

A CRITICAL ASSESMENT OF DECENTRALIZATION AS A
TOOL FOR DEVELOPMENT: A CASE STUDY OF CHEHA
DISTRICT, ETHIOPIA

BY

MENTESNOT ELIAS TEJEJI



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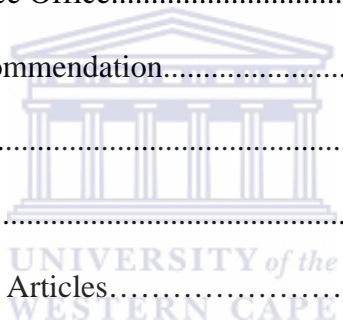
Supervisor
Professor Christo De Coning

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Declaration

I declare that A Critical Assessment of Decentralization as a Tool for Development: A Case Study of Cheha District is my own unaided work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references as indicated in the text. Furthermore, I declare that this mini-thesis has not been submitted at any university, college or institution of higher learning for any degree or academic qualification.



Mentesnot Elias Tejeji

17 October 2008

Dedication

This mini-thesis is dedicated to my unforgettable father Elias Tejeji who passed away in 2006 and my beloved brother Dr. Yitbarek Elias who passed away in 1998. They have a very special place in my heart for their unstinting support in making my dreams come true.

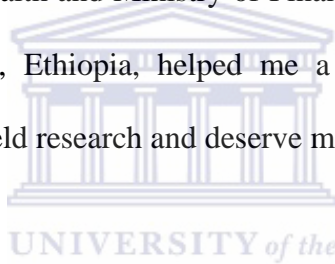


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There are many people who directly or indirectly contributed to my research, be it in South Africa, Ethiopia and Germany, and I am very grateful to them.

Keywords

Decentralization

Devolution

Transparency

Reporting

Community participation

Community capacity

Responsibility

Good governance

Accountability

Institutions



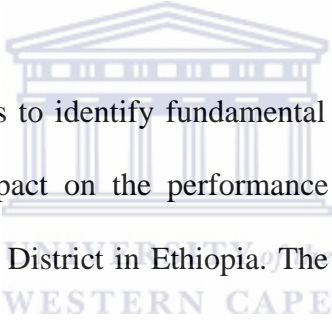
Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
Art	Article
BOD	Burden of Disease
CSA	Central Statistical Authority
FDRE	Federal Democratic Republic of Ethiopia
FMOF	Federal Ministry of Health
HCs	Health Centers
HDI	Human Development Index
HIV	Human Immune virus
HPs	Health Posts
HSDP	Health Sector Development Program
KAAD	Katholischer Akademischer Ausländer-Dienst
KM	Kilometer
MOH	Ministry of Health
NGOs	Non-governmental Organizations
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities and Peoples' Regional State
UNDP	United Nations Development Program
W.H.O	World Health Organization
WHO	Woreda Health Office



Abstract

Ethiopia is exercising decentralisation of the health system and thus this study assesses lessons learned about the experiences of the decentralization of institutions in theoretical terms. The problem investigated in this study concerns the lack of institutional capacity to effectively provide services, lack of transparency, responsibility and accountability. Decision making is also very remote from the people with regard to resource allocation and public health service delivery. The scope of this study covers the Southern Nations, Nationalities and People's Regional State of Ethiopia and its relationship with the Cheha District in the area of health service decentralization.



The objective of this study was to identify fundamental elements of decentralization of health institutions and the impact on the performance of the health system at local government level in the Cheha District in Ethiopia. The specific objective of this study was to find out how the provision and delivery of health services are related to decentralization policies, analyze and discuss the federal, national and local policies for health service decentralization and their significance for health service delivery. An additional aspect of this study is to provide some insights into intergovernmental relations as far as health service decentralization is concerned and, to this effect, this study applied the principal agent approach.

In this study health service decentralization policies in Ethiopia at national and local levels were analyzed to gather information relating to the service delivery process. Most of the data for the study was collected during field research conducted between August

and November 2005. During the field research, interviews were conducted with experts, community members and government officials both at the local and national level. The field research also focused on collecting data which is relevant to explain the relationship of the principal, in this case the Federal Ministry of Health (FMOH) and the SNNPRS Health Bureau at the regional government level and its agent, the Cheha District Health Office.

The field research also identified the different mechanisms, tools, and institutional arrangements (annual reports, meetings, and supervision) that exist in SNNPRS and the Cheha District to achieve the broader objective of the health system.



Chapter 1: Introduction and Background

The Mini-thesis focuses on the experience of the institution of decentralization by the Federal Government of Ethiopia particularly with regard to the health system, taking the *Cheha*¹ District, which is located in the Southern Nations, Nationalities and Peoples' Regional State (SNNPRS)² as a case study.

The Federal Democratic Republic of Ethiopia has practiced the decentralization policy since 1991. It must be remembered that Ethiopia is a country with a very centralized state history. During the Imperial regime, the feudal monarchy controlled all political and administrative institutions and during the military regime (the “Derg”³ regime), all power belonged to the central government. The institutions of that time also centralized and controlled provision of services under the name of socialism⁴.

However, since 1991, the order of centralized government began to be challenged by the new regime that is the Ethiopian People's Revolutionary Democratic Front (EPRDF). The centralized government failed and hence the country started new practices and ideas. As a result, political, fiscal and administrative decentralization were introduced and the unitary state of Ethiopia became federal. New boundaries were drawn and decentralization through devolution was the strategy adopted. The existing constitution is the legal basis for practicing decentralization in Ethiopia.

¹ *Cheha is a District with a population of around 200,000 people, located in the southern part of Ethiopia. The District is where the author of the thesis was born and grew up, thus being able to experience and observe the environment.*

² *Southern Nations, Nationalities and Peoples' Regional State (SNNPRS) is one of the 9 regional states of Ethiopia with more than 100 districts, 45 ethnic groups and a population of 11 million.*

³ *“Derg” is the name of the military government of Ethiopia in the local language.*

⁴ *Levi, 2002, pp.10-35.*

Accordingly, nine regional states, entrusted with broad powers including a right to secession⁵ if some conditions are fulfilled, were established. The Southern Nations, Nationalities and Peoples' Regional State (SNNPRS) is one of these regional states with a population of 11.3 million and, administratively, it is divided into 12 zones (Sub-Regions) and 104 Districts. Cheha is one of the Districts located at the southern part of the SNNPRS with a total of 175,000 inhabitants.

Following the political decentralization, the government of Ethiopia also decentralized sector offices and hence the health system is also decentralized in Ethiopia. The Ministry of Health (MOH), at least in principle, transferred power and responsibilities to Regional Governments, and Regional Governments claim that they devolved the responsibility and resources to the District Administrations.

1.1 Research problem and key research question

The main goal of decentralization is to strengthen existing local government units to achieve effective functioning of the fiscal, political and administrative assignments allotted to them. Decentralization has been considered as being a way of enhancing the economic development of a country, along with good governance, democratization and increasing citizen participation. The failure of a centralized system to meet national goals is the main reason for many countries looking seriously beyond top-down developmental and fiscal management strategies than they have in the past⁶.

⁵ Article 39 of the 1994 Ethiopian Constitution.

⁶ Paul Smoke 2004.p.1.

Decentralization is discussed as the transfer of authority and responsibility for public function from the central government to subordinate or quasi-independent government organizations or the private sector⁷. Therefore, decentralization is also considered a key means of improving health sector performance as it involves different mechanisms to transfer fiscal and administrative ownership and/or political authority from the central Ministry of Health (MOH) to alternate institutions⁸.

It must be noted that, during the last two decades, health sector decentralization policies have been implemented on a broad scale in many developing countries mainly as part of a broader process of political, economic and technical reforms⁹.

Though the health system in Ethiopia is said to be decentralized, there are many problems related to the process of exercising the principles of decentralization. The government claims that they have exercised a devolution type of decentralization and hence, in principle, District Governments are endowed with all powers for decision-making.

However, one can easily discover that there are many problems at the District level concerning health service delivery by the Cheha District Health Office. As it is impossible to deal with all the problems facing the Cheha District Health service delivery system, the Mini-Thesis analyzes the following specific problems. The intergovernmental relationship, that is to say, the relation of the FMOH, SNNPRS Health Bureau and the Cheha District Health Office is not as strong as it should be. The intergovernmental transfer used by the SNNPRS to assign the District grant is also vague. The other major

⁷ Litvack and Seddon, June 20 <http://www.gtz.de/en/index.htm> internet-team@gtz.de.

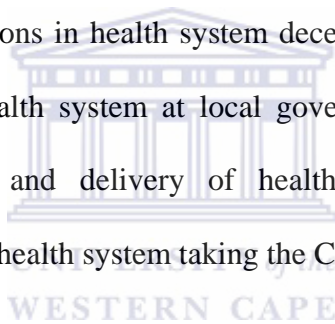
⁸ World Bank, 1993.p.26.

⁹ Thomas J Bossert and Joel C Beauvais, 2002.p.16

problem of the Cheha District Health Office is the lack of appropriate resources (budget, health professionals and equipment) in place to provide efficient health service delivery. Most of the people in Cheha District do not have access to primary health services and this is mainly because of a limited number of health facilities and professionals in the District. The majority of the people of Cheha District also do not have the ability to pay for the health services. There is very limited or no access to free medical services which negatively affects vulnerable groups.

1.2 Purpose and Objectives

The main purpose and research objective of this Mini-Thesis is therefore to identify fundamental elements/ institutions in health system decentralization and the implication on the performance of the health system at local government level. The Mini-Thesis assesses how the provision and delivery of health services are related to the decentralization policies in the health system taking the Cheha District as a case study.



1.3 Significance of the study

There has been limited research done concerning the decentralization policy in Ethiopia, particularly in relation to service delivery, which has not been discussed in detail in the past. This Mini-Thesis will therefore provide some insight for different policy makers in Ethiopia and it can also be used as a source for the Cheha District Health Office, which doesn't have any well-documented resources as far as health service delivery is concerned.

1.4 Scope of the study

The Mini-Thesis assesses health service decentralization in Ethiopia by taking into account only one regional government, the SNNPRS, and its relationship with the Cheha District in terms of health service decentralization.

1.5 Setting of the Methodology

Most of the data for the study has been collected during field research conducted between August and November 2005. The relation of the Ethiopian Ministry of Health (MOH) with the Southern Nations, Nationalities and Peoples' Regional State (SNNPRS) Health Bureau is a suitable case to study as concerns the decentralization of the health system in Ethiopia as the SNNPRS is among the biggest regional state of the country comprising more than 45 nationalities. There are more than 120 Districts in the SNNPRS. However, taking into account the limitation both in terms of time and other resources, it is impossible to study more than one District in detail during the field research and, hence, the research concentrated on one District, that is, the Cheha District and this will enable a relatively good analysis¹⁰.

The justification in choosing the Cheha District as the case study is based on my knowledge of Ethiopia in general and that of the SNNPRS and the Cheha District in particular. I have chosen the Cheha District as my case study to assess the decentralization of health services in Ethiopia and its implication in health service delivery as this District is considered to be relatively effective with regard to health service provision. The researcher of this Mini- Thesis was born and raised in this District and therefore has a linguistic advantage in conducting the study there. The other

¹⁰ *Cheha* is considered as a relatively better district with regard to the health sector.

justification in choosing this area is that the District is considered to be a relatively successful District in the SNNPRS not only with regard to health service delivery but also in having better local government administration¹¹ and hence assessing the situation is more pertinent and interesting.

As with any Mini-Thesis there are limitations in this research too and such limitations include the fact that choosing a single District might not be as representative as one would wish since the researcher was not able to conduct comparative checks whether the decentralization of health services has the same or comparable relationship and implications for service delivery in other districts too. This is because all the Districts in the SNNPRS have different backgrounds and realities and hence the findings of the Cheha District will not necessarily reflect the realities of other Districts although there are a lot of common findings. The other limitation of this research is that the researcher could not analyze the impact of health system Decentralization on the beneficiaries as this was not manageable given the limited time and resources allocated for the research.

When we come to the data needed for the analysis of health service decentralization in Ethiopia, we should bear in mind that the overall aim of health sector reform in the country was to improve health service delivery and distribute it equitably. The research therefore concentrates on collecting data which is relevant to explain the relationship of the principal, in this case the Federal Ministry of Health (FMOH?) and the SNNPRS

¹¹ *The SNNPRS health office report on annual activities for the year 2005 indicates that the Cheha district is among the more relatively effective districts in the region with regard to health and governance issues.*

Health Bureaus at the Regional Government level and the agent, that is, the Cheha District Health Office.

In assessing the principal-agent relationship, the way decisions are taking place with regard to health systems at the federal, regional and district level have been studied and hence data has been collected to identify who decides on what. The research has also identified how health financing is collected and distributed, and to what extent the District exercises independent decisions with regard to health spending and planning. The formal laws and regulations which guide and bind the principal-agent relationship, including enforcing mechanisms, have been also studied during the field research. The research also identified the different mechanisms, tools and institutional arrangements (annual reports, meetings and supervision) that exist in the SNNPRS and the Cheha District to achieve the broader objective of the health system. Identifying the different mechanisms through which the Federal Ministry of Health and the SNNPRS Health Bureaus (principals) encourage the Health Bureaus at the District level (local agent) to achieve the objectives of the health system is also part of this research.

There are various performance indicators in health sector reform reflecting the objective of access, equity, quality, effectiveness and efficiency. Studying health system performance is not the objective of this research. However, the research focused on analyzing the implication such a health service decentralization policy had on the access and equity objective of the health system and has been taken in account. Therefore the implication of health system decentralization for health service delivery by the Cheha

District health office at the local level has been assessed. Access here is defined as the presence or absence of physical or economic barriers that people might face in using health services¹². The indicators for access include distance and time to the nearest health facility, transport for emergency medical cases, staff: population ratio, clinic hours and economic access.

Equity in the health sector is defined as minimizing avoidable disparities in health services and its determinants between groups of people who have different levels of social advantage such as income/expenditure, occupation, wealth and education. Indicators for equity include availability of financing to pay, household burden of payment for health care and access to free services provided by voluntary organizations¹³. However, due to limitations both in finance and time, the researcher could not collect more data with regard to the equity and access objective of the health system and rather concentrated on the role of intergovernmental relations in health system decentralization. As far as the method of data collection is concerned, interviews and discussions in smaller group were carried out at different levels. Staff of the Ministry of Health and staff of the Ministry of Finance and Economic Development were part of the interviews and the discussions. Both of these ministerial offices are located in the capital city of the country, Addis Ababa. Interviews and group discussions were carried out also at the regional government level and the Regional Government Health Bureaus and the Regional Government Finance and Economic Development Bureaus participated. The spokesperson of the SNNPRS council was also interviewed. Awassa is the seat for the SNNPRS government and hence all the officers interviewed at the regional level are in

¹² World Health Organization (WHO) 2000, p.250.

¹³ WHO 2000, p.250.

Awassa. The interviews and group discussions were also carried out with important actors at the District level. Among such actors are the Cheha District Health Office and the District Finance Office located at the District Government seat called Emdibir. An interview was also conducted with representative of the Catholic Church health project which is a very important non-governmental organization in terms of health service delivery in the Cheha District. In addition to the interviews and group discussions, the researcher has studied secondary sources such as publications and documents, annual reports of government offices and policy documents relevant to the subject mater.

1.6 Organization of the study

The Mini-Thesis has the following six chapters. Following the introduction is chapter two which focuses on the theoretical overview of the field of decentralization, the different theoretical approaches, and concepts in the area of decentralization. The chapter therefore discusses the definition of decentralization, its goals and the different approaches to it. It also briefly explains the relationship between decentralization and service delivery and it discusses how the principal agent approach is used to explain the process of decentralization by taking a “decision space” approach. The concept of intergovernmental transfers, its use and character is also discussed in this chapter. The hypothesis, which is going to be tested empirically, is also discussed in this chapter followed by the last part that is the methodology.

