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Health and Decentralization: The Case of Gozamin District, Amhara State, Ethiopia

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Abstract
Decentralization is assumed to be an important tool for a quality health care service delivery. The objective of the study was to assess the impacts of decentralization on the health care service delivery Gozamin District, Amhara State, Ethiopia. Primary data for this study were collected through questionnaire, interview, and focus group discussions. Whereas secondary data were collected from annual official health sector reports and documents. The analysis part was supported by legal and official documents. The findings of the study revealed that the health care service accessibility and coverage of the District in terms of expansion of health care institutions has shown an improvement, and it reaches 100 percent. However, shortage of health personnel (midwifery, lab technician and pharmacy technician), shortage of finance for duty service and perdiem payment, and drugs shortage are the challenges of the District health care delivery system that affects the quality of the services. The costs of health care treatment is high as compared to the ability of most beneficiaries incomes, the free service scheme-which is very impressive were abused by *kebele* officials are the challenges of Gozamin District health care service delivery system.
Keywords: Decentralization, Health Care Service Delivery, health center, and health posts

Introduction

Decentralization can be defined as the transfer of authority and responsibility for public functions from the central government to lower or quasi-independent government organizations or the private sector (Rondinelli*, 1989).* Power transfer of includes political, administrative or managerial and fiscal authority from the central government to lower levels of governments (WB, 2000). Nowadays , decentralization is seen as a policy choice, where by every country is inclined towards decentralized government system in view of administering and providing services effectively and efficiently and ensuring good governance (Bernard, 2011). Regardless of difference in the levels of socio- economic and political development, both developed and developing countries have embarked on a dramatic change on the government system; from a very centralized to a decentralized one (OECD, 2004).

Historically, Ethiopia in the previous two successive regimes was characterized by a tight centralization of all socio-economic, political and administrative spheres where the centre overwhelmingly control the authority, and decentralization was considered as a threat to the central administration (Dickovick and Tegegn, 2010). However, since 1991, the Ethiopian government has undergone decentralization process and adopted federal form of government and divided the country in to nine self-governing states and Addis Ababa city Administration. Settlement pattern, consent of the people concerned, language and identity criteria were used to demarcate regions (FDRE Constitution, 46 (2). Considerable political, fiscal and administrative powers were devolved from the centre to the regions with the objectives to keep the country from disintegration via addressing a long standing nationalities question. Moreover, the 1995 FDRE constitution under Art.39 guaranteed to the Nation, Nationality and People of Ethiopia:

> *" to have unconditional rights to self-determination, including the right to secession; to have the right to speak, to write and to develop its own language; to express, develop and promote its culture; and preserve its history; to have the right to take full measure of self-government which includes the right to establish institutions of government in their respective territory that it inhabits and have equitable representation in state and Federal governments"(FDRE,* 1995: Art.39).

The FDRE constitution notes that, the State governments can establish other administrative levels if they find necessary and adequate power shall be granted to them to enable the People to participate directly in the administration of such units' (Art.50/4). Accordingly, the state governments have established local governments in a way that fits their specific circumstances. Heterogeneous states have formed Zones or special states on ethnic bases. The relatively homogenous states established District governments. The powers and functions of Local Governments (Zonal, District and kebele) therefore, derive from the states' functions and powers. The objective of District level decentralization was to improve service delivery, to have more participatory governance, and to promote economic development through empowering local communities by shifting decision-making powers down to the grass-root level (Dickovick and Tegegn, 2010; Hashim, 2010).

The Amhara state as per the federal constitution, has established its own state structure to administer

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regional socio-economic development, manage ethnic diversity that exists there and to improve public service efficiency. Accordingly, the revised constitutions of the Amhara state provides that the administrations of the states are arranged by nationality administrations, District and *Kebele* level. There are 11 functional zonal administrations in the state.

