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MINISTRY OF HEALTH-ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION

Public-Private Mix Implementation Guideline for RMNCAH Services

Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Directorate

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Acronyms

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CPR	Contraception Prevalence Rate
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program of Immunization
EPSA	Ethiopian Pharmaceuticals Supply Agency
ESPA+	Ethiopian Service Provision Assessment Plus
FBO	Faith-based Organizations
MOH	Ministry of Health
FP	Family Planning
HMIS	Health Management Information System
HSTP	Health Sector Transformation Plan
IEC	Information, Education and Communication
IMNCI	Integrated Management of Childhood and Neonatal Illnesses
IMR	Infant Mortality Rate
IPLS	Integrated Pharmaceuticals Logistics System
ISS	Integrated Supportive Supervision
JSS	Joint Supportive Supervision
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MgSO4	Magnesium Sulfate
MMR	Maternal Mortality Ratio
MoU	Memorandum of Understanding
NGO	Nongovernmental Organization
NICU	Neonatal Intensive Care
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Solution
PFSA	Pharmaceutical Fund and Supplies Agency
PHSP	Private Health Sector Program
PPM	Public-Private Mix
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PPP	Public-Private Partnership

RHB	Regional Health Bureau
RMNCAH	Reproductive Maternal Newborn, Child and Adolescent Health
RRF	Request and Requisition Form
SBCC	Social Behavioral Change Communication
SDG	Sustainable Development Goals
SNNP	Southern Nations and Nationalities People
TFR	Total Fertility Rate
THO	Town Health Office
TT	Tetanus Toxoid
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department
ZHO	Zonal Health Office

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This guide is a reflection of the commitment of the Ministry of Health and its development partners to strengthen Reproductive Maternal Newborn, Child and Adolescent Health (RMNCAH) services in Ethiopia. The Private Health Sector Project (PHSP), funded by the United States Agency for International Development (USAID), provided technical assistance and financial support in the preparation, development, and dissemination of the guideline with the ultimate goal of ensuring standardized care and improving service quality, documentation, and reporting at private health facilities.

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Foreword

Ethiopia has made impressive progress by achieving several national and global health indicators because of strong leadership of the Ministry of Health (MoH), coordination of efforts, and intensive investment in the health system by the government, partners, and the community at large.

As a result, the maternal mortality ratio (MMR) declined from 676 per 100,000 live births in 2011 to 412 in 2016. Over the same period, the contraceptive prevalence rate (CPR) increased from 29% to 36%, and the total fertility rate (TFR) dropped to 4.6 with a shift to long-acting, reversible contraceptive methods. Births attended by skilled providers reached 28% from 10% in 2011.

However, the Health Sector Transformation Plan (HSTP) set ambitious targets: an MMR of 276/100,000, CPR of 55%, and TFR of 3.0 at the end of 2020. To achieve these targets, the MoH is implementing a set of high-impact interventions – antenatal, skilled birth, postnatal care, and others – to improve quality of and access to service delivery.

Ethiopia's public health sector cannot do this alone – it needs to partner with the private health sector in the delivery of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services. For the partnership to succeed, there is a need to document clear lines of responsibility for the public and the private sectors, in what is called the public-private mix (PPM) model. The PPM model is being used by the government in other areas of health care and other sectors.

Although the private sector has huge potential for delivering RMNCAH services, there has been a lack of comprehensiveness and relatively poor quality of care in its service delivery – largely due to lack of essential drugs and other family planning and maternal and child health commodities, as documented in a study conducted by the Private Health Sector Program in 2015/16.

In response to the study, the MoH's RMNCAH Directorate decided to develop a guiding document to the commodities gap and remediate irregularities in family planning services. With this guideline, the private sector in general and private health facilities in particular are expected to increase access to and improve the quality of services as per HSTP goals and targets of 2015/16-2020 and beyond.

For the above compelling reasons, the directorate convened a technical work group and started the development of the implementation guideline, which took nearly a year of hard work and consultations.

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Operational Definitions

Public-Private Partnership (PPP): "[A] long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance" (World Bank, IDB, & ADB, 2014).

Public-Private Mix (PPM): PPMs are arrangements between government, private sector, and civil society entities working in concert toward a common goal. According to the World Health Organization, PPM is about combining different skills and expertise in a framework of defined responsibilities, roles, accountability, and transparency to attain a common goal of achieving universal access to the best-quality health care that may be unattainable by independent action.

Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) Commodities: In this guideline, RMNCAH commodities are essential drugs and vaccines for family planning and maternal, neonatal, and child health care.

1. Introduction

Over the past five years, there have been significant improvements in health services – in particular RMNCH services – provided by private and public health facilities in Ethiopia. According to the Ethiopian Demographic and Health Survey (EDHS) 2016, the maternal mortality ratio (MMR) has been reduced to 412/100,000 live births from 676/100,000 live births in 2011 (EDHS, 2017), evidence the country is progressing toward the expected improvements in maternal health. The total fertility rate (TFR) was found to be 4.6 while the contraceptive prevalence rate (CPR) for any method increased to 36% from 29% in EDHS 2011. There was a marked increase in the use of Long-Acting and Reversible Contraception (LARC) and improvement in unmet need was reduced to 22% from 26% in EDHS 2011. Births attended by skilled providers reached 28% compared with 10% in EDHS 2011. Child health findings included a steady decline in under-5 mortality rates, from 165/1,000 live births to 67/1,000 live births, and a drop in infant mortality from 95/1,000 live births to 48/1,000 live births; the neonatal mortality rate remained at 29/1,000 live births (EDHS, 2017, p. 21).

Despite the aforementioned improvements, health challenges remain. For instance, the current EDHS also showed that 5% of infants under 6 months of age are not breastfed. The percentage of exclusively breastfed infants decreased sharply with age, going from 74% of infants of 0-1 month of age to 64% of those age 2-3 months and to 36% of infants aged 4-5 months (EDHS, 2017, p. 42). According to the EDHS 2016 report, the proportion of pregnant women who received antenatal care (ANC) services at least once exceeded 98%, but continuity of service and quality of care is not optimal as evidenced by low coverage of skilled delivery, tetanus toxoid (TT) vaccine uptake, and screening for syphilis and utilization of insecticide-treated nets.

According to the Ethiopian Service Provision Assessment Plus (ESPA+) 2014 survey conducted by the Ethiopian Public Health Institute, nearly 65% of all facilities, excluding health posts, offer vaginal delivery services. Almost all (99%) government-managed facilities offer normal delivery services while only 27% of private for-profit facilities and 69% NGO facilities provide the services. A similar study by the Private Health Sector Program (PHSP) demonstrated that up to 78% and 53% of the studied private facilities have services in modern family planning (FP) and ANC, respectively. However, government facilities offering normal delivery services are more

likely to apply the seven Basic Emergency Obstetric and Newborn Care (BEmONC) signal functions than are private facilities, due to the latter's lack of training and essential drugs such as magnesium sulfate.

According to the rapid assessment that PHSP conducted on RMNCH in 2015/2016, which covered 90 facilities in eight regions (all except Ethiopian Somali) and two city administrations, private facilities have great potential to provide a wide range of reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services. With the objective of improving RMNCAH services nationwide and reducing the MMR to 267 per 100,000 live births, a set of high-impact interventions, including ANC, skilled birth services, and postnatal care (PNC), is being promoted in both private and public health facilities.

The purpose of this document is to set and standardize implementation guidelines to provide high-quality RMNCAH services considering the continuum of care model (from pre-pregnancy, pregnancy, birth, PNC, newborn health, child health, and adolescent health) so that standardized services are accessible to patients in public and private facilities in a comprehensive way through the PPM model. This guide will serve to implement PPM interventions specific to the delivery of RMNCAH health care services as per the national guidelines and standards in Ethiopia.

1.1 Public-Private Mix

The term "public-private mix" as used in this document refers to a range of context-specific approaches to involve all relevant health care providers – public and private – in the provision of quality-assured RMNCAH care. A strong PPM model allocates the tasks, obligations, and risks among the public and private partners in an optimal way. Public-private partnerships (PPPs) recognize that the public and private sectors each have certain advantages, relative to the other, in performing specific tasks.

The public partners in a PPM model are government entities, including ministries, departments, and state authorities. The private partners can be local or international and have technical or financial expertise relevant to the provision of RMNCAH services and care to patients and clients. They may be not-for-profit (usually providing free or subsidized services), owned by

nongovernmental or faith-based organizations (NGOs and FBOs), or for-profit health individual providers and facilities including clinics, health centers, hospitals, pharmacies, and drug shops. Some workplaces also offer a private sector venue for providing MCH and other services, including FP. A detailed description of PPM benefits can be found in Section 1.3.

As countries move toward their Sustainable Development Goals (SDGs), all women and adolescents need to get better FP care, which increases the need for domestic funding and other resources. The private sector should be engaged as an active partner to achieve SDGs.

1.2 Rationale

In view of the aforementioned, a systematic involvement of all relevant health care providers in delivering effective RMNCAH services to all women, children, and adolescents is critical to achieving the national goals set in Health Sector Transformation Plan (HSTP) and national reproductive health strategies. It is clear that a health care service that fails to recognize the contribution of private health facilities in improving quality and access to RMNCAH services is not going to achieve its long-term targets.

Engagement of the private health sector in the delivery of RMNCAH services is a key strategy of expanding available and standardized services to all segments of the population at an affordable cost. In Ethiopia, there is a strong political commitment from the Ministry of Health (MoH) to engage the private health sector to contribute to the health care delivery system. Growing interest within the private health sector in health investments has created an enabling environment for PPPs to grow. In the past several years, private health facilities have flourished and currently there are more than 12,000 private facilities in Ethiopia. Other workplace health facilities are showing a growing interest in engaging RMNCAH services as one of the key activities in their health care delivery packages.

Engaging a large proportion of the private health care providers is expected to improve the quality, access, and affordability of RMNCAH services, which in turn will contribute to reducing the MMR, TFR and neonatal mortality rate. Thus, national RMNCAH programs need to scale up country-specific PPM approaches.

1.3 Benefits of PPM in RMNCAH Care

The PPM model has already proven to be successful in the national TB program in Ethiopia. The benefits of PPM in RMNCAH care are:

- **Quality care for clients/patients:** PPM helps health care providers to adopt evidence-based RMNCAH services. It introduces private facilities to national and international standards for quality of care to continually improve and expand their services.
- **Improved adherence to standards:** PPM has shown a significant uptake of national guidelines, protocols, client registration tools, and reporting mechanisms aimed at improving service delivery. Adhering to regulatory frameworks has improved the rational use of drugs, decreasing over-prescription or under-prescription of medicines.
- **Improved equity and access:** PPM improves access to care by involving health care providers to serve the poor, marginalized, and most vulnerable.
- **Reduced financial burden and improved convenience:** PPM reduces costs to patients by ensuring that price of commodities and essential drugs are kept to a minimum. PPM can also reduce indirect costs for patients by providing services closer to their homes or workplace.
- **Improved partnership among health care providers:** PPM helps improve referral and communication networking among public and private health care providers.
- **Improved management capacity:** PPM improves the capacity of public and private health facilities through trainings, mentoring, and supervision to enhance their ability to provide and manage RMNCAH services efficiently.
- **Improved monitoring:** PPM ensures the gathering of performance data from private providers and contributes to achieving regional or national targets in RMNCAH care and FP.

1.4 Intended Users of this Guideline

The current national policy promotes the inclusion of both private and public health sector providers to be engaged in RMNCAH services according to the standardized methodologies and procedures included in this implementation guideline.

