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Public Health Service Delivery in a Decentralized System: A Qualitative Study of the Perception of Health Providers and Community Members in Gida Ayana *Woreda*, Western Ethiopia

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Public Health Service Delivery in a Decentralized System: A Qualitative Study of the Perception of Health Providers and Community Members in Gida Ayana *Woreda*, Western Ethiopia

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Abstract- Some policy-makers believe a decentralized health system enhances service delivery by improving authority, autonomy, accountability, and community participation at the local level. Evidence on the extent to which these benefits have been realized and whether there are gaps in service delivery is essential for policy designs and system reinforcing strategies. The study gathered data through 29 interviews with service providers and policy-makers and eight FGDs with residents and analyzed it for themes. The results showed several benefits of the decentralization system program that includes increased autonomy over staff planning, budgeting, appointments; increased participation in service boards, in cash and kinds. The findings also revealed several challenges that hinder the effective functioning of decentralization including lack of authority to recruit staff, interference in the appointment, transfer of cases, procurement; limited decision making power over local revenue resources; lack of community responsibility in service planning and monitoring. Although the designing of decentralized health program was appropriate in earnest, critical elements for attaining adequate decentralization are still lacking. The region has still played the biggest role in staff recruitment, resource transfer, planning/ programming. These deficiencies have resulted in inadequate information, nominal service monitoring, and low quality of services outcomes. Better quality of service delivery necessitates financial independence and significant service monitoring.

Keywords: decentralized health service, Ethiopia, authority, autonomy, effects of decentralization.

I. Background

Calls for health system decentralization dated back to the Alma Ata Declaration (Beard & Redmond, 1979) and became more urgent during the 1990s (Mehrotra, 2006). Conceptually, decentralization in the context of health services entails the transfer of administrative authority to lower offices accountable to the centre (Rondinelli et al., 1989). Mills (1990) described decentralization as a process of offering routine managerial authority to semi-autonomous health facility boards reporting to politicians and decentralization is the move of power and structures for health from the central government to the local government answerable to electorates (Smith, 1997) and according to Hutchinson (1999) it is a shift of public health to private providers.

Local authority and autonomy overcome the disadvantages of centralized institutional and spatially distant bureaucracies; minimize costs, increase responsiveness to local needs; improve community involvement; and ensure accountability of local politicians, health managers, planners, and decision makers (Tang & Bloom, 2000; Rifkin, 2014). Several health sector reforms recommend citizen participation to ensure local accountability of health program management for granting adequate service delivery, monitoring the allocation and utilization of monies for health services, and developing and monitoring programs that permit them to voice their rights (Molina, 2017).

Some of studies have emphasized the need for local institutional authority, autonomy, participation, and accountability for effective implementation and improvements of health services outcomes (Mill,1990; Murthy & Klugman, 2004; Menon, 2006). However, evidence drawn from 10 countries indicates that decentralization of public systems, including health systems, has increased only slightly in Africa recently, with few achievements in the areas of autonomy, accountability, and capacity in service delivery (Wunsch, 2014). Many healthcare professionals have raised that only a few of the policy designs and systems, in practice, reinforce strategies for health that use authority, autonomy, participation, and accountability as basic guidelines for effective health policy programs (Mill,1990; Murthy & Klugman, 2004). Some studies also report a lack of effort to systematically examine this situation even though these aspects are essential for the implementation of decentralized public health services (Kassa & Shawel, 2013; Kwamie et al., 2015).

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Before 1991, Ethiopia was a centralized country with a unitary form of authoritarian government. The government made decisions at the center in the absence of formally established sub-national governments accountable to the needs of local communities (Gebre-Egzhiabher, 2014). The unitary government channeled decisions on production and distribution of public health services from the capital, Addis Ababa, without actual authority, autonomy, accountability, or participation at the lower levels (Kloos, 1998; Fiseha, 2007).

With the introduction of decentralization following the downfall of the authoritarian military regime in 1991, the sub-national governments gained status in the country (Gebre-Egzhiabher, 2014). As a result, the reform transferred power to the regions and *woredas* (district) as part of a broader process of political and economic reform in two waves (Dickovick & Gebre-Egziabher, 2014). In the early 1990s, the country implemented the first wave, or regional decentralization. The program divided Ethiopia into nine regional state structures (The Federal Democratic Republic of Ethiopia, 1995). This considerably devolved power, authority, functions, and resources to the sub-national governments. In 2002, Ethiopia implemented the second wave, or *woreda* (district) decentralization program. This reform further deepened decision-making power, authority, and resource transfer from the regions to *woredas* (district) governments for service delivery (Dickovick & Gebre-Egziabher, 2014).

Public health service delivery functions were among the most crucial service areas devolved by the program to regional and *woreda* levels (Wamai, 2009). However, decentralization studies in Ethiopia often ignored the possible effects of decentralized reform on health service delivery (Kassa & Shawel, 2013). Studies have revealed that inadequate local authority and autonomy over resources, poor accountability, and insufficient local participation have inhibited effective health delivery outcomes (Kassa & Shawel, 2013; Kassa, 2015; Kilewo & Frumence, 2015; Pundhi & Boke, 2015; Regmi et al., 2017). There is a need to explore the details of the *woreda* decentralization to understand the extent to which the decentralization program shaped local healthcare delivery system and outcomes (Wamai, 2009; Kassa & Shawel, 2013; Lee, 2015).

The aim of this paper was to find the views and perceptions of participants regarding whether the decentralized public health system has improved health service delivery and management at the community level in four sub-districts or *kebeles* (the lowest government structure in Ethiopia) of Gida Ayana *Woreda*. The study provides baseline data about the health sector reform implementation and the health status of the study groups. Moreover, it adds to the existing evidence about some impediments to health service delivery reform and some of the outcomes. Lastly, the results of this study call for policy-makers to revisit decentralized health programs to ensure that *woreda* government structures have adequate authority, autonomy, resources, accountability, and popular participation in the implementation, management and provision of quality health care services.