Health service under decentralization system necessitates transferring certain functions to the local levels so as to meet the health needs of the citizens (Kwoyiga, 2010; Bossert, 1998). This is because of the fact that decentralization promises for the betterment of local health service provisions for a better quality of life (UNICEF, 2009). In line with this sprite, health service responsibilities have been separated among the Federal, State, Zonal, and District level of government. The District levels of governments are assigned to carry out socio-economic responsibilities within their jurisdictions. They are also assigned to provide basic social services such as education, health and water services. Hence, the aim of this paper was to investigate the impacts of decentralization on the health care service provisions in Gozamin District in Ethiopia.

Materials and Methods

Site description

Gozamin District is located in East Gojjam zone of Amhara State. It is one of the 18 Districts found in the East Gojjam Administrative Zone. It is located at 300 Km and 265 km away from Addis Ababa and Bahir Dar cities respectively. And bordered by Senan District in the North, Basso-liben District and Oromia state in the South; Debaye Telatgin and Aneded Districts in the East; and Machakel and Debre Alias Districts in the West. The total area of the Districts is 1217.8 square KM. The land form is characterized by plains (74%), highlands (16%), mountains (9%), and valley (1%) . The altitude ranges from 900m to 2640 meter above Sea level. There are about 23 main rivers that have potential importance for irrigation. Of these Chemoga river is the longest one which covers 45 km length and has potential to generate 2.31 Mega Watt electric powers. There are also a number of small streams in the District namely: Shegeza, Kullech, Degelle, Atemena and Wutren rivers are there (ARDOGD, 2013).

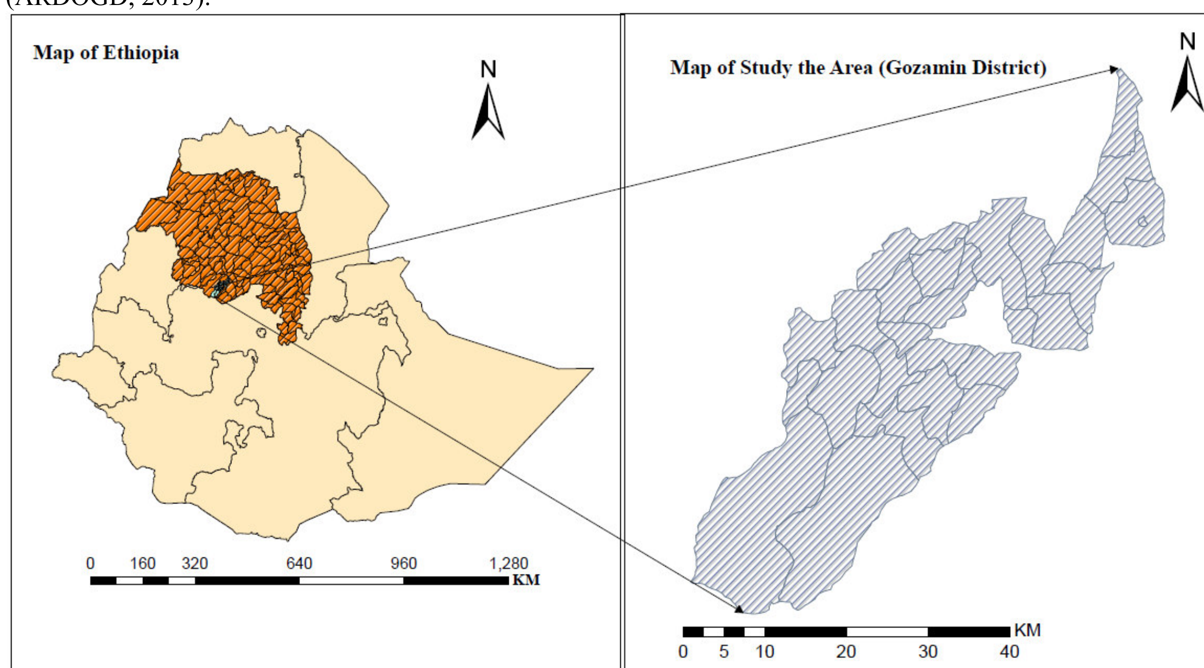

Figure 1: map of the study area

Data Collection Methods

In order to realize the intended objective of the study, both primary and secondary data were collected and analyzed. To get the required data from the primary sources, questionnaire survey, in-depth interviews, and focused group discussions (FGDs) were employed. District and *kebele* officials, the District's health office managers, and health centers directors were interviewed. Beneficiaries of health care services (households and patients) to understand their satisfaction and/or dissatisfaction with the existing health service provision. An in-depth interview was also administered to health extension workers.

