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PRIVATE PROVIDER NETWORKS IN ETHIOPIA

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This publication was produced for review by the United States Agency for International Development. It was prepared by Jeff Barnes, Carlos Cuellar and Yilma Melkamu for the Private Sector Partnerships-*One* project.

PSP-*One*
PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

Country Report

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

CONTENTS

ACRONYMS

ART	Antiretroviral therapy
BCC	Behavior change communication
CBRHA	Community-based reproductive health agent
CORHA	Consortium of Reproductive Health Associations
CYP	Couple years of protection
DOTS	Directly observed treatment/therapy short course
FGA	Family Guidance Association
FHI	Family Health International
HAPCO	HIV/AIDS Prevention and Control Office
HSDP	Health Sector Development Program
IE	Information Education
IEC	Information, education, and communication
IUCD	Intrauterine contraceptive device
IUD	Intrauterine devices
MAPPP-E	Medical Association of Physicians in Private Practice-Ethiopia
NGO	Nongovernmental organization
OC	Oral contraceptive
PRB	Population Reference Bureau
PSI	Population Services International
PSP-One	Private Sector Partnerships-*One* Project
SIDA	Swedish International Development Cooperation Agency
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

EXECUTIVE SUMMARY

In response to the United States Agency for International Development's (USAID) Ethiopia mission's request, the Private Sector Partnerships-*One* (PSP-*One*) project fielded an assessment team from February 11–24, 2007, to document the state of operations for the Biruh Tesfa network, identify strategies to improve network sustainability, and determine local organizations that could have a role in network management and support. In addition the team was asked to explore opportunities to integrate HIV services into the Biruh Tesfa network.

During the assessment the team also met with USAID representatives and stakeholders interested in private-sector provider networks to make a presentation and lead a discussion on networks and social franchising. The main purpose of this session was to clarify issues about different approaches to networks and the implications of adopting more or less intensive approaches to managing them.

The team met with Biruh Tesfa network members, Pathfinder International staff supporting the network, and government officials working with private providers. And it reviewed government documents and project reports. The principle findings of the assessment were the following:

- The Biruh Tesfa network operates effectively to support the provision of family planning in the private sector, albeit less intensively than at the outset of the project. Training and brand promotion are limited, but supervision and data collection continue and product supply is increasing.
- The structures and processes that support the Biruh Tesfa network are not strong enough to consider increasing their sustainability.
- The environment for pursuing private provider networks is favorable and the lessons learned from the Biruh Tesfa network experience can be useful in pursuing new network strategies.
- A number of interventions supporting private networks can be implemented quickly and easily. These actions include research, financing, and policy interventions that will inform and facilitate future work with private providers.
- There is no single organization that stands out as the best option to ensure franchisor functions and network support.
- There is no single network strategy that stands out as the best way to achieve the public health goals of USAID and the government of Ethiopia. The assessment team recommends combining a less-intensive network that will achieve scale more rapidly with another network option that will build local ownership and more sustainable structures for the long term.

1. COUNTRY BACKGROUND

Ethiopia has the second largest population in sub-Saharan Africa after Nigeria, with an estimated 77 million people living there. According to projections by the Population Reference Bureau (PRB) in 2006, in the year 2050 the country's population will reach 145 million people, making it one of the 10 largest countries in the world (Population Reference Bureau 2006).

Ethiopia is one of the poorest countries in the world with a Human Development Index only better than 7 of the 177 countries the United Nations Development Programme (UNDP) lists (United Nations Development Programme 2006). The gross domestic product per capita is only $756, and the combined primary, secondary, and tertiary gross enrollment ratio is only 36 percent (United Nations Development Programme 2006). Access to schools for the rural population, especially young girls, is limited.

Key health indicators, as measured by national surveys in 2000 and 2005, show measurable improvements (Central Statistical Agency and ORC Macro 2006a and 2006b). Modern contraceptive use among married women more than doubled during this five-year period, from 6 to 14 percent. Women who use a modern method show a preference for hormonal methods —oral contraceptives (OCs) and injectables comprise more than 90 percent of current contraceptive use. More than 20 percent of women obtain their method from the private sector, and for OCs nearly one-third of women use the private sector. Mortality rates for children less than 5 years old decreased significantly during this period, from 166 to 141 per 1,000 live births.

Despite the recent increase in contraceptive prevalence, reproductive health and family planning needs in the country are great as the total fertility rate is still 5.9 children per woman and the unmet need for family planning is 34 percent as of 2005. Only 5 percent of women delivered in a health facility in 2005, showing no improvement from 2000. The low rate of delivering with a skilled birth attendant contributes to one of the highest maternal mortality ratios in the world (673 per 100,000 live births). HIV is a public health threat, with approximately 1 million Ethiopians (1.5 percent of adults) infected by the virus.

2. PRIVATE-SECTOR PROVISION OF HEALTH AND THE PURPOSE OF THIS ASSESSMENT

Parallel to this increase in contraceptive prevalence has been the growth of the private health sector. The Ethiopian government has adopted policies that are favorable to private-sector development, and this approach has been extended to the health sector where the number of privately owned facilities has grown. In light of these developments, in 2000 Pathfinder International-Ethiopia, with the support of the Packard Foundation, initiated the Biruh Tesfa ("bright future") social franchise. It was one of the first attempts to organize private health practitioners with a view to increasing the provision of reproductive health and family planning services in the private sector in order to increase access to quality reproductive health services. By 2007 Biruh Tesfa had grown into a network of 150 private clinics and several hundred community-based and marketplace agents that conduct demand-creation activities and referrals. Since 2005 Pathfinder has explored increasing the sustainability of the Biruh Tesfa network. To that end Pathfinder had a role instituting the Medical Association of Physicians in Private Practice-Ethiopia (MAPPP-E) in 2003, with tentative plans to transfer leadership of the franchise to the association in the near future. While MAPPP-E has earned a good reputation as a voice for private providers, given its youth it was unclear if the organization was equipped to assume this role. With its mandate to document the best practices in private provider networks and support the sustainable provision of family planning and reproductive health services, the Private Sector Partnerships *One* (PSP-*One*) project contacted the United States Agency for International Development's (USAID) Ethiopia mission and Pathfinder about conducting an assessment of the possibilities for increasing the sustainability of the Biruh Tesfa network. USAID Ethiopia agreed to a scope of work that included:

- documenting current network operations
- reviewing the existing basket of services provided at Biruh Tesfa outlets and identifying additional services that might enhance the network's sustainability
- identifying and meeting with promising local organizations and commercial entities to assess their capacity for managing the franchise
- developing a sustainability strategy

In addition the mission asked the PSP-*One* assessment team to explore:

- opportunities to develop linkages between the Biruh Tesfa network and HIV activities
- ways to integrate more HIV services into the Biruh Tesfa network
- common communications and branding strategies for HIV and family planning services for provider franchises

The assessment team included Jeff Barnes, Deputy Director of PSP-*One*; Dr. Carlos Cuellar, Co-Founder of Prosalud in Bolivia and Chief of Party for Abt Associates' Jordan Health Systems Strengthening project; and Dr. Yilma Melkamu, a local consultant previously employed by Pathfinder who was involved in establishing the Biruh Tesfa network. See Annex 1 for the full scope of work.

3. HISTORY AND DESCRIPTION OF THE BIRUH TESFA PROGRAM

The Biruh Tesfa network was developed in the context of a Pathfinder project funded by the Packard Foundation, called the Private Sector Franchise Initiative, in 2000. It was funded for a second phase in 2002 to 2005, and the project received additional financing from USAID and the Swedish International Development Cooperation Agency (SIDA). Because of resource constraints, the project was limited to the Amhara, Oromiya, and Addis regions. The project design involved working on both the supply and demand sides of the reproductive health equation. Pathfinder acted as the franchisor to private clinics, offering free training and free contraceptive supplies. In return, providers were expected to offer staff the opportunity to participate in the training, post the Biruh Tesfa logo, adhere to quality standards, and collect data in a format provided by Pathfinder. On the demand side, Pathfinder initiated a network of market-based and community-based reproductive health agents (CBRHAs). These agents were trained to provide basic information about contraceptives, supply condoms, resupply pills, and refer clients to Biruh Tesfa providers or government clinics where clients could receive additional counseling or methods.

Pathfinder offered up to three training modules to providers: Quality of Care, Contraceptive Technology and Post-Abortion Care and Infection Prevention, which included a practicum. In practice few Biruh Tesfa providers attended all three courses. Pathfinder developed the curricula over an extended period of time in consultation with the Ethiopian government and the Consortium of Reproductive Health Associations. Adaptations of the training program were made to suit providers in terms of the timing of sessions, but no changes were made to the content of the modules themselves.

The program was well integrated with government and community infrastructures. Government health authorities were involved in the training and supervision of private providers in their area as well as in tracking the data providers reported.

The 2005 Packard evaluation of the network, conducted by the Johns Hopkins Bloomberg School of Public Health, found that the project had met or exceeded nearly all its original objectives, including:

- providing reproductive heath and family planning services through 120 private clinics
- training 348 CBRHAs, 97 marketplace agents, and 40 workplace agents, who were providing information, education, and communication (IEC); counseling; and supplies
- reaching more than 150,000 new clients for family planning services through the network
- achieving a higher level of perceived quality of services in Biruh Tesfa clinics versus other ones

4. SITUATION ANALYSIS OF BIRUH TESFA

This assessment did not reevaluate the Biruh Tesfa network nor did time or resources permit a representative sampling of member clinics. Rather the following situation analysis is an update on the network with a view toward identifying its elements that can be supported into a more sustainable program. While the Packard evaluation was conducted while the project was ongoing, during PSP-*One*'s assessment (in February 2007) Pathfinder did not have the resources to recruit new providers or continue training or conduct promotional efforts. It has simply maintained the existing systems of product supply, data collection, and supervision. Therefore readers should not expect to find the same level of activity.

NUMBER AND DISTRIBUTION OF MEMBER CLINICS

There are 154 facilities in the Biruh Tesfa network, consisting of 5 hospitals (3 percent), 36 higher clinics (23 percent), 6 special clinics (4 percent), 45 medium clinics (29 percent), and 62 lower clinics (40 percent). Table 1 shows the number and distribution of Biruh Tesfa clinics by type and region.

TABLE 1: DISTRIBUTION OF BIRUH TESFA CLINICS BY TYPE AND REGION

Region	Hospitals	Higher clinics	Special clinics	Medium clinics	Lower clinics	Total	Percent
Addis Ababa	5	33	2	26	20	**86**	56
Amhara	0	3	4*	16	32	**55**	36
Oromiya	0	0	0	3	10	**13**	8
Total Biruh Tesfa clinics	**5**	**36**	**6**	**45**	**62**	**154**	100
Percent	3	23	4	29	40		

* = Two Biruh Tesfa clinics function as workplace clinics and were categorized as special clinics.
Sources: Federal Ministry of Health; Pathfinder International records

Biruh Tesfa clinics comprise 10 percent of private clinics in the three regions where the network operates, with significant variance by type of clinic and region.