Chapter three deals with decentralization and health service delivery in Ethiopia in general and that of the SNNPRS and the Cheha District in particular and hence the first part gives brief information about Ethiopia, the SNNPRS and the Cheha District. The chapter also presents the decentralization exercised in Ethiopia and the country’s health

policy and governance. The last part of this chapter deals with the health profile of the country at a national level and that of the SNNPRS at regional level.

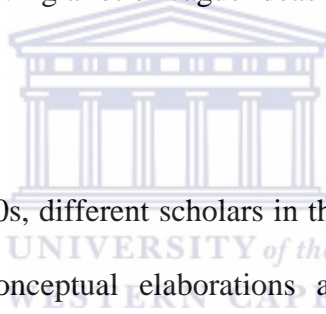
In chapter four, the first part of the empirical findings is presented and it deals with principles governing fiscal decentralization in Ethiopia. This is followed by the second part which is intergovernmental transfers in Ethiopia in general and that of the SNNPRS in particular. This chapter also discusses the allocation of expenditure between different administrative levels and the last part of the chapter deals with the allocation of Woreda financial resources.

Chapter five is a continuation of chapter four and hence discusses the findings of the empirical evidence and concentrates on assessing the important actors influencing the provision of health services by the Cheha District Health Office at different levels of government and the first part presents the circumstances around the Ethiopian Federal Ministry of Health, i.e. the way health service decentralization took place and the role of the ministry in the country's health policy. This is followed by the second part on the Federal Ministry of Finance. Here the way the federal government assigns grants to different regional governments is discussed. The third and the fourth parts of this chapter are about the SNNPRS Health Bureaus and the region's Finance Office followed by the Cheha District Health Office. The last part of the Thesis discusses the Cheha District Finance Office and the way budget is assigned for District sector offices including health. Chapter six is the last chapter of the Thesis and it deals with the conclusion made based on the research and this is followed by some recommendations.

Chapter 2: Theoretical Framework.

2.1 What is Decentralization?

The literature concerning decentralization since the 1950s has been full of different contradictory concepts. Sharing this same view, Dianna Conyers as quoted in Cohen /Peterson¹⁴ argued that there has been a lack of consensus among international development professionals, academics and senior government decision-makers on the definition of the concept of decentralization and, due to this, it was very difficult to carry out meaningful, comparative and empirical studies on decentralization. Decentralization is also described as a complex and often illusive phenomenon, a topic that receives much international attention but involving a lot of vague ideas so that there is still much that is not known about it¹⁵.



However, during the early 1980s, different scholars in the field of development came up with a number of crucial conceptual elaborations and definitions with regard to decentralization¹⁶. Though decentralization is said to be an illusive phenomenon, currently however there is a growing consensus with regard to the conceptual definitions of decentralization.

Decentralization can be defined in many ways but, for the sake of this thesis, the definition of decentralization in its broader sense is selected as it is more useful to analyze the decentralization policy introduced in Ethiopia which is targeted to devolve all powers and resources to the District Governments. The growing role of NGOs and the

¹⁴ Cohen/ Peterson 1999. p.28.

¹⁵ Smoke 2003. p.7.

¹⁶ G.Shabbir Cheema, John R .Nellis Dennis. A Rondinelli are crucial scholars in the field of decentralization in 1980s

private sector demanded the transfer of authority and power of government to the private sector and NGOs and hence the definition of decentralization adopted in this thesis takes into account this fact.

Decentralization therefore here is defined as “the transfer or delegation of legal and political authority and resources to plan, make decisions and manage public functions from central government and its agencies to field organizations and those agencies, subordinate units of government, semi-autonomous local governments or public corporations, area-wide or regional development authorities or functional authorities, autonomous local governments or non-governmental organizations”¹⁷.

The above definition can be simplified as the transfer of power to local-level authorities and state enterprises. It incorporates all three forms of decentralization, including de-concentration as a means of transferring administrative functions to subordinate sub-national units; delegation as a means of transferring complex tasks and responsibilities to semi-independent authorities; and devolution as a transfer of power to sub-national political entities which are, via local/regional parliament or council, answerable to their electorates. The definition above does not go so far as to include privatization and other forms of economic decentralization, which follow a different logic compared to the redistribution of tasks and responsibilities within the governmental system. Accordingly, decentralization may incorporate one or all of the three dimensions of administrative, financial and political decentralization.

¹⁷ *Cheema/Randinelli 1983, p.18.*

However, recent international discussion on decentralization in the context of public sector reform has sparked lively discussion on the (new) role of the private sector. In this recent discussion, decentralization is defined in this context as "the transfer of authority and responsibility for public functions from the central government to subordinate or quasi-independent government organizations or the private sector"¹⁸. In this definition, economic decentralization is directly included. We have seen above the definition of decentralization and, in the next part, we will see the different approaches to classifying decentralization, which will help us to analyze the type of decentralization in Ethiopia.

2.2 Types/Approaches of Decentralization

Cheema, Nellis and Rondinelli's approach to decentralization is based on the analytical classification of decentralization and hence it is called a type-function framework¹⁹.

According to the type-function approach, decentralization should be classified according to its objectives and hence the different forms are political, spatial, market and administrative.

A political form of decentralization which is used by political scientists is interested in democratization and civil societies. Identifying the transfer of decision-making power to the grass root level of governmental unit, citizen or their representative is the central point in political decentralization. Spatial decentralization is a term used by regional planners and geographers who are involved in the formulation of different policies and programs with regard to reduction of excessive urban concentration in some cities. Therefore promoting regional growth that has the potential to become a center for agricultural and manufacturing marketing is the central objective. Market forms of

¹⁸ Litvack and Seddon June 20 <http://www.gtz.de/en/index.htm>internet-team@gtz.de

¹⁹ This part of the discussion is from John M. Cohen and Stephen B. Peterson 1999,pp.25-30.

decentralization which become more prevalent due to the recent trend towards liberalization and privatization are mainly used by economists to analyze and promote actions that facilitate creation of a situation by which goods and services are created and distributed by market mechanisms. The last but not the least is the administrative form of decentralization which is the interest of mainly lawyers and public administrative professionals. The central point here is the reform of hierarchy and functional distribution of powers and function between the central and local governmental units. Administrative decentralization has three sub-types and the first one is de-concentration which can be defined as the transfer of authority over specified decision-making but only within the jurisdictional authority of the central state. Devolution is the transfer of authority from the central government to the local level governments which are endowed with corporate status which is granted under state legislation. Federal states in general are devolved by definition while devolution is very much un-common in the case of unitary states. The last form of administrative decentralization is delegation which means the transfer of government decision-making and administrative authority for specific tasks to institutions and authorities which are independent or under the control of the central government²⁰.

Though the type–function approach is accepted by many scholars, it is not free from some criticism. Disciplinary and linguistic preferences are the basic problem that this framework faced. There are literatures to address this problem and hence a new framework which gave emphasis to economic growth, financial incapacity of the state, spatial concentration of development and bureaucratic reforms was being developed,

²⁰ *John M. Cohen and Stephen B. Peterson 1996. p.29.*

based on concepts and words which are neutral with regard to discipline and language group.

2.3 Goals of Decentralization and Its Relation to Service Delivery

It is argued that decentralization has many goals and some of these are complex. It is important to review the goals of a decentralization policy as it will enable the analyzing of the goals of the health service decentralization which took place in Ethiopia in general and in the SNNPRS in particular.

There are many potential and often conflicting goals of decentralization while improvement in efficiency, governance and /or equity in the public service delivery process and outcomes are the major ones²¹. These goals of decentralization can be referred to as direct goals. According to a World Bank report, decentralization holds great promise for improving delivery of public services but outcomes depend on its design and on the institutional arrangements governing its implementation²².

There are goals of decentralization which can be referred as indirect since they are not the direct goal or aim of decentralization. Such indirect goals include different hidden agendas of local and central governments.

2.3.1 Direct goals of decentralization

The direct goal of decentralization in general includes a more efficient delivery of services, innovation through experimentation and adaptation of local conditions. Greater equity through distribution of resources, improved quality, transparency, accountability,

²¹ *United Nations Department of Social and Economic Affairs 2004.p.2.*

²² *World Bank 2001.p.1.*

and legitimacy due to user oversight and participation in decision-making are said to be also the direct goals of a decentralized policy²³.

2.3.1.1 Efficiency

According to the proponents of decentralization, improved efficiency is one of the potential advantages of decentralization. This is because people are different within a country and they have different needs of public services and sub-national governments are said to be near to the people, have better access to local information and understand the local context well. If this is the case then they can better identify the type and level of services that their constituents need than those at higher level and hence finally will improve efficiency.

However there are certain services which local people want that may best be provided at greater scale by a higher level government for macroeconomic stability and some may affect other jurisdictions and hence should not be left to the control of one single local government²⁴. Economists also justify decentralization based on a locative efficiency. The main argument here is that decisions concerning public expenditure that are taken by the grass- root level government, which is more responsible to the local constituency, and is more likely to reflect the demand for local service than similar decisions taken by a remote central government. Here, it is further said, people are more willing to pay for services which are their priorities and particularly for those services which are the outcomes of people's participation in decision making processes with regard to service delivery²⁵.

²³ Thomas J Bossert and Joel C Beauvais 2002, p.16.

²⁴ World Bank, June, 2005, www.ciesin.org/decentralization/English/General/Rational.html

²⁵ World Bank Thematic Team, June 2005.

2.3.1.2 Good Governance

Improved governance is also one of the potential advantages of decentralization and this is due to the belief of people that their interaction with elected local governments will lead to decisions which are most consistent with their wishes than those made by those at higher levels. This is because people will feel that they are better connected to local governments if the people are able to influence public affairs in at least some modest ways that directly affect them, empowering people and giving them a sense of control and autonomy. However, there are exceptions to this point since governance and collective actions are not purely local; people do not necessarily have to have everything they want when key national goals must take precedence over local needs.

2.3.1.3 Equity

Improved equity is the other goal of decentralization and if local governments are familiar with local circumstances, this might help them to be in a position to distribute public resources equitably and target poverty within their own jurisdictions. Internal resources might be a constraint here but the redistribution from richer areas to poorer areas must be the responsibility of the central government.²⁶ Some jurisdictions are better endowed with resources than others, perhaps because of size or location. In addition, historical circumstances (e.g., apartheid) may have created regional or local differences. Thus, an intergovernmental fiscal program through decentralization may be designed to shift resources to disadvantaged areas to ensure that all citizens enjoy a minimum level of service, regardless of location, or receive enhanced assistance to accelerate amelioration of deficits, because of location²⁷.

2.3.2. Indirect Goals of Decentralization

The indirect goals of decentralization are mainly associated with what Smoke calls the more “ambitious”²⁸ medium and long-term goals of stronger economic development and poverty reduction. This indirect goal of decentralization also includes the hidden political

²⁶ United Nations department of social and economic affairs 2004, p.2.

²⁷ World Bank thematic team June 2005.

²⁸ World Bank 2001, p.1.

interest of a given government. Sharing the same view, one report from the World Bank noted that much of the decentralization that happened in the past was motivated by political concern. It is argued that decentralization in Latin American countries, for example, has been a very important part of the democratization process as the central regimes are changed by elected governments. The spread of multi-party political systems is quoted as the main reason for the demand for a stronger local voice in decision-making and this in return motivated decentralization in Africa .In some African countries like Ethiopia, decentralization was considered as a response to pressure either from regional or ethnic groups for greater political control and participation while, in the case of Mozambique and Uganda, decentralization came about as an outcome of a long civil war, providing political opportunities at the local level and enabling greater participation of all former warring fractions²⁹. Decentralization in the transition economies of former socialist countries happened due to the fall of the old central apparatus, and the absence of any other meaningful alternative structure of governance to provide local government service is the other reason for massive decentralization in different countries.

2.3.3. Goals of Decentralization in the Health Sector.

Decentralization in the health sector can be discussed as a process which involves a variety of mechanisms to transfer fiscal and administrative, ownership and/or political authority for health service delivery from the central Ministry of Health (MOH) to alternate institutions. Hence, in the health sector, decentralization has been promoted as a key means of improving health sector performance and the main argument with regard to its relation with service delivery is that the policy of decentralization has a potential to improve the locative efficiency by allowing the mix of services and expenditure to be shaped by local user preferences. It will also improve the technical efficiency through greater cost consciousness at the local level.

²⁹ *World Bank 2001.p.1.*

Decentralization theory therefore argues that services should be decentralized if demand and supply conditions are highly localized as in the case of primary health care. Local benefits include improved health and productivity in specific jurisdiction and reflect the local nature of demand³⁰.

It is argued that health sector governance and popular participation at the local level are important elements of decentralization in the health sector. This is because the influence held by different stakeholders over the decision process could express the priorities of the local people and then also address issues for locative efficiency. The other goal of decentralization in the health sector is that of providing a means of holding the local health staff accountable for higher quality care. Community participation and the capacity of the local governments in managing health service delivery are therefore important in health sector decentralization³¹.



2.4. The Principal-Agent Approach

The following section of the thesis reviews the principal-agent approach, one of the frameworks that is used in the recent literature of decentralization, particularly within the health sector.

“When two parties agree to work together within a hierarchy or on a lateral basis, they invoke a kind of contractual relationship”. If the relationship is bilateral as in the case of a buyer and seller, the seller normally carries out the task assigned by the buyer and hence, in this case, the seller is called the agent while the buyer is the principal. The principal is mainly concerned about the achievement of the task assigned to the agent. On the other hand, the agent is primarily interested in receiving remuneration in return for

³⁰ *Matthew Andrews and Larry Schroeder 2003, p.2.*

³¹ *Thomas J Bossert and Joel C Beauvais 2002, p.24.*

the accomplishment of the task. The agent seeks to maximize his or her returns, subject to the constraints and incentives offered by the principal³². The principal conversely seeks to structure the relationship with the agent so that the outcome produced through the agent's efforts are the best the principal can achieve, given the decision to delegate in the first place. There is, then, a natural conflict of interest between the two³³.

The principal-agent theory proposes principals who are either individuals or institutions with specific objectives, and agents who are needed to implement activities to achieve those objectives. The agents may share some of the objectives of the principal; however, they might also have other interests such as increasing their own income or shrinking it. Agents have also more information about what they are doing than the principal, giving them an advantage and allowing them to pursue their own interests at the expense of that of the principal's. The principal might be interested in overcoming this information of the agent's but gaining information might be either costly or even impossible. The principal seeks to achieve his goals by shaping incentives that are in line with the agent's own interests. Selective monitoring and punishments to encourage agents are also used by the principal to implement activities to achieve the given objectives. In this approach, it is assumed that the principal receives the benefits of any profit that is produced by the agents. In addition to the information asymmetry, the principal-agent theory also focuses on issues of control of information and monitoring³⁴.

³² *Mc Cubbins and Kiewiet 1991,p.24.(as quoted by Kusnanto)*

³³ *Hari Kusnanto from the Internet June,2005 www.hsph.harvard.edu/takemi/RP198*

³⁴ *Bossert, 1998,p.6.*

The principal-agent approach was developed by economists primarily to examine choices made by managers of private corporations. It has also been used to analyze federal intergovernmental transfers to states in the United States. Recently, sociologists also used it to analyze the relationship between provider and patient in the health sector³⁵.