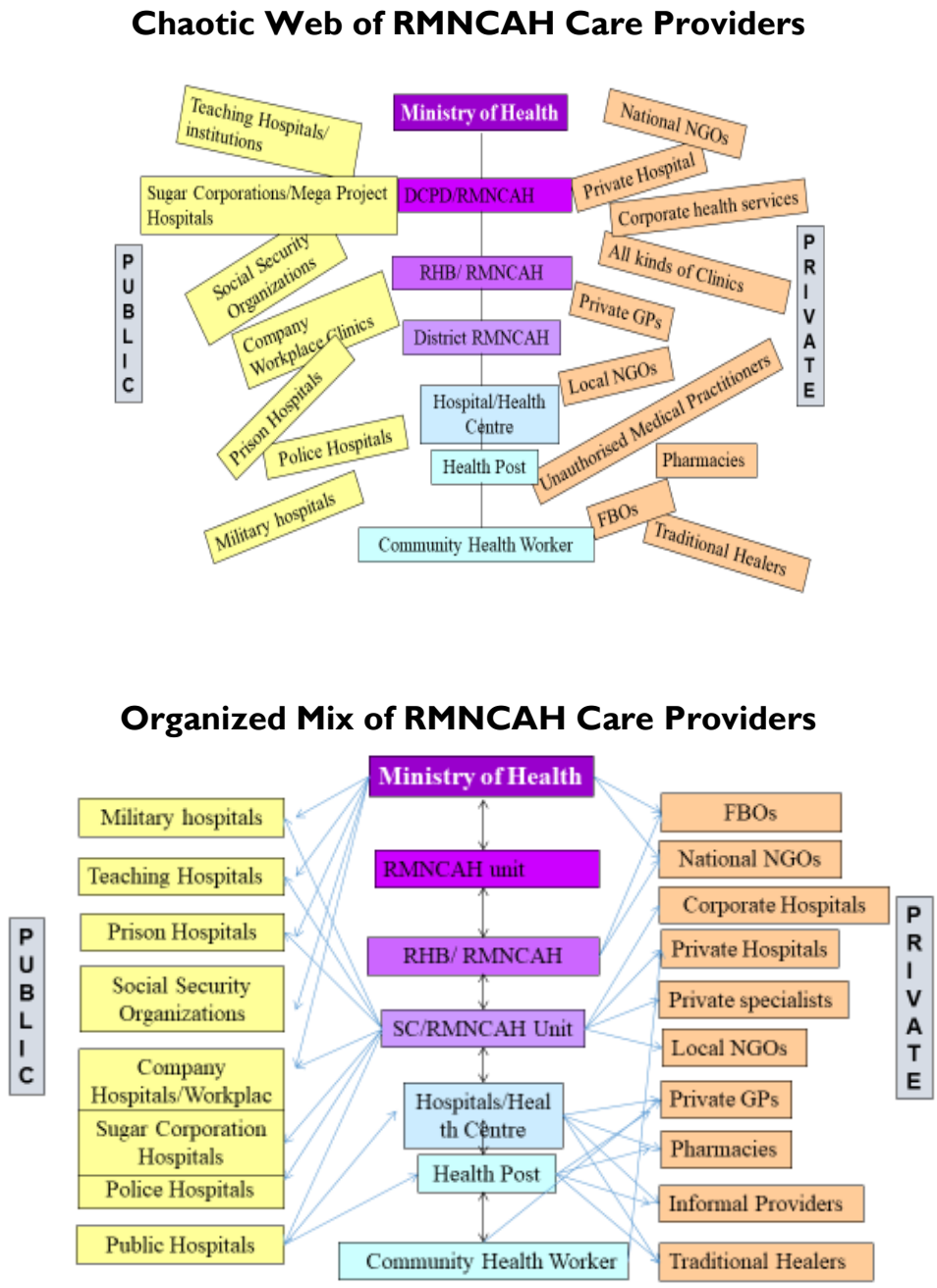
The different stakeholders involved in the coordination, management, implementation, and monitoring of RMNCAH programs include the following:

- Policymakers
- Program managers and implementers
- Professional associations
- Academic communities
- Research institutes
- Health care providers,
- Private sector business owners
- Development partners

2. Engaging PPM Health Care Facilities

Administratively, PPM health care facilities are not directly linked with the national RMNCAH structure. PPM is an agreement between the government and private sector and civil society entities to achieve the common goal of improving and expanding the provision of quality health care and treatment services. This agreement includes public entities like the Ministry of Health, regional health bureaus (RHBs), zonal health offices and woreda health offices (WoHOs), maternal and child health departments, state authorities, and NGOs, as well as private for-profit facilities such as hospitals, MCH centers, or clinics providing RMNCAH service. As depicted at the top of Figure 1, if the abovementioned parties in the public and private sectors fail to engage in a PPM agreement, there would be an uncoordinated network of health service providers with limited capacity to fulfill the demand for health services, and this would negatively affect the achievement of SDGs in general and HSTP RMNCAH targets in particular. Instead, if the public and private sectors coordinate under PPM, they will have an orderly and effective relationship that will move them toward achieving their common goal as depicted in the second part of Figure 1. This includes mechanisms such as support and/or oversight, coordinated referral system, and access to medical supplies and commodities to address public health needs.

Figure 1: Relationships between RMNCAH Care Providers and the Ministry of Health



2.1 National Policy Support for PPM Engagement

Ethiopia has enabling policies and programs that promote public-private collaboration. Since 1997, national health policies have been promoting the participation of the private health sector and NGOs in health care delivery. The National Drug Policy, investment policy, Growth and Transformation Plan, Health Care Financing Proclamation, and other legislative documents also support the partnership between private and public sectors in health service delivery.

The MoH has initiated and coordinated the development of a strategic framework for PPP. The current national health policy also emphasizes the need to widely promote inter-sectoral collaboration to address gaps in health service delivery. The PPM approach can play a crucial role in achieving the four HSTP transformation agendas: quality and equity in health care, information revolution, woreda transformation, and developing caring, respectful, and compassionate health professionals by providing additional opportunities for the public health sector to engage more health care providers outside its structure.

The HSTP has reiterated the importance of having a collaborative endeavor with development partners and the private for-profit health delivery system to achieve better health outcomes. The collective actions taken by all stakeholders outside the health sector, including other public and workplace health care providers, would also play a critical role in improving the health status of the people.

2.1. Goals and Objectives of PPM-RMNCAH in Ethiopia

The overall goals of PPM-RMNCAH in Ethiopia is to improve access to and quality of comprehensive RMNCAH services within public and private health facilities following standard high-quality practices.

Specific objectives are:

- To ensure standardization of RMNCAH service provision
- To improve quality of care in RMNCAH service provision through continuous quality improvement processes
- To improve efficacy of services being provided
- To improve equity, access, and affordability in service provision

- To reduce the financial burden on the public health system
- To strengthen referral linkages and communication among public and private health care providers
- To improve service expansion and access to resources to private and public sector facilities

2.2. Principles and Values of PPM in Ethiopia

PPM is an arrangement between some combination of government, private sector, and civil society entities working in concert toward a common goal. According to the World Health Organization (WHO), PPM is about combining different skills and expertise in a framework of defined responsibilities, roles, accountability, and transparency to attain a common goal of achieving universal access to a quality of health care that may be unattainable by independent action.

The principles of PPM include:

- Securing trust between public and private partners
- Establishing parity of relationship among public and private sector partners
- Nurturing PPPs
- Sustaining collaboration among partners
- Being equitable and inclusive
- Creating an enabling policy environment

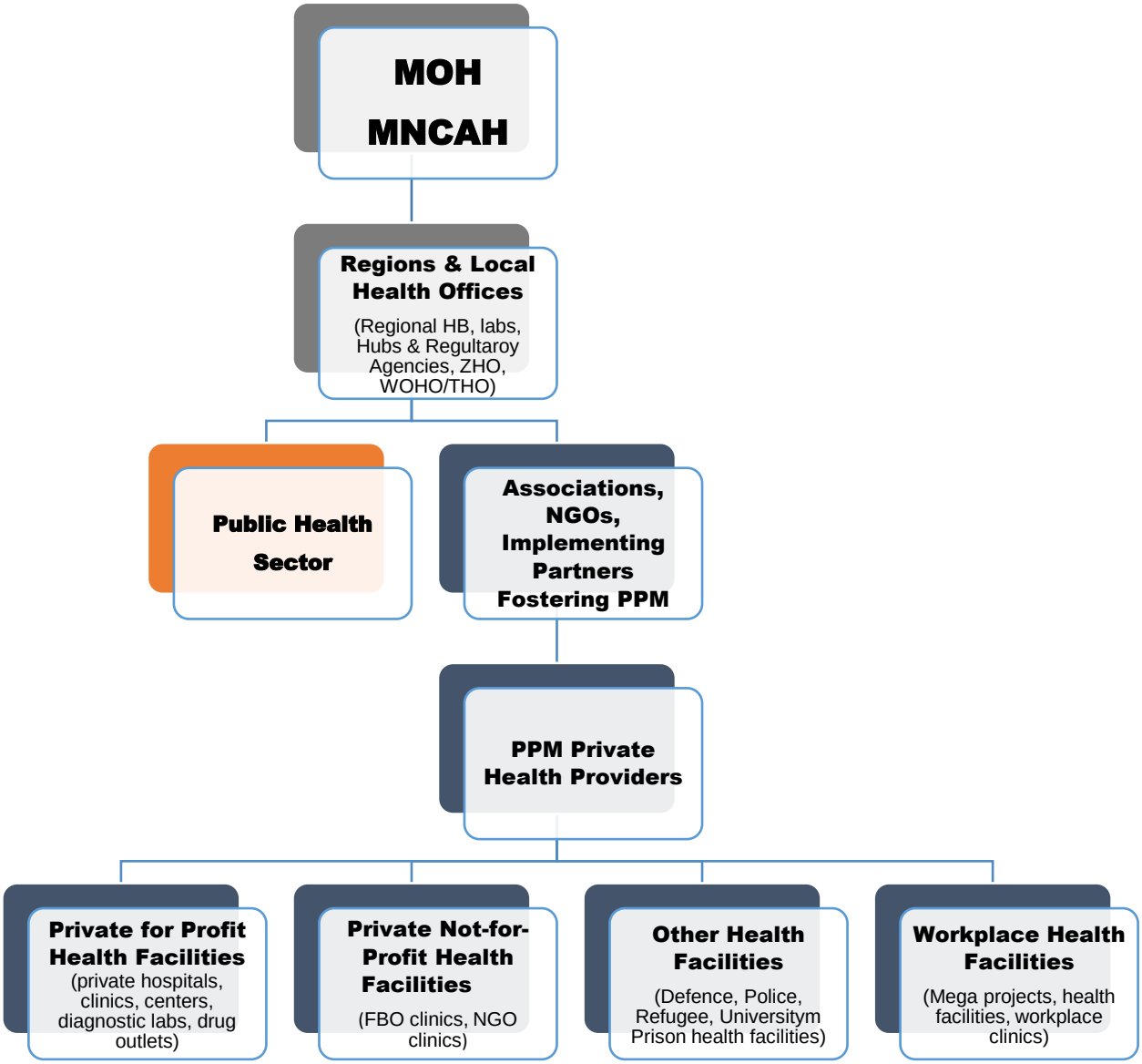
The potential values of PPM include:

- Participation, accountability, transparency, and consensus building
- Leadership, shared vision, capacity building, and ownership
- Community-centered health planning and implementation
- Compliance with the code of professional ethics
- Provision of Compassionate and Respectful Care (CRC)
- Being flexible and ready to accommodate new health developments and innovations.

2.3. The PPM-RMNCAH Model in Ethiopia

PPM-RMNCAH in Ethiopia is being implemented under a strong framework of organization, coordination, and management at different levels of the health structure using a care model that fits into the existing health service delivery system as seen below in Figure 2.

Figure 2: PPM-RMNCAH Model in the National RMNCAH Program



2.4. Roles and Responsibilities of Stakeholders in PPM-RMNCAH

PPM-RMNCAH program implementation requires committed and rigorous contributions of various stakeholders within the national health system. Identifying the roles and responsibilities of each stakeholder is key to ensuring a partnership is effective at all levels. Sections 2.4.1–10 specify the roles and responsibilities of the main stakeholders.

