%(Above 50 Years). This indicates that very significant majority of the respondents were within the age group of 41-50years. While, very small (insignificant) number of the respondents were between 18-20 years of age this makes the data collected from responsive sources.

Table 4.4: Education and Years as a Customer

Education		Frequency	Percent
	Illiterate	6	6.4
	Below high school	20	21.3
	High school	29	30.9
	Diploma / certificate	18	19.1
	Bachelor's degree and above	21	22.3
	Total	94	100.0
Years as a customer in the health center			
	Below 2 years	34	36.2
	3-5 years	17	18.1
	6-10 years	24	25.5
	Above 10 years	19	20.2
	Total	94	100.0

Source: from field Survey data 2020

Regarding, to the education level, 6(6.4%) of the respondents were illiterate, 20(21.3%) of the respondents were below high school, 29(30.9%) of the respondents were high school, 18(19.1%) of the respondents were diploma holder and 21(22.3%) of the respondents were Bachelor's degree and above. This shows that the majority of the respondents are educated and at least completed primary education and thus they can read and write. Regarding to their years as a customer in the health centers 34(36.2%) of the respondents were below 2 years, 17(18.1%) of them were between 3-5 years, 24(25.5%) of them were between 6-10 and the rest of 19(20.2%) of the respondents were above 10 years. This shows that majority of respondent's reply their customer relationship with the institution is below 2 years and this means they know the current updated quality service of the health institution.

4.3. Mean and Standard Deviation of Decentralization Indicators and Quality of health care service delivery

The objective of this study is to point out the effect of decentralization on quality of health care service delivery. In order to measure the extent of actual practices 28 items were provided for

employees that were selected and 8 items provided for customer. Table summarizes the data collected from employees and customers with regard to the decentralization and service delivery.

Table 4.5 Summary of Mean and Standard Deviation of decentralization indicators and quality of health care service

	N	Mean	Std. Deviation
Institutional health care framework development	95	2.8589	.68347
Financial health care framework development	95	2.6947	.70731
Accountability health care framework development	95	2.6596	.57320
Health care capacity development Framework	95	2.7614	.61964
Health care communications and coordination framework	95	2.9544	.65026
Quality of health care service delivery	94	2.7580	.52389

Source: from field Survey data 2020

The above table 4.5 clearly indicates that the corresponding arithmetic mean and standard deviation of every construct totals (total of every individual categorical construct). Thus, Institutional health care framework development categorical has a mean of 2.8589 and a standard deviation of .68347, Financial health care framework development categorical total has a grand mean of 2.6947 and a standard deviation of .70731, Accountability health care framework development categorical total has a mean of 2.6596 and a standard deviation of .57320; Health care capacity development Framework categorical total has a mean of 2.7614 and a standard deviation of .61964 and Health care communications and coordination framework categorical total has a mean of 2.9544 and a standard deviation of .65026 and finally quality of health care service delivery categorical total has a mean of 2.7580 and a standard deviation of .52389. This shows that all the independent and dependent variables were below the standards.

This analysis of mean categorical constructs showed that the Institutional health care development, financial health care development, Accountability health care development, capacity development Framework and Health care communications and coordination framework has a mean value less than the average standard. This implies that all the independent variables

were affected to dependent variable or the dependent variable was influenced by the independent variables.

4.4. Correlation Analysis

According to Pallant (2005), correlation analysis is used to describe the strength and direction of the linear relationship between two variables. In this analysis, Bivariate Pearson Product-Moment Coefficient (r) has been used to see the relationship between the independent and dependent variables. Correlation analysis, in this study determines the strengths of relationship between (factors of effective decentralization system and quality of health care service delivery).

In the hypothesis testing, the item that should be noticed is the probability (p) value. If $p > 0.05$, it means that independent variable does not influence the dependent variable. If $p < 0.05$ it means that independent variable influences the dependent variable (Pallant, 2005). The test also indicates the strength of a relationship between variables by a value that can range from -1.00 to 1.00; when 0 indicates no relationship, -1.00 indicates a negative correlation, and 1.00 indicates a perfect positive correlation (Pallant, 2005). The result tabulated in Table 4.6 below.

On this study Pearson's Product moment correlation Coefficient was used to determine the relationship between factors of effective decentralization system and quality of health care service delivery.

Table 4.6: Pearson Correlation between factors of effective decentralization system and quality of health care service delivery

Factors of effective decentralization system		quality of health care service delivery
Institutional health care framework development	Pearson Correlation	.785**
	Sig. (2-tailed)	.000
	N	95
Financial health care framework development	Pearson Correlation	.866**
	Sig. (2-tailed)	.000
	N	95
Accountability health care framework development	Pearson Correlation	.290**
	Sig. (2-tailed)	.000
	N	95
Health care Capacity Development Framework	Pearson Correlation	.888**
	Sig. (2-tailed)	.000
	N	95
Health care communications and Coordination frame work	Pearson Correlation	.943**
	Sig. (2-tailed)	.000
	N	95
quality of health care service delivery	Pearson Correlation	1
	Sig. (2-tailed)	
	N	95
**. Correlation is significant at the 0.01 level (2-tailed).		
*. Correlation is significant at the 0.05 level (2-tailed).		

Source: from field Survey data 2020

The Pearson Correlation Analyses were employed among variables. Table 4.6, shows the correlation analyses among all constructs decentralizations on quality of health care service delivery. The coefficient of correlation between institutional health care framework development and quality of health care service delivery is 0.785, $p < 0.01$. It shows that there is strong and

positive relationship between them. The relationship is significant at 0.05 level of significance. The coefficient of correlation between financial health care framework development and quality of health care service delivery is 0.866, $p < 0.01$. It shows that there is strong and positive relationship between them. The coefficient of correlation between accountability health care framework development and quality of health care service delivery is 0.290, $p < 0.01$. It shows that there is moderate and positive relationship between them. The relationship is significant at 0.05 level of significance. It was also indicated that the capacity development framework and quality of health care service delivery is 0.888, $p < 0.01$. It shows that there is strong and positive relationship between them. The relationship is significant at 0.05 level of significance. The coefficient of correlation between health care communications and coordination framework and quality of health care service delivery 0.943, $p < 0.01$. It means that it has strong relationship between construct. The relationship is significant at 0.05 level of significance.

Based on the results in table 4.6 shows that five explanatory variables tested in this study, there is a significant and positive correlation between independent variables and dependent variables i.e. quality of health care service delivery. This shows that all of the null hypotheses are rejected.

4.5. Regression Analysis

This section reports the results of multiple regressions Analysis conducted. Multiple regression analysis is “an analysis of association in which the effects of two or more independent variables on a single, interval scaled dependent variable are investigated simultaneously” (Zikmund et al., 2010). In examining the factors that could affect quality of health care service delivery, the researcher used a regression analysis to test the effect of five independent variables on the dependent variable i.e. quality of health care service delivery. Thus, in this study the researcher used multiple regression analysis, in which tests have been made to examine whether one or more independent variables influence the variation on dependent variable. To show how well the model containing those of five explanatory variables actually explains the variations in the dependent variable, i.e. quality of health care service delivery, it is necessary to test it through goodness of fit statistic.