- 92 percent of Biruh Tesfa clinics are concentrated in the Addis Ababa (56 percent) and Amhara (36 percent) regions. The remaining 8 percent are in Oromiya. The limitation to these regions reflects the original target area selected for the Packard project, but the lack of coverage in Oromiya is noteworthy.
- 69 percent of Biruh Tesfa clinics are lower (40 percent) and medium (29 percent) ones.
- When comparing the percent of the private sector clinics we find they represent 23% of all private clinics in Addis Ababa, 26% of all private clinics in Amhara, and only 2 percent of private clinics in Oromiya.
- Roughly 25 percent of hospitals and higher clinics in the three regions are part of the Biruh Tesfa network, compared to 13 percent and 6 percent of medium and lower clinics.
- Lower and medium clinics appear to have greater potential for recruitment, especially in the Oromiya region.

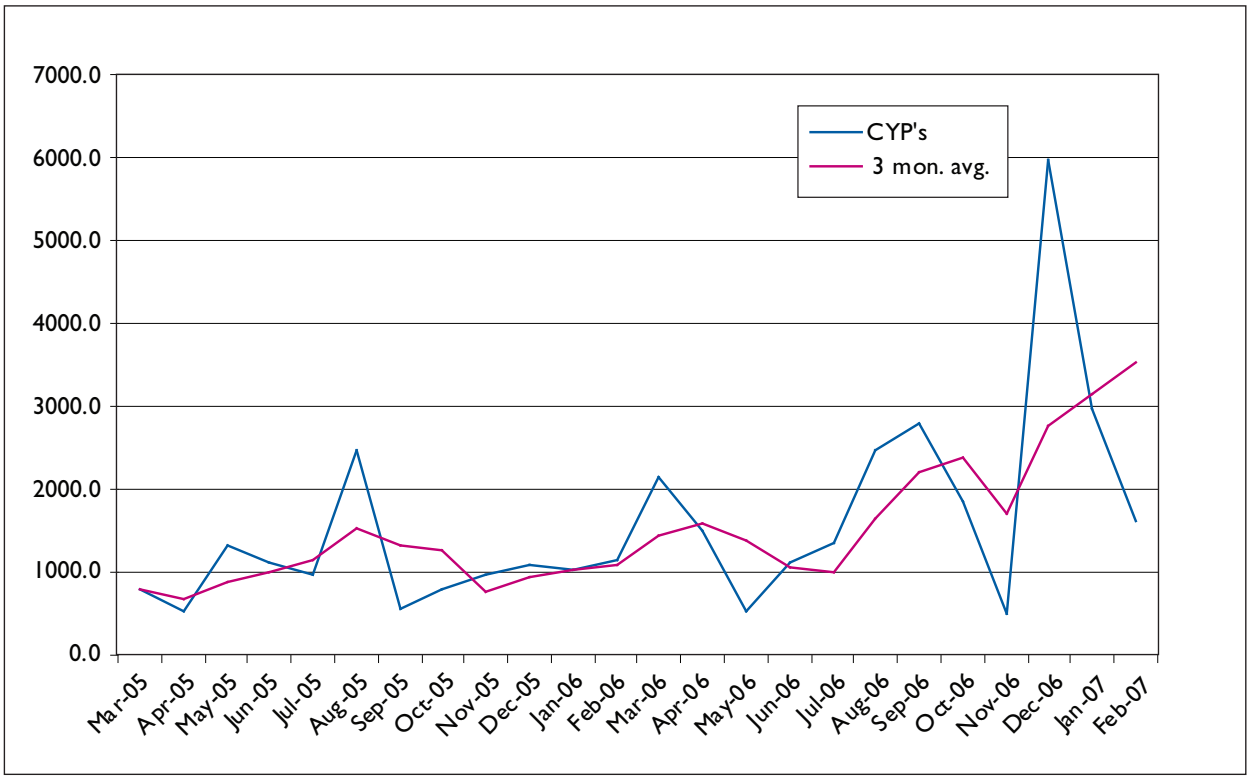
PRODUCTS, SERVICES, AND METHODS SUPPLIED

The package of services Biruh Tesfa supports is mainly focused on family planning methods and post-abortion care. Other potential areas (such as delivery, antenatal care, and HIV/AIDS) were not included in the training or product-supply support, although many providers in the Biruh Tesfa network furnish these services. The Biruh Tesfa clinics visited are providing family planning products and services according to the agreement signed between the provider and Pathfinder. Providers interviewed for this assessment confirmed that joining the network increased access to family planning services for their clients by integrating services with products, delivered as part of a package of services in those clinics. The main focus in most of the private clinics visited is curative care, but family planning products and services is one area where counseling and preventive care are provided. A number of the providers interviewed indicated that when joining the network they had no expectation that providing family planning services would help the business side of their practices, but they have been pleasantly surprised to see their client flow increase, and they feel that it is partly because of the introduction of family planning services.

Family planning services include counseling about and providing OCs, Depot medroxyprogesterone acetate, intrauterine devices (IUDs), *Norplant*, and condoms. The array of services depends on the type of clinic and the training received by the provider. Providers interviewed referred to training materials and guidelines Pathfinder provided as the basis of their practices. Although some project activities, such as training and recruiting are dormant, product supply continues to grow. The couple years of protection (CYP) supplied through private providers actually increased during the last two years, from a three-month average of 800 to more than 3,000. Injectables contribute 63 percent of the CYP supplied, IUDs make up 13 percent, and *Norplant* comprises 12 percent.

None of the providers interviewed indicated they experienced significant problems with the product-supply chain. The possible exception was for resupply of *Norplant*, which has become difficult to obtain for Pathfinder as the manufacturer is replacing it with a new form of implant, *Jadelle*. Given the distances and the number of stakeholders involved, maintaining an effective supply chain to private providers is a significant achievement, especially as the network is no longer really an active project with Pathfinder. That said, the network still depends on the link to USAID, which supplies product to the providers for

FIGURE 1: COUPLE YEARS OF PROTECTION SUPPLIED IN BIRUH TESFA NETWORK



free. Many Biruh Tesfa providers mentioned that they also carry DKT International products, which are readily available, but must be purchased by the client or by the provider in which case the cost is passed on to the client.

TRAINING

Pathfinder has developed and mastered a state-of-the-art family planning training curriculum that is being used for both public and private providers. Pathfinder offered training to Biruh Tesfa providers using selected modules from its comprehensive Training Curriculum for Clinic-Based Family Planning and Selected Reproductive Health services. The courses offered included Quality of Care Management (4 days), a refreshment course on Contraceptive Technology (3 days), and Long-Term Contraceptive Methods (10 days). The duration, methodology, and content of these courses are standardized and based on trainings conducted to public-sector providers. Each training module is well thought out, well-documented, and has had the benefit of extensive testing and refinement done in partnership with the Ministry of Health and other reproductive health organizations that are members of Consortium of Reproductive Health Associations (CORHA).

Although private providers interviewed for this assessment appreciated the training they received from Pathfinder, their ability to receive more training was restricted by the opportunity cost of leaving their clinics for a long period of time. The Pathfinder trainer said some of the workshops' times were changed to suit the private providers' schedules, but in the view of the assessment team, more flexibility will be required to facilitate uptake of training among private providers. For example, modules designed for five consecutive full days could be split into half-day sessions, so private providers can attend to patients in

the morning and participate in training in the afternoon. Facilities with 10 or more providers also could organize training activities on-site, rather than at an off-site training center. Recognizing that expertise varies, the government could test providers on some modules so they can be certified and able to benefit from network activities without having to review material with which they are already familiar. Some creativity and experimentation are required to adapt training programs to meet the needs of private providers.

Increasing access to training for private providers is essential given their growth and what is reported to be the high turnover of staff at private facilities. The records of providers Pathfinder trained do not permit a systematic analysis of how many providers were trained at each Biruh Tesfa facility, whether the trained providers are still there, or the total number of workshops and modules each trained provider attended during the project. Most of the providers interviewed for the assessment had attended only one workshop. A sample of 45 Biruh Tesfa clinics from the training records showed that an average of 1.13 providers were trained per facility and that the average number of workshops attended per trained provider was one. The Packard evaluation of Biruh Tesfa, however, showed high percentages of Biruh Tesfa providers as having received training in family planning counseling (83 percent), OCs (91 percent), IUDs (67 percent), and injectables (92 percent) as of 2004. These findings could be explained by the small sample of providers contacted for this assessment, by high turnover in Biruh Tesfa clinics since 2004, or by the small number of providers in lower and medium clinics. Many of the lower clinics only have one or two providers who can be trained.

Pathfinder did not establish a minimum training requirement for facilities to be considered part of the Biruh Tesfa network. The assumption may have been that as most of the clinics had few providers, training one or two would be adequate. It is understandable that at the outset of the program, Pathfinder did not want to set the bar too high in order to encourage more private providers to enroll. Indeed this strategy appears to have paid off, as Pathfinder enrolled a significant number of clinics and reached its targets for new clients. The lack of a system for analyzing facility capacity, however, has implications for quality assurance and the branding of the network. If the trained person is only 1 of the 10 providers that clients may visit at the facility, in what sense can the facility be said to be up to the Biruh Tesfa standards? If the network brand is to be a meaningful reflection of the quality of care clients receive, then the franchisor must ensure that participating providers are all certified in core modules and that each facility has mechanisms to ensure the dissemination of the training or retraining when trained providers leave.

It is possible that there are few Biruh Tesfa clinics where trained providers are a small percentage of all providers. In all likelihood, however, such a situation is limited to medium and higher clinics. The criticism is not that the number of providers trained is inadequate, but rather that the franchisor does not have a management system that permits one to determine whether the number of providers trained per facility is adequate or not. Ideally such a system should take account not only of the number of providers, but also of staff turnover and should be updated periodically.

QUALITY ASSURANCE AND SUPERVISION

The quality of services in the Biruh Tesfa network has been monitored through supervision activities Pathfinder personnel conducted in the Addis Ababa region. In the two other target regions, Pathfinder supervises the clinics in collaboration with local grantee nongovernmental organizations (NGOs), zonal

and district health offices, and its regional offices. One supervision checklist is used for lower clinics, and another one is used for medium and higher clinics. The supervision tool covers the presence of promotional materials, cleanliness, maintaining client privacy, availability of trained personnel, record keeping, and the availability of contraceptives.