2.4.1. Ministry of Health

- Provides overall leadership, stewardship, and oversight of the PPM initiative
- Formulates national policy and guidelines and monitor adherence during implementation
- Sets national targets and provides direction for the expansion of PPM-RMNCA
- Designs monitoring and evaluation (M&E) framework
- Builds capacity of RHBs and associations to effectively implement RMNCAH services
- Ensures allocation of adequate resources for implementation of PPM activities
- Leads and coordinates the national PPM technical working group
- Ensures inclusiveness of the private sector in the health management information system (HMIS), review meetings, and joint supportive supervision (JSS)
- Facilitates access to essential commodities free or subsidized whenever possible
- Includes private health sector representatives in RMNCAH national training of trainers

2.4.2. Food and Drug Authority and its Regional Offices

- Formulate enabling policies and regulatory frameworks for PPM health care facilities
- Regulate to ensure PPM-RMNCAH sites are staffed, equipped, and operational to deliver services following national standards
- Ensure that RMNCAH care is delivered according to national standards
- Participates in site assessment, site selection, and authorization of RMNCAH services for PPM sites
- Ensure facilities have submitted performance reports regularly before relicensing
- Approve the supply program for drugs and supplies from the government side

2.4.3. Ethiopian Public Health Institute and Regional Laboratories

- Ensure that the private health sector is included in RMNCAH assessments and studies
- Implement laboratory quality assurance procedures
- Ensure the functionality of the laboratory network, and sample referral and results delivery system

2.4.4. Pharmaceuticals Fund and Supplies Agency (PFSA)

- Procures, stores, and monitors inventory of RMNCAH pharmaceuticals including at PPM health care facilities

- Distributes essential commodities (Vit. A, Vit. K, magnesium sulfate, vaccines) and FP commodities (not commercially or through social marketing) to PPM-RMNCAH facilities
- Ensures that private facilities are included in national quantification exercise of RMNCAH commodities
- Distributes RMNCAH commodities to PPM sites
- Builds the capacity of PPM health care facilities in areas of pharmaceutical supply management and rational pharmaceutical use through provision of technical support (see section 4 for more information)

2.4.5. RHBs and zonal health offices

- Identify private clinics that are able to deliver national-standard PPM-RMNCAH services
- Assess, select, and prepare private clinics for RMNCAH service provision
- Enter into an agreement by signing a memorandum of understanding (MoU) with private facilities
- Decertify PPM-RMNCAH sites in cases of MoU breaches
- Engage regional regulatory bodies, and ensure provisions and standards are considered in the selection and certification of PPM-RMNCAH clinics, centers, and hospitals
- Provide facilities with data-recording tools for proper recording, reporting, and supply chain tracking and management
- Include the private facilities in distribution of guidelines, job aids, and information, education and communication (IEC)/social behavior change communication (SBCC) materials
- Ensure transparent costing for RMNCAH care is provided
- Ensure total program implementation is in accordance with the national standards
- Provide trainings, supportive supervision, and program M&E services including in logistics management (see Section 4)
- Facilitate access to essential commodities and cold chain equipment free or subsidized whenever possible

- Engage the private health sector in RMNCAH national training of trainers
- Include the private facilities in referral linkage networks
- Ensure that all PPM sites received specific HMIS codes
- Ensure mechanisms are in place to facilitate commodities including vaccine transfer from public health facilities to catchment PPM sites
- Collect activity reports, disaggregate and involve private facilities in review meetings, JSS

2.4.6. Woreda/Town Health Offices

- Identify private and other governmental health facilities that are capable of delivering standard RMNCAH services
- Participate in the assessment, selection, and preparation of PPM health facilities for RMNCAH services
- Identify training needs of PPM health facilities and communicate to the RHB/zonal health department
- Provide facilities with the relevant recording and reporting tools (HMIS recording and reporting tools, Integrated Pharmaceuticals Logistics System (IPLS) tools) for proper recording and timely reporting of RMNCAH services
- Ensure timely delivery of RMNCAH commodities and essential drugs to PPM health facilities following the national pharmaceutical supply chain system
- Ensure that all PPM health care facilities received specific HMIS codes
- Distribute national RMNCAH implementation guidelines and other provider support tools and formats
- Conduct quarterly supportive supervision and program monitoring using national/regional standard tools
- Collect, review, compile, and submit RMNCAH performance report timely to next level
- Involve PPM health facilities in RMNCAH program review meeting
- Supervise PPM health facilities logistic systems regularly (see Section 4 for details)
- Strengthen the referral linkage and communication system of public and private health care providers

2.4.7. Public Health Facilities

- Facilitate the referral and communication mechanisms with private RMNCAH health service providers
- Link PPM-RMNCAH sites with public health service facilities
- Allow access to RMNCAH services to patients referred from private facilities for further care or handling of complications
- Provide mentoring services to their catchment health centers and PPM sites
- Refill catchment PPM sites with commodities and receive Request and Requisition Forms (RRF)

2.4.8. PPM-RMNCAH Facilities

- Provide RMNCAH services per accepted national standards
- Record and report all program activities using national HMIS and other standardized data tools
- Ensure services are delivered by appropriately qualified and trained personnel
- Ensure that patients with RMNCAH emergencies are stabilized before referring them to public health facilities
- Provide service in a compassionate, respectful, and caring manner
- Maintain a strong referral and communication network with all RMNCAH service providers
- Sign and enforce MoUs with the RHB/ZHD/WoHO/town health office
- Ensure that staff undergo service training to improve quality of care
- Ensure proper RMNCAH stock management (see section on Pharmaceuticals in Chapter 4)

2.4.9. Associations (private health sector associations, professional associations, and others)

- Collaborate with the regions in site assessment, selection, initiation, JSS, and mentoring of RMNCAH service providers in PPM sites
- Advocate for PPPs
- Provide onsite in-service trainings including online courses based on national standards

- Ensure inclusion of the private health sector in continuous professional development and annual conferences tailored to working conditions. Actively participate and assist in the formulation of enabling national policies and guidelines
- Distribute updated guidelines including PPM sites
- Provide technical and operational support to implementation processes

2.4.10. Implementing Partners and Civil Society

- Provide technical and financial support for effective implementation of RMNCAH programs
- Collaborate with the regions in site assessment, selection, and initiation of RMNCAH services in PPM sites
- Ensure delivery of quality RMNCAH services in PPM sites as per the national standard
- Work closely with the local health offices and PPM sites to generate and disseminate evidence and good practices
- Assist regions in organizing capacity building for PPM health care providers
- Plan and implement RMNCAH activities in close collaboration with the MoH

3. Program Coordination and Management

3.1. Service Areas for Engaging PPM-RMNCAH Health Care Facilities

Private sector health care facilities are encouraged to become engaged in the delivery of the following services in RMNCAH:

- Reproductive health: FP, post-abortion care
- Maternal health: pre-pregnancy care, ANC, labor and delivery, PNC,
- Neonatal and child health: neonatal intensive care, essential neonatal care, Integrated Management of Childhood and Neonatal Illnesses (IMNCI), Expanded Program on Immunization (EPI)
- Youth-friendly services (adolescent and youth health)

Service delivery can be realized in either of the following ways:

- Advocacy, communication and social mobilization, and standardized service delivery,
- Participation in diagnostics and quality assurance services

Potential private care providers to be engaged in PPM-RMNCAH in Ethiopia include:

- Private for-profit organizations
    - Private hospitals, MCH centers, Ob/Gyn specialty clinics, health centers, and work place clinics.
- Private not-for-profit organizations
    - NGO and FBO clinics, workplace clinics or other private clinics.

Public health facilities are those run by the government according to a tiered health system with specified catchment populations. The delivery of one or any combination of services can be initiated by a private facility after fulfilling the requirements (completion of preparatory procedures and signing a MoU with the appropriate governmental body: RHB or its delegates, including ZHO WoHO, or town health offices).

3.2. Procedures for Engaging PPM Health Care Facilities

There are a series of activities that, when conducted step-by-step, create a roadmap for the successful implementation of a PPM-RMNCAH program. These are:

- Sensitization and consensus-building meetings
- Facility assessment
- Site selection
- Capacity building
- MoU signing
- Service initiation support
- Referral network
- Community awareness and service promotion
- Logistics management
- M&E and lessons learned
- Mentoring, JSS, feedback, and corrective actions
- Certification when program is mature and minimal support thereafter

3.2.1. Sensitization and Consensus-Building Meetings

This is an essential component in the implementation of the PPM-RMNCAH program in private facilities. Sensitization and consensus meetings are fora organized to engage RHB officials, federal regulatory and supply authorities, woreda/town health office officials, and private providers in the initial planning process. The meetings should thoroughly explain the approach, targets, and timeline of implementation. Participants should discuss logistics, supervision, reporting, and training issues during these meetings. By explaining site selection criteria, the meetings increase transparency.

The sensitization and consensus meeting is expected to help participants understand the concept of the PPM initiative; the roles and responsibilities of each person, facility, and office in treatment, provision of drugs and supplies, referral, and reporting requirements. It also serves as a platform for participants to share experiences.

3.2.2. Facility Readiness Assessment

Using a standardized assessment format, a team composed of the RHB, the zonal health office including its regulatory department, and partners conduct a facility readiness assessment of potential private health facilities focusing on resources available and the needs of the facility. The assessment should detail each facility's current infrastructure, human resources, training requirements for staff, laboratory facility and equipment, the volume of service users (clients), and willingness to commit to the PPM-RMNCAH program (See sample tool in Annex C.)

3.2.3. Site Selection

It is important to clearly state the criteria according to which private facilities are selected to avoid confusion and ambiguity. All stakeholders need to understand and accept the selection criteria:

a) The potential to serve a high volume of RMNCAH service patients/clients
b) Evidence of facility's commitment to provide quality as per the national standard
c) Adequate infrastructure and personnel
d) Facility owner's willingness to enroll in the PPM-RMNCAH program
e) Facility owner's willingness to adopt and abide by MoH and local health office standard operating procedures and regulations

3.2.4.Capacity Building

To maintain high-quality service delivery, health care providers in PPM facilities must be appropriately trained. Some providers will need an updating of their knowledge and skills to current and evidence-based information and practice. Training also is necessary to encourage adherence to national protocols and guidelines and standardization in client care.

Once providers are appropriately trained, JSS is an important quality assurance tool for private sector facilities. It ensures facility adherence to national guidelines in the provision of care, laboratory services, drugs and FP commodities, and overall facility maintenance including infection prevention practices as well as record keeping and reporting.

The program needs to work closely with the local health structure to conduct quarterly JSS. It is recommended that new private facilities be supervised intensively for the first three to six months of participation in the PPM program.

3.2.5. Memorandum of Understanding

A MoU establishes a formal relationship between the RHB/ local public health structure and the private health facility. It should clearly articulate the roles and responsibilities of each side of the agreement.

Signing a MoU is mandatory for PPM facilities that will provide RMNCAH services. It can be customized depending on the type of PPM health care facility.

3.2.6. Service Initiation Support

Once a facility signs a MoU, a team composed of a support body and local health office RMNCAH unit should conduct a service initiation evaluation and facilitate the initiation of RMNCAH service delivery by ensuring the provision of commodities and recording and reporting tools.

3.2.7. Referral Network

PPM facilities will be included in the existing national and local referral networks for ensuring the continuity of care, enabling the tracking of patient progress, and getting patients the care they need. Full cooperation and coordination by the public and private health sector allows for full referral and feedback, handles complicated and difficult cases, and provides appropriate follow-up and monitoring. The referral network will be designed as per the national standard and bidirectional between the public and PPM private facilities.

3.2.8. Community Awareness and Service Promotion

Promotion of RMNCAH service availability at PPM private facilities creates public awareness of their ability to access RMNCAH services in the private health sector. The promotion should be done at all levels by all parties involved in the implementation of PPM-RMNCAH.

3.2.9.FP and RMNCAH Commodities Logistics Management

Logistics are a critical part of the program. PPM facilities must be assured that they will receive timely and adequate supplies of RMNCAH essential drugs and FP commodity drugs.

The National RMNCAH unit of the MoH and PFSA should develop a mechanism for the delivery of an adequate and uninterrupted supply of these commodities.

3.2.10. M&E and Lessons Learned

An M&E system must be in place to ensure appropriate use of resources, quality of service provision rendered, and evidence for decision-making. M&E helps to evaluate program outcomes and measure its short- and long-term impact. Partners, regional authorities, and facility staff need to facilitate and undertake program monitoring through supportive supervision and by organizing program review meetings with all stakeholders.

M&E frameworks also facilitate the standard documentation and timely submission of reports to appropriate health offices using the HMIS reporting format and documentation of best practices, which assist dissemination of program successes.

The MoH, RHBs, and other government structures shall include the PPM facilities in the routine planning, implementation, and M&E activities.

3.2.11. Mentoring, JSS, Feedback, and Corrective Actions

The mentoring program organized at national, regional, and woreda levels will include the PPM RMNCAH facilities.

A JSS and provision of feedback and corrective actions process already in place in the public health system will be expanded to include PPM private facilities and will take place regularly. These facilities will be included at all levels of JSS and mentoring support so they can act on the feedback and action plans provided.

3.2.12. Certification

PPM facilities will be provided a certificate for the components of RMNCAH services provided after the readiness assessment and selection process is completed. This will facilitate the close collaboration of PPM facilities with respective public health manager.

3.3. Minimum Requirements for Engaging Health Care Facilities

The minimum requirement for private health facilities to participate in the provision of RMNCAH services depends on the type of service/s they are expected to provide. Generally, a health facility should fulfill the following criteria:

- Hold a current license and other certifications by the respective authority
- Have a significant patient or client load and visits per week/month or year
- Have basic infection prevention procedures
- Be willing to participate and adhere to the national RMNCAH guidelines and standards
- Sign a MoU to participate according to the type of service provision

These facilities are expected to provide comprehensive RMNCAH services according to the national standards and guidelines and refer clients or patients who need additional care to nearby facilities that can provide the care.

