Private Health Sector Project Program Transition Plan

September 2019

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Acronyms

ART	Antiretroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
DQA	Data Quality Assessment
EQA	External Quality Assurance
FMOH	Federal Ministry of Health
FMHACA	Food, Medicine and Health Care Administration and Control Authority
FP	Family Planning
GOE	Government of Ethiopia
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
IPLS	Integrated Pharmaceutical Logistics System
MAPPP-E	Medical Association of Physicians in Private Practice
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
PFSA	Pharmaceuticals Fund and Supply Agency
PHFAs	Private Health Facilities Associations
PHSP	Private Health Sector Project
PICT	Provider Initiated Counseling and Testing (of HIV)
PPM-DOT	Public Private Mix - Directly Observed Treatment
PMTCT	Prevention of Mother to Child Transmission
PPP-H	Public Private Partnership on Health
RHB	Regional Health Bureau

RMNCH	Reproductive, Mother and Neonatal Child Health
SNNP	Southern Nations, Nationalities and Peoples
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
THO	Town Health Offices
TWG	Technical Working Group
TA	Technical Assistance
TB	Tuberculosis
USAID	United States Agency for International Development

1. Introduction

1.1. Project Overview

The Private Health Sector Project (PHSP) is a five-year United States Agency for International Development (USAID) activity implemented by Abt Associates Inc. The goal of PHSP is to elevate the active engagement of the private health sector to contribute towards the mitigation of the impact of diseases of public health importance in Ethiopia. The project has the following specific objectives:

- Enabling environment for private sector engagement in public health improved
- Access to quality services for diseases of public health importance increased through the private health sector
- Private health care system strengthened
- Program learning and innovative ventures enhanced for the private health sector for a continuous decision-making, innovation and use of data

To achieve these objectives PHSP works in collaboration with the government, specifically the Federal Ministry of Health (FMOH), its agencies, Regional Health Bureaus (RHBs) and the private health sector and its associations. The project operates in Addis Ababa, Amhara, Afar, Benishangul Gumuz, Dire Dawa, Harari, Gambela, Oromia, SNNPR, and Tigray regions. The project is working to enable the Regional Health Bureaus (RHBs), Zonal Health Departments and Town Health Offices (THOs) to effectively partner with private health providers to deliver public health importance services while improving the quality and affordability of care service for Ethiopians. The public health programs of importance include PPM-DOTS, Comprehensive HIV/AIDS including HCT, ART, and PMTCT; MNCH, Family Planning, STI and Malaria. Moreover, the project has been engaged in the establishment of a supportive policy environment for the private health sector and strengthening public-private referral system and feedback mechanisms.

This is the final year for the project and the majority of the activities focus on transitioning the project activities to RHBs and Town Health Offices (THO). PHSP activities are designed with sustainability built-in so that over time the project transitions functions to RHB and its structure to ensure sustained services beyond the project life.

RHBs are entitled to ensure accessibility, quality, and equity of public health service delivery within their respective catchment areas that includes zones and districts /towns/Woredas. Through collaboration with RHBs, the project has contributed to increased accessibility of health services in the private health facilities. The RHBs, with PHSP support, implemented and/or carried out the following project activities per the following arrangements:

The following flow chart summarizes the steps PHSP and RHB took during the engagement of the private health sector to the technical support by PHSP.

The RHBs, with PHSP support, implemented and/or carried out the following project activities per the arrangement described below. These collaborative activity build the ownership of the program by RHBs from the beginning which will help to expedite the transition and exit of the activities at the end of the project.

- RHBs and Abt Associates Inc. signed an MOU that provides the project with legal and operational mandates
- RHBs collaborated with PHSP to conduct site assessments and select private health facilities to be targeted by the project
- Signed MOU between RHB, Zonal or Town Health Office and targeted private health facilities
- RHBs coordinated provision of trainings (refresher and basic) to health professionals identified from targeted private health facilities by using national guidelines and manuals, and TOT certified resource persons
- Conducted regular supportive supervision to ensure quality of care
- RHBs organized and involved private health facilities in review meetings
- Provide recording and reporting materials to targeted private health facilities to capture client and service data for regular submission of performance reports to Woreda Health offices per the HMIS standards
- Linked the targeted private health facilities with EPSA or designated institution to get pharmaceutical supplies for public health importance services

1.2 Key Project Achievements from Year I to IV

The project expanded its geographic scope to ten regions in Year II. This included an increase in the number of targeted facilities from 330 in Year I to 490 in Year II and at the end of year IV it decreased to 356 after transferring some low yielding facilities to THO and close out of other facilities for various reasons. In the past four years, PHSP has engaged in total 699 (9.6%) of all the private health facilities in delivering PPM based programs in TB, HIV, MNCH, FP, and Malaria services. The project's program portfolio expanded to enable targeted private facilities to offer MNCH & FP besides TB, HIV/AIDS, HCT, ART, PMTCT, STI, and Malaria[1].