In support of the quality-assurance process, Pathfinder developed and implemented a simple and effective clinical record for family planning clients (called a "client card"), a reporting system through a daily activity record form, and a quarterly programmatic reporting form. No other quality-assurance tools, such as peer reviews or self-assessments, have been implemented.

In the second phase of the project, Pathfinder made a sub-grant to MAPPP-E to nurture a local professional association that could assume more of the franchisor functions, especially regarding advocacy, training, and supervision. Most of the private providers the assessment team interviewed had heard of MAPPP-E, and some providers were members of it. There is interest and a perceived need by private providers for a professional association that addresses their concerns. This belief suggests that using a professional association to assume some franchisor functions is a sound strategy. That said, MAPPP-E is a young organization with few resources, so significant investment would be required to enable it to take on training and supervision functions. MAPPP-E does seem to have embraced the advocacy role and has some successes in engaging the national government health authorities on behalf of private providers.

NETWORK BRAND

Awareness of the Biruh Tesfa brand among consumers and providers is limited. This finding is not surprising given how little money was spent promoting the brand and that most of the promotion occurred more than three years ago. Even providers and staff in Biruh Tesfa facilities, however, do not have a good awareness of the brand and even less about what the brand is supposed to mean. Although the agreement specifies putting the Biruh Tesfa logo on the gate to the clinic, none of the clinics in Addis did so. Apparently the municipal authorities in Addis charge a tax for signage on private facilities, and as the project budget did not cover this fee, no Biruh Tesfa signs were hung. Nearly all facilities the assessment team visited had Biruh Tesfa stickers or print materials bearing the Biruh Tesfa logo in waiting rooms, but to the average client the logo could be a brand of antibiotic as it is mixed in with other promotional materials. The most common perception of the Biruh Tesfa logo is that it has something to do with care and support for people living with HIV/AIDS. This finding is not too surprising as most public campaigns in the past few years have pertained to AIDS, especially for people living with AIDS, and the image of the Biruh Tesfa logo itself (two hands shielding a rose) suggest something to do with caring for something fragile. Moreover the Packard evaluation conducted in 2004 and 2005 also found low awareness of the Biruh Tesfa logo or association with quality care.

Due largely to resource constraints, the logo did not benefit from formative research, it was not pre-tested with consumers, nor was a branding strategy articulated or followed. Some useful promotional strategies for the brand appear to have been implemented in the early days of the project, but as time went on and project funds for promotion were depleted, communications about the brand and what it should mean declined. In particular the idea of branding the CBRHAs by giving them Biruh Tesfa bags, hats, and t-shirts could have been effective, provided the agents were briefed about what the brand stood for and on the condition that the branding was maintained.

DEMAND CREATION

Most of the community agent networks created for the private network project still exist and operate. Although the agents are volunteers, they receive a monthly transportation allowance to attend meetings, which is often perceived as a salary for their work. Indeed maintaining this transportation allowance is a significant budget allocation for Pathfinder given the large number of community agents. This strategy for promoting family planning seems appropriate given the low access to media among the target population. It is not clear, however, that it is as appropriate in 2007 as it was in 2000. The government is rolling out an ambitious program of fielding health agents throughout the country, and approximately 9,000 of them have been assigned to field posts thus far with plans to train and field 25,000 agents nationally. Their tasks include many of those assigned to the CBRHAs (such as promotion of preventive maternal care, family planning, supply of condoms, and resupply of pills), so Pathfinder is wondering whether it makes sense to maintain the community-based strategy in its present form. In some areas Pathfinder's CBRHAs are introducing the new government health extension workers to the communities.

The tremendous progress from 2000 to 2007 in terms of increasing acceptance and knowledge of family planning principles and methods means that communications campaigns now can go beyond basic information. This change in attitudes and knowledge of family planning and reproductive health also explains increased interest by private providers in offering family planning services. By all accounts, even with a favorable arrangement with providers, it was not easy to recruit private facilities into the Biruh Tesfa network in 2000. Now, even though no one from Pathfinder is recruiting providers, private ones are contacting Pathfinder and asking to be a part of the network. This success also suggests that the time might be appropriate for a more balanced agreement between the franchisor and network members, including possibly requiring membership fees.

CONCLUSIONS/LESSONS LEARNED

The Biruh Tesfa network initiative has achieved its objectives of increasing access to family planning and reproductive health services through the private sector. The experience has generated lessons learned that should inform future efforts to pursue network strategies with private providers in Ethiopia.

- The environment in Ethiopia is favorable for using private provider networks as a strategy for achieving public health goals whether in reproductive health, AIDS prevention, AIDS care and treatment, or other areas. There is an increasing pool of private facilities, a large and growing segment of the population that perceives the value of private health care and is willing to pay for it, and a willingness in the private sector to invest in training and quality improvement when it can be shown to advance their practices.
- Private providers will respond to opportunities when they perceive value. Getting them to recognize the significance of initiatives with public health objectives often takes time and investment. Providers were reluctant to join the network at the beginning, in spite of a favorable arrangement offering them free training, free promotion, and free product supply. After seeing the benefits of providing family planning and other services, their involvement improved and word-of-mouth advertising seems to be motivating new private providers to request membership in the network. This pattern is consistent with worldwide network experiences; favorable arrangements have to be offered at the outset of network creation, but as providers perceive the increased value of network membership, they should be asked to contribute to the costs of network benefits.

- Community outreach can increase the volume of network clinics: Linking the community-based agents with clinic providers boosted clinic clients as well as increased access to all methods for clients. This strategy was an effective one for targeted facility promotion.
- High-volume hospitals and higher clinics are less interested in the benefits of a family planning network. Clinics with a large client load, especially the higher clinics in Addis Ababa, showed less interest in joining Biruh Tesfa, and some that joined later dropped out of the network. The reasons seem to be that they perceive less potential benefit by adding a program that will constitute a small part of their business and will require time away from work for providers, additional data collection and reporting, and will not significantly increase its client flow. This belief may be due to their focus on curative and diagnostic services or that most of their clientele may be referred from primary care providers. Primary care providers in lower and medium clinics may have more interest in building a faithful clientele that appreciates the personal attention providers show through a family planning or other preventive program.
- Trust between the public and private sectors can be built by working toward a common goal. In the case of Biruh Tesfa, involving local government officials in the training and supervision of private providers created a more sustainable structure for quality assurance and helped prevent distrust of private providers by the government authorities.
- The experience supporting MAPPP-E demonstrates the need for and interest in a professional association that focuses on private providers. Such a professional association has the potential to take on some franchisor functions. MAPPP-E, however, is not in a position to assume major franchisor functions in the short term. The organization seems best suited to the role of advocacy and representation.
- Biruh Tesfa did not establish any structures in terms of a dedicated support unit, a business-operating plan, or brand equity that consumers and providers recognize and understand. No fees were charged for membership, training, or product supply, so there is no base for financial sustainability. All of these practices are understandable given Pathfinder's desire to achieve its objectives in the most cost-efficient manner. These findings, however, suggest that it may be premature to talk about sustaining the network. The focus should be on creating the foundations for future sustainability by introducing a new set of structures and processes and striking a new balance between provider benefits and obligations to the franchisor.

In view of these findings, the assessment team did not develop sustainability strategies focused on Biruh Tesfa. Instead the team felt it would be more useful to the stakeholders interested in pursuing a private provider network strategy to analyze the opportunities to ensure different franchisor functions and to identify interventions that could enhance any private provider network activity in Ethiopia.

5. ENSURING THE NETWORK FRANCHISOR FUNCTIONS

This section analyses each major function a franchisor typically provides to network members (such as training, quality monitoring, product supply, policy and advocacy, business operating systems, and branding and communications) and reviews some of the in-country options for ensuring each function. Given the limited time for the assessment, the team does not wish to suggest that the organizations mentioned or the strategies suggested are the only options for ensuring an effective network. Not every franchisor function needs to be built into a network for the network strategy to be useful. If the objective is to get more private providers to offer a specific service, then it may not be cost-effective to task the franchisor with ensuring business operating plans, conducting advocacy, or building a common brand for network members.

TRAINING

Ethiopia's capacity for delivering training in family planning to private providers is extensive. A number of organizations the team interviewed have a track record in training capacity, and there are likely others that could conduct training which the assessment team did not have time to meet with, including international NGOs like Intrahealth. Moreover the training modules that Pathfinder and other organizations had a large role in developing are in the public domain and can be used by any organization certified by the government of Ethiopia.

Pathfinder has strong capacity and experience delivering training to prepare participants to provide quality family planning and reproductive health services. The curriculum can be used to instruct physicians, nurses, counselors, and midwives. Parts of the modules may be adapted to the needs of community-based workers. Pathfinder's comprehensive Training Curriculum for Facility-Based Family Planning and Selected Reproductive Health Services consists of 19 modules that are certified and endorsed by the Ministry of Health. Pathfinder's comprehensive training curriculum consists of the following modules:

- Reproductive Health Overview
- Natural Family Planning Methods
- Barrier Methods
- Combined Oral Contraceptives
- Progestin-Only Pills
- Injectables
- Implants
- Intrauterine Contraceptive Device (IUCD)
- Emergency Contraception

- Infection Prevention
- IEC/Behavior Change Communication (BCC)
- Counseling
- Reproductive Tract Infections
- HIV and AIDS
- Infertility
- Adolescents and Reproductive Health
- Reproductive Cancers
- Management and Integrated Supervision for Quality of Services
- Training of Trainers

Obviously the experience that Pathfinder staff has gained through the Biruh Tesfa network is a plus for future work with private providers. Pathfinder also has the administrative and logistical capacity necessary for organizing, supporting, and documenting any training programs.

Consortium of Reproductive Health Associations (CORHA) is an established umbrella organization that provides a forum for exchanging and promoting best practices among NGOs focused on reproductive health in Ethiopia. CORHA has a small staff and has demonstrated the administrative capacity to manage sub-grant programs. Some CORHA staff members conduct training activities directly, and they have a small resource center that could be one facility for professional training. CORHA's capacity to mobilize technical expertise is somewhat dependent on the capacity of its members, which includes Pathfinder, Marie Stopes, Family Guidance Association (FGA), CARE, Dkt, and more than 70 other national and international associations working in reproductive health. CORHA itself, as well as most of its members, work primarily with the public and NGO sectors, so CORHA may have to adapt training to the private-sector context and learn to be responsive to the needs of the private sector. It is most cost-efficient to work through an organization like CORHA to develop a network of training expertise, which can be drawn on for short-term needs rather than try to house all requisite training expertise permanently in a single organization. This strategy could help keep franchisor training costs down while making the most of local capacity. The challenge in such an approach would be to ensure consistent quality in training implementation.