Table 4.7. Result of multiple regression analysis (Independent variables as predictors on quality of health care service delivery)

Model Summary^b				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.948 ^a	.900	.897	1.11150
a. Predictors: (Constant), Institutional health care framework development, Financial health care framework development, Accountability health care framework development, Health care Capacity Development Framework, Health care communications and Coordination frame work				
b. Dependent Variable: Quality of Health Care Service Delivery				

Source: From field survey data, 2020

R Represent the relationship between dependent and all the independent variables.

R² Represent how much of the dependent variable can be explained by the independent

From the equation, a multiple regression analysis was conducted to examine the effect of independent variables on the dependent variable. The analysis was done to establish how the specific the decentralizations contributed to the quality of health care service delivery in Kirkos sub-city Health center. The relationship between the independent variables and the dependent variables is 0.948 which is very strong and positive.

The result as shown in the model summary also indicates institutional health care framework development, Financial health care framework development, accountability health care framework development, Health care Capacity Development Frame work, Health care Communications and Coordination frame work explained 90 % of change in the quality of health care service delivery of Kirkos sub-city health center. Henceforth, the remaining 10% of the variation on the dependent variable is explained by other variables not included in this study. This outcome empirically indicates that the independent variables in this study are the major determinants of quality of health care service delivery. Thus, all the Null hypothesis (Ho1, Ho2, Ho3, Ho4 and Ho5 does not have a significant effect on the quality of health care service delivery) are rejected and on the contrary the alternative hypothesis are accepted.

Table 4.8. Analysis of Variance Results of the Regression Analysis between Predictor Variables and quality of health care service delivery

ANOVA ^a						
Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	2025.415	5	405.083	327.888	.000b
	Residual	226.084	183	1.235		
	Total	2251.499	188			
a. Dependent Variable: Quality of Health Care Service Delivery						
b. Predictors: (Constant), Institutional health care framework development, Financial health care framework development, Accountability health care framework development, Health care Capacity Development Frame work, Health care communications and Coordination frame work						

Source: from field survey data, 2020

From above table 4.8 regarding to coefficient of determination explains the extent to which changes in the dependent variable can be explained by the change in the independent variables or the percentage of variation in the dependent variable (Quality of Health Care Service Delivery) that is explained by all the five independent variables (Institutional health care framework development, Financial health care framework development, Accountability health care framework development, Health care Capacity Development Frame work, Health care communications and Coordination frame work).

The F-ratio found in the ANOVA table indicates the probability of a chance departure from a straight line. The significance value is 0.00 which is less than 0.05 thus the model is statistically significance in predicting how institutional health care framework development, financial health care framework development, accountability health care framework development, health care capacity development frame work, health care communications and coordination frame work show influence to the quality of health care service delivery. And the F critical at 5% level of significance was 0.00. Since F calculated is greater than the F critical (value = 327.888), this shows that the overall model was significant.

Table 4.9. Regression Coefficients of the Relationship between Quality of Health Care Service Delivery and the Five Predictive Variables

Model		Coefficients ^a				
		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	9.178	.720		12.741	.000
	Institutional health care framework development	.249	.192	.270	1.294	.000
	Financial health care framework development	-.292	.175	-.199	-1.664	.000
	Accountability health care framework development	.097	.093	.102	1.044	.000
	Health care Capacity Development Frame work	-.340	.090	-.444	-3.760	.000
	Health care communications and Coordination frame work	1.312	.116	1.299	11.315	.000
Dependent Variable: Quality of Health Care Service Delivery						
Represent co-efficient of the independent variable						
Sig. Represent the statistically significant level of the model						

Source: From field survey data, 2020.

The coefficients table sought to identify which predictors are significant contributors to the 90.0% of explained variance in Y (i.e., $R^2=.900$) and which ones are not -and in what way (s) do the significant ones help us to explain Y/dependent variable.

The established regression equation was:

$$Y = \beta_0 + \beta_1 \text{IHcFD} + \beta_2 \text{FHcFD} + \beta_3 \text{AHcFD} + \beta_4 \text{HcCDFW} + \beta_5 \text{HcC\&CFW} + \Sigma$$

$$Y = 9.178 + .249 \text{IHcFD} - .292 \text{FHcFD} + .097 \text{AHcFD} - .340 \text{HcCDFW} + 1.312 \text{HcC\&CFW} + .720$$

Where:

Y: Quality of Health Care Service Delivery

β_0 is the intercept term- it gives the mean or average effect on Y of all the variables excluded from the equation, although its mechanical interpretation is the average value of Y when the stated independent variables are set equal to zero then, β_1 , β_2 , β_3 , β_4 , and β_5 refers to the coefficient of their respective independent variable which measures the result and change in the mean value of Y, per unit change in their respective independent variables.

IHcFD: Institutional Health Care Framework Development

FHcFD: Financial Health Care Framework Development

AHcFD: Accountability Health Care Framework Development

HcCDFW: Health Care Capacity Development Framework

HcC&CFW: Health care Communications and Coordination Framework

Σ : **error term**

The regression coefficient explain the average amount of change in dependent variable that caused by a unit of change in the independent variable. The larger value of Beta coefficient that an independent variable has, brings the more support to the independent variable as the more important determinant in predicting the dependent variable. In the next section the effect of each independent variable tested under this study is discussed and analyzed based on the theoretical predictions.

As shown in table 4.9 above, of the total five explanatory variables tested in this study, were statistically significant at 5 percent or lower. In this study, there is significant positive relationship between independent variable and quality of health care service delivery with a regression coefficient, and P-value of 0.000.

From above table 4.9 analysis the co-efficient value result regarding to the quality of health care service delivery in Kirkos sub-city health center to customer showed that individually indicated to positively 9.1% applicable which is the performances result indicated that the lower the quality of health care service delivery in Kirkos sub-city health center registered and the positive imaged by respondent's decentralizations contributed to the quality of health care service delivery in Kirkos sub-city health center is expected to confirmed.

As it is presented on table 4.9, regression coefficient analysis result regarding to the effect of institutional health care framework development contributed was found that in the likely (coefficient of 0.249) which is increasing the quality of health care service delivery in Kirkos sub-city health center at significance level of (P Value=0.05). Thus, from the result it can be concluded that institutional health care framework development was contributed to 24.9% significance contributions to the quality of health care service delivery in Kirkos sub-city health center. This was statistically significant ($0.00 < 0.05$) i.e. the variable (institutional health care framework development) is making a significant unique contribution to the prediction of the dependent variable (quality of health care service delivery).

In contrary with these ideas the advocators of institutional health care framework development quarrels that decentralizing the delivery of local public goods with no significant influence overflows progress the efficiency and responsiveness of the public sector in at least three ways by promoting a locative efficiency, by fostering productive efficiency and accountability, and by facilitating cost recovery (Azfar et al, 2010).

