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ASSESSING THE ROLE OF THE PRIVATE HEALTH SECTOR IN HIV/AIDS SERVICE DELIVERY IN ETHIOPIA

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ASSESSING THE ROLE OF THE PRIVATE HEALTH SECTOR IN HIV/AIDS SERVICE DELIVERY IN ETHIOPIA

CONTENTS

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BOH	Banking on Health project
CS-Pro 3.3	Census and Survey Programming Statistical Software
CT	Counseling and Testing for HIV
DACA	Drug Administration and Control Authority
FHI	Family Health International
FMOH	Federal Ministry of Health
FP/RH	Family Planning/Reproductive Health
FHAPCO	Federal HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
MAPPP-E	Medical Association of Physicians in Private Practice in Ethiopia
MTCT	Mother-to-Child Transmission
NGOs	Nongovernmental Organizations
OIs	Opportunistic Infections
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHARMID	Pharmaceutical & Medical Supplies Import & Wholesale Share Co.
PMTCT	Prevention of Mother-to-Child Transmission
PPM-DOTS	Public-Private Mix Directly Observed Therapy
PPP	Public-Private Partnership
PPS	Probability Proportional to Size
PSP-E	PSP-Ethiopia
RHB	Regional Health Bureau
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TB/DOTS	Directly Observed Therapy for Tuberculosis
WHO	World Health Organization

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EXECUTIVE SUMMARY

The private health sector has the potential to help Ethiopia meet its goal of universal access to HIV prevention, treatment and care. However, as in many countries, the role of the private health sector in delivering HIV/AIDS services is not well understood. Better information on private provision of HIV/AIDS services – including strengths as well as gaps – will aid the Government of Ethiopia (GOE) in maximizing this sector's contribution to achieving national health objectives.

The number of private health facilities in Ethiopia totaled 1,578 in 2003 (FHAPCO 2007), and emerging empirical evidence indicates that the private health sector has contributed to expanding access to reproductive health services in the country (Kidanu 2002, Yeneheh 2003). Yet little is known about the current or potential role of private providers in meeting the growing need for HIV/AIDS services.

Ethiopia's growing recognition of the private health sector is evident in the *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support* (Multisectoral Plan of Action), which emphasizes collaboration with the private health sector across all levels of HIV/AIDS service delivery (FHAPCO 2007). To fully harness the private sector's potential to help Ethiopia reach its goal of universal access, it is first necessary to understand the sector's current contributions. This study seeks to assess the role of private health facilities and pharmacies in HIV/AIDS service delivery in Ethiopia, and specifically to identify factors that could enable greater involvement of this sector in addressing the HIV epidemic.

The study employed a cross-sectional survey design in the study sites of Addis Ababa city administration and Amhara and Oromia regional states. These three regions were selected based on a review of available data, which indicated that the majority of private facilities are concentrated in these areas. The survey assessed private hospitals, clinics (lower, medium, and higher), and pharmacies. In-person interviews were conducted with health facility administrators/owners, health care workers, pharmacy owners, and pharmacists. The study included a total of 280 private facilities and 121 private pharmacies.

Survey instruments were designed to collect a wide array of information on HIV and related services. Instruments for the health facilities and pharmacies were designed to be as similar as possible. Administrators/owners were asked questions on facility characteristics and management, access to financing, and business training. Direct service providers (i.e. clinicians and pharmacy personnel) were asked about their work history, training and education, HIV/AIDS and related service/drug provision, record keeping and referrals, and awareness of standards of care. Data collection took place from November 2007 to December 2007.

KEY FINDINGS

PRIVATE HEALTH FACILITIES

Health Provider Characteristics

- The majority of health providers in the survey (89 percent) were male. In hospitals, however, females comprised nearly 55 percent of respondents.
- Nurses represented the highest proportion of respondents (41 percent), followed by health assistants (29 percent), general practitioners (18 percent), health officers (6 percent), and physician specialists (4 percent).
- Twenty-two percent of the overall sample reported belonging to a professional association, with membership ranging from 12 percent in lower clinics to 61 percent in private hospitals. Physicians are most likely to report such an affiliation.
- Six percent of the provider sample reported simultaneously working in the public sector.
- The most commonly cited reasons for working in the private health sector were *better salary* (60 percent) and *better working environment* (37 percent).

Training

- Private providers have received limited training on HIV/AIDS and related services, particularly antiretroviral treatment (ART) and prevention of mother-to-child transmission (PMTCT). *Lack of opportunity* and being *unaware of training* were the two major reasons cited for not receiving training.
- As might be expected, levels of training corresponded with the level of facility. For example, whereas only 5 percent of lower clinic providers had received training in ART, 55 percent of hospital workers had received training.
- One exception is training on diagnosis and treatment of sexually transmitted infections (STIs), where lower and medium clinics were on par with higher clinics and hospitals (approximately 75 percent trained).
- The FMOH and nongovernmental organizations were major sources of training related to HIV/AIDS.
- There was strong interest in future training and notable willingness to pay for training among providers across all levels of private facilities.

HIV/AIDS Service Provision

- HIV counseling and testing (CT) was universally provided in private hospitals and in over half of higher clinics. CT was rarely provided in lower and medium clinics. Rapid testing was the major method these facilities used.
- Survey results on indications for HIV testing, when compared with World Health Organization guidelines, revealed multiple missed opportunities for testing – a problem that could readily be addressed through training.
- Whereas no lower clinics reported testing for HIV on site, 11 percent of medium clinics, 65 percent of higher clinics, and 100 percent of private hospitals reported this practice.

