Mekelle University

College of Business and Economics

Department of Management

An Assessment on Decentralized Service Delivery in the Health Sector: The Case of Ahferom Woreda

A Thesis Submitted in Partial Fulfillment of the Requirement for the Award of Master of Arts Degree in Development Studies (Governance, Democracy and Development)

BY

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Declaration

I, **Gebremedhin Mezgebe Weldegebrieal** declare that this thesis Entitled **“An assessment on Decentralized Service Delivery in the Health Sector: The case of Ahferom Wereda”** is my original work and has not been presented for a degree, diploma or followship to any university and all the sources of materials used for the thesis are duly acknowledged.

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Certification

This is to certify that, this thesis entitled **“An assessment on Decentralized Service Delivery in the Health Sector: The case of Ahferom Wereda”** submitted in partial fulfillment of the requirements for the award of Master of Arts Degree in Development Studies done by **Mr. Gebremedhin Mezgebe Weldegebrieal** carried out under our guidance and submitted with our approval.

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Abstract

This study attempted to investigate the An assessment on Decentralized Service Delivery in the Health Sector in Ahferom Wereda which is one of the administrative divisions of Tigray National Regional State. The main objectives of this study was to examine adequate human resources and health service availabilities including pharmaceutical commodities, the local level health service delivery arrangements in terms of accountability, the institutional capacity of local government in implementing and coordinating decentralized health service programs and policies and identify the challenges of decentralized governance in the process of health service provision. The study used a descriptive survey research design and employed both qualitative and quantitative data types, specifically semi -questionnaires, semi-structured interviews and focus group discussion. In addition to this, study was employed both primarily and secondary sources of data. The sampling designs used in this study are both probability and non probability sampling designs. These are, purposive, clustered, lottery method, proportionate sampling and finally convenience sampling was employed. For the purpose of this, the study used a sample of 190 house hold heads. In addition to this, the study used 20 key respondents purposely. The key respondents with regard to this objective were officials in health related management and health service providers of the wereda .The major findings of this study reveals that though decentralization is contributing better health services availability, it constrains ensuring of adequate human recourse, geographical accessibility and adequate pharmaceutical commodities for better health service delivery to the public. Besides, there is failure of accountability in relation to financial planning, reporting and implementation of activities, the availability of channeling procedures for complaints, strong institutional capacity in terms of leadership, human resources management and financial management capacity. In relation 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 study recommended organizing public to participate in financing and health service delivery, enhancing leadership and improvement, filling vacancies and enhancing competency of the staff, strengthening standardized auditing instrument and improving and strengthening inter-organizational relations with different NGOs are more relevant.

Key words: Decentralization, accountability, institutional capacity, Heath service Delivery

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency syndrome
ASDM	Alternative Service Delivery Model
CIPFA	Chartered Institute of Public Finance and Accountancy
DSDM-	Direct Service Delivery Model
DSDSM	Decentralized Service Delivery Model
EPRDF	Ethiopia Peoples' Revolutionary Democratic Front
FDRE	Federal Democratic Republic of Ethiopia
FMoH,	Federal Ministry of health
HIV	Human Immune Virus
HRM	Human Resource Management
HSDP	Health sector development program
LG	Local Government
LGIs	Local Government institutions
MDGs	Millennium Development Goals
N.d	No date
PSDMP	Privatization Service Delivery Model
RHBs -	Regional Health Bureaus
SNNP	Southern Nations Nationalities and Peoples
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health organization

Content

Title **Page**

List of Tables

List of figures

Glossaries

Tabia/kebeles is the lowest unit in the administrative hierarchy of Ethiopia, referred to as a community or a peasant association

Woreda is an administrative division of Ethiopia (administered by a local government), which is equivalent to a district.

Service Delivery

Service Delivery: Service Delivery is conceptualized as the relationship between policymakers, service providers, and citizens. It includes services and their sustaining systems that are typically regarded as a state liability (Government of Nepal ministry finance and Asian Development Bank, 2010).

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).

Masso and Norman (2009) 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). According to Gropello (2002), 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.

There are 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 result of central governments were unable to be more responsive, accountable, inefficient or ineffective at delivering public services (Yilmaz and Boex, 2010). 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 (Ibid).

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 (ibid).

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). Ahmed (2006) 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.

Like many other 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, 2007). Besides, (Ford, nd) 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 unever seen decentralized governance since 1995 (Tegenge, 2007). 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.

1.2. Statement of the Problem

Even though almost all of the countries of the world have adopted the system of decentralized governance, the exact reasons why some decentralization efforts brings improved service delivery while other are either ineffective, or worsen local conditions, remains an open area of active research and country specific (Fritzen and Lim, 2006). As a result, different scholars have tried to investigate the performance of decentralized governance through different methods of measurements. To this end, Kassahun and Tegegne (2004), argue that many countries have implemented decentralized governance to provide effective service, and local self-rule through developing authorities and responsibilities at various levels of government with a belief to improve quality of service, greater participation in development planning and, management, and increase democratic governance.

In this regard, like other decentralized countries, Ethiopia's health sector decentralization was pursued among the other social sectors since 1993, to promote effective and efficient service at the grassroots level **(**Wamai, 2009**).** In this sector, different studies have been conducted by different researchers for improving the service delivery system. From these researchers, Kumera (2006) investigated the performance and constraints of decentralized governance in four sectors including the health sector, education, water supply and rural road service delivery. This research was conducted in Oromia region, Arsi zone Digelu and Tijo woreda and it was also comparative study between two woredas. Besides the study conducted by Saharty et al (2009) was improving health service delivery in Ethiopia. This study was under taken with the comparative analysis of four regions; these are Oromia, Amhara, Afar and SNNP. The other study is the role of local governments in promoting equity in PHC (primary health care) and it was conducted by

Gebraeb, (1998) in Tigray region and North Omo zone .This study is also a comparative analysis by taking 20 woredas taking 10 weredas from each region . However, this study has a practical gap from each of these studies. However the difference with study made by Kumera is that, personally feel there can be a difference in terms of budget allocation, availability of human resources, Policy implementation and governance system of the regions and the wereda and this can lead to a further research as far as this type of research is not conducted in Tigray region particularly in the study area and specifically the performance and challenges of decentralized governance in health service delivery only. With regard to the study conducted by Saharty et al (2009), there is a place of a gap as it was conducted in Oromia, Amhara, Afar and SNNP but not in Tigray region, particularly in the study area. Through the study conducted by Gebraeb (1998), there is a time gap as it was conducted before fourteen years and after this research was conducted different reforms has been introduced. Due to this all differences, this study is going to investigate the decentralized service delivery in the health sector in Tigray region particularly at Ahferom wereda as per any research has not been conducted in the selected study area.

1.3 Research questions

- ✓ Are there adequate and skilled human resources and available pharmaceutical commodities in the provision of health service in the study area?
- ✓ Has the wereda health service delivery ensured accountability, financial planning, reporting, hearing and responding complains and the like?
- ✓ To what extent are the wereda health intuitions capable in terms of resource, knowledge, skill, leadership and financial management capacity in implementing and coordinating decentralized health service programs and policies with regard to the public demand?
- ✓ How is decentralized governance performing and what challenges are affecting decentralized governance in health service delivery at Ahferom Wereda.

1.4. General objectives of the study

The main objective of this study is to assess decentralized service delivery in the health service in terms human resource and health service availability, accountability, and institutional capacity at Ahferom Wereda.

1.4.1. Specific objectives

The specific objective of study was to.

- ✓ Examine human resources and health service availabilities including pharmaceutical commodities in the study area.
- ✓ Examine the local level health service delivery arrangements in terms of accountability.
- ✓ Examine the institutional capacity of local government in implementing and coordinating decentralized health service programs and policies with regard to public demand.
- ✓ Identify the challenges of decentralized governance in the process of health service provision.

1.5. Significance of the study

Decentralization is leading to the dispersion of political, fiscal, and administrative responsibilities across different tiers of government and between the public and the private sector. In terms of delivery of services and it is the fundamental aspect of governance to reach the grass root level and almost of all of the countries of the world are practicing it. Having this understanding the study will be an input to the existing body of knowledge relating to decentralization in general and to the performance and challenges of decentralized governance.

Again this study will contribute to develop the understanding of policy makers how policies and programs are implementing and what factors are affecting the performance of local health service delivery. In addition this study will able evaluate the current statues of local governance in health service delivery of the region and particularly to the local government of the study area. Therefore, the wereda administration and the regional government can significantly advantageous to rearrange the local health service delivery system.

1.6. Scope and limitation of the study

Theoretically this study cannot be free of restraint as far as term decentralized governance constitutes multidimensional connotations and the main study focus of this study is on the decentralized service delivery in the health sector.

Conceptually, different researchers had been used different measurement for decentralized governance in health service delivery but for the purpose of this study the researcher was measured through the availability of human resources and health service including pharmaceutical commodities, the challenges of decentralized governance in the processes of health service delivery, performance of local governments in health service delivery in terms of accountability and the institutional capacity of local health sector office in promoting health service delivery at the grass root level. The other methodological limitation of this study is it could have been good had it been conducted with a comparative of the bad and good performed weredas i.e the study area. But due to the time, financial this study has been conducted in the model wereda.

Geographically the study was conducted in Tigray regional state, central zone particularly in Ahferom Wereda. The study focused on the decentralized service delivery in the health sector at this particular Wereda. So the results of this study may not represent for woredas' of Tigray region.

CHAPTER TWO-REVIEW OF RELATED LITERATURE

2.1 An Overview of on the Models Service Delivery

According to UNDP, (1999) service delivery is a place of institutional arrangements approved by the government to offer public goods and services to its citizens. Accordingly, the institutional arrangements that significantly affect the piece of public service delivery in different systems of services can be classified in to four fundamental forms of public service delivery preparations that governments applied in all places: The following are the forms service delivery.

1. **Direct Service Delivery Model (DSDM**) - The central government carry out legislation, put into effect it, appoint employees, spends, generates and allocate services, either straightly in service from the center or through deconcentrated line agencies, presuppose complete accountability, and is responsible not only for provisioning but also for delivering services.

2. **Privatization Service Delivery Model (PSDM)** - administration moves the public services to private delivery enterprises for the purpose of effective service. In this system the government has no accountability except supervising the business companies' based on the lawful systems. Transportation and communication services are privatized in various nations. The essential reason of privatization is to increase benefit of allocative efficiency of the market mechanism and to meet supply gaps through assembling private sector speculation in the public service sector.

3. **Decentralized Service Delivery Model (DSDSM) or Local-level governmental systems** - is 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. Through desirable quality of being nearest to citizens, 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.

4 Alternative Service Delivery Model (ASDM) - In the ground of public service delivery. Alternative Service Delivery Model' is a moderately latest occurrence. It simulates matrimony between the government and private sector with different contractual arrangements. Though, the definitive 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.

With regard to the relevance of the above forms of service delivery, decentralization Service Delivery Model is more related with the concept of decentralized governance and service delivery. Based on this understanding this research assessed the performance and challenges

2.2. Decentralization

According to Tesfaye, (2006) decentralization is difficult to give a specific definition. Many scholars define decentralization in various ways. Hence, the concept has guide to different description, broad assortment of ambiguities and even confusion in design and accomplishment of decentralization policies (Thomas, 2010/11).

However the most inclusive explanation of decentralization is specified by Rondinelli, (1989) .He asserts decentralization as the transfer or delegation of legal; and political authority to plan, make decisions and manage public functions from central government and its agencies to lower units of government, semi-independent public corporations, area broad or local development authorities; functional authorities, autonomous local government or non-governmental organizations. In line with this he also defined as a shift of responsibility and autonomous power for development, administration and the raising and allocation of resources from the central government and its agencies to the lower level of government, semi-independent public authorities or corporations; area broad regional or functional authorities or nongovernmental private voluntary organizations that are closer to the public to be served .

Beside to this Turner and Hulme, (1997) cited in Thomas (2010/11) defines decentralization in sight 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 unit of government.

2.2.1. Types of Decentralization

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** means transfer of political authority or of electoral capacities to Sub-national actors. Where such transfer is made to a local level of public authority that is autonomous and fully independent from the devolving authority (Vochiğa and Gruescu, 2009).

2**) Fiscal decentralization** involves a level of resource reallocation to local government which would allow it to function appropriately and furnish allocated service delivery responsibility, with arrangements for resource allocation regularly negotiated between local and central authorities. The fiscal decentralization on policy would normally al so address such issues as assignment of local taxes and revenue-sharing through local taxation and user an d market fees (Olsen, 2007).

3) Administrative decentralization refers to transferring the responsibilities to accomplish public obligations among governmental authorities on various State levels. Responsibility for local planning, operational administration and in part also for the financing of infrastructures and public services is transfer from the central administration to lower government units (Nath, nd).

2.2.2. Forms of decentralization

According to Egbenya, (2009) there are three major forms of administrative decentralization are deconcentration, delegation, and devolution.

Deconcentration is the redistribution of decision making authority and financial management responsibilities among different levels of the central government Egbenya, (2009).

Delegation is a more extensive form of decentralization in which the central government transfers responsibility for decision-making and administration of public functions to semi-autonomous organizations not wholly controlled by the central government, but ultimately accountable to the government (UNDP, 1999)

Devolution - is the strongest for m of decentralization is achieved by in which voted local governments are authorized, by the transfer of specific service deliver y functions. The global trend has been toward the development of nominated forms of local government that have, in addition t o their straight up accountability, a strong public service delivery role and direct account ability t o its citizens(Neven,nd). Besides Kundishora, (2009) reveals that devolution is habitually a transfer of farm duties for services to local governments that elect their own representatives, lift their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear officially recognized physical boundaries in excess of which they exercise authority and surrounded by which they perform communal functions.

2.2.3. Objectives of Decentralization

According to Muriisa,(2008) decentralization in most developing countries occurs in the 1970s due to the displeasure with the centralized governance that were the consequence of previous colonial rule. But these systems had been stress in the 1950s and the 1960s in the time of struggle for self-government. Following this the 1970s saw an interest to involve the mass of the grassroots in the planning and administrative process, and to direct planning to people's needs.

In the 1990s the World Bank were influenced decentralization as a essential part of structural development to promote efficient use of resources and to address local needs of developing countries(Ibid).

Coming in to practice Golola (2003) presents as decentralization policy has four main objectives among these improved service delivery as their main component: (1) devolution of power to the regions aimed at reducing the workload of central government officials; (2) to bring administrative and political control to the point where services are delivered; (3) to improve financial accountability through institution of a patent links between tax payment and service provision; and (4) to improve the capacity of local councils to plan, finance and administer the delivery of services to their communities.

2.2.4. Conditions for Effective Decentralization

Decentralization necessitates a quantity of obligations and the continuation of well arranged institutions to improve public service and promote holistic development at all level (Negaleng, 2010). In doing so, (Fritzen and Lim, 2006) suggested the following criteria's as prerequisite for successful decentralization.

• **Political Commitment**: The base for effective accomplishment of decentralization policy is getting a special advocacy from the administrative body. The extents to which nationwide political leaders all through the political pecking order are devoted to decentralize planning aims determine the effectiveness of decentralization policy.

• Successful Inter-organizational Relations: Decentralization requires some sort of special implementing machinery, including an agency especially responsible for coordinating and implementing an action plan.

• **Availability to access to resource required**: lack of resources leads to lack capacity of any organization. But least developing countries are frequently inhibited by deficiencies of finance to implement decentralization and it development policies.

• **Capacity of implementing public institutions** or organizations: effective decentralization has to be a well organized institution to implement their own organizational policies. The characteristic of initiations determine the capacity of government agencies through the products of decentralization policies.

• **Complementary support:** A successful process of decentralization must be based on mutual reinforcement of institutional settings to manage the upward and down ward limitations with regard to the activities of different stockholders.

2.3 .Decentralized Governance and service delivery

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 21stcentury.For doing so, Mitullah (2012) reveals that most of 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 local residents want and need. 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 the load of financing services can be transferred to sub-national units and private providers which can produce these at lesser cost (Robinson, 2007).

Bertucci, (2001) recognized that while decentralization policies and programmes 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.

• Adequately empowered and provoked to recognize poverty diminution priorities, and to distribute resources to pro-poor programmes;

• Local government should be knowledgeable about local preferences, capable and enthusiastic to provide services in response to the locally uttered preferences, and unrelenting in the search for efficiency and impact in the allocation of resources;

• Able to handle and administer pressure from various social organizations in compared to inner agencies, local governments face pressure from councilors and their constituents; the demands construction and/or maintenance of feeder roads, health posts, primary school classrooms, and other facilities that favor the poor, and for investment on large-scale capital development projects such as trunk roads, referral hospitals, and airport terminals);

• Competent of forging and spiraling institutionalized relations with recipient of the public services.

• Proficient at obtaining, recovering, applying, and updating information, and data in sequence local development issues and resources.

2.4. Decentralization and Access to Health Services

The Alma-Ata declaration on "Health for All by 2000"is a benchmark in the process of in health services decentralization (Pokharel, 2001). Partners for Health Plus. (2002) decentralization is followed for many rationales: methodological, political, and financial systems on the technical side, it is frequently suggested as a means to improve administrative and service delivery effectiveness. However as Hutchinson, et al (2004), maintains that decentralization does not guarantee improved health sector efficiency or improved health system outcomes. Numerous conditions, often overlooked, influence the success of decentralization processes, including local managerial and technical capacity, systems of accountability, clear and transparent legal frameworks that delineate the division of responsibilities, and sufficient funding to fulfill mandates and to meet local priorities. In line with this Economic Policy Research Centre, (2010) suggested that decentralized health services can only work if there is (a) adequate financing (for staff, drugs, and equipment); (b) clear performance measurements (e.g. at the health facility level); (c) proper information flows (hence the importance of the Health Management Information Systems (HMIS); and (d) effective supervision, inspection and enforcement of performance standards.

According to Kaseje, (2006) the measurement of system effective public health care should be based on the life sequence to ensure participation and access. Significant elements of ECPH may include newborn care, nutrition, focused pre-natal care, prevention of mother to child transmission of HIV, delivery by trained midwives, family planning, family and community support, community integrated management of childhood illnesses, education, employment, investment, and screening .

2.4.1. Access to health service

Service delivery access refers to the capability of a population to reach appropriate health services. (In this assessment, the WHO-make clears that accessibility, coverage, and acceptability coverage have been combined.)Various factors can reduce access, including presence of physical and transportation barriers, lack of financial resources, or lack of cultural appropriateness. Effective coverage refers to the proportion of the population in need of an effective intervention that actually received the intervention (Awoyemi1 T. T. and et al, nd).

Bagheri et al, (2005) maintains that access to primary health care /service is one of the manifestations to achieving the goal of “health for all” and it has different definitions depending upon different contexts. According to these authors there are two key dimensions for access, potential and realized. Potential accessibility is seen when an underprivileged residents live in place and time with an excited and capable health care delivery system realized or actual access, follows when all impediments to public health care are removed. Penchansky and Thomas (1981) cited in Bagheri, et al, (2005) reveals that access to healthcare reflects the fit between characteristics and expectations of the providers and the clients. They group access under five dimensions theses are: availability, accessibility, affordability, accommodation, and acceptability.

Besides (Joseph, 2002) suggested that, in deciding to improve the existing service delivery alternatives for their areas, local governments should consider the following principles. These are; a) accessibility of services; b) affordability of services; c) quality of outcomes and services, d) accountability for services; e) integrated progress and services; f) continuity of services; g) value-for-money .

Availability in the context of primary health care refers to the number of health care service points which needy people can choose and accessibility is geographic convenience, which is strong-minded by how easily the client can physically reach the provider's location (Bagheri, 2005). These first two groups are spatial in nature .The o Effect of travel and distance on the use of healthcare services (ibid). A lack of specialty care and primary care in rural areas means that residents must travel away from their communities to obtain healthcare services their three dimensions are a spatial and reflect socio-cultural and economic factors(Beedasy**,**2010). To this end decentralization may improve physical accessibility, mainly in authority where the majority of the population lives in rural areas, if local planners choose to shift resources from more costly urban-based secondary or tertiary care to less costly rural primary health care **(**Hutchinson and LaFond, 2004).

