Challenges Of Decentralized Public Health Service Delivery:
The Case Of Afar National Regional State.

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Abstract
Decentralization in Ethiopia occurred first from Federal to Region, and subsequently into lower level of governments since the fall of Dereg Regime in 1991. There are several issues that affect the decentralization process in Ethiopia. To address the inherent constraints in the health sector, Ethiopia has included deliberate decentralization efforts aimed at strengthening the effective implementation of activities at the district level, enhancing peoples’ participation, fostering closer coordination and collaboration among the sectors. The study used both primary and secondary data sources. The result of the study indicates the major challenges of decentralized health service delivery in the region are: shortage of human resource, lack of awareness both in the service providers and service seekers, transport problem, lack of infrastructures such as electricity and road, absence of career structure (incentives), stepping down of health extension workers training at the national level and environment related problems. Despite the challenges there are some opportunities to improve decentralized health service delivery like villagization program.

Keywords: Decentralization, Health Extension Worker, Decentralized Service, Maternal Health Care, Service Delivery.

Introduction
Currently, decentralization is becoming a popular and prominent development strategy in most developing countries (Boschmann, 2009). Decentralization is a means of increasing the number of people involved in planning and implementing development activities and increasing the influence of those at the local level Vis-à-vis those at the center and increases access to service delivery and considered as the indicator of good governance (World Bank, 2008).

Basic public service delivery at the local level is one of the factors that drive federal political systems. Service delivery improvement on its part is aimed at enhancing all aspects of development effort through enabling of lower level governments to facilitate resources and enhance local development (Geoffre, 1998). Decentralized health service delivery is expected to bring significant change in social, political, and economic development. Ethiopia adopted federal state structure that allow autonomy/power and decision making authority at regional and local levels (Boschmann, 2009).

Since 1991, Ethiopia has brought improvement in public service delivery in some public service sectors like education, and road, after decentralized system of administration which mainly aimed to improve democracy, popular participation and service delivery (Tegegne, 2007). The main objectives of decentralization is to increase the coverage, effectiveness, efficiency, quality of social services in accountable, responsive and transparent fashion (Solomon, 2008).

As Meheret mentioned (2002) that the current Ethiopian federal government structure consists of the federal and the regional governments. Since 1992 the powers and responsibilities of basic public service provisions of the central government have been devolved to lower levels of governments based on Proclamations 7/1992, 33/1992 and 41/1993. Ethiopia experienced a heavy burden of diseases with a growing prevalence of communicable infections (MoH, 2010).

The decentralization process of Ethiopian has two phases. The first was practiced from 1991-2002 which was known as mid-level decentralization, and the second phase which has been practiced since 2002/2003, is the district level decentralization program (DLDHP) to expand the process of decentralization to woreda level (Tegegne and Kassahun, 2007).

Currently, the government is following a twenty-year health development implementation strategy, known as the Health Sector Development Program (HSDP), with a series of five-year investment programs (MoH, 2005). HSDP aims to develop a health system which provides
comprehensive and integrated primary health care services, primarily, focuses on communicable diseases, common nutritional disorders, environmental health and hygiene, reproductive health care, immunization, the treatment and control of basic infectious diseases like upper respiratory tract infections, the control of epidemic diseases (MoH, 2010).

In health service provision, the federal government has the responsibility to develop overall national health program concepts, health policy, national health standards and implementation guides Article51(3), determining career structure for health professionals, providing communication tools and materials to regional states, mobilizing national and international resources and setting up national health management system (MoH, 2007). Moreover, the federal government has its own responsibilities. From the powers and functions some are national standard setting, national policy designing on any matters, international relation, and foreign loans etc. are some of the federal government’s powers and functions. On the other hand, regions are responsible for formulating regional health policy, coordinating health extension activities, establishing and administering training institutions and junior colleges, providing technical support to Zones and Woredas (districts), establishing and administering health examination centers; building and maintaining referral hospitals; coordinating the control of communicable diseases, purchasing and distributing medical facilities, and preventing and controlling HIV/AIDS. In large regions, zones are responsible for providing technical support to woreda; establishing and administering zonal and district hospitals; constructing and administering pharmacies, preventing and controlling HIV/AIDS (World Bank, 2002).