- Treatment of other STIs was widely offered in all levels of private clinics and hospitals, while tuberculosis (TB) treatment was offered in only a few private hospitals, a finding in line with existing regulations.
- At the time of the survey, ART had been initiated in private hospitals, but not yet in private clinics. This may change as a result of a policy task force led by FHAPCO to address this barrier, by exploring the feasibility of using nurses trained in the national ART curriculum to dispense ARVs.
- Awareness of standards of care for ART ranged from 16 percent in lower clinics to 82 percent in private hospitals, whereas awareness of standards for TB diagnosis and treatment ranged from 48 percent in lower clinics to 88 percent in private hospitals. Awareness of STI standards were even higher.
- The majority of provider respondents reported that *additional training* and *additional equipment* would facilitate the provision of HIV and related services at their facility.

Regulation, Referrals and Record Keeping

- Private facilities by and large could correctly cite the government entity that regulated the facility.
- The majority of facilities had been visited at least once in the past year; on average private facilities received 2.7 supervisory visits in the past year.
- All private hospitals and over 75 percent of private clinics state they report service statistics to the appropriate government entity.
- Private facilities (excluding lower clinics) appear to be an important source for identifying HIV-positive patients. According to facility records, the proportion of patients testing positive (among patients tested for HIV) in the last six months ranged from 16 percent to 21 percent.
- A high proportion of health providers from all levels of private health clinics reported referring clients elsewhere for ART and PMTCT services, primarily to public facilities using a standard referral form.

Facility Administration

- In private facilities, the majority of administrators (61 percent) were also clinicians.
- The owner/clinician phenomenon is highest for lower clinics (77 percent) and decreases with level of facility (64 percent for medium clinics, 36 percent for higher clinics, and 17 percent for hospitals).
- The most commonly reported administrative challenges among private facility administrators were *excessive government regulations* (50 percent), patients' *inability to pay* (42 percent), *lack of access to finance* (41 percent), and *difficulty obtaining continuous supplies* (38 percent).
- Interest in obtaining a future loan was highest for lower and medium clinics – with over half expressing this interest. Nearly 30 percent of hospitals and 40 percent of higher clinics also reported interest in accessing credit in the future. Intended uses of the loan include renovating their facility and purchasing medical equipment.

PRIVATE PHARMACIES

Drug Dispenser Characteristics

- About 72 percent of respondents were pharmacists, 19 percent were druggists, and 7 percent were pharmacy technicians.
- Nearly three-quarters (72 percent) of respondents were men, and the median age was 40 years.
- Sixty-six percent reported being a member of a professional association, the majority being affiliated with the Ethiopian Pharmaceutical Association.

Training

- About half of pharmacists surveyed were trained on ARV drug dispensing, with the Drug Administration and Control Authority (DACA) being the major provider of training.
- Among pharmacists who had not received training, at least 90 percent reported interest in attending training in dispensing ARV, TB, and STI drugs.
- Similar to the health provider results, pharmacists reported a high willingness to pay for such training.

Dispensing HIV/AIDS Drugs

- Few pharmacists in the private sector—only three among the entire sample—reported dispensing ARV drugs.
- No pharmacy respondents reported stocking TB drugs, a finding in line with current national regulations.
- The most commonly reported reason for not dispensing ARV and TB drugs was *not authorized to dispense*.
- Despite the current restrictions, pharmacists expressed high interest in dispensing ARV drugs in the future.
- Among surveyed pharmacists, 57 percent were aware of written standards of care for the dispensing of ARV drugs.
- About 61 percent reported awareness of standards of care for dispensing TB medicines.

Regulation and Referrals

- Private pharmacies reported receiving regular visits from DACA (for pharmacies located in Addis Ababa) or their regional health bureau (for pharmacies located in Oromia or Amhara).
- Many pharmacists reported customers seeking information about HIV testing, ART, and TB treatment. Over 50 percent reported they provide counseling in these instances, while over 75 percent refer the client for further assessment, primarily to public health facilities.

Pharmacy Administration

- Similar to the private health facility survey, a high percentage of pharmacists either managed or owned the pharmacy. For more than 80 percent of the surveyed pharmacies, the respondent answering the owner/administrator module also responded to the drug dispenser module.
- The greatest challenges for pharmacies were *difficulty in obtaining continuous supplies* (56 percent) and *client inability to pay* (40 percent).
- *Competition* from both public and private pharmacies, and *excessive government regulations*, were also reported as concerns.
- Pharmacy administrators reported moderate interest in accessing credit to expand the pharmacy. About 37 percent of those who had not previously received a loan reported interest in taking out a future loan.

RECOMMENDATIONS

STRENGTHEN THE PUBLIC-PRIVATE PARTNERSHIP UNIT TO ENGAGE THE PRIVATE SECTOR ON BEHALF OF FMOH

By creating a Public-Private Partnership (PPP) unit within the FMOH, the Government sent a message to both its own staff and to the private health sector that it is ready to engage the private sector. To further strengthen its PPP unit, the FMOH could take the following actions:

- Elevate the authority and visibility of the PPP unit, creating direct lines of communication to senior policymakers within the FMOH.
- Draft a PPP policy framework to confer authority on the PPP unit to represent the FMOH with the private health sector. This will enable the PPP unit to establish common ground with the private sector through dialogue, joint problem-solving, and the development of an actionable framework for collaboration.
- Build the PPP unit's capacity to work with the private health sector by offering them training in key skill areas (e.g., formulation of policy and regulatory frameworks, private sector mapping, health financing, legal/regulatory analysis) and by supporting their travel to observe PPP units in other countries.

RAISE AWARENESS AND OPERATIONALIZE THE GOVERNMENT'S PLAN TO WORK WITH THE PRIVATE SECTOR

Although Ethiopia's *Multisectoral Plan of Action* clearly includes the private health sector in its goals for scaling up services, many uncertainties continue to exist regarding the policies affecting private sector collaboration. Since the private sector has clearly become more central to HIV/AIDS service delivery through the FMOH mandate, the private and public health sectors must be made aware of their respective roles in contributing to national HIV/AIDS strategies.