Medical Colleges: One of the unusual environmental factors in Ethiopia has been the recent rapid growth of private medical colleges. These schools represent another pool of training expertise that can be drawn upon, and their graduates represent a new labor pool that can help support the growth of private facilities. The assessment team did not have the time to conduct a thorough review of all private medical colleges, but based on comments from informants, the quality of instruction varies and the standards for accreditation of the medical colleges are not strictly applied. Obviously any strategy to draw on medical college training staff as a resource would have to ensure a quality standard among trainers.

FGA of Ethiopia: FGA has experience training health professionals. Its model Sexual Reproductive Health Clinics, Youth Centers, and Community-Based Sites are used as practical learning and demonstration centers. FGA is also a member of CORHA. Courses FGA offers include:

- Norplant Insertion/Removal
- Contraceptive Technology Update & Pap Smear
- Basic Sexual Reproductive Health/Family Planning
- Sexual Reproductive Health/Family Planning Counseling
- Client-Oriented Provider Efficient
- Voluntary Counseling & Testing for HIV
- Minilaparotomy under local anesthesia
- No-Scalpel Vasectomy
- Training of Trainers on Norplant and IUCD
- Adolescent Reproductive Health
- Post-Abortion Care
- IEC/BCC

In the area of HIV, there is also significant in-country capacity for provider training for counseling and testing, care and support, management of sexually transmitted infections, and antiretroviral therapy (ART). The experience in this area, however, is not as extensive as in the family planning area, and most of the capacity to conduct provider training sits with international organizations such as Family Health International (FHI), the Centers for Disease Control, and their closest partners. HIV training has focused on public-sector providers, so there would be a similar need to adapt tested training curricula to the needs of private providers.

In terms of opportunities to integrate HIV with family planning and reproductive health initiatives, it is not clear how well this action would work in the training area. Because these interventions often target different clients, they may need to focus on different providers. Specifically the priority in family planning and reproductive health is reaching rural providers and clients, while HIV interventions need to focus on high-risk groups, which are found primarily in urban areas.

In terms of institutionalizing approaches to technical training and building local capacity, the family planning sector seems more advanced, likely because of a longer history of family planning programs in Ethiopia. The process by which Pathfinder and other family planning and reproductive health NGOs worked with the government to develop training modules and test, refine, document, and disseminate them through CORHA to other national and international organizations seems to be a good model for the HIV sector to follow.

QUALITY ASSURANCE/MONITORING

Although the model Pathfinder adopted for Biruh Tesfa seems to have been successful, there may be other approaches to quality monitoring and supervision that may be beneficial for interventions beyond

family planning. For voluntary counseling and testing (VCT), for example, it is common to conduct periodic mystery client surveys to ensure that providers respect established norms. The project budget did not permit such monitoring tools for Biruh Tesfa, and no random monitoring took place. The public sector customarily conducts provider supervisory visits, but this approach is expensive and requires a structure with large technical staff and the logistical means to conduct site visits. Moreover this approach is often not well received by private providers who tend to view such visits as investigations by the "quality police." Pathfinder's practice of using only local government officials who are known by the private providers and who may have had a role in training the providers seems to be a good approach to get around some of these issues. It requires considerable effort, however, to build such a network and establish positive working relationships between the local health authorities and private providers.

Another approach that PSP-*One* has been developing and promoting is the use of self-assessment tools. Such tools can be designed to address the specific needs of private providers. Also they are more empowering to private providers, as they have to buy into the quality-improvement process and are often more aware of their shortcomings than an external supervisor who visits infrequently. Such tools can be used with or without supervision and should lead to action plans that address the areas where improvement needs are identified. Self-assessment tools also can be complemented with voluntary peer reviews within the same facility or between facilities. PSP-*One* is testing the efficacy of a self-assessment tool in Uganda with and without supervision.

In terms of the in-country capacity to implement one of the aforementioned approaches, this function requires drawing on similar technical expertise needed for training. So some of the organizations that were cited for training can be considered for the quality-assurance function. The additional elements beyond the technical capacity are having sufficient logistical capacity and experience implementing quality-improvement systems. In view of the latter elements, Pathfinder, FHI, and Intrahealth would be appropriate implementing partners. The assessment team also feels that MAPPP-E could add value to the process by being involved in reviewing the clinical guidelines and standards that go into the quality-assurance tools. Its understanding of the private providers' perspectives and the conditions in which they work would help make the tools more suitable and more acceptable to private providers. MAPPP-E has the technical capacity to assume an operational role in quality assurance, but this would require donor support to hire dedicated staff and build up logistical capacity.

MANAGEMENT AND OPERATIONAL SUPPORT

If a network is going to be more than a loosely structured training program, there is a management role that the franchisor must assume. Ideally network members should have a single contact point, even if some of the network functions are conducted through partnerships with other training organizations or supervisory structures. In some of the deeper network options (for example, a standalone franchise) the franchise manager must address all aspects of how facilities are run—from what services are provided, to what forms are completed, to how client flow is managed and how the waiting room is decorated. Such approaches require developing a detailed business plan, training facility staff on how to abide by that plan, and monitoring to ensure adherence.

Even in a less structured approach, such as a fractional social franchise, at a minimum the network manager has to manage and monitor the network agreements to ensure that providers are adhering to the terms of the agreement. And when providers fail to meet network obligations, they must be made to comply or expelled from the network. This enforcement is important if future network strategies are

to build more sustainable systems based on charging network members fees for benefits. If the network manager lets every member receive the benefits without meeting the obligations, then soon every member will stop meeting its obligations.

There are also management tasks involved in ensuring that the different franchisor activities are coordinated. For example, providers should not be receiving IUD supplies unless personnel in the facility have completed IUD training and have been certified to provide this service. Facilities that are not providing the required range of services or fail to meet quality standards should not benefit from network branding if the network includes a network brand and a shared-promotion strategy. Providers that are not reporting their service data should not benefit from continued training or product supply. Whether a single organization or some combination of organizations ensures the franchisor functions, they have to be coordinated.

To ensure these management roles, an organization must have significant capacity in its administration and financial management with strong internal controls. Ideally the network managers should be able to track all activity between the franchisor and the individual facility members, such as what training the facility has received, what products it has received, what fees it has paid, and what data it has reported. This function also necessitates significant capacity in information technology, both in creating and managing databases. Staff should be able to analyze data and prepare reports based on that analysis to inform stakeholders as well as feed back market data to network members.

There is no single organization that stands out as best able to ensure a broad network-management function. All potential network-manager organizations would require varying levels of investment and technical support. The largest organizations would require the least investment, and they could access technical support from within their own structures. But most of these entities are international organizations (such as Pathfinder, FHI, Population Services International (PSI), Marie Stopes, and Dkt), so investments would not be assured of those remaining in Ethiopia. To address this issue, an international organization could be funded to create a dedicated network-management unit with a view to transferring the unit to a local organization, such as CORHA or FGA, to assume the management function at some future time. If a lighter option for provider networks is chosen (for example, an unbranded training program), then minimal management functions could be assigned to a lead local organization for training and quality monitoring. This approach might require technical assistance for the local organization in designing membership agreements, setting prices for services, and data collection and management.

POLICY AND PRIVATE-SECTOR ADVOCACY

As the private health sector continues to grow in Ethiopia and the government embraces the vision of private-sector participation in the delivery of public health, there is a need for private providers to have a voice in informing and setting national policy. Professional associations, such as MAPPP-E, are suited to fulfill this function, but a network franchisor may be able to represent the private interest as well—particularly if the franchisor is seen as sharing the government's public health goals and not just trying to preserve the private sector's ability to run profitable practices.

Ethiopia formulated a comprehensive national health policy in 1993. The policy emphasizes reaching and responding to the needs of the rural population, which constitute more than 85 percent of the total population. The policy stipulates that health services should be delivered in a decentralized way with a

primary focus on preventive care. It states that multisectoral collaboration should be promoted at all levels, and that NGOs and the private for-profit sector should be involved in the process.

To translate the policy into action, the country has been implementing the Health Sector Development Program (HSDP) since 1997. After completing the first phase of the HSDP in 2002 and the second phase in 2005, the country now is implementing the third phase which continues to 2010 (Federal Ministry of Health of Ethiopia 2005). The private sector (including both the not-for-profit and for-profit sectors) is seen as an important partner in expanding the health service coverage in the country.

Health-service delivery in Ethiopia operates in a decentralized way with authorities at federal, regional, and *Woreda* (district) levels sharing in decision-making. The service-delivery setup follows a four-tier system that consists of a primary health care unit (five health posts and one health center), district hospital, zonal hospital, and specialized hospital. The government also recently introduced the Health Service Extension Program with the intention of enhancing preventive care and reaching more underserved people, especially in the rural areas.

The Potential Health Service coverage in Ethiopia has increased in the last few years. The Ministry of Health defines the Potential Health Service coverage as the percentage of the population covered, based on the existing health centers and health posts in each catchment area. In the last six years (1999 to 2005), Potential Health Service coverage has increased from 57 to 72 percent. When the contribution of private health facilities is considered, coverage climbs to 83 percent (Federal Ministry of Health).

According to the Ministry of Health, the government runs 600 health centers; 5,873 health posts; and 85 hospitals. Private for-profit providers also have flourished in the past two decades. There are 19 private for-profit hospitals and 1,578 different private clinics throughout the country. This sector is growing, and the government has recognized this phenomenon as an important opportunity to achieve short- and long-term targets, including the Millennium Development Goals.

The assessment team's discussions with government officials at federal and regional levels indicated that the government is willing to support and engage the for-profit health sector in the national health system. The HIV/AIDS Prevention and Control Office (HAPCO) is ready to collaborate with the sector, and there is a plan to involve it in national-level planning and proposal development for international funding. The head of federal HAPCO said that he would like to see better-organized private providers and have a coordinating body that brings together the public, for-profit, and NGO sectors. He indicated also that MAPPP-E should be strengthened and represent private providers with HAPCO. HAPCO had provided financial and technical support to some private providers to support their HIV/AIDS-related activities (such as IE, BCC, and VCT services). One example of such support is HAPCO's donation of 4 million birr to Bethzatha Hospital to establish affordable VCT centers in Addis Ababa and a couple of regional towns.

The Health Services Department at the federal Ministry of Health is reorganizing itself, and there is a plan to establish a dedicated unit that supports and monitors the for-profit sector at the federal level. The Ministry of Health has started working with approximately 14 professional associations in the country, including MAPPP-E. The head of the Health Services Department indicated that the ministry is involving MAPPP-E in the revision of the existing clinic-licensing guidelines, which shows how the government is opening up to collaborating with the for-profit sector. Thus far the government has not developed an incentive scheme to encourage providers to open clinics. The ministry has started outsourcing some activities to the private sector, including laundry and catering. There is no outsourcing of clinical health services so far.