3.3.1. PPM FP Facilities

Health care facilities eligible to provide FP services, including post-abortion services, are medium clinics, specialty clinics, private health centers, and hospitals as part of their primary care services. Some of these types of facilities do not have the adequate infrastructure and human resources to provide comprehensive RMNCAH services but they are capable of providing FP services and referrals.

Private facilities agreeing to provide PPM FP services must meet the following requirements:

- Be willing to provide FP services according to national standards
- Have a designated room for FP service provision (separate or integrated with other programs/ activities), with water supply inside the room
- A health care provider trained on national standards for FP

3.3.2. PPM MCH Facilities

Health care facilities eligible to provide FP, ANC, PNC, normal delivery services, and other gynecologic services, including comprehensive abortion care, are medium clinics, Gyn/Obs specialty clinics, private health centers, and hospitals. These health care facilities do not have the adequate infrastructure and human resources to provide comprehensive RMNCAH services but they are capable of providing some MNCH heath care services and referrals. PPM private facilities agreeing to provide FP, ANC, PNC, normal delivery, and gynecological services, such as Comprehensive Abortion Care (CAC), should fulfill the following requirements:

- Willingness to provide outpatient FP, ANC, PNC, immunization, and gynecological services, and normal delivery services with referral for interventional delivery as per the national standard
- Designated rooms for MCH services with water supply inside the rooms as per the standard
- Health care providers (midwives or other providers) trained to provide FP and BEmONC as per the national standards

3.3.3. PPM Comprehensive MNCH Facilities

Health care facilities eligible to provide FP, pre-pregnancy, ANC, PNC, comprehensive abortion care, normal delivery including interventional and Caesarian section, neonatal and child health care at the outpatient and inpatient level are MCH clinics, MCH centers, and hospitals. These facilities have the infrastructure and human resources needed for comprehensive RMNCAH service and they provide all or part of the MNCH services along with referral services. Private facilities agreeing to provide comprehensive MNCH services with PPM should fulfill the following requirements:

- Willingness to provide comprehensive MNCH services as per the national standard
- Designated separate rooms for comprehensive MNCH service including immunization as per the national standard
- Appropriate number of midwives and other health care providers trained to provide FP, comprehensive abortion care, BEmONC or Emergency Obstetric and Newborn Care (EmONC), and Essential Newborn Care (ENBC) as per the national standard.

3.3.4. PPM Child and Adolescent Health Facilities

Eligible private health care facilities that provide growth monitoring, and child, adolescent, and youth health care services usually are pediatric specialty clinics, pediatric specialty centers, MCH clinics, MCH centers, and general hospitals and other private facilities with adolescent and youth services. These facilities do not have the adequate infrastructure and human resources for comprehensive RMNCAH service but they can provide some MNCH services and referral

services. Private facilities agreeing to provide pediatric health services should fulfill the following requirements:

- Willingness to provide child, adolescent, and youth services as per the national standard
- Designated rooms and providers trained to provide adolescent and youth-friendly services as per the national standard

3.3.5. Training of Health Care Providers for RMNCAH Services

The success of PPM-RMNCAH initiatives depends on how well health care providers are sensitized and trained. Service providers in PPM health care facilities should be trained on different components of RMNCAH as per the national standard according to the level of engagement. National training materials and methods should be used to develop additional training materials tailored to the different working conditions of different types of providers.

3.4. Service Charges Related to RMNCH Commodities

The private health facilities can charge for the services they provide based on their level of services and their for-profit or not-for-profit status. It is important to note that the cost of FP/ MNCH commodities are not passed on to patients in the PPM health care facilities if the facilities acquired the supplies used for free from the public supply. This will improve equity of health care services in PPM facilities.

However, to ensure continuity of service and the provider's commitment to the program, the private health facilities may charge a reasonable service fee to cover its indirect costs in making the PPM RMNCAH services available to users. The PPM facilities shall clearly present/ communicate the fees/ costs of services in visible places. Whenever possible, the RHB may negotiate the cost of RMNCH services with PPM health care facilities to make the service more affordable and accessible.

3.5. Patient Referral Services

A referral is when a patient is sent to another health facility for better diagnosis and management and/or other health care reasons. An appropriate referral network for MNCH shall be instituted and patients can be referred both from private health facilities to private or public ones, and from public and private facilities to private ones according to the national protocol.

To strengthen the referral and feedback system between facilities, appropriate health offices should map, prepare, and communicate the updated list of facilities providing RMNCH services to all health facilities located in the catchment area. When a patient is referred or transferred, the referring facility should complete the national referral form and take all the necessary precautions included in the National Patient Transfer and Referral Guideline. The receiving facility should send feedback on the arrival and /or provision of care of the referred patient to the referring facility.

3.6. Certification and Decertification

Certification is the process by which the national PPM program officially documents that a PPM facility of any size has met the appropriate criteria to provide the specified RMNCAH services requiring certification. Certification requires compliance with a uniform set of national standards and procedures essential for proper delivery of standardized, quality RMNCAH care. Certified facilities may be decertified for repeated failures to abide with standards after proper warnings.

Major causes for decertification include

- Charging a fee for RMNCAH commodities freely accessed from the public source
- Repeated failure to provide RMNCAH services in accordance with national standards
- Failure to provide regular reports about the RMNCAH services provided in the facility
- Failure to comply with MoU
- PPM facility failure to provide contracted services?

Decertification involves withdrawing the facility's certificate, revoking the MoU, stopping provision of free RMNCAH commodities/supplies to the facility, and officially announcing the facility's decertification for specific RMNCAH services to facility and government partners.

If the facility wants to voluntarily discontinue the PPM for its own reasons or for other regulatory causes, the facility shall notify the RMNCH unit of the local health office and return the certificate according to the agreement/ MoU.

3.7. PPM RMNCH Quality Assurance Mechanism

The following are the suggested national RMNCAH quality assurance mechanisms for PPM facilities:

- Institution of standardized RMNCAH recording and reporting system for monitoring of RMNCAH services provided as per the national guidelines
- Institution of performance improvement system using facility data as per national standards
- Timely delivery and adequate supplies of drugs and other consumables to the PPM facilities
- Basic indicators to monitor the national RMNCAH activities (refer to updated RMNCH program manual/ guidelines)
- Staff training, mentoring, and supportive supervision will be conducted regularly by the national and regional RMNCAH program units in the PPM facilities to assure the quality and standardization of services provided
- Health care services are improved by conducting operational research activities in PPM health care facilities

3.8. Incentives

Incentives are usually most effective when they are not financial. PPM facilities tend to retain clients and gain recognition from the health system and national program by enhancing their service alternatives and servicing society. One indirect incentive the facilities receive is distribution of commodities by the national program free of charge. The program also offers health care provider training, mentoring, supportive supervision, and other general support to PPM health care facilities to improve case management and enhance patient satisfaction and confidence in the facility and its providers. This is an important perceived benefit for private health providers as consumer satisfaction is of key significance and determines future health-seeking behavior of their clients.

3.9.Procedure for Service Close-Out

See information on the Certification and Decertification Section 3.6 on page number 24.

4. Pharmaceuticals Supply Management System

In order to achieve sustainable RMNCH service implementation, it is essential to ensure that every health care facility involved in PPM has an adequate and uninterrupted supply of essential medicines, medical supplies, and commodities of assured safety, quality, and efficacy.

4.1. Integrated Pharmaceuticals Logistics System and PPM Health Care Facilities

According to the IPLS, PFSA will deliver pharmaceuticals directly to health facilities whenever the facilities are geographically accessible. For facilities that are inaccessible, the pharmaceuticals will be delivered to the WoHO, to 'woreda pass-through' health facilities, or to their catchment health centers or hospitals, from which the inaccessible facilities will collect them.

PPM sites eligible to provide RMNCAH services will follow the same IPLS strategy: retrieve RMNCH pharmaceuticals directly at PFSA hubs when feasible or at their catchment health facilities. PFSA is scaling up within the public health system, and ultimately all PPM health facilities will receive the pharmaceuticals directly from PFSA hubs.

Delivery and collection of pharmaceuticals are scheduled every two months for PPM sites that collect their pharmaceuticals directly from PFSA and every month for PPM sites that collect their pharmaceuticals from the WoHO and the nearby health facilities. PPM RMNCAH health facilities can have a maximum of four months' stock and a minimum of two months' stock at any given time. The pharmaceuticals that PPM health facilities get from PFSA are limited to those listed in the Guidelines for Programmatic and Clinical Management of RMNCAH. The RMNCAH commodities mainly accessed from the national program through the current national supply chain system for free are the following:

FP commodities:

- Condoms
- Oral contraceptive pills (OCPs)
- Injectable DMPA
- Implants

- Intrauterine devices
- Emergency contraceptives

MNCH commodities:

- Magnesium Sulphate
- Calcium Gluconate
- Vaccinations
- Ferrous Sulfate + Folic Acid (Fefol)
- Oxytocin
- Mefipristone
- Misoprostol
- Vitamin K inj.
- Vitamin A oil capsule,
- Oral rehydration solution (ORS)
- ORS with zinc
- TTC eye ointment

4.2. Medicine Consumption Recording, Reporting and Requisition Forms

PPM health facilities are required to use and routinely update the following IPLS formats to monitor and report pharmaceuticals consumption:

Bin Card

Each PPM health facility is required to regularly register all pharmaceuticals received and issued/dispensed to clients. Bin cards should be updated by facilities during any transactions.

HMIS RMNCH Registers

These registers contain all the necessary patient-related information and the type and quantity of RMNCH pharmaceuticals taken by the clients. The data should be aggregated on a monthly basis and can be used to quantify the future needs of the facilities.

Requisition Form and Private Clinic Monthly Report and Resupply Form

This form is used by PPM RMNCH health facilities accessing the RMNCAH commodities from nearby public health facilities. At the end of their reporting period, all PPM RMNCAH health facilities, which collect pharmaceuticals every two months, are required to fill and submit the RRF to their PFSA hub, copying their WoHO.

All PPM facilities that collect pharmaceuticals every month are required to fill and submit the Private Clinics Monthly Report and Resupply Form (PCMRRF) to their catchment health facility or WoHO.

4.3. Roles and Responsibilities of PPM Stakeholders on Pharmaceutical Supply Management

4.3.1. PPM Health Care Facilities

- Keep appropriate stock of pharmaceuticals at all times
- Regularly update the Logistic Management Information System (LMIS)
- Keep up-to-date records of stock on hand, reflecting consumption, loss/adjustments, etc.
- Follow storage guideline as per IPLS standard operating procedures to maintain the safety, quality, and efficacy of all pharmaceuticals
- Fill and submit RRFs on time as per the agreed reporting period and send copies of the RRFs to the health office with which they signed the MOU
- List the types and quantities of pharmaceuticals that have expired and promptly notify the entity responsible for disposal, as per the directive
- Ensure the rational use of medicines, including rational prescribing and proper counseling, in accordance with the APTS (Auditable Pharmaceutical Transactions and Services) system
- Dispense the pharmaceuticals received from PFSA to patients, for free
- During supervisory visits, open facilities and make all documentation available and implement recommendations

4.3.2. MoH and PFSA

- Conduct trainings on IPLS and other pharmaceutical supply management topics, and provide technical assistance to staff at private health facilities

- Provide the necessary pharmaceuticals and request and requisition forms.
- Conduct regular supportive supervision and give constructive feedback on the management of pharmaceuticals at PPM health care facilities
- Check the quality (completeness, accuracy, and timeliness) of each RRF and PCMRRF, and provide feedback to the PPM heath facilities
- Regularly update the list of PPM RMNCH facilities to reflect facilities that are new or withdrawing from the program
- Advocate for financial sources to strengthen and sustain the PPM program
- Participate in pharmaceuticals forecasting with PFSA

4.3.3. Local Health Offices (Town, Woreda, and Sub-city health offices and Zonal Health Office)

- Supervise stock management, ordering, and reporting functions of PPM health facilities
- Compile and aggregate data from health facilities' RRFs; submit the data to PFSA hubs and use them for managerial decisions
- Check the quality (completeness, accuracy, and timeliness) of RRFs and PCMRRFs, and provide feedback to PPM heath care facilities
- Make sure that pharmaceuticals are being used for the intended purpose
- Monitor the supply chain system performance (reporting rates, consumption rates, stock levels, storage conditions)

4.4 Regulatory Standards for PPM Facilities

The national RMNCAH program uses the PPM-RMNCH strategy to increase access to and utilization of the RMNCH services available in the private health sector. Hence, a private sector facility may engage in RMNCH activities using the PPM approach after reaching an agreement with its RHB or local health office by signing a MoU prepared by the National RMNCH unit of the MoH. (See template in Annex B.)