ADDRESS POLICY AND REGULATORY BARRIERS

The study revealed that some of the barriers to greater participation of the private health sector in delivering HIV/AIDS services and products stem from the current legal and regulatory environment. For example, one ongoing issue preventing ART provision in private higher clinics is the requirement that a pharmacy professional dispense ARVs. Recently, FHAPCO led a policy task force to address this barrier by exploring the feasibility of using nurses trained in the national ART curriculum to dispense ARVs. This example demonstrates how creative, yet workable, solutions can be found by bringing divergent health actors (private clinicians, facility owners, FMOH, FHAPCO, and DACA) together to expand quality service delivery with Ethiopia's available resources, both public and private.

STRENGTHEN COLLABORATION AMONG THE VARIETY OF PROVIDERS OFFERING HIV/AIDS AND RELATED SERVICES

The large and diverse constellation of providers involved in the continuum of HIV/AIDS-related services (e.g., lab technicians, pharmacists, counselors, physicians, nurses, data clerks) requires careful tracking and sharing of patient information and records to ensure that patient care, support, and statistics are carefully monitored for quality, consistency, and health planning purposes. It is possible to create a more integrated health system within and between the public and private sectors by adhering to the following recommendations:

Manage and utilize a database of private providers. The difficulty of compiling a list of private health facilities and pharmacies for this survey highlights the need for a comprehensive database of the private health sector. Currently, FMOH is establishing such a database to enable efficient management, planning, resource distribution, and future research.

Utilize professional associations to reach out to private providers. Private provider membership in professional associations is prominent in Ethiopia, particularly among the higher level facilities. These associations should be viewed as instruments for public-private collaboration. Professional associations can mobilize, educate, and communicate new policies to the private sector and can advocate for the needs of providers, enabling them to practice more effectively.

Strengthen referral system between public and private providers: The continuum of HIV/AIDS services requires comprehensive care by a variety of providers. Pharmacists, lab technicians, counselors, nurses, physicians, and obstetricians are all involved in this continuum, ensuring that patients receive education, prevention, testing, counseling, and consistent access to treatment.

Improve private sector reporting to FMOH. Over 75 percent of private providers in our sample state they report service statistics to the FMOH. While this percentage is fairly high, there is still some room for improvement. The FMOH could work with a core group of public and private providers to identify constraints to health reporting and, together, determine solutions.

ADDRESS QUALITY ISSUES IN THE PRIVATE SECTOR

While this study did not assess quality of care comprehensively, in terms of reported awareness and adherence to accepted standards of care and HIV testing procedures, improvements could be made. Awareness of standards of care for ART, TB and STI care were lowest among lower clinic providers, and highest for hospital providers, reflecting current regulations which restrict ART and TB provision. Reported reasons for encouraging patients to be tested for HIV were also found lacking. Two strategies the FMOH can employ to close the gap in private sector performance and compliance are to widely disseminate the norms and guidelines throughout all private facilities and invite private providers to participate in relevant training sessions.

FURTHER ENGAGE THE PRIVATE SECTOR THROUGH A VARIETY OF INCENTIVES

In addition to expanding training opportunities, incentives for the private sector to provide HIV/AIDS services include providing discounted supplies or medicines to private facilities, increasing access to credit to improve their facilities, and compensating private providers for delivering health services to the poor through contracting or voucher mechanisms.

IMPROVE ACCESS TO CREDIT

The private health sector's access to financing is important for quality improvement, staffing, facility upgrades, and expansion of the private health sector. Administrators across all levels of facilities indicated a strong desire to have greater access to credit, with the need greatest among lower and medium clinics. To address this issue, the FMOH should become familiar with USAID-funded activities such as Banking on Health (BOH) and Private Sector Partnerships-Ethiopia (PSP-Ethiopia), which work with local financial institutions to promote health sector lending and improve credit-readiness of private providers through business skills training.

CONCLUSION

The study describes current private sector involvement in HIV/AIDS service delivery in Ethiopia, and explores the potential for an expanded role in the future. The report points to policy and operational reforms that could further engage this sector in national plans to expand access to HIV prevention, treatment, care, and support services. Extending training opportunities and offering other incentives to private providers, ensuring continuous supplies of medicine and equipment, and operationalizing proposed plans to engage the private sector could contribute to the achievement of the government's goal of universal access to HIV care and treatment.

1. INTRODUCTION

1.1 BACKGROUND

With a population estimated at 77 million and a complex HIV/AIDS epidemic marked by heterogeneity and regional variations, Ethiopia has one of the largest populations living with HIV/AIDS in the world. A recent epidemiological synthesis on HIV/AIDS in Ethiopia, conducted by the Federal HIV/AIDS Prevention and Control Office (FHAPCO) and the World Bank (2008), reveals that single prevalence estimates for the country are inadequate for capturing the scale and severity of the disease. With its highly varied at-risk population (diverging from sexually active single females, to discordant couples, to men in uniform), the country has experienced tremendous demand for HIV/AIDS care and treatment, and faces many challenges in addressing the varied needs of the population. Prior donor and government efforts have focused on building the capacity of public sector provision of HIV/AIDS services. While these efforts have largely increased access to and quality of HIV/AIDS services, the government alone may not be able to meet the growing demand. Further, the diverse socioeconomic concentration of the epidemic demands a collaborative mobilization of all available resources to offer a client-centered response.