The theory was developed also to explain the relationship between private contractual parties such as landlords and tenants or owners and managers. The theory however was utilized in describing bureaucratic and public institutions. The central and local governments provide an example of a hierarchical power structure, in which the central government (the principal) has the right to write contracts in a centralized system and the local government or district health office (agent) has to accept the contracts, although it may be allowed to give some input into the contractual agreements.³⁶

One of the crucial issues in decentralization is the appropriateness of power structures among the central and local parties³⁷. Bossert, who discuss decentralization as the expansion of decision choices at the local level, applied the principal-agent approach to the health system and viewed the Ministry of Health as a principal, with the objectives of equity, efficiency, quality and financial soundness. He also considered the local health authorities as agents who are given resource to implement the general policies in achieving the above objectives. The principal-agent theory, which is said to encourage examination of how the principal monitors, performs and shapes incentives and punishment, was used by Bossert to develop a symmetrical framework for research on the decentralization of health systems and hence the following part discusses the application of this theory to health sector decentralization.

³⁵ Bossert 1998. p.6.

³⁶ Hari Kusnanto from the Internet June,2005 www.hsph.harvard.edu/takemi/RP198

³⁷ Hari Kusnanto from the Internet June,2005 www.hsph.harvard.edu/takemi/RP198

2.5: Models for Analysis of Decentralization of Health Systems

In order to assess the implications of decentralization on health service delivery, this part of the thesis focuses on a crucial framework which can be used to analyze the decentralization of the health system. Decentralization of the health system has been studied by Bossert using a “decision-space” approach. “Decision-space” refers to the amount of decision-making authority transferred to local officials for the execution of health services³⁸. The decision-space approach is based on the theory of principal-agent which is discussed above and Bossert used a comparative analytical tool called the “decision-space map”.

The unique features and strength of the decision-space approach is that it clearly provides a framework which enables us to measure the three basic elements of decentralization: 1) the amount of choice transferred from central institutions to institutions at the periphery of the health system, 2) the choices local officials make with increased discretion and, 3), the effect these choices have on the performance of health system³⁹.

The objective of the decision-space approach is therefore to begin to draw lessons about how to design more effective processes of decentralization and to clearly identify the ways in which reforms in the health sector affect local health sector decision-makers and the range of choices available to them in the various spheres of health service management. It also allows exploring of the level and type of decisions taken at the different tiers of government and how such decision-space influence health service delivery at local level. This will also enable one to assess the implications of

³⁸Thomas J Bossert 1998, p.17.

³⁹Thomas J Bossert 1998, p.17.

decentralization on the performance of the health system in achieving objectives of equity, efficiency, quality and financial soundness⁴⁰. The analytical framework that is used here is therefore based on the principal–agent approach and, in this perspective, the Ministry of Health is the “principal” and hence sets the goals and parameters for health policy and programs. This principal grants authority and resources to local “agents” which includes municipal and regional governments, decentralized field offices or autonomous institutions for implementation of its objective⁴¹.

According to the principal-agent approach, local agents often have their own preference for the mix of activities and expenditure to be undertaken, and respond to a local set of stakeholders and constituents that may have different priorities than the national principal. This means local institutions may have to evade the mandate established by the central government. Bossert further argues that since agents have better information about their own activities than does the principal, they have some margin within which to change or shirk centrally defined responsibilities and pursue their own agendas. Since the cost of the principal of acquiring information is often prohibitively high, according to Bossert, the central government seeks to achieve its objective through the establishment of incentives and sanctions that effectively guide agent behavior without making losses both in efficiency and innovation. Different mechanisms are used to achieve this objective and this includes monitoring and reporting, inspections, performance reviews, contracts and grants⁴².

⁴⁰ Thomas J Bossert and Joel C Beauvais 2002, pp.18-21.

⁴¹ Thomas J Bossert and Joel C Beauvais 2002, pp.18-21.

⁴² Thomas J Bossert, 1998, p.19.

Bossert further argues that the principal may use different mechanisms through which it can influence the agents. This includes broadening the formal “decision-space” or range of choice available to local agents within the various functions of finance, service organizations, human resources, targeting and governance. Here it is noted that the central principal transfers formal authority to the agents in a voluntarily way so as to promote its health policy objective. The level and nature of the transfer differs from case to case. However, it shapes the functioning of the principal-agent relationship and the characteristics of the decentralized system as a whole⁴³.

To put it in a nutshell, Bossert argues that decentralization should not be seen as an end in itself, but rather as a means to an end of accomplishing the goals of equity, efficiency, quality and access to health care. His model clearly allows analyzing each area of the decentralization of the health system such as finance, service organizations, human resources and the like. Bossert’s approach to decentralization should therefore provide a useful model of analysis that separates the decision making process for fiscal decentralization from that of health service administration and human resource management. This is crucial for analysis of any health system as differences in these four areas of the decentralization of a health system are clearly identified which could potentially affect health outcomes. Bossert’s model also ranks degrees of decision-making authority as narrow, moderate and wide for each area of a decentralized health system⁴⁴.

⁴³ Thomas J Bossert, 1998, p.19.

⁴⁴ Amy Nunn 2005, p.5.

The allocation decision made by the central authorities toward the decentralized entities will influence the relation of the principal and agent respectively. Health sector finance, both at its absolute level and its distribution, is crucial to effective health service delivery and hence the following part of the paper revises intergovernmental transfers.

2.6 Intergovernmental Transfers

There are different important concepts which can determine the relation of the central government with sub-national or local governments with regard to service delivery by local governments, and an intergovernmental transfer is the basic concept. Sharing the same view, one report from the World Bank noted that intergovernmental transfers are the dominant source of revenue for sub-national governments in most developing countries. The design of these transfers is of critical importance for efficiency and equity of local service provision and the fiscal health of sub-national governments⁴⁵.

2.6.1 Use of Intergovernmental Transfers

There are many justifications given for intergovernmental fiscal transfers and one of them is that of addressing vertical differences. Due to the insufficient revenue-raising power of local governments, they are not able to cover the cost of services which they are supposed to provide and intergovernmental transfers can help to cover this vertical gap or differences. The other reason is that of bringing about horizontal equalization. It is very common that the ability of local governments or regional states varies from region to region. This might be due to the existing differences in resource endowments of the different regional states. And, since local governments are responsible for financing public services through their own local resources unless there is an intergovernmental

⁴⁵ World Bank, June, 2005, www.ciesin.org/decentralization/English/General/Rational.html

transfer, there will be a difference in the provisions of local services both in quality and quantity which might bring about a problem even at the macroeconomic level. Sub-national fiscal capacity differences therefore can be minimized by intergovernmental transfers⁴⁶.

The other reason for intergovernmental transfers is to correct inter-jurisdictional spillovers or externalities. Sometimes a service produced by one local government might positively or negatively affect other local governments. Some local government services might generate inter-jurisdictional spillovers which might be either benefit or cost, which might affect others too. Local governments might not be willing to provide some of the services in a very efficient way if they believe that other local governments might benefit from those services. Under such conditions, central government may transfer resources to local governments so that they will be spent only on services that generate spillovers and this is just to ensure that the local government provides a greater amount of services. Intergovernmental transfers will also be used to correct major administrative weaknesses and streamline bureaucracy. The idea here is that centralizing the management of certain taxes will increase administrative efficiency. Local governments can also levy some taxes which are clearly reserved by the central government, but there are taxes which are likely to be well and efficiently managed through a central administration tax system than a fragmented system. Hence such taxes are often collected nationally and redistributed to local governments through a transfer system⁴⁷.

2.6.2 Criteria for Intergovernmental Transfers

⁴⁶ *Smoke 2001, p.24.*

⁴⁷ *Smoke, 2001, p.25.*

It is true that intergovernmental transfers are the dominant sources of revenue for sub-national governments in most developing countries and hence the design of such transfers is very important for the efficiency and equity of local service provision, particularly for the fiscal health of sub-national governments⁴⁸The transfer system therefore highly affects the activities of local governments and hence highlights those points which help to evaluate a given transfer system. Autonomy is the first criterion and hence devolved governments should have complete independence and flexibility in setting priorities, and should not be constrained by the categorical structure of programs and uncertainty associated with decision-making at the center. Tax-base sharing, allowing sub-national governments to introduce their own tax rates on central bases, and formula-based revenue sharing is consistent with this objective. Revenue adequacy is the second criterion and hence sub-national governments should have adequate revenues to discharge designated responsibilities. Equity is the other criterion and this means that allocated funds should vary directly with fiscal need factors and be inverse to the taxable capacity of each province⁴⁹.

The grant⁵⁰ mechanism should ensure predictability of sub-national governments' shares by publishing projections of funding availability. The grant design should be also neutral with respect to sub-national governments' choices of resource allocation to different sectors or different types of activities. Simplicity is also the other important criterion and hence the sub-national government's allocation should be based on objective factors over which individual units have little control. The formula should be also easy to

⁴⁸ World Bank, 2005, www.ciesin.org/decentralization.

⁴⁹ World Bank June, 2005, www.ciesin.org/decentralization/English/General/Rational.html

⁵⁰ Grant here is just used as having the same meaning as intergovernmental transfers.

comprehend⁵¹. Incentive is also the other crucial point and hence the proposed design should provide incentives for sound fiscal management and discourage inefficient practices. Last but not least is the fact that grant design should ensure that certain well-defined objectives of the donor are properly adhered to by the grant recipients. This is accomplished by proper monitoring, joint progress reviews, and by providing technical assistance, or by designing a selective matching transfer program. It is also argued that the various criteria specified above could be in conflict with each other and therefore a grantor may have to assign priorities to various factors in comparing policy alternatives.

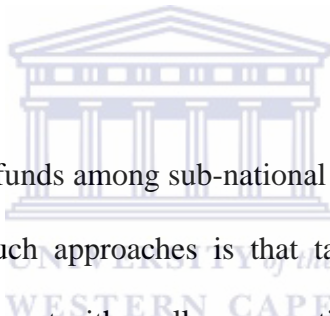
Smoke argues that the capacity of a grant to provide and promote legitimate local spending needs is important in the flow of resources from the center to the local governments. If a given transfer system is designed to enable and ensure local governments to have enough resources to cover their unmet revenue needs and when there is an appropriate growth of the transferred resources with need over time, then it can be said that the transfer system meets the criteria of revenue adequacy and growth.

Fiscal planning needs certainty with regard to the flow of resources from the center. Therefore sub-national governments should know the amount of money and other resources that they will receive for the coming fiscal year before they start working on the planning and budgeting process. This will help local governments to make future plans and minimize large swings in resource availability. The volume of transfers should also be predictable for local governments and this will help them to plan and budget in a

⁵¹World Bank, June, 2005, www.ciesin.org/decentralization/English/General/Rational.html

stable way from year to year. The transfer made to local governments should be distributed for their use and it must be also timely⁵².

There are three different policy issues related to the mechanism by which funds are transferred from one government to another. Hence intergovernmental transfers need to make clear how to decide the total amount of resources that are going to be distributed, how to allocate the resources across the sub-national governments and whether to restrict or not with regard to how the transfer funds can be used. However, for the sake of this thesis, I will discuss the second policy issue, that is, the way funds are allocated among different local governments.



With regard to how to allocate funds among sub-national governments, there are different approaches and the first of such approaches is that tax-sharing transfers return to a particular sub-national government either all or a portion of the tax collected by the central government in the jurisdiction of the given sub-national government. The second type of transfers is those allocated on the basis of objectively defined formulas. Such transfer approaches are becoming very popular through time as they meet some of the main evaluative criteria such as transparency. Such transfer approaches are transparent for the recipient governments and also help the granting government considerable position in determining which objectives of the transfer mechanism need to be emphasized. However, in many developing countries, there is a lack of adequate and timely data which is required to implement the allocation formula. It is also common in such developing countries to see a tendency of trying to achieve many objectives with a

⁵² *Smoke 2001, p. 26.*

single transfer program and, according to Smoke, especially in the case of Ethiopia, many indicators are being added to the formula. Subsidization is also another way of making transfers. Here such type of cost-sharing can be of two types and these are either total or partial cost-sharing. Subsidization needs to have very clear reasons otherwise it will distort the budget of the recipient government⁵³.

The other important point here is the degree of sub national spending autonomy and this means the extent of autonomy which given recipients, sub-national governments, exercise with regard to utilizing the funds from the transfer instrument. Greater sub-national autonomy means lesser control by the central government with regard to use of funds. In case of general purpose allocations, local governments have full autonomy over the utilization of transferred funds. The recipient jurisdiction can allocate the money for any purpose it desires, be it labor or non-labor input. According to the proponents of decentralization, such powers are very close to full devolution of spending powers. Sectorally limited block allocation also permits the recipient government to choose how the fund is going to be used but in a limited sector only. In the case of purpose-specific transfer, it can be very restrictive in terms of how the funds are spent. The restriction might apply for choices between labor and non-labor input and/or for particular spending plans. Here the development project grant will be sent based on the provisions of the project submitted by the local council while the central ministry has the right to approve or disapprove it⁵⁴.

⁵³ *Smoke, 2001, p.27.*

⁵⁴ *Smoke, 2001, p.27.*

We have seen in the above discussion the different criteria and concepts which should be considered in a transfer system. This is also the case in the health sector financial transfers and, in the Ethiopian case, the health finance transfer system from the center that is the MOH to the sub-national governments influences health service provision by the local governments. The intergovernmental transfer discussed above will therefore help in explaining the level and type of decision-making power of both the regional government and the district government and how this decision-space is influenced by the relations within government. Decisions concerning the health finance transfer from the center that is the Ministry of Health (MOH) to the local governments, in this case the Cheha district health bureaus, will also be assessed.

2.7 Hypothesis

The previous part of the thesis introduced the different mechanisms by which the principal, which is the Ministry of Health (MOH), influences the agents, that is, local governments, and these include broadening the range of choice of local agents by decentralization among the functions of finance, service organization, human resource, access rules and governance rules. This will determine the implementation of the objectives of the principal, which is the efficient and effective provision of health services. We have also seen how the transfer system can influence the relationship of the central and local governments with regard to service delivery.

As it might not be possible to analyze the decentralization of the health services in Ethiopia and its implication for public health delivery in all the functions mentioned above, and the fact that health sector finance is a very important factor in explaining the

relation of the Ministry of Health to the sub-national governments in Ethiopia, this thesis will focus only on one specific area - the health sector finance transferred from the Ministry of Health to the local entities determining the efficient allocation of health service delivery by local governments.

The hypothesis will therefore consider the implication of health service decentralization for the provision of health services by local governments, taking the *Cheha* district as a case. As was discussed above, researchers in the field argue that the decentralization of the health system among other things depends on the range of choice of local agents among the other requirements of finance, service organization, human resource, access rules and governance rules. However, taking in to account the decentralization of the health system in Ethiopia, the researcher believes that the range of choice of local governments with regard to health sector finance has more implications for health service delivery by local governments. Hence the effective and efficient provision of health service by local governments in Ethiopia among other things, as in the case of other countries⁵⁵, depends on the following three important factors: 1) the distribution of health spending, 2) the sources of income and fiscal autonomy, and 3), local discretion in expenditure decisions⁵⁶.

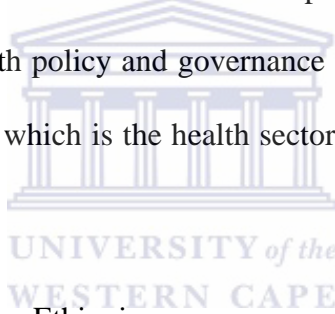
⁵⁵ Thomas J Bossert, 1998, p.24.

⁵⁶ Thomas J Bossert, 1998, p.24.