Article 90(1) of the constitution of FDRE gave power to the federal the government to facilitate better health service delivery to the public at large shall be aimed to provide public goods and services such as health, education, food, housing, and clean water etc.

Afar National Regional State stands unique from other National Regional States. It is highly characterized by desert, mobile communities, and the practice of traditional administration system. Therefore, the study dedicated to analyze/explore how these typical characteristics affect the practice of decentralized public service delivery by taking variables including institutions, manpower, environment and community participation. Some of specific objectives of the study are:

1. Identify the achievements done by the region in relation to allocated duties and responsibilities.
2) Identify the duties and responsibilities assigned to the local institutions and assess their level of coordination and integration in health service delivery.
3) Identify human and financial resources available in health service delivery in the region
4) Investigate the performance and nature of primary health service in the region.
5) Examine community participation of the region to enhance decentralized health service delivery at the grass root level. Based on the above research objectives the following basic research questions are made.

1) What are the challenges and opportunities of decentralized health services delivery in the region? 2) What are the duties assigned to the region to enhance health of the community? 3) Does the region have sufficient capacity to fulfill demand of health service at their districts level? 4) What is the level and nature of primary health service delivery? 5) What is the role of community in study region to enhance decentralized health service delivery at the grass root level?

Methodology

As Abiy, et al (2009) mentioned that, a descriptive case study which describes phenomenon or event. The study examined the ongoing implementation of decentralized public health Service delivery in Afar National Regional State. In this study, both primary and secondary data sources were used. The researcher made several field trips for data collection. The primary data sources collected through key informant interviews from (The Regional Health Bureau Head, The Regional Water and Sanitation Office Head, the Regional Finance and Economy Bureau Head, randomly selected health employees, and randomly selected clients). None-participant observation also used at public health institutions and I observed beds, population crowdedness, and availability of drugs, infrastructure), as well as conducted focus group discussions in Dubti, Awash and National hospitals with clients. Official reports, guide lines, manuals, regional and federal constitutions and books also reviewed.
Results

In developing countries like Ethiopia, decentralized service delivery is a key strategy to solve complicated health problems. In decentralization, lower levels of administration center like regions and woredas are responsible to perform health service activities. These are: resources allocation, coordinating activities of governmental and non-governmental bodies, monitoring and evaluating local health institutions, providing technical and financial support, providing supportive supervision of HEWS, overall management of health centers and health posts, planning and providing training to HEWS and woreda health office staffs, and investigating reports from health posts and health centers (MoH, 2007).

Public Service Delivery: Powers and Functions of Regional State and Woredas

Article 52 of FDRE Constitution indicates the powers and duties of regional governments. Accordingly, National Regional states have the following duties and responsibilities regarding basic social services.

- To enact and execute the state constitution and other laws in accordance with their situation without contravening the federal constitution;
- To formulate and execute economic, social and development policies, strategies and plans of the State based the national policies and strategies;
- To administer land and other natural resources in accordance with Federal laws, and international situations or environmental conventions;
- To levy and collect taxes and duties on revenue sources reserved to the States and to draw up and administer the State budget;
- 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; in addition to those reserved powers are left to the regional states.¹

However, all regional states are not equally exercising their duties and responsibilities given by the constitution. Large disparities exist in service coverage among regions, with immunization coverage as low as 44% in Afar (compared to the national average of 86%) and 59% of zones in the country achieving more than 80% coverage, due to geographic access, security, human resource capacity, health infrastructure (including availability of functional cold chain systems) and lifestyle, among other factors (WHO, 2013).

