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PROGRAM TRANSITION AND SUSTAINABILITY PLAN

Private Health Sector Project

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PROGRAM TRANSITION AND SUSTAINBILITY PLAN

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ACRONYMS

ART	Antiretroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
EMLA	Ethiopia Medical Laboratory Association
EPHI	Ethiopian Public Health Institute
EQA	External Quality Assurance
FMOH	Federal Ministry of Health
FMHACA	Food, Medicine and Health Care Administration and Control Authority
FP	Family Planning
GOE	Government of Ethiopia
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IPLS	Integrated Pharmaceutical Logistics System
MAPPP-E	Medical Association of Physicians in Private Practice
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
PFSA	Pharmaceuticals Fund and Supply Agency
PHFA	Private Health Facility Association
PHSP	Private Health Sector Project
PPM-DOT	Public Private Mix - Directly Observed Treatment
PMTCT	Prevention of Mother to Child Transmission
PPP-H	Public Private Partnership for Health
QA	Quality Assurance
RHB	Regional Health Bureau
RMNCH	Reproductive, Mother and Neonatal Child Health
SNNP	Southern Nations, Nationalities and Peoples
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
THO	Town Health Office
USAID	United States Agency for International Development

1. INTRODUCTION

1.1 PROJECT OVERVIEW

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

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

To achieve these objectives, PHSP works in collaboration with the Government of Ethiopia (GOE), specifically the Federal Ministry of Health (FMoH) and its agencies, and the private health sector and its associations. The project operates in Addis Ababa, Amhara, Afar, Benishangul Gumuz, Dire Dawa, Harari, Gambela, Oromia, SNNPR, and Tigray regions. The public health programs of importance include Public Private Mix - Directly Observed Treatment (PPM-DOT); tuberculosis (TB); comprehensive HIV/AIDS including HIV Counselling and Testing (HCT), anti-retroviral treatment (ART) and preventing mother-to-child transmission (PMTCT); reproductive maternal, neonatal, and child health (RMNCH); family planning (FP); sexually transmitted infections (STIs); and Malaria. PHSP activities are designed with sustainability built-in so that over time the project transitions functions to local institutions to ensure sustained services beyond the project life. Every phase of implementation supports ownership and strengthening sustainable capacity to achieve the GOE's goals to mitigate the impact of diseases of public health importance.

1.2 TRANSITION AND SUSTAINABILITY PLAN

This document describes PHSP's roadmap to transition, in a phased approach, key responsibilities and activities to public and private sector partners for continued expansion of services provided by private sector providers, improvement of service quality, and the conduction of continuous technical support and oversight of private sector facilities by the GOE after the end of the project. The sustainability plan is designed to combine short- and long-term strategies to achieve project goals and incorporate activities into each unit's yearly plan, using lessons from past experience and building on past interventions.

The objectives of the transition and sustainability plan are:

- To describe PHSP's overall sustainability and transition strategy
- To describe how key project areas will transition to local partner responsibility and be sustained over time. This includes advocacy for private health sector, regulation of health

services and product delivery, provision of key health clinical services including comprehensive HIV, TB, Malaria, RMNCH, FP, STI; and private health sector access to resources

For the purposes of PHSP, and in consideration of the current landscape in Ethiopia, **transition** is defined as the process of **providing technical assistance (TA) and resource support** to transfer project tasks to local institutions within the project period. This will enable progress towards the delivery of integrated health services during the implementation phase of the project and sustain those activities after project phase out. Sustainability is regarded as the ultimate aim of the project to build capacity of Ethiopian institutions and individuals to effectively provide good governance and manage processes and operations for the delivery of health services and products beyond the project with minimal external donor support. It is to be noted that sustainability is not an all or nothing proposition. There are many factors that contribute toward having a process become sustainable over time. For a process to transition from being 100% dependent on external, subsidized support to being 100% locally owned, implemented, and financed may take many years that cover multiple phases of donor support. In recognition of this, PHSP's focus is to make progress toward sustainability on all dimensions, while recognizing that full sustainability may not be achieved during the life of the project.

2. TRANSITION AND SUSTAINABILITY STRATEGY

2.1 PRINCIPLES AND APPROACHES FOR SUSTAINABILITY

Underpinning PHSP's transition and sustainability strategy is using a health systems strengthening approach to ensure enhanced capacities and alliances of public health sector stakeholders and private sector health players, so that the private health sector can actively and collaboratively deliver priority health care services. This approach combines strengthening individual and institutional capacities, systems, governance and operations to enhance the role of the private health sector in clinical and non-clinical health services. This will ultimately improve access to comprehensive HIV services, diagnosis and treatment, TB, RMNCH, FP, early diagnosis and treatment of STIs, malaria and other high impact public health interventions.

Based on this principle, the project expanded its geographic scope to ten regions in Year II. This includes an increase in the number of targeted facilities from 330 in Year I to more than 390 in Year II and III. Additionally, the project's program portfolio expanded to enable targeted private facilities to offer RMNCH in addition to TB, HIV/AIDS, HCT, ART, PMTCT, STI, and Malaria. Table 1 presents the current regional distribution of private health facilities by health services.

Central to PHSP's approach building partnerships and strategic alliances between public health sector stakeholders and the private health sector. From project inception, PHSP has relied on, and will continue to facilitate, close collaboration with the FMOH, regional health bureaus (RHBs) and Food, Medicine and Health Care Administration and Control Authority (FMHACA), and the private health sector.

Table 1: Current Regional Distribution of Private Health Facilities by Health Services

Regions	# of Facilities	HCT	ART	PMTCT	TB			FP	STI	Malaria
					All	Tx	Dx			
Addis Ababa	61	59	26	23	34	33	1	20	27	0
Afar	20	15	0	0	15	15	0	0	0	15
Amhara	116	79	20	16	101	77	24	30	22	37
Benishangul Gumuz	18	12	0	0	18	12	6	0	0	18
Dire Dawa	19	13	3	0	15	13	2	5	4	15
Gambela	12	12	0	0	12	12	0	0	0	12
Harari	6	5	1	0	6	5	1	5	1	0
Oromia	117	86	14	17	112	82	30	33	20	39
SNNP	55	30	1	6	37	28	9	18	3	30
Tigray	66	29	10	7	29	24	5	17	10	48
Total	490	**340**	**75**	**69**	**379**	**301**	**78**	**128**	**87**	**214**

This model is expanded to include Private Health Facility Associations (PHFAs) as a key facilitator to expand delivery of quality health services and products. The role of brokering agreements between private facilities and the public sector, along with quality assurance (QA) for public health services delivered through private clinics, will be gradually transferred from PHSP to the PHFAs. Given the mandates of FMOH, RHBs and FMHACA in national health system strengthening measures and their stake in this effort, the project will continue to foster these strategic alliances, and transfer capacities to continue these relationships The project has already seen positive impact in the delivery of quality health services through the private facilities. As shown below in Table 2, PHSP has already provided technical support to PHFAs so that they are able to provide clinical mentoring to facilities and contribute to increasing accessibility of priority health services.

Table 2: Number of Health Services from Facilities Mentored by PHSP and PHFAs[1]

Description	# of Services Supported by PHFAs with PHSP Guidance		
	Year I	Year II	Total
HCT	45,958	61,096	107,054
HCT Positive	1,537	1,819	3,356
ART Current Performance	4,360	**5,181**	**5,181**
PMTCT ARV Performance	96	120	216
Total TB	3,942	4,601	8,543
FP	10,347	15,292	25,639
Malaria Cases confirmed and diagnosed	3,529	1,475	5,004
STI	1,435	1,996	3,431
Total	**71,204**	**87,220**	**158,424**

[1] PHSP started capitating PHFAs to provide clinical mentoring to selected private facilities from year I. The number of facilities receiving this technical support started at 45 and increased to 66 in year II. As the technical capacity of PHFAs increases, the number of facilities provided with clinical mentoring will also increase in the remaining years of the project as evidence of sustainability of activities beyond the project period.

The PHSP approach emphasizes coordinated capacity strengthening support to PHFAs to foster and position the private health sector as an integral part of the national health system. In view of sustaining the delivery of priority and quality health services by private health facilities against cost effectiveness, the project plans to revisit its targeting and aims to maintain the number of targeted clinics at 391 by phasing out of its TA to about 100 of them. Depending on availability of financial resources, the same approach may be taken into account in the forthcoming years so that the number of targeted facilities will differ accordingly. In addition, 47 private facilities operational in Afar, Benishangul Gumuz and Gambela regions will also be excluded from the transition plan as there are no PHFAs in these regions. The capacity building activities required will be addressed by PHSP, and transition and sustainability concerns will be managed in coordination with the respective RHBs. With this approach, the project will save time and resources by not adding new sites apart from potential replacement sites to maintain an optimal number, which is 391, that is believed to ensure cost-effectiveness and program impact. In the remaining three years, the project will optimize costs by transitioning project activities, such as clinical mentoring and advocacy to PHFAs to enable them to progressively take on project activities and maximize program effectiveness. For sustained engagement of the private health sector however, additional efforts are required from the public health sector to embrace on-going ventures and transparently regulate implementation of the new health facility standards and continuing professional development requirements, and public-private partnership for health initiatives (PPP-H).

