Covid-19 and Decentralised Health Service Delivery in Ethiopia: The Case of Dejen Woreda and Debre Markos City Administration in the Amhara Region

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Abstract

Decentralised health service delivery at the local level was affected by the outbreak of the Covid-19 pandemic in Ethiopian federal system. This study assesses the effects of the pandemic on decentralised health service delivery in Dejen Woreda and Debre Markos City Administration in the state of Amhara in Ethiopia, based on data collected using interviews, documentary analysis and focus group discussions. The arrival of Covid-19 at the local level caused the interruption of medical follow-up among patients, a shortage of resources and health professionals, and a decline in the internal revenues of health centres. To prevent and control the pandemic, a lockdown policy and a state of emergency were declared. Task forces were established which collaborated with health offices and engaged in the collection of resources in cash and in kind. The government of the state of Amhara supported the Dejen Woreda Health Office by hiring health professionals using its own budget. However, due to the prolonged intervention of the regional government in the administrative autonomy of the Woreda, a situation was created that made regionally hired professionals unaccountable to the local health office. The article argues that lifting the state of emergency was the only precondition for lifting the intervention of regional government in the administrative autonomy of local governments.

Keywords: *Covid-19, local government, decentralisation, health service, autonomy*

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1. Introduction

There are studies that show the legal and institutional frameworks for managing public health emergencies, in particular the Covid-19 pandemic, the measures taken to contain their spread, the relative performance of states in managing their effects, and responses to the challenges posed by their outbreak at the international and national level (Steytler, 2022; Ayele, et al., 2021; Cameron, 2021; Ayele & Fessha, 2022). However, there are gaps in the studies when it comes to examining the effects of Covid-19 on health service delivery at local level. Responsibilities for public health, including handling emergency public health in federations, are often joint responsibilities that had an impact on performance when dealing with the Covid-19 pandemic (Cameron, 2021). For instance, the absence of a committed federal leadership to combat the pandemic created divisions and quarrels among federal-state and state-local governments in the United States (US). In March 2020, this led to the registration there of the highest number of cases and deaths from the coronavirus in the world (Cameron, 2021: 8).

In Ethiopian federalism, the competencies of health care and emergency issues are shared between the federal and state governments. In terms of Article 51(3) of the Constitution of the Federal Democratic Republic of Ethiopia (FDRE), the federal government has the power to "establish and implement national standards and basic policy criteria for public health." Article 52(2)(c) also guarantees state governments the power to make detailed policy for health care, based on national standards. As per Article 93 of the FDRE Constitution, the federal government has the power to develop policies and framework legislation on emergency health issues, such as containing pandemics. The state governments also have the competency to declare a state-wide state of emergency when an epidemic occurs (Article 93(1)(b), FDRE Constitution). Thus, "states have competencies in the area of containing the spread of a global pandemic such as Covid-19" (Ayele et al., 2021). The competence of local governments with regard to health care is not mentioned in the federal constitution. State constitutions also do not clearly define the competencies of local governments vis-à-vis emergency health issues, though woredas and cities have the responsibility to implement their own

plans on social and economic matters (Ayele, 2014). In practical terms, though, local governments are responsible for providing primary health care.

In terms of institutions, at federal level the institutions responsible for providing health care, including emergency health care, are the Federal Ministry of Health (MOH), Ethiopian Public Health Institute (PHI), and Ethiopian Food and Drug Control Authority (EFDCA) (Ayele & Fessha, 2022). The MOH is obliged, among other things, "[to] follow-up the implementation of strategies for the prevention of epidemic and communicable diseases" as well as "take preventive measures against events that threaten public health [and] in the event of an emergency situation, coordinate measures of other stakeholders to expeditiously and effectively tackle the problem" (Article 27(6)– (7), Proclamation No. 1097/2018). The MOH also has the power "to restrict movements to certain countries, or to the areas where there is epidemic, or to close schools or recreational areas, or to remove workers with communicable diseases from their working places, and to take other similar measures whenever an epidemic occurs" (Article 17(3), Proclamation No. 200/2000). The main responsibility of the PHI is "to detect and prevent public health emergencies"; it is required to institute early warning systems that enable other concerned organs, including the MOH, to take appropriate and timely measures" (Ayele & Fessha, 2022: 323). At state level, there is a health bureau, while at local level there are offices of health as counterparts of the federal MOH.

With regard to health facilities, the Ethiopian health sector has a three-tier health-care delivery system at primary, secondary and tertiary levels. The primary health-care system, which is found at the local level of government, consists of a primary hospital (covering 60,000–100,000 people), health centres (covering 15,000–25,000 people) and their satellite health posts (covering 3,000–5,000 people). The secondary health-care system is composed of general hospitals that serve as referral centres for the primary level of care, while tertiary-level health-care comprises specialised hospitals that serve a population of 3.5–5 million (HHM, 2020). In health service delivery, cooperation between the federal, state and local government is a requirement for effective service delivery, as set out in the Health Harmonisation Manual

(HHM) developed by the MOH. The HHM functions under the slogan, "one plan, one budget, one report" (HHM, 2020).

Following the report of the first coronavirus infection in Addis Ababa on 12 March 2020, regional states, including local governments (woredas and cities), began to take measures to prevent the spread of the virus by declaring a partial lockdown (such as in cities in Oromia) or complete lockdown (such as in cities in Amhara) (Ayele & Fessha, 2022: 328). In April 2020, the federal government also declared a nation-wide state of emergency (SOE) to prevent and control the spread of the coronavirus for five months consecutively. The declaration of a nation-wide SOE placed all levels of government and their institutions, including health facilities at the local level, under centralised command.

The objective of this study is to assess the effects of Covid-19 on decentralised health-service delivery at a local level, using the case of Dejen Woreda and Debre Markos City Administration in Amhara Regional State. How did the outbreak of Covid-19 affect decentralised health service provision at the local level? What measures were taken to prevent and control the spread of Covid-19 at local level? Did the challenges posed by Covid-19 have policy implications that could help to improve decentralised planning and budgeting for managing unforeseen public health emergencies? Data for the study were collected using key informant interviews, documentary analysis and focus group discussions. Key informant interviews were held with eleven health professionals in East Gojjam Zone Health Department, health officials in Dejen Woreda and Debre Markos City Administration, and health professionals in Dejen Health Centre, Debre Markos City Health Centre and Weseta Health Centre in Debre Markos city.

The study sites, Debre Markos City and Dejen Woreda, were selected due to their exposure to Covid-19 in East Gojjam Zone. Dejen Woreda was a high-risk area for the spread of Covid-19, since the Woreda is the main entry-point for passengers coming to the Amhara region from Addis Ababa. Debre Markos city, the capital of the East Gojjam Zone, was selected since it is one of the main urban areas in the Zone, with a large and mobile population. Documents collected for the study include Covid-19 directives, regional implementation documents, and reports of zonal health

departments and health offices. Two focus group discussion were held, one with patients of Dejen Health Centre and the other with patients of Debre Markos City Administration Health Centre. Data were analysed using descriptive methods.