[1] In year X, PHSP *has handed over the PEPFAR funded comprehensive HIV/AIDS (including HTS, ART, and PMTCT) to the RHBs. It also has transferred 327 primary clinics participating in presumptive TB patient identification and referral, and 70 low yield facilities engaged in TB diagnosis and treatment were handed over to their respective THOs.*

Table 1: Current Distribution of PHSP's Targeted Private Health Facilities by Regions, August 2019.

All Sites / Services							
Region	**TB**	**TBTx**	**TB_Referal**	**RMNCH**	**FP**	**Malaria**	**TOTAL Sites/ Region**
Addis Ababa	25	19	6	27	19	0	**51**
Afar	11	11	0	0	0	19	**22**
Amhara	51	51	0	9	24	28	**68**
Benishangul gumuz	8	7	1	0	0	15	**15**
Dire Dawa	15	13	2	3	6	14	**16**
Gambella	9	9	0	0	0	15	**15**
Harari	5	4	1	2	3	0	**6**
Oromia	71	64	7	11	30	35	**82**
SNNP	24	21	3	2	14	18	**38**
Tigray	20	19	1	6	19	25	**43**
TOTAL	**239**	**218**	**21**	**60**	**115**	**169**	**356**

Over the past four years the project has achieved important results:

- Between October 2015 - June 2019 a total of 61,882 TB patients were diagnosed and 76,000 TB patients reported by private health facilities
- The MOH, with technical and financial contributions from the project, has an updated, revised PPM DOTS implementation guideline, 3rd edition and a national PPM TB scale-up plan prepared and implemented
- A total of 1.28 million (64% of the 5 year plan) malaria-suspected cases were properly screened, and 225,974 confirmed malaria cases received treatment as per the national recommendations and those cases were reported to the respective Woreda or THO using the national reporting tools.
- PHSP successfully piloted the implementation of temporary clinics in hard-to-reach areas during malaria transmission season where significant numbers of migrant workers are deployed to work on large private farms in Benshangul Gumuz, Amhara, Gambella and Tigray regions
- PHSP supported facilities have provided modern FP services to 128,881 women, approximately14% who received long acting methods

- 60 facilities have been supported to deliver MNCH, 8 of which were enrolled in Q3 of year four. In total, 51 health facilities have provided ANC to 84,894 and skilled delivery to 49,948 mothers

The detail achievement in the last four years is shown in Table 2 below.

Table 2: Summary of Major Project Indicators, October2015 - June 2019

S.N	Indicator	Target of 5 years	Achieved	%
1	Total TB Case Detected	76,000	61,882	81%
2	TB cases retained	20,000	8,506	43%
3	TB Patients with documented HIV Status	19,000	7,111	84%
4	TB/HIV_Coinfected	15%	1,146	16%
5	ART for TB/HIV co-infected patients	90%	958	84%
6	RR/MDR Detected & linked		25	
7	Malaria Cases Diagnosed and Treated	540,000	225,601	42%
8	FP User	202,000	128,881	64%
9	Long Acting FP Use	30%	14%	0%
10	ANC1 Attendee	83,670	84,894	101%
11	ANC4 Attendee	20,869	34,657	166%
12	Skilled Delivery	55,361	49,948	90%
13	Early PNC Care	32,701	40,433	124%
14	Penta3	23,448	23,793	101%
15	Measels	23,822	22,537	95%
16	Fully Immunized	25,008	21,707	87%

1.3 Achievements on cross cutting areas

- **Policy**: to create private sector engagement and practice

  - ✓ Established and built the capacity of seven regional PHFAs and the national PHFA.
  - ✓ Supported private health sector to access finance through the local banking system. Utilizing the USAID Development Credit Authority (DCA) loan guarantee mechanism, the project facilitated private health facility owners to obtain loans through selected banks. This established a platform and precedence for the private health sector to access finance like any other development sector.
  - ✓ Establishment of PPP TWG at FMOH and PPM-TB focal person and TWG at the NTP in FMOH
  - ✓ Strengthened the regulatory environment through capacity building

- **Laboratory:** work in assuring private labs have internal quality control and external quality assurance and work towards accreditation to support the PHSP supported private facilities in providing the best quality lab services in TB, HIV, and malaria.

    ✓ Private facilities are included in the functional regional external quality assurance (EQA) system

    ✓ All PHSP supported private health facilities are networked to the sample referral system in their towns and regions

    ✓ The project has procured two gene expert machines and provided to high yielding PPM-DOTS sites (GAMBY and Teklehaymanot hospitals)

- **Pharmacy**: to ensure a functional supply chain system, monitor and reconcile facility drug use for PHSP supported services.

    - Revision of the national Integrated Pharmaceutical Logistics System (IPLS) standard operating procedures (SOP) and the associated training work book to be inclusive of private health facilities. Both documents are uploaded on the e-IPLS implementation website of central EPSA
    - Prepared and distributed the commercial access directory for FP commodities for FP sites for FP commodity procurement. This document targets those FP sites which are not linked to government supply agencies.
    - All PPM sites under the project are formally linked with their respective government supplier for their drugs and pharmaceuticals supply need through FMOH and EPSA.

- **Monitoring and Evaluation:** One of the greatest achievements of PHSP is its support to the private sector to utilize FMOH's registration and reporting formats which enable the RHBs and FMOH to disaggregate and measure contribution of private health facilities particularly in TB and HIV/AIDS. Currently, private facilities are being supported to document and report their performances using DHIS2.