CAPTER 3: Descriptive Background and Context

3.1 Decentralization and Health Service Delivery in SNNPRS and the Cheha district.

The main objective of this Chapter is to test the hypothesis against the findings of the field research and hence the structure is the continuation of the hypothesis. This Chapter is further divided in to three sub-chapters. General background information about Ethiopia is contained in the first part followed by the second part which gives general background information and introduces the SNNPRS and the Cheha district including their history and administrative structure. The third part is about the decentralization policy in Ethiopia and the health policy and governance of the country. This is followed by the last part of this Chapter which is the health sector profile both at the national and regional level.



3.1.1 Background Information on Ethiopia

Ethiopia is located in the Horn of Africa covering an area of around 1.1 million square kilometers. It shares borders with Djibouti, Eritrea, Sudan and Somalia. Ethiopia is a Federal Democratic Republic with a bicameral parliament: the House of Representatives and the House of Federation. The administrative boundaries within the country have changed three times since mid-1970s and currently the country has nine regional states and these are: *Tigray, Afar, Oromia, Somalia, Benishangul gumuz, Southern Nations, Nationalities and Peoples' Regional State (SNNPRS), Gambella and Harrari* and two administrative cities (*Addis Ababa and Dire-dawa*). The National Regional States and city administration are further divided into 551 *woredas* (districts). A district is the basic

decentralized administrative unit having an administrative council composed of elected members. The 551 districts are further divided into roughly 15,000 rural and urban *kebeles*, the smallest administrative unit in the country.

Ethiopia's total population in 2004 was estimated to be 69.1 million⁵⁷ and with an average growth rate of 2.7%, it is expected to reach 81.2 million by 2009. Above 85% of Ethiopians live in rural areas, making the country one of the least urbanized countries in the world. 43.5% of the population is younger than 15 years of age, and 51.9% of the population is between 15 to 59 years of age while those above 60 years of age comprises only 4.6% of the total population. Since almost the vast majority of the population living in the rural part of the country depends on agriculture, in order to ensure national development, it is necessary to maintain and improve the health status of the rural population. Average population density is 52.2 persons per square kilometers with substantial variations among regions and hence population densities are higher in the highland than the eastern and southern lowlands.

Ethiopia, with an estimated per capita income of USD100 is one of the least developed countries in the world. Around 47% of the total population lives below the poverty line and, accordingly, the UNDP Human Development Index (HDI) for Ethiopia is 0.309 and, when this index is adjusted for gender differences, it drops to 0.297, which reflects the gender inequalities.

⁵⁷ Central Statistics Authority (CSA), 1994 Population and housing census.

Rapid population growth, poor economic performance and educational levels exasperate the economic development of the country and all this has an impact on health status. The literacy rate, estimated to be 29%, is also very low.

3.2 The SNNPRS and the Cheha district

Art 1 of the 2001 revised constitution of the Southern Nations, Nationalities and Peoples' Regional State proclaims the establishment of the SNNPRS and hence the SNNPR, established in 1992, is one of the nine regional states and two urban administrations in the country⁵⁸. The region is located in the South bordered by Kenya in the south, Sudan in the southwest, the *Gambela*⁵⁹ region in the west and Oromia⁶⁰ region in the north, northeast and east. The region is organized into 13 zones⁶¹ and 104 woredas⁶². Hence, the SNNPRS is among the widest regional states of Ethiopia. The SNNPRS is a unification of four regional states and they become one for the sake of administrative and political reasons. There are more than 45 ethnic groups in the region and the region is the worst in terms of development when compared to other regional states of the country. The map below shows the administrative structure of the regional state and also the location of the Cheha district in the regional state.

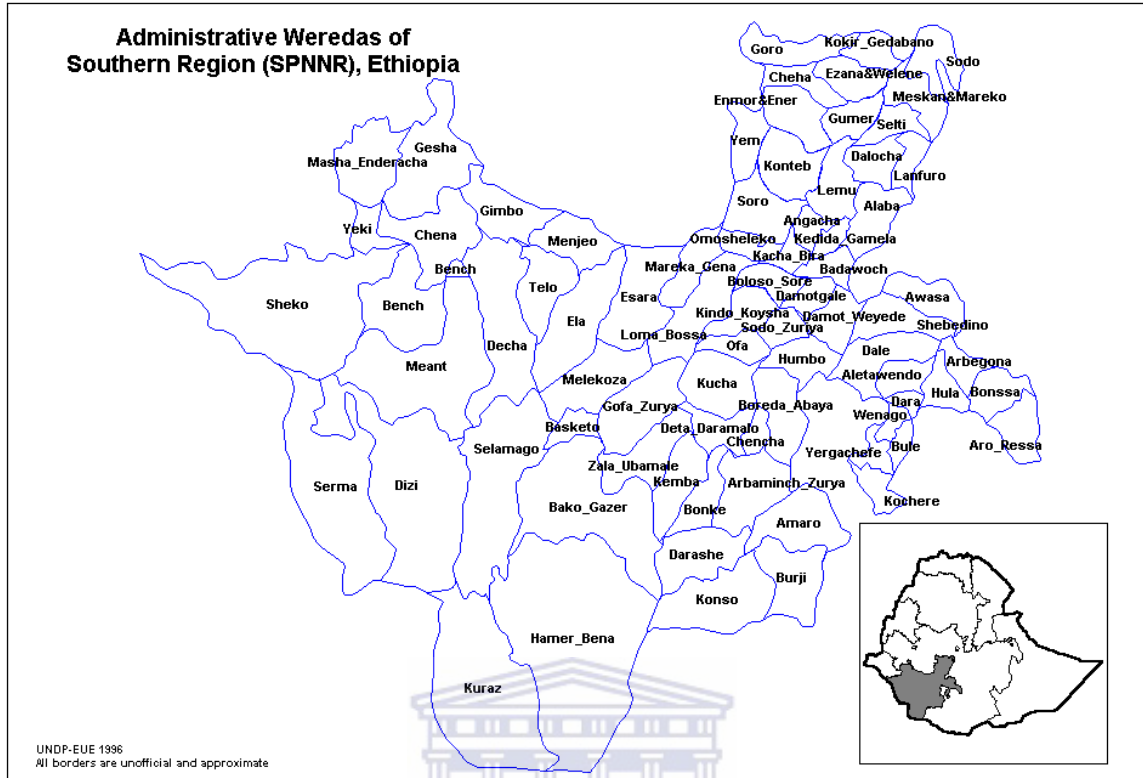
⁵⁸ The Revised Constitution, 2001 of the Southern Nations Nationalities and Regional State.

⁵⁹ *Gambela* is one of the regional states in Ethiopia.

⁶⁰ *Oromia* is also one of the regional states of Ethiopia with more than 40% of the whole population of the country.

⁶¹ Zone is a middle level administrative unit which coordinate, organize and follow up the activities of *woredas*.

⁶² *Woreda* is the local language for the district level administrative unit of the government.



Source: UNDP-EUE 1996

The region has an area of 118,000 sq km, which consists of 10% of the total area of the country.

According to the population projection done on the 2004/5 census, the region had an estimated population of 14,484,000 in 2004/05, which was 20% of the total national population. The central, eastern and northeastern parts of the region are densely populated with 92 persons per sq km. The southern and southwestern parts of the region are sparsely populated areas with a predominantly nomadic population. According to the census, more than 93.5% of the population is rural while the remaining 6.5% is urban. 4.26% of the population are children under the age of one, while children younger than

five years make up 18.87% of the total population. Women of childbearing age (15-45) comprise 23.76% of the population, of which 4.26% are pregnant women. 50.9% of the population (15-64 years of age) is within the productive age, which indicates that almost half of the population is economically dependent.

The region's economy is based on agriculture, with substantial crop production resulting in a very poor standard of living in the rural community. 20% of foreign currency is generated through the export of leather and hides and coffee production.

The SNNPRS is one of the regions well known for its more than 56 nations and nationalities, languages and cultural diversity. More than 50% of the country's languages and cultural heritages are found in the SNNPRS. The languages spoken in the region are classified under four language families: Omotic, Cushitic, Semitic, and Nilotic⁶³.

The Cheha district is therefore one of the districts in the SNNPRS and the people are called the *Guraghes*. *Cheha woreda* is around 44072 square meters area wise and the district is located at 1200-2600 meter above sea level. 60% of the district land is plateau while 40% is highlands. As far as the weather is concerned, 20% of the district is cold, 70% medium and 9% very hot or arid. The woreda has subsistence agriculture which depends on rain and the main rain season is from June to September each year.

⁶³ Interview with Fikre, 15,9,2005

Coming to the administrative structure of the district, the Cheha district is subdivided into 39 lower administrative units called *kebele*⁶⁴ and the kebeles have 134 sub-kebeles and 511 government representative groups. The overall population of the Cheha district is estimated to be 178 249 and among this 87 042 are male while the rest, 91 201, are female. According to one report from the district, the district shows 2.9% economic growth, though there is no sound research conducted to conclude this.

3.3. Decentralization, Health policy and governance in Ethiopia

This part of the thesis deals with the decentralization policy introduced in Ethiopia, how decentralization is used as an instrument in the health sector and the governance of the health policy of the country.



3.3.1 Decentralization in Ethiopia

Ethiopian policy-makers argue that the country's experience has shown that where there is no political order, there can be no development; and where that order is not based on democratic principles, there can be no sustainable development⁶⁵. And hence, in principle, it is said that democratic governance, taken in its broadest sense, is a necessary condition for development. Although democratic systems of government vary in their forms, structures and institutions, they are predicated on common principles based on the will of the people expressed in regular free and fair elections, limited powers of government, and an independent judiciary to protect individual rights, the constitution and the laws. There are also additional attributes of democratic government. Among these are government accountability to citizens, transparency of government procedures and

⁶⁴ *The lowest administrative unit of locale government*

⁶⁵ *Regionalization and decentralization in Ethiopia: policies and implementation, an abstract by Kifle Wedajo*

operations, and citizens' participation in all levels of government, especially at the local level.

Decentralization of political powers is therefore considered one of the attributes of Ethiopia's democratization. This policy has had, and continues to have, positive impacts on several dimensions of development. The main objective of the government in introducing decentralization were therefore enabling people to participate directly in the management of their affairs so that people become development-oriented, to make local administration more accountable and responsible, and to improve local services such as health, education and agricultural extension by allowing local governments to have local control of allocated taxes and revenues⁶⁶.

The type of decentralization dominant in Ethiopia is devolution and this, among other things, incorporates the shift of expenditure assignment, fiscal decentralization and the prevalence of decentralized elected councils at all level of government. Power is devolved to the nine regional governments and two city administrations and then the government started what it referred to as the second wave of decentralization, and this was the decentralization of power to the districts (woredas) and this was only since 2002. The primary objective of the decentralization is to deepen the process for empowering communities to initiate and control their development activities and enhance the scope and quality of the delivery of basic services such as health. Currently, most districts have access to decision-making powers.

⁶⁶ Kifle Wedajo, 1995:1.

The constitution of the Federal Democratic Republic of Ethiopia (FDRE, 2002) clearly defines the powers and functions of the federal government and regional governments. It also reveals the separation of state power, checks and balances, and transparency and accountability among different government organs. The federal constitution therefore provides the broader framework for policy formulation. Policies are initiated in consultation with decentralized governments and participation of the public which are then discussed and approved by the constituents. Similarly, based on the constitution of FDRE, each regional state promulgated its regional constitution in 2002, taking into account the objective reality of the region and the aim to achieve rapid economic development, enhanced democracy, and lasting peace and security.

Decentralization therefore has been the main policy of the Federal Democratic Republic of Ethiopia since the early 1990s and, according to the constitution, the regional states have significant expenditure power and responsibilities together with certain revenue collection power. Tax responsibilities are explicitly stated for each level of government⁶⁷.

3.3.2. Health Policy and Governance in Ethiopia

Over the past decades, the government of Ethiopia has initiated a comprehensive economic reform program which includes health as one of its sectors. Accordingly, the country adopted a new economic policy which is aimed at establishing a market-based economic transformation, and the strengthening of social services such as education, health, investment in roads and water resource through privatization.

⁶⁷ Referto the part “allocation of expenditure between different administrative levels”.

According to a report from MOH, the government of Ethiopia⁶⁸ has issued a health policy which is based on commitment to democracy, empowerment of people that emanates from democracy and to decentralization as a very crucial instrument of the government. The report further noted that the Ethiopian government's health policy places a strong emphasis on the fulfillment of the needs of the less privileged rural population which constitutes 85% of the total population in the country.

The Ethiopian government's health policy, therefore, mainly focuses on the decentralization and democratization of the health system, development of preventive and promotive health services, ensuring access to health to the whole population, promoting inter-sectoral collaboration by involving NGOs and the private sector, and promoting and enhancing national self-reliance in health development.

According to the MOH report, the health policy of Ethiopia identified the priority intervention areas and strategies to be employed to achieve the health policy objectives, and it is stated that the government policy on decentralization is the most significant policy influencing the design and implementation of the health policy in Ethiopia. Within the health sector, primary responsibility in delivering services including management is devolved to the regional Health bureaus (RHBs) and, since 2003, the management of the health system and the responsibility of service delivery are devolved to district (woreda) level. It should be noted that increasing local decision-making and participation aimed at strengthening ownership in the planning and management of social services is the

⁶⁸ *FDRE, MOH: Accelerated Expansion of primary health care coverage in Ethiopia, 2004, Addis Ababa*

primary objective of the political, administrative and economic decentralization policy to woreda or district level⁶⁹.

As a result of the health care decentralization in Ethiopia, the decision-making processes both in the development and implementation of the health system are shared between the Federal Ministry of Health (FMOH) and the regional health bureaus (RHBs) and the woreda health office (WHOs). Recently, some measures were taken by the government and hence the FMOH and the RHBs were made to focus more on the area of policy and technical support while the woreda health offices have been made responsible for managing and coordinating of the primary health care facilities at the woreda level.

Therefore the administrative structure of Ethiopia has been set to incorporate the federal government, regions, the woredas and kebeles⁷⁰. However, there are some regional states with zone-level administrative units but the government says that these zone-level units are temporary and with limited functions such as giving logistical support and overseeing the zonal hospitals. The next part of the thesis introduces the Southern Nations, Nationalities and Peoples' Regional State (SNNPRS) and the Cheha district which are the focus of the thesis.

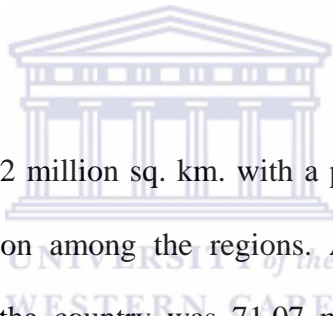
⁶⁹ See Chapter six for the details concerning the power and responsibility of the Federal, Regional and woreda health offices.

⁷⁰ Kebele is the lowest administrative unit at the bottom of the overall administrative structure next to the woreda level. A kebele has an estimated population of 5000 or about 1000 households.

3.4 Health sector profile

3.4.1 National health profile

Ethiopia is amongst the least developed countries in the world with regard to economic development and standard of living. Some scholars claim that the basic cause for this poverty is the predominant backward economic system and outlook as well as the man-made and natural disasters that occurred over many years in the past. Therefore it should be borne in mind that health and other social problems are a reflection of the already existing backwardness. More than about 47% of the population of Ethiopia therefore lives below the poverty line.



The country has an area of 1.12 million sq. km. with a population density of 52 people per sq. km with great variation among the regions. According to the 2004 census estimated total population of the country was 71.07 million with an average annual growth rate of 2.7%. 43.5% of the population is under 15 years of age, and 51.9% of the population consists of people aged 15 to 59 years while those above 60 years of age comprise only 4.6% of the total population. Since almost 85% of the population lives in the rural part of the country and depends on agriculture, in order to ensure national development, it is necessary to maintain & improve the health status of the rural population.

