

PRESENCE AND USE OF LEGISLATIVE GUIDELINES FOR THE DISTRIBUTION OF DECENTRALIZED DECISION MAKING AUTHORITY IN THE JIMMA ZONE HEALTH SYSTEM, SOUTHWEST ETHIOPIA

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ABSTRACT

BACKGROUND: Decentralization ultimately involves the execution of most health care activities at lower levels of the health system. However, when poorly implemented, decentralization can create confusion about roles and responsibilities. Therefore, the objective of this study was to assess the presence and use of legislative guidelines depicting the distribution of decentralized authority for decision making in the Jimma Zone health system, Southwest Ethiopia.

METHODS: A cross sectional study employing both qualitative and quantitative methods was undertaken from 16th January to 15th March 2007 in Jimma Zone. Health managers at relevant departments of the Federal Ministry of Health, Oromia Regional Health Bureau (RHB), Jimma Zonal Health Department, 13 Woreda Health Offices of Jimma Zone and the health centers and health posts in these districts were included in the study. Data was collected using interview guides and self administered structured questionnaires prepared for each level of the health system. Tape-recorded qualitative data was transcribed and analyzed using thematic framework approach while SPSS for windows version 12.0.1 was used to analyze the quantitative data obtained.

RESULTS: According to the regional guidelines, ensuring achievement of regional health service targets is the responsibility of the RHB. This was clear to 97 (97.9%) of the health managers included in this study. However, almost equivalent proportion of the respondents, 95 (95.9%) agreed that the FMOH should be responsible for this. Similarly, 71 (73.9%) of the health managers knew that approval of health budgets and efforts for local resource generation is the responsibility of the Woreda Administrative Council while the remaining 27.1% were uncertain or disagreed about this regional direction. Such confusions were observed in almost every functional area. Moreover, legislative guidelines were not available in most of the district health offices and health facilities.

CONCLUSION: Legislative guidelines depicting the distribution of decentralized authority in decision making in the health system were prepared at national and regional levels. However, the findings of this study suggested that health managers in the Jimma Zone health system did not appear to have the right perceptions about roles and responsibilities of the various levels. It is, therefore, very important to clarify such confusions along with capacity building efforts to match the changing roles of each level.

KEY WORDS: Decentralization, Authority, Responsibility, legislative Guidelines, Health Manager

INTRODUCTION

During the last two decades, health sector decentralization policies have been advocated and implemented on a broad scale throughout the

developing world (1, 2, 3). Decentralization, often in combination with health finance reform, has been considered as a key means of improving health sector performance and promoting social and economic development (4, 5, 6).

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Throughout most of Africa, there have been proposals for decentralization and development of sub-national units with some degree of autonomy (7). In Zambia, the central Ministry of Health delegated operational authority to a Central Board of Health. Similarly, Ghana delegated operational authority to the Ghana Health Service (8). Uganda transferred the planning, decision-making and administrative authority from the central government to regional branch offices, local governments, and/or non-governmental organizations (9). In 1991, Senegal has undergone decentralization through the adoption of a district system in the health sector. Recent decentralization efforts in the United Republic of Tanzania facilitated the handing over of authority to 35 districts (10).

In the Ethiopian health system, the current Sector wide approach period uses decentralization as the most influential administrative determinant. The Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Zonal Health Departments (ZHDs) and Wereda Health Offices (WrHOs) which are the administrative body at each level are the key institutions involved in health care delivery in the country (11).

Decentralization potentially changes the roles of the central ministry staff from line management to policy formulation, technical advice and program monitoring (12). Ultimately, decentralization involves more activities being conducted at lower levels of the health system. Hence, decentralization implies greater responsibility and authority for local governments, organizations and communities (13, 14).

Ambiguity in the management role is a frequent experience of countries and organizations that are undergoing such changes as new roles and responsibilities are rarely defined in sufficient details to allow managers or stakeholders to clearly understand their expected responsibilities and powers for decision making (15, 16).

A constitutional and/or legislative framework is needed to reinforce the legitimacy of the political decision and commitment for reform and to provide coherent direction and purpose to the whole exercise (14). In most developing countries, lack of clear guidelines to achieve the objectives of decentralization with the insufficiently developed managerial skills, in terms of quality and quantity, hampers the reform process (17). Saide and Stewart (18) pointed that, in the absence of clear guidelines, continuous monitoring and an adequate supply of

human and financial resources, decentralization processes are more likely to have a low impact and can, to a certain extent, provoke inequalities between regions of the same country.