2.2 PHSP's Sustainability Strategy

PHSP's role is to facilitate improvement of knowledge, skills, systems, processes and policy/guidelines by guiding and supporting our counterparts, rather than performing their roles for them. This means that when the project and/or USAID TA ceases, the MOH's and local partners' capacity to perform tasks is enhanced, and there is minimum/no gap left in human resources due to the exit of project staff. The project pursues an adaptive capacity building approach, in line with the specific needs of the partner and balanced with a focus on technical, institutional and resource capacities of local partners. In addition, PHSP uses a continuous quality improvement approach that includes support to partners to monitor their progress, and take corrective action when appropriate. PHSP's capacity building includes multi-method solutions, to ensure continual support is available and accessible to ensure performance improvement. For example in-class training includes post-intervention reinforcement, such as coaching or on-the-job training.

2.3 Key Elements for Sustainability

The PHSP strategy to progressively transition activities to public and private sector local institutions for continued delivery of health services and products beyond the life of the project is focused on three key elements that underpin an organizations capacity to operate and function effectively. For local partners to sustainably provide their mandates, the following must be present:

- Technical Capacity: the skills and knowledge to support and/or provide the delivery of health products and services at a quality standard. This includes the technical capacities to lead, manage, coordinate, support and provide and oversee health service delivery; conduct advocacy and policy dialogue.

- Institutional Capacity: the organizational and operational capacity to manage and operate an organization based on transparency, accountability, and good governance to support the delivery of health services.
- Financial Capacity: partners have the capacity to identify and mobilize sufficient funding to continue activity implementation with appropriate resources

Within the period of transition to sustain operations, the project's technical support and resource assistance are designed to strengthen the key elements of sustainability in all local partners, adjusted to each of their responsibilities. This will ensure local partners attain the necessary organizational, operational and technical capacities to operate in a way that not only promotes the private health sector agenda but also addresses the project's goal of contributing towards the mitigation of impact of diseases of public health importance.

3. SUSTAINABILITY OF ACTIVITY RESULTS

The following sections provide details on how PHSP's results achieved during the project will be sustained. We discuss sustainability in relation to the identified local partners role and responsibility to carry out functions. It is important to note that PHSP considers sustainability to be of its core result areas and makes maximum effort to produce sustainable changes. We indicate these areas in the sections below and where possible, describe what PHSP will do to mitigate the effects of the end of the project on the functioning of systems. In general, PHSP's sustainability plan relies on the assumption that local resources and commitment within the Ethiopian public and private health system will either remain the same or increase.

3.1 PRIVATE HEALTH FACILITY ASSOCIATIONS (PHFAS)

Since the inception of seven regionally based PHFAs in 2014, PHSP and its predecessor project have supported the development and growth of these local institutions. While the mission and objectives of the regional PHFAs have remained consistent since their inception[2], the support provided by PHSP has shifted over time as these young Associations develop their internal capacities and mature organizationally. Since the launching of PHSP in 2015, components of PHSP capacity building support have combined provision of financial assistance through Institutional Grants and Fixed Obligation Grants. Through Institutional Grants, PHFAs have established functioning secretariats staffed with professional Executive Officers to coordinate day to day activities; program officers to provide clinical mentoring; and support staff to establish and maintain operational and administrative systems. PHSP has provided Fixed Obligation Grants to PHFAs to organize, manage and conduct clinical training programs and strengthen technical capacity of member constituents' to deliver select health services. The combined effect of these support has enabled PHFAs to provide clinical mentoring to select private facilities.

[2] Adapted from the PHFAs strategic plans 2014-2018: In summary the seven regional PHFAs describe their purpose is to "Offer products and services to enhance operational capacities and quality services of the Association's members and constituents of the private health sector in general; Serve as a forum for the private health sector, providing a comprehensive array of Promotion, Administrative, Knowledge-sharing and Networking services to its members; Partnering with the Ministry and Bureaus of Health, other State Organs, Development Actors and Community Based Societies to establish linkages and cooperation and contribute towards improved health policy and health outcomes."

Overall the PHFAs have achieved impressive results in a short period of time as evidenced by the increase in membership mobilization and fee collection; growing name and brand recognition within the regions amongst private health facilities and RHBs; increased advocacy for private health sector interests; and a growing portfolio of services provided by these organizations such as training and mentoring of private providers.

On the pathway to sustained operations of these associations, PHSP will focus and balance its activities with the associations in years III, IV and V to ensure these organizations develop and maintain:

- Technical Capacity to include clinical training management, clinical mentoring and supportive supervision, advocacy, networking and partnership building
- Institutional Capacity in terms of organizational governance, administrative operations, human resource management, program operations management, communication, membership mobilization, performance management
- Financial Capacity with a focus on resource mobilization, adherence to financial policies and procedures, internal controls and financial systems

The PHSP methodology to strengthen capacity of the associations is a systematic process customized for each regional unit, based on an adaptive capacity strengthening approach, grounded in a continuous performance improvement model. This includes conduction of an organizational capacity assessment of each regional PHFA to establish a baseline of the operational and organizational capacity for the unit. Information from the assessment is used to 1) provide targeted support to regional PHFAs based on the baseline results and the functional areas that require support; and 2) provide cross-cutting capacity strengthening to all regional PHFAs to streamline project support that are required for all units.

While the capacity building will ultimately enable PHFAs to support all private facilities in partnership with key stakeholders, PHSP will transition 67% of the private facilities to the PHFAs through a phased approach. Table 3: Site Transition Plan National PHFAs, below displays current standing and future transition plan of private facilities over the remaining project years.

To achieve this plan, PHSP identified the following key activities to support PHFAs.

- Coaching PHFAs to conduct an annual organizational capacity assessment
- Providing Institutional Grants and Fixed Obligation Grants to ensure continuity of functioning secretariats of PHFAs
- TA and training to PHFAs' secretariats and board members on association leadership and management to operate as a member-based organization
- TA and mentoring to PHFA staff on managing and organizing basic and refresher clinical training programs, clinical mentoring and site supervision
- TA and mentoring to association secretariat on grant management
- TA to coordinate support between PHFAs and professional associations, such as MAPPP-E and Ethiopia Medical Laboratory Association (EMLA)

Table 3: Site Transition Plan to National PHFAs

Regional PHFAs	# of Facilities Targeted	# of Private Facilities Transitioned to PHFA Support per Year					Total
		Year I	Year II	Year III	Year IV	Year V	
Oromia	100	12	0	9	19	19	59
Amhara	79	11	0	8	20	18	57
SNNPR	42	0	12	1	14	1	28
Tigray	48	10	0	5	20	1	36
Addis Ababa	52	12	0	3	19	1	35
Dire Dawa	17	0	9	1	7	0	17
Harari	6	0	0	0	0	0	0
Total	**344**[3]	45	21	27	99	40	232
Cumulative Total		**45**	**66**	**93**	**192**	**232**[4]	

With these activities, PHSP will support regional associations to demonstrably improve and capably operationalize their objectives during the project period. While promoting the private health sector agendas, PHFAs will be able to effectively perform their role support continued provision of quality health services in facilities and communities.

3.1.1 Process to Transition and Sustain PHFAs Responsibilities

In year II of the project, PHSP in collaboration with each regional association conducted organizational capacity assessments for each unit. The assessment provided baseline information on the three areas of sustainability – technical, organizational and financial – and measured capacity against main pillars of efficient and well-functioning organizations. PHSP will use this information to target areas where capacity development is required. The tool composes the following ten assessment domains:

1. Organizational Governance
2. Administrative Operations
3. Human Resources Management
4. Financial Management
5. Program Operations Management
6. Communication and Networking and Partnership Building
7. Project Performance Management
8. Membership Mobilization
9. Clinical Training Management
10. Clinical Mentoring and Supportive Supervision

[3] From the 490 private health facilities, PHSP plans to review its targeting and foresees phasing out of its TA to about 100 private facilities. Accordingly, the number of targeted private facilities will be limited to 391 in year III. Depending on availability of financial resources, the same approach may be taken into account in the forthcoming years so that the number of tagged facilities will vary accordingly. In addition, 47 private facilities operational in Afar, Benishangul Gumuz and Gambela regions are excluded from the transition plan as there are no PHFAs in the three regions. The capacity building activities required by 47 facilities will be addressed by PHSP, and transition and sustainability concerns will be managed in coordination with the respective RHBs.