Health Service Facilities in Afar National Regional State

Drugs and medical supplies are essential to treat patients effectively. But shortages of health facilities in the region are the main challenges that hinder decentralized health service delivery. The data gathered from informants and FGD participants showed that, facilities of hospitals, health centers and health posts in the region are below the normal standard and provide poor service.² The regional Health bureau deputy head mentioned that “the three hospitals (Dubti, Dalifag and National) are relatively better in their health facilities comparing with Kelwanand Abala hospitals.³ Let alone having sufficient drugs, health facilities and medical treatment, hospitals and health centers are affected by shortage of electricity, water and lack of skilled man power. In line with this, Nada expressed (2007). Ethiopia is a poor country with weak health care systems and infrastructure. Reproductive health, like most aspects of health sector is generally poor, with significant regional disparities in access to services and in health outcomes.

Access and Actual Coverage of Safe Drinking Water in the Region

Water is decisive for survival of all living things in life. Different researches exhibited that large population suffered from lack of safe drinking water and the problem is common in sub-Saharan

¹The 1995 FDRE constitution
²Interview with Ahmed Mohammad (Deputy Head of Afar National Regional State Health Bureau) in 12-11-2012
³interview with Ahmed Mohammad (Deputy Head of ANRS Health Bureau) in 12-11-2012
Africa. This condition exposes the people to be suffered by water related diseases (Gorge, 1992). From the interview and FGD indicates that, safe drinking water is not adequate especially in rural kebeles. Many factors contribute for this problem including; low participation of communities, low intersectoral coordination, insufficient human resources, and lack of awareness of the community in the region.  

Table 1. Actual coverage of safe drinking water in Afar region

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of users of safe drinking water</th>
<th>% of safe drinking Water coverage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>2008/9</td>
<td>105485</td>
<td>712674</td>
<td>73</td>
</tr>
<tr>
<td>2009/10</td>
<td>114485</td>
<td>775174</td>
<td>77.6</td>
</tr>
<tr>
<td>2010/11</td>
<td>127236</td>
<td>784817</td>
<td>83</td>
</tr>
<tr>
<td>2011/12</td>
<td>132325</td>
<td>801894</td>
<td>83</td>
</tr>
<tr>
<td>2012/13</td>
<td>137618</td>
<td>830602</td>
<td>83</td>
</tr>
</tbody>
</table>

Source: ANRS Water Bureau

As depicted from the Table 1 access and actual coverage of safe drinking water in the region is low, especially in rural parts. In rural areas of region only 59.87% from total rural population have access of pure water.Due to this, many people exposed for water related diseases. In addition, Regional Water and Sanitation Bureau head stated “rural communities in the region suffered by lack of safe drinking water”. As it is seen from Table1, urban areas have better access and coverage of safe drinking water. In urban areas 83% residents accessed to safe drinking water. The Water and Sanitation Bureau faced resource scarcity to solve water problems in the region. They have no enough professionals who have good capacity to design water projects to minimize the existing serious problems of safe drinking water in the region. In fact, the Regional Water and Sanitation Bureau initiated to solve the problems in collaboration with governmental, non-governmental organizations, and local communities. But the existing NGOs like World Vision Ethiopia and WASH (water, sanitation and hygiene) have no sufficient capacity to expand water and sanitation projects to solve the existing serious problems. Even the already done water projects by those organizations are not as such functional for long period of time.

Primary Health Care Service Delivery

The health service system in Ethiopia is decentralized along the nine regions. Ethiopia experiences a heavy burden of diseases with a growing prevalence of communicable infections. Many Ethiopians face high disease morbidity and mortality largely attributable to potentially preventable infectious diseases and nutritional deficiencies (MoH, 2007). In order to reduce those problems and to achieve MDGs the Ministry of Health set the following minimum primary health care standards.