4.5 Documentation of Memorandum of Understanding

To determine if a PPM private facility is allowed to provide specific RMNCH services according to the national standards, all PPM-RMNCH sites must have a copy of the signed MoU in the clinic for regulatory purposes. Upon discontinuation of the designated services, the facility must return the original signed MoU to the RHB or appropriate local health office.

4.6 Assessing and Handling of RMNCH Commodities and Supplies

In PPM-RMNCH facilities, handling of essential RMNCH commodities is allowed for health professionals with IPLS/ LMIS training/ orientation. The storage, recording, and reporting of the drugs will be done according to the National Pharmaceutical Standards.

4.7 Staffing and Trainings for PPM Facilities

All PPM-RMNCH facilities must have appropriately trained health professionals at all times for direct delivery of health services and follow-up of patients in the program as per the RMNCH program standards.

4.8 Recording and Reporting of PPM Facilities

Any PPM health care facilities should keep records of all patient data on the national RMNCH registers and forms and report the data according to the national HMIS procedures.

RHBs and local health offices ensure that all PPM health care facilities are reporting to the respected administrative body during the reporting period.

4.9 Regulatory Issues Related to PPM-RMNCH Services

The national PPM-RMNCH program will provide all the standards and requirements for selection and implementation of RMNCH services in private facilities.

The regulatory body in turn needs to:

- Participate in the process of facility identification, assessment and selection for the program and ensure the proper implementation of the criteria while selecting new sites
- Be informed about the profiles of trained personnel from private health facilities
- Be aware of any MoU signed between the RHB and the private facilities for certification purposes
- Conduct regular inspection to ensure the program is running according to the MoU and the necessary standards are fulfilled as in the RMNCAH implementation guidelines
- Ensure PPM-RMNCH facilities compile and submit reports to respective RHB or local HMIS units
- Be informed with a sufficient time period of patient transfer and safe handover if the clinic is closing

5. Monitoring and Evaluation

Establishing a reliable M&E system is vital for monitoring the contribution of PPM health care facilities to the national RMNCAH program implementation. (The PPM RMNCAH program needs to have an M&E system that is harmonized with the national HMIS.) Supportive supervision and mentoring should be conducted at least two times per year considering the national RMNCAH guidelines.

5.1. Performance Monitoring

Regular performance monitoring for PPM RMNCAH sites should be done through mentorship and supportive supervision with the participation of all stakeholders at all levels.

Supportive Supervision

The overall aim of supportive supervision is the promotion of continuous improvement in service provision and program performance. Supportive supervision consists of observation, discussion, and provision of support and guidance. It is an important tool for proper implementation and assurance of quality of care in PPM-RMNCAH sites. Regular program supportive supervision should be carried out to address the quality of information and performance gaps. Both joint supportive supervision (JSS) and integrated supportive supervision (ISS) should be conducted regularly at all levels. After each supervisory visit, the supervisory team should share strengths, weaknesses and problems identified, and recommendations with the PPM health care facilities and responsible local health office. The findings should be used to improve the performance of the PPM sites or to decertify a facility that did not abide by the MoU and did not provide the service as per the national standard. Frequency of visits is based on the national standard.

Mentoring

To improve quality of RMNCH services, highly skilled health care professionals from public and private catchment hospitals or other health facilities should provide clinical mentoring to providers at PPM facilities. The purpose is to foster the ongoing professional development of mentees to deliver sustainable high-quality clinical care following the national standardized mentoring guideline.

5.2. Program Review

Program review should be done at various levels of program implementation and be carried out at each levels regularly with the involvement of different stakeholders and local health offices.

5.3. Recording and Reporting

Effective RMNCAH requires a standardized recording and reporting system. Recording and reporting is used to systematically monitor and evaluate client/patient progress and outcome as well as the overall program performance.

All PPM-RMNCAH sites should use the national standardized forms, registers, and reporting templates. Reporting must adhere to the MoH's national HMIS.

5.3.1. Tools for Recording and Reporting

National RMNCAH program reporting requires that collaborative activities be reported to the HMIS and all forms and registers throughout the country be standardized and aligned with the HMIS. All information concerning clients/patients should be completely and correctly recorded. Registers and reporting forms should be kept neatly and maintained properly.

RMNCAH recording and reporting tools are the following:

- ANC register
- Labor and delivery register
- PNC register
- HMIS center/clinic/hospital
- WoHO /ZHD / RHB quarterly service delivery report form
- Immunization and growth monitoring registers
- FP register
- Bin cards, RRF, drug dispensing register

5.3.2. Compilation and Submission of Quarterly Reports

The HMIS Quarterly Service Delivery Report forms have to be filled completely and correctly, in a timely manner. The data are generated mainly at the health facility level, and each site is expected to compile and submit a complete report to the responsible health office on timely basis. The facility is required to analyze the data and use the data to make informed decisions and improve service delivery.

5.3.3. RMNCAH Program Monitoring and Evaluation

Program sites must be treated like any public RMNCAH provider. The local health office must provide the facilities all the necessary M&E materials and reporting guidelines, and give them feedback as they would with any public facility.

5.4. Evaluation

The PPM-RMNCAH program should be evaluated as required, and good practices documented for future scale-up. Needed corrective actions should be taken to adopt performance improvement mechanisms available for public health programs.

5.5. Key Indicators for Program Monitoring for PPM-RMNCAH Sites

It is important to use a standard set of indicators to monitor RMNCAH implementation and the quality of the program in the private sector. (See Annex A for details.)

The following are key indicators for monitoring performance of RMNCAH programs. Individual facilities may adopt additional indicators for their own use.

- Capacity-building training and certification based on the national standard
- Number of PPM-RMNCAH sites implementing continuous quality improvement
- Number of model sites identified based on quality improvement standard
- Number of PPM-RMNCAH facilities that received regular mentoring and supportive supervision
- Number of PPM-RMNCAH facility labs that participated and qualified with External Quality Assurance programs

- Number of PPM-RMNCAH facilities without stock-out of medical supplies for specific programs
- Number of PPM-RMNCAH sites that provides comprehensive user-friendly adolescent health services

5.6. Operational Research

Operational research may be conducted to address specific questions related to the implementation of PPM-RMNCAH services. The MoH should closely work with partners and research institutes to generate evidence-based information on the implementation of PPM-RMNCAH programs to identify areas for improvement.

Annexes

A. PPM Health Care Facilities Monitoring and Evaluation Indicators

This document presents standard indicators that all PPM RMNCAH facilities must measure. The indicators are listed by type of service. These lists do not include additional indicators that facilities may collect for their own program management purposes.

Maternal Health Indicators

1. Contraceptive acceptance rate (CAR)
2. Immediate postpartum contraceptive acceptance rate (IPPCAR)
3. Antenatal care (ANC) coverage – First visit
4. Antenatal care (ANC) coverage – Four visits
5. Proportion of pregnant women tested for syphilis
6. Skilled delivery attendance
7. Stillbirth rate
8. Early postnatal care (PNC) coverage
9. Caesarean section rate
10. Number of women receiving comprehensive abortion care services
11. Institutional maternal deaths
12. Number of maternal deaths in the community
13. Number of teenage girls under19 years tested positive for pregnancy
14. Proportion of kebeles that are 'home delivery free'

Prevention of Mother-to-Child Transmission (PMTCT) Indicators

15. Percentage of pregnant, laboring, and lactating women who were tested for HIV and who know their results
16. Percentage of HIV-positive pregnant women who received antiretroviral therapy (ART) to reduce the risk of mother-to-child transmission during pregnancy, labor and delivery, and postpartum period
17. Proportion of HIV-exposed infants given a virological test

18. Percentage of infants born to HIV-infected women who were started on co-trimoxazole prophylaxis within two months of birth
19. Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis to prevent mother-to-child transmission
20. Percentage of partners of pregnant, laboring, and lactating women tested for HIV during the reporting month
21. Percentage of HIV-exposed infants receiving HIV confirmatory (antibody) test by 18 months

Child Health Indicators

22. DPT1-HepB1-Hib1 (Pentavalent first dose) immunization coverage (< 1 year)
23. DPT3-HepB3-Hib3 (Pentavalent third dose) immunization coverage (< 1 year)
24. OPV 3 (Oral Polio Vaccine third dose) immunization coverage (< 1 year)
25. Pneumococcal conjugated vaccine (PCV3) immunization coverage (< 1 year)
26. Rotavirus vaccine 2nd dose (Rota2) immunization coverage (< 1 year)
27. IPV (Inactivated Polio Vaccine) immunization coverage (< 1 year)
28. Measles (MCV1) immunization coverage (< 1year)
29. Measles second dose (MCV2) immunization coverage (12-24 months)
30. Full immunization coverage (< 1 year)
31. Proportion of infants protected at birth against neonatal tetanus
32. HPV 1 (Human Papilloma Virus vaccine (1st dose) immunization coverage (9-year-old girls)
33. HPV 2 (Human Papilloma Virus vaccine (2nd dose) immunization coverage (9-year-old girls)
34. Vaccine wastage rate
35. Early institutional neonatal death rate
36. Early neonatal death at community
37. Proportion of under 5 children with pneumonia received antibiotic treatment
38. Proportion of sick young infants treated for sepsis/VSD (Very Severe Disease)
39. Proportion of children treated for diarrhea

40. Proportion of low birth weight or premature newborns for whom Kangaroo Mother Care (KMC) was initiated after delivery
41. Proportion of asphyxiated neonates who were resuscitated (with bag and mask) and survived
42. Treatment outcome of neonates admitted to Neonatal Intensive Care Unit (NICU)

Nutrition

43. Percentage of low birth weight newborns
44. Proportion of children under 2 years of age who participated in Growth Monitoring and Promotion
45. Proportion of children under 5 years screened for acute malnutrition
46. Treatment outcomes for management of severe acute malnutrition in children under 5 years
47. Proportion of children age 6-59 months who received vitamin A supplementation
48. Proportion of children age 24-59 months dewormed
49. Proportion of pregnant and lactating women screened for acute malnutrition
50. Proportion of pregnant women who received iron and folic acid supplements

Pharmaceutical Indicators

51. Proportion of health facilities submitted timely RRF
52. Proportion of health facilities submitted complete and accurate RRF

B. Memorandum of Understanding (MoU) Template between the Regional Health Bureau (RHB) and Private/Non-public/ Health Facilities Providing RMNCAH Services

Operational Agreement made on RMNCAH services between RHB, _____ SCHO/Woreda health office and _____ MCH/ Obstetrics and Gynecology Specialty Center/ Hospital /Clinic.

The purpose of this MoU is to use the opportunity and effort of the private sector to contribute to the major indicators of RMNCAH programs to include Antenatal Care (ANC), labor and delivery, Basic Emergency Obstetrics and Newborn Care (BEmONC), Prevention of Mother to Child Transmission of HIV (PMTCT), immunization programs, child health, HIV Counselling and Testing (HCT), and family planning services.

Objective:

To implement comprehensive RMNCAH services in private health facilities (MCH centers, clinics, obstetrics and gynecology specialty clinics, and primary hospitals).

Roles and Responsibilities of the Parties:

Roles and responsibilities of the Regional/City Administration Health Bureau, respective Sub-city Health Office, and the PPM-RMNCH site are hereby presented below.

Whereas: **the Regional/City Health Bureau** (here after referred to as **RHB**) is a lead organization of preventive, promotive, and curative health services in accordance with the powers and authority vested in executive organs by regional states or city administrations to enable the RHB to expand its provision of **RMNCAH services** as well as to create policies and strengthen systems for all health care delivery.

Whereas: The RHB has identified_____ and that the facility, within the scope of this MoU, qualifies to provide _____services. Furthermore, the facility has potential to initiate other similar public health interventions of top priority to the RHB as may be important in the future.

Whereas: _____ has shown willingness to collaborate with the RHB in providing RMNCAH services and the facility agrees to perform and provide public health services as per the requirement of national program implementation guidelines and region-specific service provision procedures. Moreover, the facility has been assessed and identified to fulfill the minimum criteria needed to provide RMNCAH services as per the requirements of national/regional program policy and program implementation guidelines.

ARTICLE I

AGREED FUNCTIONs AND RESPONSIBILITIES OF REGIONAL HEALTH BUREAU

The RHB shall:

As per the National RMNCAH program implementation guideline and within the scope of agreement stated in this MoU.

1. Supply to these private health facilities RMNCAH commodities in accordance with the RMNCAH services agreed here.
2. Provide to these private health facilities RMNCAH program recording and reporting materials (registers and report formats) that are needed for the program.
3. In collaboration with local health offices assist in facilitating the engagement of these private health facilities in their respective catchment referral network.
4. In collaboration with partners, provide to the relevant health providers of the facility training on various RMNCAH topics.
5. Provide to these private health facilities relevant policy directives, standard program management and treatment guidelines, job aids, and IEC/BCC materials.
6. Conduct supportive supervision, mentoring, and site support to all program activities.
7. Engage these private health facilities in regional program performance review meetings.