2.4.2. Availability of Human Resource

The availability of trained health workers is one the most important problem of health policy accomplishment. Having this case, WHO has identified a threshold in workforce density below which high coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals (MDGs), is very unlikely. Based on these estimates, there are currently 57 countries, including Ethiopia, with critical shortages equivalent to a global deficit of 2.4 million doctors, nurses and midwives (Samuel Girma etal. nd).

Shortage of staff in Ethiopia has always been critical. Health worker/population ratios, for example are 3 to 4 times lower than even East African standards. This has been exacerbated by the rapid expansion of facilities in the 1st years of HSDP. Allocation not related to workload has also meant severe shortage in some areas while some health workers in other locations remain idle. Performance at most levels is also considered low (ibid).

According to the WHO, accessibility coverage refers to the percentage of people for whom sufficient resources have been made available, the ratio of human and material resources to the total population, and the proportion of facilities that offer specific resources, equipment and materials, and other health service delivery necessities (WHO 2001). In other words, it is the degree to which health facilities that are functional, adequately staffed, equipped, and supplied are available to the population in a country (Beedasy, 2010).

2.4.3. Medicines, Supplies, and Logistics Systems

Access to essential medicines and supplies is primary to the good performance of the health care delivery system. Availability of medicines is commonly cited as the most important element of quality by health care consumers, and the absence of medicines is a key factor in the underuse of government health services.

The be short of access to essential drugs, vaccines, and health commodities in developing countries is globally recognized as being of enormous significance, and various agencies and Organizations, including WHO, have compiled data to estimate the extent of the problem (Report of the WHO-MSH Consultative Meeting, Ferney-Voltaire, France, 2000).WHO (2004), estimates that one-third of the world’s population lacks access to essential medicines.

Problems in access are often related to inefficiencies in the pharmaceutical supply management system, such as inappropriate selection, poor distribution, deterioration, termination, and irrational use. Where medicines are available, price may be a barrier for the poor. Pharmaceutical subsidies, fee waivers, and availability of affordable generic medicines are some of the pharmaceutical financing move toward that can alleviate barriers to access.

2.5. Decentralization and Accountability in Decentralized Health service Delivery

According to Schedler (1999) accountability is conceptualized as a relationship wherever single party has the responsibility to reply questions concerning decisions and/or actions raised by another party, and the accountable party is subject to sanctions for failures or transgressions Horizontal accountability concerns the classic separation of powers, but also includes a variety of oversight entities, such as audit offices, ombudsmen, courts of accounts, electoral commissions and so on. Vertical accountability refers to actors located outside the state that play a role in holding state actors accountable.

According to Ahmad, (2005) the essence services delivery attracts strong relationships of accountability between the actors in the service delivery chain .Besides (Ekpo, 2007) suggested that the delivery of public services absorbs at least two relations of accountability. (i) Clients as citizens have to hold policy makers or politicians accountable for allocating resources towards these services and; (ii) policymakers in return require clutching the service providers accountable for delivering the service. (Ahmed, 2005) also recognized that the long route of accountability while opposite to the shot route which suggests the direct responsibility of providers of clients. In this case however one or both of the relations the long route of accountability has a collapse that there will be a failure in service delivery results. Beside to this ,based the frame work of World Development Report (2004) cited in Garcia and Rajkumar (2008) the chain of accountability is defined by the roles of four actors: politicians/policymakers; organizational providers (public, private, nongovernmental organizations); frontline professionals (doctors, nurses, and so forth); and citizens/clients (patients, students, parents, voters). The accountability relationships are defined by rules and arrangements that include delegation, financing, performance, information, and enforcement.

In line with this 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 LGs); 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.

To make concerned bodies in health service delivery accountable, accountability-enhancing strategies can focus on: reducing abuse, assuring compliance with procedures/standards, and improving performance/learning. In practice, efforts to increase accountability are possible to include more than one of these. Plummeting abuse is both the “failure to pay” strategy and a pillar supporting the other two purposes; it focuses on repression of deception, misuse, and corruption (Brinkerhoff, 2003).Strategies for compliance with procedures/standards involve regulation, oversight, monitoring and reporting necessities. Sources of sanctions include the country’s legal framework and judicial system, administrative rules and operating procedures, markets and quasi-markets, professional norms and ethics, certifying and official approval, and socio-cultural values. Strategies for improved performance/learning often include: clarifying chains of accountability to determine more precisely who is responsible for what, shortening the chains to make feedback on performance more direct and timelier, and/or making the chains more powerful to increase incentives for responsive performance. Strategies can select targets at three levels: the health system, facility, and/or individual service provider (Brinkerhoff, 2003).

On the other hand voice and accountability reflect external accountability, the effectiveness of citizen and institutional influences on government action. Although much of the broader concerns are with human rights, in health factors such as the viability of the political system, media independence and trust in government reflect the degree to which citizens can influence government decisions that affect them(Lewis,2006). According to Matovu, (2008) there are three prerequisites for effective decentralized service delivery. These are the roles assigned to the different tiers of government, the resources at the disposal of each tier, and accountability patterns and relationships in all public services. Coming to the Ethiopian case, legally Article 8 of FDRE constitution affirms that sovereignty resides in Ethiopians who exercise this authority through their elected representatives. Citizens are also officially authorized to recall their elected representatives if the latter's behaviors and actions are contrary to their responsibilities and mandates. Having this the Woreda government has two layers of accountability that are key elements of representative accountability and administrative/ service delivery. In this case representatives are accountable to their constituencies, and citizens at the grassroots level in specific physically surrounded areas and Administrative/Service Delivery Accountability mainly refers to woreda-sector officers (health, education, agriculture, etc), and their outreach branches at the Kebele-level who are not elected (CIDA, 2005. In making service providers accountable the local government has different monitoring mechanisms in line with their responsibilities. Though it needs a further investigation how much service providers and local government are accountable to their actions.

2.6. Decentralized Governance and Local Government Institutional Capacity

Institutional capacity in LGIs refers to the capability of these institutions to build up and manage systems, procedures, structures, staffing, decision making, planning, implementation and monitoring (PRIA Global Partnership, nd).As in most countries of the global south LGIs were created much after the strength and centralization of decision making powers by the national governments, these capacities are mainly needy on the dej ure devolution of power and authorities to the former by the latter, effected through some kind of policy or legislative interventions. On the other hand, many such provisions have not been translated in to def acto devolution of power leaving the LGIs at the mercy of the national and provincial governments (Ibid).

"Institutional capacity" thus encompasses, on the one hand, the functions (tasks) that institutions should have the competence (ability) to perform, and, on the other, the resources (human, technical and financial) and structures they need to that end. For ease of analysis, we subsume relations, rules, values, behavior, etc. within the concept of "structure".

2.7.1. Capacity of Local Institutions

A lack of professional, technical or political capacity at local level is a common problem which can seriously hinder the effectiveness of a decentralization programme. This does not mean that functions should not be decentralized, although central government agencies which are opposed to decentralization for other reasons often try to argue to the contrary. What it does mean is that decentralization must be accompanied by specific *measures to enhance the capacity of local institutions, so that they are able to perform the functions decentralized to them (Matovu, 2008).*

In line with this Bandara, (2011) reveals that one of the major critical factor of efficiency and effectiveness of services provided by decentralized LG 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.

LG in the Third World lacks human resources 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).

2.7.2 Dimensions of Institutional Capacity

According to USAID Center for Development Information and Evaluation, (2000) an organization can be thought of as a system of related components that work together to achieve an agreed-upon mission. The following list of organizational components is not all-inclusive, nor does it apply generally to all organizations. But to a certain extent, the components are representative of most institutions involved in development work and will differ according to the type of organization and the circumstance in which it functions**.**

I. **Administrative and Support Functions this includes the** administrative procedures and management systems, Financial management (budgeting, accounting, fundraising, sustainability), human resource management, management of other resources (information, equipment, infrastructure).

II. **Technical/Program Functions:** Service delivery system**,** Program planning Program monitoring and evaluation and Use and management of technical knowledge and skills

III. **Structure and Culture: Organizational** identity and culture Vision and purpose Leadership capacity and style Organizational values and Governance approach

IV. **External relations:** in terms **resources,** human resource, financial resource and other.

Though all the above points are relevant to assess in relation local government institutional capacity, time, financial and the broadness of this topic were the major impediment not to incorporate all these measurements. Due to this fact researcher tried to assess only three variables. From the administrative and support functions, human resources management capacity and financial management capacity were selected and from the Structure and Culture, leadership capacity and style is selected. In selected these variables, the researcher tried to consider the causes and effect relationships of the variables with the general topic of this study. For explanations of the concepts regarding the selected variable are elaborated as follows.

1. **Leadership capacity and style**

Leadership is reefers to the capacity to generate and converse a clear vision of the organization's mandate and goals, to model behaviors expected of others, to hold and show values reliable with the vision, and to mobilize others to do the same. In the current public service atmosphere emphasis has been placed on client service and on ensuring staff have the training, tools and autonomy to act in the best interest of the customer (Veterans Affairs Veterans Affairs Canada, 2000).

Leadership is the engine that powers local governance and service delivery and precisely for decentralized governance to spring up and thrive, it requires a well-built leadership that not only takes pleasure in the trust of the people, but also trusts in the power of the people. Weak leaders who do not trust the people and who lack trust from the people fear decentralization because they wrongly perceive it as further weakening their power and authority .Governments under strong (read capable) leadership tend to decentralize while governments under weak leadership tend to disintegrate.(Kauzya, 2005),

2. **Human Resources Management Capabilities**

This category examines the effectiveness of the HR staff, policies and programs, and services in meeting the needs of internal clientele. Most staff was highly regarded for the services they provided on demand. This included staffing, job evaluation, training and labor relations and general responses to requests for information (Veterans Affairs Veterans Affairs Canada, 2000)

Human resource management can be defined as the integrated set of roles, functions, decisions, systems and processes in an organization that meet the desires and hold up the work performance of staff in order to achieve the mission, goals and strategies of the organization (Johnson, 2000).

Besides he also reveals that improving human resource management capacity in health services organizations has great budding for meeting sector and institutional goals, adding value and delivering results.

According to Yambesi, (2012) HRM deals with issues related to people such as human resource Planning (HRP), performance assessment, reimbursement management, and development, welfare administration, healthy and safety administration, obedience administration, employee inspiration, complaint handling, performance evaluation, institute improvement and labor relations. Effective HRM facilitates employees to contribute effectively and efficiently to the overall organization way and the achievement of the institution's goals and objectives.

According to Bratton and Gold ,(2007) cited in Tegene,(2008) human resource management in decentralized health service system human resources management capacity a strategic approach to managing employment relations which emphasizes that leveraging people's capabilities is critical to achieving competitive advantage, this being achieved through a distinctive set of integrated employment policies, programmes, and practices. The resourceful and successful management of human resources is an essential component of a high performing health system and can influence the achievement or breakdown of health sector reform and different organizations or institutions. Health sector human resource management processes have compensated some attention to analyzing existing personnel in the health system, projecting human resource (HR) needs in a reformed health sector and allowing for the training and allocation of these resources (Johnson, 2000).

Beside to this (Chairperson, 2010) maintains that the eminence of human resources is a critical factor in the capacity of the government to deliver on its mandate. Human Resource Management (HRM) is seriously important in that it ensures that human capital is well managed and that all issues relating to this resource are effectively dealt with.

3. Financial recourses management capacity

The Chartered Institute of Public Finance and Accountancy (CIPFA) has defined Financial management is the system by which the financial aspects of a public body's business are directed and controlled to support the delivery of the organizations goal.

Finance is a major component of decentralization. Experience in the countries reviewed shows that there is no one best formula for financing decentralization. The central and local governments must decide how to finance decentralization based on their individual circumstances, needs, and resources (Asfaw etal). However, Sasaoka, (2005) in Ethiopia Wereda decentralization began in 2002, and capacity building has been progressing rapidly. Supplementary funds have been transferred from the recurrent budget to woreda using the new formula, but the advance budget is motionless managed by regional state governments. 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 dcenteralized 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.

2.7. The Issues and challenges Decentralized Governance in service delivery

As Devas,(2005) maintains that**,** the capacity for effective and responsible decentralized governance differs from one country to another, due to the historical, economic and political circumstances. Despite the fact that, the performance and accountability of local governments can be inhibited by a number of limitations such as limited resources, weak institutional capacity, inadequate mechanisms of accounting and accountability, and limited availability of information. In line with this Scott-Herridge (2002) noted that at the same time as decentralization has potential advantages, there are serious issues to be faced and it will not succeed without full commitment from national and local governments. Some of the key challenges decentralized governance includes: weak financing capacity, human resource capacity, and elite capture. Besides, Olowu (2006) and Capuno, (2009) also noted that broadly, decentralized governance necessitates extra widely distributed management and technical capacities linked to service delivery, and transferring substantial responsibilities, resources and accountability arrangements from central to decentralized governments involves high costs .

In contrary with these idea the advocators of decentralized governance 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 allocative efficiency, by fostering productive efficiency and accountability, and by facilitating cost recovery (Azfar etal, 2010).

Beside Muriisa, (2008) maintains that the targeted objective of decentralization dealing with people's desires at the grassroots. It is not an easy task to determine the successes or failures of decentralization though it is being constantly applied by different countries. But it is possible to identify levels of success, particularly, efficiency, market, effectiveness, performance and accountability though there are limitations to measure. Efficiency: According to advocates of decentralization, it promotes efficient allocation of resources. Efficiency measures the extent to which output is maximized using minimum resource inputs. There are two kinds of efficiency-namely *allocative* and productive *efficiencies*. Allocative efficiency considers a match between public service and local needs while productive efficiency considers a match between provision of the public service and its costs, improved accountability and reduced levels of red tape.

Market: This implies to the production using the cheapest means. In competitive tendering, it is assumed that resource inputs are obtained from the cheapest source while services are provided by the lowest bidder.

Effectiveness: This measures whether the original objectives and policy goals are successfully achieved or not. However, it should be realized that all the above measures are not separated from each other but rather influence and impinge on each other. For instance, increased economy may be realized with loss of effectiveness and efficiency. Therefore, a rise in school enrolment may lead to loss of effectiveness unless it is accompanied with an increase in recruitment of teachers as some children may lack sufficient attention.

Accountability: Looking upon decentralization, accountability deals with one to whom the public officials account. There are two forms of accountability that include political and administrative accountabilities. Political accountability implies the situation in which the elected representatives account to their electorates while administrative accountability refers to the degree to which managers and leaders achieve the desired goals. The focus is usually on the extent to which goals and objectives are achieved within the allocated budget. Both forms of accountability are applicable.

Having realized all the aforementioned potential benefits of decentralization, Walker (2002) and Olowu (2006) identify the challenges of decentralized governance. These are (1) Elite capture: Local elites may incarcerate the reimbursement of decentralization and are not essentially more pro- poor than national elites; b) Revenue minimization: Local government may have limitations in their capacity to mobilize local financial resources, or be unwilling to do so; c) Corruption: More people have political influence under decentralization an consequently the risks of corruption may be higher; d)fragile administrative and management systems: The transfer of responsibilities and resources to local government requires effective and efficient administrative and management systems, which may take a while to develop at the local level; and e) Lack of participation: The decentralization of resources and authority will not automatically result in more participatory and inclusive processes and top-down approaches to development may continue regardless; f)Poor human resource base: Professional staff are often unwilling to live and work in remote areas. Staffs that are available are often poorly trained, lacking in motivation and have low levels of capacity.

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

According to Abraham, (2011) before 1991, likes 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 unever 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). With the failure of the half-hearted 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).

2.8.1. Decentralization and under the EPRDF Regime Post -1991

Ethiopia has been a centralized state and deconcentrated and delegated forms of decentralization have characterized public service delivery till 1991. A devolved form of governance is a current occurrence, which is considerably a going away from the history of the country in common (Kumera, 2006). Consequently as decentralization was one of the questions of all nations' nationalities and peoples of Ethiopia as far as the mass were victims of public service. The Derg government collapsed after a long time civil war since the in 1991(Negalegn, 2010). Following this, the transitional Government of Ethiopia adopted the federal or decentralized form of governance and the present decentralized government structure was assumed in 1995.Then the 1995 federal constitution recognized nine Regional States. According to the constitution, these are the states of Tigray, Afar, Amhara, Oromia, Somalia, Benshangul/Gumuze, Southern NationsNationalities Peoples, Gamella and the Harari People (Yilmaz and Venugopal, 2008).

Decentralization in Ethiopia has adopted in two phase. The first was covered from (1991-2001). Despite the fact that the first wave of decentralization has realized remarkable success in local governance and regional self-governance, it was not capable of bringing genuine self-rule particularly at lower levels of administration where governance and decentralization matter most. As a result of this the second phase of decentralization was introduced since 2002(Tegenge, 1998)

During the first wave of decentralization the devolution of power and function were restricted to the regions. Regions were made to deliver all health and education services except tertiary education and training of secondary school teachers (Garcia & Rajkumar, 2008).

At the time regions were dependent on federal government while woredas were dependent on the regions (Gebre-Egziabher & Berhanu, 2007) cited in Obsaa (2010). The woredas and their constituencies had limited administrative and fiscal autonomy and this has hindered public sector efficiency, grassroots empowerment and accountability and hence replaced with the second wave of decentralization (Garcia & Rajkumar, 2008). But currently almost all of the public services are devolved to the local governments till the Kebele level through the system District level decentralization for effective and efficient service at the grassroots level. Hence health service is one of the decentralized social services, assessing how health services delivery system is arranged, how resources are mobilized, how local institutions are performing and what challenges are affecting the process of the local health service delivery are significant points. Hence, these can able to evaluate the local government performance and its challenges in health service delivery.

2.8.2. Decentralized Governance and health service delivery Structural arrangements in Ethiopia

As a result of simultaneous global impediments across the world countries, the necessities towards more decentralized forms of governing have point at a perquisite for more efficient delivery of various public services. Consequently many countries had started with decentralization of their governing structures since the 1990s (Petak, 2004,) Coming to Ethiopia, Ethiopia was a centralized country and the decisions making power were vested merely in the hand of the central government with no accountability to the desires of the local communities. After, the dictatorial government of Derg was collapsed since 1991, the transional government was come up with a new decentralized form of governance .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 FMoH, regional Health Bureaus (rHBs), and Woreda health offices sharing the decision-making about the design, development, and implementation of the health system(USAID, nd**).** 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 ..

For the implementation of all theses 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 was replaced by four-tier system. The four-tier system consists of primary health care units (a health centre with five satellite health posts), primary hospitals, general hospitals, and specialized referral hospitals with catchment population of 25 000, 100 000, 1 000 000 and 5 000 000 respectively (World Health Organization and Global Health Workforce Alliance nd).

2**.8.3. Duties of Regional Governments and Woreda Administration in Ethiopian Health Service Delivery**

According to Garcia and Rajkumar (2008) the Woreda administrators are answerable for coordinating primary preventive and curative healthcare and implementing health extension; constructing and administering health stations and health posts; administering clinics; and preventing and controlling HIV/AIDS and malaria. Their responsibilities consist of the hiring of health staff assigned to health stations, health posts, and clinics.