2. Project Transition Plan

In 2017, PHSP prepared a program transition and sustainability plan which described the project's road map to transition and sustainability strategy to be implemented in a phased approach starting year four of the project. The plan intended to strengthen the technical, organizational and financial capacity of the representatives of the private sector and government health bureau as well. However, with the drastic reduction of funding from PEPFAR starting year III and subsequent complete termination of PEPFAR program in year IV, PHSP was compelled to halt sub granting private health sector associations; expedite the transition of TA in regulation, financing, PPP and implementation of clinical support in HIV/AIDS to private health facilities to the appropriate government offices. This drastic cut of budget has hampered the implementation of the plan and PHSP has implemented the technical aspect of the capacity building and transited the HIV/AIDS program support to the regional health bureau.

2.1 Lessons Learned During Transitioning of PEPFAR Program

In December 2019, PHSP transitioned PEPFAR funded project interventions to the government and private sector which include PPP, DCA, sub granting of PHFA, and clinical support to 235 HTS, 70 ART and 43 PMTCT services provided by private health facilities in seven regions.

PHSP did an above-site (MOH, EPHI, EPSA, RHBs, Regional labs) and site level (health facilities) assessment to identify critical gaps in capacity and resources which need to be filled in before transition and to assess the degree of commitment to sustain the HIV/AIDS program in private health facilities in the absence of support from intermediate agents like PHSP.

All governmental health offices, the health facility owners and providers have the commitment to keep delivering clinical services in HIV/AIDS in private health sector. A concern from the government was that they may not have the needed resources and capacity to fulfil the expected level of support needed by the private health facilities. Despite the challenges, the government made it clear that they will integrate private health sector into their annual implementation and monitoring plans. The private sector was similarly cognizant of the weaknesses of the health system and acknowledged they may not get the technical support they used to get from PHSP, hence have promised to commit additional resources to sustain the delivery of HI/AIDS services in their facilities (like printing the registers, tracking referred patients).

Because most of the facilities engaged in HTS, ART and PMTCT transitioned to the RHB/THO, are still supported by PHSP for PPM-TB, MNCH/FP, we have the opportunity to monitor how the HIV program is running after the transition. Even though the program is still running in all the regions, many of the facilities have interrupted HTS because of shortage of HIV RTK and have difficulty of accessing HIV viral load testing through sample transportation by the postal system (courier).

Though PHSP has invested in building capacity of PHFA in delivering training, providing mentoring and supportive supervision and performance monitoring, the RHBs are not ready to utilize this capacity to sustain the HIV/AID services in private health facilities. Both MOH and RHBs are not committed to allocate funds to PHFA to enable them to be intermediate agents between the government and private health facilities and facilitate dialogue and public health program implementations.

The PPP activity was transited to the FMOH who is continuing the PPP task with financial and technical support from the World Bank and Clinton Foundation. PHSP is continuing its participation in the national TWG for PPP.

The DCA activity was terminated at the end of year III earlier than other PEPFAR activities. PHSP transferred all the facilitation of access for loan and post-loan monitoring to DCA accredited banks. Though capacity building activity was given to the national PHF association to enable the association to provide support to its members in developing business proposal for bank loan, facilitation of loan and post-loan monitoring, the association is not able to initiate and provide the support because of financial shortages.

The technical assistance to Ethiopian Food Medicine and Health Services Administration Authority (EFMHCA) on the regulation of health facilities (standard development and revision, training of supervisors, and supervision of facilities) was transferred directly to the Authority itself. Due to restructuring of the

health system in the country, the responsibility of regulating of health facilities, health services and health professionals has recently been transferred from EFMHCA to MOH.

The overall transition and handover process was smooth but was cumbersome and resource intensive. All the RHB and THO have appreciated the approach followed by PHSP as it has engaged them throughout all the transitioning steps up to physically handing over the facilities. The RHBs and THO have requested PHSP staff to continue supervising the HIV/AIDS program whenever they visit the health facilities to give support for other programs like TB, MNCH and Malaria. PHSP assured the RHBs that it will not completely detach itself from the program because all ART/PMTCT sites do also have PPM-TB or MNCH and FP or Malaria which give opportunity to regularly visit the health facilities and provide support also to the services in HIV/AIDS.

PHSP has been doing post-transition monitoring and providing support to the comprehensive HIV services being conducted in health facilities. However, most of the health facilities are not getting HIV RTK and had difficulty of transporting samples for viral load. In most of the instances, these are unresolved challenges despite reporting by the facilities to the THO.

2.2: Lessons Learned from Transitioning of PPM-TB

Following the closure the project's office in Dire Dawa in December 2018, PHSP transitioned the technical support in PPM-TB services in 16 private facilities to the Health Bureau of Dire Dawa City Administration. The health bureau committed itself to integrate the support into their plan and provide all required technical support while the private facilities agreed to continue delivering the services per the stipulations in the MoU. PHSP monitored the post transition performance of the facilities for the past nine months. These facilities had diagnosed and reported 701 patients with tuberculosis from Oct 2017 to Sept 2018 and diagnosed and reported 760 patients with TB from Oct 2018 to Sept 2019 which is 8.4% higher than the previous year when PHSP was providing full support. In the past year the facilities had participated in two rounds of EQA, quarterly supervision and training in TB. When both the TB unit at RHB and regional labs are committed and the private health facilities do not face high turnover of trained providers, the sustainability of PPM-TB program in private health facilities is very high and has proven to be successful.