II. Methods

a) Study approach

This qualitative research used a naturalist approach, which tries to understand phenomena in context-specific settings and gives insights of participants' experiences of the world (Frumence et al., 2013; Tong et al., 2018). The qualitative approach was considered suitable because it can elucidate the experiences of those who are directly dealing with the planning and implementation of healthcare reforms as well of community users (Kwamie et al., 2015; Abayneh et al., 2017). Our study focuses on intermediate outcomes of decentralization, such as local authority, autonomy, accountability, and participation, in a case study of Gida Ayana *Woreda*.

b) Study setting

We conducted the study in the Oromia Region, Gida Ayana *woreda* (Figure 1), western Ethiopia. The study purposively selected Gida Ayana because it is one of the *woredas* of the Oromia Region that, according to the Zonal Assessment Report, has low performance in health facilities compared to other *woredas* in the Eastern Wollega Zone (The Oromia Health Bureau [OHB], 2015). However, different civil societies and local organizations supported the *woreda* during the implementation of the decentralization process (OHB, 2015). With 140,484 people in 2013, Gida Ayana is also one of the most populous *woredas* in the Oromia Region (Central Statistical Agency of Ethiopia [CSA], 2013). Because of its size and other characteristics, the *woreda* can provide evidence as to whether decentralization has resulted in improved health services delivery.

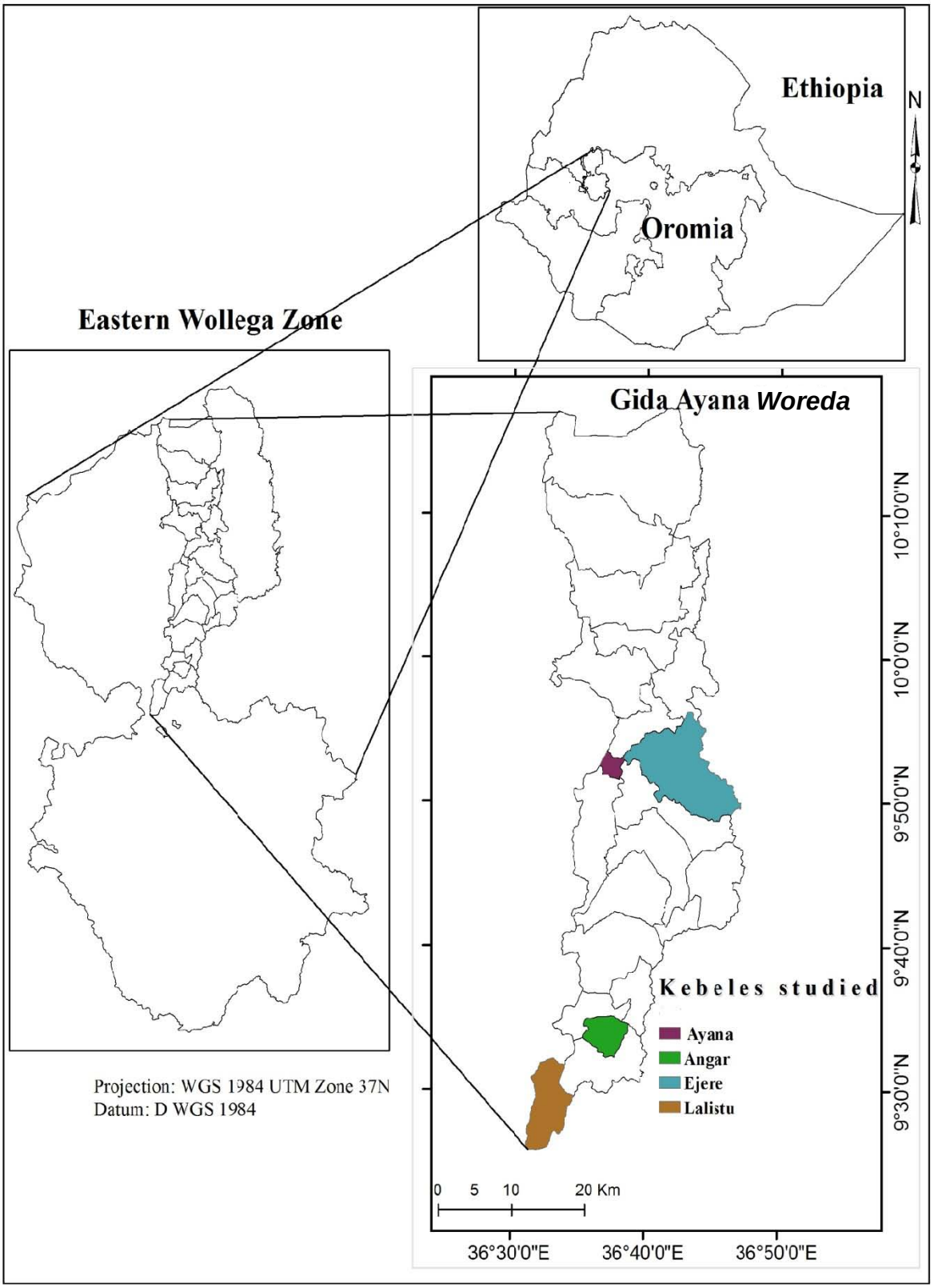

Figure 1: Study area

c) Participants

The study categorized the participants into three groups: local service providers, policy makers, and community members. We held a total of eight focus group discussions (FGD) with community member participants among four random *kebeles*: Ayana, Ejere, Angar, and Lalistu. The study purposively identified male and female community members representing different

socioeconomic, sex, and age groups to capture their experiences with the health service delivery system and quality in the *woreda*. The interviewers placed women and men participants in separate FGDs.

We conducted a total of 29 in-depth interviews or IDIs (Table 1) with local service providers and higher-level policy-makers. Data collection involved local service providers who are delivering health services at the *woreda* level. It included service providers because they had experienced people in the implementation, management, and delivery of the decentralized health care reform (Abayneh et al., 2017). The interviewees consisted of participants from the *woreda* health office (WHO) (n=6), facility heads (FH) (n=7) from the study *kebeles*, and service board members (SB) (n=12). We use purposive sampling to chosen local service providers based on information from local officials. Policy-makers (PM) (n=4) were those involving in policy, planning, and service development at both national and regional levels and the study also purposively chosen them by their work experience in public health policy-making and their knowledge of the subject matter (Tong et al., 2018).