FGD has been employed with the objective to capture feelings, experiences and diverse perspectives of the residents of the District through group interaction that might not have been articulated in the one-to-one interview. The FGDs were organized in each selected health center with six participants involving both genders.

The participants of the discussions included Nurses, mid-wifery, lab Technicians, pharmacist and Health Officers. For the purpose of discussions; Semi-structured questions were prepared to guide the discussion process.

Besides to interview and focus group discussions, field observation was also part of the primary data source. Observation enabled us to investigate the physical or the visible apparatus/ equipments of the health institutions such as number and quality of beds, quality and arrangement of drug stores, sanitary and related services. Secondary data sources such as federal and State governments' health policy documents and proclamations were reviewed.

Sampling Design

For this paper we had three categories of informants. The first category consists health workers (Nurses, Health officers, midwifery, pharmacy technician, and Health Extension workers); the second is comprised of households and patients; and the third category includes District health office managers, Health Center directors, *kebele* and District officials**)**.

The District under study, stratified with six health centers[1], and 26 health posts. However, we cannot cover the whole Health Centers under studies. Hence, out of the six Health centers three of them were selected[2], on the bases of their degree of urbanization and distance from the center were considered. This type of combination in sampling method would enabled us to make simple comparisons between them and to assess the impacts of decentralization on the nearer and remote *kebeles* (geographical location) with regard to health care service quality, and availability of health resources.

Determination of Sample Population

Out of the total of 69 health workers who are currently working at the selected health centers, 36 (25%) employees were selected for FGDs on the basis of their work experience. These were 18 nurses, 5 midwifes, 4 health officers (HO), 5 pharmacy technician, and 4 Lab. technicians. We have also selected 4 key informants for in-depth interview purposely from District health officials. In addition, 6 health extension workers (two from each health center), 12 households who previously visited and knew the health centre were also interviewed. Finally, a total of 18 patients were selected. Patients were included as an informant only those who have not severe illness but those who had mild cases and the volunteer one so as to get appropriate response. About ninety households were taken as sample population for the questionnaire.

Methods of Data Analysis

Data collected through questionnaire were analyzed quantitatively using percentages, figures, and tables were employed. Data collected through interview, focus group discussion and field observation were compiled, expressed and analyzed qualitatively by cross checking with responses of questionnaires.

Result and Discussion

Impacts of decentralization on health care service delivery in the Study Area

Literatures point out that decentralized health care service will bring health institutions closer to the beneficiaries. Local officials have information advantages in identifying health priorities needs of the local people. As a result, decentralization will improve the access, quality and affordability of health care service delivery at local level. The findings of this study try to investigate the impacts of decentralization on health care service delivery based on the above elements which are explained as below.

Accessibility of health institutions

Accessibility refers to both the physical location of health institutions as well as patient mobility (Kwoyiga, 2010). In this paper our concern is assessing accessibility in terms of the geographical location (its closeness and remoteness) of health institutions to the beneficiaries.

Access to minimum standard of public service (such as health, education, clean water, food and social security) is the rights of citizens as it is stipulated by the Ethiopian Federal Constitution (FDRE, Art. 90/1). These public services actually are the concurrent power of the center, the State and District governments. To realize this rights, increasing the number of health institution and make it more closer to the people are the prior tasks of the government. To this end, decentralization of health care system to lower echelons of government was a one step forward to achieve this goal.