Table 2: Minimum Primary Health Care Standards in Ethiopia

<table>
<thead>
<tr>
<th>Performance indicators</th>
<th>Minimum Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>People should have a life expectancy of at least 60 years</td>
</tr>
<tr>
<td>Malaria incidence</td>
<td>The population should have a 10% or less chance of becoming seriously ill from malaria in malaria exposed areas.</td>
</tr>
<tr>
<td>TB incidence</td>
<td>The population should have a 4% or less chance of dying</td>
</tr>
</tbody>
</table>

4 Interview with Abdu (Head of ANRS Water and Sanitation Bureau) in 12-11-2012.
5 Interview with Abdu (Head of ANRS Water and Sanitation Bureau) in 12-11-2012.
6 Ibid
7 Ibid
8 Ibid.
from TB when treated at woreda health facilities

| HIV prevalence | HIV prevalence rate for adults should be less than 2.4% |
| Maternal mortality rates | The chance of pregnant women dying in childbirth should be 600 or less per 100,000 |
| Infant and child mortality rates | The chance of newborn children dying soon after birth or children under 5 dying is 45 or less per 1,000 |
| Insecticide treated nets adjacent to malaria | All those living in malaria exposed areas should receive a treated mosquito net |
| Coverage of HIV/AIDS awareness programs by kebeles | All kebeles should be covered by HIV/AIDS awareness campaign |
| HIV/AIDS voluntary testing and Counseling | Testing and counseling for HIV/AIDS should be available at all health centers. |
| Number of Health Posts appropriately staffed | Health posts available for every 5,000 people (generally available 5-10 km for all households) |
| Number of health centers appropriately staffed | Health centers available for every 25,000 people (generally available within 10 km of all households) |
| Availability of drugs | All health facilities should have essential drugs available at all times |
| Number of village health promoters | Every village will have a village health promoter |
| Availability of Hospitals | District hospitals available for every 250,000 people |

**Source** (Lijalem, 2008)

Depending on Table 2; ANRS is far from the national minimum primary health care standards. In fact, in the region access radius to health posts and health centers building is approximate with the standard but the region is highly exposed to malaria and there is no sufficient material to control malaria. However, based on the Table 3, 4, 5, 6, 7, and 8, the region is far from the national minimum primary health care standards.

**Table 3: Ratio of health professionals to the population in Afar Region**

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Number</th>
<th>Ratios to total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Extension Workers</td>
<td>572</td>
<td>1:2,466</td>
</tr>
<tr>
<td>Nursing</td>
<td>477</td>
<td>1:2,959</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>99</td>
<td>1:14,254</td>
</tr>
<tr>
<td>Health officer</td>
<td>50</td>
<td>1:28,222</td>
</tr>
<tr>
<td>Doctors</td>
<td>21</td>
<td>1:67,195</td>
</tr>
<tr>
<td>Specialists</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Source**: Afar Regional State Health bureau

In the study region, doctor to population ratio is 1:67,195, health officer to population 1:28,222, nurse to population 1:2,959, pharmacy to population ratio 1:14,254 and HEWs to population 1:2,466. The majority health centers and hospitals in the region lacked health professionals who are key for effective health service delivery. Similarly, most health centers have no sufficient midwife to treat pregnant women during delivery service. The delivery service is being conducted by health officers and clinical nurses who are not specialized and this leads to maternal death. In line with this, FGD participants mentioned that, sometimes in rural parts of the region, the health centers and health posts are not open regularly because the health workers spend their time in towns rather than helping the people. Thus, the region and woredas are far from achieving the national primary health care standards.

**Maternal and Child Health Care**
The Ethiopian government has sought to reform the health service system in the country into a cost-effective and efficient system which is known as HSDP aligned with the plan for Accelerated Development to End Poverty and to achieve Millennium Development Goals (MDGs). Currently, the country is implementing the fourth year of HSDP III which proposes intervention against poverty-related disease particularly improving maternal health; reducing child mortality are the focal points at the national level (MoH, 2009).