In the case of the Ethiopian health system, problems of accountability include delays in expenditure reporting, weak monitoring of expenditure outcomes, and delays in closure of accounts and unpredictability in fiscal flows to lower tiers of the government (19). An evaluation report stated, "*It is not clear how closely the FMOH wants to, or should, follow activities in the [Southern Nations and Nationalities People Region] in light of the current policy of decentralization and regional autonomy (20).*"

But as a core to successful implementation, management function in a decentralized system should be able to indicate an efficient division of responsibility among the different levels. This is crucial in order to minimize unnecessary duplication and overlap of activities, and maximize efficient use of scarce resources. These rules should be explicit and transparent to all involved (2, 14). Therefore, the objective of this study was to assess the presence and use of legislative guidelines for the distribution of decentralized decision-making authority in the Jimma Zone health system, Southwest Ethiopia.

METHODS

The study was conducted in Jimma zone, one of the 17 zones in Oromia Regional State, from 16th January to 15th March 2007. The zone is governed by the Oromia Regional State and is currently divided into 18 districts, which have 456 rural and 27 urban kebeles (the smallest administrative units in Ethiopia). During the study period, each district had at least one functional health center except Gumay, Seka Chekorsa, Chora Boter and Nano Benja districts.

The study design employed was cross sectional with the use of both qualitative and quantitative methods. Several health managers including heads and vice heads of relevant departments of the FMOH, Oromia RHB, Jimma ZHD and 14 WrHOs in Jimma zone were included in the study. At the district level, health managers at public health institutions (from district hospital to health post) were also included. All respondents for the study were identified using purposive sampling technique. All districts of Jimma Zone having at least one functional health center were included in this study.

A structured questionnaire adapted from the Responsibility and Authority Mapping Process (RAMP) template (15) was used to assess the perception of the health managers about the distribution of responsibility and authority along the health system. Another structured questionnaire adapted from similar study was used to assess the practice of the managers on the same issues (5). In each case, adapting the questions considered the recommendations of the regional guideline. Roles of the central, regional and district levels of governance in a decentralized health system was searched from the web and other documents to supplement descriptions of the situation in Jimma Zone. For the in-depth interview, interview guides were developed for each level of governance based on the regional legislative guideline and World Health Organization (WHO) recommendations. Issues raised in the practice questionnaire were different from and meant to complement those in the in-depth interviews. However, matters considered in the assessment of perception were some how similar to those in the in-depth interviews. All the instruments were translated into the local language (Amharic) by a second year MPH student and checked for consistency by the principal investigator.

During data collection, three second year postgraduate students from public health faculty of Jimma University were oriented and conducted the in-depth interviews. Completion of self-administered questionnaire by the health managers was facilitated by the same data collectors and the principal investigator. The in-depth interviews were conducted before providing respondents with the self-administered questionnaire. The legislative guideline for each level of the health care delivery system was obtained from Jimma ZHD.

Quantitative data was edited and entered into SPSS for windows version 12.0.1 to produce relevant frequencies, percentages and tables. Tape-recorded qualitative data was first transcribed and analyzed using thematic framework approach

where familiarization with the transcripts was followed by theme identification, coding and interpretation. Direct quotes of the respondents were presented whenever appropriate.

The study proposal was approved by the Ethical Clearance Committee of the Public Health Faculty of Jimma University. Each of the health managers in the respective offices received a letter from the Department of Health Services Management requesting his/her cooperative participation with some of the relevant subordinates in the offices. Consent was obtained from all the respondents and all identifiers were replaced with numbers and other codes to ensure confidentiality of responses.

A notable limitation of this study is the inability to include the views and expectations of the community. Moreover, some of the health managers interviewed have been in the managerial position for a short period which might affect the quality of data obtained from them.

RESULTS

Health managers from all the four levels (Woreda, Zone, Region and Federal) of the health system of Jimma Zone were included in this study. Of the total 99 respondents for the assessment of perception, 90 (90.9%) of the respondents were from the district level (i.e. WrHOs and health facilities). In the in-depth interview, a total of 46 health managers were included: 38 from the WrHOs and health facilities and the remaining 8 from zonal [3], regional [3] and federal [2] levels. To supplement the findings of the in-depth interviews, 50 health managers were communicated to complete a structured questionnaire. Of these, 44 individuals completed and submitted to yield a response rate of 88%. While 24 (54.5%) of these respondents were from the WrHOs, the remaining were from the health facilities under their jurisdiction (Table 1 and 2).