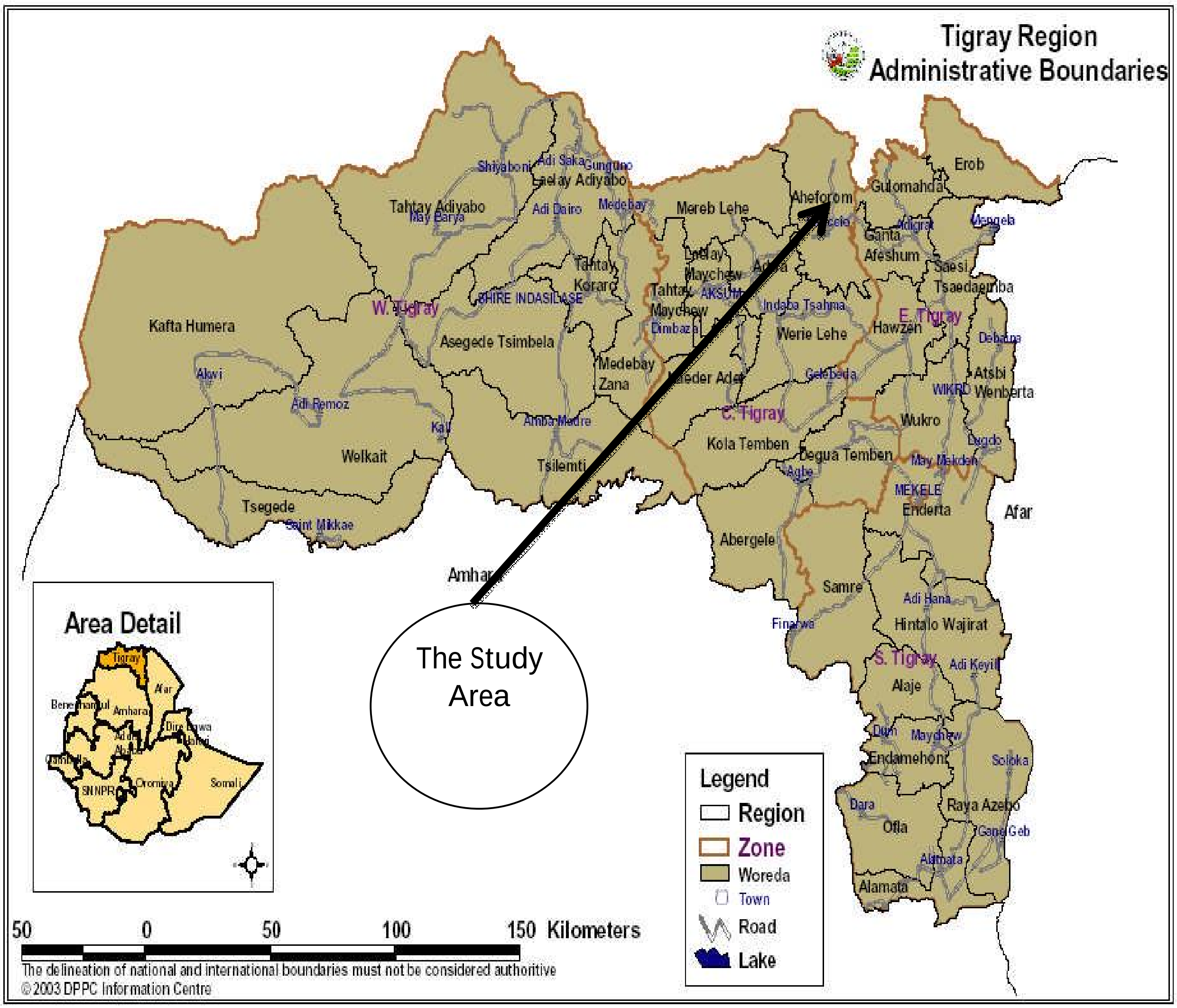
The regions are answerable for formulating regional health policy; organizeing health extension activities; instituting and administering training institutions and junior colleges for junior health professionals; training health professionals; giving technical support to zones and woredas; establishing and administering health exam-nation centers; building and maintaining referral hospitals; coordinating the control of communicable(Garcia & Rajkumar, 2008).

As USAID, (nd) presented that the most important duties and responsibilities of hospital boards and health center governing bodies are; check up and approve the strategic and annual plans of the facility, manage and follow up on the overall activities of the facility, review and endorse activity reports of amenities, devise mechanisms to improve resource mobilization of the hospitals, determine services that are contractually outsourced to third parties. Having these responsibilities the effectiveness to put into practice, the decentralized policies and programs needs full of technical and systematic arrangements of the public health services.

CHAPTER –THREE: METHODOLOGY OF THE STUDY

3.1 Description and Rationales for Selection of the Study area

This study was conducted in Ahferom Wereda to investigate the performance and challenges of decentralized governance in health service delivery. The main rational for the site selection of this area is due its better performance in implementing health policies and strategies. According to the regional health bureau the selected wereda is the model Woreda to others (Tigray regional health burau 2003/4 E.C). In addition the wereda is the most populated and geographically it is a wide area that has various topography. Having this in mind, the researcher is interested to invest his effort to assess how the wereda is performing and what challenges are facing. Ahferom Wereda is found in the Central Zone of Region Tigray. The wereda has seven health centers and 22 health posts. The wereda is also more intoxicated with some common disease such as malaria, cholera; common cool, TB and the like Ahferom Wereda is located in the Northeast of the Central Zone with in a distance of 55km from Axum, the capital of the Zone.



Source; @2003 DPPC Information Center

Figure 1: Location of the study area in a map

3.2 .Research Strategy and Design

The research design used in this study was cross-sectional survey studies. This research design is more applicable when the survey study employing large numbers of people or respondents questions about their attitudes and opinions towards the specific issue, events or phenomena at one time (Marczyk and DeMatteo et al, 2005). In this study a combination of approaches, qualitative and quantitative, was employed. The quantitative approach was employed to grasp the attitude of respondents regarding the health service availabilities, health service accountability, institutional capacity and the challenges of better health service delivery in the study area.

Theses data's was collected from respondents using, questionnaires. Again the qualitative data was collected using interview and focus group discussion.

3.3. Data Type and Source.

The types of data used in this study were both quantitative and qualitative data and the study has also used both the primary and secondary data sources. The primary sources of data in this research includes household heads, health service providers (nurses, doctors) and the wereda health administrators and the required information were gathered using questionnaires. The secondary data was gathered from the wereda health office reports, human resource manual and the wereda year book (2004 and 2005 EC).

3.4. Sampling Procedure, Frame and Sample Size Determination

The target populations of the study were all the residents of the wereda and the wereda has 33 Tabias/Kebeles. In this case, the researcher purposely divided the *Tabias/Kebeles* in to two cluster towns and rural areas. Because the researcher convinced that there could be difference in getting access to health service delivery in the town and rural areas. In addition to this, there might be a difference in the demographic characteristics of respondents. Three sample *Tabias (Kebeles)* were selected in this study as taking more than this number is unmanageable by the researcher. Accordingly, the researcher took one kebelle from the town and two of them from that of the rural kebeles. Hence, there are two from the rural kebeles is that, because there is a difference in population size between the town and rural areas. For instance, the total population size of households in the town is 8,321 under three kebelles and the rural households population size is 36,968. In selecting this Tabias/kebeles the researcher selected using lottery method from each of the two clusters, one from the town and two of the kebeles from rural *kebelles.* Finally as per the list of *Kebelle* household residents exists in each of the kebeles, the population sample size of the study is determined through the Kothari formula.

The selected Tabias/Kebeles include Enthicho/02 that represents the town area, and Erdijeganu and Laelay Migariatsebri which are from the rural kebeles with their household population size of 1546, 2058, and 1698 respectively. Then the total population of these kebeles is 5294. Having this total population, the sample size of the study was determined as in the following manner.

$$n = \frac{z^2 .\ p.\ q.\ N}{e^2\ (N-1) + z^2 .p.q}$$

Where:

N= size of population

p = sample proportion of successes

n = size of sample

q = 1 – p

z = the value of the standard variety at a given confidence level

e = acceptable error (the precision)

Thus, N= 5294 p= 0.02 z= 2.005 e= 0.02

Therefore, $$n = \frac{(2.005)^2\ (0.02)\ (1 - 0.02)\ (5294)}{(0.02)^2\ (5294 - 1) + (2.005)^2\ (0.02)\ (1 - 0.02)}$$

$$n = \frac{(4.020025)\ (0.02)\ (0.98)\ (5294)}{(0.0004)\ (5293) + (4.020025)\ (0.02)\ (0.98)}$$

$$n = \frac{0.0804005\ (0.98)\ (5294)}{2.1172 + 0.0787925}$$

$$n = \frac{417.1275}{2.1959925} = 189.94942 = 190$$

To collect the relevant data using questionnaire the researcher selected the participants based on convince sampling. This is to mean that the wereda has about seven health centers which are open for health service. So to gather the required data, the researcher had taken three health centers out of seven. In taking these health centers the researcher selected based on the number of visitors who come from the surrounding kebeles. Then the researcher used proportional method based on their population size of the two clusters. In deciding the number of respondents, the researcher took 55 from the town and 135 from the rural kebeles based on their proportion. Then the researcher asked respondents by going to the health centers. In addition to the sample respondents the researcher took 20 respondents from service providers and administrators. This was conducted by the researcher in collaboration with well aware enumerators.

3. 5. Data Collection Methods

To get hold of appropriate data from different sources, multiple data gathering techniques have been employed for triangulation reason. As a result, questionnaires, semi structured interviews and focus group discussions. Specifically the instruments of primary data collection that the researcher used and how they employed are stated as follows.

Questionnaire: This instrument is semi structured questionnaire was used to collect data from the sample respondents. This type of data collection method was used to collect data from the respondents to address the following variables. These variables include the availability human recourses and health accessibilities including pharmaceutical commodities, the challenges of decentralized governance in the process of health service provision, and the local government accountability, in health service delivery. This instrument helps to have relevant information concerning of the performance and challenges of decentralized health service delivery to the demands of the society. Additionally the researcher took 20 respondents from service providers and administrators, to measure the local government institutional capacity. The questionnaire was prepared in English and translated into Tigrigna that is local language that can be easily understood by the respondents. Then the questionnaires were administered and collected by a trained three enumerators who have completed their secondary education.

Interview: The type of interview, employed in this study is semi-structured and it was conducted by the researcher. It helped the researcher to know specific information. The researcher undertook an interview with 10 individuals by preparing list of specific questions and an interview schedule. These prepared questions were asked to all interviewees to ensure continuity. This had been done purposefully by selecting participants from health service providers and Wereda health officials. Specifically, the researcher employed an interview with the wereda health service providers and health center coordinators, in a relation to the availability of human resource, medical supply, laboratory equipment and challenges of better health service delivery in the wereda.

Focus Group Discussion: The focus group discussions were arranged with issues which were not included and answered through questionnaire. And it was also included questions that were included in the questionnaires, but which needs further information. In the focus group discussion, officials, health service coordinators, health service professionals, experts, and women who did not included in interview and answering questionnaires were participated. The number of individuals who participated in the focus group discussion was about six and they were selected purposefully based on their experience and knowledge in relation to the local health services delivery. This was conducted by the researcher and three focus group discussions were conducted. This technique helped to receive a wide range of responses during the meeting.

3.6. Data Processing and Analysis

After the accomplishment of data collection, processing and analysis was took place. Data processing includes manual editing, coding, data entry, and consistency checking. Thus, the researcher made all these activities of data processing. Accordingly, the data collected from respondents through survey were fed into a computer and analyzed by using SPSS version 16.0 software and simple quantitative analysis techniques such as percentage and frequency distributions. Besides, the data collected through interview and focus group discussions were scrutinized descriptively.

CHAPTER FOUR: RESULT AND DISCUSSIONS

4.1. INTRODUCTION

This section of the study deals with analysis and discussion of the data collected through various techniques such as questionnaire, interview and focus group discussions. The major elements of this chapter includes demographic characteristics of the respondents in the study area like health service availability, and access to pharmaceutical commodities, health service accountability, the challenges of better health service delivery and the local government in institutional capacity in terms of leadership, human resources management and financial management.

In this study a total of 190 questionnaires were distributed to collect data for this study, and all these questionnaires were completed and collected properly as per the questionnaires were distributed with the help of three enumerators. In addition to the sample respondents, the researcher took 20 from the wereda health bureau officials and the wereda health service providers to complete the required information on the Wereda health service institutional capacity. All these questionnaires were distributed purposely considering their experience. Again all the points gathered for this study are analyzed through frequency tables, diagrams and the data analysis technique the focus group and interview questions also analyzed using summary of answers.

4.2. Demographic Characteristics of Respondents

The demographic characteristic of respondents includes the type of house hold heads, educational background and age of respondents. Based on these sequence respondents demographic character is explained as follows.

Table 1: Household Type, Age and Educational Background of Respondents

Variables	Cases	Frequency	Percent
Household type	Male headed	126	76.3
	Female headed	64	33.7
	Total	190	100
Age group	18-27	30	15.8
	28-37	86	45.3
	38-47	45	23.7
	48-57	19	10
	58-67	10	5.3
	> 67	-	
	Total	190	100
Educational Background	Illiterate	43	22.6
	1-4	35	18.4
	5-8	44	23.2
	9-12	39	20.5
	TVET	4	2.1
	Diploma	16	8.4
	Degree and above	9	4.7
	Total	190	100

Source: Own survey result, 2013

Table1 indicates the house hold type, educational background and age of respondents. In relation to the house hold type, the majority 76.3% of the respondents were male head and 24.7 % of them were female head house hold types of respondents. With regard to the age of the respondents the majority 45.3% of them were from the age of 28-37, 23.7% of them from the age of 38-47, 15.8% of them were from the age of 18-27, 10 % of them were from the age of 48-57, and 5.3% of them were found in the age of 58-67.

Regarding, to the educational level, 23.2% of the respondents were illiterate, 18.4% of them were 1-4, 22.6% of them were 5-8, 20.5% of them were 9-12, 2.1 % of them were TVET 8% them were diploma and 4.7% them were degree holders .

4.3 Health service and human resources availabilities including pharmaceutical commodities in the study area

Delivering better service is one of the main functions of decentralized governance. Hence the table indicated below shows to what extent health services are available in the study area.

Table 2: Health service availability

Variable		Respondents 'stand		
		Yes	No	Total
Are you receiving health service from your local health center?	Fr	189	1	190
	Prt	99.5	0.5	100
If yes, have you accessed to the following service?				
Family planning services	Fr	173	16	189
	Prt	91.5	8.4	100
Antenatal care (ANC) services	Fr	165	24	189
	Prt	87. 3	12.6	100
The prevention of Mother-to-child transmission of HIV (PMTCT) service	Fr	164	25	189
	Prt	86.7	13.3	100
Delivery (including normal delivery, basic emergency obstetric care, and/or newborn care services	Fr	151	38	189
	Prt	79.9	20.1	100
Child immunization services, either at the facility or as outreach	Fr	157	32	189
	Prt	83	17	100
Preventative and curative care services for children under 5	Fr	155	34	189
	Prt	82	18	100
HIV counseling and testing services	Fr	142	47	189
	Prt	75.1	24.9	100
HIV/AIDS antiretroviral prescription	Fr	132	57	189
	Prt	68.9	30.1	100
Diagnosis or treatment of STIs, excluding HIV	Fr	146	43	189
	Prt	77.2	22.7	100
Diagnosis or management of non-communicable diseases	Fr	137	52	189
	Prt	72.4	27.5	100
Diagnosis, treatment prescription, or treatment follow up TB	Fr	118	71	189
	Prt	62.4	37.6	100
Any surgical services, including caesarean section	Fr	36	153	189
	Prt	19.1	80.9	100
Blood transfusion services	Fr	35	154	189
	Prt	18.5	81.5	100
Laboratory diagnostics, including any rapid diagnostic testing	Fr	118	71	189
	Prt	62.4	37.6	100
Storage of medicines, vaccines contraceptive commodities	Fr	183	6	189
	Prt	96.8	3.7	100
Treatment of malaria	Fr	178	11	189
	Prt	94.2	5.8	100

Source: Own survey result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 2 shows health service availability in the study area. In this case, almost all (99.5 %) of the respondents responded that there are availabilities of health services. As pointed out in table 2, almost all of the services which are expected to be available and accessible to all peoples are listed down. As a result, the researcher got the responses what health services are available or not. As shown in table 2, majority of the respondents (96.8%) replied that they were getting storage of medicines, vaccines, or contraceptive commodities. This shows that the people get the storage of medicines, vaccines, or contraceptive commodities service. Again, 94.2% of the sample respondents replied that diagnosis or treatment of malaria is accessible to them. In line to this, 91.5% of the respondents also replied that family planning services is accessible for them. In the same way, 86.8% of the respondents also replied that antenatal care (ANC) services are more accessible to them. Correspondingly, 86.7% of the participants of the survey study indicated that the prevention of mother-to child transmission of HIV (PMTCT is reachable to them. 82.6% of the respondents also responded that child immunization services, either at the facility or as outreach preventative, is accessible or available to them. Again 82% and 79.9 % of the respondents responded that curative care services for children under 5 and delivery (including normal delivery, basic emergency obstetric care, and/or newborn care services respectively are more available to the local people.

On other hand, significant number of respondents (81.4%) and (80.9%) of respondents respectively replied that there is no service availability for blood transfusion services and surgical service, including caesarean section. In addition to the above questions, the participants were asked an open ended question, which says "what types of services are more accessible?" For this question, most of the respondents (60%) explained that maternal health, child immunization, treatment of malaria, TB, family planning and contraceptive commodities were more available and accessible to the local people.

With regard to the effectiveness of health service provision, participants of the focus group discussion provided that it focused on the public demand and priorities of the public. For instance, the wereda health service provision in a way of practicing the HSDP VI and more emphasis is given for reducing maternal death, child death, TB, HIV/ADIS and malaria. In giving this service the wereda health centers have performed remarkable achievements.

Besids the focus group and interview participants responded that although there are good achievements in the general availability of health service. Again, the researcher tried to ask an interviewees whether the local health centers equipped with the requisite laboratory equipments that would enable them to provide efficient health service for clients or not. According the interviewees, all the required laboratory equipments are available. Again, the interviewees were asked to respond whether clients' behavior and culture have any influence to consider service delivery or not. Regarding of this issue, the interviewees indicated that there is a problem of culture and feeling embarrassment of mothers to come to the health centers at the time of birth when service providers order them to take an injection, especially, the aged people. Besides, the interviewees viewed as there is a problem of not coming to the health centers when they feel pain rather they come after they get to a dangerous stage illness which is difficult to treat.

Furthermore, the interviewees were asked to view whether there is sufficient physical resources such as vehicles, communication facilities (telephone, internet and fax), computers, necessary drugs laboratory equipments and type writers, discharge of responsibility or not**.** For this question, the respondents responded that totally, there are three cares in the wereda available for mothers during child birth. However, there is a shortage of vehicles for service providers to supervise, to assess health service implementation activities and to support health extension workers at the rural areas. Regarding to the shortage of vehicles, the problem is not only shortage but there is problem of arrangement and lack of efficient system in using the resources. Besides, there is shortage of communication farcicalities like line phones to communicate with clients at urgent times. For instance, when mothers need ambulance service, there is no well known phone number always available to public and this problem is resulting delays for urgent health care. There is no publicized phone; rather the public is using informal or personal phones of service providers. As a result, there are delays for getting ambulance services urgently. Totally, there are no fax and internet service .There are shortages of computers, there is also shortage of necessary drugs, and there is problem of laboratory equipments in some of the health centers.

With regard to the availability of human recourses, the researcher tried to assess through interview. In relation to this, participants of the interview explained that there is shortage of human resources in relation to the structure of the health centers. Specifically, there are shortages of doctors of health officers in the wereda health centers. In this case, different literatures indicated that Ethiopia is one of the 57 countries in the world with a critical shortage of health workers (World Health Organization and Global Health Workforce Alliance, nd).

For further explanation with regard to the wereda human resource availability and shortages be full filled based on the structure of health centers is drawn below.

Table 3: Human resource Availability

Name of heath centers	HO		C/Nurse		Midwife		Pharmacy		laboratory		E/heath professional		HMIS	
	Req	Avai	Re	Avai	Req.	Avai	Req.	Avai.	Req.	Avai.	Req	Avai	Req	Avai
Enticho	2	1	12	11	3	4	2	3	2	1	1	1	1	1
F/may	2	1	8	7	3	2	2	1	2	2	1	0	1	1
A/Afero	2	1	8	7	3	2	2	2	2	2	1	1	1	0
G/surna	2	0	8	7	2	2	2	2	2	2	1	1	1	1
Dibdbo	2	1	8	7	3	1	2	1	1	1	1	1	1	1
Mezbr	2	0	8	6	3	2	2	1	2	1	1	0	1	0
M/kerts	2	0	8	6	3	1	2	1	2	1	1	0	1	0

***NB. Req = Required* –Avai= Available**

Source: the wereda health bureau human resource manual, 2013

As it has indicated in table 3 except the town (Enticho health center) all the wereda health centers have shortage of human resources based on the structure. Especially the two health centers Mezbr and Maykerets have a serious problem of human resources.