Emerging empirical evidence shows that the private health sector has made encouraging contributions to expand and strengthen reproductive health services in Ethiopia and other African countries (Kidanu et al. 2002, Yeneneh et al. 2003, Chukudebelu et al. 1997). Yet less is known about the role private providers are currently playing in meeting the growing need for HIV/AIDS services in the country.

The private health sector has a unique role in the fight against HIV/AIDS in Ethiopia and beyond. Not only is it independent of government financial support, the sector is often more accessible to clients because of its longer operating hours as compared with the public sector. The private sector is also often perceived as offering better quality service and privacy protection, service features that are particularly important for many at-risk populations.

In 2002, the private-for-profit sector in Ethiopia employed 55 percent of the country's general practitioners, 65 percent of specialists, and 79 percent of the laboratory technicians (FMOH 2006). By 2003 there were 1,578 private health facilities in Ethiopia (FHAPCO 2007). The involvement of this large body of private health providers could significantly contribute to meeting the challenges posed by Ethiopia's HIV epidemic. Ultimately, the diversity of the HIV epidemic in Ethiopia calls for a collaborative solution that mobilizes all available resources, whether public or private, to meet the needs of its population.

The Ethiopian government has increasingly recognized the importance of involving the private sector in achieving public health goals. The *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia* (FHAPCO 2007) (Multisectoral Plan of Action) and other important research and policy documents have explicitly outlined the role the private sector can play as a partner in the effort to address Ethiopia's complex HIV/AIDS epidemic (Jeffreys 2004).

To better understand the current and potential role of the private health sector in delivering HIV/AIDS services, and thus to better inform decision making, it was necessary to quantify what services private hospitals, clinics, and pharmacies currently provide, as well their interest and willingness to offer HIV/AIDS services, while also taking inventory of the barriers preventing current participation.

The Private Sector Partnerships-*One* (PSP-*One*) project, a global project funded by USAID to increase the sustainable provision of essential health products and services through the private health sector, conducted the current study. This report presents the findings of the research, which can be considered a baseline with which future surveys can be compared to measure the private health sector's contribution to HIV/AIDS services. The authors hope that the policy implications revealed by the survey may inform advocacy and regulatory reforms to fully harness the potential of the private health sector to address national health goals, such as universal access to HIV prevention, treatment, and care.

1.2 RESEARCH OBJECTIVES

The study's overall goal was to better understand the role of the private health sector in the delivery of HIV/AIDS and related services, products, and information. The survey sought to identify areas in which the private sector could play an enhanced role in HIV/AIDS service delivery, in partnership with the Federal Ministry of Health (FMOH).

Specific objectives included the following:

1. Estimating the proportion of private providers and pharmacists currently providing HIV/AIDS services or stocking HIV and related drugs and supplies.
2. Assessing the interest of private providers in offering or expanding HIV/AIDS services.
3. Assessing levels of HIV-related training among private provider and pharmacists while gauging interest in future training.
4. Identifying sources of training among private providers and pharmacists.
5. Briefly assessing indicators of quality (e.g., knowledge of standards of care) of HIV/AIDS care provided by private providers.
6. Identifying factors hindering participation in HIV/AIDS and related service provision.
7. Examining the extent to which private providers have accessed health financing mechanisms and gauging the potential interest in accessing finance in the future.

2. SURVEY METHODOLOGY

2.1 STUDY DESIGN

The study employed a cross-sectional survey design in the study sites of Addis Ababa city administration and the Amhara and Oromia regional states of Ethiopia. These three regions were selected based on a review of available data (see Table 2.1), which indicated that the majority of private facilities are concentrated in these areas. The survey assessed private hospitals, clinics, and pharmacies. In-person interviews were conducted with health facility administrators/owners, health care workers, pharmacy owners, and pharmacists.

TABLE 2.1: GOVERNMENT STATISTICS ON REGISTERED PRIVATE HEALTH FACILITIES, 2003

	Hospital								Clinics				
	MoH				Govt.	Other			Private Owned Clinics				
	Spec.	Zone	Woreda	Total	OGO	NGO	Private	Total	Lower	Medium	Higher	Special	Total
Tigray	0	5	7	12	2	0	1	13	0	24	3	4	31
Afar	0	1	1	2	0	0	0	2	3	0	0	0	3
Amhara	2	4	10	16	2	0	0	16	215	76	11	2	304
Oromia	0	12	9	21	5	4	0	25	564	92	13	3	672
Somali	0	3	3	6	0	0	0	6	1	1	0	0	2
Benishangul	0	1	1	2	0	0	0	2	16	3	0	0	19
SNNPR	0	6	6	12	1	4	0	16	80	24	10	2	116
Gambela	0	0	1	1	0	0	0	1	6	1	0	0	7
Harari	0	2	1	3	2	0	0	3	6	14	1	0	21
Addis Ababa	4	5	0	9	4	2	17	28	109	103	90	80	382
Dire Dawa	0	0	1	1	1	0	1	2	4	7	4	6	21
Uniformed	0	0	0	0	17			17	0	0	0	0	15
Total				85	17	10	19	131	1,004	345	132	97	1,578

Source: Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia Road Map 2007-2008/10, p. 66.

2.1.1 PRIVATE HEALTH FACILITY SAMPLE

The first step was to develop a comprehensive list of private facilities. We consulted three sources to compile the sampling frame for private clinics and hospitals: (1) FMOH, (2) Addis Ababa Regional Health Bureau, and (3) dkt Ethiopia (social marketing product distributor). The facilities were stratified by region and then clustered by administrative units or *woredas*[1] prior to selection in two stages.