As it is presented on table 4.9, regression coefficient analysis result regarding to the effect of financial health care framework development was found that in the likely (coefficient of -.292) which is decreasing the quality of health care service delivery in Kirkos sub-city health center at significance level of (P Value=0.05). Thus, from the result it can be concluded that the poorest predictor of the dependent variable.

Similarly, study was found by Gulliford et al (2002), adds that bed capacity is an important indicator raised concern that financial health care development is not enough to measure access because of financial or organizational obstacles, which could hinder one from accessing available services. Gulliford et al. (2002) posit that access largely depends on physical accessibility and affordability. Social Protection Committee (2013) adds that financial health care framework development is measured by the number of health workforce with the correct skill mix to match people's needs and the supply of medicine and equipment as well as access to pharmacies (Campbell et al., 2000).

From the above table 4.9, regression coefficient analysis result regarding to the effect of accountability health care framework development was found that in the likely (coefficient of 0.097) which is increasing the quality of health care service delivery in Kirkos sub-city health center at significance level of (P Value=0.05). This was statistically significant ($0.00 < 0.05$) i.e.

the variable (accountability health care framework development) is making a significant unique contribution to the prediction of the dependent variable (quality of health care service delivery).

According to Bratton and Gold, (2007) cited in Tegene,(2008) accountability health care framework development in decentralized health service system was found positively in a strategic approach to the quality of health care service delivery in health center which emphasizes that leveraging people's capabilities is critical to achieving competitive advantage, this being achieved through a distinctive set of integrated employment policies and practices.

From above table 4.9, regression coefficient analysis result regarding to the effect of health Care capacity development frame work was found that in the likely (coefficient of $-.340$) which is decreasing the quality of health care service delivery in Kirkos sub-city health center at significance level of (P Value=0.05). Thus, from the result it can be concluded that the poorest predictor of the dependent variable.

Similarly, study was found by Shrestha (2010) argues that there may in adequate supply of facilities and staff close to the people but they may not be utilized the capacity development. In such scenarios, people tend to move to other areas in search of affordable services. Therefore, it is important to take account of the capacity development aspect. This dimension includes indicators such as the percentage of population insured, the existence of subsidized programs for some groups and the percentage of out of pocket expenditure as a total of private expenditure on health (IOM, 1993).

As it is presented on table 4.9, regression coefficient analysis result regarding to the effect of health care communications and coordination frame work was found that in the likely (coefficient of 1.312) which is increasing the quality of health care service delivery in Kirkos sub-city health center at significance level of (P Value=0.05). Thus, from the result it can be concluded that the best predictor of the dependent variable.

Among the five independent variables health care communications and coordination frame work is the best predictor (with a beta value of 1.312 , sig = $.000$) of quality of health care service delivery. This is followed by health care capacity development frame work (with beta value of $-.340$, sig = $.000$) and financial health care framework development with beta value of $-.292$, sig = $.000$) was found the poorest predictor of the dependent variable. In fact the least predictor is statistically significant at 99% confidence level.

4.6 Hypothesis Testing

This particular section presents the results of the study indicated by statistics, using correlation analysis. The correlation between independent variables and quality of health care services delivery was compared against the hypotheses tested in the investigation. The results shows that there are significant relationship between independent variables such as institutional development, financial development, accountability development, capacity development and communication and coordination framework development and the dependent variable i.e. quality of health care service delivery. This showed that the independent variables were strong and positively affected to quality of health care services delivery. In the next section the effect of each independent variable tested under this study is discussed and analyzed based on the theoretical predictions, prior empirical studies and hypothesis formulated.

Table 4.10 Hypothesis testing

		Accept/Reject
Ho1: Institutional framework development does not have a significant effect on the quality of health care service delivery		Rejected
Ho2: Financial framework development does not have a significant effect on the quality of health care service delivery		Rejected
Ho3: Accountability framework development does not have a significant effect on the quality of health care service delivery		Rejected
Ho4: Capacity development does not have a significant effect on quality of health care service delivery		Rejected
Ho5: Communication and coordination framework development do not have a significant effect on quality of health care service delivery		Rejected

All the null hypotheses are rejected because all the independent variables are statistically positive and significant relationship at 99% confidence level. So, all the alternative hypotheses are accepted.

Ho1: Institutional framework development does not have a significant effect on the quality of health care service deliver

As it is presented on table 4.6, the correlation result shows there is a significant positive relationship between institutional health care framework development and quality of health care

service delivery. The Pearson correlation result shows a significant positive correlation between institutional health care framework development and quality of health care service delivery with correlation coefficient of $r = 0.785$ and significant at 0.000. Thus, from the result it can be concluded that significantly affects quality of health care service delivery. Hence, it is concluded that the hypothesis (H_0) which states that does not have a significant relationship between institutional health care framework development and quality of health care service delivery in Kirkos sub-city is rejected.

Consistent with the result of this study prior empirical evidence found significant relationship between institutional health care framework development and quality of health care service delivery (Muriisa, 2008) maintains that the targeted institutional health care framework development dealing with people's desires at the grassroots positively.

Ho2: Financial framework development does not have a significant effect on the quality of health care service delivery

From the table 4.6, the correlation result shows there is a significant positive relationship between financial health care framework development and quality of health care service delivery. The Pearson correlation result shows a significant positive correlation between financial health care framework development and quality of health care service delivery with correlation coefficient of $r = 0.866$ and significant at 0.000. Thus, from the result it can be concluded that significantly affects quality of health care service delivery. Hence, it is concluded that the hypothesis (H_0) which states that does not have a significant relationship between financial health care framework development and quality of health care service delivery in Kirkos sub-city is rejected.

The finding of this study is supported by the conclusions forwarded by (Social Protection Committee (2013).

Ho3: Accountability framework development does not have a significant effect on the quality of health care service delivery

As it is presented on table 4.6, the correlation result shows there is a significant positive relationship between accountability framework development and quality of health care service delivery. The Pearson correlation result shows a significant positive correlation between accountability framework development and quality of health care service delivery with

correlation coefficient of $r = 0.290$ and significant at 0.000. Thus, from the result it can be concluded that significantly affects quality of health care service delivery. Hence, it is concluded that the hypothesis (H_0) which states that does not have a significant relationship between accountability framework development and quality of health care service delivery in Kirkos sub-city is rejected.

Consistent with the result of this study prior empirical evidence found significant relationship between accountability framework development and quality of health care service delivery (Johnson, 2000).

Ho4: Capacity development does not have a significant effect on quality of health care service delivery

From the table 4.6, the correlation result shows there is a significant positive relationship between capacity development framework and quality of health care service delivery. The Pearson correlation result shows a significant positive correlation between capacity development framework and quality of health care service delivery with correlation coefficient of $r = 0.888$ and significant at 0.000. Thus, from the result it can be concluded that significantly affects quality of health care service delivery. Hence, it is concluded that the hypothesis (H_0) which states that does not have a significant relationship between capacity development framework and quality of health care service delivery in Kirkos sub-city is rejected.