Table 1. List of health offices and health institutions contacted during the conduct of the study, Southwest Ethiopia, February 2007.

Woreda level				
Woreda (WrHOs)	Health Offices	Health Centers	Health Posts/ Station	Other levels
Mana		Yebu	Gudeta Bulla & Kenteri	Jimma ZHD
Dedo		Sheki	Warokolobo & Defqela	Oromia RHB
Kerssa		Serbo		FMOH
Limu Kossa		Limu Genet health center and hospital		
Gera		Gera		
Sigmo		Sigmo		
Setema		Gatira		
Shebe Sombo		Shebe		
Limu Seka		Limu		
Agaro		Agaro		
Goma			Qota and Getabore	
Sekuru			Deneba	
Trio Afeta		Akko	Dimtu	
Omonada		Asendabo	Lafteka	

Table 2. Place of work place of health managers included in the study, Southwest Ethiopia, February 2007.

Place of work	In-depth interview	Self-administered survey
Health facility	25 (54.3%)	70 (70.8%)
Woreda health office	13 (28.3%)	20 (20.2%)
Zonal health Department	3 (6.5%)	4 (4.0%)
Regional health office	3 (6.5%)	3 (3.0%)
Federal Ministry of Health	2 (4.4%)	2 (2.0%)
Total	46	99

Only 3 of the 46 respondents of the in-depth interview and 4 of the 99 respondents of the perception assessment claimed to have received any training related to management recently. In some cases, the time the health managers spent on the position was insufficient to respond for some of the

questions raised regarding authority and responsibility. Of the 23 respondents who reported duration of stay on the current managerial post, 13 (56.5%) stayed for 1-3 years while 7 (30.4%) of them worked for less than a year (Table 3).

Table 3. Measures helpful for enhancing proper perception of decentralized authority and responsibility at the woreda level, Jimma Zone, Southwest Ethiopia, February 2007

Factors for proper perception	Number (%)
Managers who received training on decentralization and management issues	
In-depth interview respondents (n=46)	3 (6.5%)
Perception assessment respondents (n=99)	4 (4.0%)
Duration of service on the current managerial post (n=23)	
Less than a year	7 (30.4%)
1-3 years	13 (56.5%)
More than 3 years	3 (13.1%)
Availability of guidelines	
Woreda Health Office (n=13)	6 (46.2%)
Health Centers (n=12)	0
Health Posts (n=8)	8 (100%)

As a means of enhancing health services delivery and its management, several kinds of guidelines were developed both by the FMOH and the Oromia RHB. For instance, the RHB has developed and distributed a guideline depicting the authority and responsibilities of the RHB, ZHDs and WrHOs clearly in the decentralized health system. A manager at the RHB said that all kinds of guidelines are developed and distributed with expenditure of significant resources and energy. She added, “... *we don't simply send newly developed guidelines. Orientations are always given to zonal and woreda health officials and they are strictly advised to reflect the new ideas and concepts to health care providers and managers down the line.*” However, observations at the WrHOs and facilities under their jurisdiction revealed that most health managers don't even know where the guidelines are kept in their office.

At the Jimma ZHD, it was claimed that central and regional policies, procedures and guidelines are conveyed to the WrHOs on time. A manager emphasized that, “*Immediately after we received guidelines and other directives from above, we provide trainings and send appropriate documents [guidelines or other relevant documents] to all the woreda offices.*” Similarly, a respondent from a WrHO said, “*When new guidelines indicating regional and national rules and regulations arrive, they are immediately communicated to health institutions under the office.*” In spite of these claims, it was only in 6 of the 13 districts visited where the guideline indicating the authorities and responsibilities of the WrHOs in the decentralized

health system were available. This was also true at the health centers. On the contrary, in most of the health posts visited respondents reported to have a guideline stating the roles and responsibilities of the HEWs.

As a head of a health center mentioned, the absence of guidelines that clearly indicate authority and responsibility of different bodies in the health center is one of the major obstacles facing a health manager whilst exercising his/her duties. Most frequently mentioned reason for the absence of standard guidelines both at the health offices and institutions was the reluctance and negligence of health managers who first received these important documents. Moreover, some health managers indicated that other possible explanations include high turnover of the health managers at different levels and failure of the WrHO to send all guidelines to the health centers.