Table 1: Demographic Characteristics of Participants Interviewed

Characteristic	*n* (%)
Local service providers	
Woreda health officials	6 (20.7)
Facility heads	7 (24.1)
Service board members	12 (41.4)
Higher level policy-makers	4 (13.8)
Work experience (years)	
5-10	17 (58.6)
11 or more	12 (41.4)
Gender	
Male	22 (75.9)
Female	7 (24.1)
Educational level	
Diploma or certificate	4 (13.8)
First degree	17 (58.6)
Second degree or higher	8 (27.6)

d) Data collection

In-depth interviews and FGDs were the primary data collection methods. In all, the study conducted 29 face-to-face IDIs and eight FGDs to gather data. We completed four FGDs with men community groups and four with women groups. The study conducted data collection between January and June 2017. The authors prepared a topic guide for the interviews and FGDs by a literature review (Yin, 2003; Tong et al., 2018). The guide explored participants' experience with and perceptions of the *woreda's* authority, autonomy, accountability, and community participation and awareness in health planning; roles and responsibilities of the *woreda* government in service delivery and management; and effects of the reform on local health care. The study piloted the questions with three officials and one FGD to establish face validity (Tong et al., 2018). Two senior staff of a local university who had previous experience in data collection with other research projects in the same *woreda* and the corresponding author undertook data collection.

The study run each in-depth interview in the interviewee's working office and all FGDs at *kebele* halls. The FGD group consisted of 8-12 participants. On average, each discussion with stakeholder participants lasted between 60 and 90 minutes. The interviewers used a local language, Afan Oromo, in the data collection with the local service providers and the English language with policy-makers. Data collectors informed participants about the objective of the study before they started data collection. They approached the community participants, initially by local administrators. Interviewers also obtained verbal consent and also told the participants to decline the interview at any stage if they wish to do so. To protect the anonymity of participants, the study used only pseudonyms in the analysis and presentation of data. Data collection consistently employed probing approach during interviews. The study sound recorded all interviews, and discussions and took handwritten field notes.

e) Data validity and reliability

The study pretested the instrument in an adjacent *woreda* to ensure reliability, to check for clarity and comprehension. After the pre-test, the corresponding author revised some interview questions. Data collectors validated frequently transcribed data by participants' feedback immediately after each interview and FGD. The interviewers adjusted fundamental inputs where necessary, and they carefully compared emerging themes alongside the data to ensure the validity of the data. This enabled the authors to manage deviant cases in their analysis.

f) Data analysis

The study had interviews and FGDs transcribed verbatim and the transcriptions used for analysis. The corresponding author crosschecked audio files and transcripts for accuracy before coding and analyzed the data systematically. The researchers read and re-read the transcripts, ensuring a clear understanding of the content (Tong et al., 2018), and used the thematic framework approach deductively, based on the topic guide, and the conceptual framework, and inductively by subthemes or quotes emerging from the data.

III. Conceptual Framework

Autonomy, authority, accountability, and participation are intermediate results of decentralization, not the end result (United States Agency for International Development, 2009; Wunsch, 2014). Achieving these

results ensures service quality and measures the improvement of health coverage, quality, and availability of medical supplies, and quality of decision and services obtained from skilled providers (Kassa & Shawel, 2013). Our paper investigates whether these intermediate outcomes achieved in the study area and whether they have resulted in service improvement (Figure 2).

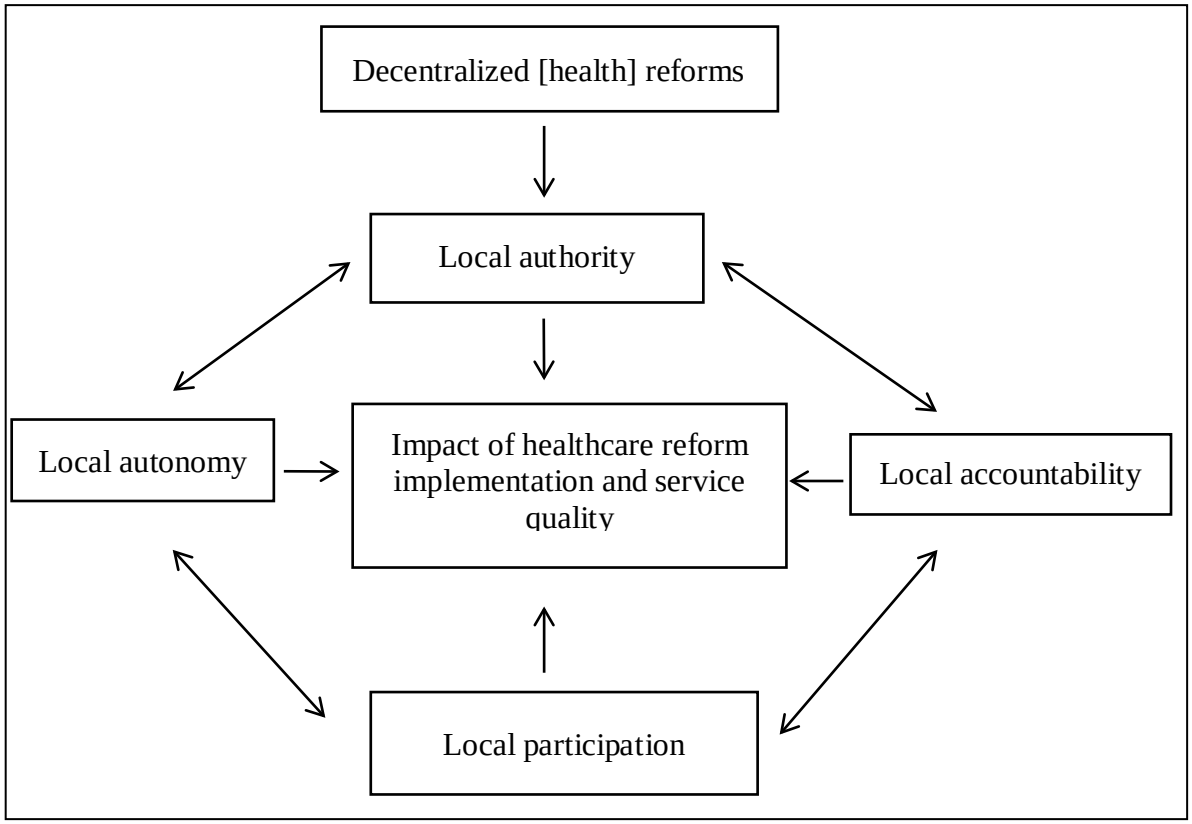

Figure 2: A conceptual framework for the study of decentralized healthcare delivery (adapted from USAID, 2009).