There are initiatives to involve the for-profit health sector in reproductive health and HIV/AIDS-related services by the Family Health Department and the Disease Prevention and Control Department of the Addis Ababa Regional Health Bureau. The Family Health Department is working with Save the Children USA to start youth-friendly reproductive health services in some clinics in Addis Ababa. The Disease Control and Prevention Department is supporting for-profit providers in Addis Ababa furnish affordable VCT by providing test-kits and training. The department also has started working with some providers on directly observed treatment/therapy short course (DOTS) for tuberculosis. The bureau is happy with the collaboration thus far and satisfied by the compliance of private providers in ensuring quality, record keeping, and timely reporting.

The government is not just paying lip service to working with the private sector; its encouraging statements have been backed up with concrete partnerships. Efforts include involving the private sector in HIV/AIDS and reproductive health and family planning issues. There are also efforts to involve the private sector in joint revision of the existing provider certification guidelines by the federal Ministry of Health. The following table provides a summary of existing partnerships.

TABLE 3: EXAMPLES OF PUBLIC-PRIVATE PARTNERSHIPS IN ETHIOPIA

Organizations	Activities
HAPCO and the regional disease control and prevention departments	▶ Supply of test-kits ▶ VCT for less than 10 birr ▶ ART drugs (in a pilot phase) ▶ Training (VCT and ART) ▶ Quality monitoring, recordkeeping, and reporting
PSP-Ethiopia, MAPPP-E, federal Ministry of Health, and regional health bureaus	▶ Public-private mix-DOTS (in a pilot phase) ▶ Training and drug supply ▶ Quality monitoring, recordkeeping, and reporting
MAPPP-E and Pathfinder	▶ Created advocacy forum to bring the government, donors, NGOs, and for-profit sector together ▶ Resource mobilization ▶ Removing operational barriers that affect the for-profit sector
Federal Ministry of Health and MAPPP-E	▶ Initiated joint revision of standards and certification guidelines for the for-profit sector
Save the Children-USA and Addis Ababa Health Bureau	▶ Initiating youth-friendly programs for public and for-profit facilities
Regional health bureaus and FHI formed VCT counselors association	▶ To reduce counselor burn out ▶ To standardize quality of services ▶ To improve recordkeeping
Biruh Tesfa, zonal, and district health offices	▶ Joint monitoring and training, provision of supplies

In the policy and advocacy area, MAPPP-E is the standout organization. It has established constructive working relationships with the government to represent the private sector's interests in both the family planning and HIV sectors. That said, the team recommends that MAPPP-E partner with a more neutral body (a local or international NGO) to give it more credibility and to help MAPPP-E become a more viable organization. There are concerns that as MAPPP-E officials have their own facilities, they will use the organization to the benefit of selected members rather than representing all of them equally. Whether this perception is based on facts is not the issue. Because the leaders of MAPPP-E have their own facilities, the potential for a conflict of interest must be managed—either by involving an independent body in managing MAPPP-E or by drafting organizational statutes to prevent conflicts of interest.

The other condition that the assessment team recommends is to insist that MAPPP-E focus as much or more on increasing its operating revenues from members and entrepreneurial sources of funding as it does on donor funding. Since MAPPP-E received funding from Pathfinder, membership revenues fell. Moreover the strategic plan that was completed recently seems to focus on raising more funds from donors than from members. While donor funding could be an appropriate way of increasing MAPPP-E's capacity quickly, the long-term viability and indeed the credibility of the professional association is demonstrated by what percentage of its members are willing to pay for the benefits they receive. Without this commitment MAPPP-E will become another health NGO and will not be able to claim that it speaks for its members. Donors and the government do not need another NGO; they need a viable professional association that has the support of private-sector health professionals. MAPPP-E should be encouraged to consider expanding its mandate to include other private health professionals to boost support and fee revenue.

COMMUNICATIONS/BRANDING

One of the less successful components of the Biruh Tesfa experience was the development of its network brand. As noted earlier funding was not sufficient to promote the brand effectively, and the steps used to create and disseminate the brand did not take sufficient account of consumer and provider perceptions. It is possible that Biruh Tesfa would have achieved the same results if it had conducted the training, supervision, product supply, and community-agent activities without any brand or logo.

Although the Biruh Tesfa brand does have some recognition, the understanding of what it means is low and it is confused with HIV care and treatment. Given this uncertainty, it would be harder to correct misperceptions about an existing brand than to start fresh with a new one for the new network initiative. It is better to think of Biruh Tesfa as the brand for a campaign than as a network organization. For a brand to serve as a true network or franchise identity it must be linked to quality standards on the provider side and it must be linked to standardized services on the consumer side.

Provider network strategies can be established without a brand. A network could begin with a training program, and once the network has a critical mass of members that provide the desired range of services at the minimum quality standard, then a brand could be developed and promoted for those members. This approach ensures that the network brand keeps its promise of quality to consumers from the outset. This approach only should be taken if there are sufficient resources to promote the brand intensively to consumers. And it must have a clear, focused message that tells consumers what they can expect and what the benefits will be from attending branded facilities. If done effectively having

the brand will increase client flow and non-network providers will see the benefits of branding. The brand then provides an incentive to private providers outside of the network to attend training, pay their fees, and reach the quality standards. Once they are part of the brand, the threat of brand removal also supports quality-monitoring activities by providing additional incentives. Having a brand that reflects quality and increases demand allows it to be both a carrot and a stick in support of quality health services.

Achieving this goal takes time, resources for brand promotion, and management discipline to enforce network agreements (such as remove the brand for providers that fail to maintain quality standards). Because expelling members works against expanding access and makes it harder to reach donor targets, NGO franchisors often lack this management discipline.

The organizations with the capacity to develop, promote, and maintain a network brand identity are limited to international social marketing and behavior-change organizations: PSI, Dkt, FHI, and Johns Hopkins University's Center for Communication Programs. There appear to be few strong market research organizations in Ethiopia, so the communications organizations should have in-house capacity for market-research design and analysis. If an international organization provides leadership on the network brand, the team recommends having strong links to the organization providing management functions as well as to local organizations that can conduct local, targeted community promotion and referrals for network members.

PRODUCT SUPPLY

As noted previously the product-supply system created by Pathfinder for Biruh Tesfa members seems to have been effective. Although there were periods of stockouts, demand for product supply is growing. And although network support has been reduced, Biruh Tesfa members continue to supply family planning products, especially injectables, to their clients.

The major concern of the assessment team in the product-supply area is the lack of sustainability and that products are distributed for free. In that sense it is not really a private-sector supply system, but rather an extension of the public sector's distribution system to the private sector. There is value in this structure, especially in terms of increasing access, but the downside is that a function with the greatest potential for sustainability is not viable. Moreover having the private sector dependent on public-sector sources does not improve the country's contraceptive security. If USAID and other donors stop supplying free contraceptives to the public sector or if there are significant interruptions in supply, this shortage will be felt in the private as well as the public sector. If the private sector has an independent source of supply (or, ideally, multiple independent sources of supply), then even when public-sector supplies are lacking, the private sector will be able to provide for the needs of Ethiopians.

The assessment team talked to a number of pharmacies about where they source their products (including contraceptives) and learned that there are few large wholesalers or distributors. Many small ones exist, but most of these operate only in the largest towns with limited capacity to distribute nationally. The number of pharmacies relative to the population of the country is also low, and they are concentrated only in a few urban areas. Until the pharmaceutical sector grows, private-sector supply systems will have to work beyond the pharmaceutical chain. After the government and the public sector's system of distribution, Dkt has the most effective distribution infrastructure in the country with warehouses, vehicles, and distribution and sales staff in all 11 regions.

Establishing a commercially sustainable supply chain to serve private providers is an intensive, long-term task. Dkt has built its infrastructure through years of continuous development using both donor resources and product sales revenues. In the short term, shifting more providers to Dkt as a source for supplies would improve the network's sustainability and contraceptive security. Providers would have to pay for their IUDs, injectables, and implants and then would pass on the cost to their clients. It is not clear if providers would have an additional profit margin on the product or how much buying the products would increase their costs to consumers. Nor is it known if small increases in prices would discourage use of the services, but this information could be assessed through research.

In the medium to long term, more private commercial capacity needs to be built to distribute contraceptives and other drugs nationally under safe conditions. Donors cannot be expected to invest in commercial companies, but this area is one where donor-supported interventions with the banking sector to increase lending to pharmaceutical and health providers could have a positive effect. It is likely that some of the small pharmaceutical wholesalers and distributors have the technical capacity to expand, but are unable to due to a lack of access to finance.

CONCLUSION

Although the assessment team does not feel that there is a single organization that could easily assume all franchisor functions for an intensive provider-network model, such as a standalone social franchise, the capacity and resources to ensure all franchising functions can be found in Ethiopia and could be coordinated into a single franchisor function. Obviously there are issues around institutional conflicts, working with different donor regulations, priorities, practices and partnerships that would have to be considered if a franchisor were to be put together from multiple partners. The assessment team did not explore these factors in depth, but acknowledges that they would have to be considered in designing such a function.