The article is organised into eight sections, including the introduction. Section 2 sets out the study's conceptual framework regarding decentralisation and local government autonomy. The third section looks at the autonomy of local governments in the Ethiopian federation, focusing on their autonomy (if any) in the health sector. Section four deals with health policy, strategies and the harmonisation of health service delivery in Ethiopia. Health service delivery following Covid-19 in Dejen Woreda and Debre Markos city is discussed in section five. Section six deals with measures taken to prevent and control Covid-19 at a local level, while section seven examines the challenges that Covid-19 posed to decentralised health services and their implications for planning to manage future public health emergencies at a local level. The last section draws the conclusions of the study.

2. Decentralisation and local government autonomy

The concept of decentralisation can be broadly defined as the transfer of power from the national government to subnational units including local governments (Backenford, 2011). Depending on the form of government, the transfer of power can be constitutionally guaranteed, or can be done using ordinary statutes or directives. Often, in unitary forms of government, the transfer of power from the centre to subnational units is not entrenched in a constitution and is subject to withdrawal, revocation or amendment by the central government. In federal forms of government, the power transferred to states is constitutionally entrenched and cannot be taken back unilaterally either by the federal government or the states (Fiseha, 2018). There are three types of transfer of power: deconcentration, delegation and devolution.

Deconcentration is a type of decentralisation in which the central government transfers administrative duties and responsibilities to subnational units without political power or autonomy. In other words, subnational units are considered as administrative arms of the central government, without any substantive political power.

Delegation is a system in which subnational units act in the name and on behalf of central government as its agents. In the case of delegation, sub-units may have some degree of administrative authority, but only central government has the political autonomy and mandate to decide on policy issues. Devolution, also called political decentralisation, refers to the transfer of power by a constitution or enabling legislation to allow subnational units to exercise self-government by regularly electing sub-units' legislative and executive councils, as well as having a degree of functional competence or administrative and financial autonomy, in addition to political autonomy. The constitutional guarantee of devolved power in federations protects subnational units from undue political interference in their autonomy by the national government (Watts, 2008; Fiseha, 2018).

Though all federal constitutions transfer power to subnational units or states, the transfer of power to local government is not always entrenched in the federal constitution. In classic federations such as Switzerland, the US, and Canada, and in emerging ones such as Ethiopia, the power of local governments is not entrenched in the federal constitution. Some federal constitutions, such as the South African 1996 Constitution and the Nigerian 1999 Constitution, include the powers and status of local governments. The constitutional entrenchment of the powers and status of local governments in a federal constitution gives them security of existence as orders or spheres of government.[37] This in turn gives local governments a degree of political, administrative and fiscal autonomy in the area of competencies allocated to them by the constitution (Steytler, 2005; Ayele, 2014). In a context where the federal constitution lacks provisions that directly devolve power to local governments, states have the power to structure and determine the autonomy of local governments.

Transfer of power through devolution by a constitution or other enabling laws guarantees local governments the highest form of political, administrative and fiscal autonomy in which they are able to "decide on local matters free of interference by senior levels of government" (Ayele, 2018: 15). Local political

37 In a situation where local governments have security of existence in the federal constitution, which is central to their autonomy, any change to or creation of local governments is undertaken on the basis of constitutional principles. This prevents the arbitrary making and unmaking of local governments, be it by the federal or state government (Fiseha, 2018).

autonomy assumes a system of devolution that guarantees its security of existence by giving constitutional recognition and protection to local-level governments. Politically autonomous local government units have local councils and executive organs which are democratically elected in regular free and fair elections. Devolution of relevant and clearly defined competencies to local level is also a component of local political autonomy.

The second element of local government autonomy is financial autonomy. Financial autonomy of local government has two aspects: revenue-raising autonomy and budgetary autonomy. Revenue-raising autonomy is "the power of local governments to raise the necessary revenue from internal sources by way of levying taxes, collecting users' fees, and the like" (Ayele, 2018: 16). Adequate sources of revenue are devolved to local governments to minimise their dependence on either the federal or state government. However, the internal financial sources of local governments often generate insufficient revenue, making a fiscal gap between local revenue and local expenditure responsibilities inevitable. As a result, local governments require transfers from the federal government. Studies suggest that, to safeguard local autonomy from federal government interference, the transfer needs to be in the form of an unconditional grant, such that local governments can use it for any purpose necessary for the local community. The federal government can also use "conditional grants to ensure equity and maintain national standards in the provision of certain services" (Ayele, 2018: 17).

The third form of local government autonomy is administrative autonomy, which is related to determining local administrative structures and, inter alia, hiring and firing local personnel. Local administrative autonomy is important to curb federal government interference that can undermine the political and financial autonomy of local government.

As global trends show, the devolution of power to local level, or local government autonomy, is considered one of the main tools for carrying out the developmental role of the state, particularly in the provision of basic social services such as education, health and water, in that it brings government closer to the people and increases the efficiency of service provision to local communities.

However, local government autonomy alone is not enough to ensure effective service delivery, since it can be exposed to corruption, including elite capture of public institutions, policies and resources. Thus, scholars suggest that the institutional design of autonomous local government needs to balance local autonomy and central supervision in order to achieve its developmental role (Ayele, 2018). The main purpose of the supervision is to prevent shortcomings in local autonomy by setting minimum standards that must be fulfilled in terms of service delivery, so that citizens, regardless of where they live, have access to basic services. Supervision by the federal government involves regulation, monitoring, support and intervention using framework legislation, policies, manuals and other instruments (Ayele, 2018). But, to prevent the federal government from using excessive power in its supervision and encroaching on local autonomy, the grounds for intervention need to be clearly defined in a way that leaves little room for abuse.[38]

Another important institutional design that needs to be considered in decentralised systems so as to enable effective service delivery at local level is intergovernmental cooperation among orders of government, including local governments. Intergovernmental cooperation gives the federal government an incentive to "genuinely relinquish power to local governments"; secondly, it "mitigates the danger of promoting narrow local interests at the expense of national development"; thirdly, it is necessary to clearly demarcate competencies among the different levels of government; and, finally, it is an "institutional mechanism for communicating local needs that cannot be addressed by local government to senior level of government" (De Visser, 2005: 210). Unlike supervision, intergovernmental cooperation is not hierarchical; rather it assumes the "equality" of different levels of government. It may have both horizontal and vertical dimensions: in its vertical dimension, it looks into harmonisation of local activities with national policies and strategies, as well as bringing local interests into consideration in national policies and strategies (De Visser, 2005; Watts, 2006). This requires the institutionalisation of intergovernmental cooperation, which is built on the principles of inclusivity, transparency and better attendance of meetings.

38 Central intervention can be triggered by audited findings of financial misappropriation, the failure of a local council or local executive council to meet for a certain period of time, or the failure to approve budgets.