[1] The six health centers found in the District are: Chertekel, Aba Libanos, Fendeka, Yebokla, Giraram, and Gozamin.

[2] The three sample health centers were; Chertekel, Gozamin and Giraram. Of these, Gozamin health center is relatively more urbanized than the others; while Chertekel is less urbanized than Gozamin but better urbanized and nearer to the center (in-between) as compared to Giraram-which is very remote from the urban center and mountainous health center.

The majority of patients and households in the three health centers replied that there is accessibility of health care services. 67% of patients and 75% of households at Chertekel health care, and 83% of patients and 75% of households at Giraram health centers responded that the health care service system is accessible in the District. Conversely, 17% of patients and 25% of households at Giraram District replied that the health care service system is not accessible. Similar to this, majority of patients (67%) and households (75%) at Gozamin health center were asserted that the health care service system is not accessible. The Gozamin District health office directors viewpoints support the responses of the patients and households made at Chertekel and Giraram health centers. According to them, the District health institutions become closer to the people. The average distance of kebeles from Health centers is not more than 7km.

Relatively speaking health posts or *kebeles* encompassed under Gozamin Health center is located far from the center than *kebeles* found at Chertekel and Giraram Health centers. For example, Desa Enesi Health Posts are the most farthest (15km) than any other *kebeles* found at Chertekel and Giraram.

The interview from households affirm that there is an improvement in the accessibility of health institutions in their surroundings. The following case put the issue in point.

> *"… Now, we have health center closer to us. No more going to Debre Markos in search of medical treatment. We easily access health institution around us without the need for travelling long distance as we did so far. The maximum distance of the health center from my house is not more than 7 km. We would like to thank God and our government…" (Households).*

Local people can easily get access to health institutions around their vicinity, which was not the case in the past two decades. Similarly, interview from health extension workers, FGDs at Chertekel and Gozamin health centers and District health administrator show that there is an improvement of health service accessibility. In each kebele there is at least one health post with two health extension experts.

Quality of health care services provision

Providing quality service, among others, is an inherent aim of decentralization in the health sectors. Through devolving power to local government, it can brought internal competitions with regard to the provision of quality and efficient provision of goods and services and improve the responsiveness of the government to the public and enhance the quality of service provision. Quality of service is about providing necessary health care services at the right time, in the right way for the right beneficiary. Hence, the immediate beneficiaries of the service are patients. At Gozamin health center, the majority of the respondents argue that there is quality of health care services. The reverse is true for respondents at Chertekel and Giraram Health Centers. 83% of patients and 75% of House Holds at Gozamin Health Centers responded that there is quality of health care service provision. In Chertekel health center, 33.3% of patients and 25% of households asserted that they could get quality of health service in their health centre. But majority of respondents asserted that there is no quality of services. However, the majority of patients (83.3%) and households (75%) disagree with the presence of quality health service at Giraram health center. Interviews results from patients assure that there is no harmony relation between health workers and patients. For example, health workers insult patients, they frequently absent from work place, patient wait lengthy time for once return, offer unrelated drugs with the disease, postponing of treatment for another day are some of stated problems of quality service

From the FGDs, it was possible to understand that lack of adequate infrastructure such as clean water, electricity, rooms for office, inadequacy of drug supply, health personnel and financial constraints are the major problems that affect the quality of health care services.

Affordability of health care Service

Affordability is the ability of people to pay the direct cost for example, for drug, card fee, and the indirect cost, for instance transportation fees of the health services (Kwoyiga, 2010). The ability of beneficiaries to pay the cost of the service is therefore, the determinant factors in determining the affordability of health care services provision. With the aim to make the health care services affordable to all sections of the people, the government of Ethiopia in general and the Amhara state in particular, established free health service scheme[1] for the poor people and exempt some selective public health care services from service charge.