Ho5: Communication and coordination framework development do not have a significant effect on quality of health care service delivery

As it is presented on table 4.6, there is a positive correlation between health care communications and coordination framework development and quality of health care service delivery with a correlation coefficient of .943 and significant at 0.000. The correlation between health care communications and coordination framework development and quality of health care service delivery has a good value. Therefore, it is concluded that the hypothesis (H_0) which states that does not have a significant relationship between health care communications and coordination framework development and quality and quality of health care service delivery in Kirkos sub-city is rejected. Consistent with the result of this study prior empirical evidence found significant relationship between health care communications and quality of health care service delivery (Matovu, 2008).

CHAPTER FIVE

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Summary of Major Findings

In this study institutional health care framework development, financial health care framework development, accountability health care framework development, health care capacity development framework and health care communications and coordination framework on the planning of decentralization were considered as independent variables and quality of health care service delivery was considered as a dependent variable.

According to the correlation output all the independent variables (institutional health care framework development, financial health care framework development, accountability health care framework development, health care capacity development framework and health care communications and coordination framework) are positively correlated with quality of health care service delivery. Consequently, all Null Hypothesis between the independent variables and quality of health care service delivery are rejected.

The regression study finds that the Independent variables (institutional health care framework development, financial health care framework development, and accountability health care framework development, health care capacity development framework and health care communications and coordination framework) have a statistically significant effect on the dependent variable – health care service delivery. Thus, 90% of the variations in the health care service delivery were explained by the five independent variables under study while the remaining 10% are explained by external variables i.e. not included in this study. As a result the Null hypothesis: the entire Null hypothesis between the independent variables and quality of health care service delivery are rejected and the alternative hypothesis which is the dependent variable is accepted.

Result finding regarding to institutional health care framework development which is assign functions, responsibilities and resources according to the intended objective for the respective level of government as well as a realistic assessment of the technical and financial capacity at

each level was contributed to 24.9% significance contributions to the quality of health care service delivery in Kirkos sub-city health center.

Accountability health care framework development is making a significant unique contribution 9.7% to the prediction of the dependent variable (quality of health care service delivery).

From the five independent variables, Health care communications and Coordination frame work with a beta value of 1.312 was found the best predictor of quality of health care service delivery.

Health care capacity development framework with beta value of -.340 and financial health care framework development with beta value of -.292 was found the poorest predictor of quality of health care service delivery.

5.2 Conclusion

The purpose of this study was to show the effect of decentralization on quality of health care service delivery. The study targeted a total of 256 respondents. However, only 189 respondents responded and returned their questionnaires contributing to 73.8% response rate. The data was analyzed into frequency distribution, percentages and Pearson correlations using the SPSS. The data was presented using tables. Respondents are from different age groups, sex, educational background, and year of experience are represented in the data collected. From the summary of the findings and based on the objectives of the study the researcher reflects the following conclusion concluded.

Decentralization of health-care services has the potential to improve efficiency of health services and equity of outcomes. The sub-city which is at different levels of decentralization agreed on the strategic framework and that there was a need to address factors influencing the process of decentralization.

The independent variable system factors have great impact on dependent variable. This is due to; health care communications and coordination frame work helps them to improve the system of decentralization for the organization.

The Regression analysis conducted the effect of explanatory variables on quality of health care service delivery revealed a positive and significant relationship between health care communications and coordination frame work and quality of health care service delivery. This

signified that decentralization if conducted well in the sub-city leads to improved quality of health care service delivery.

Strong effects of independent variables are witnessed in the area of health care communications and coordination framework. These implied clarifying objectives and setting clear future objectives needs to be established to enhance quality of health care service delivery plays a significant role so, it should always be preserved to ensure an organizations existence and to enhance the dependent variable as well.

- Financial health care framework development at the local level is not effective in finance to bulled health infrastructure in Kirkos sub city Health center.
- For effective decentralization of health-care services, improvement of managerial capacity and clear understanding of the decentralization concept at all administrative levels is a prerequisite. It is a challenge to keep the quality of health care service delivery in public health sector.
- Institutional health care framework development which is Assign functions, responsibilities and resources according to the intended objective for the respective level of government as well as a realistic assessment of the technical and financial capacity at each level was contributed to 24.9% significance contributions to the quality of health care service delivery in Kirkos sub-city Health center.
- Accountability health care framework development which is constructed by analyze towards government and health center introduce a monitoring framework to ensure accountability of the local government regards to service delivery quality, accessibility and affordability has contributed 9.7% the quality of health care service delivery in Kirkos sub-city health center.
- Health care capacity development framework train health workers to meet shortfalls compromising efficient health service delivery was found negatively which is lowering the quality of health care service delivery in Kirkos sub-city health center.
- Finally it was concluded that the level of quality of health care service delivery regarding to the current decentralization practice and employees perception about the independent variables were low in Kirkos sub-city.

5.3 Recommendations

Based on the research findings and objective of this study to investigate the effect of decentralization on quality of health care service delivery in Kirkos sub-city, the researcher provides the following recommendations to the sub-city.

- Since weaknesses are observed in the areas of financial health care framework development and health care capacity development framework. The sub-city needs to put in place well effective in finance and capacity development for efficient and effective decentralization. In this area the sub-city must focus on financial resource and capacity to improve the quality of health care service delivery.
- The quality of health care service delivery in the current situation is poor. Therefore, the sub-city should work to improve it/ implement effective decentralization practice in the sub- city health center.
- Kirkos sub-city lacks the required financial management capacity and to produce sufficient funds through the local health centers rely on their own financial income. Furthermore, the sub-city health centers have lack of self-sufficiency to deliver efficient health service. Hence, in order to overcome such financial constraints, inter-organizational linkages and communication with NGOs is advisable and the sub-city should allocate resources for decentralization of health-care services.
- The Sub-city should work hard to alleviate shortage of budget allocation can be alleviated by allocation of budget based on office requirement and plan. Financial health care framework development at the local level should effective in finance to bulled health infrastructure in sub-city health center.
- Kirkos sub-city health center should give much emphasis for essential health care capacity development at all levels to implement the various health care frameworks required for efficient and effective decentralized health service delivery. And also in the whole system stewardship at the central level and recruit and train health workers and civil servants in planning and managerial skills at the decentralized level.
- Employees' accountability plays a significant role. So, it should always be preserved to ensure a health centers existence and to enhance quality of health care service delivery.
- Health service provider should be clear description of responsibility in health service center in order to hold or to develop its management unit and worker accountable.