Coming to the health situation, the country's health service coverage is very low and there is a high incidence of communicable diseases causing high levels of morbidity and mortality in the community. Moreover, increasing prevalence of HIV/AIDS in the

community is also aggravating the health problems experienced and number of HIV/AIDS patients is growing at an alarming rate, making the country among the few African countries with a high prevalence of HIV/AIDS. The HIV prevalence rate was estimated at 4.4% of the adult population in 2003. It is also estimated that 1.5 million people are living with HIV/AIDS.

Due to lack of safe water supply and environmental health services and inadequate health education, preventable diseases are very common in the community, causing huge health problems. Based on the MOH 2003/04 health data, the national immunization (DPT3) coverage is 60.78%; delivery service coverage, 9.45%; contraceptive prevalence rate, 22.99%; average life expectancy, 54 years; infant mortality rate, 96.8 per 1000 live births; mortality rate for children under 5 is 140.1 per 1000 live births; maternal mortality rate is 871 per 100,000 women of childbearing age, and the prevalence of maternal malnutrition accounts for 10-23%.

Some health indicators revealed that Ethiopia has a poor health status compared to other sub-Saharan countries. For instance, the number of children who die before celebrating their first birthday (out of 1000 live births) is 66 in Kenya, 88 in Uganda, 95 in Zambia, 65 in Zimbabwe, 105 in Tanzania and 85 in Madagascar, whereas 96.8 children die in Ethiopia. Regarding population access to safe water, it's 45% in Kenya, 50% in Uganda, 64% in Zambia, 85% in Zimbabwe and 54% in Tanzania whereas it is 24% in Ethiopia.

In order to solve such complex health problems, the Federal Democratic Republic of Ethiopia has formulated a prevention-oriented national health policy and health sector strategy.

3.4.2 SNNPRS Health Profile

The SNNPRS recently gave priority to enhance the implementation of community-based preventive and rehabilitative health care services, with a focus on primary health care service expansion, particularly the health centers with the special health posts. However, it is possible to argue that there has not been a corresponding level of service utilization by the communities of the SNNPRS.

According to one report from the SNNPRS, at all levels, priority has not been given for community-based preventive services that enhance communities' concern for their own health. Health education has not been community-centered either which resulted in low community awareness and unsatisfactory behavioral change. The fact that health facilities didn't endeavor to create discussion forums between professionals and the community to solve health problems jointly is also another major factor for low health coverage. In addition, lack of supportive supervision, evaluation and health research had a negative impact on the quality and efficient delivery of health service. Hence, the community could not fully benefit from the sector.

Different vital indicators bear witness that the health status of the region ranks among the lowest in the country. Life expectancy is 48.6 years at birth (CSA, 1994)⁷¹. Infant and child mortality rate are estimated at 107 and 157 per thousand live births respectively. The crude birth rate is estimated to be 42.6 per thousand. The maternal mortality rate of the region is estimated to be similar to that of the country at 871/100,000 live births (same source). The table below also shows the indicators of the basic health services.

⁷¹ *Central Statistical Authority, 1994, 32*

Though one can see a positive trend in the basic health indicators below, it is not compatible with the increase in population. From 1998 to 2003, the population increased by more than 20% while the public health coverage increased only by 2.2 %. Though there is an increasing trend in health service utilization, it is much lower than that in other regional states where the health service utilization is a minimum of 50%. The following table summarizes some of the basic health indicators in the region.

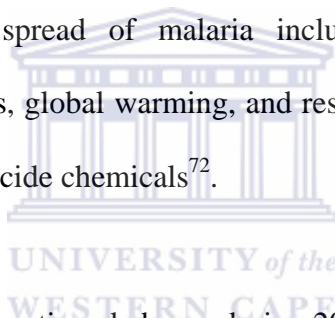
Indicator	1998	1999	2000	2001	2002	2003
Total population	12132000	12514999	12903020	13293012	13686011	14084988
Public health coverage (%)	44	45	45	46	47	47.2
Health service utilization (%)	-	-	-	21.9	26.8	37.51
Family planning (%)	9.5	11.1	13	14.5	24.71	28.93
Antenatal Coverage (%)	40.7	43	52	42.5	32.15	40.88

Table 3.1: Summary of basic health indicators in SNNPRS.

Source: SNNPRS Health Bureau

The burden of death (BOD) in the SNNPR, measured by premature death from all causes, comes from primarily preventable causes and is dominated by communicable diseases. The leading causes of morbidity and mortality in the region are mostly attributable to lack of clean drinking water, poor sanitation, and low public awareness of environmental health and personal hygiene practices.

From the entire geographic area, about 60-70% of the population is exposed to malaria, and health facility reports imply that malaria is one of the major causes of morbidity. The main reasons for the high spread of malaria include lack of community-based environmental control activities, global warming, and resistance of malaria parasites and mosquitoes to drugs and insecticide chemicals⁷².



According to the same report mentioned above, during 2004, there were 544,892 malaria cases seen at outpatient visits, making up about 23 % of the top 20 reasons for hospital outpatients visits, and ranking first at the hospital level. Among those who were admitted for hospital care, malaria accounts for 15 %. During the same year, the number of reported deaths from malaria were 1, 755, ranking first and representing 55.5% of all hospital deaths.

Moreover, HIV and tuberculosis are posing a huge burden. In particular, the high spread of HIV is increasing tuberculosis cases in the communities. On average, about 20 000 tuberculosis cases are registered annually as compared 5 000 to 8 000 cases 8 years ago.

⁷² SNNPRS, Regional health bureau, paper on health sector development program, June, 2005, Awassa.

In the year 2004, tuberculosis ranked second to malaria as a leading cause of morbidity, admission and death in hospitals. An estimated more than 35000 AIDS cases with over 220 000 people living with HIV/AIDS makes the problem worse with the highest level of infection in the age group between 15-24 years.

The existing health infrastructure in the region is low in number and unevenly distributed among zones, districts, and urban and rural areas. The ratio of population per health institution also shows significant variations. As can be seen from the report of the RHB of the SNNPS, currently there are a total of 15 hospitals, 154 health centers, 210 growing health stations and 690 health posts in the SNNPRS. There are also 15 pharmacies, 41 drug stores and 417 rural drug vendors. Current facility to population ratios are far from those proposed by the government under the new four-tier structure of health services. It is also possible to see from table 3.1 that health professionals are also very few in the regional state and for example, in 2002, only 4 391 health professionals were engaged in the health sector. Of these health professionals, 112 were physicians (all types), 2 370 nurses (all types), 225 sanitarians (all types), 159 pharmacy technicians, 814 health assistants, 6 pharmacists, 155 health officers, 355 lab technicians, 20 X-ray technicians and 747 female health extension agents. One can see that the ratio of health professionals to population is: 1:6,114 for nurses (all type) and 1:129,372 for physicians (all types). If we compare this ratio with the international standards, it deviates from the international standard of one physician to 10,000 people and one nurse to 5 000 people.

It is possible to see the number of health facilities from the following table and, according to the table, there is a decreasing trend concerning the number of private clinics and also pharmacies. The number of health centers is increasing while that of hospitals shows very small progress. The number of health stations shows a decreasing trend and the same is true for the number of drug shops. For further details concerning the number of health facilities and their trend of expansion in the region, refer to the following table.

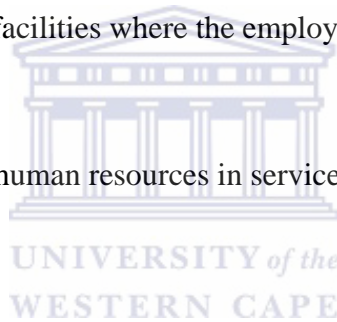
Year	1998	1999	2000	2001	2002	2003
Hospitals	9	12	12	13	14	15
Health centers	83	95	107	114	114	127
Health stations	366	366	350	357	347	347
Health posts	247	210	290	294	310	450
Private clinics	143	200	249	195	144	154
Pharmacies	26	31	27	23	34	24
Drug shops	42	43	43	39	48	41
Rural drug vendors	470	478	480	473	473	417

Table 3.2: The trend in the Number of Health facilities in the SNNPRS

Source: SNNPRS, Regional health bureau, paper on health sector

When we look at the number of health professionals in the region they are not only few in number, but also they face unfair assignments, training, transfer and termination and this has been affecting the initiative for the efficient provision of health services⁷³. The government has been trying to alleviate the shortage of professionals by building institutions for health professionals; however, the output is far from satisfactory. In some Woredas, there are no medical doctors at all while in others there are some but only in either NGO or private hospitals. The number of doctors in public hospitals is even lower and even the already few are not as such motivated to work. The main reason given as justification for such a situation by the government is the departure of health professionals to private health facilities where the employment benefits are attractive.

The following table shows the human resources in service in the SNNPRS.



⁷³ SNNPRS, Regional health bureau, paper on health sector development program, June, 2005, Awassa

Human resource	1998	1999	2000	2001	2002	2003
Physicians	215	180	161	164	177	123
Health Officers	30	40	52	80	113	145
Nurses all type	792	957	1140	1302	1655	2034
Health assistance	1447	1430	1308	1147	988	814
Pharmacist	10	12	11	18	18	13
Biologist	6	6	7	14	13	9
Lab. Technician	104	153	212	258	306	335
X ray technician	23	24	24	26	24	22
Sanitarian	133	157	171	183	200	225

Table 3.3: The Trend of Human Resources during the six years in the SNNPRS

Source: SNNPRS, Regional health bureau, paper on health sector

As can abundantly be seen from the above table, the number of physicians decreased at an alarming rate and when the number of physicians in 1998 is compared to that of 2003, it decreased by around 50% and this mainly, among other things, is because health professionals look for better incentives in private health institutions. Most of the pharmacies are owned by the private sector and, according to the report of the SNNPRS

health office, the higher tax levied on the private pharmacies is the reason for the negative trend concerning the number of pharmacies.

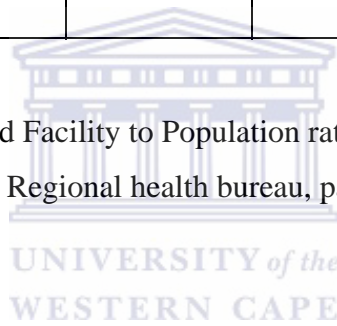
Though this has helped the privates sector to provide efficient health service, it has, on the other hand, affected the quality and efficiency of health services in public health facilities. It can be seen from the following table that current health facility to population ratios are far from those proposed and planned by the government⁷⁴. By specialized hospitable, it is meant that those who serve as referrals and such hospitals are well equipped both in human resources, drugs and medical equipments. Zone hospitals are just hospitals serving in an average way and when they have a very serious case they might refer their case to the specialized hospitals. District hospitals are those with a very limited service group, so they are only used by the district they are located in and, from the table, the number of existing hospitals and the service given to the people is far less than the number of planned hospitals and the number of people that were supposed to be covered under them by the government. The table below therefore summarizes the difference in the existing health coverage and the proposed health coverage by the regional government.

⁷⁴ *SNNPRS, Regional health bureau, paper on health sector development program, June, 2005, Awassa*

Facility type	Current number	People Covered	Proposed Facility type	People covered
Hospitals (all)	15	1:939,000	Specialized hospital	1:500,000
-Zonal	6	1:2.4million	Zonal hospital	1:1,000,000
-District	9	1:1.6million	District hospital	1:250:000
Health centers	154	1:94,088		1:25,000
Health posts	690	1:20,999		1:5,000

Table 3.4: Current and Proposed Facility to Population ratio

Source, Regional health bureau, paper on health sector



CHAPTER 4: Discussion of Empirical Findings - Part One

The main objective of this Chapter is to analyze one of the important variables in testing the hypothesis against the findings of the research and hence this Chapter is dedicated to analyzing intergovernmental transfers. In the first part of the Chapter, the nature of the administration and the principles of fiscal decentralization are reviewed in brief and this is followed by the second part that is a detailed discussion of intergovernmental transfers in Ethiopia and examines how such transfers, especially with regard to health finance, are related to health service provision by local governments. The third part is a detailed analysis of the allocation of expenditure at the federal, regional and district government levels, giving more emphasis to that of the woreda expenditure assignment. Therefore, the Chapter will cover general information about intergovernmental transfers in Ethiopia, how finance is allocated by different administrative units, the power of the different administrative units in intergovernmental transfers and how all this affects health service provision by local governments.

4.1 Principles governing Fiscal Decentralization in Ethiopia

The principle of fiscal decentralization emanates both from the federal and regional constitution and devolving fiscal decision-making powers to lower tiers of government was the main objective. Minimizing fiscal gaps, effective and efficient delivery of services and ensuring fiscal autonomy were also among the basic objectives. Therefore the specific objectives of the fiscal decentralization in Ethiopia include enabling regional and district governments/administrations to provide standard services in accordance with their functional assignments; narrowing the horizontal fiscal gap and ensuring horizontal

equalization; promoting efficiency in the allocation of financial resources and, last but not least, maintaining consistency between macroeconomic stability and fiscal decentralization. One of the important instruments to achieve this is intergovernmental transfers and, in Ethiopia, the fiscal decentralization strategy has been designed to articulate the existing transfer mechanism in a very holistic manner across the different tiers of government. One of the principles is therefore making transparent the overall calibration of the fiscal administrations and other stake holders, and indicates current development and future direction of the fiscal decentralization landscape.

4.2. Intergovernmental Transfers in Ethiopia

As in most federal systems, the aggregate revenue-raising capacity and the aggregate expenditure obligation do not correspond in Ethiopia as well. In addition to this, the extent of incompatibility of aggregate expenditure requirements and revenue-raising capacity among the same level of government is not the same. The introduction of intergovernmental fiscal transfers is one of the methods to reduce these vertical and horizontal imbalances and hence this part of the thesis, as mentioned above, analyzes the intergovernmental fiscal transfer system in Ethiopia in general and that of SNNPRS in particular⁷⁵.

The type of intergovernmental transfer from the federal government to that of the regional states involves revenue-sharing, general purpose grant, and specific purpose grant. Revenue-sharing arrangements are placed together with assignments of tax responsibilities and the federal constitution, under article 98, states that the following taxes: profit, excise and personal income taxes, on enterprise jointly established by the

⁷⁵ Ministry of finance, public expenditure program preparation manual

federal government and regional states; profits of companies and on dividends due to shareholders; and on income derived from large-scale mining and all petroleum and gas operations as well as royalties on such operations are jointly levied and collected. It is the House of Federation which determines the division of revenue between the federal and the regional states⁷⁶.

Revenue-sharing is therefore one of the constituencies of intergovernmental transfers applied to relax the powers of sub-national governments to provide services with determined shared revenues. It should be noted that revenues collected by sub-national governments on the taxes assigned and also on shared revenue are not absorbed by the grant system (i.e. the revenues are additional to the grant provided).

As far as the general purpose grant is concerned, the government identified decentralization as a precondition for democratization and economic development and poverty reduction. The constitution therefore creates federal state structures that devolve responsibilities and resources. In the fiscal aspect, this has been explained by the introduction of a general purpose grant initially from the federal government to the regional states, and later on from the regional government states to the districts.