Consequently, health managers at the different levels of the Jimma Zone health system have numerous confusions and misunderstandings about the roles and responsibilities their own and those of others in the system. For instance, at the district level the highest bodies responsible for handling health care delivery issues are the WrHO and its Wereda Health Management Team (WHMT), which are directly accountable to the Woreda Administrative Council (WAC). Although this was well understood by 30 (73.2%, n=41) of the woreda health managers, the ZHD was regarded as an overseer by 10 (24.4%) of the respondents. Moreover, the WHMT is responsible for the

monitoring and evaluation of health activities in the district and take appropriate decisions when necessary. This was well perceived by 81 (81.8%) of the health managers at all levels. However, 97

(97.9%) of the respondents agreed that the ZHD is responsible for the monitoring and evaluation of health activities at the district level (Table 4).

Table 4. Perception of health managers about decentralized authority for decision making in the health system, Jimma Zone, Southwest Ethiopia, February 2007

Functional area	Authorized body as per the guideline	Proportion of managers with correct perception
Handling all district health activities (n=41)	WrHO and WHMT	30 (73.2%)
Monitoring and evaluation of district health activities (n=99)	WrHO and WHMT	81 (81.8%)
Setting overall national health targets (n=99)	FMOH	84 (84.8%)
Translating national health policies into a district health plan (n=99)	WrHO and WHMT	84 (84.8%)
Management of human resource for health (n=95)	WrHO and WHMT	58 (61.1%)
Assisting development of human resource for health (n=96)	ZHD and RHB	91 (94.8%) and 84 (87.5%)
Approval of district health budgets (n=96)	WAC	71 (73.9%)
Monitor the financial performance of the WHMT (n=96)	ZHD	86 (89.6%)
Strengthening, provision, management and use of health information (n=99)	WrHO and WHMT	89 (90%)

Eighty four (84.8%) of the health managers correctly implied that the FMOH should set the overall health service targets for health programs and facilities in the country. However, about 79 (79.8%), 64 (64.6%) and 59 (59.6%) of the respondents perceived that the RHB, ZHD and WHMT, respectively, have the authority to set overall health service targets for health programs and facilities. Consequently, 89% (n=37) of the woreda health managers did not initiate any new program or new way of providing services that were not already in existence or recommended by the RHB. In cases of disagreement with RHB priorities, 24 (61.5%, n=39) of the health managers added their own priorities to the required activities by the regional bureau while about 12 (30.8%) of the managers said that they have not tried to include local priorities other than resorting to the implementation of what have been required by the RHB.

Eighty four (84.8%) of the health managers said that, the WHMT should be responsible to translate the national health policies into a comprehensive annual district health plans in accordance with local situations. Practically, however, only 23 (62.1%, n=37) of the woreda health managers claimed to have discharged this

responsibility. Owing to the confusion among the health managers, the health facilities and WAC were considered to be responsible for this by 79.2% (n=96) and 72.2% (n=97) of the respondents, respectively.

Responses from the health managers at the WrHOs and health centers implied that there is confusion about the technical supervision and monitoring of health services extension program in Jimma Zone. In the extreme scenario, where the WrHO provides technical supervision and monitors activities in all health posts of a woreda, health centers appear to have no stake in the program and Asendabo health center of Omonada woreda is one among such centers. The health center neither conducts supportive supervisions nor receives monthly reports from health posts within its catchment area. To make things worse there is no referral link between the health center and health posts around it. Almost similar situations prevail in Gera and Limu Kossa woredas. Moreover, all health posts included in this study regularly sent performance reports to the WrHO and not to a supervising health center, if at all it exists. There is also a slight difference in the timing of the reports. While most reports are made on monthly interval, the health post in Defkela (Dedo woreda) makes its

report weekly. Lafteka and Getabore health posts make weekly reports on malaria prevention and control activities.

In other woredas, a health center supervises and monitors the activities of the health posts in its catchment area. Kersa is one among such woredas where Serbo health center is in charge of providing technical support and supplies and receives monthly reports from 2 health posts in its catchment area. The center's head explained, *"We have a supervision team which conducts on site supervision to both static and outreach activities of HEWs, gives feedback accordingly and receives monthly reports."* Likewise, Sigmo and Gatira health centers not only provide supervision and supplies but also receive monthly reports from all the health posts in their catchment area. A little bit different third variety was observed in Yebu woreda where the WrHO receives the monthly report and the health center provides the technical supervision and supplies.