The Ethiopian government took the maternal health care as a core element of MDGs. To achieve it, maternal vaccination is a key element. Women should get sufficient medical services for creating sustained social welfare. In every corner of the country, each woman has the right to get prenatal, postnatal, and other vaccinations (ibid).

<table>
<thead>
<tr>
<th>Maternal health care services</th>
<th>2008/9</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>% clients</td>
<td>%</td>
</tr>
<tr>
<td>Family planning</td>
<td>12</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Prenatal service</td>
<td>26</td>
<td>42,333</td>
<td>30</td>
</tr>
<tr>
<td>Delivery service</td>
<td>6</td>
<td>42,333</td>
<td>7</td>
</tr>
<tr>
<td>Postnatal service</td>
<td>4</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Delivery with help of HEWs</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

As it can be shown from the table 4, in 2008/9 the coverage of the Regional family planning was 12%. Similarly, in 2009/10 the regional family planning coverage was reduced from 12% to 9%. In 2009/10, 91% of women did not get family planning. But in 2010/11 family planning was relatively increased by 20%. From this it is possible to conclude that family planning in the region is too low due to the fact that low awareness of society about family planning.

In 2008/9, there were 42,333 prenatal customers visited health centers. However, the prenatal service coverage was very low, only 26% women got prenatal services, which is very basic to achieve MDGs. In 2009/10 the prenatal service coverage increased from 26% to 30%. In 2008/9 the delivery service with professionals was only 6% this implies 94% of clients are out of health institutions in return it causes temporal and permanent health problems on women’s who are in reproductive age. Most of the time deliveries took place at home that resulted problems such as over bleeding, transmission of diseases.

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother, baby, or both (Van Lerberghe and De Brouwere 2001; WHO 2006). In the region, in 2008/9 the delivery service with the help of health extension workers is at zero level. This means the role delivery service by HEWs is almost nonexistent. The region is characterized by high maternal and neonatal mortalities, high unmet needs for family planning, and shortage of skilled birth attendants, inadequate health workers at health centers, health posts, and hospitals. The data collected through FGD indicates that, the main reasons that hinder maternal health care were lack of awareness, distant health facility, and work overload for women’s.

Universal immunization of children against six common vaccine-preventable diseases, namely tuberculosis, diphtheria, whooping cough (pertussis), tetanus, polio, and measles, is crucial to reducing infant and child mortality (CSA, 2016). The coverage and access of health services in pastoralist areas as well as the Developing Regional States (Gambella, BenishangulGumuz, Afar, and Somali) is very low, making the population vulnerable to various health problems (WHO, 2013:29). Currently,
Ethiopia is implementing the HSDP IV which proposes intervention against poverty related disease particularly improving maternal health; reducing child mortality are the focus points at the national level. During growth and transformation period, the country planned to eliminate communicable disease and universal access of primary health care (MoH, 2012). The main objective of HSDP was to develop an effective and efficient health system, which provides comprehensive and integrated health services that respond to population needs.

### Table: 5 Child Immunizations (2008-2012)

<table>
<thead>
<tr>
<th>Immunization Type</th>
<th>2008/9</th>
<th>2009/10</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>No of vaccinated</td>
<td>%</td>
</tr>
<tr>
<td>Penta 3</td>
<td>45</td>
<td>-</td>
<td>70</td>
</tr>
<tr>
<td>Measles (Kufign)</td>
<td>39</td>
<td>-</td>
<td>65</td>
</tr>
<tr>
<td>Tetanus (PAB)</td>
<td>28</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>-</td>
<td>-</td>
<td>227</td>
</tr>
<tr>
<td>“Tsereanger”</td>
<td>-</td>
<td>-</td>
<td>228</td>
</tr>
</tbody>
</table>

Source: ANRS Health Bureau Reports (2008-2012)

As table 5 shows, Penta 3 coverage was very low in 2008/9. The coverage improved in 2009/10 and 2011/12 and reached 70% and 72% respectively. This shows, the region has showed improvement in Penta 3 coverage through time. In line with this, “kufign”/measles immunization coverage was limited in 2008/9. The coverage improved in 2009/10 and reached 65% from 39% in the former year. But the coverage is deteriorating in 2011/12 which was only 60.3% of children immunized from measles.