[4] While pursuing accountability for all targeted private facilities, PHSP proposes transitioning 67% (232) of the 391 targeted facilities to PHFAs by the end of project period. Accordingly, PHSP monitors the performance of PHFAs in the delivery of overall site supervision and clinical mentoring.

The first seven domains contain core organizational functions and practices for successfully running a membership-focused non-governmental organization. The last three domains are areas PHFAs are required to develop per their establishment and assume the responsibilities, currently shared with PHSP and provide management of clinical training, clinical mentoring and supportive supervision.

PHSP will follow the same basic steps for all regional PHFAs, which are described below:

1. Private Health Sector Development team members (the Director, Capacity Building Manager and Capacity Building Officer) and the Senior Project Management Advisor, in coordination with all PHFAs will conduct **baseline self-assessments** at the beginning of years III, IV and V.
2. Based on results of the baseline, PHSP will work with regional PHFAs to **determine capacity areas** that require strengthening and develop **short term individualized plans**. PHSP will also determine cross cutting areas for all regional PHFAs that will be addressed using group oriented interventions. For example, during year II, the assessment indicated that regional PHFAs need a financial management policy and manual. PHSP will coordinate the production of this and provide group and/or individual trainings.
3. PHSP Capacity Building Manager, Capacity Building Officer and PHSP regional managers will **provide ongoing capacity strengthening activities**, based on the individual plans and group plans.
4. PHFAs will **repeat the self-assessment annually** to assess their progress towards sustainability. PHSP will work with the PHFAs to develop annual capacity building plans at the beginning of each year that include progress to date and share of responsibilities.
5. Based on the results of each self-assessment, PHSP will adjust the inputs provided to each regional association and begin to **gradually phase out its support**.

Of particular importance for years III and IV, PHSP will work closely with the associations to build their capacity to mobilize additional resources. This can include capacity to respond to and/or solicit external funding and development of additional income streams. An additional area of focus is to work with the associations to develop and provide specific membership benefits.

3.1.2 Limitations

- The PHFAs are managed by board members who are volunteers. Their commitment and the time they allocate for the association work varies from association to association.
- Limited funding for building capacity of PHFAs. During the project period, PHSP is leveraging the resources allocated for the implementation of the different public health services in the private setting.
- The GOE's acceptance of PHFAs is not yet solidified. PHSP will work on facilitating the development of smooth relationship between them and adopt the transition and sustainability plan accordingly.
- The policy gap that has been hindering the project will present a barrier to the associations in implementing the services.

3.1.3 Measuring the Progress of Transition Activities

PHSP will track the association's capacity development at the end of each year. A capacity building support log will be maintained for each association and annually tracks the support and capacity development tasks administered, facilitated and the level of attainment of the planned capacities in each domain areas. The Project will monitor the transition of responsibilities using the following indicators:

- Number of PHFAs that adopted improved organizational systems/tools/processes
- Number of PHFAs that provide mentoring services to supported private health facilities.
- Number of PHFAs that regularly participate in site supervision of private health facilities in coordination with RHBs
- Number of PHFA management boards that met and reviewed performance of capacity strengthening plan
- Number of PHFAs with increased membership base and fees
- Number of regional PHFAs linked with banks/financial institutions to facilitate access to finance member private health facilities

3.2 Private Health Facilities

PHSP works to increase access to quality priority health services and the uptake of services in the private health sector. In addition to the basic and refresher clinical training delivered to the 490 targeted private health facilities, the project works to strengthen linkages between private health facilities with advanced lab testing centers (standalone basic and advanced), laboratory external QA (EQA) centers, the Ethiopian Public Health Institute (EPHI), regional laboratories, and pharmaceutical supply chain operated by Pharmaceuticals Fund and Supply Agency (PFSA).

With this understanding, the overarching business model of the project is to sustainably expand services by the growing number of private sector providers, improve quality of health services, and strengthen support and oversight of the private sector by both government and PHFAs. Considering the project's efforts over the past two years, PHSP will conduct capacity assessments of each facility and establish a baseline to guide transition of activities to sustain increased uptake of priority health services through private health facilities. Information from the assessment will be used to: 1) compare capacity building support delivered against the attainment level at facility level over the past two years; 2) define project activities to address identified gaps and further requirements; 3) specify resources, responsibilities and timeframe for implementation of identified capacity building activities; 4) determine transition criteria; 5) monitor progresses to fine-tune capacity building support; and 6) coordinate facility transfer to regional PHFAs over the remaining project period (see Table 3).

PHSP will conduct the capacity assessments using a checklist to be developed in coordination with RHBs and PHFAs. The checklist will include questions to identify facility readiness of trained health professionals to deliver priority health services, supportive supervision and clinical mentoring; participation in region review meetings; referral linkages with regional labs; commodities; registries/documentations; data quality; and health management information system (HMIS) reporting practices, self-assessment in reference to the applicable health standards among others. Based on the

results, PHSP will design remedial measures to address the identified gaps with active participation of RHBs and PHFAs. The capacity building activities can include basic and refresher clinical training programs; supportive supervision including clinical mentoring; facilitate linkages in commodity supply provision through PFSA's hubs and/or Woreda/town health offices (THOs); coordinate with regional labs for sample transport and laboratory EQA; and continuous monitoring of quality health services, access to finance, reporting and compliance with requirements of HMIS. The project will integrate this approach into its monitoring and evaluation plan and regularly review the information generated in the bi-annual and annual review and planning meetings at the project and regional levels. With this practice, PHSP will systematically guide capacity building activities to targeted private health facilities. PHSP will continue to provide this support in coordination with health authorities of the regions and towns where targeted private health facilities are operational. In the regions where there are no PHFAs, PHSP will work with the RHBs.

The project has identified means of directly and indirectly supporting targeted private health facilities to sustainably deliver quality health services. The project will implement the following key activities to targeted private health facilities in the remaining three years.

- Training to targeted private health facilities including basic and refresher thematic clinical training programs including Stepwise Laboratory Improvement Process Towards Accreditation (SLIMTA) and Strengthening of Laboratory Management towards Accreditation (SLMTA)
- TA and supportive supervision and clinical mentoring to targeted private health facilities through PHSP and/or PHFAs in coordination with RHBs/THOs
- TA to targeted facilities to conduct self-assessments and comply with health facility standards
- TA and training to targeted facilities to ensure data quality and HMIS reporting to RHBs
- TA to targeted private health facilities on business plan development to access to bank loans
- Indirect support to private health facilities through the provision of TA to RHBs and PHFAs to coordinate access to commodities through RHBs and Woreda/THOs/PFSA regional hubs
- Indirect support to private health facilities through the provision of TA to coordinate laboratory EQA with EPHI and QA through Regional Labs
- Indirect support to private health facilities through the provision of TA to coordinate with RHBs to transport sample to regional laboratories
- Indirect support to private health facilities through the provision of TA to EMLA to provide to targeted private health facilities that deliver ART and malaria link receive regular lab mentoring.

3.2.1 Process to Transition and Sustain Provision of Health Services by Private Health Facilities

PHSP will follow the following basic steps:

1. Under the guidance of the Deputy Chief of party, the Clinical Director and Senior Project Management Advisor will develop and implement a capacity assessment tool for targeted private health facilities. The assessment will be carried out at the beginning of year III and will serve as a baseline. The tool will produce a quantitative score that can be disaggregated by gaps in:

- Resources (manpower, job aids, medical instruments and commodities, access to finance etc.),
- Gaps in skill to be addressed by on-site support that includes mentoring, supportive supervision and off-site support comprising of basic and refresher training programs
- Demand creation and health promotion, referral (clinical and lab)
- Regulatory and reporting requirements (self-inspection, standards and HMIS) and