- Strengthen health information systems at national and sub - national levels to collect analyze and use data for quality of health service delivery improvement.
- In order to ensure the proper financial resources and management capacity, the federal government with the help of the sub-city administration should strengthen the presence of standardized auditing system and fill vacant a position with adequate and qualified personnel's in the sub-city health centers' finance.
- To maximize the benefits of decentralization, all the necessary resources such as finance, health care capacity development, accountability health care framework development, institutional health care framework development and health care communications and coordination framework on the planning of decentralization should be deployed up to the required level of quantity and quality in health service providing institutions.
- Improve primary care services and strengthen referral systems to ensure continuity of care for achieving high quality of services distributed in an equitable manner
- Develop and strengthen the human resource development and deployment policy, taking into consideration measures for retention of skilled staff, career development and performance-based incentives.
- The sub-city health bureau, health center coordinators and health board committees should jointly devise effective mechanisms and collaborate with minister of health in operational research for improving effectiveness of decentralization.

Reference

- Ahmad,A., Bose, M. and Persson, T.H. (2007). Decentralized provision of primary healthcare in rural Bangladesh–A study of government facilities: In The annual conference of the Norwegian association for development research on making institutions Bergen (pp.5-7).
- Ahmad,J., Devarajan, S., Khemani, S., and Shekhar, S. (2005). Decentralization and Service Delivery. World Bank Policy Research Working Paper 3603 May.
- Akpan, H. (2007). Decentralization and Service Delivery: A Framework.
- Asia-Pacific Leadership and Policy Dialogue for Women’s and Children’s Health, by unanimous author Note for Discussion 2012) accessed at [https:// www.who. int/pmnch/ media/news/ 2012/implementation decentralisation_04112012.pdf](https://www.who.int/pmnch/media/news/2012/implementation_decentralisation_04112012.pdf)
- Azfar, O., Kahkonen, S., Lanyi, A., Meagher, P., and Rutherford, D. (2004). Decentralization Governance and public service: The Impact of Institutional Arrangements in M.S,Kemenyi and p, Meagher (eds), Devolution and Development.
- Babbie, Earl R. (2010). The Practice of Social Research. 12th ed. Belmont, CA: Wadsworth Cengage,
- Bandara, (2011).Decentralized Governance for Democracy, Peace, Development and Effective Service Delivery. United Nations Department of Economic and Social Affairs, Brussels. Retrieved from www.unctad.org
- Barasa EW, Manyara AM, Molyneux S, Tsofa B, (2017).Recentralization within decentralization.
- Barbara, K, (, 2002). Researching -user views of Primary Health Care. Health Policy and Planning.
- Brady, M. and Cronin, J. (2001). “Assessing the effects of quality, value, and customer satisfaction on consumer behavioral intentions in service environments”, *Journal of Retailing, Volume 76 (2), P. 193–218.*
- Collins & Green, (1994). Decentralizing health services in the UK: a new conceptual framework. *Public Administration.*
- County hospital autonomy under devolution in Ruanda and Uganda. PLoS ONE 12(8):
- Daniel, T. (2002). Decentralization and the Quality of Government.

- Daniel, T. (2002). Decentralization and the Quality of Government; MA Thesis University of California. Delivery: Master's Thesis, Addis Ababa University, Ethiopia.
- Ekpo, A., 2008. Decentralization and service delivery: a framework. African Economic Research Consortium, Nairobi. Kenya.
- Ekpo, H. (2007). Decentralization and Service Delivery: A Framework, University of Uyo, Nigeria.
- Eryilmaz, B. (2011), Public Administration- Okutman Publishing Okutman Yayıncılık, Ankara.
- Fenta, M. (1998) 'Decentralization in Post Derg Ethiopia: Aspects of Federal Regional Relations', M.A. Thesis, Regional and Local Development Studies, Addis Ababa University, Addis Ababa.
- Fisman, R., and Roberta, G. (2002). Decentralization and Corruption: Evidence across Countries," Journal of Public Economics.
- Francis, P. and James, R., (2003). Balancing rural poverty reduction and citizen participation: The contradictions of Uganda's decentralization program. World Development, 31(2), pp.325-337.
- Garcia, M. and Rajkumar, A. (2008). Achieving Better Service Delivery through Decentralization in Ethiopia World Bank Washington, D.C., U.S.A. Working Paper No. 131
- Gebremedhin, M. (2013). An Assessment on Decentralized Service Delivery in the Health Sector: The case of Ahferom Wereda. Master's Thesis, Mekelle University, Ethiopia.
- Gropello, E. (2006). An Assessment of the Impact of Decentralization on the Quality of Education in Chile. World Bank Economists' Forum Vol. 2 (2006), pp. 117–154.
- Hair, J., Black, W., Babin, B., Anderson, R., and Tatham, R. (2007). Multivariate Data Analysis. New Jersey: Pearson Education, Inc.
- Hutchinson, P. and Lafond, A. (2004). Monitoring and Evaluation of Decentralization Reforms in Developing Countries Health Sectors, Emory University Rollins School of Public Health, Philoxenia International Travel, Inc. No. TE05.

- Jha, S., and Mathure,p. (1999). Decentralization and Local Politics: Readings in Indian Government and Politics, Sega Publication India, Pvt Ltd.
- Joel D. Barkan (1998). Decentralization and Democratization in Sub Saharan Africa, International Programs University of Iowa
- Kasa A., (2015) District level decentralization and public service delivery in Ethiopia, case in Amhara Region. *International journal of African and Asian studies. Volume 10,2015.*
- Kaseje,D. (2006) health care in Africa: challenges, opportunities and an emerging model for improvement, great lakes university of kisumu presented at the woodrow wilson international center for scholars.
- Kassa, T. (2011). Decentralization and Service Delivery in Ethiopia Master's Thesis, Addis Ababa University.
- Kassa, T. (2011). Political Decentralization and Service Delivery in Addis Ababa.
- Kondalkar, V. G. (2007). Organizational Behaviour. New Age Intention (P) Limited Publisher, New Delhi-110002.
- Kothari, C.R. (2004). Research methodology, methods and techniques. New age international ltd, publisher
- Kumara, K. (2006). Decentralized governance and service delivery: a case study of Digelu and Tijo woreda of Arsi zone in Oromia region, Master's Thesis, Addis Ababa University, Ethiopia.
- Lijalem, Wakgari (2008); District level decentralization program and service delivery: A case
- M. M. Daemane . M (2011) Decentralization in Lesotho: Prospects and Challenges, A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in fulfillment of the requirement of the degree of Doctor of Philosophy in Development Studies.
- Mahmud Muktar. (2011), Assessment of the effects of decentralization on urban service