In addition to correcting the vertical and horizontal imbalances, the general purpose grant to the sub-national level of government will help to create financial capacity for the provision of minimum standard of government or public services. The federal grant to regions is a very important element in the structure of public finance in Ethiopia and this

⁷⁶ Ministry of finance, public expenditure program preparation manual

accounts for not less than 75-80% of the government's expenditure. A grant to a region is allocated by using a formula which is designed by the Ministry of Finance and Economic Development and approved by the House of Federation. A formulaic approach in allocating transfers or grants to regional governments was first attempted in Ethiopia in 2001/02. However, there are attempts to improve the methodology of determining the size and character of the transfer based on countries' experience and constructive comments by from different stakeholders⁷⁷.

Accordingly, a new approach was introduced and proposed concerning the federal-regional general-purpose formula, and the new principle is based on horizontal fiscal equalization, which indicates that each regional government should be given the capacity to provide the average or standard of public services assuming it operates at an average level of efficiency, and make all the effort or average effort to raise revenue from its own sources. It takes into account those factors which determine existing disparities in expenditure needs and in the revenue capacity of regional governments. The determination of expenditure needs is made distinctly for each of the main categories of regional expenditure through expenditure assessments. However revenue capacity is also determined distinctly for each of the main regional tax instruments by the revenue-base assessment method.

The grant from the regions to districts is also allocated using formulas which are more or less similar to the federal-regional transfer type and the following part will analyze this in detail.

⁷⁷ Ministry of finance and Economic development, 2002

Article 52(2) of the Federal constitution of Ethiopia⁷⁸ and Article 47(H) of the constitution of SNNPRS⁷⁹ states that consistent with sub-article 1 of this article, States shall have the following powers and functions:

“To establish a State administration that best advances self-government, a democratic order based on the rule of law; to protect and defend the federal constitution; To enact and execute the state constitution and other laws; To formulate and execute economic, social and development policies, strategies and plans of the State; To administer land and other natural resources in accordance with Federal laws; To levy and collect taxes and duties on revenue sources reserved to the States and to draw up and administer the State budget”.



This same Article under sub-Art 2 states that regional states shall have the powers *“To enact and enforce laws on the State civil service and their condition of work; in the implementation of this responsibility it shall ensure that educational; training and experience requirements for any job title or position approximate national standards; To establish and administer a state police force, and to maintain public order and peace within the State”.*

The SNNPRS therefore prepares draft proclamations every year and approves the budget for each fiscal year. The regional government therefore approves the budget appropriated to the Regional, Sub regional (zone) and Woreda public bodies. As far as the budget administration is concerned, the Bureau of Finance and Economic Development is

⁷⁸ Constitution of the Federal Democratic Republic of Ethiopia, adopted sep,2000

⁷⁹ The Revised Constitution ,2001 of the Southern Nations Nationalities, and Peoples Regional State

authorised and directed to distribute the regional government revenue and other funds for undertaking by their respective organs. The Bureau of Finance and Economic Development has the authority to delegate the power of budget transfer to other public bodies including zones, special woredas⁸⁰ and woredas.

The SNNPRS public financial sources therefore include treasury funding, loans, assistance and retained money .However 80% of the finance of the region is covered by federal treasury transfer, while the rest 15%, 0.4% and 4.6% are being covered by regional tax and non-tax revenue, retained money and loan assistance respectively.

4.3 Allocation of Expenditure between the Different Administrative Levels

The cabinet at the federal level oversees the implementation of the fiscal decentralization strategy of Ethiopia and hence the strategy is primarily executed by the Ministry of Finance and Economic Development and hence this organ is responsible for designing the different intergovernmental transfers to regional states.

The regional government office of economic finance and development is in charge of this responsibility while the municipality and the finance office are responsible at the district level. At every tier, and regional government woreda and kebele⁸¹ levels, there are elected councils, administrators, deputy administrators, spokespersons, deputy spokesperson, 3-5 standing committees and cabinets composed of 7-9 members. The district administration and spokesperson report to the regional government.

⁸⁰ Special woredas are woredas who have more power than woredas because they represent one ethnic group who do not have zonal administrative structure.

⁸¹ Kebele is an administrative unit at the grass root level and hence under woreda administration.

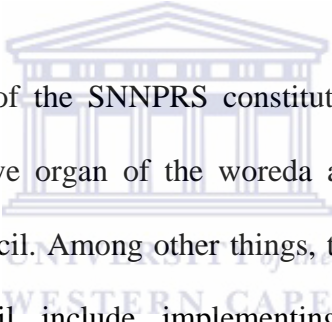
The financial resources of the regional state are allocated to the different administrative level (Region, zone, woreda and towns) and functions (contingency and region-wide programs) based on the expenditure assignment of each administrative levels. Finally, the money allotted to each administrative level is distributed to each individual woreda and town on a formula base. Hence, from the total sums, the fund for contingency and regional programs is deducted initially and then the rest will be allocated to the different levels. The actual budget allocation is the task of each administration and public body at each local government level.

In order to best understand the allocation of the district financial resources in the SNNPRS, the nature of district or woreda administration and their power first needs to be examined.

Article 90 of the SNNPRS states that the woreda administration is next to zonal administration hierarchies and consists of woreda council, the woreda administrative council and the woreda court⁸². Article 91 of the same constitution states that “the woreda administration shall have all powers necessary to prepare, determine and implement within its own administrative region, plans of social services and economic development and to enforce laws, policies and directives issued by the regional state“. It is also stated that “without the prejudice to the powers and rights to develop its own region and determine its own internal affairs, it shall be a subordinate to the regional state and zone”. [check quote] Members of the woreda council are directly elected by the people residing in the woreda and hence they are accountable to the people who elected them. Article 93

⁸² *The revised Constitution, 2001 of the SNNPRS.*

of the same constitution further specified the powers and function of the woreda council and hence the woreda council is the highest authority of the woreda and is accountable to the people of the woreda. The woreda council's powers and functions include approving social services, economic development, administrative plans, programs and budget of the woreda; approving the members of the woreda administrative council up on recommendation by the chief administrator; issue its own rules of procedures and ensure the timely collection of land tax, agricultural income tax, agricultural products sales tax and other taxes and payments. The woreda council can also call and question the chief administrator and other officials and investigate their responsibilities.



According to Art 97 and 98 of the SNNPRS constitution, the woreda administrative council is the highest executive organ of the woreda and is responsible to the chief administrator and woreda council. Among other things, the powers and functions of the woreda administrative council include implementing laws, regulations, policies, directives, plans, and programs issued by state and federal government; coordinating the executive organ of the woreda; following up and supervising their activities; preparing the woreda's annual budget; submitting it the woreda council and implementing the same on approval, and preparing socioeconomic and administrative plans and submitting it to the woreda council for approval.

4.3.1 Allocation of the district or Woreda Financial Resources

Let us analyze how the woreda financial resources are distributed by taking the planned budget of the SNNPRS for three years. The proposed budget of woredas in SNNPRS for 2005/6, 2006/7 and 2007/8 were Birr 960, 1061 and 1175 million respectively. Here the

source of finance is 79.3%, 18.5% and 2.2 % from regional treasury transfer, woreda revenue, and loan and assistance respectively. In allocating the financial resources to individual woredas in the form of block grants, the regional government since 2003/4 applies “the needs-based output conditional formula”⁸³. Initially 77% of the woreda finance is allocated for recurrent needs and the remaining 23% is allocated for capital budget needs and is added together into the block grant. The formula used to calculate the woreda block grant is summarized as follows.

$$BGw = BGr + BGc$$

$$BGr = \text{Salary} + \text{Operational Cost}$$

$$\text{Salary} = \text{Edusal} + \text{Healthsal} + \text{Agr.sal} + \text{Watersal} + \text{Roadsal} + \text{AGsal}$$

$$\text{OpCost} = \text{Edopc} + \text{Healthopc} + \text{Agri.opc} + \text{Wateropc} + \text{Roadopc} + \text{AGopc}$$

$$BGc = \text{Average of infra deficit and revenue indices} * \text{Woreda capital share.}$$

Where:

BGw = Block grant woreda

BGr = Block grant recurrent

BGc = Block grant capital

OpCost = Operational cost

Edopc = Education operational cost, e.t.c.

⁸³ SNNPRS Finance and Economic Development Coordination Bureau, June, 2005, Awassa.

It should be noted that both salary and operational costs of each sector are calculated by multiplying unit costs of beneficiaries in the sector programs by the target beneficiaries⁸⁴. The sector budget allocation is done by the woredas themselves during block grant allocation. However, the sector financial need is calculated and it is the basic element of the formula. Accordingly, the sector share from the recurrent budget is shown in the following table.

Table 4:1 Sector budget share from the recurrent resource in %

Source: SNNPRS Finance and Economy Development Coordination bureau

Sector	2004/5	2005/6	2006/7	2007/8
Education	44	49	49.7	51
Health	10.8	12	12	12
Agriculture	15.6	17	17	18
Water	1	0.6	0.5	0.5
Road	0.2	0.8	0.8	0.8
Adam and G.S	28.5	20.5	20	17.5
Total	100.0	100	100	100

⁸⁴ SNNPRS Finance and Economy Development Coordination bureau, paper on medium-term fiscal framework, 2005, June, Awassa.

The SNNPRS allocates health finance based on the following formula:

$$BG_w = BGr + BGc$$

$$BGr = BGe + BGh + BGw + BGr + BGa + BGag$$

BGc is calculated based on the relative infrastructure deficit index of the five sectors and revenue collection index where:

BGw = Block Grant Woreda

BGr = Recurrent component of the Woreda Block Grant.

BGc = Capital component of the Woreda Block Grant.

BGe = Education component of the recurrent Block Grant.

BGh = Health component of the recurrent Block Grant.

BGw = Water component of the recurrent Block Grant.

BGr = Road component of the recurrent Block Grant.

BGa = Agriculture component of the recurrent Block Grant.

BGag = Administrative and general service component of the recurrent Block Grant.

$$BGh = UC * \text{Beneficiaries}$$

Beneficiaries = all new visitors of health institutions

UC = $\frac{AvHWSal}{BHWR}$ + Standard operational cost per beneficiaries where:

BGh = Health component of the recurrent Block Grant

UC = unit cost

$AvHWSal$ = Average health workers salary = $\frac{\text{total health worker salary}}{\text{total health workers}}$

BHWR= Beneficiaries health workers ratio = Beneficiaries/Total health workers

Standard operational cost per beneficiaries = Standard cost for existing institutions/theoretical coverage

Theoretical coverage:

Health Center =25,000 population

Clinic = 10,000 population

Health Post= 5000 population

Standard cost for existing institutions:

Health Center = Birr⁸⁵115, 200.00

Clinic = Birr 23,600.00

Health Post = 8,200



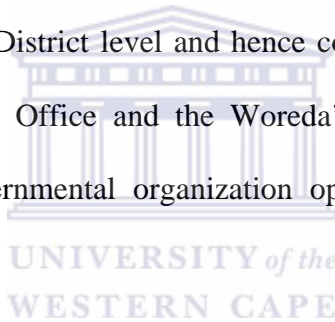
Though each health office, at administrative level, plans its health sector expenses, together with the finance office in each level, the above report from the SNNPRS finance and economic office⁸⁶ indicates that the share of the health sector to the different districts or woreda is determined by considering the number of health service beneficiaries as the major cost driver. The formula does not consider other factors in the allocation of health finance and many people in the district argue that the allocation of health finance is not fair.

⁸⁵ Birr is the Ethiopian paper money and 1 Birr = 0.1 Euro.

⁸⁶ SNNPRS Council, 2004, unpublished material

CHAPTER 5: Discussions of empirical findings - Part Two

This chapter is the continuation of the previous chapter and hence presents the main and major findings of the Thesis during the field research in Ethiopia. This chapter therefore has three parts. The first part deals with the different findings at the federal level and hence mainly concentrates on the Federal Ministry of Health and Federal Ministry of Finance and Economic Development. The next part of the paper addresses the findings at the regional level and hence it is devoted to analyzing the findings from the SNNPRS Health Bureaus, the Region's Finance and Economic Development Bureaus and the Council of the Regional Government People's Representatives. The last part of the paper deals with the findings at the District level and hence covers the Cheha District Health Office; the Woreda's Finance Office and the Woreda's Council. The view of other stakeholders such as nongovernmental organization operating in the District is also considered here.



5.1. The Federal Ministry of Health

Over the last decade, the government of Ethiopia has initiated a comprehensive economic reform program which has had an important bearing on the development of the key socioeconomic sectors including health. The Federal Ministry of Health has taken important steps in the decentralization of the health system and, as a result, the decision-making process in the development and implementation of the health system is shared between the Federal Ministry of Health (FMOH) the Regional Health Bureaus (RHBs) and the Woreda Health Offices (WHOs). The FMOH, after health service decentralization, concentrates only on policy matters and technical support.

The FMOH, in 2000, took two crucial measures and these are the development of the introduction of a new national health policy and subsequently the formulation of a comprehensive health sector development program (HSDP). Both of the reform measures undertaken are said to be the result of the critical assessment and analysis of the nature and causes of the country's health problem.

The Ministry of Health has specific focuses as far as the decentralization of health in Ethiopia was concerned, and it is argued that during the health system decentralization, the Ministry of Health strongly focused on democratization and decentralization of the health service system and hence there was an effort to democratize the health system⁸⁷. The ministry worked hard in the implementation and establishment of health councils with strong community representation at all levels and health committees at grass root levels to participate in identifying major health problems, budgeting, planning, and implementation, monitoring and evaluating health activities⁸⁸.

It is also argued that the health system decentralization in Ethiopia is realized through the transfer of the major parts of decision-making, health care organization, capacity-building, planning, implementation and monitoring to the regions with a clear definition of roles⁸⁹. It is further noted that, as a result of the decentralization of the health system in Ethiopia, the Ministry of Health is able to establish a health sector development programme which is based on the sector-wide approach (Swap). The ministry has a long-term strategic framework built on the partnership of the Federal Government, the health

⁸⁷ Ahmed, Sept 11, 2005.

⁸⁸ Ahmed, Sep11, 2005.

⁸⁹ Gedissa, Sep13, 2005.

sector donors and NGOs and the private sector in the planning, implementation, monitoring and evaluation of the program. Concerning the problems the health sector of the country has, it is argued that shortage and quality of skilled human resource at all levels and financial constraints for capital investment and to meet recurrent costs are the major ones⁹⁰.

Theoretically speaking, it is said that decentralization in the health sector can be discussed as a process which involves a variety of mechanisms to transfer fiscal and administrative ownership and /or political authority for health service delivery from the Central Ministry of Health (MOH) to alternate institutions. The main objectives are also efficiency, quality and equity and these were also the objectives of the FMOH in Ethiopia too. As far as the decentralization of the health system in Ethiopia is concerned, the Ministry of Health, as a principal, has transferred huge duties and responsibilities to the agents which are the Regional Health Bureaus and Woreda Health Offices⁹¹. The Federal Ministry of Health (FMOH), as a principal, is responsible for the formulation of health sector policies, plans and health care standards, provision of technical assistance, logistical support and advice to RHBs. The Ministry Office as a principal is also responsible for the promotion of expansion of equitable health service throughout the country, conducting and coordinating monitoring and evaluation activities, coordination of foreign assistance and other resources for the health sector and, in collaboration with appropriate institutions, the development of policy guidelines and standards for the training of health workers.

⁹⁰ *Gedissa, Sep 11, 2005.*

⁹¹ *FDRE, Ministry of Health, 2005.*

The Principal, the FMOH, has interests in the agents and this is the efficient provision and promotion of the expansion of equitable health services throughout the country and, for that reason, it transferred many responsibilities so that the ministry would realize the national health objectives of the country. The Ministry, as a principal, has controlling mechanisms through which it will make sure that the agents, the RHB and the WHO, are implementing the national health policy of the country. This includes monitoring and evaluation, supervision and follow-ups of the activities of the RHB and that of the WHO. Though the agents have an agreement to implement the interests of the principal, they have their own interests too. In the SNNPRS RHB, for example, there are areas of priorities that the Bureau wants to address first which might not be the interest of the principal. There are region-based diseases, for example, which are the interest of the agents and this might not be of interest to the principal, who has a national health policy.