IV. Results

a) Background characteristics of study participants

Table 1 shows the socio-demographic background characteristics of the interview participants. Of the 29 individuals participating in the interviews, 6 (20.7%) worked at the *woreda* health office, 7 (24.1%) were facility heads, 12 (41.4%) were service board members, and 4 (13.8%) were regional and federal level policymakers. The majority (75.9%) were male; 58.6 percent had 5 to 10 years of work experience. The four men and four women FGDs each had 8-12 members.

The study cited the responses of several of the study participants in this section and identified them by letter and number code. Those designated WHO were from the *woreda* health office, those designated SB were service board members, and those designated FH were facility heads. The IDI in the code indicates the information came from an in-depth interview; the FGD denotes information from a focus group discussion.

b) Authority

The decentralization system in Ethiopia established three constitutionally recognized tiers of government: federal, regional and *woreda*. In the health sector, the Federal Ministry of Health and the Oromia Region Health Bureaus are policy-making and regulatory institutions (Ethiopia Health Sector Development Program, 2006). Zonal Health Departments in Oromia are a conduit between the region and *woredas*; they provide support and channel information to both structures (Oromia Regional State [ORS], 2001).

The regional constitution gives *woreda* governments legal authority to prepare, approve, and implement their development plans; monitor their implementation; set and collect certain taxes and service fees; and manage local resources (ORS, 2002). *Woreda* decentralization program also charged *woreda* governments with the accountability for service delivery and engaging local communities (ORS, 2005). Legally, *woreda* health offices are responsible to performing the following functions (ORS, 2014): develop and implement health plans; administer facilities; provide reproductive health, family planning, vaccination, and sanitation services; control communicable diseases and quality of healthcare; promote health education and information and community participation; undertake procurements and implement civil service programs; control resources; monitor and evaluate service performance;

manage complaints; and ensure the implementation of policies, proclamations, and directives (ORS, 2013). Health center and hospital service boards were delegated authority to govern the facilities (ORS, 2005).

The above indicates that the *woreda* government and the *woreda* health office have significant authority under the decentralized system to govern the health system. However, the extent to which these decentralized institutions fully exercised the decision making power bestowed on them is a critical issue because legal authority by itself may not imply full power and ability to discharge responsibilities. The next section, on autonomy, elaborates on this issue by identifying some critical areas of engagement.

c) Autonomy

In this section, we explore Gida Ayana *Woreda*'s administrative and fiscal decision-making autonomy organized around themes that emerged during analysis: (i) personnel management, (ii) fiscal autonomy, (iii) procurements, and (iv) service planning and programming.

i. *Personnel management*

Personnel management involves the planning for staff needs; recruitment, hiring, employing, and disciplining/firing of staff; transfers; appointments; and the provision of incentives. This section describes the prevailing practices of the Gida Ayana *Woreda* on these issues.

In terms of planning for local staff needs, most informants from the service board pointed out that the *woreda* has a considerable degree of latitude over planning and budgeting for health staff. The facility head confirmed that the *woreda* was fully accountable for planning and budgeting for health service providers needs. In this regard, the reform is fully autonomous and competent. An informant further noted that the sector prepares a recruitment plan to be presented to the *woreda* cabinet. The cabinet approved human resource needs after scrutinizing the required numbers, the levels of qualification, and the budget for remuneration. Upon approval, the health office directly requests higher offices to either post the recruitment and deploy to the *woreda* or ask the ministry to assign new graduates.

An informant from the health office emphasized his appreciation of the autonomy of the *woreda* in planning for staff needs as follows:

Yes, since 2002,woreda government had obtained self-government. With this arrangement, the woreda preserved its independence from higher officials and woreda ultimately began to produce personnel need plans locally. The hospital also plans its personnel need and requests the region to recruit (*WHO, IDI5*).

In response to the question of whether the informant from the sector office believed the autonomy improved the decisions of local politicians, one informant from *WHO* replies the following:

Yeah, with local rights we can plan, budget, and satisfy local staff needs (WHO, IDI2).

However, responses to the question of the authority and autonomy for recruiting and hiring of staff for local facilities show mixed results. According to health officials, decentralization program fully devolved the recruitment of support staff with the diploma and below diploma qualifications to the *woreda*. Thus, the sector office and civil service department post vacancies and recruit and hire for such posts. Zone and higher level authorities recruited and employed all technical staff for positions with specific educational requirements and supportive office workers for vacancies requiring an academic degree above the diploma. Some facility heads approve of the *woreda's* autonomy for the recruitment of non-technical posts:

All right, we are vested with the right to recruiting non-technical staff with the diploma and below the diploma. We post, select, and hire competent candidates. The process is very prompt, and such employees are relatively stable and quick at adapting to our work environment compared to staff employed by higher officials who even disappear after receiving an employment letter or one month salary (FH, IDI3).

A WHO interviewee declared that the *woreda* has no autonomy to recruit or hire technical staff:

Yes, we have no avenues open for recruiting these staff, no say about who is selected or not for our medical staff posts. Higher bosses hiring the candidates and lastly deploy to the woreda for the formalization of the employment (WHO, IDI5).

Several local informants had serious concerns over the management of posting and recruiting local technical staff at higher levels, explaining that the practice promotes dependency of local institutions on higher authorities. These informant also described that the lack of concern among higher officials about hiring skilled staff compromised the quality of local services. A health center head noted the challenges of hiring inappropriate staff as follows:

Sub-national governments often recruit staff without considering our demand. Why? For instance, in 2016, Hangar Health Center requested community health agents for a rural health post, but they hired clinical nurses (*FH, IDI7*).

In terms of disciplining health workers, several informants noted that Gida Ayana has some autonomy in penalizing frontline workers who violate civil service laws. One official described his experience as follows:

Yes, the head of Angar Health Cener reported to us in 2016 that they disciplined five technical staff members by withholding one month salary for repeated absenteeism from work (*WHO, IDI6*).

All facility heads and service boards reported that complaints come from service users workers

provided inadequate services and these complaints should serve as a basis for penalizing offenders. Many male FGD participants suggested that several service users do not know their rights due to illiteracy, poor awareness, and lack of capacity that prevents them from exercising their rights. A community representative on a hospital board reflected her experiences as follows:

Users often preferred to tell board members about complaints they faced at the hospital to hold providers accountable due to fear of retribution and so forth. We informally obtained users' complaints and reported them to the head to take measures. For example, the hospital fired a general practitioner from his job in 2016 due to users' complaints (*SB, IDI4*).