Lack of knowledge about the chain of command and administration in the health system has contributed to the existence of confusion in the management of health services extension program. A health center head explained, *"People at the WrHO are not aware of the proper channel of communication and supervision regarding health services extension program."* Interestingly, most of the HEWs knew that they should be directly accountable to a supervising health center and not to a WrHO. Moreover, the frequency and variety of supervision in some of the health posts was quite interesting. A HEW in Warokolobo kebele said, *"At least twice a month supervisors from the WrHO visit the health post. In addition, people from RHB, ZHD and international organizations such as UNICEF visit us frequently."* While another health post in the same woreda earns such visits only every 4 months even by the supervisors from the WrHO.

On the other hand, most of the health posts included in the survey met the recommendation of the RHB, which expects a close working relationship with other community health workers and community based organizations in their respective kebeles. A HEW indicated, *"We meet with kebele officials every 2-3 weeks and discuss the major problems encountered during our activities."* However, written reports to the Kebele Councils are submitted only in Gudetabula and Kenteri kebeles of Omonada woreda. Moreover, in

Qota kebele of Goma woreda 6 individuals from each Got assist HEWs. However, the two health stations included in this study did not have linkage with the Kebele Councils. Instead, monthly, quarterly and yearly reports are presented to the WAC. Generally, activity reports of the community health workers are received by the HEWs to be compiled and sent to the WrHOs in all cases except Deneba health station.

With regard to human resource management, the RHB and ZHD, which by their mandate should have played lesser role, were viewed to have the authority to manage health human power in the district health system. This was voiced by 65 (68.4%, n=95) and 63 (66.3%) of the health managers, respectively. It was only by 58 (61.1%) of the respondents that the WHMT was perceived to be responsible for this activity. The WHMT was considered to have the authority to define, establish and award financial incentives for employees by 69 (73.4%, n =94) of the respondents. Whether health facilities and the WAC have such an authority was uncertain for 31 (32.6%, n=95) and 25 (26.3%) of the managers, respectively. However, according to the views of the respondents, the zonal (94.8%, n=96) and regional (87.5%) offices were correctly perceived to have the responsibility to assist health human power development in the districts.

Taking a look at financial management issues, it was found that across all the woredas included in the study budget allocation to district health activities is prepared by the WrHO and submitted to the WAC, which will determine and approve the amount of financial resource to be available for the district health services. This approved budget will be received from the Woreda Finance Office. In this regard, 71 (73.9%, n=96) of the health managers were clear that approval of health budgets and efforts for local resource generation is the responsibility of the WAC while the remaining 27.1% were uncertain or disagreed about this regional direction. However, only about half of the respondents (n=93) disagreed to the suggestion that the WHMT alone should be responsible for such activities in the district.

The suggestion that the ZHD should be responsible to monitor the financial performance of the WHMT was acceptable to 86 (89.6%, n=96) of the managers, although 58 (61.7%, n=94) of the respondents indicated that the RHB should be responsible for this task. During the in-depth interviews, however, it was found that monitoring

the financial performance of district health systems in the zone is beyond the ZHD's jurisdiction. In all the woredas, detailed reports of financial expenditure, logistic and program performance are communicated to the WACs and the Woreda Finance Offices. The ZHD usually receives a short summary about the performance of programs and the related logistics.

A focus at the health management information system (HMIS) revealed that 89 (90%, n=99) of the managers positively viewed the WHMT to be responsible for strengthening, provision, management and use of health information to support evidence-based planning and decision-making in the district health system. However, significant proportion of the respondents considered the ZHD, 83 (83.8%), and RHB, 63 (63.6%), to be responsible for the management of HMIS at district level. Uncertainty to this role was voiced by 20 (20.2%) of the health managers. Besides, 87 (87.9%) of the respondents correctly perceived that interpreting data and providing feedback in the district health system should be the responsibility of the WHMT. The ZHD and RHB were also perceived to be responsible for these activities by 77 (78.6%, n=98) and 60 (61.2%) of the managers, respectively.

DISCUSSION

During this study, it was found that most of the health managers leading the health system of Jimma Zone did not receive meaningful training in relation to managerial work in general and decentralization in particular, since they have been assigned to their current posts. This could be partly explained by the high turnover of professionals both at health offices and health facilities. As decentralization implies greater responsibility and authority for local governments, failure to orient the newly assigned health managers would affect the performance of the reform process (13, 14).