5.2 The Federal Ministry of Finance.

The other important principal in the health system decentralization is the Federal Ministry of Finance and Economic Development which is responsible for the fiscal decentralization taking place in the country. The fiscal decentralization has a direct impact on the health system decentralization, as the health finance allocation is changed by the fiscal decentralization⁹². The main responsibility of the Finance and Economic Development Ministry of Ethiopia in the decentralization of the revenue-expenditure was implementing sound fiscal decentralizations and hence to devolve fiscal decision-making power to lower tiers of government such as the Regional and Woreda Governments. The other specific objectives of the ministry were to enable Regional and Woreda Governments/Administrations to provide standard activities in accordance to functional

⁹² *Tizta, ministry of Finance, Sep2005.*

assignments; to narrow the horizontal fiscal gap and ensure horizontal equalization; to promote efficiency in the allocation of financial resources, and to maintain consistency between macroeconomic stability and fiscal decentralization⁹³.

Concerning the grant system, the Federal Government applies, it is argued, that the general purpose grant provides discretion on the use of financial resources by the regional government and subsequently to the Woredas⁹⁴. Therefore, encouraging local decision-making is the main value of the Ministry office. It is also said that the transfer formula addresses both efficiency and equity during the allocation of resources to regions and also considers policies, the available resources and expenditure needs at macro level. According to the focus group discussion with staff of the Ministry of Finance and Economic Development (MOFED), the Ministry designs the intergovernmental transfer formula but it needs to be approved by the House of Federation with the aggregate level and its distribution needs to be approved by Cabinet and Parliament⁹⁵. The formula is calculated by taking in to account population, level of development, expenditure needs or development level variables and fiscal effort as well as performance measurement in key sectors with weights assigned to the main indicators. The formula, the ministry applies therefore may change from year to year based on needs to adjust it. It is very difficult to understand how the level of development was used to grant finance and, sometimes under the cover of this variable, there are regions that got inequitable grants compared to others

⁹³ Ministry of Finance and Economic Development, policy paper, 2004.

⁹⁴ Ministry of Finance and Economic Development, policy paper, 2004.

⁹⁵ Focus group discussion, Sep13, 2005.

and hence the variable lacks sound definition⁹⁶. However it should be noted that population, poverty, level of development/expenditure needs and revenue- raising effort and sectoral output performance are the main indicators.

The transfer mechanism definitely affects the provision of services such as health by local governments. This is because the Ministry of Finance takes into account the number of beneficiaries in the health sector, for example, when they calculate the need for expenditure.

5.3 SNNPRS Health Bureau

The SNNPRS Health Bureau is a very important actor in the decentralization of the health system in the SNNPRS and hence it is an agent for the FMOH. As an agent, it has a contract with the Ministry of Health and hence is responsible for implementing the national health policy at the regional level. The type of relationship the regional health bureau has with the FMOH is based on mutual interest and the RHB has the power to independently formulate regional health care plans and programs based on national health policies and health development programs. The establishment and management of the health facilities (health centers, health posts) and training institutions, and recruitment, training and administration of mid-level health professionals including health extension workers, are also the responsibility of the RHB. The procurement and distribution of drugs, equipment and other medical supplies; invitations for bids, evaluating contract awarding, and supervision of construction of health facilities (HPs and HCs); monitoring

⁹⁶ Getachew, head of the finance office of the SNNPRS health office, Sep16, 2005(Getachew further noted that as the intergovernmental transfer indicators such as population are vague the regional government is in the process of changing the criteria for the intergovernmental transfers).

and evaluation of the implementation of health programs and writing progress reports on the implementation of the FMOH are also the major responsibilities of the RHB⁹⁷.

It is argued that the community of the SNNPRS seems not to accept the regional health policy which gives emphasis to protection against diseases⁹⁸. Zeleke argues that the regional state was somewhat forgotten during the previous military government's rule and hence the region's health coverage, taking into account the criteria of the World Health Organization, is only 50%. According to the World Health Organization, an area is said to be covered under health services if the community can access health institutions such as hospitals within two Kilometers. It is also noted that health service provision by the SNNPRS Health Office is only urban area-based and hence this is a very great obstacle to providing health services for the rural people who comprise more than 80% of the total population of the region. As far as the major problem of providing health services in the region is concerned, it is noted that lack of health professionals and health finance is the major ones⁹⁹.

It was further noted that though power is devolved up to the District level, lack of resources such as skilled manpower and capital challenged the efficient provision of health service. Asked about the mechanism which the regional government uses to follow up the activities of the Woreda level health offices, the head of the SNNPRS Health Office noted that a meeting is held every six months with the District Health Offices in order to discuss problems related to health service provision. He also said that there are

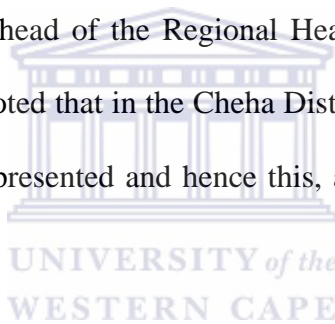
⁹⁷ *Federal Democratic Republic of Ethiopia, Ministry of Health, 2005.*

⁹⁸ *Zeleke, SNNPRS, Sep15, 2005*

⁹⁹ *Zeleke, SNNPRS; Sep15, 2005.*

efforts to organize different workshops and conferences in order to share experiences with different District Governments.

The Regional State which is very wide¹⁰⁰ has little contact with the Cheha District and there are no appropriate monitoring and evaluation mechanisms which the RHB as a principal uses to make sure that the Woreda Health Office that is the agent is acting according to the Regional health policy. There is a very wide gap as concerns the relation of the RHB with that of the WHO, and this is creating a problem with regard to information-sharing. Asked about the way the Cheha District Health Office is operating with the District Council, the head of the Regional Health Bureau said that he has no information at all. It must be noted that in the Cheha District Council Cabinet, the Health Office of the District is not represented and hence this, according to the District Health Office, has a negative impact.



5.4 The SNNPRS Finance Office

The SNNPRS Finance Office is the other important institution in the decentralization of the health system in the SNNPRS. This is because it is the Finance Office which decides on the distribution of the block grants which go to the different Districts including the Cheha District. The Finance and Economic Development Office of the SNNPRS has a tremendous responsibility in allocating the block grant which is transferred to the Woreda Districts and hence this part will focus on an in-depth analysis of how the Regional intergovernmental transfer is allocated by the office.

¹⁰⁰ SNNPRS is a unification of four previous regional states that are squeezed into one by the federal government for the sake of administration, and has more than 114 districts.

It is argued that, in the SNNPRS, the decentralization of the health system was introduced in 2002 when the region was devolving all powers to the District Governments and hence the financial responsibility was also devolved to the Woreda Finance Office¹⁰¹. The Region's Finance Office allocates the block grant to the Woreda Finance Office and it is the responsibility of the Woreda Finance Office to allocate the money to the different sector offices of the District. It is further noted that though revenue and expenditure power was devolved to District Governments, the decentralization took place in a region that is suffering from a lack of adequate human resource at the District level. In the mechanisms by which the block grant is transferred from the Regional Government to the District Government, population, revenue-raising ability of District Governments and the level of backwardness¹⁰² are the main criteria in determining the amount of the block grant. It is said that the idea of decentralization is always good and an intergovernmental transfer is a very good instrument to address the problems related to revenue-raising power by local government. However, in the SNNPRS, before implementing the devolution type of decentralization, the Districts need to be capacitated first both in revenue expenditure responsibility and in terms of human resources, and hence, the decentralization that took place in the SNNPRS is ambitious¹⁰³.

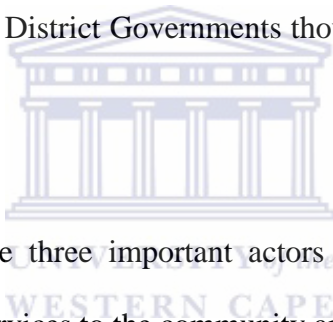
The other crucial institution in the decentralization of the health system is the Woreda Health Office, and both the FMOH and the SNNPRS HBS are the principal while the Woreda Health Office is the agent. The Cheha Woreda Health Office (WHO), as an

¹⁰¹ Getachew, head of the finance office of the SNNPRS health office, Sep16, 2005

¹⁰² Level of backwardness is measured in terms of access to socio economic services such as infrastructure, health service coverage and education.

¹⁰³ Getachew, head of the finance office of the SNNPRS health office, Sep16, 2005

agent, needs to work on the basis of the rules and regulations of the two principals. The responsibility of the WHO therefore includes District level health planning, resource allocation implementation, and monitoring and evaluation. Implementation of health programs include the construction of health facilities, management of District health facilities (District hospitals, HCs and HPs), including human resources, and the selection of sites for the construction of health facilities including the supervision of construction are the activities performed by the agent and hence the following part of the thesis analyzes the institutions affecting health service delivery. Therefore, the SNNPRS health office focuses only on policy issues and hence the health service provision responsibilities are devolved to District Governments though they face many obstacles to implement them.



5.5 The Cheha District

At the District level, there are three important actors which affect the efficient and effective allocation of health services to the community and these are discussed below.

5.5.1 The Cheha District Health Office

The Cheha District Health Office is located in the District's main town called Emdibir and the main task of the office is to provide health services by combining the resources from all interested stakeholders such as NGOs working in the District, other neighboring District Health Offices and in the community of the District. Therefore, improving the health conditions of the community is the central objective of the District Health Office.

The Woreda Health Office is responsible for District level health planning, resource allocation, implementation, monitoring and evaluation. It is also responsible for implementation of health programs including the construction of health facilities, and the

management of District health facilities such as District hospitals, health centers and health posts¹⁰⁴. The selection of sites for the construction of health facilities including the supervision of construction is also the mandate of the District Health Office.

Although the District Health Office has such goals, the realities on the ground and the observation of the researcher are that the District Health Office has so many challenges and obstacles that hinder it from achieving its goals¹⁰⁵. The figure about the number of health institutions is a bit shocking and hence there is only one hospital, two health centers, three clinics and 6 health posts which provide health services for about around 200,000 people¹⁰⁶. There is no public hospital at all, and hence even the hospital and the two health centers are owned by nongovernmental organizations, and this shows the lack of concern from the government's side with regard to the health services in the District and, due to this, the primary health care coverage is only 49.4%¹⁰⁷.

According to the report of the Cheha District Health Office¹⁰⁸, there are 57 health professionals working in the government-owned health centers while there are also around 57 health professionals in nongovernmental organizations operating in the area. Among the 57 health professionals working in the District, only four of them work in the District's Health Office in the area of management while the rest are assigned to different health institutions operating in the District. Of these four health professionals serving the

¹⁰⁴ Health centres are bigger institutions than health posts.

¹⁰⁵ Eyoel, Sep17, 2005, Emdibir.

¹⁰⁶ Focus group discussion and observation, Sep19, 2005.

¹⁰⁷ Cheha woreda Health office report of the 2004/5 health service activities.

¹⁰⁸ Cheha woreda Health office report of the 2004/5 health service activities.

District Health Office, there is no Medical Doctor and hence all are Nurses¹⁰⁹. The District has a very serious shortage of health professionals and even the four Nurses serving the District Health Office are not well trained in the necessary skill to manage the District health system. None of the Nurses are trained in management and hence lack the appropriate management skill¹¹⁰.

Though there are still many problems related to the provision of the health services by the Cheha District Health Office, there is some progress and improvement in the provision of health services over recent years¹¹¹. This can be understood from the table below which shows the different health services provided by the District Health Office.



¹⁰⁹ *Eyoel, Sep17, 2005, Emdibir.*

¹¹⁰ During the focus group discussion, the participants said that they never had training on management-related issues and this undermined their actions in managing the activities of the health service in the district.

¹¹¹ Focus group discussion, Sep20, Emdibir.

Type of health services.	Number of Beneficiaries in % 2002	Number of Beneficiaries in % 2003	Number of Beneficiaries in % 2004	Planned Number of Beneficiaries in % 2005/2006
vaccination coverage for children,	50.8	51.1	57.4	93
Smallpox	55.3	32.9	55.3	75
Vaccination for pregnant women	53.3	25.5	62.8	70
Vaccination for non-pregnant women	37.5	22.2	35.7	85
Health education coverage	-	29.1		90

Family planning coverage	13.7	24.2	44.3	60
Sanitation coverage	31.7	40.5	96.3	98

Table 5.1: Health service provision by the Cheha district health office
Source: Cheha district health office.

From the above table, it is possible to see that the number of beneficiaries of the health service increases from time to time. For example, the smallpox vaccination coverage increased by 6.6 % from the years 2002 to 2004, and vaccination for non-pregnant women also shows an increase of 9.5 percent. We can see a very dramatic change with regard to the health education coverage and, according to the panelists, there was no health education for the community during the year 2002 and 2003 but, in 2004, the Woreda Health Office provided health education for 29% of the community and this was mainly because of the spread of HIV-AIDS at an alarming rate. The District Health Office also planned to provide health services for 90% of the community by 2005/6.

The District Health Office has also been able to realize a increase in family planning as the number of people who are using family planning increased by 30.6% when we compare the figures for the year 2002 with that of 2004. However, the panelists told the researcher that most of the health centers, including the hospitals, are owned by the Catholic Church and

this had an adverse effect on the introduction of family planning as the Church believes only in natural and not man-made methods of family planning. We can see also a very good improvement especially in the provision of sanitary services. The panelists told the researcher that community awareness about sanitation increased greatly, and they had started building communal latrines in collaboration with the local community and, by 2004, 96.3 % of the District's community had access to sanitation.

Therefore, it is noted that the Cheha District Health Office has committed staff that work hard and are doing their best in order to provide effective health services for the community¹¹².

It is noted that though there are efforts to provide health services in an efficient way, there are still many problems and obstacles facing the Cheha District Health Office¹¹³. Therefore, it should be understood that the main activities of the Cheha District Health Office include organizing and conducting training for the health professionals in the District, monitoring and evaluation of the activities of all health institutions in the District and making a follow-up visit to the different health centers in the District. The District Health Office implements the Regional Health Bureau's health policy and, in doing so, the office gets much support from the Zonal¹¹⁴ level Health Office whose responsibility is only coordinating the activities of District Health Offices and giving some technical assistance to the District Health Office staff.

¹¹² Focus group discussion, Sep20, Emdibir

¹¹³ Tamrate, Sep, 20, 2005, Emdibir.

¹¹⁴ Zone is a local government administrative unit above woreda but its role is only coordination.

As far as the outcome of decentralizing the health system is concerned, the Cheha District witnessed some progress in the allocation of health services. It is further said that, before the health system decentralization took place, it was the Zonal administrative unit which implements all the health policy and hence the District Health Office was directly accountable for the Zonal Health Office. However, after the health system was decentralized to the District level, it was the District Health Office that implemented the Regional Health policy, monitored and evaluated the health institutions operating in the District and hence exercised more power¹¹⁵. The District Health Office prepares its annual plan, proposes the required budget to implement its activities, and also prepares reports on activities conducted by the Regional Health Bureaus.