ARTICLE II

AGREED FUNCTIONS OF THE PRIVATE HEALTH FACILITY SELECTED FOR THE RMNCAH SERVICES

PPM-RMNCAH sites:

1. Maintain the minimum infrastructure and human resource requirements needed for the delivery of agreed RMNCAH services and provide these services as per the national minimum programmatic requirement (clinical, pharmaceutical, and laboratory).
2. Ensure safety and proper management of drugs, test kits, and logistics/supplies secured from the RHB and its structure to provide the services agreed in this MoU.
3. Safeguard drugs, supplies, vaccines, HIV test kits, and other items provided to the facility and make sure that the drugs and supplies are not to be used for purposes other than for the intended program.
4. Ensure timely ordering and acquisition of supplies/logistics required to maintain minimum stocks availability and prevent intermittent supply as per the PPM-RMNCHA guideline.
5. Adhere to the national recording, information storage, and data compilation guidelines and as per the standard reporting requirement of each of these programs make timely report to the appropriate government health authority.
6. Agree to provide services with affordable and transparent costs (consultation and minimum service fees).
7. Inform the public of the availability of these services through different advertisement mechanisms.
8. Receive guidelines, technical assistance, training, and supportive supervision from RHB and its structure or from a partner delegated by the RHB to execute these activities.
9. Upon termination of the service contract, make sure to officially communicate with the RHB and its structure at least 3 months before expected time of service termination.

ARTICLE III

LIABILITY

1. Subject to the provision of this operational agreement, both parties are liable to perform the functions specified on this agreement and any damage or demand arising out of malfunction or failure to perform the functions shall be indemnified or be the sole responsibility of the doer of the action.

2. Failure to adhere to the terms and conditions of this agreement shall result in its cancellation.

ARTICLE IV

TERMINATION

THIS AGREEMENT SHALL BE TERMINATED UPON FAILURE OF EITHER PARTIES TO ADHERE TO THE MATTERS AGREED UPON HERE.

ARTICLE V

ENTRY INTO FORCE, REVIEW

This agreement:

1. Shall enter into force and be effective where and when it is duly signed by the contracting parties and shall remain effective as of ____/____/_____.
2. May be amended or terminated by exchange of note between the parties pursuant to the provision.
3. Disputes on interpretation of this agreement will be mutually solved with the view to successfully attain the goal and objectives of the implementation of the regional RMNCAH programs and on policy and system strengthening.
4. In witness the parties hereto intending to be bound by the term of this memorandum of understanding in a manner agreeable to both parties hereby sign the agreement at the place and on the date and year specified below:

For and on behalf of RHB	**For and on behalf of_____SCHO/WHO**
Name _____	: _____
Title _____	: _____
Signature _____	: _____
Place _____	_____
Date _____/_____/_____	Date _____/_____/_____

C. Health Facility Assessment Tool to Explore the Potential of the Private Health Sector to Provide Comprehensive RMNCAH Service Packages

August, 2018

INTRODUCTION

My name is _____

I am here to obtain information on your facility's readiness to provide reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services including sexually transmitted infections (STIs). The objective of this assessment is to identify and select health facilities that meet the requirements to engage in the Public-Private Mix (PPM) model to provide different RMNCAH service packages based on their level. We will gather the necessary information on the private facility's existing overall capacity, current service volume, and type and distribution of health care providers to provide the abovementioned services. The assessment finding, therefore, will provide RHBs and other key program stakeholders with valuable information that could be used in planning for the scaling up of PPM approaches in the private health sector.

I assure you that the individual questionnaires will not be shared with third parties and no labeling will be done.

Are you willing to participate in this assessment?

Yes ⟶ Continue

No ⟶ Thank the respondent and go to other HF

General comment in the checklist

Note for the interviewer: For Sections A–C, conduct the assessment with the owner or manager of the facility

Part A: General Information

Name of data collector: _____

Date of assessment: _____

Facility name: _____ Facility ID /Code_____

Date/month the facility established: _____

Contact person for the facility: _____

Telephone address: +251

(_____/_____)

Name of the interviewee _____Work Position _____

	Question	**Reply**			**Remark**
A1	Region/ City Administration:	1. Tigray 2. Afar 3. Amhara 4. Oromia	5. Gambella 6. Benshangul 7. SNNP 8. Diredawa 9. Ethiopian Somali	10. Harari 11. Addis Ababa	
A2	Town/City				
A3	Kefle Ketema [Woreda]				
A4	Kebele				
A5	House Number				
A6	Level of Facility	1. Lower/Primary Clinic 2. Medium Clinic 3. Gyn – Obs Specialty Clinic/Center	4. MCH Specialty Clinic/center 5. Primary Hospital 6. Specialty Hospital 7. Other level (specify)_____		

A7	Type of Facility	1. Private for-Profit 2. Private Nor-for-Profit FGAE, MSIE…etc.]	
A8	What is the profession of the owner or manager?	1. Health professional 2. Non-health professional	

INFORMATION ON PROGRAMS

	Assessment Question	**Answer**	**Skip**	**Remark**
	Note: Ask the interviewee if the facility provides the following services!			
A9	FP	1.Yes 2.No		
A10	ANC	1.Yes 2.No		
A11	PNC	1.Yes 2.No		
A12	Skilled delivery	1.Yes 2.No		
A13	BEmONC	1.Yes 2.No		
A14	Child health care	1.Yes 2.No		
A15	PMTCT	1.Yes 2.No		
A16	Laboratory	1.Yes 2.No		
A17	Ultrasound	1.Yes 2.No		
A18	Adolescent health	1.Yes 2.No		
A19	Inpatient service for pediatrics	1.Yes 2.No		
A20	Inpatient service for maternal conditions	1.Yes 2.No		

A21	CEmONC	1.Yes 2.No		
A22	STI diagnosis and treatment	1.Yes 2.No		

Infrastructure Assessment

	ASSESSMENT QUESTION	**REPLY**	**Remark**
A23	Does the facility have a renewed license for the stated Ethiopian calendar (EC) year? [check]	1.Yes 2.No	
A24	If it has a renewed license, which color is given for its quality? [check]	1.Green 2.Yellow 3.Red	
A25	Is the gate accessible for emergency ambulance transportation? [observe]	1. Yes, easily 2. Yes, with difficulty 3. No	
A26	Is there a common waiting area? [check]	1.Yes 2.No	
A27	Does the facility have a main electric supply from town? [check]	1.Yes 2.No	
A28	Does the facility have a functional back-up generator? [check]	1.Yes 2.No	
A29	Which kind of waste disposal system does the facility use? [check]	1. Incinerator 2. Dumping 3. Both 4. Other_____ 5. No disposal system	
A30	Does your facility have water supply for 24 hours? [ask]	1.Yes 2.No	

A31	Is the service for emergency conditions available 24/7? [ask]	1.Yes 2.No	

Human Resources

	Assessment QUESTION			**Remark**
	Note: Ask if the following categories of health professionals are working with the facility; if the answer is 'yes' specify the number of each	**REPLY**	**If " yes" How many**	
A32	Full-time obstetrician/gynecologist?	1.Yes 2.No		
A33	Full-time pediatrician?	1.Yes 2.No		
A34	Full-time general practitioner?	1.Yes 2.No		
A35	Full-time health officer?	1.Yes 2.No		
A36	Full-time nurses?	1.Yes 2.No		
A37	Full-time midwives?	1.Yes 2.No		
A38	Full-time lab technician?	1.Yes 2.No		
A39	Full-time radiologist?	1.Yes 2.No		
A40	Part-time obstetrician/gynecologist?	1.Yes 2.No		
A41	Part-time pediatrician?	1.Yes 2.No		
A42	Part-time general practitioner?	1.Yes 2.No		
A43	Part-time health officer?	1.Yes 2.No		
A44	Part-time nurses?	1.Yes 2.No		

A45	Part-time midwives?	1.Yes 2.No		
A46	Part-time radiologist?	1.Yes 2.No		
A47	Part-time lab technicians?	1.Yes 2.No		
A48	Anesthetic	1Yes 2.No		
A49	Scrub nurse	1Yes 2.No		

Part B

Note for the interviewer: The assessment from Part B to Part I is conducted after confirming the answers given to Questions A9-A26 [availability of the program]. Then the assessment should be done by visiting where the service is given together with the responsible service provider for that service.

B- Assessment for ANC service-Page 6

C- Assessment for PNC service-Page 8

D- Assessment for skilled delivery service-Page 11

E-Assessment for BEmONC service-Page 13

F- Assessment for child health serviec-Page16

G- Assessment for STI service-Page 19

H- Assessment for laboratory service-Page 18

I- Assessment for family planning service-Page 72

J- Facility Readiness Assessment/willingness-Page 19

1. Assessment for Focused Antenatal Care Service

	QUESTION	REPLY		Skip	Remark
B1	How is the service given regarding room arrangement? [*ask and observe*]	1. Separate room 2. Together with PNC 3. Together with EPI 4. Together with adult OPD 5. Together with delivery 6. Other_____			
B2	Does the room have a screen or separate room for physical examination? [observe]	1.Yes 2.No			
B3	Does the room have a hand-washing area? [observe]	1.Yes 2.No			
B4	Is there soap for hand washing? [observe]	1.Yes 2.No			
Service provision					
B5	Who is responsible to take vital sign for clients coming for ANC? [ask]	1.Nurse 2.Midwife 3.HO	4.GP 5.Specialist		
B6	Who is responsible for providing the ANC service? [ask]	1.Nurse 2.Midwife 3.HO	4.GP 5.Specialist		
B7	Is there a trained staff on focused ANC? [ask]	1.Yes 2.No			
Ask what components of focused ANC they provide for **ALL** clients on their **first visit [Questions B8 to B17]. Circle "yes" if the provider mentions it, and circle "no" if the provider doesn't mention it.**					
B8	Confirm pregnancy?	1.Yes 2.No			

B9	Check for hypertension/ measure blood pressure?	1.Yes	2.No		
B10	Check for anemia?	1.Yes	2.No		
B11	Check for pitting pedal edema?	1.Yes	2.No		
B12	Check body weight?	1.Yes	2.No		
B13	Check for syphilis with serological test?	1.Yes	2.No		
B14	Test for HIV?	1.Yes	2.No		
B15	Check for blood group?	1.Yes	2.No		
	Hepatitis vaccination				
B16	Provide TT vaccination if not fully vaccinated?	1.Yes	2.No		
B17	Prescribe iron-folate?	1.Yes	2.No		
Ask what components of the focused ANC they provide for **ALL** clients on their **revisit [Questions B18 to B25]. Circle "yes" if the provider mentions it, and circle "no" if the provider doesn't mention it**					
B18	Check for hypertension /measure blood pressure?	1.Yes	2.No		
B19	Check for anemia?	1.Yes	2.No		
B20	Check for pitting pedal edema?	1.Yes	2.No		
B21	Check body weight?	1.Yes	2.No		
B22	Check for growth of fetus with abdominal examination?	1.Yes	2.No		
B23	Check for the presentation of the fetus?	1.Yes	2.No		
B24	Provide TT vaccination if not fully vaccinated?	1.Yes	2.No		

B25	Prescribe iron-folate?	1.Yes 2.No		
Check/Observe for the presence of the following items in the room [**Questions B26 to B31].**				
B26	Functional BP apparatus?	1.Yes 2.No		
B27	Weight scale?	1.Yes 2.No		
B28	Fetal-stethoscope or Doppler?	1.Yes 2.No		
B29	Height board?	1.Yes 2.No		
B30	Functional refrigerator?	1.Yes 2.No		
B31	Ultrasound			
HMIS, IEC/BCC, guidelines/reference material, registration book, ANC client volume, reporting. Ask and check!!!				
B31	Is there a national guideline for focused ANC? *[ask and observe]*	1.Yes 2.No		
B32	Is there IEC/SBCC material on ANC? *[ask and observe]*	1.Yes 2.No		
B33	Is there a standardized national registration book/log book? *[ask and observe]*	1.Yes 2.No		
B34	How many total ANC visits registered? (The previous one EC year) *[observe and count]*	#_____		
B35	How many ANC4 visits registered? (The previous one EC year) *[observe and count]*	#_____		
B36	How many tests for HIV done? (The previous one EC year) *[observe and count]*	#_____		

B37	How many high-risk pregnancies documented? (The previous one EC year) *[observe the summary in the HMIS or count]*	#_____		
B38	Do you regularly report performance to the government? [*ask and observe for the copy]*	1.Yes 2.No		
Information on referral (inter- or intra-facility). Ask:				
B39	What will you do if you encounter HIV- positive pregnant women? [ask]	1. Link with PMTCT program inside the facility 2. Refer to government facility 3. Refer to private facility 4. Simply make appointment for next visit 5. Other_____		
B40	Do you refer pregnant women for HIV testing? [ask]	1.Yes 2.No		
B41	Do you refer pregnant women for TT vaccination? [ask]	1.Yes 2.No		

2. Assessment for Postnatal Care Service

	QUESTION	REPLY	Skip	Remark
C1	How is the service given regarding room arrangement? [*ask and observe]*	1) Separate room 2) Together with ANC 3) Together with EPI 4) Together with adult OPD 5) Together with delivery 6) Other_____		

C2	Does the room have a screen or separate room for physical examination? [observe]	1.Yes 2.No		
C3	Does the room have a hand-washing area? [observe]	1.Yes 2.No		
C4	Is there soap for hand washing? [observe]	1.Yes 2.No		

Postnatal Care Service – Maternal Component

For Question C5 to C12, ask the service provider what specific services and check-ups including advice he/she provides for women coming for PNC. Give adequate time to mention and check if the items in the list below were mentioned. Circle "yes" if mentioned, and circle "no" if not mentioned.