PHSP has also transitioned off of the RHBs/THO 327 primary clinics who were engaged in the identification and referral of patients with presumptive tuberculosis. PHSP has demonstrated that the primary clinics have significant contribution to identify missed TB cases because up to 20% of the patients referred from these facilities were found to have TB. Though it was the expectation of PHSP that the RHBs will scale up to engage more primary clinics and continue supporting the facilities transferred from PHSP, because of the shortage of finance and manpower all regions are not providing support to primary clinics. Amhara region is providing engagement of primary clinics with the technical assistance from TB REACH.

3. Transition Goals, Objectives and Approaches

The goal of PHSP's transition plan is to ensure/assure the continuation of high impact programs that had been supported by the project in part or all when the project ends.

The objectives of the transition plan are:

- To describe PHSP's overall transition strategy
- To describe the list of activities to be transited to local partners (RHB) and private health facilities
- To outline strategies to sustain the engagement of the private health sector

For the purposes of PHSP, **transition** is defined as the process of providing technical assistance and resource support ***to transfer project tasks to FMOH and its structure within the project period***. This will enable to define critical gaps to fill in during the transition and strengthen the capacity of the public and private health facility health sector to maintain the PPM mechanism in the absence of intermediate agents like PHSP.

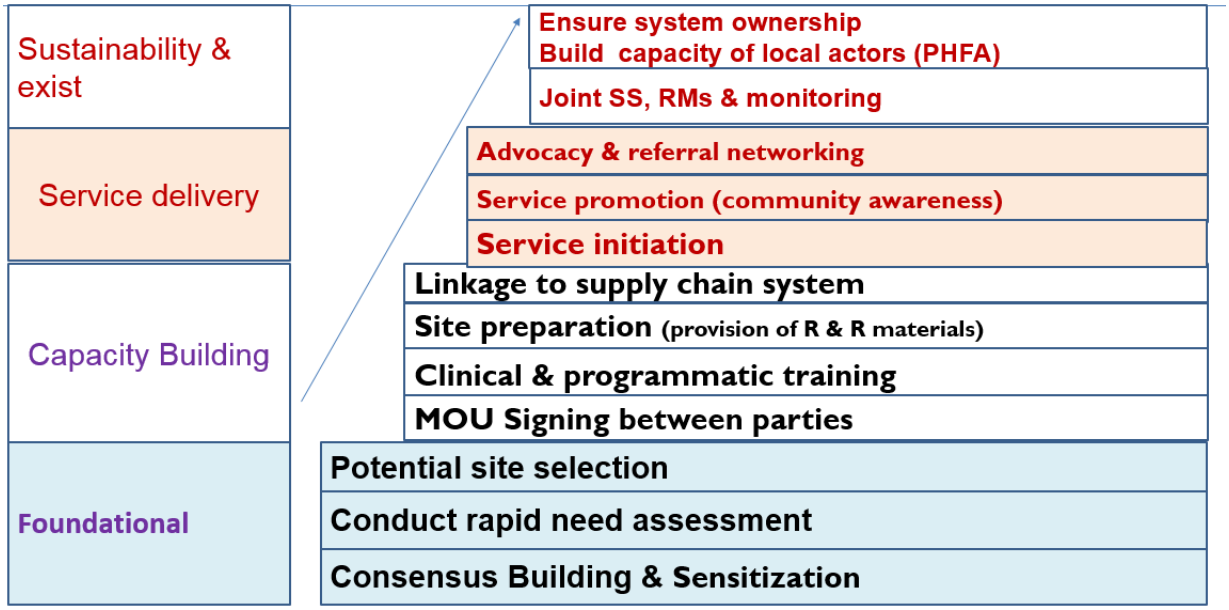
PHSP's transition approach is using a health systems strengthening approach to ensure enhanced capacities and alliances of public health sector stakeholders and private sector health players, so that the private health sector can actively and collaboratively deliver priority health care services. This approach combines strengthening individual and institutional capacities, systems, governance and operations to enhance the role of the private health sector in clinical health services. Much of the transition focuses on strengthening the trust between the government and private health sector, and transferring the technical capacities to both the government and the private health facilities which enables them play their active roles in the delivery of affordable and quality health services in TB, malaria, and MNCH/FP through private sector engagement.