3. Local government autonomy in Ethiopian federalism

The FDRE Constitution explicitly establishes two levels of government under Article 50(1): the federal and the state governments. The competence of establishing local governments is given to state governments under Article 50(4). Article 39(3) recognises the right to self-government of the ethnic communities of the country, and gives a legal framework for the establishment of "ethnic local government", which is aimed at accommodating intra-state ethnic minorities. Intra-state ethnic minorities are communities that find themselves in the minority either in one of the five states that have a dominant ethnic community (Amhara, Tigray, Somali, Oromia, and Afar), or in those that share one of the three states with other communities in which none of them is in the majority (Gambela, Benishangul-Gumuz and the Southern Nation, Nationalities and People's Region, or SNNPR) (Ayele & Negussie, 2018: 27). Thus, the FDRE Constitution sets out a framework for the establishment of two types of local government, which are referred to as regular local governments and ethnic local governments. But the competence of establishing local government, including the smallest administrative unit (kebele), is the competence of state governments.

States in Ethiopia, like those in many federations, have the power to adopt state constitutions (Article 52(2)(b), FDRE Constitution). Accordingly, all states in Ethiopia except the newly established states have adopted revised state constitutions.[39] The nine states adopted their constitutions in the same year (1995) in which the FDRE Constitution was adopted. However, the state constitutions did not comply with the federal constitution's requirements of establishing autonomous local governments, and so they revised their constitutions in 2001 and 2002 in order to reorganise their local governments.[40] The federal government initiated the revision of state constitutions in order to implement its "Plan for Poverty Reduction and Sustainable Development aimed at reducing extreme poverty in the country through the provision

39 The Ethiopian federation has eleven states. Nine states – Tigray, Afar, Amhara, Oromia, Somali, Gambela, Gembela, Harari and the Southern Nations, Nationalities, and People's Region (SNNPR) – were established under Article 47(1) of the FDRE Constitution, while the other two states, Sidama and South Western State, were established by proclamation following political reforms in 2018.

40 The states of Amhara, Oromia, SNNPR, and Tigray revised their constitutions in 2001, while the states of Benishangul-Gumuz, Afar, and Somali revised theirs in 2002 (Tegene, 2007: 2).

of public services such as drinking water, health services, primary education, and the like" (Ayele & Negussie, 2018: 29). This led to the revision of state constitutions in a way that devolved certain competencies and sources of revenue to local government.[41]

Various types and tiers of local governments were created following the revision of state constitutions. All regional states established regular local governments, and five regional states established ethnic local governments in addition to regular local governments, in the form of either nationality zones or liyu Woreda/special districts. Ethnic local governments are autonomous local governments with constitutional rights to secede from the state and become separate states, as per Article 47(2) of the FDRE Constitution. Regular local governments consist of rural Woredas and city administrations. Each Woreda, including liyu Woredas and city administrations, are divided into several kebeles, except in the city of Addis Ababa. A kebele is an administrative subdivision of a Woreda or city administration, but not an autonomous local government. In terms of local political autonomy, nationality zones, liyu Woredas, Woredas and city administrations each have an elected representative council, an executive council, and various sectoral offices. An executive council or cabinet of a nationality zone/liyu Woreda and a Woreda is composed of a chief administrator, who is elected or appointed from the council, and the heads of different sectoral offices such as the health sector of the local unit. The highest executive organ of the city is composed of a mayor and mayoral committee, who are heads of the executive organs of the city.

City administrations have two main functions: state and municipal. State functions are those considered areas of intervention for poverty reduction in the sustainable Poverty Reduction and Development Programme (SDPRP), which includes provision for primary education, health care, drinking water and agriculture (Ayele & Negussie, 2018). The state function of a city administration is carried out by the mayor and sectoral offices such as the health sector.[42]

41 Among other things, the state constitution defines the status, structure and power of local governments.

42 The municipal function of cities, that is, their urban-specific services, are carried out by the city manager and municipal organs organized by the manager.

With regard to the power and functions of local governments, the state constitutions do not list or clarify the competencies. A constitution "simply provides that woredas can plan and implement their own 'economic development and social services', without defining the relevant functions" (Ayele & Solomon, 2018: 32). Empirically, however, studies indicate that Woredas perform, first, the provision of primary and adult education, the printing and distribution of primary school text books, and the administration of primary schools. Secondly, they implement health extension services by constructing and administering health stations and health posts, administering clinics, and controlling and preventing HIV/AIDS and malaria. Thirdly, they construct wells and supply drinking water to municipalities. Fourth, they plan and implement agricultural and pastoral development and administer rural land use and other natural resources. Fifth, they construct rural roads connecting kebeles and implement state functions in municipalities within a Woreda (Ayele & Negussie, 2018).

In terms of financial autonomy, the local governments of Ethiopia, particularly Woredas and cities, do not have, as such, independent sources of internal revenue. As per state constitutions, states are given the power to determine the rate of taxes in the state, while Woredas are mandated to assess and collect state taxes (Ayele & Solomon, 2018). Woredas collect income taxes from their employees, employees of enterprises licensed by the Woreda, small traders, and traditional miners. Woredas also collect user fees from clinics, libraries, community halls; licence fees from water wells and irrigation schemes; and fees for the registration of births, deaths, marriages and divorces. Cities collect urban land-lease fees, land-use fees and municipal service fees (Yilmaz & Venugopal, 2008). Other than taxes, Woredas collect revenue from the sale of movable and immovable properties (other than land) under their ownership and of building materials such as sand, stone and wood. In addition, Woredas receive "financial assistance from donors that either provide direct budgetary support or finance specific projects" (Yilmaz & Venugopal, 2008: 36).

The external sources of revenue of local governments include the unconditional and conditional grants that they receive from the state (Ayele & Negussie, 2018). Unconditional or block grants are

the main source of the annual budget of Woredas. These cover their recurrent and capital expenditure for health care, education, agricultural extension services, rural roads, and the like (Yilmaz & Venugopal, 2010). Woredas also receive special-purpose grants from donors or the federal government for federal government projects that are executed by state governments; this is done by transferring the fund to local governments for food security programmes, safety-net programmes, road funds, HIV/AIDS programmes, and so on. Though Woredas and cities have the same status, cities receive conditional grants, unlike Woredas. The grants are used to finance the recurrent costs of the cities' state functions. In order to examine the framework which balances local autonomy and central supervision and that enables intergovernmental cooperation in the provision of health services, it is imperative to have an overview of the health policy, strategies and health-sector harmonisation manual adopted by the Federal Ministry of Health (FMOH) and implemented at federal, regional and local levels.

4. Health policy, strategies and harmonisation

Following the change of regime in 1991, Ethiopia adopted a health policy in 1993 that encourages decentralisation as well as the expansion of the primary health-care system (Wamai, 2009). The policy allows for partnership between public health-care providers, private health-care entities, and non-governmental organisations (NGOs).[43] To implement the health policy, four five-year consecutive health-sector strategies, called Health Sector Development Programmes (HSDP), have been adopted since 1997–98. They have been supplemented by the HHM since 2007, as well as the Health Sector Transformation Plan I (2015–2020).[44]

43 The private health-care system in Ethiopia services a very small percentage of people, primarily those in the major urban areas where less than 20 per cent of the population lives. As a part of public-private partnerships, private wings have been established in government hospitals; the establishment of community-based health insurance programmes is another area of public-private partnership under active development. Freedom House. (n. d.). Retrieved August 1, 2009 from http://freedomhouse. org/template. cfm? page=22 & country=7175 & year=2007.