Sharing the same view, it is argued that the Cheha District Health Office is doing its best to make the community a greater participant in the provision of health services¹¹⁶. It is also noted that there are two lower hierarchical administrative levels below the Woreda Health Office, and these are the Kebele Health Posts and the Village Health Posts which are located at the grass root level in the community. This structure of the District Health Office, according to the information from the Cheha District Health Office, helped the office to access the community very easily and hence was very effective for health service delivery. I have asked also if there is a controlling mechanism which the District Health Office uses, and the Woreda Health Office made it clear that there are controlling mechanisms through which the District Health Office ensures that the lower level institutions are performing their activities efficiently and these includes following-up the activities of the Kebele and Village Health Posts through monthly meetings, session

¹¹⁵ *Tamrate, Sep, 20, 2005, Emdibir.*

¹¹⁶ *Argawe 19,2005,Emdibir*

encompassing all role-players, monitoring and evaluation and supervision. Field visits are also another mechanism for following up on their activities.

Asked about the main problems the Cheha Health Office faced, staff of the Office noted that the problems of health service delivery in Cheha District are very complex and complicated. Some of the problems include lack of skilled manpower, unfair and inadequate allocation of health finance, and these are among the major obstacles for health service delivery in the District. It is said that the District Health Office has a wide gap as far as health professionals are concerned and, currently, only four professionals are serving the office, which has 12 vacant posts. Therefore, 75% of health professionals are not recruited in the District, and the reason given for this is the lack of adequate finance for the health sector and the migration of health professionals from government-owned health institutions to the private sector in their search for better incentives.

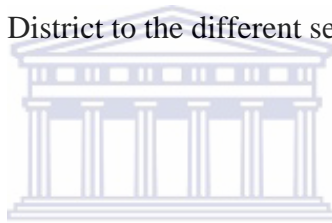
According to the Cheha District Health Office, health finance allocation is the biggest problem in the provision of efficient health services. This is because, according to two staff members of the Health Office, it is the District Council¹¹⁷ which has more say about the distribution of the District revenue to the different sectors such as education, health and agriculture. What is surprising is the fact that the Health Office has no say at all on health finance except to propose the necessary amount of money needed for the health service activities¹¹⁸. Therefore, the Health Office always gets very little health finance and hence

¹¹⁷ It is the woreda council who decides the budget share of each sector including health, and the district does not have a formula on which the share of each sector can be decided. This is not the case at regional level as the regional government has some formulas to determine the grant allocated to different districts.

¹¹⁸ Tamrate, Sep, 20, 2005, Emdibir.

the revenue distribution by the District Council is not based on a scientific formula or needs assessment and is vague. The district Council is the government institution and most of its staff don't have any education and are basically appointed for political reason only mainly for supporting the ruling party.

The District Health Officers therefore noted that their Office is not represented on the Cabinet that approves the budget allocated to the different sectors. As a consequence of this, the researcher interviewed one of the important institutions influencing health service provision and that is the District Finance Office. The researcher studied how the Finance Office allocate the revenue of the District to the different sector offices, and this is discussed in the next part.



5.5.2 The Cheha District Finance Office.

According to Art.98(1) of the revised constitution, 2001 of the SNNPRS, the Woreda Administrative Council has the right to prepare the Woreda's annual budget , submit it to the Woreda's Council and implement the same on approval. The Woreda Finance Office is the responsible organ for determining the share of the different sector offices of the District such as health, and the proposed budget needs to be approved by the Woreda Administrative Council which consists of the chief of each sector such as capacity-building, agriculture etc. As we have seen above, the information from the Cheha District Health Office testified that health finance allocation among the different sector offices by the Finance Office is not fair, and is unjustly allocated. However, according to the Cheha District Finance Office staff, the District Finance Office is doing well, and hence the

allocation of District revenue among the different sector offices is fair. The District Health Office has rules and regulations whereby revenue is distributed and the Office works hand-in-hand with the Woreda Council and other sector offices.

The Finance Office is also encouraging the community to be aware the relevance of paying taxes so that the revenue-raising power of the District is improved. The community, according to the Finance Office of the District, is now well aware of the relevance of paying taxes and hence the Office is doing well in this regard.

The chief executive of the District Finance Office further noted that the Finance Office is expected to mobilize the revenue for the District and the main tax base for the District is the income tax from workers, merchants and the peasants. The District Finance Office distributes the revenue for the different sector offices based on the number of beneficiaries proposed by each sector office. Most of the budget, which goes to the different sectors, comes from the intergovernmental transfers by the Regional Government in the form of block grants. Poverty reduction, rural development and education are the priority of the Woreda Finance Office. Concerning the mechanisms through which the Finance Office determines what money should go to which sector or the criteria used in transferring the money to different sector offices, the Finance Office needs to revise and develop it well. The Finance Office accepts the budget requisition from each sector office and then determines the budget for each year without applying any sound criteria though there are some developed by the Regional State Finance Office. The final decision concerning the budget is done by the Woreda Council Cabinet. According to Art.97 of the SNNPRS

constitution, the Administrative Council or the Cabinet is the highest administrative organ of the Woreda. It is responsible to the chief administrator and the Woreda Council. It should be noted that the Administrative Council comprises the chief and deputy administrators and heads of offices. It must be remembered that according to staff of the Woreda Health Office it is being mentioned that there is unfair allocation of health finance, but the information from the Finance Office, against the view of the Health Office staff, indicates that the Woreda Finance Office has a formula through which it allocates a budget and the only problem they had is the inadequate funds allocated to them¹¹⁹.

However, unlike the view of the chief executive of the Finance Office that the Office has a good mechanism in determining the allocation of funds to the different sector offices, the researcher observed that there are no written and documented rules and regulations or formulas which the Woreda Finance Office uses to distribute the budget to different sector offices. The Finance Office organizes a meeting and then listens the budget requisition of the representative of each sector office, which are members of the Administrative Council. Then the budget is allocated based on the argument of each individual who represents the different sectors. Unfortunately, the Health and Education sector offices are represented by one individual from the education sector in the Administrative Council and, hence, the health sector was getting a much smaller budget, unlike the other sector offices which have a very limited budget need.

¹¹⁹ Zeytuna 24,2005,Emdibir

Therefore though in the law of the Regional Government it was stated that the Woreda Administrative Council should consist the head of each sector office in the Cheha District, the Health Office is not represented at the Council and this has a negative impact on the allocation of health finance.

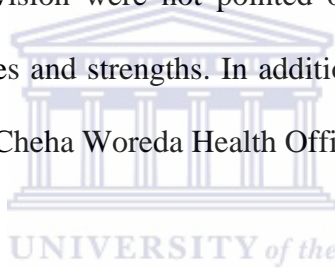
The Woreda Finance Office has also a serious problem with regard to professional capacity. Most staff, including the chief executive, are in their positions not because of merit but for political reasons or because they are loyal to the ruling party. The member of the ruling party controlled all key positions in the office and there is a very serious need for professional workers as the finance office seems unable to work in an efficient manner. There are very clear symptoms of the possibility of corruption in the office and, for example, the chief accountant of the District Finance Office is the husband of the chief executive of the Finance Office and such relations may put accountability and responsibility in danger.

The interference of the ruling party in each and every staff complement of the civil service in the finance office, the lack of professional staff and lack of responsibility and accountability therefore seem to be the main problem in the revenue and expenditure allocation responsibility of the District, and this has a very negative impact on the provision of social services such as health. The finance Office however noted that the lack of willingness of the community to pay taxes is a major problem in the District, and the community needs to pay taxes on time. The government should try to recruit professional workers and should also try to capacitate the District with human resources and this will contribute to the efficient allocation of finance for health services.

Chapter 6: Conclusion and Recommendation

The objective of this last Chapter of the Thesis is to conclude the findings of the Thesis and then make some recommendations based on the findings of the Thesis.

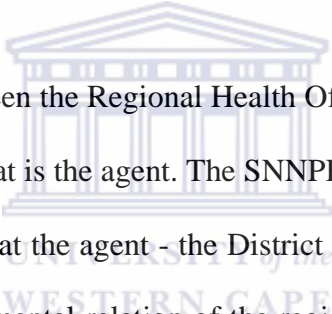
The implementation of health policy at community and household level is crucial to ensure rural development and healthy citizens. Key obstacles in the sector that hinder the SNNPRS Health Bureau's vision in general and that of the Cheha District Health Office's vision in particular from being realised were not properly identified previously. There was not a lot of research done in the SNNPRS and the Cheha District, and the problems related to health service provision were not pointed out with regard to internal and external situations, opportunities and strengths. In addition, problem-solving approaches are not yet implemented at the Cheha Woreda Health Office.



However, based on the findings of the paper, it is possible to conclude the following points:

The FMOH has exercised decentralization of the health system in Ethiopia, and hence devolved all power and responsibility to the Regional Government's Health Office, and finally to the District level Health Office. The SNNPRS Health Office therefore also devolved all power and responsibility to the Cheha District Health Office at the grassroot level of the government. The Cheha District Health Office has full rights in terms of deciding health issues in the District with the exception of health finance, and interference from higher level government institutions such as the MOH and the SNNPRS Health Bureau is very low. It is thus possible to conclude that the decision-space of local governments in the SNNPRS is very wide.

The SNNPRS, as discussed in Chapter four, has a vague intergovernmental transfer, especially with regard to the indicators of the intergovernmental formula. This is because some of the criteria are not well defined and are vague. For example, backwardness is said to be one of the criteria in distributing the block grant among the existing Woredas but the term ``backwardness'' is not well defined, and the politicians simply point out one of the Woredas they belong to as being backward and favor them during the allocation of finance. Therefore, the intergovernmental transfer needs to be studied well and revised based on scientific methods.



There is a very weak link between the Regional Health Office that is the principal and the Cheha District Health Office that is the agent. The SNNPRS Health Bureau does not have the instruments to make sure that the agent - the District Health Office -is performing its function well. The intergovernmental relation of the region is therefore somewhat weak. Weak supportive supervision and feedback from higher levels such as the Regional Health Bureau and that of the Zonal Health Office also made health service delivery inefficient. The Regional Health Office needs to strengthen its relations with the Woreda Health Offices through different mechanisms such as meetings, workshops and supervision.

The Council of the Cheha Woreda District, which is the other important principal, also has very poor relations with the District Health Office. The way the Council assigns the budget among different sector offices is very vague and lacks openness and needs to be

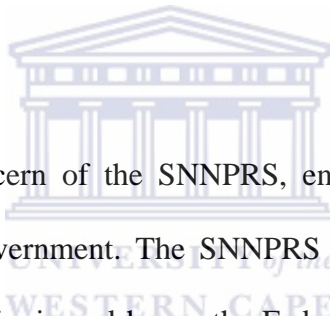
revised. The Health Office is also not represented in the Cabinet of the District Council and this also needs to be assessed, and the health sector should be represented like other sector offices in the Cabinet.

The other key obstacles to the provision of the service include budget shortages for the health sector and a lack of professionals in the Health Office, both in the area of health and management. The health finance assigned to the Cheha District is not enough and hence there is limited access to health services and also a limited utilization of the already existing health resources. The quality of the available services is also poor. Weak implementation and absorptive capacity at all levels, especially at the grassroots level, and weak integration with partners and empowerment of the community in health care delivery and co-management of health care system are also the problems of health services in the District. The Cheha District Health Office also has poor analysis and utilization of decision-making capabilities, and private health sector expansion is also very poor in the District.

Although the above-listed problems are impediments both to the SNNPRS and the Cheha District health services, the key problem is the shortage and unfair allocation or assignment of health professionals in management posts and the lack of adequate response to structural demands as well as the recurrent budget deficits with regard to health finance.

It is the belief of the writer of this Thesis that the following recommendations can be made based on the findings of the research, and the recommendations will contribute to solving the problems related to health service delivery in the SNNPRS in general and the Cheha District in particular.

The first recommendation is that the role of intergovernmental relations in Ethiopia in general and that of SNNPRS in particular need to be well studied and conceptualized. The intergovernmental transfer by the SNNPRS needs to be studied in-depth and revised. The criteria for assigning the expenditure budget to each District needs to be studied well.



As health is the primary concern of the SNNPRS, enough health finance should be allocated by the Regional Government. The SNNPRS is one of the widest and most complex regional states of Ethiopia and hence the Federal Government needs to further study the disadvantages and advantages of administering such a very large and complex region under one regional state¹²⁰. The Ministry of Finance and Economic Development also needs to thoroughly follow up the activities of the SNNPRS Finance Office. The Ministry also needs to work on improving the intergovernmental relations it has with the SNNPR Finance Office.

In addition, the Ministry of Health needs to strengthen its relations with the SNNPRS Health Bureau specially with regard to solving the severe health professional shortage in

¹²⁰ SNNPRS is a unification of four regional states and there is a very strong armed struggle being waged by some of the ethnic groups to have their own regional state. As Ethiopia is following ethnic federalism, it is very difficult to govern more than 45 ethnic groups residing in the Southern part under one regional state. The people need to be asked whether they want to be administered as one regional state or not. It was the government which simply squeezed the four previous regional states into one regional state.

the region. The SNNPRS Finance Office is recommended to strengthen its source of finance and also review the intergovernmental formula it uses to allocate the block grant to different Woreda Administrations. The SNNPRS Health Office is also expected to work hand-in-hand with the Cheha Woreda Health Office, especially with regard to training for health professionals who serve in management positions in the Cheha District Health Office.

The Cheha District Council needs to avoid interfering with the activities of the different sector offices such as health and needs to respect the power granted by the constitution of the country. The Council also needs to represent each sector office in its Cabinet. The Cheha District Finance Office also needs to have a very sound and open formula through which the District expenditure is allocated to the different sector offices in a justifiable way. The District Finance Office also needs to make sure that the budget of the Woreda is used for its intended objective, and not for some political agenda of the government and, hence, there should be neutrality. The Finance Office also needs to strengthen its controlling mechanism with regard to its financial management.

The Cheha District Health Office also needs to strengthen its relationship with other stakeholders, such as the private sector and NGOs and the Ethiopian Catholic Church which has so many health-related projects in the District. The District Health Office needs to raise its capacity through training and workshops by working with the Regional Government Health Office. The District Health Office therefore needs to work on in-house staff training, especially in the area of monitoring, evaluation and training in the fields of administration.

List of Interview Partners.

Ahmed Dereje. Staff member Ministry of Health, September 11, 2005, Addis Ababa, Ethiopia.

Argawe, Roba, Coordinator of the Cheha district health offices, Cheha district health Office, Sep 21, 2005, Emdibir.

Eyoel Tesema. Project officer of the Emdibir Archdiocese of the Catholic Church, Sep, 17, Emdibir.

Fikru Zeleke, Spokesperson of the SNNPRS people representative council, SNNPRS Council of the people's representative, Sep 12, 2005, Awassa, Ethiopia.

Gedissa J. Data and Information Office Coordinator, Ministry of Health, Sep 13, 2005. Addis Ababa, Ethiopia.

Getachew Eshetu, Program Coordinator, Economic and Finance Coordination Office of the SNNPRS, Sep15, 2005, Awassa, Ethiopia

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Tizita Amare, Program Coordinator of regional budget affairs, Ministry of Finance and Economic Development. Sep 3, 2005, Addis Ababa, Ethiopia

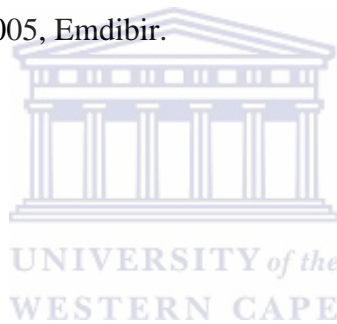
Zeleke Gobe, Head of the SNNPRS Health Bureau, SNNPRS Health Bureau, Sep 15, 2005, Awassa, Ethiopia

Zeytuna, Ibrahim, chief executive of the Cheha district finance office, Cheha district finance Office, Sep, 21, 2005, Emdibir.

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