4. Major Transition Activities

The Public-Private-Mix (PPM) mechanism for engaging private sector to deliver priority public health services requires that there should be an enabling policy and legal environment allowing the MOH and its agencies and the RHBs to engage private health facilities by allocating resources (like drugs, supplies, IEC BCC materials, giving trainings and supervision etc.) in order to increase access and assure quality of clinical services in TB, Malaria, MNCH/FP in private health facilities. To this effect FMOH has published a national framework for public private partnership in health (PPP-H) which indicates commitment of the government to strengthen the health system by engaging private health sector by augmenting in-country manufacturing of pharmaceuticals, availability of advanced tertiary clinical services, production of Human Resource for Health (HRH) and delivery of priority public health diseases like TB, HIV, Malaria and MNCH. Currently, there is a national guideline endorsed by NTP to facilitate the engagement of private health facilities in delivery of tuberculosis prevention and care; similarly national guidelines to facilitate engagement of private health facilities in delivery of malaria prevention and control and MNCH/FP are prepared and waiting for endorsement by the State Minister of the MOH.

PHSP has a PPM implementation mechanism which has been applied for the past decade in implementing engagement of private health facilities in delivery of clinical services in PPM-TB, HIV/AIDS, malaria, MNCH and FP. These implementation steps are depicted in Figure1 and described below.

Figure1: PHSP PPM Implementation Strategy



4.1 Foundational interventions include

- **Consensus building and sensitization about the program**: this involves dialogue with national and regional programs usually when seeking creating an enabling environment to initiate and/or scale up a program. Sensitization and advocacy workshops with stakeholders from public, private and partners should be done to get buy in from all stakeholders.
  Currently, there are MoH endorsed national guidelines for PPM implementation of TB and MNCH/FP making the initiation, scaling up, transitioning PPM programs relatively easier. The national malaria program has not up to now endorsed the guideline for engaging the private health facilities which demands an enhanced advocacy and policy dialogue during the transition phase. However, the regional health bureau do recognize that engaging private providers in malaria case management is essential which has been the basis for PHSP to implement malaria program in the past several years.
- **Rapid assessment of the potential in the private sector:** this will help to establish the magnitude, distribution and potential of the private health facilities and providers in a geographic location.
- **Health facility selection:** A health facility assessment tool specific to the type of the program type is developed to assesses the scope of clinical services in the facility, the size and mix of

health professionals practicing in the facility, the patient load, and most importantly the willingness and commitment of the owner and providers of the facility to participate in the delivery of a program using PPM mechanism. PHSP will hand over the health facility assessment tools to the RHB and THO so that they can utilize it to enroll new facilities.

4.2 Capacity Building

- **Signing of MOU between the health facility and the RHB/THO:** When a health facility is found eligible for PPM engagement, it shall enter into an agreement by signing an MOU with the RHB or THO. The MoU outlines the purpose of the partnership and responsibilities of the RHB/THO and the private health facility.
- **Training of providers (clinical and programmatic aspects of the services):** One of the objectives of PPM is to standardize quality of clinical services and ensure that clients receive diagnosis and treatment of public health diseases according to the national guidelines, providers in private health facilities should receive in-service trainings in TB, Malaria, FP and MNCH and updated whenever guidelines are revised. More importantly, private health facilities need to assign a trained professional to serve as a focal person for the programs for all exchanges of information including submission of performance reports to the RHB/THO.
- **Linking the health facility with EPSA hub or public facility to access drugs and supplies:** Drugs used to treat tuberculosis, malaria, vaccines, FP commodities and some drugs for MNCH are not available in the private market in Ethiopia, which requires linking private health facilities to a source site (EPSA or nearby public health facilities) to access these drugs. The private facilities shall be oriented on the national IPLS mechanisms and shall request and receive drugs and supplies from source site using EPSA endorsed requesting and reports forms (RRF). This is one of the linchpins for sustaining PPM which should be strengthened during the transition period.
- **Networking with regional lab or public facility and the courier for DST, viral load:** The private facilities do not have the capacity for advanced tests (GeneXpert and DST) to diagnose tuberculosis and drug resistance TB. Networking of the private health facilities to the laboratories with GeneXpert or DST should be done so that clients of private health facilities can access advanced test to diagnose TB. This also requires networking with the courier for transportation of sample and reports between the private and public labs.
  Additionally ensuring the quality of laboratory diagnosis of tuberculosis and malaria in private health facilities need to be checked regularly through participation of reginal EQA (External Quality Assurance) schemes. Labs need to be linked to the EQA centers in the public system.
- **Provision of all registers for documenting and reporting:** Private facilities engaged in PPM program have to utilize government approved registration books and reporting books so that the performance of the private facilities is measured and demonstrated in regional and national performance reports. PHSP will supply the facilities with all monitoring and evaluation tools which can serve the facilities for the next year after transition. The private facilities will receive the soft copies to reprint the registers whenever they need it so that the facilities will not demand to supply

them with M and E tools. Performance of PPM TB is disaggregated at region and national levels which helps to measure the contribution of private health sector to the case detection rate of TB in Ethiopia. Performance and contribution of private facilities in malaria, FP and MNCH is not yet disaggregated at regional and national levels.