Afar Regional State still has a large number of unimmunized children. This resulted many children infected by preventable diseases such as Measles and Pertussis and affected most adults. The region is characterized by the prevalence of high infant mortality. Poor child feeding habit contributed for high mortality rate in the region. The nutritional status of children under five years of age is very poor and most of them are underweight.

### Capacity of the region for Health Services Delivery

According to Vander Loop (2002), decentralization is a means to ensure the participation of the public in diverse affairs of their locality. Decentralization not only allows local governments to effectively attend the needs of local residents but also promotes inter-jurisdictional competition and innovations in the provision of public services. Effective decentralized public service delivery in general and health service in particular requires sufficient financial, human, and mobilization of local communities. Decentralized public service delivery needs high local communities’ mobilization capacities in order to utilize the existing local human, financial, and non-financial resources. Effective decentralized health service delivery requires active grass root communities’ involvements in multi dimensions.

### Human Resources capacity for Health Service Delivery

Professionals are essential for decentralized public service delivery. As many scholars mentioned that lack of skilled man power affect the effectiveness of service delivery in general and health service in particular (Tegegne and Birhanu, 2004). The regional Health bureau head expressed some kebeles have not health extension workers due to environmental factor and the workers forced to leave the area due to high temperature.”9 Health posts and health centers are not appropriately staffed. In relation to this, the regional Head of Health bureau stated that “in the region all health centers are below 50% in their professional staffing due to absence of infrastructures such as pure water, house and electricity etc.10

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9Interview with Mohammad Ahmed (Deputy Head of Health Bureau) in 04-12- 2012.
10Ibid
The region has 1,411,092 total populations. The Ratio of Doctor to population is 1:14,662, health officer to population ratio 1:4,725, health extension worker to population 1:2,500, and nurse to population 1:4,725. In the 4th year of HSDP III MoH achieved to 1:36,158, 1:48,451, 1:3,869, 1:2,514 doctor to population, health officer to population, nurse to population, and HEWs to population ratios respectively (MoH, 2009).

Community Participation for Decentralized Health Service Delivery

The participation of local communities in creating the structure and designing policies and proposals, decision making, managing, implementing programs, the communities finance and non-financial contribution and evaluating of the socio economic development projects and programs are essential in decentralized service delivery (Tegegne and Kassahun, 2007). To meet effective health care service delivery one of HSDP III strategies was also emphasized to community participation in the planning, implementing, monitoring and evaluating of health care. Various reports and books showed that decentralization has ensured substantial to increase communities’ contribution. Nevertheless, in the regional state, woreda Health Offices are not fully capable to mobilize local communities and other local resources. The regional Health bureau had capacity limitations to mobilize Woredas communities for effective health care service delivery. Woredas’ communities participation in health service are very limited both in financial and labor towards the establishment or maintenance of a facility, construction of health posts, HC, malaria prevention, home construction for HEW, and HC workers, and preserving them. But as regional deputy Health Bureau Head mentioned that “the communities’ participation in decision making process, monitoring and evaluating the health projects and programs of the woredas are very weak.”

From this it is possible to understand that in the region, community participation is very low even the Woreda administrators and Woreda Health Offices had low mobilization capacity and awareness in involving the communities in decision making, designing, structuring, and evaluating of health programs and health projects.