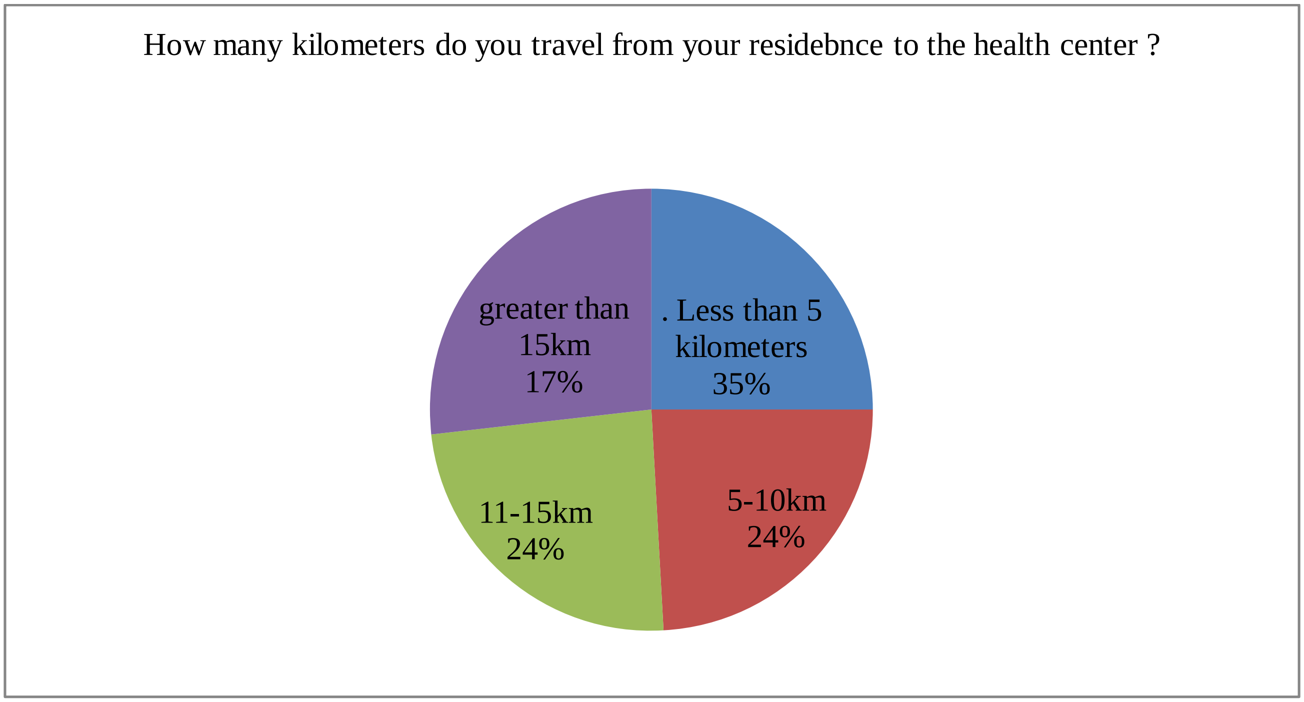
Concerning the competence of staffs in terms of education, experience, ability and knowledge, the researcher also asked interview questions. For this question, the respondents viewed that the educational level, experience, ability, and knowledge of the professionals is good but as the researcher grasped from other respondents said that most of the professional have the required skill with the exception of few number of staffs. On the other hand the interviewees explained that the educational level, ability and the knowledge they have is poor and sometimes there are complaints from clients. In contrary the respondents replied even though some of the professionals lack the ability, skill and knowledge they have good experience and some of the professional who have a good educational level ability and skill also have lack of experience.

According to the interviewees the reason why their knowledge and ability of the staff is poor is that there are some nurses and midwifes who upgraded and appointed based the experience they have and their knowledge and ability is not as good as others.

In relation to the availability and access to medical supplies, the researcher tried to assess through interviewing for the service providers and preparing alternative questionnaires under different variables. Regarding of this, almost all of the sample respondents, service providers, and focus group discussion participants said that there is shortage of medical supply. Again participants the focus group discussion suggested that even though medical supplies are available in the store, the service providers tell patients/or clients to buy medicines from the private pharmacies and this problem is resulting a serious financial problem because the price of the medicines are not affordable. In this case, there were the two contradictory ideas viewed by service providers and the client during the focus group discussion. In directly this can show how much the health service providers are cheating the public. Regarding this issue, the researcher tried to ask other questions saying, “If there is no shortage of medicines why service providers order clients to buy medicines from private pharmacy?” The clients replied that they did not know the case. This shows the issue of pharmaceutical supply needs a further investigation.

Pi chart 1: Relative Distance of Residents from home to health centers

A lack of nearest primary care in rural areas means that residents have to travel away from their sourounding areas to obtain healthcare services. Travel from rural areas for health services can be intimidating when one is sick, particularly if on very long isolated roads and/or during adverse weather conditions. Based on this fact, the chart below is explained how far the local people have geographic access in the study area .



Source: own survey Result, 2013

The above diagram indicates the travel distance of residents from their home to the local health. According to the survey data illustrated in figure 4.1, majorly of the respondents replied that the distance from their home to the health center is more distant than 5km. From this response it can be suggested that majority of the population (clients) of the study area are living below the standard to be nearest to the local health centers. According to the world standard for geographical access to health service, peoples must live at a minimum distance of 5km (Beedasy**,** 2010). Increasing and strengthening these services, health programmes could address important accessibility issues for the poor such as travel time and cost to the nearest facility or to a facility with needed or desired services, and residence in a rural or neglected area. Beside, these is Al-

Taiar et al (2010), recognized that geographic accessibility, the distance that must be traveled in order to utilize health facility, may present an important obstacle of access to health services

4.4. Accountability and local health service delivery

Table 4: Accountability and Health service delivery

One of the major objectives of decentralized governance in public service delivery is making service providers accountable to the public when they render a service to the people. Hence; the researcher has summarized the respondents' view in relation to accountability in the sector**.**

		Respondents' View on Health service Accountability				
		SDA	**DA**	**Not sure**	**Agree**	**SA**
Health service providers share information related to health plans, budgets and implementation reports with citizens	Fr	40	45	37	54	14
	Prt	21.1	23.7	19.5	28.4	7.4
Your complains are heard and responded by the local health center officers	Fr	42	48	32	50	18
	Prt	22.1	25.3	16.8	26.3	9.5
Documentation/reports on local health service accountability are distributed to the people	Fr	45	68	21	39	17
	Prt	23.7	35.8	11.1	20.5	8.9
You get clear and comprehensible information from the health service center	Fr	64	53	24	35	14
	Prt	33.7	27.9	12.6	17.4	8.4
There is clear relationship among clients, service providers and the local officials of health services ensure improvements in access to the services needed	Fr	45	64	24	45	12
	Prt	23.7	33.7	12.6	23.7	6.3
There is well established accountability system in a failure for responsibility	Fr	46	53	31	46	14
	Prt	28.2	27.9	16.3	20.2	7.4
Citizen's voice is heard by service provider	Fr	47	71	4	41	27
	Prt	24.7	37.4	2.1	21.6	14.2

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 4 shows how much health service providers and public officials are accountable to the clients. Hence, significant number of respondents (28.4%) proved that service providers share health service related plans, budgets and implementation reports to the public. Whereas 23.7 % of the respondents oppose the service providers with regard to sharing information related to health service plans, budgets' and accomplishment reports. Further, 19.5% of the respondents are not sure whether health service providers share health related plans, budgets and implementation reports. This implies that the local people are not fully involved in approving plans, deciding annual budgets and in hearing implementation reports.

Again, participants of the focus group discussion said that there is clear communication system among the three stakeholders, service providers, clients and the public. In explaining this question, the participants said that the health centers are administering through health finance board, and the health finance board consists of seven members who are represented from different associations, one from traders, one from women's association, one from wereda farmers association, one from health professionals, health center administrator himself, one from the Kebele administration and teachers. Theses members are also accountable to the wereda council.

The researcher asked whether there are procedures of channeling for complaints and answers. In this case, 26.3% of the respondents agree that the local health service delivery system has channeling procedures for complaints and answers. Conversely, almost equal numbers of respondents (25.3 %) said that they disagree. Still, 16.8% of the respondents are not sure whether there is a procedure of channeling for complaints and answers.

Combining the above presented facts, it is possible to say, maximum number of respondents' responses resembled towards the absence of procedures of channeling for complaints and answers. If it is so, this may result in a serious problem of accountability in health service delivery, and this problem may also lead to another problem which rotates as a vicious circle and this result is in contrary with the ideas of (Brinkerhoff, 2003) and Lewis (2006).

Regarding with accountability in public service, the mass should be accessed with documents/reports through the system of distributing documents in a way which can show service providers' accountability. Vis-à-vis with this issue, the researcher tried to investigate whether the public has knowledge on what the local health service providers are doing. In this case, 5.8% of the respondents said that they disagree, and 23.7% of the respondents viewed as they strongly agree. In line with this issue, 20.5% of the respondents agreed as they do have an access to use accountability documents/reports. In concluding these issues it can be suggested that accountability documents are not accessible to the public as the majority of the respondents viewed between the ranges of strongly disagree and disagree. If it is so, health service providers may not be accountable to the public, and as a result of this, it may be a trouble for improved health service delivery.

In any public service delivery, reports must be comprehensible and provide clear information to the public as a whole. If it is so examining how much the local health service reports are comprehensive and can provide clear information to the public is important to know to what extent the service providers are accountable. Providing this information, the researcher assessed how much the local health service providers in the study area provide comprehensive and clear information. Accordingly, 33.7 % of the respondents replied strongly disagree, and 27.9 % of respondents also said disagree. In contrary with the former answers, 17.4% of the respondents agreed as the reports are comprehensive and provide clear information to the public.

Based on the above stated information, majority 60% of the respondents believes that the reports are not comprehensive and cannot provide clear information. This may be a factor that can affect health service delivery as there is nontransparent and unclear information sharing among the clients and service providers.

Commonly, if there is clear and strong relationship among clients, service providers and the local officials, there may be health services improvements in delivering services to needy people *(*Ahmad, 2005), (*Matovu, 2008)* and (Ekpo, 2007). Because of this reason, the researcher tried to assess to what extent the relationship among client, service providers, and official in the local health service provision. Accordingly, 33.7% of the respondents strongly agree with this issue and 23.7% of them disagreed with this statement. On the other hand, 23.7% of the respondents agree that there is clear and strong relationship among the three stakeholders. Concerning this issue, it can be suggested that there is no strong and clear relationship among client's, service providers and public officials. Due to this fact, the problem of weak accountability system may be resulted in, and this problem may lead to a poor health service delivery system. This result is not similar with ideas of the above authors.

Being accountable for one's own responsibility in the system of public service is the main component for better health service delivery. Hence, for achieving improved better health service delivery, service providers must be accountable for their failure in rendering services. With regard to this issue, 27.9% of the sample respondents disagree with the issue. Alongside to this, 28.2% of the respondents replied strongly disagree, whereas 20.2% of the respondents agreed as there is well established systems to make service providers to be accountable for their failure. Based on this fact, majority of the respondents said there is no well established system that makes the service providers to be accountable in failing to do their responsibilities.

With regard to the voice and accountability presented in table 4, significant numbers of respondents (37.4%) do not agree with the statement that citizen's voice is heard by service provider. Besides, 24.7% of the respondents strongly disagree with the same statement. From this, it can be suggested that the public has no voice which can make service providers accountable and this finding is very much in contrary with the idea of Lewis (2006), who provides that voice and accountability authorizes communities to be involved in decisions and oversight health care services.

Table 5.The challenges of clients while accessing health services

When social services like health service delivery decenteralize till the grassroots level people may face challenges while accessing health services as a result the table below indicates what type of challenges are facing the clinents in the study area.

Variables	Cases		Respondents Stand		
			Yes	No	Total
Challenges					
	Financial problems	Fr	82	108	190
		Prt	43.2	56.8	100
	Favoritism	Fr	55	135	190
		Prt	28.9	71.1	100
	Poor treatment from health service provides	Fr	73	117	190
		Prt	38.4	61.6	100
	Poor transportation service	Fr	111	79	190
		Prt	58.4	41.6	100
	Lack of pharmaceutical commodities	Fr	140	50	190
		Prt	73.7	26.3	100

Source: Own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As it is shown in table 5, the challenges of clients while accessing health services are presented. Based on the fact presented in table 5, majority of the respondents (73.7 %) responded that lack of pharmaceutical commodities is a challenge confronting while they are accessing health services. Secondly, 58.4% of the sample respondents also replied that there is poor transportation service. Thirdly, significant number of respondents (43.2%) responded as they are facing with financial problems. Fourthly, 38.4% of the respondents said that a poor treatment by the health service provider is another challenge in accessing health services. Lastly, considerable number of respondents (28.9 %) also replied as there is favoritism from service providers in treating clients.

Commencing this reality, it can be stated that though all the listed challenges are affecting client's service lack of pharmaceutical commodities and poor transportation service are the serious challenges which are upsetting clients health service in the study area.

Table 6 .Successes Stories achieved to solve the problems of health Service delivery in the study area.

The main intention of reforming decentralized governance is for improved service delivery , as this is the case it is mandatory to assess what successful achievement have been achieved as a result of decentralized governance.

Variables	Cases	Respondents Stand		
		Yes	No	Total
Success Stories				
There good ambulance service	Fr	160	30	190
	Prt	84.2	15.8	100
Maternal death is reduced	Fr	148	42	190
	Prt	77.9	22.1	100
Child death is reduced	Fr	124	66	190
	Prt	65.3	34.7	100
There are pharmaceutical	Fr	26	164	190
Commodities that we need	Prt	13.7	86.3	100
There is no favoritism	Fr	72	118	190
	Prt	37.9	62.1	100
There is good treatment from	Fr	18	172	190
health service providers	Prt	9.5	90.5	100

Source: Own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As one can see in table 6, 84.2 % the respondents believed that there is a good ambulance service and only 15.8% of the respondents replied as transportation service is not improved yet. In line with this, few respondents (26 %) replied in the open ended questions that there is only good transportation service for maternal health services. As the information gathered from the participants of interviews and focus group discussions, the access to ambulance service is greatly improved. However, there are hard to reach areas such as, Mayhamato, Semhal, Zibangula, Daeromabesa, Hoya medeb, Mishig, Erdijeganu Laelay hahale and Kudo. These areas have no access to ambulance service due to its topographic problem, distance and the problem of boarder conflict. Especially, the participants of the focus group discussion explained that still mothers greatly are obliged to give to birth their child at home as a result of this problem. In addition to this, some respondents (23 %) forwarded that there is less commitment of service providers and poor communication service to get ambulance services from health centers.

With regard to the maternal death, majority of the participants (77.9%) replied that maternal death is reduced and 22.1% of the respondents replied as it is not reduced. Here, participants of interviews and focus group discussions s share similar views with the information gathered from the questionnaires. According to them, the maternal and child death is reduced; yet there are cultural problems which makes mother to feel shame coming to the health centers either for pregnancy check up or child delivery. So totally it is difficult to say the degree of maternal and child death is reached zero. In connection with pharmaceutical commodities or medical supplies, majority (86.3%) of the participants of the study replied that there is a shortage of medical supplies or pharmaceutical commodities. In line with this problem different literatures, reveal that lack of access to indispensable drugs, vaccines, and health commodities in developing countries is internationally acknowledged as being of huge implication, and various agencies and Organizations, including WHO, have compiled data to guess the extent of the problem (Report of the WHO-MSH Consultative Meeting, 2000). Derived from this information it can be suggested that, this area is free from the shortage of pharmaceutical commodities or medical supplies. In the case of favoritism, 62.1% of the respondents responded that there is favoritism and 37.9% of them were replied as there is no favoritism.

With regard to the treatment of health service providers for client's very large number 90.5% of respondents replied that there is no good treatment from service providers. In addition to this, as some respondents suggested in the open ended questions even there is hardship from health service providers.

In addition to the above points the interview and focus group discussion answers were also related success stories achieved after decentralized health service delivery system was devolved to the grassroots level. According to the responses of the respondents, there are dynamic achievements with regard to the reduction of child death, maternal death; ambulance service and family planning, treatment of TB, Malaria and people's awareness come to health centers.

4.5. Challenges to better Health Service Delivery

In this case, the researcher tried to assess the challenges of better health service delivery in the study area and this question was addressed through focus group discussion and interview questions. According to the focus group and interview, Participants the challenges of better health service in the study area were weak leadership, lack of human resource, low availability of medical supplies, and lack of financial resource. In line to this, the focus group and interview participants replied that though all these problems are manifesting in different levels, rent-seeking behavior of service provider's, shortage of finance, and weak wereda administration are the major challenges of better health service in the study area. This result is very much related (Walker, 2002), (Olowu, 2006) and (Pradeep, 2011) as these authors also recognized these are the major challenges in a decentralized public service delivery.

Table 7: Demographic characteristics of Service providers and health service administrators

Variables	Cases	Frequency	Percent
Sex	Male	14	70
	Female	6	30
	Total	20	100
Age group	21-30	10	50
	31-40	4	20
	41-50	6	30
	51-60	-	-
	58-67	-	-
	> 60	-	
	Total	20	100
Educational Background	Certificate	3	15
	Diploma	8	40
	Degree and above	9	45
	Total	20	100
Experience	3-6yrs	12	60
	7-10yrs	3	15
	11-14yrs	1	5
	Above 18yrs	4	20
	Total	20	100

Source: Own survey result2013

NB: Fr. = Frequency Prt. = Percentage

Table 7 shows the demographic characteristics of service providers and health service administrators in terms of sex, age, educational back ground and experience. With regard to sex, 70% of the respondents were males while 30 % of them were females. This number shows that there is low proportion of female service providers in the study area. Concerning the age of respondents, half (50%) of the respondents were found in the age of 21-30, and 30% of them were found in the age of 41-50. Again, 20% of them were in the age of 31-40. None of the respondents were found in the ages of 51-60, 58-67 or older than 60 years.

With regard to the educational background, most of the respondents (45%) were degree holders, 40% of them were diploma holders and 15% of the respondents were certificate holders. This result shows that the majority of the wereda health bureau officers and service providers were diploma and degree holders. Looking upon the experience of the respondents, the majority of the respondents (60%) have 3-6 years, 20 % were found above 18 years, 15% of the respondents have 7-10 years experience and a small number of the respondents (5%) were found with 11- 4 year experience.

4.6. The wereda Institutional Capacity in terms of Leadership, Human resource management and financial management capacity

Local government institutional capacity has a lot of dimensions to be measured. But here the researcher assessed leadership, human resources management capacity and financial management capacity in the study area. For assessing theses issues, the researcher tried to set question using Likert scales. Accordingly the respondents viewed their stand as stated below.

Table 8. Leadership capacity

Leadership capacity is the ability to generate and converse a clear vision of the organization's mandate and goals, to model behaviors expected of others, to hold and show values reliable with the vision, and to mobilize others to do the same. To this end this study assessed how much the wereda is capable in terms leadership.

Leadership		SDA	DA	Not sure	Agree	SA
The Local health institutions has a clear vision, acknowledged at all levels in common values	Fr		1	2	11	6
	Prt		5	10	55	30
The local health service activities are interconnected with institutional mission and priorities	Fr	1	4	13	2	2
	Prt	5	20	65	10	10
The institution are characterized by effective staff involvement in planning and teamwork work	Fr		3	13	2	2
	Prt		16	64	10	10
The local government is supporting the local government units, particularly to the health centers, and health posts to provide sufficient health service	Fr		3	6	7	4
	Prt		15	30	35	20
There is conducive environment in which subordinates are motivated to implement health programs at the grassroots level.	Fr		4	5	8	3
	Prt		20	25	40	15
There is good leadership in order to influence efficient and effective health service delivery under the conditions of scarce recourses	Fr	3	3	5	6	3
	Prt	15	15	25	30	15

Source: Own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

In table 8, item 1 shows that whether the local health institutions have a clear vision that is acknowledged at all levels in common values. For this question, 55% of the respondents agreed that the local health institutions have a clear vision, acknowledged at all levels in common values. Along with this, 30% of the respondents also strongly agree with the case. Commencing this information, it can be suggested that, the local health institutions have a clear vision, acknowledged at all levels in common values.