4.3 Service Delivery

- **Intensive service initiation support through mentoring:** When an new facility starts delivering PPM program, it demands intensive monthly mentoring for at least three months until the providers are familiarized with national guidelines, able to capture and document important indicators in the registers, and able to submit performance report to the THO on their own.
- **Advocacy and referral networking:** at the initiation of a program in a town or region advocacy and referral networking workshops in order to promote the initiation of the program in private health facilities and facilitate referral of patients to and from private and public health facilities.
- **Mentoring and supportive supervision:** PHSP has supportive supervision tools designed to supervise the inputs, processes and outputs of program related activities in the facilities. It has also a mentoring tool which focuses mainly quality improvement of the clinical services which are initiated based on performance gaps. These tools for PPM-TB are harmonized to the tools which are utilized by the district offices. The tools for MNCH/FP and Malaria are specific to the project which need to be negotiated with the RHB and THO during the transition phase for integration to the public system.
- **Performance reporting to THO:** see above

4.4 Sustainability and Exit

The PPM program has an in-built mechanisms which serve to integrate the implementation of the national and regional program implementations in all the programs: TB, Malaria, and MNCH/FP

- There are national implementation guidelines to guide the engagement of private health facilities in PPM-program in the country
- Trainings for private providers are delivered using national training manuals prepared by the government and using facilitators from the government
- The registers used at private facilities are identical to the HMIS/DHIS2 tools of the government and the health facilities have been reporting their performance to the THO
- Health facilities are networked to regional and sub regional labs to access advanced diagnostic tests and participate in regional EQA schemes

Therefore during the transition phase PHSP will ensure that the RHBs/THO are:

- Disaggregating of performance of private facilities and tracking contribution
- Integrating PPM programs in TB, Malaria, MNCH and FP into the n national and regional annual plans. We are sure that PPM-TB is well integrated into the National strategic plan (NSP) and the

annual plans at MoH and region levels. The integration of malaria, MNCH/FP into the national plan and regional plans is not yet well practiced and requires more advocacy during the transition phase.

- Harmonize training, mentoring, and supportive supervision tools to the government tools
- Well acquainted with the implementation of PPM program and peculiarities of the private health sector in relation to training durations, providing mentoring and supportive supervision. PHSP will provide orientation training to program officers from RHBs and THO on ppm implementation and peculiarities of private health facilities before transitioning of the health facilities.

In order for the process of transitioning to take place smoothly and to be able to monitor post transitioning performance of the facilities, PHSP will undertake the following activities:

a. Officially inform the program units at FMOH and the RHBs that the technical assistance in PPM-TB, malaria and MNCH/FP will end this year
b. Convene regional consultative meetings on the project transitioning plan
c. Finalize region and program specific transition plans based on the inputs from regional consultative meetings
d. Provide gap filling trainings, provide M and E tools, strengthen linkage and networking with labs and postal courier, and EPSA.
e. Provide capacity building training to the program officers at the district health offices focusing
    a. PPM-implementation and peculiarities of private health facilities.
f. Prepare health facility profile and hand over to the district health offices
g. Perform post transitioning performance monitoring of facilities.
h. Conduct a national project close-out at the beginning of quarter four.

5. Transition Schedule for Programs

After completing the preparatory activities (finalizing transition plan and consultative meetings with all stakeholders in the regions) PHSP will immediately start on gap filling interventions and transitioning of the health facilities according to the following schedule. Detailed breakdown of activities with time table is attached on Annex 2.

Table 3: Schedule for Transitioning Health Facilities by Program

Program	Transition Period	Post-transition Monitoring	Remarks
MNCH	First quarter	Second quarter	Program specific transition report will be produced following the post transitioning monitoring
Malaria	**First /early second quarter**: for facilities located in towns with low or no migrant workers	Second to fourth quarter	
	Fourth quarter: temporary clinics and facilities serving migrant and mobile workers	Fourth quarter	Report shall be prepared at the end of quarter four
PPM-TB	First quarter and second quarter	Performance will monitored at second and third quarter	Transitioning report to be ready early fourth quarter.

6. Potential Threats or Risks

Successful transitioning of the programs from PHSP to the government will demand unwavering commitment of the project, government counterparts, and the private sector. It is prudent to anticipate the occurrence of potential threats which may delay or hamper the transitioning process and sustainability of the clinical services in the post transition periods. Table 1 in Annex 1 depicts the potential risks, why they are risk, and how they can be mitigated during the transition and afterwards.

7. Transition Monitoring and Measuring Progress

In order to measure and monitor PHSP's progress in facilitating transitioning activities indicators are identified to each stakeholder. Summary of identified priority activities that will lead to smooth transition are detailed on Annex I. The transition of activities between the project and RHBs will be tracked quarterly.

PHSP will coordinate with RHBs the planning, implementation, and monitoring of the transitioning supports. With the technical and operational leadership and programmatic back-stopping from the central PHSP staff, the regional managers will continue to offer professional support to the RHBs for 6-9 months.