Free health services- the introduction of free service delivery enables poor people to afford and enjoy free health care services. This has contributed a lot for saving the lives of the poor. The major objectives of free health service provision is, to ensure just or reasonable distribution of health services to all people through

[1] '**Free health service'**- means a service in which the costs of the services are covered by the government in order to have opportunity for the poor individuals or households (who cannot able to afford cost of services) to get medical services without any payment. On other words, it is the rights of the poor people to get free health service from health institutions (Proclamation no. 117/2006).

making health services afford to all including the poor. Once the poor identified by the kebele residents, the eligible poor have the right to access identification card. Although the power to identify the poor is given kebele people, it was however dominated by, and left to the kebele administrator. In doing so, the kebele administer ask few residents of the kebele questions like, who are the poor, do they have land and how many families do they have etc separately. Indeed, people who asked by the administrator are biased to their relatives and close friends. For example, there are poor people to the extent of incapable to get their daily meal, but cannot be part of the program simply because they have land regardless of taking the productivities of the land in to consideration. Though the availability of free health service for the poor is valued by the people, the beneficiaries were dissatisfied by the procedure employed to select the poor. It lacks fairness, transparency and abused by kebele officials. There is a possibility of exclusion of target poor and an inclusion of wealthy group. This incident is happen due to the result of misuse of power, corruption, discrimination or biased treatment by the local officials.

Exempted service[1]- it is another means of making the health care services affordable to all. Some of the exempted public services are: immunization, antenatal care, delivery at primary health care unit, postnatal care and family planning services, treatment of tuberculosis, etc. This service however faced a problem. For instance, a research result done by USAID in Ethiopia show that , scarcity of drugs, absence of clear guidance on whether to fully or partially charge for services, and extra costs incurred for the provision of exempted health services, and inadequate support both from the government and NGOs for the provision of these services are some of the problem encountered in the process of providing exempted services (USAID, 2012). Similar results were also found from the majority of patients (67%) and households (50%) who expressed that the health care service delivery is not affordable. The card and treatment fees are beyond the pocket of the Patients. The price of drug is increase since 25% from its original price is added. A research done by Alemayehu *et al* (2006) has proved that more than 35% of the patients in Ethiopia could not get the prescribed drugs because of lack of money.

Conclusions

The findings of the research revealed that, decentralization improves the accessibilities of health care institutions to the beneficiaries and the numbers of health centers and posts increase significantly. The transport and time costs incurred by the patients relatively reduced. The number of health personnel also increase, and hence, the ratio of both health institutions to the people and health workers to the people has also improved. However, the quality of health care service delivery is still poor. Inadequate supply of drugs, financial problem, and shortage of human resources are some of the constraints of rendering quality health care service in Gozamin District health institutions. The findings show that the health service given in the District is not as such affordable to all beneficiaries.

Recommendations

On the bases of the above mentioned discussions and findings the following recommendations are suggested to the regional health bureau in general and the Gozamin District health office in particular:

i. The fee waiver program has enabled poor people to get health care services. However, still there are many poor people who are under covered by the fee waiver schemes. Therefore, the government should consider these poor sections of the society while approving annual health budget.
ii. Concerning free services provision, caution has to be made in the process of identifying target groups (poor) who are eligible to the services from the non target one. Hence, there must be strong cross checking mechanism while the beneficiaries of free services are selected.

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[1]'**Exempted service**- is a medical service provided by the health center for all beneficiaries of the kebele residents free of charge. The difference between free health service and exempted service is that, under free service scheme- there is discrimination between poor and rich people. In other words, free health service is not available for all, instead it is merely poor and risky centered. Rich people (who able to afford medical services they used) are not entitled to use free services. Whereas, exempted service is available to all (rich + poor). In both cases however, the costs of the service are covered by the government. In the case of free services, besides to the government, other third parties –who enter an agreement with health institutions on behalf of the poor in order to cover the costs of the services, might be involved. **NB:** A free service does not mean that the costs of the services that the health institutions incur are not compensate or covered at all. It is free because the services are offered to the poor by health institutions without the need for cash payment from the service recipients but by the government expenses, not by the health institutions.

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