- Matovu,G (2008), Issues Related To Developing Requisite Capacities For Effectively Implementing Decentralization Policies In Africa ,Municipal Development Partnership for Eastern and Southern Africa (MDP-ESA) May 2008 gmatovu@mdpafrika.org.zw
- Mitullah, V. (2012). Decentralized Service Delivery in Nairobi and Mombasa Policies, politics and inter-governmental relations, Working Paper No. 2012/92
- Muriisa, K. (2008). Decentralization in Uganda: Prospects for Improved Service Delivery Africa Development, Council for the Development of Social Science Research in Africa, Mbarara University of Science and Technology, *Vol. XXXIII, No. 4, 2008, pp. 83–95.*
- Okojie,C.(2009).Decentralization and Public Service Delivery in Nigeria, Department of Economics and Statistics University of Benin, Benin City, Nigeria
- Olsen, B. (2007). Decentralization and Local Governance. Module 1: Definitions and Concepts.
- Panda, and Thakur, (2016). Decentralization and health system performance – a focused review of dimensions, difficulties, and derivatives in India. *BMC Health Serv Res 16, 561* <https://doi.org/10.1186/s12913-016-1784-9>
- Pranab Bardhan (2002) Decentralization of Governance and Development. *Journal of Economic Perspectives—Volume 16, Number 4—Fall 2002—Pages 185–205*
- Priyantha, W. (2019). The Discussion of Theory and Practice on Decentralization and Service Delivery (Ph.D. Candidate), Graduate School of International Relations, International University of Japan, Niigata, Japan.
- Rajendra Kumar 2008). Research methodology. New Delhi. S.B. Nangia
- Rasheed Luke, (1995:74), Development Management in Africa, West view press, USA.
- Rasheed, Sadig and Luke, David Fashole, ed, (1995), Development Management in Africa, West view press, USA
- Robbins, S. P. (2001). Organizational Behavior, New Jersey: Prentice-Hall.
- Robinson, M. (2007). Introduction: Decentralizing Service Delivery? Evidence and Policy Implications. Institute of Development Studies. IDS Bulletin Volume 38 Number 1.

- Roemer, M., Montoya, C., and Aguilar, A. (1998). Quality assessment and assurance in primary health care. WHO offset publication, No.105,
- Rondinelli, A. (1983). Decentralization in developing countries: A review of recent experience. Washington, DC: The World Bank.
- Rondinelli, D. (1999), What Is Decentralization, Litvack, Jennie and Jessica Seddon (Eds.).
- Saharty, E. Sosen, K. Dubusho, O, and Siadat, B., (2009). Improving Health Service Delivery in Ethiopia Country Case Study: Paper prepared for the Health, Nutrition and Population Unit, Human Development Network, The World Bank
- Saharty, E., Sosen, K., Dubusho, O., and Siadat, B. (2009). Improving Health Service Delivery in Ethiopia Country Case Study. Paper prepared for the Health, Nutrition and Population Unit, Human Development Network, The World Bank Service: Master's Addis Ababa University, Ethiopia.
- Seye, A. (2019). The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health Policy and Planning, 2019, Vol. 34, No. 8*
- Shah, A., and Theresa, T. (2004). "Implementing Decentralized Local Governance: Treacherous Road with Potholes, Detours and Road Closures." *Policy Research Working Paper 3353*. World Bank, Washington, D.C.
- Simon, H., Keith, William J., and Mc, Cluskey. (2004) World Health Organization. (2007). Everybody's business strengthening health systems to improve health outcomes: WHO's framework for action. Report.
- Social Protection (2013). Recommendation concerning national of social protection. Geneva: International Labour Organization;
- Study of Gimbi Wereda, Oromia National Regional State, Ethiopia; thesis, RLDS, Addis Ababa University, pp.86-90.
- Sutiyo,M. (2014). Decentralization: Potentiality and Challenge for Rural Development. Senior Civil Service District Government of Purbalingga, Indonesia.

- Taye, A., and Tegegne, G. (2007). Decentralization in Ethiopia: Forum for Social Studies, Yamahbarawi tenat Madrak (Ethiopia)
- Tegene A. (2008). The Human Resource Management Function in Ethiopia: Focus on Civil Service in Southern Regional Government (SNNPRG) In partial fulfillment of the requirements for obtaining the degree of masters of arts in development studies, Graduate School of Development Studies 12 November 2008.
- Tesfaye, (2006). Assessing the Challenges of Urban Land Governance in Ethiopia. Master's Thesis, Mekelle University, Ethiopia.
- Thomas, H. (2010/11). Assessment of Decentralized Education Service Delivery: A Case Study of Dubti Woreda, Afar National Regional State. MA Thesis, Addis Ababa, Ethiopia
- Tirunesh Bazezew (2013). The Effects of Health Care Financing Reform on Quality of Health
- UNDP (1999). Decentralization: A Sampling of Definitions. Working paper prepared in connection with the Joint UNDP-Government of Germany evaluation of the UNDP.
- United Nations Economic and Social Council (2006). Definition of Basic Concepts and Terminologies in Governance and Public Administration Committee of Experts on Public Administration Fifth Session New York.
- Vincent, K. (1991) total quality and productivity management in health care organizations, institutes of industrial engineers and the American society for quality control.
- Wakida, P. (2005) understanding the Impact of Decentralization on the Quality of Primary Health Care in Pallisa District in Uganda
- Wamai, L. (2009). Reviewing Ethiopia's Health System Development. International Medical Community
- White, S. (2011). Government decentralization in the 21st century. A report of the CSIS program on crisis, conflicts, and cooperation. Centre for Strategic and International studies Washington D.C.

World Bank (2001). Ethiopia Focusing Public Expenditures on Poverty Reduction, Volume II, Appendixes and Statistical Tables, Report No. 23341-ET, World Bank Country office in Ethiopia, Country Department 6, Africa Region.

World Bank (2008), Decentralization in Client Countries: An Evaluation of World Bank Support (1990-2007), the World Bank, Washington, D.C.

World Bank (2014). Introduction to the Public Sector: developed to show up Governance and Accountability Series.

World Bank group (2001) also accessed at [http://www1.worldbank.org/publicsector/decentralization/ service.htm](http://www1.worldbank.org/publicsector/decentralization/service.htm)

World Health Organization (2004). Health systems in transition, improving quality of health

World Health Organization. (2010). Decentralization of Health-Care Services in the South-East Asia Region Report of the Regional Seminar Bandung, Indonesia, 6-8 July 2010

World Health Organization. (2018). The Organization for Economic Co-operation and Development; international Bank for Reconstruction and Development/The World Bank.

Yilmaz, S. and Venugopal, V. (2008). Local Government Discretion and Accountability in Ethiopia: International Studies Program, Working Paper 08-38

Zikmund, W.G.; Babin, B.J.; Carr, J.C.; and Griffin, M. (2010). Business Research Methods, 8th edition. Australia: SouthWestern Cengage Learning.

APPENDIX

Appendix 1

Addis Ababa University

College of business and Economics

Department of Public Administration and Development Management

Master of Arts in Public Management and Policy

Questionnaires to be filled by service provider

Dear Sir/Madam,

My name is Bahlbi Brhane, a postgraduate student of Masters of Arts in Public Management and Policy (MPMP) program at the Department of Public Administration and Development Management, College of business and Economics, Addis Ababa University. I am conducting a study on **“The effect of decentralization on quality of health care service delivery at local level in Addis Ababa: The case of Kirkos sub-city.”** I understand that your time is expensive, but I would appreciate it if you would spend some minutes to complete this questionnaire. Your completion of the questionnaire is critical to the success of the study. As each of responses has a significant impact on the final findings of the study, I kindly request you to respond genuinely to each question. I assure you that all of your responses will be kept confidential and used solely to carry out this particular research. Thank you for your timely completion and return of the questionnaire.