Table 8: Ratios of Public Health Institutions to Population in Afar Regional State

<table>
<thead>
<tr>
<th>Health institutions</th>
<th>Number</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health post</td>
<td>294</td>
<td>1:6,408</td>
</tr>
<tr>
<td>Health center</td>
<td>52</td>
<td>1:36,230</td>
</tr>
<tr>
<td>Hospital</td>
<td>5</td>
<td>1:376,793</td>
</tr>
</tbody>
</table>

**Source:** ANRS Health Bureau

In relation to the National Ministry of Health standards as it can be seen from the Table 8, it is possible to understand that the region is far from national minimum primary health care standards. Table 8 shows that, one health post serve on average for 6,408 people, a single health center serves for 36,230 people and one hospital 376,793 people which are beyond the national standard. Although, the national minimum primary health care standard set as all those living in malaria areas should receive a

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11Interview with Ahmed Mohammad (Deputy Head of Health Bureau) in 04-12- 2012.
treated mosquito net. Afar region is highly malaria exposed area because of desert climate. But mosquito net distribution is based on the number of households and still it is insufficient to keep all residents in the region. Awareness campaign in each kebeles and existence of professional HIV/AIDS councilors in each health centers are crucial to minimize its risk (MoH, 2009). In contrary, in Afar regional State, HIV/AIDS awareness campaigns at the kebele level and professional councilors in health centers is very limited. As the data obtained from the regional Health bureau’s report of 2012 indicates that, the health coverage reached to 70%. Yet, the researcher observed that health service delivery in the region is below the standard and need further intervention.

Challenges and Opportunities of Decentralized Health Service Delivery in the Region

As mentioned in the previous section challenges that hinder effective health service delivery in the region some of the challenges are.

Lack of Electricity /Power: - Electric power is decisive for effective and sustainable health care service provision. Ethiopia is known as water tower of East Africa which is important source of electric power. Unfortunately, majority people have not been benefited from electric power. Electricity power is essential to provide health service but it is limited provision become a tackle for health service provision in most health institution in Afar National Regional State. Many of the health institutions have no sufficient electric power which has great impact in the provision of effective health services delivery.

Lack of Awareness about Decentralized Service Delivery:- Another key challenge for effective decentralized health service delivery is the gap between clients and providers about the basic principles and benefits of decentralized service delivery. Even though, Service deliveries have been improved in recent year than before majority of the people have problem of awareness about decentralized service delivery. In the region, the implementation of decentralization is at its infant stage. The pastoralists and semi pastoralists are not voluntary to participate in different conferences and to discuss with health workers and most of the time they expect that the goal of the conference, workshop and training for the benefit of government officials and HEWs for the purpose of per diem.

Lack of Effective Coordination: - Effective implementation of decentralized service delivery at the local level requires active community participation, good coordination between or among different government sectors, NGOs and with local communities (Tegegne, and Kassahun, 2007). For the accomplishment of tasks there is always vertical and horizontal coordination. In this context the vertical coordination is to mean that the coordination of woreda health office with Zonal health department, regional health bureaus, and Federal ministry of health. The horizontal coordination includes at the Federal level the coordination ministers; at the regional level the coordination of different bureaus, at the woreda level coordination of different sectors such as the coordination of the woreda health office with the woreda water and sanitation office, education office etc. In Afar Region, there is no sufficient coordination among woredas, and regions between or among the public sectors. The regional Health bureau has no sufficient coordination with the regional Finance and Economy bureau, regional Water and Sanitation bureau, regional agriculture bureau and regional Cabinets etc.

Transportation Problem:- Road infrastructure and availability of sufficient vehicles in the region is essential for the woredas health office for its effective health service delivery to the communities in the woredas. Transport is one of the key elements for the local, regional and national development. In relation to this, Afar National Regional State, one of the critical problems for decentralized health service provision is transportation. In each Zone, the government faced shortage of vehicles even the existing vehicles need repair. In addition, the topography has great impact of on mobility of goods and

12 FGD at Dupti Hospital in 06-12-2012
13 Ibid
14 Interview with Hamza Mohammad (NARM) 13-09-2012
15 Ibid
16 Ibid
17 Interview with Mekonnen Awoke Amibara Woreda Health office Head 23-12-2012
18 Interview with Kebede Seid (Abala Woreda Health Office Head) 23-12-2012
ervices such as medicines and supervisors. The road infrastructural development in the region is low especially in rural parts. Absence of Community Participation: Active community participation is very essential for effective decentralized service delivery. All the FGDS are not satisfied with the existing health service delivery in the region because hospitals and health centers not providing adequate service for clients. However, lack of effective community participation in planning, implementation and in decision making in development activities in the region is visible.