An important issue in human resources management has to do with staff transfer and appointments. Many facility heads noted that the *woreda* has some autonomy for making appointments for local positions. Others stated their concern about the political patronage and clientelism in the appointment of staff. A medical director observed that officials give priority to certain individuals regardless of their performance and sometimes use their power to appoint their relatives and family members to positions in health centers and hospitals even if they are non-health personnel. One informant stated that staff appointment reinforced local patronage:

The code of having non-partisan and merit-based civil servants is right only on paper. The actual case, however, shows a partisan bias. The woreda often selected members of the local ruling party and those who had links with politicians. It usually nominated three staff for a single position, and the party then selects a candidate. The processes fed up usbecause our exhaustive proposals are like a 'toothless dog' (*SB, IDI11*).

Some of informants noted that the *woreda's* full autonomy over staff transfers within its jurisdiction across facilities, where patronage is also widespread. Some cited cases in which cabinet members pressured health officials to transfer their relatives from rural posts to facilities in the *woreda* capital. The head of a health post elaborated as follows:

The politicians bring their relatives from rural to urban vacancies even in other sector offices or deliberately give them political positions which might cause rural facility closure, community mistrust (*FH, IDI7*).

In principle, the *woreda* is responsible for sending and receiving staff to and from other *woredas* through transfers. But higher officials sometimes overruled *woreda* decisions, and as a result, there have been numerous unplanned transfers out of or into the *woredas* without the discretion of *woreda* health officials. The provision of an incentive scheme is critical to retaining health workers in rural areas and reducing staff turnover. In this regard, several health center heads noted that local facilities are currently experiencing high staff turnover due to a lack of established local staff incentive programs. They added that living and working conditions in remote rural *woredas* are not appealing to frontline workers and female workers often marry urban partners to leave the *woreda*. A board member of a health center noted as follows:

Ejere and Lalistu kebeles usually experience high staff turnover because health workers use such settings as a ladder to obtain better jobs in towns (*SB, IDI6*).

ii. *Fiscal autonomy*

Several health officials noted that health sector finance had heavily relied on sub-national government transfers to the *woreda* council, which accounted for over 85 percent of the *woreda*'s total expenditures. Except for small amounts of capital earmarked for items such as a drug fund, are spent on staff salaries took a large proportion of the transfer, over which the *woreda* council has little fiscal latitude. The head of the sector expressed his concern as follows:

Majority of the council's health budget comes from regional grants. We have also exercised little fiscal autonomy in collecting a small portion of revenue from local resources like land taxes, and user charges within the regional purview. These are low yielding sources and contribute little to the total budget (WHO, IDI5).

Budget distribution dissatisfied all heads of facilities and these informants also mentioned that though the cabinet rhetorically declares health as a priority, they rarely translated into action. In theory, 15 percent of the total *woreda* budget goes to health, but in fact the sector receives a smaller share. Health officials gave their opinion on whether budget distribution complies with the sector's budget proposals submitted to the council as follows:

We fail to fill some vacant posts. We often use the salaries of staff who died, left their jobs and the like to fill our budget gaps (WHO, IDI6).

All facility heads noted that facilities autonomously collect and utilize service fees upon approval by service boards and upon the final deliberations by the councils, which have moderately increased facilities' fiscal autonomy and flexibility in service planning. But setting and improving local tax bases or user fees rates is still subject to the approval of regional councils. The council imposed such a decision-making process and regulations in an exercise of top-down authority, in contrast with bottom-up management. The regional government also legislated extensive rules and regulations to control the utilization of this revenue.

iii. *Procurements*

Several informants from the health centers noted that the *woreda* finance buys office and stationery

materials through the pull system, following requests from all sectors, including the health office. The informants had some concerns that the finance office obtains bids only from its procurement committee. There is no space for other sectors, communities, and civil societies to scrutinize the transparency of the bidding and procurement processes. It was very traditional, less inclusive modes of decision-making.

Some informants in a sector office also questioned the quality and types of materials supplied. They further noted that the purchases were not compatible with purchase requisitions and specifications. For example, the marketing of tires for vehicles is often fraudulent. Furthermore, according to these informants, health facilities can purchase drugs and some medical equipment independently of the *woreda* pull system. A service board member also noted that the Oromia Regional Government office sometimes interfered in the drug procurement autonomy of the *woreda*. For instance, in 2016, the regional office retained earmarked drug funds without the knowledge of Gida Ayana *Woreda* officials and failed to send commensurable amounts of drugs. Retaining some amount of drug funds at region constrained the fiscal authority and autonomy of the local government.

iv. *Service planning and programming*

All local health sector informants noted that the *woreda* is not vested with the power of targeting new programs; it can deliver only the services already developed by the region. Regional informants described that all the health programs implemented in the *woreda* are joint ventures of the national and sub-national governments. According to policy makers/planners at the federal level, health programs currently offered at the lower primary health level are centrally determined by the primary health care packages but are open to regional-level adaptation without requiring further consideration by the *woredas*. A local board member noted that no forum was even prepared at the local level to inform targeted communities, private sectors, civil societies, and others about the recently introduced programs.

Zones play a significant role in the preparation of the *woreda* health plans. All local informants mentioned that the *woreda* planning team prepares the first draft plan at the zonal level after orientation by higher officials on regional or national programming guidelines, key indicators, regional targets, and a brief training on how *woredas* prepare *woreda* health plans based on the template. A health official added:

Our plans start in the zone. Every year, local planning teams, including facility heads travel to the eastern Wollega to set a draft plan from which we develop our final woreda-based health sector plan (WHO, IDI4).