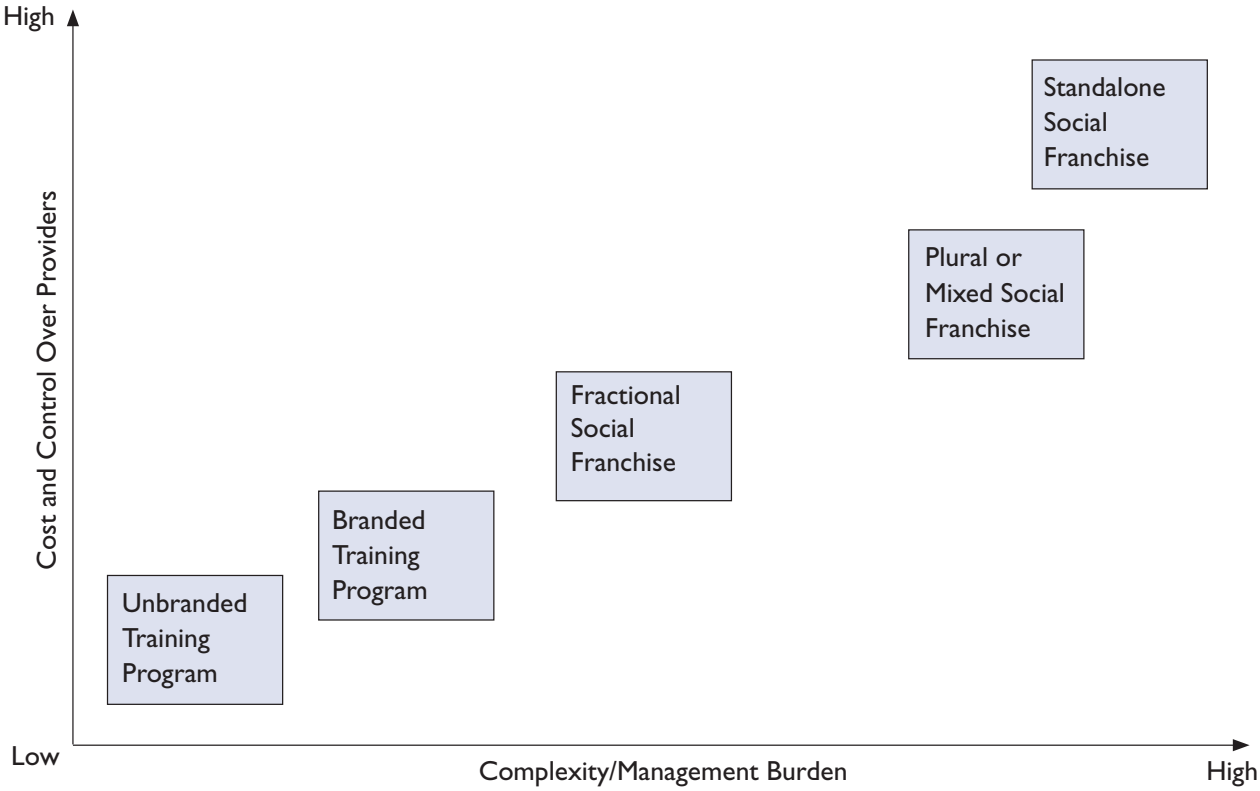
To sum up, the team sees the following strengths, weaknesses, opportunities, and threats to ensuring the franchisor functions in Ethiopia:

Strengths	**Weaknesses**
▸ Training capacity and experience ▸ Quality assurance and monitoring	▸ Private sources of product supply ▸ Franchise management, operating system design and implementation, information system design, and management
Opportunities	**Threats**
▸ Growth of private facilities ▸ Growth of medical schools and graduates ▸ Private provider interest in professional association and the emergence of MAPPP-E ▸ Public-sector recognition of the private sector's role and its willingness to include private sector	▸ Difficulties of working across organizations and donor-funding mechanisms ▸ Newness of concept ▸ Difficulties of NGOs knowing how to speak the language of the private sector ▸ Competition for health providers and risk of emigration

6. NETWORK OPTIONS

The assessment team did not want to limit its recommendations to a single network strategy, as there is a range of interests in network strategies. As was discussed during the presentation on networks and social franchising, network approaches vary according to their cost, management complexity, degree of control over providers, potential for increasing quality and access, and potential for long-term viability. Figure 2 shows how some of the network options compare on a scale with these factors.

FIGURE 2: COMPARING NETWORK OPTIONS



OPTION 1: INTEGRATED UNBRANDED TRAINING AND SUPPLY PROGRAM

The first option for a private provider network strategy would not be creating a true franchise, but rather a looser program involving training and supplying products. The range of training and product supply would not be limited to family planning, but would integrate family planning with HIV/AIDS and eventually other sectors, such as tuberculosis and malaria. Recruitment of private facilities still could begin with providers that are members of Biruh Tesfa, but the recruiting and training efforts should be billed as a new endeavor, not a Biruh Tesfa activity. It might be useful to treat it as a new

campaign targeting private providers or have the providers recognize it through the main implementing organization, whichever one that might be. A new participation agreement could be drawn up describing the obligations and benefits of members. Some of the elements of the Biruh Tesfa agreement still would be applicable—training and subsidized product supply in exchange for data reporting and adherence to quality standards. The team recommends requiring fee payments as a part of the agreement: a small fee for joining the network and a small fee for specific training events. The objective would not be to recover a significant percentage of the management or training costs (at best the fees might cover 5 percent of them), but rather to test the providers' level of interest and to establish a foundation for future sustainability.

In this option there would be no branding of the network at the outset of the program. This approach would save brand development and promotional costs and permit greater focus on training providers. At the same time, excluding branding at the initial stage would not preclude introducing it when sufficient numbers of providers have been trained and reached the quality standard. Branding could be introduced as recognition of members' achievements in providing quality services. And in the process of introducing the brand, the providers' willingness to pay a fee for joint promotion also could be tested.

The training and product package offered to providers would depend on donor and government priorities and clinic levels. For HIV counseling and testing, for example, providers would have to agree to participate in training and adhere to national standards in exchange for the training and subsidized rapid test kits. Lower and medium clinics could participate in such an arrangement. Provision of ART probably would have to be limited to higher and special clinics.

Even if products are sourced from public-sector supplies, the team recommends charging private providers a share of their cost to build sustainability. This also would be contingent on the private providers staying within an appropriate price ceiling. Apparently this policy exists for private providers with access to free rapid test kits: they cannot charge more than 10 birr for the test if they want to get them for free. Fixing a price ceiling is preferable to trying to fix prices given the range of clientele being served in the private sector. Obviously if providers were expected to pay for the test kits, the ceiling would have to be raised higher than 10 birr.

ADVANTAGES:

Not having to build a network brand would save resources and allow the network manager to focus on providing an effective training program and supporting trained providers with needed products or supplies.

The key advantage to integrating HIV/AIDS with family planning (and possibly other interventions, such as tuberculosis and malaria) are the efficiencies that could be achieved for the providers, as they only would have to deal with one network manager, one set of data-collection systems, one quality-assurance monitoring system, and one source of supplies. Because this network option is light in that there is no business-operating plan, no joint promotion or branding, and a limited set of obligations, the time and costs of starting the operation are much lower than some of the other network options. Being able to offer a wider range of training services and products also would facilitate provider interest and attract a wider range of providers.

DISADVANTAGES/RISKS:

The advantage of integrating to simplify operations for providers would have to be weighed against the additional complexity for the network manager. Inevitably, if HIV, family planning, and other health issues were to be addressed, the implementing organization would have to consult with a broader range of organizations and donors and be faced with multiple administrative and reporting requirements. One issue would be having different priorities for recruiting member providers. As noted previously an HIV-focused program would work primarily in urban areas, with providers serving high-risk groups. A family planning and reproductive health program would need to recruit outside of the main urban areas.

Charging membership, training, and product-supply fees would discourage some providers from participating, especially those with minimal interest in the network and those that may have been accustomed to receiving training and products for free.

Finally not addressing the business practices of private providers and focusing on training and product supply would mean that no sense of network identity is being built and no structure is being created for the long term. Once the training program is over and the subsidy for product supplies ended, the only lasting impact would be the increase in private providers' skills and the increased range of services offered through the private sector. Depending on donor objectives, this result may not be seen as a disadvantage, but the assessment team feels it is important to cite it as a potential missed opportunity.

OPTION 2: SEPARATE UNBRANDED TRAINING AND SUPPLY NETWORKS

This option is a variant of Option 1, but instead of trying to identify one lead organization to integrate family planning and reproductive health training and product supply with HIV training and product supply, the recommendation is to have two separate network leads, one focused on family planning and reproductive health and the other focused on HIV. Given target group priorities, each lead would initiate separate recruiting efforts focused on providers in different areas and with different clientele, although there would be a little overlap as some providers would be recruited into both networks.

ADVANTAGES:

Having two separate network leads should expedite the roll out compared to Option 1, because there would be less upfront coordination and consultation between all the stakeholders and implementing organizations. Data-collection and quality-assurance mechanisms could be better tailored to the specific needs of each health sector and would require fewer rounds of review.

DISADVANTAGES/RISKS:

The disadvantages and risks of this strategy are the same as in Option 1, but with the additional concern that some providers would be recruited into both networks and therefore would have to deal with different lead organizations, reporting, and quality systems. This could affect providers' willingness to be part of both networks. This disadvantage could be managed upfront if the lead network organizations agree to coordinate efforts. One possibility would be to have MAPPP-E involved in reviewing the data-collection and quality-assurance systems with a view toward minimizing the burden on private providers while still ensuring quality and satisfying the needs of donors and the government.

If branding of the network or networks were to be added at a later stage, then it seems unlikely that a single brand could be developed for both a family planning and reproductive health network and a network focused on HIV services. This situation means fewer opportunities for economies of scale in brand building and increased costs. Moreover developing brands for HIV services that are not integrated with other preventive care services is often more difficult to do as the brand communications must be crafted carefully to avoid stigmatizing the facility or the clients going to the facilities.

OPTION 3: STANDALONE MODEL: SHARE RISK AND INVESTMENT WITH MEDICAL ENTREPRENEURS

The fundamental concept of this option is to share risk and investment with medical entrepreneurs in a geographic area to establish a network of private facilities that is operated by private providers and linked with the public sector and the community. By medical entrepreneurs, the team is thinking of providers contacted during the assessment that are investing their own funds into starting clinics at different levels as well as pharmacies and medical colleges. Some of the key elements of this option include:

- building or renovating a model clinic outside Addis Ababa with an existing clinic owner willing to expand coverage (a model clinic shall qualify for a higher clinic or a hospital)
- developing a service-delivery, financial, and franchising model for the network
- expanding the package of services once a business model is proven and offering an array of integrated services (preventive and curative) that include family planning, HIV, tuberculosis, and others (ancillary services such as laboratory and ultrasound would be made available)
- sharing investment and risk with owners to replicate clinics in underserved areas (satellite clinics would include medium and lower clinics)
- employing young providers from medical colleges
- recruiting community agents for demand creation and referral
- coordinating better with the public sector, including policy work, to develop incentives to attract private providers while ensuring quality controls
- exploring the recruitment of entrepreneurs from expatriate Ethiopian doctors
- documenting and developing guidelines for replication in other areas of Ethiopia

ADVANTAGES:

This approach is intensive but has the advantage of building solid ownership and leveraging Ethiopian entrepreneurship and capital. There would be little doubt about providers' commitment to pursuing the network objectives, because there would be a requirement that they invest their own capital from the outset. Once a business model is developed, replication of it could expand quality services to underserved areas. This model is a true public-private partnership in that donor support in providing start up capital only is made available on the condition of adhering to quality standards and serving underserved areas. The start up costs of lower and medium clinics are low according to some providers. In some areas such clinics can be established for $15,000 to $20,000. Establishing new clinics rather than

adding a range of services to existing ones has a much bigger impact over the long term for increasing access to health services.