44 The goals of the HSTP I are to improve the quality and equity of health-care coverage and utilization of essential health services, and enhance the implementation capacity of the health sector at all levels of the system – community, facility and Woreda. The targets set in the HSTP I and II are in line with the SDGs and support Ethiopia's overall vision of becoming a middle-income country by 2035. The ultimate purpose of the national health sector strategic plan is to guide the implementation of high-impact interventions to improve the health status of the people of Ethiopia in an equitable manner.

HSDP I (1997/8–2001/02) focused on disease prevention and decentralising health-service delivery. However, the targets were not met and a new strategy, HSDP II (2002/03–2004/05), was developed, one which included NGOs in the implementation of the basic health package. The third strategy, HSDP III, developed in 2005/06, stressed the need to increase national health spending, strengthen the strategic role of NGO-government partnerships in achieving universal primary health care, and implement health-care delivery at the Woreda level (Wamai, 2009).

To improve the efficiency of health-sector planning and implementation by coordinating efforts and removing redundancies in the system, as well as to enhance efficiently decentralised health-service delivery, the HHM, which came into being in 2007, was revised in 2020. The overall objective of this manual is to set out a framework for the effective coordination and alignment of programmes within the public sector and its implementing partners to enable the country to achieve relevant aspects of the Sustainable Development Goals (SDG) and universal health coverage (UHC). The manual focuses on putting all stakeholders' efforts into one basket by emphasising the importance of using the HSDP as a nation-wide strategic plan. The HHM is intended to be used by all stakeholders in the health sector at federal, regional, zonal and Woreda levels of government. It is particularly relevant for professionals involved in planning, finance, monitoring and evaluation, or reporting.

"One plan, one budget, one report" is the motto of the HHM. "One plan" refers to using one national strategic plan derived from the Growth and Transformation Plan (GTP) by the National Planning Commission to prepare regional and Woreda strategic plans as well as in the preparation of the annual plan. "One budget" refers to using a government channel to finance the health sector. "One report" means using one monitoring system and one monitoring calendar across all institutions and stakeholders in the health sector (HHM, 2020). It is assumed that harmonised planning, budgeting and reporting enhance efficient decentralised health service delivery. Whether this assumption holds water or if some diversion in planning and budgeting is required during health emergencies at local level is a matter that can be assessed by examining health service provision in Dejen Woreda and Debre

Markos city administration in the state of Amhara following the outbreak of Covid-19.

5. Covid-19 and health services in Dejen Woreda and Debre Markos City

Dejen Woreda and the Debre Markos City Administration are found in the East Gojjam Zone of the state of Amhara. East Gojjam Zone is one of the nine Zones of the state of Amhara and contains twenty Woredas and four city administrations. Its population is 2,778,169 according to estimates in 2021/22. In the Zone, there are 90 rural health posts, 40 urban health posts, 104 health centres, nine primary or district hospitals, one general hospital, and one specialised hospital. These health facilities provide health promotion, protection and treatment services (East Gojjam Zone Health Department, 2022).

Table 2: Number of public health facilities in East Gojjam Zone

Health posts		Health centres	Primary hospitals	General hospital	Specialised/tertiary hospital
Rural	Urban				
90	40	104	9	1	1

Source: East Gojjam Zone Health Department (2022)

Dejen Woreda is the southern entry area to East Gojjam and the state of Amhara from Addis Ababa and the Oromia regional state. This made the Woreda, particularly its capital city, which is also called Dejen, one of the main Covid-19 temperature-check and -testing centres for passengers coming from Addis Ababa, Ethiopia's capital city, and the Oromia region, following the declaration of the SOE to prevent and control Covid-19. The population of Dejen Woreda is 130,541 as per estimates in 2021/2022. The Woreda is organised into two urban kebeles and 24 rural kebeles. In the Woreda, there is one hospital, Dejen Primary Hospital, as well as five health centres, 22 rural health posts, and two urban health posts. The Woreda's private health facilities consist of one moderate clinic, five medium clinics, and three pharmacies (Dejen Woreda Health Office, 2020/21).

Table 3: Type and number of health facilities in Dejen Woreda

Public health facilities						Private health facilities		
Health posts		Health centres	Primary hospital	General hospital	Tertiary hospital	Moderate clinic	Medium clinic	Pharmacy
Rural	Urban							
22	2	5	–	1	–	1	5	3

Source: Dejen Woreda Health Office (2021/2022)

Debre Markos city is the capital city of East Gojjam Administrative Zone, located 300 kilometers north-west of Addis Ababa and 265 kilometers south-east of Bahir Dar, capital city of the state of Amhara. The city is bordered by two Woredas, that is, Anded Woreda in the east, and, in the remaining three directions (to the west, north and south), by Gozamen Woreda. The city is 2,420 meters above sea level and has temperate weather conditions. The population of Debre Markos city, according to 2020/2021 projections, is 138,996. Of the total population, an estimated 50.1 per cent of residents are women. The city administration has eleven kebeles. In the city there are three public health centres, eleven health posts, and one tertiary hospital, Debre Markos Hospital, which serves the population of the Zone as a referral hospital. There are three governmental medium-level clinics. The city has different types of private and non-governmental health facilities, namely six specialised clinics, eight medium-level clinics, two medium-level NGO clinics, one diagnostic laboratory centre, two dental clinics, three pharmacies, and 22 drugstores (Debre Markos City Administration Health Office, 2020/21).

Table 4: Type and number of health facilities in Debre Markos City

Public health facilities				Private and NGO health facilities					
Health posts	Health centre	Medium-level clinics	Tertiary hospital	Med- level clinic	Specialised clinic	Med. NGO clinic	Dental clinic	Diagnostic laboratory centre	Pharmacy
11	3	3	1	8	6	2	2	1	3

Source: Debre Markos City Administration Health Office (2020/21)

In East Gojjam Zone, by February 2022, a total of 29,331 Covid-19 suspects had been tested; of these, 1,586 cases were found positive, and 65 deaths (4.1 per cent) were registered.[45] From August 2021 to December 2021, 246 Covid-19-positive cases and 14 deaths were registered in Debre Markos city. In the same period in Dejen Woreda, the number of positive tests for Covid-19 was five, while there were no registered deaths (East Gojjam Zone Health Department, 2022). This shows that Debre Markos city had a higher number of Covid-19 patients and deaths than Dejen Woreda. The difference may lie in their population densities. Dejen Woreda is a rural Woreda with a dispersed settlement pattern, while Debre Markos city is an urban area with a relatively dense population.