At the first stage, woredas were selected. The total number of sample woredas to be included in each region was proportionally allocated to the number of clinics in each region, using probability proportional to size (PPS). At the second stage, a fixed number of clinics, usually three, was sampled from each woreda using systematic random sampling. Given the small number of private hospitals

[1] For simplicity, this study refers to all administrative units as *woredas,* even though Addis is divided into administrative units called subcities or *kebeles*

in Ethiopia and the high interest in their potential role in delivering HIV/AIDS services, all identified private hospitals in the selected areas (n=24) were included in the survey. Five special clinics were also surveyed, but given the small sample size, this category was excluded from analysis.

The inaccurate or outdated information available on private facilities meant that some sampled units either no longer existed or could not be located. Additional facilities were selected randomly from the nonselected list of facilities to compensate for missing health facilities in a given region.

The actual number and allocation of private clinics and hospitals for each region is shown in Table 2.2. It is interesting to note that while 1,578 private facilities were registered nationwide in 2003 (as shown in Table 2.1), as of 2007 we identified at least 1,763 private facilities in the three study regions alone.

TABLE 2.2: SAMPLE OF PRIVATE HEALTH FACILITIES BY REGION

Region	Total # of clinics identified	Total # of woredas selected	Desired # of clinics in sample	Actual # of clinics surveyed	Total # of hospitals surveyed
Addis Ababa	427	20	60	61	21
Amhara	463	27	70	84	2
Oromia	849	39	114	116	1
Total	**1,739**	**86**	**244**	**261**	**24**

2.1.2 PRIVATE PHARMACY SAMPLE

We obtained a list of registered pharmacies and drug stores from Drug Administration and Control Authority (DACA), and supplemented this with a distribution list from dkt Ethiopia. In total we identified 267 pharmacies in the three study areas. The objective was to obtain a minimum of 33 responses per region (99 pharmacies total in Ethiopia). Due to the low number of pharmacies in two regions, we included all the 36 pharmacies in Amhara and 39 pharmacies in Oromia in the sample. Sampling was done only in Addis Ababa, where we selected a sample of 66 pharmacies assuming a 50% response rate. We used equal probability systematic sampling to select these 66 pharmacies. Before sample selection, the list of pharmacies in each region was sorted by woreda and name to ensure geographical representation in the sample. The method of selection was exactly the same as the method for clinics. Drug stores were sampled only as a secondary measure, to ensure the minimum sample size was met for each region. The sample of private pharmacies is shown in Table 2.3.

TABLE 2.3: SAMPLE OF PRIVATE PHARMACIES BY REGION

Region	Total # of pharmacies identified	Desired # of pharmacies in sample	Actual # of pharmacies surveyed
Addis Ababa	192	34	42
Amhara	36	33	39
Oromia	39	33	40
Total	**267**	**100**	**121**

2.1.3 SELECTION OF RESPONDENTS

The survey instrument contained separate modules for administrators and practitioners (facility health worker or drug dispenser/pharmacist). To the extent possible, initial contacts with the owner/administrator were made by telephone prior to visiting the facility, to schedule the interviews at a convenient day and time. When entering the facility, the interviewer asked for the owner or manager. After introducing the study to the owner and obtaining his/her consent to participate, the interview commenced. During the interview, the administrator was asked to identify a practitioner who was most knowledgeable about HIV/AIDS. The interviewer then approached the practitioner identified by the owner/administrator and asked him/her to participate in the survey. In some instances, the owner and practitioner were one and the same.

2.2 DATA COLLECTION

2.2.1 SURVEY INSTRUMENT

The survey instrument was designed to collect a wide array of information on HIV and related services. Instruments for the health facilities and pharmacies were designed to be as similar as possible. Each included sections about respondent's demographic characteristics, facility management, access to financing, drug or medical supplies, training and education, HIV/AIDS and related service provision, record keeping and referrals, and awareness of standards of care.

The instrument was developed in English and translated into Amharic for administration. A pretest was conducted to assess the suitability in terms of ease of language, flow, and length. Modifications were made based on the pretest results and feedback from the data collectors and local consultants. (See Annex B for English questionnaires.)

2.2.2 TRAINING

The survey was implemented in collaboration with SuDCA Development Associates, a local research firm. Experienced nurses and graduate students of public health were recruited as interviewers to administer the questionnaire to health facility and pharmacy personnel.

To ensure consistency and quality among the field interviewers and supervisors, PSP-*One* oversaw an intensive three-day training to ensure data collectors understood the purpose of the study, were familiar with the content of the questionnaire, and had the requisite skills to successfully administer the surveys. Experts in survey research, public health, and sampling conducted the training. As part of the training, operational definitions were developed and incorporated into the survey training manual to ensure standardized data collection.

2.2.3 SURVEY IMPLEMENTATION

A total of 12 interviewers and four supervisors conducted the field work. Interviewers obtained informed consent prior to conducting any interviews. Respondents were assured that participation was voluntary and that they had the right to refuse questions or withdraw from the interview. Interviewers carefully explained the confidentiality of data gathered, first to facility administrators/owners and subsequently to identified practitioners. Interviewers reported any refusals or missing facilities, and replacements were made accordingly.

Prior to implementation, the FMOH approved the study in November 2007[2]. The actual field work took approximately one month starting November 8, 2007. The field work took longer than anticipated due to difficulty in locating some facilities, facility closures, relocations, and refusals. These challenges were more pronounced in Addis Ababa and the Amhara region.

To ensure reliable data collection, a system was developed to rigorously monitor the data collection process. Team supervisors and expert consultants completed daily logbooks, which detailed interviewers' practices.

2.3 DATA ENTRY AND CLEANING

Census and Survey Programming Statistical Software (CS-Pro 3.3) was used for data entry. This software provides exact paper format of the questionnaire on the screen, and data checking systems such as double entry, skip, and range checks were incorporated to facilitate data entry and minimize errors. Data entry clerks experienced in CS-Pro 3.3 were employed. Prior to data entry, the questionnaires were checked for completeness and validity.