2. Consensus building with RHBs/FMHACA and PHFAs on the use the self-assessment and its applicability to monitor delivery of priority health services by targeted private health facilities. Once a consensus is built among key partners, the checklist will be integrated into the previously signed a memorandum of understanding (MOU) between RHBs and PHSP, and appraised in the bi-annual and annual review meetings.
3. Based on agreed-upon capacity assessment tool, PHSP regional team will assess capacity of targeted private health facilities. The conduction of the assessment will be facilitated to encourage targeted private health facilities to conduct a self-assessment and use this tool as a continuous performance improvement approach.
4. Based on results of the capacity assessment, PHSP will coordinate with RHBs and PHFAs and develop a plan of action to **refine the package of inputs** to targeted private health facilities towards improving identified capacity needs.
5. PHSP in coordination with RHBs will **determine the target duration for addressing identified capacity needs of targeted private health facilities over** a period of 24 to 36 months.
6. In coordination with the RHBs, respective PHSP Regional Managers coordinate with Director of Regional Programs and the Senior Project Management Advisor to ensure targeted private health facilities **repeat the self-assessment every six months to progress** towards transition.
7. Based on the results of each self-assessment, PHSP in collaboration with RHBs will adjust the support provided to targeted private health facilities to progressively **phase out capacity building support and transition to RHBs/regional PHFAs**. As private health facilities begin to reach their targets for particular components, PHSP will phase out support related to those systems. As more targets are met and inputs phased out, the project will intensify support to the areas requiring specific attention.
8. At the scheduled transition time, targeted private health facilities will **perform a final self-assessment** as part of PHSP and RHBs coordinated capacity building support. RHBs and PHSP will analyze the final assessment results. If some targets are not met, PHSP will work with RHBs and PHFAs to develop a plan for reaching the remaining targets with periodic TA. Anticipated strategies include:
    a. Based on number of private health facilities on intensive support and availability of project resources, PHSP will coordinate with RHBs to continue to provide targeted technical support to achieve the remaining targets;

b. PHSP may provide indirect technical back-stopping to private clinics with unmet project targets depending on availability resources

3.2.2 Limitations

- Owners of private health facilities may give less emphasis to priority health services than others and tend to regard transition procedures as time consuming and distracting from their business motive.
- Many of the targeted private health facilities are not members of the regional PHFAs. This may diminish PHFAs' influence over the facilities and constrain joint efforts to transition project activities.
- The policy gap that has been hindering the project will also present a barrier to the private health facilities in implementing the services.

3.2.3 Measuring the Progress of Transition Activities

PHSP will track the capacity attainment of private health facilities at the end of each year. A capacity building support log will be maintained for each private health facility to annually track the support and capacity development tasks administered, facilitated and the level of attainment of the planned capacities in each domain areas. The project will monitor the transition of responsibilities using the following indicators:

- Number of facilities conducting self-assessments
- Number of facilities that fully comply with reporting requirements of HMIS
- Number of facilities that identify additional financial needs and accessed loan from banks
- Number of facilities that access commodities through PHSA and/or RHBs' structures as Woreda/THOs
- Number of private health facilities that participate in the basic and refresher clinical training programs organized by RHBs
- Number of targeted facilities that participated in review meetings organized by RHBs

In view of the limitations of project resources and duration, PHSP will eventually phase out its direct involvement in building capacities of the private health clinics through a phased approach. It is the intention that as PHSP phases out of direct support to private health facilities, RHBs and PHFAs will take up the responsibilities such as mentoring, supportive supervision, and training. PHSP cautiously monitors the implementation of transitioned project activities in coordination with RHBs by involving PHFAs annually, at the end of each year.

3.3 Regional Health Bureaus (RHBs)

RHBs are entrusted to ensure quality, accessibility and equity of public health service delivery within their respective catchment areas. These units are the first entry points of the project's work at the regional level and the subsequent implementation in the zones and districts/Woreda. In view of this,

PHSP has and will continue to partner with RHBs to increase accessibility of health services through the private health sector through the following arrangements:

- RHBs and Abt Associates Inc. signed an MOU that provided the project with legal and operational mandates
- Based on the MOU, PHSP collaborates with RHBs to conduct site assessments and selection of targeted private health facilities
- In the implementation of training programs (refresher and basic) for health professionals identified from targeted private health facilities, PHSP coordinates with RHBs and use of relevant guidelines and assignment of training of trainers certified resource persons
- RHBs conduct regular supportive supervision to targeted private health facilities to ensure quality of care
- RHBs organize and involve private health facility in region specific review meetings
- RHBs and their respective health structure at zonal and Woreda levels provide targeted private health facilities with registries to capture client and service data for regular submission of performance reports to Woreda Health offices per the HMIS requirements
- RHBs link targeted private health facilities with regional labs and EPHI to establish Viral Load, Drug sensitivity Test, diagnose of Multi Drug resistant TB and GenXpert result reporting and capturing mechanisms
- RHBs link targeted private health facilities with PFSA's regional hubs or Woreda/District health offices to facilitate supply of pharmaceutical commodities dedicated for the treatment of disease of public health importance.

Further to sustain the increased accessibility of health services in the private health facilities, PHSP will continue to collaborate with seven RHBs in years III, IV, and V of the project period. The focus will be to strengthen RHB capabilities in overall site supervision, identification of gaps in capacity of PHFAs to partner in the planning, implementation and monitoring of project activities as well as participate in performance review meetings; quality improvement; commodity supply, and health management information system (HMIS) among others.

PHSPs capacity building support will enable the RHBs to effectively exercise their mandate and embrace regional PHFAs to ensure continuity of increased service delivery quality and affordable priority health services by targeted private health facilities. PHSP Regional Managers will determine specific inputs required by each RHB to productively work with PHFAs as part of the transition plan. The main tool the project will use is a Terms of Reference (TOR) that clearly defines duties and responsibilities of RHBs and PHSP and serve as a road map to guide and monitor the transition of project activities to the PHFAs and specify the supportive role of RHBs in the process. The key areas of the TOR and subsequent activities will emphasize on the readiness of the RHBs to forge alliances with PHFAs for continuity and maintenance of increased accessibility of quality and affordable priority health services through the private sector during and beyond the end of project period. PHSP regional managers will continuously guide refinement of the support and inputs based on findings from their observation and participation in

joint supportive supervision at facility levels, such as biannual performance assessments. We summarize PHSP's key inputs to RHBs in the list below.

- TA to RHBs to organize and conduct planning meetings between RHBs and regional PHFAs to develop a TOR, coordinate joint supportive supervision and channel inputs to private facilities such as basic and refresher trainings, commodity supply through PFSA, etc.
- TA to RHBs to get participation of regional PHFAs and targeted facilities in bi-annual and annual review meetings
- TA to RHBs in the facilitation of processes, analysis of results, and plan of action in support of the integration of private health sector
- TA to RHBs to identify support needed by private health facilities to link with Regional labs, PSFA, FMHACA among others, and follow-up decisions in coordination with regional PHFAs.
- TA to RHBs to involve PHFAs to participate in Joint Support Supervision and mentoring of targeted private health facilities in the region
- TA to RHBs to facilitate provision of registries to targeted private health facilities to capture client and service data for regular submission of performance reports to Woreda Health offices per the HMIS standards

3.3.1 Process to Transition and Sustain RHBs Responsibilities

PHSP will follow the following basic steps:

1. PHSP (Deputy Chief of Party and in coordination with Directors of Private Health Sector Development, Regional Programs and Senior Project Management Advisor) and the RHBs will develop TOR to involve PHFAs in the planning, implementation and monitoring of targeted private health facilities continue with the provision of priority health services and meet project targets for years III, IV, and V.
2. Based on the TOR, PHSP will coordinate with RHBs to **refine the package of inputs** provided to each RHBs to improve capacities specified in the TOR.
3. PHSP in coordination with RHBs will **determine the duration for addressing identified capacity needs of RHBs over** a period of 24 to 36 months
4. PHSP's Deputy Chief of Party will **determine the transition criteria** for each RHBs as defined in the TOR.
5. At the scheduled transition time, PHSP and RHBs jointly review the implementation of activities per the TOR. In the event where respective targets are not met, PHSP will develop a catch-up plan for reaching the remaining targets with periodic TA. Anticipated strategies for the plan include:
    a. PHSP will coordinate with RHBs to continue to provide targeted technical support to achieve the remaining targets;
    b. RHBs may take over support to private clinics for reaching their respective targets at the Woreda level and PHSP may provide indirect technical back-stopping.

c. RHBs may identify private health facilities with high performance to share their experience to the public and private health sector in review meetings. Participating private health facilities may cover their own costs associated with this travel and accommodations.

d. RHBs and PHSP may facilitate linkage with current donor and/or identify another partner/donor/project that can provide the support needed to achieve the remaining targets.