Table 5: Number of infections and deaths from August-December 2021 in study area

Area	No. Covid-19-positive	No. of deaths
Debre Markos city	246	14
Dejen Woreda	5	0

Source: East Gojjam Zone Health Department (2022)

The state of Amhara was one of the first regional states in Ethiopia to begin preparation for the prevention and control of Covid-19, and started providing Covid-19 surveillance and screening in the entry area into the regional state in places such as Dejen Woreda and in densely populated areas such as Debre Markos city. Even though health facilities were among the institutions which did not close following the lockdown policy in Amhara regional state and the declaration of a nationwide SOE by the federal government, the number of patients who went to health centres decreased markedly for nearly a year, due to limited services given by health

45 In the Amhara region, 12,045 people had been tested for Covid-19 until 12 August 2021. Of these, 4,581 were admitted as Covid-19-positive (Amhara Public Health Institute, 2021). Between August and December 2021, the regional death rate was 5.4 per cent (East Gojjam Zone Health Department, 2022).

centres and fear of infection by the Covid-19 virus.[46] For instance, regular health service patients who required follow-ups, such as mothers, tuberculosis (TB) patients, and HIV patients requiring anti-retrovirus treatment (ART), were forced to interrupt their follow-ups, and there were situations in which pregnant women delivered in their homes.[47] In this regard, the last quarter of 2019/2020 Dejen Woreda report indicates, the performance of the first and fourth prenatal care examination of mothers was at 60.3 per cent and 39.5 per cent, respectively, while the execution of delivery in health centres and postnatal care was at 30 per cent and 40.4 per cent, respectively. The annual report of 2020/21 indicates that first and fourth prenatal care examination performance was at 60 per cent and 37 per cent, respectively, while the performance of delivery in health centres and postnatal care was at 26 per cent and 35.4 per cent, respectively. The reports for both years show low levels of execution. This was mainly due Covid-19, according to informants from Dejen Woreda Health Office.

With regard to HIV patients on ART, the 2019/20 annual plan execution of Dejen Woreda was 79 per cent, while in the 2020/21 budget year it reached 85 per cent. Regarding TB patients, in the 2019/2020 annual plan execution report of Dejen Woreda, the coverage of suspects sent to health centres by referral was 24 per cent, while patients who had finished their TB medication was 90.9 per cent. In the 2020/21 annual report, the coverage of TB suspects sent to health centres by referral was 25 per cent, while the number of patients who finished their TB medication was 93 per cent. In both years it was remarked in the reports that the TB execution level was low. As was noted in focus group discussions and interviews, fear of being infected by coronavirus and fear of being suspected of Covid-19 were the main factors for the limited number of suspects sent to health centres, the interruption of follow-up/medication, and the avoidance of accessing health facilities.[48]

46 Interview with Ato Melkamu, head of the Debre Markos City Administration Health Office, 14 March 2022; interview with Ato Fetene, head of the Dejen Woreda Health Centre, 16 March 2022. In the Debre Markos City Administration, following the declaration of a lockdown, one health centre, Weseta Health Centre, was closed and converted into a quarantine facility until quarantine centres could be established in Debre Markos University and Debre Markos Hospital. After a month, following the preparation of quarantine centres in the latter two sites, Weseta Health Centre was free to provide regular health services for the surrounding community. However, it took it nearly a year to return to normality, unlike other health centres in the City Administration and Dejen Woreda. Interview with head of the Debre Markos City Administration Health Office, 14 March 2022.

47 Focus group discussion, Dejen Health Centre, 17 March 2022.

48 Ibid

Similarly, the Debre Markos City Health Office 2019/20 annual report regarding maternal health shows that prenatal care in first and fourth examination execution was 88.5 per cent and 43.1 per cent, respectively, while delivery in health centres and postnatal services was 11.7 per cent and 8.8 per cent, respectively. The report highlighted that the 2019/20 annual plan execution was below the previous year. In the focus group discussion in Debre Markos Hospital, it was stated that home delivery increased markedly following the arrival of Covid-19 in Ethiopia. However, the annual plan execution with regard to prenatal care, delivery and postnatal care showed improvements in the following year's report (2020/21),[49] although it had not reached the required level.

With regard to HIV patients and ART users in the 2019/20 report, patients who had not interrupted their medication were at 81.6 per cent, while in the 2020/21 report they were at 87.1 per cent. Regarding TB, the Debre Markos Health Office 2019/2020 execution report shows that the coverage of suspects sent to health centres by referral was 50 per cent, while that of patients who had finished their TB medication was at 81.5 per cent. In the 2020/21 annual report, coverage of suspected TB patients sent to health centres by referral was 61 per cent, while that of patients who had finished their TB medication was 96 per cent. It was remarked that, for TB patients, execution in both years had been low. In regard to reducing the interruption of medication, the head of the Debre Markos City Health Office head stated:

> Following the declaration of the nationwide SOE to prevent and control the Covid-19 pandemic, TB patients were given a month's medicine to take home and take themselves rather than coming to health centres daily and exposing themselves to the virus, even though this is not an effective treatment mechanism for TB patients given a societal culture of not taking medicine and ignoring medical advice.[50]

In this regard, it was said in focus group discussions that "though health centres were not closed, we did not go to them for fear of

49 In 2020/21 annual report first and fourth examination execution was 98.5 per cent and 39.6 per cent respectively, while delivery in health centres and postnatal services was 15.4 per cent and 34.9 per cent, respectively

50 Interview with Ato Melkamu, head of the Debre Markos City Administration Health Office, 14 March 2022.

being suspected of having Covid-19. We prefer to use traditional medicine if the illness is not serious."[51] People often refused to test for TB for fear of being suspected of having Covid-19.[52] This was the case mainly until the end of 2020.

At the time of data collection for this study (March 2022), Covid-19-related health services, particularly screening, case identification, sample-taking, treatment and vaccines, were provided in all health centres both in Dejen Woreda and Debre Markos city. However, many people were not willing to take Covid-19 vaccines. For instance, in Weseta Health Centre in Debre Markos city, in the third round of the mobilisation campaign days for Covid-19 vaccines (from March 4–13, 2021), the health centre had planned to give 8,035 Covid-19 vaccines but vaccinated only 2,199 people.[53] People were not willing to get vaccinated for different reasons such as religion. The rate of infection in the country was low when compared to other causes of death such as the war (since November 2020) in the Tigray and Amhara regions. There were also societal attitudes that disregarded the seriousness of Covid-19, considered it similar to a flu, and held it as an ailment to be treated with traditional cures.[54] Participants in focus group discussions expressed similar views and felt that Covid-19 had not brought as much damage as the regional war in Ethiopia. Nevertheless, health facilities worked hard to raise the community's awareness of Covid-19 and encourage people to get vaccinated.

6. Measures taken to prevent and control Covid-19

To prevent and control the spread of Covid-19, national and regional command posts and task forces were established at federal and subnational levels following the report of an infected person in Addis Ababa. In the Amhara regional state, the main role and responsibilities of the regional command post were to give leadership on issues that would enable the region to prevent and control the spread of Covid-19. Under the command post

51 Focus group discussion, Debre Markos City Health Centre, 15 March 2022.

52 Interview with Ato Melkamu, head of Debre Markos City Administration Health Office, 14 March 2022.

53 Interviews with health professionals in Weseta Health Centre and officials of the health offices in Dejen Woreda and Debre Markos City Administration, March 2022.