Double data entry was conducted to ensure the quality of the data. Any unmatched cases were corrected. Batch editing (consistency and correction checking program) was also performed to address outliers and inconsistency. For more in-depth cleaning, the SPSS data "EXPLORE" command was employed for data screening, outlier identification, description, assumption checking, and characterizing differences among subpopulations (groups of cases). Standard statistical descriptive procedures and plots were also used to validate the data sets.

2.4 DATA ANALYSIS

Data analysis was conducted with *STATA 10* Statistical Software. Separate analysis was conducted for health facilities and pharmacies. Given the complex study design, the sample weights were computed according to the probability of selection and nonresponse rates. All results were adjusted accordingly.

We present the results from the private facility survey first, followed by the results for the private pharmacy survey. Results are structured around clinical and business aspects of private sector provision of HIV/AIDS and related services.

[2] The research was also approved by the Internal Review Board of Abt Associates, Inc., the primary contractor for the PSP-*One* project, in October 2007.

3. PRIVATE HEALTH FACILITY FINDINGS

This chapter presents the results from the private health facility survey, describing the characteristics of the facilities and staff, detailing the services and information they offer, and providing a snapshot of their business practices. The results of the pharmacy survey are presented in Chapter 4 in similar order.

3.1 CHARACTERISTICS OF THE SAMPLE PRIVATE HEALTH FACILITIES

As shown in Figure 3.1, the distribution of surveyed health facilities reflects the relative share of each type of facility, with 133 lower clinics, 81 medium clinics, 42 higher clinics, and 24 hospitals.

FIGURE 3.1: PERCENTAGE DISTRIBUTION OF SAMPLED PRIVATE HEALTH FACILITIES BY TYPE (N=280)

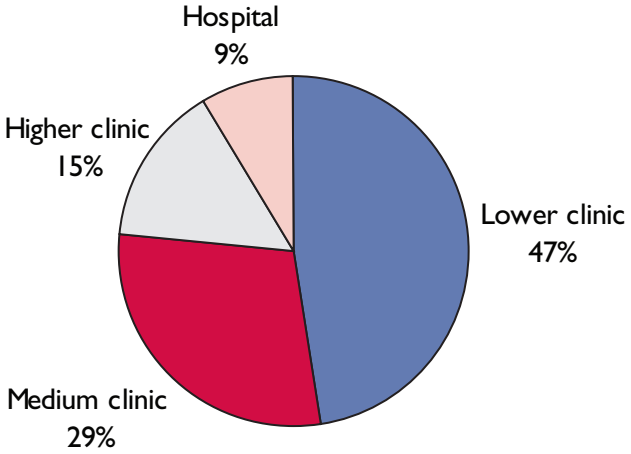
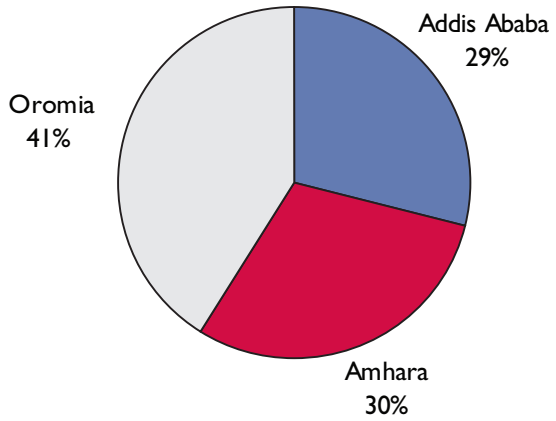


Figure 3.2 presents the geographic distribution by region, again reflecting the relative share of private health facilities across the study regions.

FIGURE 3.2: GEOGRAPHIC DISTRIBUTION OF SAMPLED PRIVATE HEALTH FACILITIES (N=280)



3.1.1 DAYS AND HOURS OF OPERATION OF PRIVATE HEALTH FACILITIES AND HOSPITALS

Overall, 80 percent of private facilities operated daily; 18 percent operated every day except Sunday. Medium and higher clinics and hospitals were more accessible than lower clinics in terms of operational hours. Half of sampled facilities were open 24 hours a day. This is in contrast to the public primary care facilities, which generally operate from 8:30 a.m. to 5:30 p.m. Although some public clinics offer limited duty staff to handle emergencies, services such as family planning, directly observed therapy for tuberculosis (TB/DOTS), and antiretroviral therapy (ART) are not available outside of regular working hours.

TABLE 3.1: DAYS OF OPERATION FOR PRIVATE HEALTH FACILITIES BY FACILITY TYPE

Days of Operation	Lower clinic	Medium clinic	Higher clinic	Hospital
Every day	71.5	88.2	90.2	91.3
Every day except Sunday	24.5	11.8	9.8	8.7
Other	3.4	0.0	0.0	0.0
N	133	81	42	24

3.1.2 PATIENT VOLUME AT PRIVATE HEALTH CLINICS AND HOSPITALS

Patient volume corresponds with the level of facility: lower clinics reported the lowest daily volume, whereas hospitals reported the highest daily volume of patients. Client volume as reported by administrators was relatively low in lower and medium clinics: 82.8 percent of lower clinics and 62.1 percent of medium clinics saw 10 or fewer patients daily. Private hospitals averaged 59 patients per day. Approximately 13 percent of private hospitals saw more than 100 patients in a day.