C5	Asking for abnormal vaginal bleeding?	1.Yes 2.No		
C6	Asking for fever?	1.Yes 2.No		
C7	Asking for foul-smelling lochia or vaginal discharge?	1.Yes 2.No		
C8	Problems related to breast feeding?	1.Yes 2.No		
C9	Advice on exclusive breast feeding?	1.Yes 2.No		
C10	Counselling on family planning?	1.Yes 2.No		
C11	Advice on nutrition and self-care?	1.Yes 2.No		
C12	Advice on hygienic practices?	1.Yes 2.No		

HMIS, IEC/BCC, guidelines/ reference material , service, registration on HMIS and reporting volume for PNC

C13	Is there a national guideline for PNC? [*ask and check]*	1.Yes 2.No		
C14	Is there standardized HMIS for PNC service? [*ask and check its contents*]	1.Yes 2.No		
C15	How many clients received PNC within 24 hours? (The previous one EC year) [*ask and check the report or count on the registration book]*	#_____		
C16	How many of the total PNC visits are done within the first week post-delivery (The previous one EC year) [*ask and check the report or count in the registration book]*			
C17	How many maternal postpartum problems detected (The previous one EC year) [*ask and check the report or count in the registration book*]	#_____		
C18	Do you make regular reporting of service statistics to the local government health bureau? [*ask and check for any copy]*	1.Yes 2.No		
C19	Is there any IEC/SBCC material? [check]	1.Yes 2.No		
C20	Is it common to have PNC dropouts? [ask]	1.Yes 2.No		
C21	Is there PNC for mothers who need special care? E.g., Perinatal loss			

Postnatal Care Service – Neonatal Care [Essential Neonatal Care] – **[Note: Visit the room for the neonatal care component if it is different from the maternal component]**				
C22	Who is responsible for neonatal care coming for PNC? [ask]	1.Nurses 2.Midwife 3.HO 4.GP 5.Pediatrician		
C23	Are there trained staff on Essential Neonatal Care? [ask]	1.Yes 2.No		
C24	Do you provide immunization for BCG/Polio? [ask]	1.Yes 2.No		
C25	If the answer is 'yes' for the above question, ask where the facility get the vaccines?	1. From local government health bureau 2. From government facilities 3. Other _____		
C26	What will you do if a neonate presents with neonatal sepsis?	1. Treat with parenteral antibiotics in the facility 2. Refer to pediatrician 3. Treat with antibiotics syrup 4. Other _____		
Ask what other specific neonatal care check-ups and advice he/she provides to the neonate coming for PNC and check whether the items in Questions C26 to C31 are mentioned.				

C27	Does mother breast feed or does she have a bf problem?	1.Yes 2.No		
C28	Ask and check for fever? [check also for presence of thermometer]	1.Yes 2.No		
C29	Check for umbilical stamp?	1.Yes 2.No		
C30	Ask and check for yellowish discoloration?	1.Yes 2.No		
C31	Advise to keep the neonate warm?	1.Yes 2.No		
C32	Advise on exclusive breast-feeding until 6 months?	1.Yes 2.No		
More assessment on feeding the newborn baby…				
C33	Is it common to encounter neonates on replacement commercial formula milk? [*ask and take his words*]	1. Yes 2. No		
C34	Do you believe that there are formula milks that adequately replace breast milk? [ask]	1.Yes 2.No		
C35	What do you commonly do if mothers' report they do not want to breast feed their neonate? [ask]	1. Advise to feed another option 2. Educate her on breast milk; dangers of formula/replacement feeding and reinforce to feed the neonate only by breast feeding		

		3. Other _____		
C36	Do you check weight of neonate? [*ask and check for appropriate weight scale]*	1.Yes 2.No		
HMIS, guidelines, IEC/SBCC, registration books, service volume: material. Ask and check.				
C37	Is there a national guideline for Essential Neonatal Care (ENC)? [ask and check]	1.Yes 2.No		
C38	Is there a standard HMIS for ENC? services? [ask and check]	1.Yes 2.No		
C39	How many total ENC visits registered? (The previous one EC year)	#_____		
C40	How many neonatal problems reported? (The previous one EC year)	#_____		
C41	If EPI service is given, how many neonates vaccinated? (The previous one EC year)	#_____		
C42	Is there any IEC/SBCC material for the service? [check]	1.Yes 2.No		

3. Assessment for Skilled Delivery

	QUESTION	REPLY	Skip	Remark
D1	Do you have a separate room for delivery service? [visit the room]	1.Yes 2.No		
D2	Is there a delivery coach? [observe]	1.Yes 2.No		
D3	Does the room have a hand-washing area? [observe]	1.Yes 2.No		
D4	Is there soap for hand washing? [observe]	1.Yes 2.No		
D5	Does the room have a window/s? [observe]	1.Yes 2.No		
D6	Is there a functional toilet inside the room or adjacent to the room? [observe]	1.Yes 2.No		
D7	Are there three buckets labeled with 5% chlorine, detergent, and water? [observe]	1.Yes 2.No		
D8	Is there a safety box in which to put used needles? [observe]	1.Yes 2.No		
D9	Do you have a labeled waste bin? [check]	1.Yes 2.No		
D10	Do you have prepared/ sterilized delivery kits? [observe and check the contents]	1.Yes 2.No *Contents: [Cord tie, 01 artery forceps, 02 pairs of scissors, 02 pairs of surgical glove, gauze pack, sterile drapes/area cover]*		
D11	Do you use a partograph to follow the progress of labor? [observe/check]	1.Yes 2.No		
D12	Do you use oxytocin? [check in the client card]	1.Yes 2.No		
D13	Do you apply TTC eye ointment to the neonate after birth? [check in the client cared]	1.Yes 2.No		
D14	Do you provide Vitamin K? [check]	1.Yes 2.No		
D15	Is there a fetal stethoscope? [check]	1.Yes 2.No		
D16	Is there a fetal weighing scale? [check]	1.Yes 2.No		

D17	When do you discharge mothers Who had an uncomplicated delivery? [ask]	1. As soon as possible 2. Within 0-6 hrs. 3. 6-24 hrs 4. After 24 hrs. 5. Other_____		
D18	When do mothers who gave birth in your facility start feeding their newborn baby? [ask]	1. Immediately/ within one hour 2. Whenever the mother is comfortable 3. After client discharged home 4. Other _____		
D19	What do the mothers feed to their newborn babies? [ask]	1. Breast milk 2. Formula milk 3. Other _____		
D20	Is there a time after which you start feeding the newborn with replacement formula milk? [ask]	1.Yes 2.No		
D21	Do you have a breast-feeding corner? [ask and check]	1.Yes 2.No		
D22	Which vaccinations do you provide before you discharge the neonate? [ask]	1. Polio 2. BCG 3. Both 1 and 2 4. No vaccination		
D22	Is there a separate neonatal corner equipped with essential materials?	1.Yes 2.No		
D23	Is there an NICU?	1.Yes 2.No		
D24	What kind of sterilization techniques do you use? [ask and check]	1. Steam sterilizer 2. Boiling 3. Both 1 and 2 4. Other_____ ___		
HMIS, IEC/SBCC, guidelines/standards, service volume [Check for the presence and count all if necessary]				
D25	Is there any infection prevention guideline?	1.Yes 2.No		
D26	Is there the standard HMIS for skilled delivery?	1.Yes 2.No		

D27	How many total skilled deliveries registered? (The previous one EC year)	#_____		

Assessment for BEmONC service

NB: This assessment should not be done at lower-level clinics

Note for the interviewer: Components of the service:

- *Instruments delivery;*
- *Neonatal resuscitation;*
- *Managing PPH with oxytocic drugs and IV fluids;*
- *Managing pre/eclampsia with MgSO4;*
- *Manual removal of placenta; evacuation of retained Conceptus Tissue;*
- *Treatment of sepsis with IM/IV antibiotics*

	QUESTION	**REPLY**		**Skip**	**Remark**
E1	Do you have a separate room for BEmONC service? [ask and check]	1.Yes 2.No			
E2	Who is responsible for managing difficult deliveries with instrumental delivery? [ask]	1. Nurses 2. Midwives 3. HO	4. GP 5. Gynecologist		
E3	Is service provider/s trained on BEmONC? [ask]	1.Yes 2.No			
E4	Does the room have a hand-washing area? [observe]	1.Yes 2.No			
E5	Is there soap for hand washing? [observe]	1.Yes 2.No			
E6	Is there a functional toilet inside the room or adjacent to the room? [observe]	1.Yes 2.No			

E7	Are there three buckets labeled with 5% chlorine, detergent, and water? [observe]	1.Yes 2.No		
E8	Is there a safety box in which to put used needles? [observe]	1.Yes 2.No		
E9	Do you have labeled waste bin? [check]	1.Yes 2.No		
E10	Do you have prepared/ sterilized BEmONC delivery kits? [observe and check the contents in one kit] *Contents: [One sponge forceps; One needle holder; One stitch scissor; One dissecting forceps; One vaginal speculum]*----	1. Yes for all 2. Yes with partial materials 3. No		
E11	Do you use a partograph to follow the progress of labor? [ask and check availability]	1.Yes 2.No		
E12	Do you use misoprostol to manage and prevent PPH? [ask and check availability]	1.Yes 2.No		
E13	Do you manage pre/eclampsia with MgSO4? [ask and check availability]	1.Yes 2.No		
E14	Do you use forceps to support difficult deliveries? [ask and check availability]	1.Yes 2.No		
E15	Do you apply vacuum pressure to support difficult deliveries? [ask and check for availability]	1.Yes 2.No		

E16	Do you manage infections with parenteral antibiotics? [ask and check availability]	1.Yes 2.No		
E17	Do you conduct E&C for retained products of conception? [ask and check for E&C set]	1.Yes 2.No		
E18	Do you perform manual removal of placenta?	1.Yes 2.No		
E19	Do you have a "heating corner" for neonates? [ask and check]	1.Yes 2.No		
E20	Do you have oxygen to assist neonatal resuscitation? [ask and check]	1.Yes 2.No		
E21	Is there suction machine to assist neonatal resuscitation?	1.Yes 2.No		
E22	Do you have neonatal resuscitation kits?	1.Yes 2.No		
E23	Do you use laryngoscope for neonatal resuscitation? [ask and observe]	1.Yes 2.No		
E24	Do you have an endotracheal tube to intubate in case of neonatal resuscitation? [ask and observe]	1.Yes 2.No		
E25	When do you discharge mothers who gave birth without complications? [ask]	1) As soon as possible 2) Within 6 hrs. 3) 6-24 hrs. 4) After 24 hrs. 5) Other_____		
E26	When do mothers start feeding their newborn baby? [ask]	1) Immediately/ within one hour 2) Whenever the mother is comfortable 3) After client discharged home		

		4) Other _____		
E27	What do the mothers feed to their new born babies? [ask]	1) Breast milk 2) Formula milk 3) Other _____		
E28	Is there a time you start feeding the new born with replacement formula milk? [ask]	1.Yes 2.No		
E29	Do you have breast feeding corner? [ask and check]	1.Yes 2.No		
E30	Which vaccinations do you provide before you discharge the neonate? [ask]	1) Polio 2) BCG 3) Both 1 and 2 4) No vaccination		
E31	What kind of sterilization techniques do you use? [ask and check]	1) Steam sterilizer 2) Boiling 3) Both 1 and 2 4) Other_____		

HMIS [Check for the presence of guidelines/standards, HMIS registration books, and service volume for questions below.]