3.3.2 Limitations

- The RHBs may lack commitment to follow on the transition and sustainability plan due to competing priorities.
- Limited funding for supporting capacity building needs of RHBs.
- RHBs' acceptance of the private health sector representatives (PHFAs) is not yet predictable.
- Policy gap that has been hindering the project will also present a barrier to maintaining collaboration between RHBs and PHFAs in coordinating efforts
- Region specific working relationship between RHBs and PHFAs may not allow pursuance of effective collaboration

3.3.3 Measuring the Progress of Transition Activities

PHSP Regional Managers play an important part in ensuring the sustainability of system strengthening efforts of the project. With the technical and operational leadership and programmatic back-stopping from the Deputy Chief of Party as well as the Regional Programs Director, the regional managers will continue to offer professional support to the RHBs between 24 and 36 months. Given the site transition plan described in 3.1 above, the role of PHSP will be tuned to facilitate linkages between RHBs and PHFAs. The Project will monitor the transition of responsibilities using the following indicators:

- Number of private health facilities who receive joint supportive supervision by RHBs and regional PHFAs
- Number of refresher and basic training programs coordinated by the RHBs and conducted by regional PHFAs
- Number of private health facilities and regional PHFA participating in review meetings organized by the RHBs
- Number of registries RHB provided to private health facilities to capture client and service data for regular submission of performance reports to RHBs per the HMIS standards,

Given the limitations of project resources and duration, PHSP will eventually phase out its direct involvement in the implementation of project activities and coordination role with RHBs. PHSP may encourage RHBs to enhance participation of the private health sector and their constituent region specific PHFAs in the annual and bi-annual review meetings. The transition of activities between the project and RHBs will be tracked annually, at the end of each year.

3.4 FEDERAL MINISTRY OF HEALTH (FMOH)

The FMoH provides overall leadership for the PPP-H program in Ethiopia and has been working to enable private sector providers to implement quality and standardized services. One of its measures includes the adoption of the Strategic Framework for PPP-H in Ethiopia in 2014 in which the FMoH identified advanced tertiary health care, Human Resource for Health development, pharmaceutical manufacturing and diseases of public health importance as the four priority thematic areas of PPP-H. For the implementation of these thematic areas, the project assisted the FMoH to develop an Implementation Guideline, Operational Manual and Users Guide. These tools are endorsed by the FMOH although use of them is pending due to the absence of a PPP proclamation. Moreover, the final draft of the PPP proclamation championed by the Ministry of Finance and Economic Cooperation (MOFEC) also lacks clarity as regards the inclusion of health. In a similar development, PHSP secured the go ahead from the FMOH to update the existing PPM guideline for TB implemented through MOUs, and develop new guidelines for Malaria, HIV/AIDs and RMNCH. Likewise, the implementation of PPM projects also requires the PPP proclamation to establish the national PPP-H framework that presupposes procurement[5] as opposed to MOUs.

In the PHSP transition and sustainability plan for activities that target FMoH, the Resource Mobilization Directorate remains the center of capacity building support in year three and four of the project period. PHSP's capacity building support TA for the operationalization of PPP-H and financing relevant activities for enhanced oversight and implementation of PPP–H. During this time, the FMoH will advocate for the inclusion of health in the proclamation and/or future guidelines and adapt the PPP-H guidelines and operational tools to include procurement procedures as specified in the final version of the PPP proclamation.

Once the tools are adapted, the FMoH will work on the design, solicitation and award and manage PPP-H projects. PHSP will support FMoH by seconding a Procurement Specialist in project years III and IV. To support the transition of activities to FMoH and sustain enhanced oversight and implementation of PPP–H, the seconded expert will provide key support by modeling (on-the-job coaching).

Components of the transition and sustainability activities listed below will focus on the identification of gaps in capacity of the Resource Mobilization Directorate to plan, implement and monitor PPP-H projects.

- Support coordination of joint planning meetings with the FMoH to develop TOR as a road map to guide the project work with FMoH that includes roles, responsibilities and duties of each party
- Support FMoH to facilitate discussions and implement plan of action to support the inclusion of health in the PPP proclamation by MOFEC

[5] The PPPH framework indicates delivery of public health importance services as one of the four thematic areas i.e. Tertiary Healthcare, Pharmaceuticals, and Human Resources Development in Health. The implementation of PPP-H will thus follow a competitive bidding process and the public and private actors enters into agreement to deliver the public health services. The agreement entails risks-sharing and payments and accountability. So far, PPM is practiced through MOUs singed between RHBs and Private Health Facilities.

- TA to institutionalize PPP-H technical working group and develop scope of work
- Provide TA and follow-up decisions of the PPP-H technical working group and secure decision from FMoH's senior management
- TA in the adaptation of PPP-H Implementation Guideline, Operational Manual and Users Guide to ensure consistency with PPP proclamation
- Build capacity of FMoH for complete management of procurement cycle of PPP-H projects that specifically include development of the design, solicitation, relevant procurement procedures, manuals, documentations
- TA and facilitate provision of PPP-H tools and events to create awareness among key partners
- Provide TA and facilitate need-based TA to initiate PPP-H by RHBs[6]

3.4.1 Process to Transition and Sustain FMoH Responsibilities

To transition responsibilities to the FMoH, PHSP will complete the following basic steps:

1. With the guidance from the Chief of Party, PHSP will develop a TOR that includes the planning, implementing and monitoring of key support to the FMoH to attain targets for year III and IV.
2. Based on the TOR, PHSP will coordinate with the FMoH to **refine the package of inputs** towards improving capacities as specified in the TOR.
3. PHSP in coordination with the FMoH will **determine the duration to address identified capacity needs over** a period of 12 to 24 months.
4. In collaboration with the FMoH, PHSP will **determine the transition of criteria** as defined in the TOR.
5. In coordination with the FMoH, the project will assess progress against performance standards established in the TOR.
6. Based on the results of each assessment, PHSP in collaboration with FMoH will adjust the inputs provided to progressively **phase out capacity building support.** PHSP phases out the inputs related to targets met and will focus and intensify support to the areas that demand specific concerns.
7. At the scheduled transition time, the FMoH and PHSP will **perform a final assessment** of the capacity building support as per the TOR. In the event when some targets are not met, PHSP will work with FMoH to develop a catch-up plan for reaching the remaining targets with periodic TA.

[6] PHSP has been receiving frequent requests from Amhara RHB for TA in PPP-H project development. The project has already started discussions with Amhara RHB and will provide need based TA. Further to ensure transition and sustainability of its support, PHSP will pursue the same steps as mentioned for FMoH. The support will not involve secondment except being coordinated by the Senior Project Management Advisor from the central project office.

8. PHSP will follow the above steps for region specific need- based PPP-H initiatives and encourage participation of federal and regional PHFAs in the planning, implementation and monitoring process.

3.4.2 Limitations

- Turnover of officials at FMoH and RHBs
- Delay in the inclusion of health in the PPP proclamation
- Limited funding for supporting capacity building needs of FMoH
- Policy gap that has been hindering the project will also present a barrier to maintaining collaboration between FMoH and RHBs with PHFAs at national regional levels

3.4.3 Measuring the Progress of Transition Activities

The core of PHSP's support involves continuing the secondment of staff to FMoH and collaboration between RHBs and PHFAs where PPP-H initiatives will take place during the transition of system strengthening efforts. With the technical and operational back-stopping from the Senior Project Management Advisor, the designated staff will continue to provide technical support to the FMoH and RHBs over the following 12 to 24 months, of needs-based TA. To monitor the transition of responsibilities, PHSP will use the following indicators:

- Number of advocacy instruments developed and submitted to MOFEC to move forward with the inclusion of health in PPP proclamation
- Implementation guidelines for HIV/AIDS, Malaria and RNMCH developed and approved by FMoH and RHBs
- Number of PPP-H projects developed, solicited, awarded

3.5 Food, Medicine and Health Care Administration and Control Authority (FMHACA)

FMHACA is the regulatory agency entrusted to ensure the introduction, monitoring and implementation of existing (59) and new health standards in Ethiopia to help protect patient safety and ensure the minimum quality standards in the public and private health sectors. As the previous project supported FMHACA to develop health standards, PHSP continued building its capacity to enable FMHACA and its regulator branches to function effectively. Given the ongoing reforms to improve quality of health care delivery systems, PHSP will continue to provide FMHACA with targeted TA by the project's seconded Health Regulation Advisor.

In view of this, the project aims to strengthen adherence to health facility standards by 1) promoting awareness among private facilities and PHFAs on the benefits of health facility standards and the need to comply with the standards, and 2) facilitating partnership/collaboration between FMHACA and the PHFAs to encourage compliance and implementation of the health facility standards. PHSP supports the secondment of a Health Regulation Advisor to FMHACA for the introduction of improved methods of inspections as well as adherence to new health standards including those related to medical equipment.