The Project will monitor the transition of responsibilities using the following indicators:

- Regional consultative meetings, reports of meetings and refining transition plans
- Number of program officers and mentors who participate in the orientation session of the private sector peculiarities.
- Number of refresher and basic training and number of participants coordinated by PHSP and RHBs.
- Number of private facilities have all necessary HMIS& IEC/BCC materials, LMIS tool, Job aids, and guidelines for all programs.
- Number of facilities that have availability of sufficient stock of drugs and commodities.
- Number of private health facilities covered by joint supportive supervision of the RHBs and its structure
- Number of private health facilities participating in review meetings organized by the RHBs
- Number of private facilities included in the regional EQA and sample transport system.
- Facility profile made to per region for all facilities
- Number of facilities with expired program drugs and pharmaceuticals isolated, documented and reported to respective RHB/THO for proper disposal
- Post-transitional performance of health facilities (one quarter): during this period facilities will be monitored if they received supervision, training, EQA, faced stock-out, participated in review meeting, submitting performance to THO, etc.
- Transition reports submitted to RHBs, FMOH and USAID

8. Management of Transition Plan

PHSP mainstreams the management of transition activities into its structure. Central and all regional staff will be involved in the execution of the transition plan. The transition plan is an integral part of the year five work plan. With this in mind, PHSP indicated resources required for the implementation of the transition activities in the year five annual work plan. The transitioning activities will be done in integrated manner for all program areas of the project (for TB, MNCH & FP and malaria).

Given the limitations of project resources and duration, PHSP will eventually withdraw its direct involvement in the implementation of project activities and coordination role with RHBs. PHSP encourages RHBs to enhance participation of the private health sector and their constituent region specific PHFAs in their annual planning, annual and bi-annual review meetings, training and others.

Annex 1

Table 1. Potential Program Transition Threats and Mitigation Measures Taken During Transition

Activities/interventions at risk of continuation	Why at risk?	What can be done during transition and to sustain the service	Priority Level (High, medium, low)	Easiness of intervention (easy, intermediate, difficulty)	Responsible
1. trainings of providers	• High Attrition of trained staff at the private facilities and owners may not timely report demand for training of providers • Government budget constraint,	• **provide training so that facilities have at least two trained providers** • **Train owner physicians so that they can mentor employees** • **owners to employ trained providers** • advocate for inclusion of private facilities in RHB/THO training plans	High	Easy	PHSP, RHB/THO, Regional Labs, PHF
2. providing mentoring and supervision	• **shortage of resource at RHB and THO** • **if not mentored and supervised quality will be compromised**	• Advocate for the 100% inclusion of the private facilities into the quarterly site level support conducted by town and woreda health offices • orient district health officers on how and when to mentor private facilities • create mentors in private facilities	medium	intermediate	PHSP, RHB/THO, PHF
3. Access to drugs and supplies	• **needs vigilance otherwise service will be interrupted** • **Private facilities use ordinary refrigerators to store vaccines and RHBs will not give vaccine for facilities without approved refrigerator.**	• provide all facilities with RRF for requesting and reporting • provide health facilities with contact addresses of EPSA hubs and public health facilities • Advocate for RHBs and THO to be responsive to the request from health facilities to refill medicines.	**High**	Easy Difficult for refrigerator b/c it requires private facilities to expend more than	PHSP, PHF, EPSA, RHB/THO, Public health facilities

		• Link MNCH facilities to a vendor/importer for approved refrigerators for vaccine		4k USD to buy the refrigerator	
3.1 continuous utilization of private based Gene xert machines	• Repeated module failure and the maintenance of which has been facilitated by PHSP; EPHI has not taken over module replacement (GeneXpert machine maintenance) activity • Shortage of consumable supplies like Cartridge that are supplied from the national system. • The machine at GAMBY hospital is not linked to the national supply and maintenance system.	• Advocacy with EPHI to include Gambi and Teklaimanot Hospitals in their annual maintenance schedule for X-pert machines. • Transfer the rights of warranty to EPHI to contact the Company (cephied) for failures with in the warranty period (next one year) • Ensure the facilities have contact addresses of the responsible person and unit at EPHI. • Revise MoU to include inclusion of EPHI to part of the MOU with the RHBs	High	Easy	PHSP, RHB, EPHI, Gambi and Teklehaimanot facilitie, Regional labs
4. Sample transportation for DST and Xpert testing	• system is weak • communication gaps with courier may disrupt access to these service	• share to private labs contact addresses of labs and courier • advocate for inclusion in plan and monitoring of sample transportation by the regional lab and THO	High	Difficult	PHSP, Courier, Regional labs, PHFs, RHB/THO
5. EQA for sputum AFS and malaria blood film	• lack of resource in Regional lab and EQA sites • tendency to sideline private lab in EQA and provide feedback timely • malaria EQA is weak	• Ensure at least all TB labs receive twice EQA during transition. • Revise lab network for EQA	**High**	**Difficult**	**PHSP, Regional Lab, and EQA centres**
6. Integration of DHIS2	• private facilities are lagging behind in integration of DHIS compared to public health facilities • if PHF do not utilize DHIS2, performance will not be captured at the regional and national level	• advocacy to support PHF to utilize DHIS2 • Initiate DHIS2 in facilities not yet using it after mapping of all PHSP supported facilities on utilization of DHIS2 status.	High	Difficulty (resource allocation, require facilities to buy computer)	PHSP, RHB/THO, PHF
7. disaggregation of data from the private sector	• Except for TB, FMOH does not request RHBs to report contribution of private facilities • RHB/THO reluctant to disaggregate data from private facilities • DHIS2 reporting forms doesn't allow the disaggregation of the malaria data.	• provide sufficient standard reporting forms to report performance • orient program officers from RHB/THO on PPM-Program • Advocate for the malaria reporting forms to separate the malaria data	High	Intermediate	