Yours faithfully,

Mobile number 0900606379

Student Researcher

General Instruction

- Please circle that properly represents your response in the multiple choice questions
- Try to answer the questions based on your current knowledge and/or experience.
- Please mark (√) your response to each statement according to the following five-point scale in terms of your own agreement and disagreement of the statement. The numbers have the following meanings: (1) = strongly Disagree; (2) = Disagree; (3) = Neutral; (4) = Agree and (5) = strongly Agree.

Section One: Demographic Characteristics of Respondents

1. Gender: A. Male B. Female
2. Age: A. Below 25 years B. 26–30years C. 31–35years D. 36 – 40 years E. Above 41 years
3. Level of Education: A. Diploma B. First degree C. MA and above
4. How many years have you spent in the present health center?
 - A. below 5 years B. 6 – 10 years
 - C. 11 – 15 years D. Above 15 years

Section Two: Items related to decentralized health care service delivery based on likert scale questions.

NO	Description of Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
		1	2	3	4	5
Institutional health care framework development:						
1	There are assigned functions, responsibilities, and resources according to the intended objective for the respective level of government as well as a realistic assessment of the technical and financial capacity at each level of health service.					
2	There are certain issues in the health sector that may be better retained with the center, e.g. epidemic control.					
3	There are a create/re-designed new administrative units/ centers of responsibility, as required.					
4	Assigned functions to avoid overlap and mismatch of responsibilities and decision-making authority.					
5	There is insulate the system from the influence of vested interests and powerful local groups, which may attempt to limit the intended objectives of the decentralization process.					

Financial health care framework development:					
6	Analyze how local governments finance health expenditures (through own revenues, transfers from central government, or shared revenues)				
7	The health center identifies where local finances may need to increase				
8	Consider approaches to increase government funding where necessary, including through alternate sources of finance such as donors, private sector, civil society organizations, and user charges.				
9	Tap these sources based on an assessment of requirements and potential to contribute the absorptive capacity at the local level.				
10	Units of administration for health expenditure are remarking funds through the inclusion of a specific budgetary line item in the central government finances..				
Accountability health care framework development:					
11	There is introduced a better monitoring framework to ensure the accountability of the local government.				
12	Health care is characterized by effective staff involvement and teamwork in planning and work.				
13	The local government is supporting the local health care units, particularly to the health centers, and health posts to provide sufficient health services..				
14	There is devise feedback mechanisms so that the local governments are not in a position to abuse their power.				
15	There are engage civil society in an oversight role with regards to service delivery quality, accessibility and affordability.				
16	This is particularly important for the health sector given it is a public good and core government service to society.				
Health care Capacity Development Frame work:					

17	We Create to enhance capacity at all levels to implement the various health care frameworks required for efficient and effective decentralization.					
18	There are well-trained government health care workers and civil servants in planning and managerial skills at the decentralized level and whole system stewardship at the central level.					
19	We recruited as train health workers to meet shortfalls compromising efficient health service delivery.					
20	There is an effective system of coordination at the grassroots level to ensure the implementation of the strategic plans of our health care sector.					
21	There is proportional staff and official/ structural positions with public health service demand.					
22	The local health sector staffs, as a group, have the requisite skills to carry out the public health service demand					
Health care communications and Coordination frame work:						
23	We implement an efficient coordination and information sharing mechanisms among the various levels of administration					
24	We have strong decision-making to ensure information asymmetry does not hamper the effective delivery of health services.					
25	Our health care has a clear vision, acknowledged at all levels in common values.					
26	Health care activities interconnect with institutional mission and priorities.					
27	There is a favorable environment in which subordinates are communicated to implement health programs at the grassroots level.					
28	There are good communications in order to influence					

	efficient and effective health service delivery under the conditions of scarce recourses					
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Please provide any other information, deemed important for this study

Thank you for your cooperation and cooperative!!!

Appendix 2

Addis Ababa University

College of business and Economics

Department of Public Administration and Development Management

Master of Arts in Public Management and Policy

Questionnaires to be filled by health center customer

Dear Sir/Madam,

My name is Bahlbi Brhane, a postgraduate student of Masters of Arts in Public Management and Policy (MPMP) program at the Department of Public Administration and Development Management, College of Business and Economics, Addis Ababa University. I am conducting a study on **“The effect of decentralization on quality of health care service delivery at local level in Addis Ababa: The case of Kirkos sub-city.”** I understand that your time is expensive, but I would appreciate it if you would spend some minutes to complete this questionnaire. Your completion of the questionnaire is critical to the success of the study. As each of the responses has a significant impact on the final findings of the study, I kindly request you to respond genuinely to each question. I assure you that all of your responses will be kept confidential and used solely to carry out this particular research. Thank you for your timely completion and return of the questionnaire.

Yours faithfully,

Mobile number 0900606379

Student Researcher

General Instruction

- Please circle that properly represents your response in the multiple choice questions
- Try to answer the questions based on your current knowledge and/or experience.
- Please mark (√) your response to each statement according to the following five-point scale in terms of your own agreement and disagreement of the statement. The numbers have the

following meanings: (1) = strongly Disagree; (2) = Disagree; (3) = Neutral; (4) = Agree and (5) = strongly Agree.

Section One: Demographic Characteristics of Respondents

1. Gender: A. Male B. Female
2. Age: A.18-20years B.21–30years C.31–40years D. 41-50years E. Above 50 years
3. Educational back ground:
 - A. Illiterate B. Below high school C. High school D. Diploma holder
 - E. Bachelor's degree and above
4. How many years as a customer in the health center:
 - A. Below 2 years B.3-5 years C. 6-10years D. above 10 years

Section Two: Question Related to Quality of service delivery

NO	Description of Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
		1	2	3	4	5
I. Quality of health care service delivery						
1	There is good service delivery link between the location of the health facilities and the location of the population while assessing the transport, time, travel cost and distance					
2	Level of service delivery was very good due to the strong implementation of the plan of action and availability of inadequate facilities, a good relationship between health staff and the communities					
3	The existence of health service delivery in our health center is verily acknowledged and improved greatly substantially good					
4	Our health center service provider contribution to excellent service deliver being reliable					
5	The employee has a conducive environment for					

	responsive service delivery to the customer					
6	Service delivery effectively due to sort intervals in implementation of long protocol structure health services.					
7	The Employees have a strong administrative background towards quality service delivery to the user					
8	The employee has strong awareness of health center service provision and about services needed in the community facility					

Please provide any other information, deemed important for this study

Thank you for your cooperation and cooperative!!!