Table 9 (under item 2) also indicates the extent of the local health service activities to interconnect with the institutional missions and priorities. Concerning this issue, majority of the respondents (65%) are not sure while 20% of them disagree with the statement.

Table 9 (under item 3) shows the extent of the local health institutions to involve staff members in the process of planning and team work. Regarding this, 64% of the respondents were not sure whether the local institutions are characterized by effective staff involvement and in planning and teamwork while16% of the respondents disagree with the case. On the other hand, 10% of the respondents agreed that there is effective staff involvement in planning and team work. Besides, 10% of the respondents strongly agree with the statement. Table 9 further shows whether the wereda health bureau is supporting the local government units, particularly to the health centers, health posts and health extension workers to provide sufficient health service. In this regard, 35% of the respondents agreed the wereda health bureau is supporting the local government units to provide sufficient health services. In line with this, 20% of the respondents strongly agree with the statement. On the contrary, 15% of the respondents disagree with the same statement while 30% of them remain neutral.

Again table 9 (under item 5) shows whether the local health service leadership system has a conducive environment in which subordinates can be motivated to implement health programs at the grassroots level. Concerning this, 40% of the respondents agree that the wereda health service leadership system has a conducive working environment and it is able to motivate subordinates to implement health programs. In line with this, 15% of them strongly agree with the case. On the other hand, 20% of the respondents disagreed with this issue while 25% of them remain uncertain.

Still, table 9 (under item 6) shows the extent to which local health centers have a good leadership in order to implement efficient and effective health service delivery under the conditions of scarce recourses. Regarding this issue, 30% of the respondents agreed that there is good leadership in order to implement efficient and effective health service delivery under the conditions of scarce recourses. Again, 15% of the respondents strongly agree with the statement. On the other hand, when 15% of the respondents strongly disagree, 15% of them disagree with the same issue. The remaining respondents (25%) are not sure on the issue.

Table 9: Human Resource Management Capacity

Human resource management is the main ingredient of effective and efficient ervice delivery. Owed this reason the researcher evaluated whether the local human resource management is capable for better health service delivery or not.

Human Recourses management capacity		SDA	DA	Not sure	Agree	SA
The local government human recourse management contributing to achieve the strategic objectives of local health services.	Fr		7	2	9	2
	Prt		35	10	45	10
The local human resources management is effective in health service delivery	Fr		2	4	11	3
	Prt		10	20	55	15
There is effective system of coordination at the grassroots level to ensure the implementation of the strategic plans of our sector.	Fr		4	6	7	3
	Prt		20	30	35	15
There is a clear legal supervision in providing health service, implementation programs, financial planning, reporting and communication among employees, officials and the public	Fr	3	1	5	9	2
	Prt	15	5	25	45	10
There is proportional staff and official/ structural positions with public health service demand.	Fr	2	5	3	6	4
	Prt	10	25	15	30	20
The local health sector staffs, as a group, have the requisite skills to carry out the public health service demand	Fr	2	5	1	9	3
	Prt	10	25	5	45	15

Source: Own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 9 under item 1 shows how the process of human resource management of the local government contributes to achieve the strategic objectives of local health services. Regarding this issue, 45% of the respondents agreed that the local government's human recourse management is contributing to achieve the strategic objectives of local health services. In contrary, 35% of them disagree with the issue. Still, 10% of the respondents are not sure on the same statement. In the same table, 55% of the total respondents agree that the local human resource management is effective in health service delivery. Besides, 15% of them strongly agree. As illustrated in table 10, 15% of the respondents strongly agree that there is effective system of coordination capacity at the grassroots level to ensure the implementation of the strategic plans of health services. In addition, 35% of them agree with this issue. However, 20% of the respondents do not agree with the issue. Even 30% of them are not sure in this case.

The other major issue explained in table 10 is the extent to which local human recourses management is practicing clear legal supervision in providing health services, implementation of programs, financial planning, reporting and communication among employees, officials and the public. In this regard, 45% of the respondents agree that there is a clear legal supervision in providing health service, implementation of health service programs, financial planning, reporting and communication among employees, officials and the public and 10% of them said strongly agree. On the other hand, 15% and 5% of them strongly disagree and disagree with the statement. Again, 25% of the respondents are not sure with the issue.

This fact shows that, the local human resources management is not practicing a clear legal supervision in providing health service, implementation programs, financial planning, reporting and communication among employees, officials and the public.

Participants of focus group discussion were asked about how local health service provision, monitoring and evaluation, legal supervision, providing technical services, financial planning, reporting, and communication are carried out. Regarding this, the participants of the of focus group discussion indicated that the wereda administration, in collaboration with the wereda health bureau and health centers, is following systems of legal supervision, monitoring and evaluation for service providers in the implementation process based on the planned activities. For instance, one of the service providers participated in the focus group discussion stated that there are regulatory supervision to avoid out dated medicines, Gimgema and screening HMIS feedback reports. One of the participants of the focus group discussion also explained that there are false report controlling mechanism and false reporters are considered as they are cheating the socio-economic development of the country.

According to the focus group participants, there is also a scheduled monitoring and evaluation system, locally called "Gimgema" program in the health centers, health posts and the lower group which is called "Limatawi Gujile" (Developmental groups). However, other participants of the focus group discussion explained that this type of monitoring and evaluation system is not well organized and regularly practiced. The reporting process ranges from weekly, quarterly and semi-annually to annually. In this case, there is no clear arrangement of monitoring and evaluation on how the public is involving in the financial planning and budget approval.

Again, participants of the focus group discussions were asked regarding the type of information gathering mechanisms using to measure performance and goal attainment. Service providers are required to maintain records of days absent from work and accountability for better health service provision and resources utilization. In this case, the participants of the focus group discussion indicated that there is a review meeting two times in a year. In such meeting, the representatives of the public have the opportunity to raise issues in relation to health service delivery to be discussed.

Furthermore, table 10 indicates the availability of proportional staff and official/ structural positions with public health service demand is also another issue. Regarding this issue, 20% of the respondents strongly agree, and 30% of them agree with the statement. On the other hand, 25% of the respondents said strongly disagree. Again 10% of the respondents said that disagree. Lastly, 15% of them also viewed not sure.

Finally, but not, the the least researcher also tried to assess whether local health service subdivision staffs, as a group, have the perquisite skills to carry out the public health service demand . For this issue, 45 % of the respondents agreed that the local health service subdivision staffs have the required skill to carry out the public service demand. In contrary, 25 % of the respondents disagree with the issue. However, in a combination of all these facts, it is difficult to judge that the staff has the required skill to carry out their responsibilities in relation to the local health service demand as per the respondents believe is almost equal in number.

4.6.1. Financial management Capacity

Table 10: Financial sufficiency for the decentralized health Service Delivery

Lack sufficient finace is one of the serious challenges in decentralized governance and service delivery and this can be the main impediment for better service delivery. Due to this fact, the table shows whether the wereda is facing with shortage of financial resources or not .

Variable		Respondents Stand		
		Yes	No	Total
Is there sufficient finance for decentralized health Service Delivery in the Woreda?	Fr	3	17	20
	Prt	15.0	85.0	100

Source: survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 10 demonstrates the availability of sufficient financial resources for decentralized health service system in the study area. In this issue, majority of the respondents (85%) replied that there is no sufficient financial resource while diminutive number of respondents (15%) replied that there is sufficient finance for the decentralized health service system in the wereda. From this fact, one can understand that there no sufficient financial resources. In line with this, participants of the focus group discussion provide that there is a serious problem to motivate employees or service providers when they supervise and go to the rural areas.

In addition, participants of the interview and focus group discussions provide that lack of sufficient finance is a challenge to provide improved health service delivery as all the required health equipments need much expenditure, especially pharmaceutical commodities.

Table11: Qualifications of personnel's to handle financial Resource management

In the case of financial management having qualified personnel is the better thing to manage the planned financial resources. For this reason the researcher examined whether the wereda has qualified personnel or not.

Variable		Respondents Stand		
		Yes	No	Total
Do you think that the wereda has qualified personnel who can handle financial management	Fr	10	10	20
	Prt	50.	50	100

Source:Own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 11 illustrates the availability of qualified personnel to manage the planned financial resources. With regard to this, 50% of the respondents claimed that there are qualified personnel to handle financial management while equal numbers of respondents oppose the idea. In this case 24 % of those who denied the case put their answer in the ended question. These respondents indicated that there are delays in salary and incentive payments, annual reports and ineffective coordination of financial plans. In addition, due lack of qualified personnel, sometimes annually released finance from the local and the federal government returned back though there is lack of sufficient financial resource.

In addition, the wereda year book indicates that there are health service centers which do not have the required qualified personnel. Furthermore, all the wereda health centers are administering through their own independent finance board. However, three of the health centers lack the requirement employees. This shows that there is shortage of qualified personnel who can handle the expected activities, and this problem may lead to poor financial management.

Table 12: Wereda Health finance boards personnel capacity for the implementation of Health finance programs

The knowledge ,ability, experience and education are invaluable and an ingredients helping health service providers makes to win the MDGs through smoothly working to achieve the objectives the national health policy. As a result, this study was assed the issue of personnel capacity.

Variables	Cases		Respondents Stand					
			Excellent	very good	Good	Fair	poor	Total
The wereda personnel capacity For the implementation of Health related financial programs								
	Education	Fr	2	7	6	4	1	20
		Prt	10	35	30	20	5	100
	Experience	Fr	2	2	8	7	1	20
		Prt	10	10	40	35	5	100
	Ability	Fr	2	2	8	6	2	20
		Prt	10	10	40	30	5	100
	Knowledge	Fr	1	4	7	5	3	20
		Prt	5	20	35	25	15	100

Source: Own survey result2013

NB: Fr. = Frequency Prt. = Percentage

Table 12 shows the personnel capacity for the implementation of health service finance programs in the study area in terms of education, experience, ability and knowledge. In relation to educational level, significant numbers of the participants (35%) provide that the educational level of personnel is very good in the woreda. Again, 30% of the respondents indicated that the woreda has personnel with good educational level. Still, 20% of the respondents replied that the educational level of the personnel is fair to implement their responsibility in relation to health service finance programs.

Looking upon the experience of the wereda personnel, 40% of the respondent replied the wereda encompasses personnel with very good experience to accomplish their responsibilities. In line with this, 35% of the respondents responded that has personnel with good experience in the implementation of health service. The ability the ability, significant number 40% of respondent replied the wereda is possessed with personnel who have very good ability to implement health related financial programs. Again 30% of the respondents responded that the wereda has well trained personnel to handle health service related programs.

As shown in table 13, 20% of the total respondents indicated that the personnel have very good knowledge to implement health related financial programs. Along with this, significant number of respondents (35%) reported that the personnel have good knowledge to implement the same task. Once more, 25% of the respondents replied that the wereda finance personnel have relatively fair knowledge about the sector they are working for.

Table 13: Availability technical resources for discharging duties

Adequate technical recourses have an inevitable effect on the effectiveness of financial management. So the necessary technical recourses for financial management and effective documentation of expenses and for the planned budgets are listed in table and the respondents responded based on the alternative of yes or no answers.

Variables	Cases		Respondents Stand		
			Adequate	Not adequate	Total
Does your sector have technical resources in the discharging of your duties?		Fr	20	-	20
		Prt	100	-	100
If yes do you have adequate?	Office	Fr	12	8	20
		Prt	60	40	100
	Computes	Fr	11	9	20
		Prt	55	45	100
	Financial software	Fr	6	14	20
		Prt	30	70	100
	Stationary	Fr	12	8	20
		Prt	60	40	100

Source: Own survey result, 2013

NB: Fr. = Frequency Prt. = Percentage

As it is shown in table 14, 100% of the respondents responded that they have technical resources in discharging their duties. But as far it is difficult to know how much or to what extent the researcher asked how much the recourse are adequate like offices, computers financial software and stationeries. In this regard, 60% of those who confirmed the presence of technical resources reported that there are adequate offices while 40% of them responded that they have inadequate offices in their sector. With regard to the availability of computers, 55% of the respondents replied that they have adequate computers, and 45% of them responded that there is availability of computers is inadequate. As presented in table 14, 30% of the respondents replied that there is adequate financial software. On the other hand, 70% of the respondents replied that there is inadequate financial software. Further, majority of the respondents (60%) replied that there is adequate stationary while 40% of them oppose the case. From this, one can suggest that there are inadequate offices, computers, financial software and stationary materials in the study area.

Table 14: Steps to be taken to protect against staff abuse of resources

At any case, misuse of public resources is the main impediment for better health service delivery and this prolem must be pro actively protected by the local government through seating different mechanisms.To this end the researcher tried what type mechanisms have the local government to protecte staff abuse of resources.

Variables	Cases	Respondents Stand Yes	No	Total
Has the wereda health office taken any step to protect itself against staff abuse of resources	Fr	17	3	20
	Pr	85	15	100
If yes through what mechanisms				
Independent audit	Fr	5	15	20
	Pr	25	75	100
Through strict supervision	Fr	5	15	20
	Prt	25	75	100
Through accountability reports	Fr	14	6	20
	Prt	70	30	100
Through punishment	Fr	5	15	20
	Prt	25	75	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As indicated in table 14, 85% of the respondents replied that the wereda health sector office has been taking to protect itself against abuse of resources by staffs. With regard to the mechanisms, 75% of the participants of the study replied that the wereda health sector is not using independent auditing system. Along with this, 75% of the respondents also responded that the health sector office follows a strict supervision. On the other hand, 70% of the respondents indicated that the local health sector office tries to apply the mechanisms of accountability reports to protect misuse of public recourses. Again, majority of the respondents (75%) replied that the wereda health sector office is not using the system of punishment. But some respondents suggested that there is a system of giving advices. This result shows that that the wereda health sector office is not using the systems of independent auditing, strict supervision and punishment. Rather, the wereda health sector office is in a way to control financial expenses through accountability reports. As a result, the wereda health sector may not be capable of protecting misuse of public recourses.

Table 15: The Relation among the public, service providers and health finance board in the wereda financial management

It is obvious that having a strong relation among the public, service providers and administrators has a great contribution for effective public service delivery and to have a strong financial management capacity. For that matter the researcher had tried to investigate the relation among health centers finance board, the public, the wereda finance administration and the wereda administration itself.

Variables		Respondents Stand					
		Excellent	very good	Good	Fair	poor	Total
How is the relation among the wereda, the local health finance board, service providers and the wereda financial management bodies ?	Fr		3	3	10	4	20
	prt		15	15	50	20	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 15 indicates the relationship between the public service providers and the health finance boards of the wereda. Regarding this issue, majority of the respondents (50%) replied that the relation is fair while 20% of them responded that there is poor relationship among the public health centers, finance board, the wereda finance administration and the wereda administration. Therefore, one can suggest that the wereda health service sector office is not in the position create good relation with other government sectors.

Table 16: Structure of the wereda health to whom health financial reports made available

In effective and capable local governments there are structures in relation to the level of administration from the top to the lower level. Within the structures there is a system of administration that is accountable to whom and in what ways can the staff manage their recourses and the like. This structure is also the main mechanism for effective financial management system.

Variables	Cases	Respondents Stand		
		Yes	No	Total
Financial implementation reports				
To the wereda council	Fr	7	13	20
	Pr	35	65	100
To the regional government health bureau	Fr	2	18	20
	Prt	10	90	100
To the public	Fr	2	18	20
	Prt	10	90	100
To the wereda finance bureau	Fr	3	17	20
	Prt	15	85	100
To the health center finance board	Fr	1	19	20
	Prt	5	95	100
Do not know	Fr	3	17	20
	Prt	15	85	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As indicated in table 17, 35% of the respondents replied that the financial and the health service activities (reports) of the health centers are made available to the wereda council, and 10% of them replied that the financial reports are presented to the regional health bureau. Again, 10% of the respondents replied that the financial reports are made available to the public. Along with this, 15% of other respondents responded that health financial implementation reports are made available to the wereda finance bureau. Finally, 15% of the participants are not sure to whom this financial implementation reports should be made available. This shows that service providers are not well informed about to whom they must submit their financial and implementation plans.

Table 17: Adequacy of request, purchasing, and stock control procedures

In any strong governmental or none government system of financial management there is adequate request, purchasing and stock control procedure for effective financial management system. Due to this reason the researcher tried to see whether there is sufficient request, purchasing and stock control practice in the study area.

Variable		Respondents Stand		
		Yes	No	Total
Is there adequate request, Purchasing , and stock Control procedures in place?	Fr	16	4	20
	Prt	80.0	20.0	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As it is illustrated in table 18, 80% of the respondents replied that there is adequate request, purchasing and stock control mechanism in the study area. Accordingly, one can suggest that there is adequate request, purchasing and stock control mechanism in the study area.

Table 18: Sources of fund in the wereda health service

In public service delivery local governmts must be well know and evaluate from where finace is come from.As a result of this issue the researcher examined the source of funds in the wereda health service delivery.

Variables	Cases	Respondents Stand		
		Yes	No	Total
Sources of funds				
From Central government/Ministry of Health	Fr	4	16	20
	Pr	20	80	100
Local government taxes	Fr	9	11	20
	Prt	45	55	100
Donors	Fr	17	3	20
	Prt	85	15	100
User fees	Fr	6	14	20
	Prt	30	70	100
Do not know	Fr	9	11	20
	Prt	45	55	100

Source: Own survey result2013

As presented in able 18, 45% of the respondents replied that the sources of fund for the wereda health service delivery come from the local government tax. Majority of the respondents (85%) reported that the sources of funds for the local health service come from donors. Further, 30% of the respondents replied that user fees are source of fund for the wereda health service delivery. On the other hand, 45% of the respondents they are not sure about the sources fund for the wereda health service delivery. In this case, the largest source of fund for the wereda health service delivery comes from donors rather than that of the central or the local governments.

Table 19: Financial Sustainability

Without having adequate and regular disbursement it is difficult to solve the problems of effective health services delivery .As a result financial requests should be adequate and regular and the researcher tried to investigate whether the is adequate and regular disbursements for effective and efficient health services or not.

Variable		Respondents Stand		
		Yes	No	Total
Are the disbursements regular?	Fr	12	8	20
	Prt	60	40	100

Source: Own survey result, 2013

NB: Fr. = Frequency Prt. = Percentage

Table 19 demonstrates weather there is adequate and regular disbursements for effective and efficient health services or not. With this regard, 60% of the respondents replied there is regular disbursement in the study area. But significant number (40%) of respondents replied that the disbursement is not regular. From this fact, it implies that there is no holistic answer in a way that respondents can believe commonly.

Table 20: The time period of fund allocation for health service delivery

In decenteralized service delivery system, the local health service provides must be well aware on the time of fund allocation and this can help them to have a better financial management.

Variables		Respondents Stand					
		Monthly	Quarterly	Semi-annually	Annually	Do not know	Total
How are funds Allocated?	Fr	3	5	2	5	5	20
	Prt	15.0	25.0	10.0	25.0	25.0	100

Source: Own survey result, 2013

NB: Fr. = Frequency Prt. = Percentage

As illustrated in table 20, funds of the health service center can be allocated quarterly (as indicated by 25% of the respondents), semi-annually (as indicated by 10% of the respondents) or annually (as indicated by 25% of the respondents). But still 25 % of the respondents do not know the period of fund allocation in the health service center. From this, one can infer that there are significant number officials and health service providers who do not know how the allocation of resources or funds. As a result of this, there may be a possibility of poor financial management capacity on the part of the local government as there is no common way of financial allocation system.

Table 21: The decision making process about utilization of fund in health service delivery of the wereda

In public service delivery the community must be actively involved in making decision with regard to the utilization and public pririties.So it is crtical to examine whether the wereda people have the opportunity in this issue**.**

Variables	Cases	Respondents Stand Yes	No	Total
Decision about utilization of funds				
By the Service providers	Fr	2	18	20
	Pr	10	90	100
By Administrators	Fr	10	10	20
	Prt	50	50	100
By the public	Fr	1	19	20
	Prt	5	95	100
By all	Fr	8	12	20
	Prt	40	60	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As shown in table 21, half of the respondents (50%) replied that the decision is made by the administrators, while 40% of them responded that the decision is made by all public health service providers and the administrators. Besides, few respondents (10%) and (5%) respectively, replied that decisions with regard to the utilization of funds are made by the service providers and the public.