Annex 2

Table 2. Detailed Transition Activity Plan USAID/PHSP, Oct-2019-Sept 2020 (see next page)

Major Activities	Activity	Milestone	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Who Implement	Remark
1. Preparatory activities for transition																
	1.1: Finalize Prepare Generic project and program specific Transition plan	Exit and Transition plan developed-													PHSP	
	1.2: Orient PHSP staff on the transition plan	All PHSP staff trained and ready to implement transition													PHSP	
	1.3: Inform FMOH, RHBs, EPHI, Regional Lab and EPSA	All informed and plan for consultative plan prepared													SMT and regional coordinators	
	1.3 : Conduct region specific consultative meeting on the transition plan	consultative workshop report and refining transition plan													PHSP/RHB/THO and PHF	Consultative meetings should be finalized early December
2. Build capacity of health facilities and THO to sustain service delivery	2.1: Provide orientation training to program officers and mentors in THO on the peculiarities of mentoring providers in private clinic	Program officers/mentors trained (TB, malaria, RMNCH)													PHSP with RHB	For cost reasons trainings will be offered to program leads in RHB, Regional Lab, EPSA hubs, and program officers selected from towns.
	2.2: Provide gap filling training to	All facilities will have at least one trained													PHSP with RHB	Low performing facilities may be excluded unless RHBs

	providers in Health facilities	providers during handing over															demanded they continue the program. need assessment will be done to plan training.
	1.MNCH															PHSP with RHB	
	2. Malaria																
	3. PPM_TB															PHSP with RHB	
																PHSP with RHB	
3. Provide gap filling M/E , Job aids, IEC/BCC material	2.3:Print and distribute all HMIS registers, forms , LMIS tools (TB, Malaria, MNCH, FP)	All facilities have registers enough for next one year														PHSP	# will be printed based on need
	2.4: Print and distribute all IEC/BCC materials (TB, malaria, MNCH, FP)	All facilities have IEC/BCC														PHSP	
	2.5: Print and distribute all Job aids, guideline (TB,Malaria, MNCH, FP)	All facilities have Guidelines and Job aids														PHSP	
4. Strengthen networking	4.1: facilitate EQA for all TB and malaria labs during the transition.	Facilities will be transited with at least one recent EQA result														PHSP with regional labs	

with public Lab	4.2: Share private labs and EQA centers contact their addresses	All facilities have contact addresses of EQA centers in their net work														PHSP/EPHI/Regional labs	Addresses of EQA centers will be printed and posted in the facility labs.
	4.3. revise networking of TB labs with DST and Xpert labs	All facilities have contact address of Courier and Labs with DST and xpert														PHSP/EPHI/Regional labs	
5. Strengthen linkage with EPSA and facilities	5.1: Network PHF to EPSA hubs and nearby public facilities for accessing drugs	All facilities have contact addresses of EPSA hubs and public health facilities														PHSP/RHB/EPSA hubs	
	5.2 . No facility will be transited with stock out of drugs	All facilities have at least two months stock of drugs during transition														PHSP/RHB/EPSA hubs	
	5.3 Facilitate disposal of expired medicines and reagents from supported facilities	• All facilities have contact addresses of EPSA hubs and public health facilities • all facilities have segregated expired medicines and handed over to THO														PHSP/RHB/EPSA	PHSP will assist the facilities to segregate expired drugs in sealed box. It will facilitate also handing over to the RHB/THO for disposal.

6. Handover facilities to RHB/THO	6.1. Prepare facility profile and status of clients	Facility profile and status of clients printed and submitted to THO														PHSP	
	6.2. joint mentoring , supportive supervision and officially handover/transfer facilities	mentoring and SS report														PHSP/RHB/THO	
	MNCH/FP	facilities handed over															Handed over end of Dec
	Malaria	facilities handed over															Handed over in two phases
	PPM-TB	facilities handed over															Handed over in Dec and Jan-Feb
	6.3. Handover all hardcopy and soft copy documents to RHBs (Site selection assessment tool, SS and mentoring tools, MoU template, guidelines etc.)	Documents handed over to RHB and THO														PHSP with RHB	
	7.1monitor post transitioning																

	performance and report															
	MNCH and FP														PHSP/RHB/THO	Q2
	Malaria														PHSP/RHB/THO	Q2 to end of Q4
7. Monitor HF after transitioning	PPM-TB														PHSP/RHB/THO	Q2 to end of Q3
	7.2submit transitioning report by program															Will document the process of transition and the post-transition status of the program and facilities.
	MNCH and FP														PHSP	
	Malaria														PHSP	
	PPM-TB														PHSP	
8. EOP event and submit report	8.1. conduct national EOP event														PHSP	There will be presentations and achievements will be displayed in posters, pamphlets and brochures
	8.2. Submit EOP report														PHSP	

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	5.2 . No facility will be transited with stock out of drugs	All facilities have at least two months stock of drugs during transition														PHSP/RHB/EPSA hubs	
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