It was argued that decentralization implies greater responsibility and authority for local governments, organizations and communities, but it will only be accepted and made to work through a process of consultation that allows "top-down" and "bottom-up" interaction (14). But the existing means of such interactions in the Jimma Zonal health system is limited to the development and distribution of different guidelines. Although the Jimma ZHD claimed that central and regional policies, procedures and guidelines are timely conveyed to the WrHOs, it was only in 6 of the 13

districts visited that a guideline implying the authorities and responsibilities of the WrHOs in the decentralized health system was approved to be available. Such guidelines and other important ones were not available in the majority of the health facilities too. However, it has been shown that in the absence of clear guidelines, continuous monitoring and an adequate supply of human and financial resources, decentralization processes are more likely to have a low impact in the process of health reform and can, to a certain extent, provoke inequalities between regions of the same country (18).

The availability of guidelines describing the authority and responsibilities of the different actors in a decentralizing health sector is a necessary but not a sufficient precondition to indicate an efficient division of responsibility among different levels (14, 21). To this end, all individuals involved in decision making should be aware of the recommendations in the guidelines. In Jimma Zone, the authority and responsibility granted to different parties and their importance is usually undermined or remains unclear to the health managers though there is a regional guideline for this matter. This could be explained by the fact that health managers at the district level rarely get orientation on this matter or those who have received the orientations are leaving the system. Another contributing factor to this is the absence of the guidelines in the majority of the health offices and health centers.

Moreover, the findings of this study suggest that inappropriate perceptions about the roles and responsibilities of different actors of the health system were quite common. To mention some, 97 (97.9%) of the health managers agreed that the ZHD is responsible for the monitoring and evaluation of health activities in the districts. Translation of the national health policies into comprehensive annual district health plans in accordance with local situations was considered to be the responsibility of the health facilities and WAC by 76 (79.2%) and 70 (72.2%) of the respondents, respectively.

On the other hand, ensuring the achievement of regional health service targets is the responsibility of the RHB, as it was correctly perceived by 97 (97.9%) of the health managers. Surprisingly, almost equivalent proportion of the respondents (95.8%) suggested that the FMOH should be responsible for this task. Similarly, in the South East Asian Region Pokharel (4) observed that the different actors at various levels (Center, region

and districts) were confused with their new roles and responsibilities with the introduction of decentralization. These findings show that although guidelines are developed and distributed by the RHB, health managers at lower levels are not fully conversant regarding the contents of this important document. However, the general view is that decentralization can be successful in protecting or enhancing priority services if new roles are clearly defined (21).

Regarding financial management, it was found that financial budget to district health activities is prepared and presented by the WrHO to the WAC, which will determine the approved amount of financial resource for district health services. Practically, however, 20.9% (n=43) of the woreda health managers claimed that the head of the WrHO and the woreda administrator alone do the yearly program budgeting at the woreda level. This confusion of roles may be attributable to the lack of awareness of the managers as in the cases discussed above.

Describing the management of the health services extension program, the regional responsibility statement states that a health center is responsible for the provision of technical supervision and necessary logistics to 5 satellite health posts and each health post should report to the supervising health centre and the Kebele Council on logistics and program performance. It is only in few of the health centers visited during this study that these recommendations were followed. Moreover, the frequency of supervision visits to the health posts varies across the woredas in the zone. Other studies in developing countries have also found that introduction of decentralization has confused supervision responsibility, diminished technical supervision capacity, and reduced the number of supervision visits (18, 22).

Interestingly, the practices of the HEWs interviewed meets regional recommendations in most instances. Close relationship with other community health workers and community-based organizations in their respective kebeles is one area of success. Logistic and plan performance reports are usually communicated to the Kebele Council and the WrHO although written copies are submitted only to the later. All health posts have annual plans, which are strictly followed by the HEWs. At this point it is relevant to recall from the findings of this study that all the health posts had guidelines depicting their roles and responsibilities.

In conclusion, clear legislative guidelines indicating the distribution of decentralized authority in decision making with accompanying responsibilities and accountability for the different levels of the health system are developed at regional and national levels. However, the guidelines were not appropriately documented and most health managers were unaware of the contents particularly at the district level. By and large, perceptions of health managers in Jimma Zone about the distribution of decentralized authority in decision making with accompanying responsibilities and accountability deviates from the recommendations of the guidelines. The Jimma ZHD, Oromia RHB and other stakeholders should realize that the development and distribution of guidelines on new roles and responsibilities of different actors should be accompanied by focused orientation and training programs with a frequency matching the rapid turnover of the health managers at different levels.

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