E32	Is there a national guideline for BEmONC? [check]	1.Yes 2.No		
E33	Is there the standard HMIS for skilled delivery? [check]	1.Yes 2.No		
E34	How many total skilled deliveries provided? (The previous one EC year)	#_____		
E35	How many total instrumental deliveries registered? (The previous one EC year)	#_____		
E36	How many C Sections done (The previous one EC year)	#_____		

E37	How many PPH is managed with misoprostol? (The previous one EC year)	#_____		
E38	How many pre/eclampsia cases managed with $MgSO_4$? (The previous one EC year)	#_____		
E39	Have you ever referred mothers for a blood transfusion? [ask]	1.Yes 2.No		
E40	How many referrals did you made for a blood transfusion? (The previous one EC year) [ask and check]	#_____		
E41	How many referrals done for operative delivery (The previous one EC year)	#_____		

4. Assessment for Child Health Services

	QUESTION	**REPLY**	**Skip**	**Remark**
F1	Is there a separate OPD for children under 5? [check]	1.Yes 2.No		
F2	Does the room have a hand-washing area? [check]	1.Yes 2.No		
F3	Is there soap for hand washing? [check]	1.Yes 2.No		
F4	Is there a rehydration corner? [check]	1.Yes 2.No		
Child Health Service [the questions are related only to under-5 children]				
F5	Who attends under-5 consultations? [ask]	1.Nurse 2.Midwife 3.HO		

		4.GP 5.Pediatrician		
F6	Is the service provider trained on IMNCI? [ask]	1. Yes 2. No		
F7	Do you prescribe ORS for diarrhea cases? [ask]	1. Yes for all 2. Yes for some 3. No		
F8	Do you prescribe zinc for diarrheal cases? [ask]	1. Yes for all 2. Yes, sometimes 3. No		
F9	What will you do for children with moderate and severe dehydration? [ask]	1. Admit and rehydrate 2. Refer to higher center 3. Prescribe ORS to be taken at home 4. Other_____		
F10	How do you treat cases of ARI/Pneumonia in under-5s? [ask]	1. Provide antibiotics [amoxicillin] 2. Provide antipyretics only 3. Other_____		
F11	Do you always check for malaria in those presenting with fever? [ask]	1.Yes 2.No		
F12	How do you manage or treat those with confirmed uncomplicated malaria cases as your first-line drug? [ask]	1. Treat with artemisinin containing antimalarial drug 2. Treat with quinine 3. Refer to higher institutions		

		4. Other_____		
F13	Do you provide routine vaccination service? [ask]	1.Yes 2.No	If no, skip to # F18	
F14	Do you have a cold chain refrigerator? [check]	1.Yes 2.No		
F15	Is the temperature, where the vaccines stored between 2^{o} and 8^{o} C? [check]	1.Yes 2.No		
F16	Are there items other than drugs stored with the vaccine? [check]	1.Yes 2.No		
F17	Do you monitor the temperature twice daily? [check if recorded]	1.Yes 2.No		
F18	Is there a functional thermometer? [check]	1.Yes 2.No		
F19	Is there a weight scale? [check]	1.Yes 2.No		
F20	Is there a height board? [check]	1.Yes 2.No		
F21	Do you always assess the nutritional status of the child? [ask]	1.Yes 2.No	If 'no' skip to F23	
F22	If 'yes' how do you assess the nutritional status? [ask]	1. Taking weight, height, and compare with the standard curve 2. Using MUAC 3. Just by looking 4. Other_____		

What advice do you provide for attendants presenting infants for medical attention? *[ask and check whether the provider mentions the following items]*				
F23	Exclusive breast feeding until 6 months?	1. Yes 2. No		
F24	Continue breast feeding until 2 years?	1. Yes 2. No		
F25	Start complementary feeding at 6th month?	1. Yes 2. No		
F26	Immunization continued as per schedule?	1. Yes 2. No		
F27	Hygiene and sanitation?	1. Yes 2. No		
HMIS, guideline, IEC/SBCC, HMIS registers, service volume [ask and check the presence and count if necessary]				
F28	Is there a national guideline for IMNCI? [check]	1.Yes 2.No		
F29	Is there a standard HMIS for child health? [check]	1.Yes 2.No		
F30	Is there a standard nutritional growth monitoring curve [NCHS or WHO]? [check]	1.Yes 2.No		
F31	How many total under-5 children consultations made? (The previous one EC year)	#_____		
F32	How many total vaccinations done? (The previous one EC year)	#_____		
F33	How many children vaccinated fully? (The previous one EC year)	#_____		

F34	Do you regularly report performance to the local government health office? [check the copy]	1. Yes 2. No		

5. Assessment for Sexually Transmitted Infection Service

	QUESTION	REPLY	Skip	Remark
G1	Who is responsible for diagnosing and managing STI cases? [ask]	1. Nurses 2. Midwifes 3. HOs 4. GPs 5. Specialists		
G2	How do you provide the service? [ask and check]	1. Integrated with other services [adult OPD] 2. Through special/separate room 3. Referred to focal person 4. Other _____		
G3	Is the responsible provider trained on the national STI case management guidelines? [ask]	1.Yes 2.No		
G4	Do you use laboratory confirmation for all STI cases? [ask]	1.Yes 2.No		
G5	Do you provide HCT for STI cases? [ask]	1. Yes for all 2. Yes for some cases 3. No		
G6	Do you have STI treatment kits in the facility? [ask]	1. Yes 2. No	If no skip to # G9	
G7	If 'yes,' where do you get the kits? [ask]	1. From government		

		2. From NGO 3. From private for profit markets 4. Other_____		
G8	Do you send partner invitation for all STI cases? [ask and check for format]	1. Yes for all 2. Yes for some with defined partners 3. Not at all		
G9	Do you plan follow-up for treated cases? [ask and check]	1. Yes 2. No		
HMIS, guideline, HMIS registers, IEC/SBCC, client volume [note: ask, check, and count if necessary]				
G10	Is there a national guideline for STI case management?	1.Yes 2.No		
G11	Is there a standard HMIS for the service?	1.Yes 2.No		
G12	How many STI cases did you see in the previous one EC year?	#_____		
G13	What is the most common STI documented in the HMIS?	1. Urethral discharge 2. Vaginal discharge 3. Genital ulcer 4. Genital swelling 5. Other_____		
G14	How many of the above STI cases were tested for HIV? [The previous one EC year]	#_____		
G15	How many partner invitations are done for STI cases treated? (the previous one EC year)?	#_____		

6. Assessment of Laboratory Services

	QUESTION	REPLY	Skip	Remark
H1	Do you test for malaria with BF? [ask]	1.Yes 2.No		
H2	Do you do a urine test for glucose? [ask]	1.Yes 2.No		
H3	Do you have a urine test for protein? [ask]	1.Yes 2.No		
H4	Do you have a serologic test for syphilis? [ask]	1.Yes 2.No		
H5	Do you have a test for blood group?	1.Yes 2.No		
H6	Do you have a test for anemia with Hgb or HCT? [ask]	1.Yes 2.No		
H7	Do you have a penile model to demonstrate how to use a condom correctly? [ask]	1.Yes 2.No		
H8	Do you have HIV test kits? [ask and check]	1.Yes 2.No		
H9	Does your laboratory test liver function? [ask]	1.Yes 2.No		
H10	Does your laboratory test renal function? [ask]	1.Yes 2.No		
H11	Is there a safety box in the room? [check]	1.Yes 2.No		
H12	Is there a face mask for the technician? [ask and check]	1.Yes 2.No		
H13	Is there running water in the room? [ask and check]	1.Yes 2.No		
H14	Is there a water sink for washing slides? [ask and check]	1.Yes 2.No		
H15	Is there a functional refrigerator for storing reagents? [ask and check]	1.Yes 2.No		

7. Assessment for Family Planning Service

	QUESTION	REPLY	Skip	Remark
I-1	Who provides the FP service? [ask]	1. Nurses 2. Midwifes 3. Hos 4. GPs 5. Specialists		
I-2	Is the responsible provider trained on comprehensive contraception? [ask]	1. Yes 2. No		
I-3	In what room arrangement do you provide the FP service? [ask and check]	1. Integrated with other services [adult OPD] 2. Through special room 3. Referring to focal person 4. Other _____		
I-4	Which type of FP methods do you provide? [ask]	1. Short-acting [OCP, injectable, EOC, condom] 2. Long-acting [implants and IUCD] 3. Both short-acting and long-acting 4. All methods including permanent [BTL/NSV]		
I-5	Do you offer HCT?	1.Yes 2.No		
I-6	Where do you get commodities for FP services? [ask]	1. From government facility/office 2. From private pharmacy/agency 3. From NGOs 4. Other _____		
HMIS, guideline, standards, job aids, IEC/SBCC, service volume [note: ask, check and count if necessary]				

I-7	Is there an FP national guideline?	1.Yes 2.No		
I-8	Is there a REDDI framework for FP counselling?	1.Yes 2.No		
I-9	Is there the standard HMIS for the service?	1.Yes 2.No		
I-10	How many FP clients served? (The previous one EC year)	#_____		
I-11	How many of the clients given OCP as FP method? (The previous one EC year)	#_____		
I-12	How many of the clients given Depo-Provera? (The previous one EC year)	#_____		
I-13	How many of the clients given implants or IUCD? (The previous one EC year)	#_____		

8. Assessment of Facility Readiness

[Note for the interviewer: This is the last part of the assessment of the readiness of the facility to work in PPM. This part of the interview should be done with the owner/manager of the facility, whom you interviewed for the first three parts.]

	QUESTION [all are asking…]	**REPLY**	**Remark**
J1	Do you know that the MoH is planning to improve the engagement of private health facilities in the overall health sector?	1.Yes 2.No	
J2	Have you heard of PHSP?	1.Yes 2.No	
J3	PHSP is working as a catalyst to improve the engagement and collaboration between private clinics and government, including promoting their services and access to public commodities. Are you interested in working with PHSP, PFSA and PHFAs?	1.Yes 2.No	
J4	Facilities will have to make formal agreements with PFSA and others; this includes agreeing to report supply management and service statistics. Are you ready to do this?	1.Yes 2.No	
J5	One of the important requirements for being selected for this program is to assign a focal person for the programs to be started. Are you willing to do this?	1.Yes 2.No	
J6	PHSP will work to improve the technical knowledge and skills of the providers through different trainings. Are you willing to send staff to such trainings?	1.Yes 2.No	

J7	PHSP with the PHFAs and others is working to improve quality of services through supportive supervision and mentoring. Are you willing to have this support?	1.Yes 2.No	
J8	Do you have a strategy to retain staff, particularly trained staff?	1.Yes 2.No	
J9	Which of the following business strategies do you practice?	1. Getting maximum from few consultations by charging high fees 2. Getting maximum by making fees less and attracting more clients 3. Other_____	
J10	Are you ready to accept if there is a chance of subsidizing/decreasing costs, to get a greater patient flow to your facility?	1. Yes 2. No	
J11	Are you willing to subsidize some costs by getting free supplies from PFSA as well as promoting your services?	1. Yes 2.No	
J12	One type of information this assessment requires is to know the cost of your basic services, which we will consider in our planning. Are you willing to provide this information?	1. Yes 2. No	If "no," end the discussion by providing a thankful respect.

Note for the interviewer: If yes, ask the cost of the following based on the services provided in your assessment:		
J13	Client card for ANC:_____ETB	
J14	Client card for delivery service: _____ETB	
J15	Client card for OPD:_____ETB	
J16	Client card for child health: _____ETB	
J17	Client card for family planning: _____ETB	
J18	Skilled delivery service: _____ETB	
J19	Instrumental delivery: _____ETB	
J20	C/Section: _____ETB	
J21	Blood group test: _____ETB	
J22	Hemoglobin: _____ ETB	
J23	VDRL/syphilis test: _____ETB	
J24	Testing for HIV: _____ETB	
J25	Applying misoprostol for PPH: _____ETB	
J26	Inpatient stay for one night: _____ ETB	
J27	Cost for inserting IUCD_____ETB	
J28	Cost for inserting Implanon/Nexplanon_____ ETB	

J29	Cost for removing Implanon/Nexplanon_____ETB	

Note for the interviewer: Please provide your appreciation and thanks for all the information provided and the time you have spent with all the owner, manager, providers, and focal person and head before leaving the facility!

Finally-DON'T forget……Make sure you have completed the questionnaire!!!!!!!!!!

For and on behalf of_____Specialty center/Hospital

Name _____

Title _____

Signature _____ _____

Place _____

Date _____/_____/_____

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