54 Ibid.

for the prevention and control of the pandemic, a regional task force was established, containing all the public sector and branch institutions in the region, including heads of the health bureau of the region, heads of branch offices of service-providing institutions, commissions, the regional council standing committee chairs, and the chair of the University Forum (Amhara Regional State, 2022). All sectors and institutions included in the task force were required to establish technical committees to work on the prevention and control of the spread of the virus in their respective institutions and to report their accomplishments to the task force. One of the main roles and responsibilities of the regional task force was to lead, establish and support the establishment of technical committees in all sectors and institutions.

Below the regional task forces for the prevention and control of Covid-9, task forces were established at zonal, woreda, kebele and health-facility levels. Taking the structure of the regional task force into account, the zonal task force for the prevention and control of spread of Covid-19 was established, including all sectors in the zone, and making the zonal administrator and head of the zonal health department chairperson and secretary of the task force, respectively. At woreda and kebele level, a task force was established that mirrored the zonal structure but included institutions which were not in the zonal structure though were available at this level, including health extension workers (HEW) at kebele level; these became the secretariat of the task force at kebele level (Amhara Regional State, 2022).

All stakeholders in the prevention and control of the Covid-19 pandemic at all levels had the responsibility to ensure the full implementation of the Covid-19 prevention and control directive, Directive 30/2020. As per this directive, to prevent and control the spread of the pandemic, the main responsibilities of each sector office, institution and its branches included: preparing hand-washing equipment; ensuring that all workers and customers wash their hands before entering the compounds of the sector; supervising workers' constant use of masks; implementing the principle of "no mask no service"; keeping two-metres' physical distance; forbidding more than three people at a table; and ensuring two-metre gaps between tables.

As indicated by the Amhara regional state Covid-19 pandemic prevention and control health task force implementation document, the task force's structure and plan needed to be uniform at all levels (Amhara Regional State, 2022). This is in line with the HHM of the Ministry of Health, which makes uniform or centralised planning one of its goals. Specifically, in the health sector, to prevent and control the spread of Covid-19 the health task force structure established seven sub-teams under the pandemic response or the Public Health Emergency Management (PHEM). These were the plan preparation and follow-up team; the health material supplies and distribution team; the disease surveillance and screening team; the medical and pollution prevention team; the environmental and private hygiene health communication team; the administration and finance team; and the public relations team.

As the Debre Markos City Health Office Covid-19 prevention and control implementation plan shows, the PHEM committee had the following responsibilities: strengthening institutional cooperation, planning, support and follow-up, establishing isolation centres and fulfilling the required materials, following up health facilities under its supervision to make full preparation, strengthening awareness-raising, surveillance and screening, strengthening information exchange, and the patient exchange system (Debre Markos City Administration Health Office, 2020).

In Dejen Woreda, according to its Health Office 2019/20 annual report, the major works done in the woreda in relation to prevention and control of Covid-19 included the following. First, as the woreda is an entry-point into the region from Addis Ababa, temperature measurement began on 24 March 2020 and the woreda health office facilitated daily information exchange. Secondly, areas exposed to the pandemic were identified, such as project areas run by Chinese, areas and institutions visited or resided in by foreigners, and areas visited by large numbers of people, such as religious groups. Thirdly, the woreda health office followed different strategies to control and prevent Covid-19, such as establishing a task force, strengthening disease surveillance and information exchange, strengthening awareness and public mobilisation, improving temperature measurement, strengthening health services, facilitating materials used for

prevention and control, and strengthening follow-up and supervision.

Fourth, in collaboration with the Zonal Health Department, awareness-raising training was given to 110 workers working in hospitals, 156 workers in factories, 54 woreda leaders and officers, 256 Prosperity Party leaders, 247 workers in health centres and HEW, 87 Idir leaders, elders and influential fathers, and 45 church denominations. Speakers conducted awareness-raising activities in each kebele of the woreda, current issues about Covid-19 were posted on Telegram channels, 236 hand-washing facilities were installed at the gates of different institutions in the woreda, and posters and written announcements were prepared and distributed communities. Fifth, there were Red Cross volunteers and other health professionals working without payment. All the work of prevention and control was performed using materials from health centres and hospitals (Dejen Woreda Health Office, 2019/20).

However, informants from the Debre Markos and Dejen Woreda Health Offices complained about the shortage of health professionals and medical resources needed to carry out the day-to-day activities of prevention and control of Covid-19. There was an urgent need for more professionals trained to give Covid-19-related health services. This was particularly the case in Dejen Woreda where temperature measurement, screening services, sample-taking and case identification were done for all passengers arriving, mainly from Addis Ababa, estimated at about 400 cars per day. Since there was a high prevalence of Covid-19 in Addis Ababa, all passengers coming from Addis Ababa to East Gojjam passed through this process in Dejen town, particularly during the SOE.[55]

55 Interview with Dejen Woreda Health Office PHEM team leader, 17 March 2022.

Table 6: Human resources by specialisation in Debre Markos City Administration Health Office

	Type of professions	Names of the health centres and their human resources														
		Debre Markos Health Centre			Hidassee Health Centre			Waseta Health Centre			City Adm. Health Office			Total		
No.		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1	HEW	0	15	15	0	14	14	0	10	10	0	0	0	0	39	39
2	Health officer	5	4	9	3	5	8	3	3	6	9	3	12	20	15	35
3	Laboratory	2	3	5	3	1	4	3	1	4	1	0	1	9	5	14
4	Midwife	0	4	4	0	4	4	1	3	4	0	0	0	1	11	12
5	Nurse	5	13	18	3	14	17	7	9	16	0	1	1	15	37	52
6	Pharmacy	1	5	6	2	2	4	4	1	5	0	1	1	7	9	16
7	Environmental	1	0	1	0	1	1	1	0	1	2	1	3	4	2	6
8	Health information	0	1	1	1	0	1	0	1	1	0	1	1	1	3	4
9	Emergency service	0	0	0	0	0	0	0	1	0	1	0	1	1	1	1
10	Nutrition	0	0	0	0	0	0	0	0	0	1	1	2	1	1	2
11	Others with 2nd degree	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1
	Subtotal	14	45	59	12	41	53	19	29	47	15	8	23	60	123	182
12	Support staff and other	13	11	24	5	18	23	10	15	25	8	3	11	36	47	83
13	On education	0	0	0	1	1	2	0	0	0	0	2	2	1	3	4
Total	27	56	83	18	60	78	29	44	72	23	13	36	97	173	269	

Source: Debre Markos City Administration Health Office (2020/21

Table 7: Human resources by specialisation in Dejen Woreda Health Office

No.	Type of profession	In health centres	In Health Office	Total
1.	MPH	0	0	0
2.	Filed Epidemiology	0	2	2
3.	Health Officer	13	8	21
4.	BSC Nurse	20	1	21
5.	Laboratory Degree	0	0	0
6.	Laboratory Diploma	8	0	8
7.	Pharmacy Diploma	17	1	18
8.	Clinical Nurse	30	2	32
9.	Midwife Diploma	11	0	11
10.	Midwife (BSC)	4	0	4
11.	Health Information Technician	5	1	6
12.	HEW	46	3	49

13.	Environmental Health Supervisor	3	1	4
14.	Other Professionals	0	5	5
15.	Other Supportive Staff	79	4	83
	Total	0	0	0

Source: Dejen Woreda Health Office (2020/21)

To assist with the shortage of health professionals performing Covid-19-related health services, the regional government employed 11 health professionals, using its own budget.[56] This was part of the support given by the regional government to Dejen Woreda.