TABLE 3.2: PATIENT VOLUME AT PRIVATE HEALTH FACILITIES BY TYPE OF FACILITY

Daily client volume	Lower clinic	Medium clinic	Higher clinic	Hospital
10 or fewer	82.8	62.1	17.6	4.4
11-100	17.2	37.9	77.9	82.6
More than 100	0	0	4.5	13.0
N	**133**	**81**	**42**	**24**

3.2. CLINICAL ASPECTS OF PRIVATE SECTOR HEALTH PROVISION

The following results pertain to the health provider module of the facility questionnaire. One respondent was interviewed at each of the lower and medium clinics, whereas up to two respondents were interviewed at each of the higher clinics and hospitals.

3.2.1 CHARACTERISTICS OF HEALTH PROVIDERS AT PRIVATE HEALTH FACILITIES

Table 3.3 shows the distribution of health providers in terms of demographic and professional characteristics. The distribution of sampled facilities by region was presented earlier and corresponded to the total number of private facilities in each region, with Oromia having the highest number of private facilities. Further examination of regional patterns, included in Table 3.3, shows a higher proportion of lower clinics existing in Oromia as compared with the other study regions, whereas Addis Ababa had a higher proportion of higher clinics and hospitals. Medium clinics were fairly evenly distributed across the study regions.

In terms of gender of health providers, the majority of respondents were male, with the exception of private hospitals, where approximately 55 percent of respondents were female. The mean age of providers was consistent across all levels of facilities, with a range of 39.0 to 40.5 years.

Respondents at lower clinics were most likely to be nurses and health assistants; respondents at medium clinics were evenly distributed across general practitioners and nurses, with relatively fewer health officers and health assistants. Similarly, respondents at higher clinics were evenly split between general practitioners and nurses, although nearly 17 percent of respondents were specialists, and there were no health assistant respondents at higher clinics. Hospitals had the largest proportion of nurse respondents, perhaps a result of the sampling methodology for this type of facility (i.e., interviewing two health providers rather than one). Furthermore, it should be noted that the distribution of health providers presented in Table 3.3 is not necessarily representative, since the survey sampled providers most knowledgeable about HIV/AIDS services as opposed to taking a census of all providers working at the facility.

TABLE 3.3: CHARACTERISTICS OF PRIVATE HEALTH PROVIDERS BY FACILITY TYPE

	Lower clinic	Medium clinic	Higher clinic	Hospital
Region				
Addis Ababa	8.1	34.4	64.7	86.4
Oromia	62.0	40.0	15.0	4.6
Amhara	30.0	25.6	20.2	9.1
Gender				
Male	93.6	95.3	70.1	45.5
Female	6.4	4.7	29.9	54.5
Age (mean)	40.4	40.5	39.0	39.5
Profession				
General practitioner	1.6	33.7	40.0	18.2
Specialist	0.0	1.7	16.5	20.5
Health officer	2.4	14.2	3.4	2.3
Nurse	46.4	32.5	38.7	52.3
Health assistant	47.7	15.6	0	0
Other	1.9	2.4	1.4	6.8
N	**133**	**82**	**62**	**44**

3.2.2 PROFESSIONAL CREDENTIALS AND TRAINING

More than 95 percent of respondents possessed a professional license to practice, as required by Ethiopian law. Membership in a professional association, a potential forum for regulation by peer practitioners, was moderate among providers in lower and medium clinics, but high among providers in higher clinics and hospitals. Respondents reported memberships in the Ethiopian Medical Association, the Ethiopian Nurses Association, and the Medical Association of Physicians in Private Practice in Ethiopia (MAPPP-E). MAPPP-E represents private physicians exclusively, with the goal of strengthening the private health sector's contribution to training, improving organization of the private sector, and increasing collaboration between the private and public sectors. More than 60 percent of health professionals employed in hospitals and nearly 50 percent in higher clinics reported membership in a professional association. Analysis of professional association membership by cadre of provider reveals that physicians are most likely to hold such affiliations, followed by health officers and then nurses, with health assistants least likely to report membership in a professional association.

Half of all health providers have worked in their profession for at least 10 years, with lower clinic providers reporting the highest median number of years (16). The majority of respondents reported working in the private sector less than half their total number of years as a health professional.

TABLE 3.4: PROFESSIONAL CHARACTERISTICS AND INTERESTS OF PRIVATE HEALTH PROVIDERS BY FACILITY TYPE

	Lower clinic	Medium clinic	Higher clinic	Hospital
Professional association affiliation				
Yes	11.9	19.6	49.6	61.4
No	88.1	90.4	50.4	38.6
# of years in the profession (median)	16	11.5	10.0	13.5
# of years working in the private health sector (median)	6.0	4.5	4.0	3.5
Concurrently working in the public sector				
Yes	3.6	6.9	10.4	6.8
No	96.4	93.1	89.6	93.2
Reasons for working in private sector				
Better salary	61.2	54.6	60.4	70.5
Better working environment	31.3	45.2	37.9	43.2
Better job opportunities	9.2	5.7	12.3	2.3
Job security	16.2	2.6	4.5	0.0
N	**133**	**82**	**62**	**44**

Note: Figures in the table are percentages, unless otherwise indicated.

Dual practice, or concurrent work in both the public and private health sectors, is allowed in Ethiopia, as long as the health provider works only part time in the private sector. As evidenced in Table 3.4, dual practice was not commonly reported by private providers in this sample.

Respondents in the survey were asked to cite reasons for working in the private health sector. Across all facility types, better salary was the most commonly reported reason, ranging from 55 percent to 71 percent. Better working environment was also an important factor cited by respondents, ranging from 31 percent to 45 percent. Better job opportunities and job security were other reasons respondents mentioned.