An informant from the *woreda* health office mentioned that:

Though we are interested in preparing a woreda health plan on our own, we still lack planning experience and computer skills. We had one planning expert with a diploma, but he left us for a better job. An absence of training is a serious problem. We also go to the zone to share and agree with zonal targets and to meet regional interests (*WHO, IDI2*).

d) Accountability

Under the following sub-themes, the study analyzed some of the local accountability dimensions of public health service delivery reported by participants: (i) consultation and community forum, (ii) information access level, (iii) service monitoring, and (iv) auditing and reporting.

i. *Consultation and community forum*

Consultation and community forums provide for stakeholder scrutiny of plan activities. Most male FGD participants across *kebeles* mentioned that service boards, health officers, and health facilities approve and submit work and budget plans with no stakeholder scrutiny or feedback on the drafts. A female FGD participant noted the following:

I have lived here for 35 years. No one comes to my kebele [Lalistu] for consultation on the plans. I don't know the officials except for a female worker who counseled me how to use maternal packages (*Female FGD1, Lalistu Kebele*).

About forums, male FGD participants noted that although there is a provision to bring together health officials, technical staff, boards, and residents to discuss service accountability, the woreda did not put this into effect. The informant added that failure to conduct a legislated community meeting and report sharing led to local actors neglecting their responsibilities.

A service board member from Ejere *Kebele* appreciated the accountability of health extension workers as follows:

What is tangible in my kebele is a pregnant-women meeting held every month by health extension workers and heads of women groups (*SB, IDI9*).

ii. *Information access level*

The availability of information regarding local health agendas and decisions is critical to ensuring accountability. Several FGD participants mentioned that the woreda had improved accessibility to health information with the deployment of extension workers and women groups. People living in poor, remote *kebeles* primarily access information through health extension workers and women groups. Many female participants indicated that health extension workers occasionally disseminate posters and provide health information to households. One male participant noted that informal sources of information are *woreda* administration council members; he reported,

We got more information on the health agenda or decisions from our neighborhood council members than from formal institutions like kebele and health officials (*Male FGD2, Ayana Kebele*).

All community participants appreciated the practice of the *woreda* council in announcing the *woreda* budget by posting it on billboards; this practice increased the accountability of the local government to ordinary residents. Others noted that institutions use various instruments to ensure their fiscal responsibility to clients:

Health facilities usually pin their budget and list of service charges on walls and notice boards to announce revenue, expenses, new drug names, and user charge-free programs (*Male FGD2, Ejere Kebele*).

Despite the above positive steps for increasing information availability, all informants noted that local channels such as radios and newspapers are lacking, and this constrains initiatives for creating awareness about health agendas among community members.

iii. *Service monitoring*

One way of ensuring accountability is by putting complaint-redressing mechanisms in place and ensuring that clients use them. Several male FGD participants, however, underscored that they lack capacity and are ignorant of their health rights, a situation that limits their ability to monitor services and forward their complaints. They added that clients fear retribution from providers for voicing complaints freely through opinion boxes or feedback booklets placed around each facility ward aimed at promoting downward accountability. Others described evasion by some facility managers of their downward answerability to clients as follows:

Many others including me usually put complaints in the opinion box on the medical ward, for instance, the absence of drugs prescribed for us by a doctor or other professionals, and frequently referral system to private drug retailers by the hospital pharmacist. But the manager never read our notes submitted to air our complaints (*Male FGD1, Ayana Kebele*).

All informants in the *woreda* mentioned the community score card that enabled citizens to assess health facilities and the survey report card that assessed user satisfaction in 2016; both were available at all facilities. However, these cards are no longer in use due to lack of adequate and skilled human power, financial resources, and training for local staff on how to administer, analyze, report, and design interventions to fill potential gaps.

iv. *Reporting and auditing*

One board member noted that:

Every quarter, the board, sector office, or regional bureau review plan performance. But the direct involvement of ordinary residents in plan and budget tracking is not yet thinkable to ensure downward accountability (SB, IDI11).

All facility informants described the transmission of activity and budget information from facility actors to the overseeing higher line offices to ensure upward accountability. They also described quarterly council hearings of reports at which the sector office and hospital manager answered to *woreda* and regional legislators, respectively.

A service board member reported that there is a local auditing system on the utilization of resources. For example, one of the results of an audit exercise in the *woreda* has been an investigation of drug funds embezzled by higher authorities in 2016.

e) Participation

The study examined the nature of public involvement in health service delivery by looking at the participatory institutional structure and the forms of participation.

i. *Institutional structure*

This analysis found two types of participatory institutional organization in the *woreda*: the service boards and the women team and network. Regarding the boards, health office informants reported that board structures have become popular in the management of health facilities. They added that the region usually appointed most of health facility committee members from *woreda sector offices* or zonal departments; this method of forming facility health governing bodies reduces their legitimacy as the best avenue for public participation. A health center informant raised concerns over the limited membership of community representatives:

The community has only one representative out of seven board members at the health center. Such under representation in the health committee is not an adequate voice for the people of the woreda (FH, IDI5).

Also, all facility heads were concerned that most board members are officials holding other public positions, which sometimes make them unavailable for board meetings. Thus, the practice of multiple appointments among health facility service board members and the centralization of their assignment at regional level negatively affected the autonomy and effectiveness of the boards. Some board members were uncertain about their role and relationship with the people to whom they are answerable and described that they did not know concerning the dynamics of the health agenda. All policy-makers noted that primary health facility board members have an independent decision-making advantage. The committee members passed most decisions at the health-unit level, cutting through bureaucratic rules that delay drug procurement, without necessarily involving the councils or the sector office.

All facility heads noted that women team of 30 members comprised five networks of six members each across the villages. These women structures are very inclusive that significantly increase women representation and roles in health promotion and mobilization. The health extension workers with women groups accomplished several health activities concerning regional policies.

Heads of health posts added that women institutions improved service availability to mothers regardless of location or socioeconomic privilege. A health center head noted that:

Their promotion is cost-effective; inclusive program, village-based structures bridge gaps during staff turnover and improve rural women's trust to use care (FH, IDI3).

ii. *Forms of participation*

Community participation took two forms: non-cash and cash mobilization of resources. *Woreda* health officers reported that the community has built and owned 21 health posts and many public toilets. The heads of Ejere and Lalistu health posts explained that residents of each *kebele* raised roughly 1,455 the $US to build houses for health extension workers in 2015. Another informant mentioned that in 2015, farmers customarily stored 99 quintals of grain and saved 2,103 the $US for pregnant women who came to a waiting home for childbirth. The community built two pregnant women temporary waiting home.

f) Effects of decentralization on woreda health service delivery

i. *Improved coverage*

Several local informants from a health office listed several improvements made in the coverage of facilities in the *woreda* since the implementation of the decentralization of health program in Gida Ayana. All facility heads added as follows:

Yes, these days all kebeles have a health post, each serving around 6,000 people, located within reach of the community, in fact in the middle of the kebele (FH, IDI7).