In line with this, participants of the focus group were asked to explain whether the wereda has the structures and procedures to encourage the local communities to review and comment upon health priorities, resource allocation decisions and better service during the strategic planning processes of the government. Accordingly, these participants provide that, as far as the wereda health centers are administered by their own finance boards, there are representatives who are to ensure priorities, resource allocation and the strategic planning. However, one of the participants of the focus group discussion reveals that this representation is not enough, and it is not clear how the representatives of the health board are represented. Not only this but also the public is not aware of this structure including the members.

Table 22: Availability of funds allocated for Special purpose

Not all times but some offices have a buguet allocated for special purpose. Based on this fact researcher attempted to investigate whether the wereda health bureau allocated funds for special purpose or not.

Variable		Respondents Stand		
		Yes	No	Total
Are there funds allocated	Fr	6	14	20
for special purposes?	Prt	30.0	70.0	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As indicated in table 22, the majority of the respondents (70%) responded that, there is no fund which allocated for special purpose. In contrary to this, significant number of respondents (30%) replied that there is a fund which allocated for special purpose. Beyond this, the researcher tried to ask open ended question that states as “if there are funds allocated for special purpose for what purpose are they allocated? In this case, 13% of the respondents suggested there are funds which allocated for workshops, training of mothers and health extension workers. Besides, 4% of the respondents indicated that there is often misuse of financial resources when the incentives for the workshop and training participants are paid.

Table 23: Availability of standardized auditing system in the process health service provision

From different sectors either governmental and none governmental organizations experience having standardized auditing system and following the system is a widely used mechanism for financial management and this also shows how the planned objectives are implementing in relation to their financial expenditures. Derived from this reality the researcher tried to make out whether the wereda health bureau have a standardized auditing system and following it or not.

Variable		Respondents Stand		
		Yes	No	Total
Is there a standardized auditing system ?	Fr	8	12	20
	Prt	40	60	100
If yes do you follow it?	Fr	8	12	20
	Prt	40	60	100

Source: own survey Result, 2013

NB: Fr. = Frequency Prt. = Percentage

As indicated in table 23, 40 % of the respondents confirmed the presence of standardized auditing system. Similarly, 40% of those who confirmed the presence of standardized auditing replied that the wereda is following it. However, for both questions majority, (60%) of the respondents also claimed that the wereda health centers have neither standardized auditing nor are following it. This implies that, the wereda health bureau and sub-ordinates may not have standardized auditing system.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary and Conclusion

The attempt of this study was to examine decentralized service delivery in the health sector in Ahferom wereda and as it is illustrated in the analysis part decentralized governance is showing incredible changes in terms of health service availability. However, there are constraints with regard to the availability of human recourses and medical supplies, and low competence of staffs. In addition to this, there is also physical limited access of health centers and the people are suffering with long distance to get health service delivery. As a result of these problems, the health service delivery system may lag behind.

In the case of accountability, the local peoples are not fully involved in approving plans, deciding annual budgets and in hearing implementation reports. On the other hand, there is a scheduled monitoring and evaluation mechanism locally called "Gimgema" programs in the health centers, health posts and at the lower group level (Limatawi Gujile) (Developmental groups) meetings to comment on the plan, budget, and implementation reports but the local people have no full commitment to participate on these meetings. As this is the case it may have a negative impact on the performance of the local health service delivery .Yet again, the clients have no access to get accountability documents in relation to health service delivery.In line with this, the issue of strong and clear relationship among client's, service providers and public officials is also not much attractive and there is no well established system of accountability while service providers fail to do their responsibilities.

In connection to the issues of success stories of decentralized health service delivery, the wereda has recorded remarkable achievements in making health service available though, there are hard to reach areas such as, Mayhamato, Semhal, Zibangula, Daeromabesa, Hoya medeb, Mishig, Erdi jeganu, Laelay hahale and kudo. Other than anything there is huge problem of medical supply and not only shortage but also mismanagement of those available pharmaceutical commodities. Furthermore, there are also problem of favoritism and poor treatment from service providers.

In relation to the general challenges of decentralized heath service delivery in the wereda health service delivery, low availability of medical supplies, lack of skilled man power, weak leadership, lack of resources, lack of citizens' participation and misuse of public resources are the major obstacles of better health service delivery in the wereda .

Regarding to the local government institutional capacity of the Wereda lacks leadership capacity the local health institutions has no visions, goals and objectives acknowledged by all employees. This implies that service providers are rendering a service with no objective and they do not know what they should have to achieve. The involvement of staff in planning and team work is weak; there is less comfortable working environment, weak leadership and scarcity of recourses. The local human resource management is not effective and there is no proportional size of the staff .This shows the idea that there is a serious human resource constraint and this may lead to poor health service delivery. The other major local government institutional capacity issue is financial management capacity. Like the above issues there are also gaps such as lack of sufficient financial resources, lack of qualified personnel, lack of sufficient technical resources ,lack of financial software's for effective financial management, lack of adequate computers for recording activities, lack of adequate stationeries and problems strong system of protecting against staff abuse of resources. These all problems imply that there is weak institutional capacity for better financial management.

On the other hand, adequate request, purchasing and stock control mechanism to control the financial utilization system. In relation to the sources of finance user fee are the major sources of the wereda health service and the funds are sustainable. However, the wereda have weak income generation capacity and the decision about the utilization of funds for health service delivery is mostly made by the administrators.

5.2 Recommendations

- The wereda health center and the wereda health bureau should give much emphasis for essential Pharmaceutical commodities, and the wereda should make strict follow up and the available /non available of medicines should also be proactively made known to ask a support from governmental and nongovernmental organizations.
- The wereda should mobilize the public through the local religious leaders, health extension workers and influential leaders of the community to be aware and avoid the problems of culture and feeling embarrassment of mothers to come to the health centers at the time of birth and when they feel pain.
- With regard the lack of human resource interview participants recommended that filling vacancies and enhancing the competency of the recently recruited staff and old staff, training, re-training and opportunities for higher education must be given because the present human resource development limited.
- In order to overcome the hurdles of geographically dispersed and hard to reach areas to use health care services, the wereda in collaboration with the regional government should establish public health centers in the core areas and this may be also not for topographically but for majority of the people who are not living nearest to local health centers with a minimum of five kilometer
- The wereda health bureau, health center coordinators and health board committees should jointly devise effective mechanisms of providing the plans, budgets and implementation reports, to service users on issues of health service delivery, allocation and other priorities should be defined jointly by health users and providers.
- The wereda lacks enhancing strategies for the purposes of reducing staff abuse, reassurance of compliance with procedures and standards, and to make service providers accountable to their clients .Therefore the wereda should enhance the strategies which legally recognized in the public health service delivery and the strategies that target compliance with procedures and standards should involve regulation, failure to notice, monitoring and reporting requirements on the accountability side.
- Concerning the challenges of health service delivery some respondents offered a number of quite comprehensive recommendations interviews and written comments in the open-

ended section of questionnaires, i.e the wereda administration in collaboration with local health centers should organize public participation in financing and in health service delivery and more than anything this can give the opportunity to public to participate in decision making process, and decide the type of health services they need and this can enable the public to have a better service delivery.

- The wereda lacks favorable working atmosphere. Consequently, in order to improve the working atmosphere every level of the wereda health service needs to keep the local health service structure steady, easy and patent, and resonance policies, favorable incentives, efficient coordination and communication need to be created among or between different sect oral offices and layers of government
- The scheduled monitoring and evaluation mechanism locally called “Gimgema” programs in the health centers, health posts and at the lower group level (‘’Limatawi Gujile) (Developmental groups) meeting should be strengthened through capacity building programs such as short term and long term trainings.
- The wereda lacks the required financial management capacity and to produce sufficient funds through the local health centers rely on their own financial income .Furthermore, the wereda or wereda health centers heave 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.
- In order to ensure the proper financial resources management capacity , the regional government with the help of the wereda administration should strengthen the presence of standardized auditing system and fill vacant a position with adequate and qualified personnel’s in the wereda health centers’ finance

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Appendices

Appendix 1: English questionnaire, interview and focuse group discussion

Mekelle University
College of Business and Economics
Department of Management
Development Studies Post Graduate Program
Household Survey Questionnaire to be Filled by Household Heads

Dear Respondents,

You have been selected as a respondent to participate in this important survey. The purpose of this survey is to assess the Performance and Challenges of Decentralized Governance in Health service in Ahferom wereda .Your response to this survey questionnaire will be considered as highly confidential. Your name does not need to appear on the questionnaire, and thus you will remain anonymous. Please try to answer all the questions as honestly as possible by taking few minutes, and help the researcher collect important information about the performance and challenges of decentralized governance. I highly appreciate in advance to your kind cooperation in providing the necessary information.

General Instruction

- Please put (√) that properly represents your response in the multiple choice questions
- To the open-ended questions, please write your response on the given space.

Section One: Demographic Characteristics of Respondents

1. Gender: Male ☐ Female ☐
2. Age of the respondent___________years
3. Education back ground:
   1. Illiterate ☐ 2. 1-4 grade ☐ 3. 5-8 .Grade ☐
   4. Certificate ☐ 5. Diploma ☐ 5. Degree ☐ 6. Masters ☐

Section two.The availability of human resources and health service accessibilities including pharmaceutical commodities .

4. Are you receiving health service from your local health center?
   Yes ☐ No ☐
5. If yes, have you accessed to the following service? Please in circle your answer from the alternatives yes / No. If yes encircle 1 and if No encircle 2

	Health Service Accessibilities	yes	No
		1	2
•	Family planning services	1	2
•	Antenatal care (ANC) services	1	2
•	Services for the prevention of mother-to-child transmission of HIV (PMTCT)	1	2
•	Delivery (including normal delivery, basic emergency obstetric care, and/or newborn care services	1	2
•	Child immunization services, either at the facility or as outreach	1	2
•	Preventative and curative care services for children under 5	1	2
•	HIV counseling and testing services	1	2
•	HIV/AIDS antiretroviral prescription or antiretroviral treatment follow-up services	1	2
•	Diagnosis or treatment of STIs, excluding HIV	1	2
•	Diagnosis, treatment prescription, or treatment follow-up of tuberculosis	1	2
•	Diagnosis or management of non-communicable diseases, such as diabetes, cardiovascular disease, or chronic respiratory disease	1	2
•	Any surgical services, including caesarean section	1	2
•	Blood transfusion services	1	2
•	Laboratory diagnostics, including any rapid diagnostic testing	1	2
•	Storage of medicines, vaccines, or contraceptive commodities	1	2
•	Diagnosis or treatment of malaria	1	2

6. Which types of health services are more accessible for you?

____

____

____

7. How many kilometers do you travel form your residence to the health center?
1. Less than 5 kilometers ☐ 2. 5-10 kilometers ☐
3. 10-15 kilometers ☐ 4.more than 15 kilometers ☐

Section- Three -Accountability

Dear respondents, the following questions examine the extent to which local health service providers are accountable to their actions. Please encircle the number that indicates the accountability of health service providers in your local health service center. The numbers have the following meanings:

5 = strongly agree; 3 = Not sure;

4 = Agree; 2 = Disagree; and 1 = strongly agree

S. No.	statement	SA	DA	Not Sure	Agree	SA
9	Health service providers share information related to health plans, budgets and implementation reports with citizens	5	4	3	2	1
10	Your complains are heard and responded by the local health center officers	5	4	3	2	1
11	Documentation/reports on local health service accountability are distributed to the people.	5	4	3	2	1
12	The report is comprehensible and provide clear information to the public	5	4	3	2	1
13	There is clear relationship among clients, service providers and the local officials of health services ensure improvements in access to the services needed?	5	4	3	2	1
14	There is well established accountability system to failures for responsibility	5	4	3	2	1
15	Citizen's voice is heard by service provider	5	4	3	2	1

Section Four: The Challenges of Decentralized Governance in Health Service Delivery (To be filled households)

16. What problems have you ever experienced while accessing health services?

1. Financial problem ☐ 2. Favoritism ☐ 3. Poor treatment from health service provides ☐ 4. Poor transportation service ☐ 5. Lack of pharmaceutical commodities ☐

6. Others specify

____

____

17. Which successes have been achieved to solve the problems of health Service delivery in your locality? you can give more one answer

1. There good transportation service ☐ 2.There is no maternal death ☐
3. There is no child death ☐ 4. There are pharmaceutical commodities that we need ☐
5. There is good treatment from health service ☐ 6. There is no favoritism ☐

18. What do you think the challenges which can make the health service delivery of your locality poor?

____
____
____
____

21. What measures do you think are to be taken by the local government to overcome these challenges?

1. ____
2. ____
3. ____

Appendix 2

Mekelle University
College of Business and Economics
Department of Management
Development Studies Post Graduate Program
Questionnaires to be filled by Officials and Health Service Providers

Dear Respondents,

You have been selected as a respondent to participate in this important survey. The purpose of this survey is to assess the Performance and Challenges of Decentralized Governance in Health service in Ahferom wereda .Your response to this survey questionnaire will be considered as highly confidential. Your name does not need to appear on the questionnaire, and thus you will remain anonymous. Please try to answer all the questions as honestly as possible by taking few minutes, and help the researcher collect important information about the performance and challenges of decentralized governance. I highly appreciate in advance to your kind cooperation in providing the necessary information.

General Instruction

- Please put (√) that properly represents your response in the multiple choice questions
- To the open-ended questions, please write your response on the given space.

Section One: Demographic Characteristics of Respondents

1. Gender: Male ☐ Female ☐
2. Age of the respondent____________years
3. Education back ground:
   1. Illiterate ☐ 2. 1-4 grade ☐ 3. 5-8 .Grade ☐ ☐
   4. Certificate ☐ 5. Diploma ☐ 5. Degree ☐ 6. Masters ☐
4. Experience _________

Dear respondents, the following questions examine the extent to which local government's institutional capacity in implementing and coordinating health policies. Please encircle the number that indicates the institutional capacity of the local government in local health service delivery system. The numbers have the following meanings:

5 = strongly agree; 3 = Not sure;
4 = Agree; 2 = Disagree; and 1 = strongly agree

S. No.	statements	SDA	DA	Not sure	Agree	SA
	Leadership					
1	The institution has a clear vision, acknowledged at all levels in common values.	5	4	3	2	1
2	Institutional activities interconnect with institutional mission and priorities.	5	4	3	2	1

3	The institution is characterized by effective staff involvement and teamwork in planning and work.	5	4	3	2	1
4	The local government is supporting the local government units, particularly to the health centers, and health posts to provide sufficient health service.	5	4	3	2	1
5	There is conducive environment in which subordinates are motivated to implement health programs at the grassroots level.	5	4	3	2	1
6	There is good leadership in order to influence efficient and effective health service delivery under the conditions of scarce recourses	5	4	3	2	1
	Human Resource Management Capacity					
7	The local government human recourse management is contributing to achieve to the strategic objectives of local health service delivery.	5	4	3	2	1
7	The local human resources management is effective in health service delivery.	5	4	3	2	
8	There is effective system of coordination at the grassroots level to ensure the implementation of the strategic plans of our sector.	5	4	3	2	1
9	There is a clear legal supervision in providing health service, implementation programs, financial planning, reporting and communication among employees, officials and the public.	5	4	3	2	1
10	There is proportional staff and official/ structural positions with public health service demand.	5	4	3	2	1
11	The local health sector staffs, as a group, have the requisite skills to carry out the public health service demand	5	4	3	2	1

12. Do you have any other comments you would like to make about the human resource management in relation to health service delivery? 1. Yes ☐ 2. No ☐

12 If yes explain your comment

____

____

____

Financial Management Capacity

13 Is there sufficient finance for decentralized health Service Delivery in the Woreda?

1 .Yes ☐ 2. No ☐

14 If no? What are the problems?

____

____

15 Do you think that the wereda has qualified personnel who can handle financial management issues? 1. Yes ☐ 2. No ☐

16 If No what problems do you have?

____

____

____

17 How would you describe the personnel at the wereda who can responsible for the implementation of health finance programs?

	High	Very Good	Good	Fair	Poor
Education					
Experience					
Ability					
Knowledge					

18 Does your sector have adequate technical resources in the discharging of your duties?
1. Yes ☐ 2. No ☐

19 If yes, how do you evaluate the availability of the following technical resources?

	adequate	Inadequate
Office		
Computes		
financial software		
stationary		

20 Has the wereda health office taken any step to protect itself against staff abuse of resources?
1. Yes ☐ 2. No ☐

21 If yes, through what mechanisms?
1. Independent audit ☐ 3. Through accountability reports ☐
2. Through strict supervision ☐ 4. Through punishment ☐
5. Others specify

____

____

____

22 How is the relation among the wereda health finance board, service providers and the wereda financial management?

1. Excellent 2 Very good 3. Good 4. Satisfactory 5. poor

23 To whom are financial reports made available?

1. To the wereda council ☐ 2. To the regional government health bureau ☐
3. To the public ☐ 4. To the wereda finance burea ☐
4. To the wereda finance bureau ☐ 5. I don't know ☐

24 Is there adequate request, purchasing, and stock control procedures in place?

25 How are funds allocated?

1. Monthly ☐ 4. Semi-annually ☐
2. Quarterly ☐ 3. Annually ☐ 5. Do not know ☐

32 . From where do the funds come?

1. Central government/Ministry health. ☐ 2. Local government (taxes) ☐
3. Donors ☐ 4. User fees ☐ 5. Do not know ☐
6. Others (Specify)

____
____

33. Are the disbursements regular? 1. Yes ☐ 2. No ☐

34. Who makes the decision about utilization of funds?

1. By the Service providers ☐ 2. By Administrators by the public ☐
4. by all ☐

35. Are the funds allocated for special purposes? 1. Yes ☐ 2. No ☐

36. For what are funds allocated?

____
____

37. Is there a standardized auditing system? Yes ☐ No ☐

38. Do you follow it? 1. Yes ☐ 2. No ☐

Appendix 3

Mekelle University
College of Business and Economics
Department of Management
Development Studies Post Graduate Program
Semi-structured Interview to Health Service Providers

Dear Respondents,
You have been selected as a respondent to participate in this important survey. The purpose of this survey is to assess the Performance and Challenges of Decentralized Governance in Health service in Ahferom wereda .Your response to this survey questionnaire will be considered as highly confidential. Your name does not need to appear on the questionnaire, and thus you will remain anonymous. Please try to answer all the questions as honestly as possible by taking few minutes, and help the researcher collect important information about the performance and challenges of decentralized governance. I highly appreciate in advance to your kind cooperation in providing the necessary information.

General Instruction

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Section One: Demographic Characteristics of Respondents

1. Gender: Male ☐ Female ☐
2. Age of the respondent____________years
3. Education back ground:
   1. Illiterate ☐ 2. 1-4 grade ☐ 3. 5-8 .Grade ☐
   4. Certificate ☐ 5. Diploma ☐ 5. Degree ☐ 6. Masters ☐
4. Experience___________

Semi-structured Interview to local health service providers

Name: ………………………………………………………

Position: ……………………………………………………

1) What is your role/function at the health center?
2) How many years have you been in your current health center?
3) What's your education background?
4) Are you equipped with the requisite tools/facilities that would enable you to provide service for clients?
5) Did service seekers' behavior have any influence to consider service delivery? If yes, how they try to influence?

6) Do you have sufficient physical resources in the discharge of your responsibility? Yes / No (please give reasons for your answer)
   1. Vehicles
   2. Communication Facilities (Telephone, Internet and Fax)
   3. Computers
   4. Necessary Drugs
   5. Laboratory equipments
   6. Type Writers

7) Do you have qualified health professionals? How many doctors, nurses, medical assistant, pharmacists, technicians and health extension workers do you have?
   1. Doctors ………
   2. Nurses…………
   3. Health Officer…….
   4. Midwives…………
   5. Pharmacy Technician …
   6. Pharmacy Assistant ………
   7. Pharmacist………
   8. Medical Assistant ………
   9. Health Extension workers
      Other (Specify)………….
   10. If your answer is no what kind of health professional does you lack?
      Specify
      ____
      ____
      ____
   11. Are there essential Pharmaceutical commodities for delivering all service available in the local health service center? Yes/ no
   12. What measurements have been taken to solve the above problems?
   13. How do you describe the competence of staffs' in terms of education, experience, ability and knowledge for better health services?
   14. In your opinion, what are the main obstacles for better health service delivery in locality?