Environmental problem: Afar National Regional State is characterized by Pastoralist and Semi-Pastoralist. The desert climate influences all health Service delivery in such a way that health professionals cannot deliver effective preventive approach primary health care service to the clients because of climate and their nomadic nature of life of the people. Due to this, there is high mobility of health professionals.

Opportunities to improve Decentralized Health Service Delivery

Despite of the fact that, the existence of many challenges which reduces the quality of health service delivery, there are also good opportunities that can be taken as a lesson to improve health services delivery in the region.

Cooperation with Mekele University: ANRSHB has good collaboration with MU in order to solve human resources scarcity. As we have seen from Table 7 and 8 Health service delivery in the region is insufficient. However, Mekelle University promised with ANRSHB to train health professionals in the region to solve shortage of skilled man power.

Villagization: In ANRS the population settlement is dispersed and mobile. Currently in Ethiopia, in four emerging regions (Afar, Somali, Gambella, and BenshangulGumuz) villagization program led by the federal government has been conducting to provide social services like education by organizing the dispersed people in to one village.

NGOs in the region: For effective decentralized public health service delivery the role of NGOs are vital. In ANRS there are many NGOs involved in helping of health sectors such as CDC Ethiopia, USAID, WASH, UNICEF and APDA.

Conclusions

The introduction of decentralization policies aims at, increasing communities’ participation in the planning, implementation, management, monitoring and evaluation of their socio-economic development. However, in the study region, the participation of communities in the planning, implementing, managing, monitoring, controlling, and evaluating mechanism is very low. In order to manage and strengthen decentralized health service delivery, it needs adequate financial and human resource. Unfortunately, in the region, health centers characterized by shortage of professionals. All health centers have been below the minimum national standard in their human resource. The regional Health bureau had weak performance in child immunization and maternal health care. The major challenges in ANRS which hinders the effective decentralized primary health care service delivery are: shortage human resource, lack of awareness both in the service providers and service seekers, transport problem, lack of infrastructures such as electricity and road, absence of career structure (incentives), stepping down of health extension workers training at the national level and environment related problems are the challenges that brought negative impacts on effective health service delivery. But, there are good opportunities that enhance decentralized health service delivery in the region.

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**Acronyms**

- AIDS        Acquired Immune Deficiency Syndrome
- ANRS       Afar National Regional State
- ANRSHB  Afar National Regional State Health Bureau
- APDA       Afar Pastoralist Development Association
- BoFEDBureau of Finance and Economic Development
- BPR       Business process re-engineering
- BSC       Bachelor of Science
- GC       General Practitioner
- C/nurse   Clinical Nurse
- CBOs     Community Based Organizations
- CDC       Center for Disease Control
- CSA       Central Stastical Agency
- DLDP      District Level Decentralization Program
- FDRE      Federal Democratic Republic of Ethiopia
- FGDs      Focus Group Discussions
- HC       Health Center
- Hews    Health Extension Workers
- HSDP      Health Sector Development Program
- MDGs     Millennium Development Goals
- MoH       Ministry of Health
- NARM     Natural Resource Management
- NGO      None Governmental Organizations
- SNNP     Southern Nations, Nationalities and Peoples
- TGE       Transitional Government of Ethiopia
- UNICEF   United Nations International Child Emergency Fund
- USAID    United State Agency for International Development
- WASH     Water and Sanitation Hygiene

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