DISADVANTAGES/RISKS:

Growing such a network would take time. In particular this option would require intensive work at the outset designing, documenting, and refining a business-operating plan for each clinic level. Mobilizing the capital also would require working with financial institutions, as it would not be desirable to have USAID or another donor simply provide the needed capital. Establishing a relationship between health entrepreneurs and local financial institutions would be more sustainable and allow more capital to be mobilized. One issue would be to define what constitutes an underserved area to meet the condition for donor support, as establishing just a lower clinic in an area with too small a population could prove unsustainable, even if the clinic were supported and well managed. It might take time to build a critical mass of network members and achieve the economies of scale necessary to provide training and product supply in a cost-effective manner.

OPTION 4: DEEPEN AND STRENGTHEN THE EXISTING BIRUH TESFA NETWORK INTO A FRACTIONAL FRANCHISE

This option deepens and strengthens the current Biruh Tesfa network. The existing loose network of Biruh Tesfa members would be transformed into a deeper fractional franchise model where providers would be asked to strengthen or add services and the franchisor would be more involved in members' business practices. The network would require providers to expand the range of services beyond family planning to other reproductive health issues, such as antenatal care, delivery, postnatal care, and child health. Services such as HIV/AIDS (especially ART, prevention of mother-to-child transmission, and VCT), tuberculosis, and malaria also could be added to the service package.

Current Biruh Tesfa support is focused on family planning with some attention to related services, such as post-abortion care. The existing Biruh Tesfa agreement requires little of providers but offers valuable benefits. As Biruh Tesfa has succeeded in promoting family planning and reproductive health services in the private sector and providers are now requesting membership, the time is appropriate to introduce a more balanced network agreement. Providers would be asked to sign a more detailed agreement that eventually would lead to receiving recognition based on their performance with regard to completing training modules and meeting quality expectations. To help the providers be more efficient and build their entrepreneur skills, they would receive training in business management and help developing a business plan. This area was never addressed under Biruh Tesfa, although it is recognized that such training is needed.

The existing training modules, which were developed mainly for the public sector, would be adapted to the needs of providers in the private sector, including scheduling at times more convenient to them. The providers also would be expected to pay membership and training fees that would cover a significant share of the expenses. Quality-assurance mechanisms also would have to be strengthened, going beyond the checklists to include observations or periodic mystery client surveys and expelling providers that perform poorly.

Once a critical mass of providers has adopted the network business practices and gone through the core training curricula, the network franchisor can develop a common brand and enlist provider support for shared promotion. Having the additional advantage of the brand should help recruit new providers. At that stage, recruitment will focus on enrolling providers from underserved areas.

ADVANTAGES:

The main advantage of this option is that it would be less costly for recruitment as it would involve established providers. This option would be attractive to the providers, as it expands their range of services and attracts more clients. It also allows for gradual expansion, especially to rural areas, and could mitigate brain drain and turnover to some extent. More importantly it would be easier to ensure service continuity and sustainability, as the providers likely would continue to provide support in the absence of support. Increasing quality controls and expanding business-practice training would ensure greater consistency and quality of providers in the network.

DISADVANTAGES:

The disadvantages of this approach are that they would require more investment for provider training and understanding providers' business practices. Stricter monitoring and supervision would be required to ensure quality of care and subsequent branding of clinics, which would increase the per clinic costs. The additional requirements for providers would not be acceptable to all providers currently in the Biruh Tesfa network, and the number of network providers likely would decline from existing levels before increasing through subsequent recruitment.

An issue that should be considered seriously before embarking on this model is having a mechanism for uninterrupted product supply. It is also important to anticipate provider dropout and poor adherence to standards and agreements. These problems, however, could be addressed through effective negotiation of new agreements.

As with Option 1, this integrated network would require consultation with a broader number of stakeholders and organizations to introduce training and product supply in a wider range of health services. Recruitment of providers would have to balance the priority of family planning and reproductive heath objectives to recruit in rural areas with the priorities of HIV objectives, which are to recruit providers in urban areas.

OPTION 5: PHARMACY AND DRUG STORE NETWORK FOR HIV

This network option is the most removed from the Biruh Tesfa model in that the focus is not on service providers, but rather it's on pharmacies and drug stores as first-line providers for people at risk of HIV infection and people living with HIV/AIDS but who are not captured in the public or private clinic system. This network option recognizes that many high-risk groups are too marginalized economically or stigmatized to seek out even curative or diagnostic services from any kind of facility. Although it is difficult to quantify the scale of the phenomenon, many people, including youth and people in high-risk groups, prefer to self-medicate rather than consult a health service provider.

The network franchisor would work with pharmacy and drug store staff (not just pharmacists, but also sales clerks) to train them to be more sensitive to the needs of these groups and to recognize which of

their clients are most in need of referrals to counseling and testing facilities or service providers. The network franchisor also would work with service providers to ensure that high-risk clients are referred to facilities that are friendly to them and understand their needs. Depending on the capacity and size of the pharmacy or drug store and its location, the network could explore the possibility of linking counseling and testing NGOs with the pharmacy so clients it refers could receive counseling and testing immediately.

Finally the network franchisor would work with finance institutions and trained pharmaceutical staff to explore opportunities to expand the number of pharmacies and drug stores, especially in underserved areas and areas with marginalized populations. As noted previously the shortage of pharmacies and drug stores relative to the population size is a major constraint for access to health in Ethiopia.

The opportunities for branding the pharmacy network could be explored so that high-risk groups or other marginalized groups would know that any store showing the network brand would be friendly and able to address their needs. Such branding and communications would have to be done in a targeted fashion to avoid stigmatizing the clients and the pharmacies.

ADVANTAGES:

Such a network would open a new channel for capturing people most at risk into the health system and referring them to public or private facilities. The network offers a new means to attract people with the greatest need for testing to facilities and identify some of those people who need to be on ART at an earlier stage.

DISADVANTAGES:

This model is probably the most innovative, and considerable time would have to be spent understanding the needs of the target groups, pharmacies, and drug stores to design a network agreement that motivates pharmacists and drug store owners and still captures high-risk groups into the health system. One possibility is to offer pharmacies or drug stores access to subsidized products related to treatment of opportunistic infections or some other appropriate health need. To provide this service, however, more work would have to be done in developing a private, commercial source of supply for the reasons noted previously.

7. NETWORK ENHANCING INTERVENTIONS

Even before embarking on a full network strategy, there is some low-hanging fruit that can be picked that will support any private provider network strategy and, indeed, any work with private providers in Ethiopia. The assessment team recommends that USAID, the government of Ethiopia, and other donors support these network enhancing interventions.

SUPPORT MAPPP-E TO CONDUCT PRIVATE PROVIDER ADVOCACY

The private health sector is emerging in Ethiopia, and the relationship between the public and private sector is evolving. In the recent past, the level of trust and collaboration between the public and for-profits sector was weak, and the for-profit sector was marginalized in training and new initiatives. The relationships between different government authorities and private clinics traditionally have been based on control rather than support.

The government, however, is adopting a more positive attitude to the private sector and recognizing its contribution to public health. The main reasons for the change include recognition of the growing role of the private sector by the government at different levels and the efforts of private providers to organize and lobby the government.

Physicians in private practice in Ethiopia established MAPPP-E in May 2003. The association was the first of its kind in the country, and it now has close to 150 members throughout Ethiopia. MAPPP-E secured legal status registration and certificate from the Ministry of Justice in December 2003 and now has its own office and three administrative staff. The association is implementing a three-year project that was funded by Pathfinder from a grant it received from SIDA. One of its main objectives is to create a forum for policy makers, the public health sector, donors, and the for-profit sector to build trust and gain support for the profit sector. So far MAPPP-E has conducted two advocacy forums, and MAPPP-E executive board members have observed positive changes from the government side. The government has started involving MAPPP-E in some federal-level initiatives, which include joint revision of private for-profit clinic licensing guidelines and involvement in an international study tour. MAPPP-E also was involved in the recently completed Private Public Mix-DOTS program.

The advocacy initiative needs to be broadened. In addition to federal-level decision makers, it also should target regional and *Woreda*-level authorities. MAPPP-E needs support to enhance this effort. The assistance could include regular identification of key advocacy issues, organizing forums at different levels, and strengthening private provider networks.

RESEARCH, MONITORING, AND EVALUATION

The private health sector is new and growing; as a result little is known about its needs, strengths, capacity, and operations. The pool of clients who prefer private providers is also new, and little or no

research has been done in Ethiopia about consumers' motivation for seeking private health care, their willingness to pay, and their expectations. Research related to private health provision is needed.

ENHANCE TRAINING OPPORTUNITIES FOR PRIVATE PROVIDERS

This intervention requires both policy work with the government and work with training institutions. The government has endorsed the family planning curricula and has accredited a limited number of organizations to certify providers that go through the curricula. Unfortunately the modules are established to be taught only in a way that is not well-suited to private providers. Training organizations need to be mandated to find more cost-effective ways of covering the same material in less time. The government even should consider certifying private providers that can demonstrate technical and practical knowledge without requiring them to sit through a five-day course reviewing material they already know or could teach themselves. Allowing providers to test out of course requirements could be a cost-effective way of enabling providers to offer new services.

IDENTIFY SOURCES OF BUSINESS FINANCE OR HEALTH FINANCING FOR PRIVATE HEALTH PROVIDERS

As noted in a number of the network options, access to finance is a limiting factor for the private sector. By enhancing the mechanisms through which private providers can access credit, donors can help the private sector grow and increase access to health care. Several options need to be explored to ensure proper access to finance, including the use of local commercial banks, the Development Credit Authority mechanism, and equity investments by entrepreneurs and providers. This issue is important to all options described previously, but is a critical element for Option 3: Standalone Model. The Banking on Health project is well designed to provide technical assistance in this area.

Health-financing options for private-sector participation need to be considered in policy dialogue. Contracting out health services and using vouchers could be considered in future policy dialogue with the government. The public sector is known to have shortages of trained personnel in many facilities. Private medical colleges and private facilities could collaborate to offer staff the opportunity to work in public facilities under subcontracting or fee-sharing arrangements.

Other financial arrangements include deferred payment agreements with companies to serve their employees or members, like the one established between the Women in Self- Employment microcredit organization and four private clinics. And pacts with insurance companies can be added to the list of options for health financing.

It is time to open a dialogue for exploring ways of enhancing the private sector's involvement. MAPPP-E, with support from stakeholders, can start discussions with the government about subcontracting some services to the private, for-profit sector. The government has started contracting out some services, such as laundry and catering for the bigger hospitals, to the private sector. With the objective of expanding access to HIV/AIDS care and support, HAPCO is funding a few private providers to undertake HIV/AIDS-related IE, BCC, and VCT service provision. Such initiatives should be strengthened, and the government can contract out some services (such as reproductive health and family planning, maternal health, and HIV/AIDS) to private providers. In addition to benefiting the private providers, this approach would ease the burden on the public sector and hence improve the quality of services. Experiences from similar countries like Malawi, where the government subcontracts reproductive health services to Marie Stopes International clinics, can inform partnerships in Ethiopia.