Appendix 3 Amharic translated Questioner

አዲስ አበባ ዩንቨርሲቲ

የቢዝነስ እና ኢኮኖሚክስ ኮሌጅ

የፕብሊክ አድመንስትሬሽን እና ደብዳቤ-ጥምነት ክፍል

ማስተር ኦፍ አርት በፕብሊክ ማኔጅመንት እና ፖሊሲ

በጤና ማዕከሉ በሚጠቀሙ ደንበኞች የሚሞላ መጠይቅ

ውድ አቶ/ ወ/ሮ

ስሜ ባህልቢ ብርሃነ ነው፤ እኔ በአዲስ አበባ ዩንቨርሲቲ ቢዝነስ እና ኢኮኖሚክስ ኮሌጅ፤ ፕብሊክ አድመንስትሬሽን እና ደብዳቤ-ጥምነት ማኔጅመንት ዲፓርትመንት፤ በፕብሊክ ማኔጅመንት እና ፖሊሲ (ኤምፒራይምፒ) ፕሮግራም ስር የአርት ማስተርስ ድግሪ ድህረ ምረቃ ተማሪ ነኝ። በአሁኑ ጊዜ “በአዲስ አበባ ውስጥ በቂርቆስ ክፍለ ከተማ ላይ በሚሰጠው የፕብሊክ ጤና አገልግሎት ጥራት ላይ ያልተማከለ አስተዳደር ያለውን ውጤት በሚል ጥናት እያደረግኩ ነው። ያልታወቀ ጊዜ በጣም ውድ ሊሆን እንደሚችል እረዳለው፤ ነገር ግን ይህንን መጠይቅ ለመሙላት የተወሰኑ ደቂቃዎችን ቢወስዱ በጣም አመሰግናለሁ። እርስዎ መጠይቁን መሙላቱ ለጥናቱ ውጤቶች በጣም ወሳኝ ነው፤ ስለዚህ ለእያንዳንዱ ጥያቄ እውነተኛ መልስ እንዲሰጡ በትህትና እጠይቃለሁ። የሚሰጡት ሁሉም መልሶች እና መረጃ በሚስጢር የሚያዝ መሆኑን እና ይህንን ጥናት ለማካሄድ ብቻ የሚደረግ መሆኑን አረጋግጣለሁ። መጠይቁን በጊዜ ሞለተው በመመለስ ለሚያደርጉት ትብብር አመሰግናለሁ።

ከምስጋና ጋር

የሞባይል ስልክ ቁጥር: 0900606379

የተማሪ ጥናት አድራጊ

አጠቃላይ መመሪያ

- እባክዎን ከታች በተቀመጡት የምርጫ ጥያቄዎች ላይ ተገቢውን መልስ ያክብቡ።
- አሁን ባልታወቁ ጥያቄዎች የእውቀት እና/ወይም ተሞክሮ መሰረት ይመልሱ።
- የሊከርት ስኬል ጥያቄዎች ለመመለስ በተሰጠው ሳጥን ውስጥ የ √ ምልክት ያስቀምጡ እና የሊከርት ስኬል ቁጥሮች የሚከተሉት ፍቺዎች ይኖራቸዋል። 1=በጣም አልሰማማም 2 = አልሰማማም 3 = ገለልተኛ 4= እስማማለሁ እና 5 = በጣም እስማማለሁ

ክፍል አንድ - የመላሶች የግል በስተጀርባ ያለውን መረጃ የሚመለከት

1. ጾታ:- ሀ. ወንድ ለ. ሴት
2. እድሜ:- ሀ. ከ18-20 ዓመት ለ. ከ21-30 ዓመት ሐ. ከ31-40 ዓመት
መ. ከ41-50 ዓመት ሠ.ከ50 ዓመት በላይ
3. የትምህርት ደረጃ:- ሀ. ማንበብና መጻፍ ለ. ሁለተኛ ደረጃ በታች
ሐ. ሁለተኛ ደረጃ መ. ዲፕሎማ ሠ. ዲግሪ እና ከዚያ በላይ
4. በጤና ጣቢያ ውስጥ እንደ ደንበኛ ስንት ዓመት ሆኖታል:- ሀ. ከ2 ዓመት በታች
ለ. ከ3-5 ዓመት ሐ. ከ6-10 ዓመት መ. ከ10 ዓመት በላይ

ክፍል ሁለት- ከአገልግሎት አሰጣጥ ጥራት ጋር ተዛማጅ የሆነ ጥያቄ

ቁጥር	የጥያቄዎች ዝርዝር	በጣም አልሰማም	አልሰማም	ገለልተኛ	እስማማለሁ	በጣም እስማማለሁ
		1	2	3	4	5
I.ጥራት ያለው የጤና አገልግሎት አሰጣጥ						
1.	በጤና ፋሲሊቲዎች ቦታ እና ህዝብ በሚኖርበት ቦታ መካከል ያለውን የትራንስፖርት፣ የጊዜ፣ የጉዞ ወጪ እና እርቀት ስንገመግም ጥሩ የሚባል የአገልግሎት አሰጣጥ ትስስር አለ።					
2.	በጤና ሰራተኞች እና በማህበረሰብ መካከል ባለው ግንኙነት መሰረት የአገልግሎት አሰጣጥ ደረጃው በጣም ጥሩ ነበር።					
3.	በጤና ማዕከላችን ያለው የጤና አገልግሎት አሰጣጥ በጣም እውቅና ያለው እና በጣም እየተሻሻለ የመጣ ጥሩ አገልግሎት ነው።					
4.	የጤና ማዕከላችን አገልግሎት አቅራቢ እጅግ በጣም ጥሩ የሆነ የአገልግሎት አሰጣጥ ለማቅረብ የሚያደርገው አስተዋጽኦ አስተማማኝ ነው።					
5.	ሰራተኛው ጠቋሚ የሆነ የጤና አገልግሎት ሰጪ ለደንበኛ የሚሰጠውን የአገልግሎት አሰጣጥ ለመስጠት የሚያስችል ምቹ የሆነ የስራ አካባቢ አለ					

6.	በአፈፃፀም ረዘም ላለ ጊዜ በሚተገበሩ የፕሮቶኮል መዋቅር የጤና አገልግሎት ውስጥ የአገልግሎት አሰጣጥ ውጤታማ በሆነ መንገድ ይከናወናል።				
7.	ሰራተኞች ጥራት ያለው አገልግሎት ለተጠቃሚው በማቅረብ ረገድ አስተዳደራዊ አካል ከጀርባቸው አለ።				
8.	ሰራተኛው ጠንካራ የሆነ የጤና ማዕከል አገልግሎት አቀራረብ እውቀት እና በማህበረሰብ ፋሲሊቲዎች ሰለሚያስፈልጉት አቅርቦት በቂ የሆነ እውቀት አላቸው።				

እባክዎ ለዚህ ጥናት ጠቃሚ ነው ብለው የሚያስቡትን ማንኛውንም መረጃ ከዚህ በታች መስጠት ይችላሉ። _____

ስለትብብር እናመሰግናለን!!!