Working under the direct authority of Medico-Legal and Standard Setting Directorate, the seconded Health Regulation Advisor provides TA to streamline the classification and licensing of various levels of healthcare standards to fit the resource constrained environment. Such efforts presuppose the agency and private facility owners have capacity to implement and enforce the standards and also implementation of a mechanism for private sector representation in the development and roll-out of the standards. PHSP's regional offices encourage private health facilities to adopt self-inspection/audit, PHFAs participate in the inspection mission, regularly monitor; analyze feedback gathered from inspectors and facility owners, and assist FMHACA to initiate changes to improve implementation of the standards and inspection processes. At the federal level, PHSP will further work with FMHACA to determine which standards need clarification or revision and facilitate agreed-upon action points of introducing revised standards accordingly. For project-supported facilities that are in a probationary status, regional project teams will increase mentoring to help the facilities meet the standards and obtain their licenses. Likewise, regional PHFAs will solicit feedback from their members, regularly monitor inspection results, deliberate on their respective review meetings to identify which issues will be handled at regional level. For issues that require national level efforts, the national association will consolidate feedback obtained from each region and pursue dialogue with FMHACA as deemed necessary.

PHSP will adopt the TOR to define duties and responsibilities of each party and key stakeholders. The TOR will be developed jointly and mutually agreed upon, will serve to review contribution of previous capacity building support, identify key action points with timeline to guide, monitor, and specify the role of the agency in the transition and sustainability processes. PHSP's key inputs to enable FMHACA to sustain this work post project are as follows:

- TA to coordinate joint planning meetings with the FMHACA and the national PHFA to develop TOR to define activities, timeline, resources, responsibilities between FMHACA and PHSP
- Work with FMHACA to develop supervisor tools, health facility checklists and job aids to facilitate supervision of health facility by FMHACA
- TA to FMHACA to organize refresher and new training programs on the revised and new health facility standards
- Support FMHACA to develop new and update existing health facility standards
- TA to FMHACA to edit new editions of health facility standards that include updated, revised and new health standards
- Update and develop TOT certification course for inspectors on Inspection Principles, Ethics, Methodologies, Enforcement and Introduction of Standards
- TA to FMHACA to provide performance-based grants to PHFAs to conduct educational and sensitization workshops with private facility owners and managers.
- Work with FMHACA to develop, review, update and implement a continuing professional development scheme
- TA to improve the quality of inspection through facilitating the identification, specification, and procurement of inspection tools,
- Facilitate other need-based TA to FMHACA

3.5.1 Process to Transition and Sustain FMHACA Responsibilities

PHSP will follow the following basic steps:

1. With guidance from the Chief of party, the Director of Private Health Sector Development will develop a TOR that describes planning, implementation and monitoring of key support to the FMHACA to attain project targets for years III, IV, and V.
2. Based on the TOR, PHSP will coordinate with FMHACA to **refine the package of inputs** towards improving capacities specified in the TOR.
3. PHSP in coordination with the FMHACA will **determine the duration to address identified capacity needs over** a period of 12 to 36 months.
4. In collaboration with the FMHACA, PHSP will **determine the transition of criteria** as defined in the TOR.
5. In coordination with the FMHACA, PHSP will assess progress of FMHACA against performance standards established in the TOR.
6. Based on the results of each assessment, PHSP and FMHACA will adjust the inputs provided to progressively **phase out capacity building support.** PHSP phases out the inputs related to targets met and will focus and intensify support that demand specific concerns.
7. At the scheduled transition time, the FMHACA and PHSP **perform final assessment** the capacity building support as per the TOR. In the event when some targets are not met, PHSP will work with FMHACA to develop a catch-up plan for reaching the remaining targets with periodic TA.

3.5.2 Limitations

- Turnover of officials at FMHACA and its delegates (mainly RHB) or branches in the region
- Changes in implementation arrangements due to restructuring of FMHACA
- Limited funding for supporting capacity building needs of FMHACA
- Time taken for endorsement of new health standards between FMHACA and ENAO

3.5.3 Measuring the Progress of Transition Activities

PHSP aims at capacitating FMHACA to assume the role of capacity builder in the inspection and application of the standards. For this to happen, inspectors of FMHACA will have improved skills on inspection methods, professional skills and ethics. Accordingly, private facilities supported by private health sector project will score 75% and above and position themselves in the green zone of the scoring system[7]. The capacity building activities to FMHACA includes secondment of staff to FMHACA. As part

[7] In the inspection of health facilities, FMHACA adopts a scoring system and rank inspected facilities in green, yellow and red zones. Those facilities ranked in the 'Green' zone qualify to maintain their status, that is usually expresses by ' levels', and will automatically renew their professional licenses while those in 'Yellow' will need to improve and get scores and move to Green Zone to get their licenses renewed. But, those in red will be downgraded to the next lower level where they meet the corresponding health standards or else their license will be revoked.

of the technical support, PHSP will facilitate linkage and collaboration between FMHACA, professional associations (MAPPP-E and EMLA), EPHI and regional labs.

PHSP will monitor the transition of responsibilities through the following indicators:

- Number of new revisions of the health standards made, adopted and published
- Number of new health standards developed and adopted with active participation of PHFAs
- Automated facility inspection results uploaded at FMHACA level
- Number of inspection missions conducted with active participation of Regional PHSP offices and PHFAs
- Performance based grant guideline developed and number of awareness creation events on the national health standards organized by PHFAs
- Development and finalization of Checklists for the most recent health standards
- Number of inspection tools and job aids developed and distributed to private health facilities
- Number and types of inspection tools procured, provided and functional by FMHACA

In view of the limitations of project resources and duration, PHSP will eventually phase out its direct involvement in the implementation of project activities and coordination role with FMHACA. PHSP will encourage the FMHACA to enhance partnership with PHFAs at the federal and regional levels. PHSP will track the transition of activities between the project and FMHACA and RHBs at the end of each year moving forward.

4. MANAGEMENT OF TRANSITION AND SUSTAINABILITY PLAN

PHSP's sustainability plan endeavors at sustaining immediate outputs and outcomes of PHSP activities so that all of the projects results, including purpose level results, to have a higher chance of also being sustained. In view of this, the management of this plan pursues improvement in knowledge, skills, systems, and supporting counterparts, rather than performing their roles for them. Local partners will exercise in the implementation phase and continue with enhanced capacity with minimal resources due to close out PHSP.

4.1 MANAGEMENT

PHSP mainstreams the management of transition and sustainability activities into its structure to implement every project activity with sustainability built-in. Hence, the integration of the transition and sustainability of project activities into the planning, implementation and monitoring phases of the PHSP will promote the private health sector agendas, capacity improvements to administer project activities. With this in mind, PHSP cascades, in addition to defining project inputs, the plan to indicate resources required for the implementation of project activities. Accordingly, local partners, particularly PHFAs, will

be able to effectively perform their role and manage support to private health facilities for continued provision of quality health services.

4.2 MONITORING

In order to measure and monitor PHSP's progress in facilitating sustained improvements in the Ethiopian health system, we have identified indicators of transition of capacity building activities specific to each of the targeted local partners. These indicators are factors to organizational capacity, institutional capacity and financial capacity to demonstrate sustainability of project activities to support provision of priority health services by the private health sector during and after the end of the project period. Summary of identified priority activities that will lead to smooth transition are detailed in the implementation plans are categorized by the major domain areas as shown in the Activity Planning and Monitoring Plan (Annex I).

Given the interwoven nature of transition activities across the five local partners, PHSP adopts process indicators and tied with regular quarterly missions and bi-annual regular review meetings to be held at different levels. As shown in the Planning and Monitoring Plan, each elements are aligned to sub-purpose level indicators of PHSP to conveniently link activity implementation and tracking progresses.

4.3 RESOURCE REQUIREMENTS

The required resources to transition project activities for each year sustainability tasks will be estimated and integrated into the annual work plans. In the list of resource requirements, this section excludes financial estimates since PHSP leverages budgets earmarked for implementation program activities. The information displayed in Annex I will serve as benchmark to indicate resource requirements to realize the transition and sustainability plan. During the yearly planning, PHSP staff will coin work-plan, allocate budget and lay down clear strategy to allow a straightforward process to identify and use the available resources to carry out activities in the implementation plan in line with the three elements of sustainability. The following are summary of basic resource requirements upon which will be updated with as a results of continuous progress monitoring.

4.3.1 Manpower

The manpower requirements of this plan involves FMoH, FMHACA and PHFAs. Starting in year I, PHSP seconded Senior Advisor to FMHACA and Procurement Specialist to FMoH. As described in the activity sections, PHSP's secondments for FMHACA and FMoH will be made until year V and IV respectively. In regards to PHFAs, PHSP has set-up sub-grantee arrangement to support staffing of PHFAs to provide coordination, professional/technical and administrative services since year one of the project. With the anticipated site transfer and expanding role of PHFAs, PHSP has also identified the need to onboard additional program officers in four regions that have a higher number of private facilities, and hence, require increased interactions with RHBs to ensure the transition of project activities. As shown in Table 4 below, PHSP foresees the total number of staff required by the PHFAs will remain 36 over the project period.