8. CONCLUSION

The Biruh Tesfa network is a pioneering reproductive health and family planning intervention that has provided important lessons for programming in the private sector. Despite limited funding the network provides reproductive health and family planning services and generates an increasing level of CYPs. The environment of 2007 is much more favorable to private provider networks than the Ethiopia of 2000 when Biruh Tesfa started. There is general consensus among the government, donors, and NGOs that private providers have to play a critical role in reducing the burden of health care provision from the public sector if Ethiopia is to have a viable, efficient health system that serves the vast needs of its population.

Private provider networks, ranging from unbranded training networks to highly structured standalone franchises, can harness the potential of the private sector by organizing individual practitioners and standardizing services and quality. This report presents five options for employing private provider networks to achieve public health goals, particularly as they relate to reproductive health, family planning, and HIV/AIDS. Each option has its strengths and challenges, and the adoption of any one of them will depend on the desired outcomes and priorities of donors and the government of Ethiopia. The team recommends and hopes that some combination of options is supported that balances short-term objectives of expanding services in the private sector with longer-term objectives of building sustainable structures that will continue contributing to public health in Ethiopia well into the future.

ANNEX 1: SCOPE OF WORK

PROPOSED SCOPE OF WORK

INCREASING THE SUSTAINABILITY OF THE *BIRUH TESFA* SOCIAL FRANCHISE

ACTIVITY

Explore strategies to increase the long-term sustainability of the *Biruh Tesfa* franchise, including transferring the role of franchisor to a local entity.

PURPOSE OF MISSION

In collaboration with Pathfinder International-Ethiopia:

- Document current network operations
- Review the existing basket of services provided at *Biruh Tesfa* outlets and identify additional services which might enhance network sustainability
- Identify and meet with promising local organizations and/or commercial entities to assess their capacity for taking over management of the franchise
- Develop a sustainability strategy

TIMEFRAME/LEVEL OF EFFORT

February 11-24/10-12 days

TRAVELERS

PSP-*One* proposes to send a three-person team to fulfill the scope of work in partnership with Pathfinder International-Ethiopia. The team will include:
Jeff Barnes, PSP-One Deputy Director
Sara Sulzbach, PSP-One Senior Advisor, Private Health Networks
Dr. Yared Abera, Regional Program Manager, Pathfinder Ethiopia
Dr. Carlos Cuellar, Co-founder of the PROSALUD Network in Bolivia, currently Chief of Party of the Systems Strengthening project in Jordan for Abt Associates, Inc.

Note: Sulzbach, Barnes and Cuellar will split their time in country between PSP-*One* and PC4 activities. In terms of PSP-*One* activities it is envisioned that Ms. Sulzbach will take the lead in assessing capacity of local entities in collaboration with Dr. Abera; Dr. Cuellar will lead efforts to document network operations and review the current basket of health services, and Mr. Barnes will explore marketing opportunities and lead the development of a sustainability strategy.

FUNDING

TDY costs will be co-funded by PSP-*One* and PC4-Ethiopia in accordance with level of effort applied to the respective projects.

BACKGROUND

Ethiopia is the second most populous country in Africa, with a population of 77 million. The country is slowly emerging from decades of socialist military rule, and has shown significant economic growth in recent years. Key health indicators, as measured by national surveys in 2000 and 2005, show measurable improvements. Modern contraceptive use among married women more than doubled during this five-year period, from 6% to 14%. Women who use a modern method show a preference for hormonal methods – oral contraceptives (OCs) and injectables comprise over 90% of current contraceptive use. Over 20% of women obtain their method from the private sector, and for OCs nearly one-third of women use the private sector. Under-five mortality rates decreased significantly during this period, from 166 to 141 per thousand live births.

While these advances are promising, reproductive health and family planning needs in the country are high. Even with the increase in contraceptive prevalence, Ethiopia's CPR of 14% is still low, resulting in a total fertility rate of 5.9 and a high unmet need for family planning of 26%. Only 5% of women delivered in a health facility in 2005, showing no improvement from 2000. The low rate of delivering with a skilled birth attendant contributes to one of the highest maternal mortality ratios in the world (871 per 100,000 live births). HIV is clearly a public health threat, with approximately 1 million Ethiopians (1.5% of adults) infected with the virus.

In recent years, private sector efforts to increase access to RH services have begun to surface. In 2000, Pathfinder International-Ethiopia initiated the *Biruh Tesfa* social franchise, one of the first attempts to organize private health practitioners. *Biruh Tesfa* has grown into a network of 130 private clinics and several hundred community-based and marketplace agents. The franchise objectives are to increase access to high quality RH services, but it has begun to add other primary health and HIV-related care services to its package of services. The long-term goal for Biruh Tesfa is to increase the sustainability of the network. Pathfinder had a role in instituting the Medical Association of Physicians in Private Practice-Ethiopia (MAPPP-E) in 2003, with tentative plans to transfer leadership of the franchise to the association in the near future. While MAPPP-E has a solid reputation, given its relative youth, it is unclear that the organization is sufficiently equipped to take on this role. Thus, this is an opportune juncture to conduct a broader assessment of potential organizations or commercial entities which may be well positioned to take over the role of franchisor, in addition to MAPPP-E.

Ensuring the sustainability of social franchises is the next step in the evolution of this unique private sector initiative, as was recently discussed at a WHO/PSP-*One* meeting on franchising in December. In recognition of PSP-*One's* mandate to promote sustainable private sector strategies to increase access to RH/FP services, PSP-*One* proposes to work in collaboration with Pathfinder International-Ethiopia to develop a sustainability strategy for the network. One of the options to explore is the feasibility of transitioning the role of franchisor from Pathfinder to a local entity, to enable local oversight and ownership and increase operating efficiencies. Transferring the role of franchisor from an international NGO to a local entity is an innovative concept, and one that holds a great deal of promise for long-term sustainability. However, the transition process also faces uncertainties, and armed with knowledge about factors that contribute to network sustainability and viability, PSP-*One* is uniquely positioned to help overcome these challenges and ensure a successful transition.

Since the initial development of this intervention concept, PC4 Ethiopia, led by Abt Associates, has received additional funding from the Mission to greatly expand private sector HIV services, including establishing a franchise. If desired by the Mission, this assessment team would also look at:

- opportunities to develop linkages between the Biruh Tesfa network and HIV activities
- ways to integrate more HIV services into the Biruh Tesfa network
- common communications and branding strategies for HIV/FP services for provider franchises

EXPECTED CONTACTS IN COUNTRY

PSP-*One* anticipates meeting with the following stakeholders and potential partners while in country:

- Tilahun Giday, Country Director, and Dr.Yared Abera, Regional Program Manager, Pathfinder International-Ethiopia
- Yoseph Waktoly, Project Director, PC4 - Ethiopia
- Dr. Ermias Mulugeta, Acting Director, MAPPP-E
- Private medical (nursing) colleges
- FGAE
- Schering Pharmaceutical Commercial distributors
- PSI Ethiopia
- Intrahealth
- Other organizations and commercial entities as deemed appropriate

DELIVERABLES

The team will present preliminary findings and recommendations to the Mission at the conclusion of the visit. An assessment report will be made available within three weeks of departure.

ANNEX 2: LIST OF CONTACTS

1. Ms. Tsigie Haile, Director, Organization for Women in Self Employment (WISE); E-mail: wise@telecom.net.et , Addis Ababa
2. Mr. Tilahun Giday, Country Representative, Ethiopia Country Office, Pathfinder International, E-mail: tgiday@pathfind.org
3. Befekadu Demmissie, Team Leader, Capacity Building & Training, Pathfinder International Ethiopia Country Office; bdemmissie@pathfind.org
4. Dr Yared Abera, Amahara Region Program Manager, Pathfinder International Ethiopia
5. Ms. Almaz Yirga, Capacity Building Team, Pathfinder International Ethiopia
6. Dr. Hasssan Mohammed, Head of the Heald Serivices Department, Federal Ministry of Health
7. Dr. Ermias Mulugueta, President, Medical Association of Physician in Private Practice (MAPPE-E); E-mail: ermias@bethzatha.org Addis Ababa
8. Dr. Birhanu, Secretary, MAPP-E
9. Ms. Tigest Alemu, Executive Director, Consortium of Reproductive Health Association (CORHA); E-mail: tigestalemu@yahoo.com Addis Ababa
10. Dr Betru Tekle, Head of National AIDS Control Secretariat (HAPCO)
11. Mr. Andrew Piller, DKT Ethiopia Director; Andrew@dktinternational.org
12. Ms. Francesca Stuer, FHI Country Director; fstuer@fhi.org.et
13. Dr. Altaye Kidane, FHI Technical Director; akidane@fhi.org.et
14. Mr. Getachew Bekele, Marie Stopes International Country Director; msie@ethionet.et
15. Sahlu Haile, Senior Program Advisor, Population Program, The David and Lucile Packard Foundation; shaile@packard.org
16. Ysehiemebet Giorgis, ARSH Program Manager, Save the Children USA; ygebregiogis@savechildren.org.et
17. Nolawi Abiy, Prevention Program Coordinator, Save the Children USA; nabiy@savechildren.org.et
18. Debrebirhan Health District, Mr Makonen, Dr Getachew
19. Adinew Husben, Program Director, Family Guidance Association of Ethiopia; adnewh@yahoo.com
20. Daniel Crapper, PSI- Ethiopia Country Representative
21. Mr. Gizaw, Head Family Health Department for Addis Ababa
22. Blanc Mesnil College, Debrebirhan Campus, Dr. Ayanaw Admasu

CLINICS AND PHARMACIES VISITED

23. BGM Higher Clinic, Addis Ababa, Dr Salomon Desalegn OBGYN
24. Dr Dembi Babo, Medium Clinic, Bole Cotobe, Sub City
25. Dr Wubayehu, Tesfa Medium Clinic (linked with WISE)
26. Hospital Saint Mary, Higher Clinic, Dr Fitsum
27. Bethezata Higher Clinic (ex- BIRUH TESFA Addis Ababa)
28. Family Guidance Association of Ethiopia, Model Clinic, Addis Ababa
29. Saris Abo Lower Clinic, Nurse Ragasa Dasa
30. Hibret Medium Clinic (non BT) Debrebirhan
31. Bruk Higher Clinic, Dr. Ayanaw Admasu, Debrebirhan
32. Red Cross Pharmacy, Debrebirhan
33. Kenema Pharmacy, Addis Ababa

ANNEX 3: BIBLIOGRAPHY, SOURCES CONSULTED

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