Informants from a service board recalled that there was only a single health center in Gida Ayana *Woreda* before the reform. However, within a few years of decentralization, the government expanded services by adding four health centers, 28 health posts, and a primary hospital. A service board member added:

We had only one nurse before the reform. Now, Ayana health center alone has five nurses (*SB, IDI9*).

ii. *Improved quality of local decisions*

All policy-makers noted that service boards at health-unit levels employed independent decisions over how public resources at health-unit levels improved local responsiveness through timely purchase of drugs. One health official explained:

The boards' decision declined local bureaucracies and delayed medical supplies. This improved the quality of service outcomes like safe births, transparency of the utilization of scarce resources (WHO, IDI4).

iii. *Improved quality of health professionals*

All policy-makers noted that in the last centralized regime, the lack of adequate deployment and quality professionals in local facilities had resulted in countless complaints, especially regarding maintaining the quality of maternal care and care for under-fives. However, it has been only in the last 15 years that the government made some efforts to find a solution to this problem. Negative attitude of some staff continues to affect the quality of health outcomes as before. A woman commented:

I know, female nurses at health centers are capable enough to handle any maternal complications. But a misbehaved nurse at a delivery ward neglected me when I gave birth to (or Bona), my last child (Female FGD2, Angar Kebele).

iv. *Quality and availability of medical supplies*

A *woreda* office head noted that the local government relatively better equipped the health centers with medical supplies since 2002 due to the empowerment of the health facilities to purchase drugs to improve health outcomes. On the other hand, female FGD members stated that lack of enough beds and poor and degraded delivery rooms built of wood and mud in the Angar health center compromised the quality of childbirth service. The results agree with the information received from interviews with facility heads and group discussions with male community FGDs. Also, a woman with a 6-months-old child summarized the problem as follows:

Old and unclean beds in the child delivery room in Angar were risks for both women and the newborns. I used unsafe bed when I gave birth to this child (or Sabanbon) (*Female FGD2, Lalistu Kebele*).

Several community participants from Ejere and Lalistu also had low trust and some dissatisfactions in the health centers because drugs were not consistently available; they ordered medicine from private pharmacies due to their inability to secure them from the health facilities. A service board member added that the embezzlement of drug funds by higher authorities also affected local health outcomes in the study *woreda*.

V. Discussion

This qualitative study explored the implementation of healthcare reform in the decentralized system of Gida Ayana *Woreda*. Results show that the health reform of 2002, although improving the overall delivery of services, has not yet adequately changed the health sector about authority, autonomy, accountability, participation, and service quality. Although the first four service governance functions are intermediate outputs of the decentralization program of the health sector, they

remain critical to the quality of health service delivery throughout all stages of the planning and implementation of the program (Brinkerhoff, 2004). About authority, the sector office has been given considerable responsibility for planning and implementing health services, administering facilities, providing and improving health services and information, controlling resources, procuring materials, and engaging the community. The delivery of services, however, depends on the extent of autonomy the *woreda* enjoys in several areas of engagement that affect service delivery.

Our study showed that Gida Ayana *Woreda* is autonomous in planning and budgeting for staff needs. We also found significant areas of autonomy over personnel management whereby the *woreda* can formalize new employment, discipline, fire, transfer internally, appoint, manage, and pay staff under the regional policy. These findings corroborate a study that concluded that decentralization improved local personnel management (Wang et al., 2002). However, administrative authority over recruitment and transfer of technical staff continues to be undertaken by higher authorities, a practice that might open ways for nepotism and clientelism. Budget constraints in recruiting new staff also remain most important challenges and affect the implementation of programs and the quality of local health outcomes. A study carried out elsewhere in Ethiopia reported similar results (Kassa & Shawel, 2013). Our study also found that the *woreda* failed to institute incentive schemes and to address poor working conditions for health staff, a basic cause of high turnover, especially in the remote rural areas of Ejere and Lalistu. A similar study linked the lack of local incentives schemes, low salaries, and poor quality of rural infrastructures to high staff turnover (Francoa et al., 2002).

Our analysis indicates that Gida Ayana *Woreda* has no adequate financial capacity and is heavily dependent on fiscal transfer from the regional office. Informants from the *woreda* health office estimated that sub-national government transfers constituted over 85 percent of the *woreda* budget and that the local taxes covered the remaining proportion of the total expenditure under the purview of the region. Other officials added that setting or increasing the local tax base and user fees is still subject to the approval of the Oromia regional government state council. An elaborated rules legislated by the Oromia state government also controlled the utilization of facility revenue in the study *woreda*. Several studies noted that inadequate funding of local authorities caused poor policy implementation and poor health outcomes (Jeppsson & Okuonzi, 2000; Kojo et al., 2011; Frumence et al., 2013).

Our study revealed that local bidding and procurement processes lack accountability and transparency. This problem persists because the *woreda* finance office conducted bidding and procurements alone, without any representation from or consultation with the concerned sectors, community representatives, and other actors. The lack of accountability and transparency in the woreda caused mismatches between the procurement plan requested and the type and quality of the actual purchase.

Gida Ayana *Woreda* has gained autonomy over the building of health posts, public toilets, maternal waiting homes, and housing for rural workers through community participation. A study in Indonesia noted that the mobilization of community resources and project monitoring by local community improved health outcomes (Purwaningrum et al., 2010).

Our study further revealed that the *woreda* is not yet autonomous over service programming because higher officials developed new programs. The targeted communities are not involved in the needs assessment process that would enable them to gear community-level program initiatives to the needs of the local people. A study carried out in India found that a low level of knowledge and awareness of the community users about preventive and curative health service packages programming adversely affected health outcomes (Panda & Thakur, 2016). Other study added that limited consultation and lack of users' involvement in the health program development influenced service utilization and outcomes (Abayneh et al., 2017). Our study found that prioritizing activities from the bottom up hardly exists in the study area. Plans are heavily scrutinized to satisfy regional indicators conveyed through the zoning department in the form of an indicative plan. The various performance indicators of the *woreda* and the region are identical.