Given the huge amount of resources and materials required to prevent and control Covid-19, the shortage of resources and materials was raised as a major challenge for health offices of the study area in particular and the government in general. To resolve the problem of marshalling resources, fund-raising or income-generating committees were established under the task force by health offices in both Dejen Woreda and Debre Markos City Administration. In Dejen Woreda, the income-generating committee planned to collect 481,842 Birr (about USD 9,636.84) using different strategies. Of this, 365,826 Birr (about USD 7,316.52) was collected. Those who promised and contributed included the Prosperity Party 40,000 Birr (about USD 800); the Amhara Rehabilitation Organisation, 99,000 Birr (about USD 1,980): an individual, 20,000 Birr (about USD 400); and the remaining monies were collected from Idris and other organisations (Dejen Woreda Health Office, 2019/20). Contributions in kind included sixty-three Kuntal or 6300kg wheat flour and two tents; the remaining such contributions were estimated at 365,852 Birr (about USD 7,317). In spite of these contributions, shortages of alcohol, masks, thermometers, and – generally – funds were reported (Dejen Woreda Health Office, 2019/20).

The Debre Markos City Administration Health Office 2019/21 annual execution report shows contributions of people of the area to the Covid-19 effort, both in kind and in cash. First, in collaboration with partners such as community, youth

56 Ibid.

associations, private colleges, Debre Markos University, Debre Markos Referral Hospital, private health institutions and other partners, activities such as awareness-raising, wealth collection and distribution were performed by establishing committees. Secondly, the collected contributions included money in cash, sanitary materials, cisterns, food, and so on. The money was used to buy medical equipment for preventing and controlling Covid-19.

Thirdly, the report shows that awareness-raising activities were done making use of electronic media, print, institutions, and influential or well-known persons. In addition, the report indicates that the Debre Markos City Administration Health Office performed continuous surveillance and surveys by identifying potentially risky areas such as transportation stations, religious institutions, health facilities, and service-providing institutions. It also performed awareness-raising, identifying persons who had contacts suspected of Covid-19, and taking suspected persons to Debre Markos University Quarantine and Isolation Centre for samples and examination. Moreover, the Health Office trained 268 health professionals, 19 HEW, 71 volunteers, and six police teams. In the first round of house-to-house surveillance, 23,684 houses were surveyed, 64,611 individuals received health education, and six persons with influenza-like symptoms were found and given medication. In the second round of house-to-house surveillance, 9,970 houses were assessed, 19,133 individuals received health education, and four of them had influenza-like symptoms and were given medication (Debre Markos City Administration Health Office, 2019/20).

The Debre Markos City Administration Health Office also gave training to two laboratory professionals from two health centres on taking samples for Covid-19. In all, three health centres were established under the Health Office contact tracers and follow-up committee. Within these health centres, examination rooms were prepared for respiratory organ disease. Under the Debre Markos City Administration Health Office, 52 individuals had contacts and been quarantined by June 2020. They were mostly from the transportation station, taxi station and prison. During this period, the number of samples taken were 294. Out of the quarantined 52 individuals, Covid-19 was found in two individuals (Debre

Markos City Administration Health Office, 2019/20). During the prevention-and-control activities, particularly screening and case identification, private health institutions worked in close collaboration with the public health facilities of Dejen Woreda and Debre Markos City Administration, but the primary responsibility for Covid-19-related health services, especially treatment and vaccine, lay with public health institutions.

7. Challenges posed by Covid-19 and their implications

The measures taken to prevent and control Covid-19, such as the regional shutdown policy and the declaration of a SOE, had the effect of reducing regular health services and patients' activities. In Dejen Woreda and Debre Markos City Administration, this put a burden on regular health service patients, particularly on those who required follow-up in health centres, including mothers, HIV patients or ART users, and TB patients, as was discussed in section 5. Participants in the focus group discussions, as well as informants in Dejen Woreda and Debre Markos City Health Office, confirmed that many patients interrupted their follow-ups and medication due to fears of Covid-19 infection, ignorance, and the traditional attitudes that undermine the benefits of follow-up.[57] However, interruption of prenatal care, home delivery and the failure to receive postnatal health-care services stood to cause health problems for mothers and infants. Interruption of medication could also make an illness more severe. In particular, interruption of TB medication can cause the disease to be transmitted to other persons. To reduce these kinds of problems during public health emergencies, and avoid the shutdown of health centres, continuous awareness-raising activities are necessary, both for the community and the users of health centres.

The other challenges Covid-19 posed to the health sector at local level were a shortage of medical equipment required for the prevention and control of Covid-19, trained health professionals, medicine and funds. Though prevention and control mechanisms for Covid-19 required many and varied kinds of medical equipment and resources, such as masks, gloves, sanitisers,

57 Focus group discussion, Debre Markos Health Centre, 15 March 2022; focus group discussion, Dejen Health Centre, 17 March 2022; interview with Ato Habite, Dejen Woreda Health Office PHEM team leader, 17 March 2022.

thermometers, cisterns, preparation of quarantine centres, provision of related services and the like, additional budgets were not allocated to health centres in Dejen Woreda and Debre Markos City Administration.[58] This would not have happened if there had been a contingency budget allocation in each fiscal year for the prevention and control of unforeseen public health emergencies.

Another challenge was the shortage of health professionals who took short-term training in providing Covid-19-related health services, particularly in Dejen Woreda. To reduce this problem, Amhara Regional State hired health professionals with specialist training to provide Covid-related health services for Dejen Woreda. This required a relatively higher number of health professionals, since the location is one of the entry and departure points into and out of the region.[59] This kind of support from the regional government would be a necessary measure in times of public health emergencies.

However, after the emergency situation was under control, these professionals were allocated to different health centres around Dejen Woreda.[60] This created a conflict of interest between health professionals hired by the local government and by the region.[61] For instance, health professionals hired by the regional government made the demand that, "as far as we are engaged in giving regular health services, we also need to engage in and benefit from overtime work as well".[62] However, the regular health professionals hired by the local government did not want them to engage in overtime work. As a result, health professionals hired by the regional government refused to engage in regular health services even though their contracts had not been interrupted. The health office of Dejen Woreda complained that regionally hired professionals had been paid by the government without carrying out any responsibilities. The local government had not hired them, so it had no power to supervise or fire them. For the

58 Interview with Ato Melkamu, head of the Debre Markos City Administration Health Office, 14 March 2022; interview with Ato Habite, Dejen Woreda Health Office PHEM team leader, 17 March 2022.