(Read all the multiple responses possible)

1. Lack human recourse
2. Poor human recourse management
3. Lack financial of resources.
4. Misuse of public recourses
5. Lack of citi2zens 'participation
6. Weak political leadership
7. Don't know
8. No answer

15. Did you experience/observe a change in the service delivery strategy of the local health office after District level Decentralization? If not why not? And if yes what did you

experience/observed? And which of these Successes are being addressed the problems of service delivery?

16. What type of problems did you face in providing service to the public in relation the culture of the society?
17. What are the obstacles that hinder the effective and efficient implementations of local government‘s mandate and responsibility? What do you think are the best solutions to deal with problems to local government‘s activity in health service delivery?
18. Do you have any suggestions to how the local government can overcome its challenges?

Appendix 4

Focus group Discussion Questions

1. What changes resulted from decentralization with regard to maternal Health, child health and other health service accessibilities in the wereda?
2. Is the existing health service delivery adequate? How? Why?
3. Is there woreda level health service strategy is effective to identify the public demands and priorities?
4. Is there clear line of accountability and communications among official's, employees and the public? If yes how do you explain it?
5. What Administrative problems are you facing in the wereda with regard Decentralized health services programs and their implementation?
6. How the local health service provision, monitoring and evaluation, legal supervision, providing technical services, financial planning, reporting, communication, are carried out?
7. Are there information gathering mechanisms to measure performance and goal attainment that are open and transparent? For example, are services providers required to maintain records of accountability for better healthcare provision services rendered, of resources utilized, of days absent from work?
8. Are there Structures and procedures exist to encourage the local communities to review and comment upon health priorities, resource allocation decisions and better service during government strategic planning processes?
9. What are the challenges on implementation of decentralization in the health service delivery in the wereda? What do you think are the possible measures to be taken to solve these problems
10. What administrative capabilities need to be possessed by local administration units in order to achieve a meaningful and successful decentralized health service delivery?

Appendix 5: Tigrigna questionnaire, interview and focuss group discussion

መቐለ ዩኒቨርስቲ

ናይ ቢዝነስን ኢኮኖሚክስን ኮሌጅ

ማኔጅመንት ትምህርቲ ክፍሊ (ክፍሊ ትምህርቲ ማኔጅመንት)

ብመራሕቲ ስድራ ቤት ዝምላእ ናይ ፅሑፍ መጠይቅ

ዝኸበርኩም መለስቲ

ናይዚ ፅሑፋዊ መጠይቕ እዚ ዋና ዕላማ ኣብ ወረዳ ኣሕፈሮም ዘይተማእኸለ ምምሕዳር ጥዕና ግልጋሎትን ቀረብን ዘለዎ ብቕዓትን ዘጋጥምዎ ዘለዉ ማሕለኻታትን ንምፅናዕ እዩ። ዝኸበርኩም መለስቲ ናሃትኩም መልሲ ነዚ መፅናዕቲ እዚ ዕዙዝ ዝኾነ ግደ ኣለዎ። ስለዚ ድማ ነቶም ሕቶታት ብደንቢ ኣንቢብኩም ነቶም ዝተለዓሉ ሕቶታት ኣብቶም ዝተወሃቡሎም ክፍቲ ቦታታት ንክምልኡ ብኽብሪ ይሓትት። ናትኩም ሓገዝን ሓበሬታትን ነዚ መፅናዕቲ እዚ ብጣዕሚ ኣገዳሲ እዩ። ብዘይ ናሃትኩም ሓገዝ ድማ ናይዚ ዳህሰሳ እዚ ዉፅኢታዉነት ኣብ ሕቶ ምልክት የእትዎ እዩ። ስለዚ ድማ ብዝተኸኣለኩም መጠን እቲ ዝድለ ሓገዝ ንክትገብሩ ብኽብሪ ይላቦ። እዚ መፅናዕቲ እዚ ዝካየድ ዘሎ ካብ መቐለ ዩኒቨርስቲ ብስነ መንግስትን ዲሞክራሲን ልምዓትን ናይ ካልኣይ ዲግሪ (masters) ንምርካብ እዩ።

ሓፈሻዊ መምርሒታት

- ንመልሶም/ሰን ኣብቶም ዝተውሃቡ ክፍቲ ቦታታት ናይ (x) ምልክት የመልክቱ/ታ
- ስምኩም ምፅሓፍ ኣየድልን
- ነቶም ክፍቲ ቦታ ዝተቐመጠሎም ሕቶታት ኣብቲ ዝተውሃበ ቦታ ግቡእ መልሶም/ሰን የቐምጡ/ጣ

    ብጣዕሚ የመስግን

    ገ/መድህን መዝገበ

ክፍሊ 1:- ናይ መለስቲ ናይ ዉልቀ ድሕሪ ባይታ ብዝምልከት

1. ናይ ስድራ ዓይነት

- ተባዕታይ ዝመረሐ ስድራ ቤት ☐
- ኣነስተይቲ እትመርሐ ስድራ ቤት ☐

2.ዕድመ ____________

3. ደረጃ ትምህርቲ ብዝምልከት

1. ዘይተመሃረ/ት ☐
2. ካብ 1ይ-4ይ ☐
3. ካብ 5ይ-8ይ ☐
4. ካብ 9ይ-12 ☐
5. ቴክኒክን ሞያን ☐
6. ዲፕሎማ ☐
7. ዲግሪን ልዕሊ ☐

ክፍሊ ክልተ ብዛዕባ ሓይሊ ሰብ፣ ናይ ጥዕና ኣቕርቦትን መድሓኒትን ምህላውን ዝምልከት

4. ኣብ ከባቢ.ኹም ናይ ጥዕና ግልጋሎት ትረኽቡ ዶ?

1. እወ ☐ 2. ኣይንረክብን ☐

5. ንቁፅሪ ኣርባዕተ መልስኹም/ን እወ እንተኾይኑ እዞም ዝስዕቡ ናይ ጥዕና ግልጋሎት ትረኽቡ ዶ? መልስኹም/ኽን እወ እንተኾይኑ ቁፅሪ ሓደ የኽብቡ/ባ እንድሕር መልስኹም/ኽን ኣይንረክብን ኮይኑ ቁፅሪ ክልተ የኽብቡ/ባ

	ናይ ጥዕና ግልጋሎትን ኣቕርቦትን	**ንረክብ**	**ኣይንረክብን**
✓	ናይ ምጣነ ስድራ ኣገልግሎት	1	2
✓	ናይ ድሕረ ወሊድ ክንክን ኣገልግሎት	1	2
✓	ካብ ኣዶ ናብ ዕሸል ዝመሓላለፉ ሕማማት ኣቐዲምካ ምክልኻል ንኣብነት ኤች.ኣይ.ቪ. ኤድስ	1	2
✓	ወሊድ ብዝምልከት /ባዕለን ከይደን ዝወልዳ፣ ብኣስቸኳይ ዝመፃን ንሓደሽቲ ወላዳት ዝግበር ክንክንን/	1	2
✓	ናይ ህፃናት ክታበት ኣብ ሕክምናን ካብ ሕክምና ወፃኢ.ን	1	2
✓	ናይ ትሕቲ 5ተ ዓመት ቅድሚ ሕማምን ድሕሪ ምሕማምን ዝወሃብ ሕክምና	1	2
✓	ናይ ኤች.ኣይ.ቪ. ኤድስ ምኽርን ናይ ምርመራ	1	2

	ግልጋሎትን		
✓	ናይ ፀረ ኤች.ኣይ.ቪ. ኤድስ መድሓኒት ኣወሳስዳን ክትትልን ኣገልግሎት	1	2
✓	ብፆታዊ ርክብ ዝመሓላለፉ ሕማማት ናይ ምርመራ ኣገልግሎት ምሃብ	1	2
✓	ምስ ዘይመሓላለፍቲ ሕማማት ብተዛማዲ ዝግበር ናይ ምርመራን ቁፅፅርን	1	2
✓	ናይ ቲቢ. ምርመራን መድሓኒትን ኣወሳስዳን ክትትልን	1	2
✓	ናይ መጥባሕቲ ኣገልግሎት	1	2
✓	ናይ ደም ምልጋስ ኣገልግሎት	1	2
✓	ናይ ቤተ ፈተነ ምርመራታት	1	2
✓	ናይ መድሓኒት፣ ክታበትን ወሊድ መከላኸሊ ግልጋሎት	1	2
✓	ናይ ዓሶ ምርመራን ምክልኻልን	1	2

6. ካብቶም ኣብ ላዕሊ ዝተጠቐሱ ኣገልግሎታት ኣብ ከባቢኹም ብዝበለፀ ትረኽብዎ ናይ ጥዕና ኣገልግሎታት እንታይን እንታይን እዮም?

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7. ካብ ገዛኹም ናብ እቲ ናይ ከባቢኹም ጥዕና ጣብያ ክንደይ ዝኣክል ርሕቐት ኣለዎ?

1. ትሕቲ 5 ኪሎ ሜትር ☐ 2. ካብ 5-10 ኪሎ ሜትር ☐

3. ካብ 10-15 ኪሎ ሜትር ☐ 4. ልዕሊ 15 ኪሎ ሜትር ☐

ካሊእ ካብዚ ዝረሓቐ እንተልዩ ______________________________

ክፍሊ ሰለስተ ተሓታትነት ብዝምልከት

ዝኸበርኩም መለስቲ ናይዞም ኣብ ታሕቲ ተዘርዚሮም ዘለዉ ሕቶታት ዋና ዕላማ ኣብ ከባቢኹም ዝወሃብ ዘሎ ናይ ጥዕና ግልጋሎትን ተሓታትነትን እንታይ ከምዝመስል ንምድህሳስ ዝዓለሙ እዮም፡፡ ስለዚ በይዝኦም/እን ኣብቲ ዝተውሃበ ክፍቲ ቦታ ናይ ተሓታትነት መጠን ይገልፅ እዩ ዝብልዎ/ኦ ብቶም ኣብ ታሕቲ ተቐሚጦም ዘለዉ ቁፅርታት መሰረት ብምግባር ናይ (x) ምልክት የቐምጡ/ጣ፡፡ እዞም ቁፅርታት ድማ እዞም ዝስዕቡ ትርጓመታት ኣለውዎም፡፡

5. ብጣዕሚ ይስማዕማዕ 4. ይስማዕማዕ 3. ርግፀኛ ኣይኮንኩን

2. ኣይስማዕማዕን   1. ፈጺመ ኣይስማዕማዕን

	ሕቶታት	5	4	3	2	1
8	እቶም ናይ ከባቢና ጥዕና ግልጋሎት ወሃብቲ ኣካላት ናይ ትልምን ፋይናንስን ኣፈፃፅማ ፀብፃባት ንህዝቢ ግልፂ ይገብሩ					
9	እቲ ናይ ከባቢና ጥዕና ምምሕዳር ጥርዓና ብኣግባቡ ስሚዑ ግቡእመልሲ ይህብ፡፡					
10	እቶም ዝቐርቡ ናይ ጥዕና ግልጋሎት ፀብፃባት ኩለመዳያዊ ኣፈፃፅማ ብግልፂ ዘርእዩ እዮም					
11	ሕብረተሰብ ናይቶም ተሓታታይነት ዘርእዩ ፀብፃባት/መዝገባት ናይ ምርካብ ዕድል ኣለዎ፡፡					
12	ኣብ ሞንጎ ግልጋሎት ወሃብቲ፣ ምምሕዳርን ተገልጋላይ ሕብረተሰብን ኣብ ምምሕያሽ ግልጋሎት ጥዕና ዘድሃበ ጥንኩር ዝኾነ ርክብ ኣሎ					
13	እቲ ናይ ከባቢና ጥዕና ምምሕዳር ሓላፊነቶም ብኣግባቡ ንዘይዋፅኡ ሰራሕተኛታት ሓላፊነቶም ብኣግባቡ ክዋፅኡ ዘኽእል መስርሕ ኣለዎ					
14	ተገልገልቲ በኣገልግሎት ወሃብቲ ፁቡቕ ተሰማዕነት ኣለዎም					

ክፍሊ ኣርባዕተ ንዘይተማእኸለ ናይ ጥዕና ምምሕዳር ዘጋጥሙ ማሕለኻታት ብዝምልከት

15. ናይ ጥዕና ግልጋሎት ክረኽቡ እንተለዉ እንታይ ዓይነት ማሕለኻታት ኣጋጢምዎም/ወን ይፈልጡ/ጣ? ካብ ሓደ ንላዕሊ መልሲ ምሃብ ይከኣል እዩ

1. ናይ ገንዘብ ፀገም ☐   2. ኣድልዎ
3. ድኹም ክንክን ☐   4. ናይ መጓዓዝ ☐ ም ☐
5. ናይ መድሓኒት ሕፅረት ☐

በይዝኦም/ኣን ካልኦት እንተልይዎም የብራህርሁ/ሃ

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16. ኣብ ከባቢኩም ናይ ጥዕና ግልጋሎት ፀገማት ንምፍታሕ እንታይ ዓይነት መፍትሒታት /ዓወታት/ ተመዝጊቦም? ካብ ሓደ ንላዕሊ መልሲ ምሃብ ይከኣል እዩ

1. ናይ ኣዴታት ሞት ቀኒሱ ☐   2. ናይ ህፃናት ሞት ቀኒሱ ☐
3. ፅቡቕ ናይ ኣምቡላንስ ኣገልግሎት ኣለና ☐
4. ናይ እንደልዮም ዓይነታት መድሓኒት ቀረብ ኣለና ☐

5. ኣድልዎ የለን ☐ 6. ፅቡቕ ዝኾነ ናይ ጥዕና ግልጋሎት ይወሃበና ☐

17. ኣብ ከባቢኦም/ን ዝተመሓየሸ ናይ ጥዕና ግልጋሎት ንክይህሉ ዝገበሩ ፀገማት እንታይ እንታይ እዮም ይብሉ/ላ?

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18. እዞም ኣብ ቁፅሪ 17 ዝተዘርዘሩ ፀገማት ንምፍታሕ እቲ ናይ ከባቢኦም /ወረደኦም ምምሕዳር እንታይ ዓይነት ስጉምቲታት ክወስድ ኣለዎ ይብሉ/ላ?

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መቐለ ዩኒቨርስቲ

ናይ ቢዝነስን ኢኮኖሚክስን ኮሌጅ

ማኔጅመንት ትምህርቲ ክፍሊ (ክፍሊ ትምህርቲ ማኔጅመንት)

ብኣገልግሎት ወሃብትን ናይ ጥዕና ኣገልግሎት ምምሕዳር ዝምልከቶም ኣካላትን ዝምላእ ናይ ፅሑፍ መጠይቅ

ዝኸበርኩም መለስቲ

ናይዚ ፅሑፋዊ መጠይቕ እዚ ዋና ዕላማ ኣብ ወረዳ ኣሕፈሮም ዘይተማእኸለ ምምሕዳር ጥዕና ግልጋሎትን ቀረብን ዘለዎ ብቕዓትን ዘጋጥምዎ ዘለዉ ማሕለኻታትን ንምፅናዕ እዩ። ዝኸበርኩም መለስቲ ናሃትኩም መልሲ ነዚ መፅናዕቲ እዚ ዕዙዝ ዝኾነ ግደ ኣለዎ። ስለዚ ድማ ነቶም ሕቶታት ብደንቢ ኣንቢብኩም ነቶም ዝተለዓሉ ሕቶታት ኣብቶም ዝተወሃቡሎም ክፍቲ ቦታታት ንክምልኡ ብኽብሪ ይሓትት። ናትኩም ሓገዝን ሓበሬታትን ነዚ መፅናዕቲ እዚ ብጣዕሚ ኣገዳሲ እዩ። ብዘይ ናሃትኩም ሓገዝ ድማ ናይዚ ዳህሰሳ እዚ ዉፅኢታዉነት ኣብ ሕቶ ምልክት የእትዎ እዩ። ስለዚ ድማ ብዝተኽኣለኩም መጠን እቲ ዝድለ ሓገዝ ንክትገብሩ ብኽብሪ ይላቦ። እዚ መፅናዕቲ እዚ ዝካየድ ዘሎ ካብ መቐለ ዩኒቨርስቲ ብስነ መንግስትን ዲሞክራሲን ልምዓትን ናይ ካልኣይ ዲግሪ (masters) ንምርካብ እዩ።

ሓፈሻዊ መምርሕታት

- ❖ ንመልሶም/ሰን ኣብቶም ዝተውሃቡ ክፍቲ ቦታታት ናይ (x) ምልክት የመልክቱ/ታ
- ❖ ስምኩም ምፅሓፍ ኣየድልን
- ❖ ነቶም ክፍቲ ቦታ ዝተቐመጠሎም ሕቶታት ኣብቲ ዝተውሃበ ቦታ ግቡእ መልሶም/ሰን የቐምጡ/ጣ

ብጣዕሚ የመስግን

ገ/መድህን መዝገበ

ክፍሊ 1:- ናይ መለስቲ ናይ ዉልቀ ድሕሪ ባይታ ብዝምልከት

1.ፆታ -ተባ ☐ 2. ኣነ ☐

2. ዕድመ ____________

3.ደረጃ ትምህርቲ ብዝምልከት

1.ዘይተመሃረ/ት	☐	5. ቴክኒክን ሞያን	☐
2. ካብ 1ይ-4ይ	☐	6. ዲፕሎማ	☐
3. ካብ 5ይ-8ይ	☐	7. ዲግሪን ልዕሊ	☐
4. ካብ 9ይ-12	☐		

4. ስራሕ ልምዲ ------------

ክፍሊ 2. ናይቲ ከባቢያዊ ምምሕዳር ናይ ምፍፃም ዓቕሚ ብዝምልከት ዝተዳለዉ ሕቶታት

ዝኸበርኩም መለስቲ እዞም ዝስዕቡ ሕቶታት ብዛዕባ ናይ ከባቢ ምምሕዳርን ኣብ ናይ መንግስቲ ናይ ጥዕና ግልጋሎት ፖሊሲታትን መምርሒታትን ንምፍፃም ዘኽእል ዘለዎ ዓቕሚ ንምድህሳስ ዝዓለሙ እዮም፡፡ ስለዚ በይዝኦም/እን እቲ ወረዳ ጥዕና ቢሮ ወይ ወረዳ ምምሕዳር ዘለዎ ናይ ኣፈፃፅማ ዓቕሚ ክገልፁልኩም ዝኽእሉ እዞም ዝስዕቡ ቁፅርታት ብምግባር መልስኹም/ኽን ብ (x) ምልክት የርእዩ/ያ፡፡ እቶም ቁፅርታት ድማ ዝስዕቡ ትርጓመታት ኣለዎም፡፡

5. ብጣዕሚ ይስማዕማዕ 4. ይስማዕማዕ 3. ርግፀኛ ኣይኮንኩን

2. ኣይስማዕማዕን 1. ፈፂመ ኣይስማዕማዕን

	ሕቶታት	5	4	3	2	1
	ኣመራርሓ ብዝምልከት					
5	እቲ ናይ ወረዳ ጥዕና ቢሮ ናይቶም ናይ ከባቢ ጥዕና ጣብያታት ዕላማታት ንምስኻዕ ናይ ባዕሉ ዝኾነ ዕዙዝ እጃም ኣለዎ					
6	እቶም ጥዕና ጣብያታት ኩሉ ተግባራዊ ዝገብርዎምን ግልፂ ዝኾኑን ራኢታትን ዕላማታትን ኣለውዎም					
7	ኣብ ሞንጎ ዝተተለሙ ትልምታትን ዝተኻየዱ ፍፃመታትን ጥንኩር ዝኾኑ ዝምድና ኣለዎም					
8	እቶም ትካላት ውፅኢታዊን ተወዲብካ ናይ ምስራሕ ባህርያትን ዘለዎም ሰራሕተኛታት ዝሓቑፉ እዮም					
9	እቲ ናይ ወረዳ ጥዕና ምምሕዳርን ናይ ጣብያ ምምሕዳር ብፍላይ ድማ ንናይ ጥዕና ማእኸላትን ኬላታትን እኹል ዝኾነ ናይ ጥዕና ቀረብ ንክህሉ ሓገዝ ይገብር					
10	እቲ ናይ ወረዳ ጥዕና ቢሮ ነቶም ታሕተዎት ናይ ጥዕና ግልጋሎት ወሃብቲ ትካላት					