Table 4: Manpower Requirement of PHFAs

Name of Associations	Chief Executive Officer	Executive Officer	Program officers	Accountant	Finance & Admin Assistant	Remark

National	1	1	1	1	1	
Addis Ababa		1	1	1	1	
Amhara		1	2	1	1	Additional program Officer will be hired in year three.
Oromia		1	2	1	1	
SNNP		1	2	1	1	
Tigray		1	2	1	1	
Dire Dawa		1	1	1	1	Dire Dawa and Harari use 1 Accountant
Dire Dawa and Harari		1	1		1	
Total	**1**	**8**	**12**	**7**	**8**	**36**

4.3.2 Vehicles

Following donor guidance, the project transferred of its vehicles to partner associations to support their operational capacities in year II of the project and will continue in a gradual manner - depending on anticipated level of activities (site support) PHFAs are to be engaged. Accordingly, PHSP transferred six vehicles to four PHFAs and one Professional Association with the approval of USAID in year II of the project period as shown below in Table 5.

Table 5: Vehicle Allocation by PHFAs

Name of Associations	Description	Quantity	Plate No.	Date Assigned	Remark
National	Toyota Land Cruiser	1	42-291	May 19, 2017	National and Addis Ababa use 1 Vehicle
Addis Ababa					
Amhara	Nissan Patrol	1	42-274	July 27, 2017	
Oromia	Toyota Land Cruiser	1	42-276	May 19, 2017	
SNNP	Nissan Patrol	1	42-275	July 20, 2017	
Tigray	Toyota Land Cruiser	1	42-277	July 28, 2017	
MAPPP-E	Toyota Land Cruiser	1	42-290	May 19, 2017	
Total		**6**			

Given the number of private health facilities, PHSP plans to combine the Dire Dawa and Harari PHFAs and assign them one vehicle. Considering the vastness of the regions and presence of significant number of private health facilities, PHSP may assign additional vehicles to Amhara and Oromia PHFAs. These two PHFAs may get additional vehicles in year III upon the approval and fulfilment of donor vehicle transfer procedure and guidance of the Client. .

4.3.3 Office Equipment and Furniture

Updating of the inventory data will be used for yearly disposition of vehicles and other logistics for stakeholders, especially for the PHFAs, in close consultation with USAID. In addition, in the final project year, the project will do inventory of all assets for transfer of assets. The inventory of non-expendable project assets that include computers, printers, photo copiers, scanners, etc. will be used to determine their transfer to local partner organizations.

4.4 Documentation and Data Handling

PHSP will regularly provide performance report of targeted private health facilities to their respective regional PHFAs with main purpose of building their capacities in program reporting and comprehending

donor requirements. More information of PHSP products (guidelines, SOPs, data, job aids, and communication materials) will be shared to these local counterparts in soft and/or hard copies

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
institutions for the oversight and support private health sector enhanced	Institutional Capacity Building	Support and coach PHFAs to conduct an organizational capacity assessment annually	# of PHFAs completed organizational capacity assessment	PHSP (DPHSD, SPMA, CBM), National Association																				
		Provide TA and training to PHFAs' secretariats and board members on association leadership and management	# of training programs organized and participating PHFAs	PHSP (DPHSD, CBM), PHFAs																				
		TA to PHFAs' staff to operate as a member-based organization. This can include training and technical support in advocacy and networking.	# PHSP targeted private health facilities joined regional PHFAs	PHSP (DPHSD), PHFAs																				
		Develop procedural guidelines and documents such as HR policy manual, financial management manual, etc.	# of guidelines developed, documented and adopted by PHFAs	PHSP (DPHSD, FD) and PHFAs																				
	Technical Capacity Building	TA and mentoring to PHFAs' staff on the management and organization of basic and refresher clinical training programs, and clinical mentoring as well as site supervision	# PHFAs' with 100% scoring of managing basic and refresher clinical training programs and supportive supervision	PHSP (SPMA, DPHSD, FD), PHFAs																				
		Support PHFAs to establish working relationship with the courier service/postal service provider to support and monitor sample transportation	# of targeted private health facilities that took part in sample transport to Regional Labs upon concluding agreement with RHBs	PHSP (DCoP, DCS, DPHSD, FD), PHFAs																				
		TA and mentoring to association secretariat on grant management	# of PHFAs with 100% scoring of IG and FOG management of grant request, tracking, reporting and compliance	PHSP (SPMA, DPHSD, FD), PHFAs																				
		Support PHFAs to coordinate with professional associations, such as MAPPP-E and EMLA for integration of private health sector in the national and regional EQA system, application of existing and new health standards etc.	# and type of solicited technical support in laboratory and advocacy to promoting the private health agendas	PHSP (DPHSD, DCS), PHFAs																				
		Coach/support PHFAs on monitoring and evaluation programs implemented by targeted private health facilities	# of coaching sessions on HMIS application	PHSP (DPHSD, DME, DRP), PHFAs																				

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.1. Capacity of local	Financial/Operational Capacity Building	Organize meetings with PHFAs to build consensus on transition of project activities of PHSP	# of meetings and consensus built between PHSP and PHFAs	COP, SMT, RHBs, PHFAs																				
		Provide institutional grants to support structural and organization development of the associations including salaries for staff, provision of office resources such as computers, software, etc.	# of PHFAs with full staffing and less turnover	PHSP (SPMA, FD), PHFAs																				
		Provide fixed obligation grants to organize and management clinical training for public health providers and conduct clinical mentoring	# of grants solicited and clinical trainings organized by PHFAs	PHSP (SPMA, FD), PHFAs																				
		Provide TA and mentoring to association secretariat on grant management	# of PHFAs with 100% scoring of grant management of grant request, tracking, reporting and compliance	PHSP (SPMA, FD), PHFAs																				
		Provide TA for establishment of business relation to access bank loans	# of negotiations and agreement concluded with banks to access bank loans	PHSP (CoP, DPHSD), PHFAs																				

Annex I (b) - Activity Planning and Monitoring Plan: Private Health Facilities

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.2. increased uptake of service for disease of public health importance from the private health sector	Technical Capacity Building	Supportive supervision and clinical mentoring through RHB, PHSP and PHFAs	# targeted private health received supportive supervision and clinical mentoring	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Organize and conduct basic and refresher thematic clinical training programs to targeted private facilities	# of targeted private health facilities received clinical training programs	PHSP (DCoP, DCS, DRP, SPMA, RMs), PHFAs																				
2.3 enhanced implementation of quality management strategies and practices with in the private heath facilities		Provide TA and training to facilitate data quality and HMIS	# of sessions/ visits made per targeted facilities	PHSP (DCoP, DME, DRP, RMs), PHFAs																				
		Provide targeted facilities with all relevant desk references (GLs, job-aids, training materials, M&E tools….)	# of references provided to target private facilities	PHSP (DCoP, DCS), PHFAs																				
		TA to private facilities to conduct facility self-assessment and comply with health facility standards	# of targeted facilities adopting self assessment	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		TA to coordinate supportive supervision with RHBs/THOs and regional PHFAs for comprehensive site support to targeted offices	# of targeted private health facilities received comprehensive site support	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
2.4: referral linkage and feedback mechanism strengthened		Develop and distribute referral SOP and directory	# of directories developed and distributed	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		TA to coordinate sample transport/referral to regional laboratories in coordination with RHBs and PHFAs	# of targeted private health facilities linked with regional labs	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
3.2: the private health sectors access to resources increased	Financial/Operational Capacity Building	TA to targeted private health facilities to identify financial needs to be addresses through bank loans	# of targeted private health facilities identified financial needs	PHSP (DPHSD), PHFAs																				
		TA and training on business plan development to access bank loan	# of negotiations and agreement concluded with banks	PHSP (DPHSD), PHFAs																				

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.3: improved enrollment and practice of accreditation among private health facilities	Institutional Capacity Building	Develop checklist and adopt capacity assessment to establish baseline to compare transition of project activities to targeted private clinics	# of targeted private health facilities with identified gaps	PHSP (DCoP, DCS, DRP, E7RMs), PHFAs E10+E22																				
		Advocate the integration of private facilities into regional EQA plan	# of targeted facilities covered by EQA	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Build the capacity of the providers to take corrective actions based on EQA	# of feedback and corrective actions taken by targeted facilities	PHSP (DCoP, DPHSD, DCS, DRP, RMs), regional PHFAs																				
		Training and engagement of more private labs in the implementation of SLMTA and SLIPTA for accreditation	# of targeted standalone/integrated labs received training	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
3.4: Supply chain management and rational drug use enhanced		Organize training on IPLS and use of SOP and distribute IPLS SOP	# of targeted facilities trained and adopting the SOP	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Access regular/timely supply of commodities to private facilities through PFSA's regional hubs and Woreda/town health offices	# of targeted facilities accessing supply of commodities	PHSP (DCoP, DCS, DRP, RMs), PHFAs																				