59 Interviews with Ato Fetene and Ato Habite, Dejen Woreda Health Centre head and PHEM team leader, respectively, 17 March 2022.

60 Ibid.

61 Ibid.

62 Ibid.

regular health professionals of the woreda, this was seen as unfair and affected their morale.

This was the situation until the end of data collection in Dejen Woreda in March 2022. Intergovernmental support in times of emergency needs to be acknowledged. However, when an emergency situation is under control, local government autonomy needs to be restored. In this case the budget for regionally hired health professionals, as well as their accountability, either needs to be transferred to the woreda, or the regional government should create other job opportunities at regional level.

The other challenge following the outbreak of Covid-19 was shortage of medicines and funds, both in Dejen Woreda and the Debre Markos City Administration.[63] The shortage of medicine was mainly due to a lack of medicine in the market and limited stocks in the store. The shortage of budget occurred due to low collection of internal revenue and lack of reimbursement of health centres' expenses for services given to the poor and for exempted services by the woreda and city governments. As can be seen from Table 7 below, Dejen Health Centre collected only 39 per cent of its internal revenue in the fourth quarter of 2019/20.

Table 8: Fourth-quarter internal revenue from each health centre of Dejen Woreda

No.	Name of health centre	Annual plan	Quarterly plan	Execution for the quarter	Execution for the quarter (%)
1.	Atinora	531,300	132,825	13,0017.75	97
2.	Kurari	456,742	114,185	95,495.96	83
3.	H/Selassie	849,375	212,334	335,222.00	157
4.	T/Mariam	582,730	145,683	189,471. 15	130
5.	Dejen	821,225	205,306	10	39
	Total	3,241,372	810,334	831,375	102

Source: Dejen Woreda Health Office (2019/20)

The main source of revenue for health centres was fee-paying customers who used their services through the refunded form

63 Interview with Ato Melkamu, head of the Debre Markos City Administration Health Office, 14 March 2022; interview with Ato Fetene, head of the Dejen Woreda Health Centre, 17 March 2022.

health insurance system for families included in the health insurance system. However, the number of fee-paying customers declined due to Covid-19, the inefficient services they received from health centres due to the unavailability of full laboratory services, and lack of medicines in health centre pharmacies.[64] The absence of commensurate reimbursement expenses for health insurance users for purchase of medicine bought from private clinics, due to unavailability of medicines in the public pharmacy, was a related factor contributing to the decline of customers at health centres.[65] Budgetary shortages are aggravated when health centres are not reimbursed for services given to the poor and for exempted services. According to informants from health centres, these expenses must often be covered by the internal revenue of the same centres.[66]

Table 9: Dejen Woreda Health Office: Free health service users and total expenditure (2020/21)

No.	Name of health centre	Poorest of poor free health service			Exempted service			Staff		
		Number of service users	Total expenditure		Number of service users	Total expenditure		Number of service users	Total expenditure	
			Birr	Cent.		Birr	Cent.		Birr	Cent.
1.	Atinora	298	278,090	40	1020	123,991	55	225	13,049	85
2.	H/Selasie	384	339,998	33	848	60,608	04	131	12,469	19
3.	Kurari	572	555,788	80	2749	259,931	85	376	30,524	55
4.	T/Mariam	204	393,211	29	804	89,496	25	73	5,788	00
5.	Dejen	282			2270	259,891	25	645	53,707	49
	Total	0	0	0	7,691	793,918	94	1450	115,479	08

Source: Dejen Woreda Health Office (2020/21)

64 Ibid.

65 Ibid.

66 In health centres, certain patients are exempt from paying fees, such as those requiring vaccines and reproductive health services.

Table 10: Debre Markos City Administration Health Office: Free health service users and total expenditure (2019/20)

No.	Name of health centre	Community-based health insurance users			Exempted service			Staff	
		Expenditure	Returned	%	No. of customer	Expenditure	Returned	No. of customers	Expenditure
1	Debre Markos	115540		0%	1094	72725	No.	346	22029
2	Hidassie	108278		0%	1088	72082	No.	544	28992
3	Weseta	118486	52894	45%	327	167609	No.	349	23143
	Total	342304	52894	15%	2509	312416	No	1239	74164

Source: Debre Markos City Health Office (2019/20)

Exclusion of public servants, who are potential customers of health centres, from the health insurance system, is also given as a contributing factor for the limited revenue of health centres. Informants concurred that the exclusion of public servants from the health insurance system, besides limiting the potential revenue of health centres, disadvantages public servants in obtaining health services. Why public servants are excluded from the health insurance system and how they could benefit from it is a policy area that needs further research.

8. Conclusion

The effects of Covid-19 on the provision of decentralised health services in federal and devolved systems is an area worth researching. Looking at two local governments in the Amhara state of Ethiopia, this study assessed the effect of Covid-19 on the provision of health services and measures taken by local government to prevent and control the spread of the pandemic; it also examined the implications of the challenges posed by Covid-19 for future planning and budgeting to manage public health emergencies.

The two local governments in this study have similar population sizes, but vary in terms of population density and livelihood. One, Dejen Woreda, is a relatively sparsely populated and rural local

government, while the other, Debre Markos, is a quite densely populated urban area as well as the zonal capital. This is why in Debre Markos city more people were affected by Covid-19 than in Dejen Woreda and the death rate was higher. In both areas, the effect of Covid-19 on health service provision and measures taken to prevent and control the pandemic was broadly similar. However, there was intergovernmental support for Dejen Woreda Health Office due to its location as the point of entry of large numbers of passengers coming into the region from Addis Ababa. These passed through temperature measurement, case identification and sample-taking.

The challenges posed by Covid-19 in the health sectors at local level afford certain lessons. First, customers of health centres who required medical follow-ups did not all return to their health centres after the lockdown policy and SOE had been lifted and health centres started to give Covid-19 vaccines. This indicates that health centres need to pursue continuous awareness-raising for patients and their families to reduce interruption of medical follow-up. Secondly, health centres have only limited revenue to draw on during new health emergencies. This is because of the absence, first, of obligatory mechanisms to make local government refund expenses of health centres used to provide free health service for the poor and exempted service users and, secondly, of a mechanism to make all sections of society, particularly public servants, beneficiaries of the health insurance system.

To deal with this problem, and enhance the internal revenue of health centres, mechanisms need to be set up to oblige local government to refund health centre expenses when providing free health services. Also, the health insurance system needs to cover all sections of society, in particular public servants who are not yet included in the health insurance system. Thirdly, to reduce financial constraints in case of new health emergencies, contingency budgets for prevention and control of unforeseen pandemics need to be one of the areas of planning at local level. This needs to be taken into account by the woreda and city administration in the allocation of budgets for the health sector.[67] Lastly, intergovernmental support is necessary in times of

67 Interviews with health professionals in Weseta Health Centre and officials of the health offices in Dejen Woreda and Debre Markos City Administration, March 2022.

emergency or pandemic. However, this support needs to respect the administrative autonomy of local government, especially once the public health emergency is under control.

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