Our study found that key actors could not have the capacity to perform their planning and budgeting roles at the *woreda* level. Specifically, inadequate technical competence and inconsistent training hindered effective planning and implementation. *Woredas* in different parts of Ethiopia often reported these technical deficiencies in setting health programs (Christian Relief and Development Association [CRDA], 2004; Wamai, 2009). Another study identified lack of capacity of key actors to carry out their planning and budgeting activities at the lower level and consequent impacts on the quality of care and services (Tsofa et al., 2017).

Our study confirms that low community involvement in planning and lack of understanding among providers about the population they serve leads to poor outcomes. These results corroborate those of other studies (Nannyonjo & Okoto, 2013; Kilewo & Frumence, 2015; Abayneh et al., 2017; Regmi et al., 2017). Other studies show that the process of deepening decentralization to *woreda* levels has undermined popular participation by civil society

organizations and communities (CRDA, 2004; Wamai, 2009; Kassa & Shawel, 2013).

Furthermore, our analysis shows that general forums and sharing of reports with ordinary citizens are still uncommon. Although primary care units are the first points of contact for patients and are viewed as mechanisms for ensuring social accountability (Collins et al., 2002), this is not the case in Gida Ayana *Woreda,* which still implements social accountability service monitoring tools at the regional level. A similar study noted that the absence of established institutional mechanisms for citizens to assess the accountability of local facilities caused information gaps (Kassa & Shawel, 2013). A study in highly constrained public institutions found cost and inadequate local skill to be critical impediments in utilizing such tools (Yilmaz & Venugopal, 2008). Similarly, although opinion boxes, reports, and auditing records are becoming increasingly used monitoring tools, users' illiteracy; fear of retribution; lack of knowledge on why, how, and where to present complaints; and the failure of facilities to respond to complaints highly limit the usefulness of monitoring tools. Such kinds of problems of presenting complaints among service users are consistent with the findings of Masanyiwa et al. (2013).

Our study showed that decentralization energized community participation through representatives in service boards and women's structures in the forms of both cash and in-kind contributions. There were, however, some limits on participation. For instance, although the revised health policy specified the need for a stronger decision space for *woreda* governments, Oromia Region has retained control over board appointments, thus significantly limiting the *woreda's* service management capability. Double-job positions and inadequate training further hindered boards from effective service management. Women's structures are slowly beginning to assist health extension workers by involving communities in health promotion. A study in Indonesia found women groups to be the main hubs for communicating health programs to the local people (Purwaningrum et al., 2010). But the potential role of women committees in Gidda Ayana remains highly unknown because of lack of training, illiteracy, and inadequate support from health officials.

The study also indicates that decentralization improved health service coverage and the quality of health professionals and health services. This finding is consistent with Wamai (2009), who noted that healthcare reform expands primary health coverage universally and increases skilled health human power which in turn increased both the quantity and quality of health services delivered (Semali et al., 2005). Several studies have reported that maternal, infant, and under-five mortality rates decrease with increasing numbers of skilled personnel (World Bank, 2004; CSA, 2017). Our study also found that local facility service boards enhance the quality of local decision-making processes, specifically in the area of drug supply. The enhancement of the quality decision making among health service board in this study agrees with a work by Yang et al. (2017). Our analysis also shows that disrepair of maternal delivery rooms, ill-equipped facilities or poor quality of beds in delivery wards, patient dissatisfaction with care received during child delivery, and providers' behavior were constraints in improving the quality of child delivery services. Similar studies in Ethiopia and elsewhere have reported that the quality of service outcomes suffers from poor infrastructure and lack of medical supplies and essential drugs, as indicated by patient dissatisfaction with the available care (Brinkerhoff, 2004; CRDA, 2004; Kassa & Shawel, 2013; Panda & Thakur, 2016; Molina, 2017).

VI. Strengths and Limitations

This study has some weaknesses. First, we confined the study to Gida Ayana *Woreda* in Ethiopia. Thus the results of the study may not represent the actual trends in the implementation and effect of decentralized public health reform across Ethiopia. Second, this qualitative study does not provide quantitative results. Despite these limitations, the study gives insights into the process of decentralizing health services in the country by identifying the challenges, opportunities, and achievements of the decentralization reform in a particular *woreda.*

VII. Conclusion and Policy Implications

Even though the decentralized public health delivery system promotes community participation in service programming and planning processes, this study found that health sector programming or planning and budgeting traditions were not prioritized based on community needs in Gida Ayana *Woreda*. Though the country had designed this reform in earnest, service programming failed to involve key actors in the design and implementation of the local health agendas. Thus, we propose that healthcare reforms include local communities and non-governmental actors towards bottom-up designing, targeting, and preparing health plans and programs (Semali et al., 2005; Abayneh et al., 2017; Tsofa et al., 2017).

The study found unnecessary and counterproductive interventions of higher officials and clientelism in different areas of local personnel management, such as staff transfer, recruitment, and appointment; these interventions had the negative impact on healthcare reform implementations and quality of care. Therefore, avoiding such interventions, improving fiscal autonomy, reducing the *woreda*'s resource dependency, and increasing *woreda* decision power through the recruitment of adequate and

competent staff with better salaries and incentives for staff retention should be priority areas (Hutchinson, 1999; Semali et al., 2005; Sakyi, 2008).

Moreover, our study shows that the quality of care suffers from poor infrastructure and supplies. Hence, improving infrastructure and ensuring adequate pharmaceutical supplies and beds in delivery wards should be prioritized (CRDA, 2004; Wamai, 2009). Also, use of the balanced scorecard and citizen report card system, advocated for close monitoring of health system strengthening interventions (Panda & Thakur, 2016), should be considered. Employing such service monitoring practices and more inclusive modes of decision-making, together with holding community forums, increasing the community's access to health information, improving literacy and awareness levels, and appointing service boards, may help to enhance the community's trust about health services. Increasing the *woreda* government's transparency and accountability can improve the quality of healthcare. Several studies have reported that access to health information increased maternal and child health service utilization and improved infant, under-five, and maternal mortality rates (Jiménez & Smith, 2005; CSA, 2017).

We recommend that potential researchers would include *woredas* in future studies of the decentralized healthcare reform in Ethiopia. Including *woredas* will allow researchers to examine wide variation in the decentralized healthcare reform implementation and identify its local impacts among the regions and also within regions.

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Availability of Data and Materials

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