Annex I (c) - Activity Planning and Monitoring Plan: RHBs

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
of local institutions for the oversight and support private health sector enhanced	Institutional Capacity Building	Promote the establishment of Private Health Sector Units at the RHBs	# of RHBs with established Private health Sector Unit	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Promote resource allocation by the RHBs in support of the private health sector	# of RHBs that allocated financial resources	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Promote RHBs to support targeted private health facilities receive EQA from regional labs	# of targeted private health facilities received EQA from regional lab through RHBs	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Coordinate outreach support with RHBs to provide joint supportive supervision to those facilities with high yield limit possible risks of under performance	# of high-yield sites identified and joint supportive supervision given	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Support RHBs to sign MOU with PHSP and PHFAs for PPM implementation guidelines for TB-DOTs, HIV/AIDS, Malaria and RNMCH	# of MOUs signed between RHBs, PHSP and PHFAs	RHBs, PHSP (DCoP, DCS, DRP, SPMA, RMs), PHFAs																				
		Provide needs-based PPP-H support to RHBs	# of need-based support given	RHBs, PHSP (SPMA, RMs), PHFAs																				
	Technical Capacity Building	Support RHBs to organize advocacy workshop on 'Phasing Out PHSP and Future Role of PHFAs' and joint follow-up meetings of the RHBs, PHFAs and PHSP bi-annually	# of participating RHBs, PHFAs, FMoH, FHMACA in the workshop, and # of bi-annual review meetings	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Work with RHBs to train PHFA members and provide training programs on thematic areas and certify them with TOT	# of training programs and professionals certified with TOT	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Support RHBs to integrate targeted private health facilities in the basic and refresher trainings organized for public health facilities	# of health professionals from targeted private health facilities attended training programs	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Organize training programs to RHBs on supportive supervision and solicit provision of tools to targeted private health facilities	# of supportive supervision training programs organized and tools provided	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Support the RHBs and structures at Woreda and Town levels continue the oversight of public sector services being delivered through private facilities.	# of supportive supervision visits conducted to targeted private health facilities	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Promote participation of PHFAs in the review meetings as representatives of private health facilities engaged in the provision of priority health services	# of review meeting organized by the RHBs with participating PHFAs	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.1. Capacity	Financial/Operational Capacity Building	Organize meetings with the RHBs and jointly develop TORs to lead transition of overall site support (targeted private health facilities) to PHFAs	# of meetings and TOR developed	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				
		Initiate dialogue with RHBs to identify their positions to the PHSP transition and sustainability plan to transition targeted facilities to PHFAs	# of meetings and consensus built between RHBs and PHFAs	RHBs, PHSP (COP, SMT)																				
		Support RHBs to develop skills in proposal writing to mobilize resources from donors and provide training on financial management procedures and reporting	# of proposals developed and training given to RHBs	RHBs, PHSP (DCoP, DCS, DRP, RMs), PHFAs																				

Annex I (d) - Activity Planning and Monitoring Plan: FMoH

Result Areas	Transition/ sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.2: enhanced oversight and implementation of PPPH	Technical Capacity Building	TA to FMoH to advocate for the inclusion of health in the PPP proclamation through the PHFAs and professional Associations	# of documents and proposals developed and submitted	FMoH-DRM, PHSP (SPMA, PS)																				
		TA to the FMoH to develop PPM implementation guidelines for HIV/AIDS, Malaria and RNMCH, revision of TB -DOTs, and get approval of the FMOH	# of PPM guidelines, manuals, user guides approved	FMoH-DRM, PHSP (DCoP, DCS, SPMA, PS)																				
		Coordinate with FMoH to sign MOU between RHBs and PHFAs on the new PPM implementation guidelines for HIV/AIDS, Malaria and RNMCH	# of MOUs signed for PPM projects	FMoH-DRM, PHSP (DCoP, DCS, DRP, RMs,SPMA)																				
	Financial/Operational Capacity Building	Support the FMoH to mobilize resources for the management of PPP-H projects	# of project proposals submitted	FMoH-DRM, PHSP (SPMA, PS)																				
		Organize meetings with the FMoH and jointly prepare TOR to lead transition of PHSP's support to FMoH	# of meetings and TOR developed	FMoH - RMD, (COP, SMT, SPMA)																				
3.1: capacity of local institutions for the oversight and support of the private health sector enhanced	Institutional Capacity Building	Promote the institutionalization of PPP-H unit in the FMoH: Recruiting professionals to handle PPP-H activities in the Ministry	# of staff recruited and PPP-H unit established	FMoH-DRM, PHSP (SPMA, PS)																				
		TA to build capacity to plan, develop, procure and implement feasible PPP-H projects	# of PPP-H projects developed	FMoH-DRM, PHSP (SPMA, PS)																				
		TA to identify, select and support regional PPP initiatives to designate PPP-H focal person and emulate the PPP-H structure of FMOH in selected RHBs	# PPP-H projects launched by RHBs	FMoH-DRM, PHSP (SPMA, PS)																				
		TA to develop PPP-H project (comprehensive/separate) implementation guidelines\ on HRH Development, pharmaceutical supply chain, tertiary healthcare, and get approval of the FMoH	# of PPP-H guidelines, manuals, user guides approved	FMoH-DRM, PHSP (SPMA, PS)																				
		TA to ensure participation of PHFAs and professional associations in PPP Technical Working Group at the FMoH and selected RHBs	# representatives participated	FMoH-DRM, PHSP (SPMA, PS)																				
		Coordinate outreach support on selected aspects of PPP-H	# of staff time committed	FMoH-DRM, PHSP (SPMA, PS)																				

Annex I (e) - Activity Planning and Monitoring Plan: FMHACA

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.3: capacity of regulatory bodies for enforcement of quality standards strengthened	Technical Capacity Building	Provide technical support to FMHACA to ensure smooth functioning of ICT system for efficient and transparent facility assessment	# of onsite inspection results uploaded	FMHACA - DMLSS, (DPHSD, HRA, IS)																				
		Support FMHACA to streamline continuing professional development into relevant professional and national associations	# of milestones developed and adopted	FMHACA - DMLSS, (DPHSD, RHA), PHFAs																				
		Support FMHACA with secondment of professional to provide TA	# of seconded staff	FMHACA - DMLSS, (CoP, DPHSD, HRA)																				
		Support FMHACA in the identification of inspection tools, specification and procurement	# of inspection tools procured	FMHACA - DMLSS, (DPHSD, HRA)																				
	Financial/Operational Capacity Building	Organize meetings with the FMHACA and jointly prepare TOR to lead transition of PHSPs support to FMHACA	# of meetings organized and TOR developed	FMHACA - DMLSS, (COP, SMT)																				
		Support the FMHACA to mobilize resources for the management, promotion and development of health standards	# of project proposals developed and submitted	FMoH-DMLSS, PHSP (DPHSD, HRA)																				

Result Areas	Transition/ Sustainability Target	Activities	Indicators	Responsible	Year I				Year II				Year III				Year IV				Year V			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.1: capacity of local institutions for the oversight and support of the private health sector enhanced	Institutional Capacity Building	Support FMHACA in revising existing and developing new health standards	# of revised and new standards	FMHACA - DMLSS, (DPHSD, HRA)																				
		Support FMHACA to organize refresher and new training programs to targeted private facilities on the revised and new health facility standards	# of training programs and participating private health facilities targeted by PHSP	FMHACA - DMLSS, (DPHSD, HRA)																				
		Support FMHACA to develop and distribute supervisor tools, health facility checklists and job aids to facilitate supervision of health facilities	# of operational tools developed and distributed	FMHACA - DMLSS, (DCoP, DCS, DRP, DPHSD, HRA)																				
		Support FMHACA to update and develop TOT certification of inspectors on Inspection Principles, Ethics, Methodologies, Enforcement and Introduction of Standards	# of inspectors received TOT	FMHACA - DMLSS, (DPHSD, HRA, DRP)																				
		Support FMHACA to develop performance-based grants to PHFAs to conduct educational and sensitization workshops with private facility owners and managers	# of workshops organized by PHFAs	FMHACA - DMLSS, (DPHSD, HRA), PHFAs																				