	ግቡእ/እኹል ዝኾነ ግልጋሎት ንክህቡ የበረታትዕ					
11	ናይ ናውቲ ሕፅረት ኣብ ዘጋጥመሉ እዋናት እቶም ኣብ ኢድ ዘለዉ መሳርሒታት ብኣግባቡ ምጥቃም ዘኽእል ዕቡቕ ኣመራርሓ ኣሎ					
ኣብ ምሕደራ ሓይሊ ሰብ ዘሎ ዓቕሚ ብዝምልከት ዝተዳለዉ ሕቶታት						
12	ናይ ጥዕና ግልጋሎት ኣብ ምሃብ ናይቲ ወረዳ ናይ ሓይሊ ሰብ ምሕደራ መስርሕ ውፅኢታዊ እዩ					
13	እቲ ናይ ወረዳ ናይ ሓይሊ ሰብ ምምሕዳር ናይቶም ጥዕና ወሃብቲ ትካላት መሰረታዊ ዕላማታት ኣብ ምስኻዕ ናይ ባዕሉ ዝኾነ እጃም ይፃወት					
14	እቲ ናይ ወረዳ ሓይሊ ሰብ ምምሕዳር ውፅኢታዊ ዝኾነ ትልሚ ብምውዳድ ተፈፃምነቱ ክሳብ ታሕተዋይ ክፋል ሕብረተሰብ ወሪዱ ይሰርሕ					
15	ኣብቲ ናይቲ ወረዳ ሓይሊ ሰብ ምምሕዳር ኣብ ቀረብ ግልጋሎት ጥዕና፣ ኣብ ኣፈፃፅማ መደባት፣ ኣብ ናይ ፋይናንሳዊ ትልምታትን ፀብፃባትን ኣብ ሞንጎ ሰራሕተኛታት፣ መማሓደርትን ህዝብን ግልፂ ዝኾነ ሕጋዊ ክትትል ኣሎ					
16	ምስ ናይ ህዝቢ ናይ ጥዕና ጠለብ ተነፃፃሪ ዝኾነ ናይ ግልጋሎት ወሃብትን ኣመሓደርትን በዝሒ ኣሎ					
17	እቶም ጥዕና ግልጋሎት ወሃብቲ ሰራሕተኛታት ናይ ህዝቢ ጠለብ ክምልስ ዝኽእል እኹል ብቕዓት ኣለዎም					

18. ኣብ ምምሕዳር ሓይሊ ሰብን ኣብ ኣወሃህባ ግልጋሎት ጥዕናን ብዝምልከት ክህብዎ ዝደልዩ ርኢቶ ኣለዎም/ወን ዶ?

1. እወ ☐ 2. የብለይን ☐

19. ንቁፅሪ 14 መልሶም/ሰን እወ እንተኾይኑ ርኢቶኦም/ኣን ዶ ክገልፁለይ/ፃለይ?

20. እቲ ናይቲ ወረዳ ዘይተማእኸለ ምምሕዳር እኹል ዝኾነ ናይ ጥዕና ኣገልግሎት ንምሃብ ዘኽእል ናይ ፋይናንስ ዓቕሚ ኣለዎ ዶ?

1. እወ ☐ 2. የብሉን ☐

21. ንሕቶ ቁፅሪ 18 መልስኹም/ኽን የብሉን እንተኾይኑ ብዘይምህላዉ እንታይ እንታይ ዓይነት ፀገማት ከ የስዕብ ኣሎ?

22. እቲ ወረዳ ጥዕና ቢሮ/ፋይናንስ ምምሕዳር ብቑዕ ዝኾነ ናይ ፋይናንስ ምምሕዳር ክኢላ ኣለዎ ዶ?

1. እወ ☐ 2. የብሉን ☐

23. ንሕቶ ቁፅሪ 20 መልስኹም/ኽን የብልናን እንተኾይኑ እንታይ እንታይ ዓይነት ፀገማት ኣጋጢሞምኩም ይፈልጡ?

24. ኣብቲ ወረዳ ዘለዉ ናይ ፋይናንስ ሰራሕተኛታት ንናይ ጥዕና መደባትን ትልምታት ብኣግባቡ ኣብ ምፍፃም ዘለዎም ዓቕሚ ከመይ ይገልፅዎ?

	ንኡዳት	ብ.ፅቡቕ	ፅቡቕ	ደሓን	ድኹማት
ደረጃ ት/ቲ					
ናይ ስራሕ ልምዲ					
ክእለት					
ፍልጠት					

25. እቲ ናይ ወረዳ ጥዕና /ፋይናንስ ምምሕዳር/ ዝተውሃቦ ሓላፊነት ንምፍፃም ዘኽእሉ ቴክኒካዊ መስርሕታት/ናውቲ/ ኣለዎም ዶ?

1. እወ 2. የብሉን

26. ንሕቶ ቁፅሪ 23 መልስኹም/ን እወ እንተኾይኑ

	እኹል	እኹል ኣይኮነን
ቢሮ		
ኮምፒዩተራት		
ፋይናንሳዊ ሶፍትዌራት		
ናይ ፅሕፈት መሳርሒታት		

27. እቲ ወረዳ ጥዕና ቢሮ ኣግባብ ዘይብሉ ናይ ንብረት ኣጠቃቕማ ንከይህሉ ዝወስዶም ዝኾኑ መከላኸሊታት/ሜላታት ኣለዎ ዶ?

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28. ንሕቶ ቁፅሪ 24 መልስኹም/ኽን እወ እንተኾይኑ እንታይ እንታይ ዓይነት ሜላታት? ካብ ሓደ መልሲ ንላዕሊ ምሃብ ይከኣል እዩ፡፡

1. ገለልተኛ ኦዲተር ብምጥቃም ☐ 2. ጥቡቕ ዝኾነ ናይ ኣፈፃፅማ ክትትል ብምግባር ☐

3. ናይ ተሓታትነት ፀብፃባትን ገምጋማትን ☐ 4. ብመቕፃዕቲ ☐

በይዝኦም/ን ካልኦት እንተልይዎም የብራህርሁ/ሃ

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29. ኣብ ሞንጎ ናይ ጥዕና ግልጋሎት ወሃብቲ፣ ወረዳ ፋይናንስ ቦርድን ወረዳ ፋይናንስ ምምሕዳርን ዘሎ ርክብ እንታይ ይመስል?

1. ንኡድ ☐ 2. ብጣዕሚ ፅቡቕ ☐ 3. ብሉፅ ☐

4. ደሓን ☐ 5. ድኹም ☐

30. እቶም ናይ ፋይናንስ መደባት ኣፈፃፅማ ንመን እዮም ኣታዊ ዝኾኑ?

1. ንወረዳ ካቢኔ ☐ 2. ንህዝቢ ☐

3. ንክልል ምምሕዳር/ ፋይናንስ ምምሕዳር ☐ 4. ንናይ ወረዳ ጥዕና ፋይናንስ ቦርድ ☐

5. ንናይ ወረዳ ፋይናንስ ምምሕዳር ☐ 6. ኣይፈልጠን ☐

31. እኹል ዝኾነ ናይ ጠለብን ዕድጊትን ቁፅፅርን መምርሒታት ኣለዎ ዶ?

1. እወ ☐ 2. የብሉን ☐

. እቶም ናይ ወረዳ ፋይናንሳዊ ሓገዛት ካበይ ትረኽብዎም?

1. ካብ መንግስቲ/ ካን ፌደራል ጥዕና ቢሮ ☐ 2. ካብ ክልል ጥዕና ቢሮ ☐

3. ካብ ናይ ከባቢ ምምሕዳር ቀረፅ ☐ 4. ገበርቲ ሰናይ ትካላት ☐

5. ካብ ጥዕና ግልጋሎት ተጠቀምቲ ☐ 6. ኣይፈልጠን ☐

በይዝኦም/ን ካልኦት እንተሃልዩዎም የብራህርሁ/ሃ

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32. እቲ ዝምደብ ገንዘብ ቀዋሚን ዘየቋርፅን ድዩ?

1. እወ ☐ 2. ኣይኮነን ☐

33. እቶም ናይ ፋይናንሳዊ ሓገዛት መዓዝ መዓዝ እዮም ዝምደቡ?

1. ኣብ ወርሒ ☐ 2. ኣብ ሽዱሽተ ወርሒ ☐ 3.ኣብ ርብዒ ዓመት ☐

4. ኣብ ዓመት ☐ 5. ኣይፈልጠን ☐

34. እቶም ናይ ፋይናንሳዊ ምደባታትን ውሳነታት ብመን ይመሓላለፉ?

1. ብግልጋሎት ወሃብቲ ☐ 2. ብምምሕዳር ☐ 3. ብህዝቢ ☐ 4. ብኹሎም ☐

35. ካብ ንጥዕና ግልጋሎት ወፃኢ ንካሊእ ዝምደቡ ናይ ፋይናንስ መደባት ኣለዉ ዶ?

1. እወ ☐ 2. የለን ☐

36. ንሕቶ ቁፅሪ 32 መልስኹም እወ እንተኾይኑ ንምንታይ? የብራህርሁ/ሃ

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37. ደረጅኡ ዝሓለወ ናይ ኦዲት ኣሰራርሓ ኣለኩም ዶ?

1. እወ ☐ 2. የብልናን ☐

38. እንተሃልይኩም ትጥቀመሉ ዶ?

1. እወ ☐ 2. ኣይንጥቀመሉን ☐

ምስ ናይ ጥዕና አገልግሎት ወሃብቲ ንዝግበር ናይ ቃለ መሕተት ዝተዳለዉ ሕቶታት

ሽም ____________________

ናይ ስራሕ መደብ ____________________

1. ኣብቲ ከባቢያዊ ጥዕና ጣብያ ዝተሰማረይሉ ናይ ስራሕ መደብ እንታይ እዩ?
2. ኣብቲ ጥዕና ጣብያ እዚ ንኽንደይ ዓመት ዝኣክል ኣገልጊሎም?
3. ኣብዚ ጥዕና ጣብያ ዝተሰማረይሉ ናይ ሞያ ዓይነት እንታይ እዩ?
4. ንተገልገልቲ እኹል ዝኾነ ኣገልግሎት ክህሉ ዘኽእሉ ናይ ሕክምና ናውቲ ቀረብ ኣለኩም ዶ?
5. ናይ ተገልገልቲ ባህርይ ኣብቲ ትህብዎ ግልጋሎት ዝፈጥሮ ናይ ባዕሉ ዝኾነ ተፅዕኖ ኣለዎ ዶ? ተፅዕኖ ኣለዎ እዩ ዝብሉ እንተኾይኖም ብኸመይ መልክዑ ከምዝኾነ ዶ ክገልፁለይ?
6. ሓላፊነቶም ብኣግባቡ ንክፍፅሙ ዘኽእልዎም እኹል ዝኾነ ናይ ቁሳዊ ናውትታት ከም በዓል ተሽከርከርቲ፣ ኮምፒዩተራት፣ ኣድለይቲ ዝኾኑ መድሻኒታት፣ ናይ ቤት ፈተነ መሳርሒታት፣ ናይ ፅሕፈት መሳርሒታትን ናይ ሓሳብ መለዋወጢ መሳርሒታትን /ስልኪ፣ ኢንተርኔት፣ ፋክስ …/ ኣለኩም ዶ?

   ኣለና ☐ የብልናን ☐

7. እኹል ዝኾነ ናይ ጥዕና ኣገልግሎት ንምሃብ ዘኽእሉ ብቑዓት በዓል ሞያታት ኣለዉኹም ዶ? መልሶም እወ ኣለዉና እንተኾይኑ ክንደይ ዝኣኽሉ ዶክተራት፣ ነርስታት፣ ናይ ሕክምና ድጋፍ ወሃብቲ በዓል ሞያታት /ሜዲካል ኣሲስታንት/፣ ናይ ጥዕና መኮንናት፣ መዋለድቲ ነርስታት፣ ናይ ቤት መድሓኒት ቴክኒሻናት፣ ተሓጋጋዛይ ናይ ቤት ምድሓኒት በዓል ሞያ፣ ናይ ቤት መድሓኒት በዓል ሞያ /Pharmacist/፣ ገዛ ንገዛ እናዞሩ ናይ ሕክምና ግልጋሎት ወሃብቲ በዓል ሞያታት /Health extension workers/፣ ኣለዉኹም ዶ?

በይዝኦም ካልኦት እንተልዩ ይሓብሩልና

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8. መልሶም የብልናን እንተኾይኑ ናይ ምንታይ ዓይነት በዓል ሞያ ሕፅረት ኣለኩም?
9. ንኹሎም ናይ ጥዕና ግልጋሎታት እኹል ዝኾነ ናይ ምድሓኒት ቀረብ ኣሎ ዶ?

   እወ ☐ የለን ☐

10. ን ቁፅሪ 9 መልሶም እንድሕር የለን ኮይኑ እቶም ፀገማት ንምፍታሕ እንታይ እንታይ ዓይነት መፍትሒታት ተወሲዶም ይፈልጡ?
11. ዝተመሓየሸ ናይ ጥዕና ኣገልግሎት ንምሃብ በዓል ሞያታት ብመዳይ ደረጃ ትምህርቲ፣ ናይ ስራሕ ልምዲ፣ ክእለትን ፍልጠትን ዘለዎም ብቕዓት ብኸመይ ይርእይዎ?
12. ኣብ ከባቢኹም ዝተመሓየሸ ናይ ጥዕና ግልጋሎት ንከይህሉ ዝገብሩ ቀንዲ ማሕለኻታት እንታይ እንታይ እዮም?
    1. ናይ ሓይሊ ሰብ ሕፅረት
    2. ድኹመ ዝኾነ ናይ ሓይሊ ሰብ ምሕደራ መስርሕ
    3. ናይ ፋይናንስ ዓቕሚ ምንኣስ
    4. ኣግባብ ዘይብሉ ናይ ንብረት ኣጠቓቕማ
    5. ትሑት ናይ ሕብረተሰብ ተሳትፎ
    6. ድኹም ዝኾነ ኣመራርሓ
    7. ኣይፈልጦን
    8. መልሲ የብለይን
13. ድሕሪ ዘይተማእኸለ ምምሕዳር ምዝርግሑ ኣብ ከባቢኹም ዘሎ ናይ ጥዕና ግልጋሎት ኣወሃህባ ተመሓይሹ እዩ ዶ ይብሉ? መልሶም ለውጢ የለን እንተኾይኑ ንምንታይ ከምዝኾነ ዶ ክገልፁለይ? መልሶም ለውጥታት ኣለዉ እዮም እንተኾይኑ ድማ እንታይ እንታይ ዓይነት ለውጥታት ወይ ድማ ዓወታት ተመዝጊቦመ ይብሉ?
14. ምስቲ ናይቲ ሕብረተሰብ ባህሊ ብዝተተሓሓዘ ኣብ ናይ ጥዕና ግልጋሎት ኣብ ምሃብ ዘጋጠመኩም/ክን ፀገማት ኣለዉ ዶ?
15. እቲ ናይ ወረዳ ምምሕዳር ብመዳይ ኣወሃህባ ግልጋሎት ጥዕና ውፅኢታውን ብቑዕ ዝኾነ ኣፈፃፅማን ሓላፊነቱ ብኣግባቡ ንከይዋፃእን ዝገብሩ ዓበይቲ ማሕነቖታት እንታይ እንታይ እዮም ይብሉ?
16. እቶም ዝተርኣዩ ማሕነቖታት ኸ ብኸመይ ክፍትሑ ይኽእሉ እዮም ኢሎም ይሓስቡ?

ምስ ተገልገልቲ፣ ናይ ጥዕና ግልጋሎት ወሃብትን ናይቲ ወረዳ ጥዕና ቢሮ ሓለፍትን ዝምልከቶም ኣካላትን ንዝግበር ምይይጥ ዝተዳለዉ ሕቶታት

1. ምስ ናይ ኣዴታት ሞት፣ ህፃናት ሞትን ካልኦት ተተሓሓዝቲ ናይ ጥዕና ግልጋሎትን ኣቕርቦትን ብዝምልከት ዘይተማእኸለ ናይ መንግስቲ መስርሕ ዘምፅኦ ለውጢ ኣሎ ዶ?
2. እቲ ዝወሃብ ዘሎ ናይ ጥዕና ግልጋሎት እኹል እዩ ኢሎም ዶ ይሓስቡ? ብኸመይ/ንምንታይ?
3. እቲ ዘሎ ናይ ወረዳ ጥዕና ግልጋሎት ናይ ህዝቢ ድሌት መሰረት ዝገበረ ድዩ?
4. ኣብ ሞንጎ መማሓደርቲ፣ ሰራሕተኛታትን ህዝብን ግልፂ ዝኾኑ ናይ ተሓታታይነትን ዝምድና ዝፈጥረሉ መስርሕ ኣሎ ዶ?

5. ምስ ናይ ዘይተማእኸለ ናይ ጥዕና ኣወሃህባ መስርሕን ኣፈፃፅምኡን ብዝምልከት እንታይ እንታይ ዓይነት ናይ ምምሕዳር ፀገማት የጋጥሙኹም?
6. እቲ ናይ ወረዳ ጥዕና ግልጋሎት ኣብ ምሃብ ምስ ቁፅፅርን ገምጋምን፣ ህጋዊ ክትትል፣ ፍሉይ ዝኾኑ ደገፋት ኣብ ምቕራብን፣ ፋይናንሳዊ ትልምን፣ ፀብፃባትን ርክብን ዝተተሓዙ ጉዳያት ብኸመይ መንገዲ የካይዶም?
7. እቲ ናይ ወረዳ ጥዕና ግልጋሎት ኣፈፃፅምኡ እንታይ ክምዝመስል ዝግምገመሉ መስርሕ ኣሎ ዶ? ንኣብነት እቶም ግልጋሎት ወሃብቲ ከመይ ይፍፀሙ ከምዝለዉ፣ ንብረት ከመይ ይጥቀሙ ከምዘለዉን ኣብ ስራሕ ቦትኦም ከምዝርከቡን ንምፍላጥ ፅቡቕ ክትትል ይግበር ዶ?
8. እቲ ናይ ወረዳ ምምሕዳር ህዝቢ ናይ ጥዕና ግልጋሎት ድሌቱ ንምግላፅ ናይ ትልምን ፋይናንስን ውሳነታት ኣብ ምሕላፍ ናይ ባዕሉ ዝኾነ ዕዙዝ እጃም ንክህልዎ ግልፂ ዝኾነ ደረጃ ብደረጃ ዝተዘርገሐ መስርሕ ኣለዎ ዶ?
9. ዘይተማእኸለ ናይ ጥዕና ግልጋሎት ኣወሃህባ መስርሕ ብዝምልከት ብመዳይ ኣፈፃፅማ ኣብ ወረዳኹም ዝረኣዩ ዓበይቲ ማሕነቖታት እንታይ እንታይ እዮም? ነዞም ዝተዓዘብኩምዎም ማሕነቖታት ከ ብኸመይ መገዲ ክፍትሑ ይኽእሉ እዮም ኢሎም ይሓስቡ?
10. ዕዉትን ውፅኢታውን ዝኾነ ናይ ዘይተማእኸለ ናይ ጥዕና ግልጋሎት ንምሃብ ብወገን ናይ ከባቢያዊ ምምሕዳር መዋቕራት ዓቕሞም ንምዕባይ ክኽተልዎም ዝግብኡ ናይ ምምሕዳር ክእለታት እንታይ እንታይ እዮም ኢሎም ይሓስቡ?