3.2.3 HIV/AIDS AND RELATED TRAINING RECEIVED BY PRIVATE HEALTH PROVIDERS

Training is a critical component to the private sector's ability to provide quality HIV/AIDS services. The survey collected information on the type of training private providers received, including pre-service and in-service, the source of this training, and reasons why they may not have been trained in key aspects of HIV/AIDS service delivery. Overall, health providers in the survey reported receiving moderate levels of training in HIV testing and counseling and lower levels of training in HIV treatment. As might be expected, health providers from hospitals and higher clinics reported highest levels of training in HIV and related services, followed by medium clinic workers, with lower clinic health workers reporting low levels of training related to HIV/AIDS. The results are presented in Table 3.5.

Health providers across all types of facilities were most likely to report having received training in HIV counseling and testing (CT). Nearly 20 percent of lower clinic providers had received CT training, rising to 35 percent for medium clinic providers and 55 percent for higher clinic workers. Nearly three-quarters of private hospital providers sampled had received CT training.

At the time of the survey, only private hospitals were allowed to provide ART. More than half of surveyed hospital workers and one-third of higher clinic workers had received training in ART. Although medium clinics are not authorized to administer ART, more than one-quarter of health providers in medium clinics reported they had received training in ART. Only 5 percent of lower clinic workers had received ART training.

TABLE 3.5: PERCENTAGE OF PRIVATE HEALTH WORKERS TRAINED IN HIV-RELATED TOPICS

	Lower clinic	Medium clinic	Higher clinic	Hospital
HIV counseling and testing	19.0	34.6	55.2	72.7
Antiretroviral therapy	4.9	26.5	37.1	54.6
Home-based care	10.5	9.2	20.7	22.7
Clinical management of adult HIV	7.3	31.3	46.3	43.2
Clinical management of pediatric HIV	3.5	26.2	31.8	45.5
PMTCT	3.6	18.3	32.0	50.0
Diagnosis and treatment of TB for HIV+ patients	7.3	34.6	50.7	47.7
Diagnosis and treatment of other OIs for HIV+ patients	8.3	42.7	42.2	65.9
Diagnosis and treatment of STIs	72.5	76.8	67.8	77.3
N	**133**	**82**	**62**	**44**

Training in other related services, such as prevention of mother-to-child transmission (PMTCT), clinical management of HIV, diagnosis and treatment of TB, and diagnosis and treatment of other opportunistic infections (OIs), follows a similar pattern. Training for diagnosis and treatment of sexually transmitted infections (STIs) appears to be more widespread, with three-quarters of all private providers reporting they had received such training, and with little variation by type of facility. This result corresponds with Ethiopian regulations, which allow for STI treatment at all private facility levels.

3.2.4 SOURCE OF TRAINING

Another important consideration is where private providers receive their training. Table 3.6 indicates that the FMOH and nongovernmental organizations (NGOs) were two major sources of HIV and related training. Among 124 health providers trained in CT, 50 percent received training from an NGO and 36 percent from the FMOH. Among 76 providers trained in ART, about 39 percent received the training from an NGO and 45 percent from the FMOH. Some health providers have also received training from regional health bureaus (RHBs) and DACA. Very few providers received clinical training from private institutions.

Although training in HIV/AIDS services can be obtained through formal medical education (pre-service) or through in-service training, the majority of private practitioners received HIV and related training through in-service training. One notable exception is where private practitioners received STI training, which was evenly split between pre-service and in-service training. The findings suggest that although STI diagnosis and treatment is commonly taught in medical education programs, HIV/AIDS services are not.

TABLE 3.6: PERCENTAGE OF PRIVATE HEALTH PROVIDERS RECEIVING TRAINING BY SOURCE AND TYPE

	Source of Training				Type of Training		
	FMOH	RHB/ DACA	NGO	Private institution	Pre-service	In-service	Both
HIV counseling and testing	36.0	15.4	49.6	6.2	10.1	88.0	1.9
Antiretroviral therapy	45.1	9.5	38.8	0	26.6	73.4	0
Home-based care	24.9	14.0	59.0	6.5	16.2	78.9	4.9
Clinical management of adult HIV	38.8	19.8	48.7	0	16.2	79.0	4.8
Clinical management of pediatric HIV	34.1	16.7	50.4	0	21.9	77.8	0.4
PMTCT	42.4	19.6	30.7	2.8	12.7	87.3	0
Diagnosis and treatment of TB for HIV+ patients	47.7	16.3	35.4	4.1	29.1	70.7	0.2
Diagnosis and treatment of other OIs for HIV+ patients	51.3	20.3	42.1	4.4	31.6	68.2	0.2
Diagnosis and treatment of STIs	54.1	16.9	19.8	5.1	50.3	44.6	5.1

3.2.5 REASONS FOR NOT RECEIVING TRAINING

If the goal is to increasingly engage private providers in the national response to HIV, it is important to understand current barriers to this objective, such as why providers have not received necessary training in HIV and related services. Table 3.7 presents the top reasons why they have not received such training. Across all levels of private facilities, the most commonly reported reason for not receiving HIV/AIDS-related training was lack of opportunity. Four out of five respondents listed this as the key barrier. HIV-related training offered by the FMOH has been primarily geared toward public providers, and, as a result, private providers have had limited access to the training. Private providers also reported being "unaware of training," which may have been a result of lack of promotion of such training. Nearly as many providers cited that they were too busy to attend HIV/AIDS training. Few private providers cited expense as a barrier to receiving training.

TABLE 3.7: REPORTED REASONS FOR NOT RECEIVING HIV/AIDS TRAINING

	Lack of opportunity	Unaware of training	Too busy	Too expensive	Not needed	Not applicable
HIV counseling and testing	83.9	18.4	16.6	0	1.0	5.1
Antiretroviral therapy	83.7	17.6	16.3	1.0	0.7	5.1
Home-based care	67.3	20.3	12.5	0.3	13.5	3.3
Clinical management of adult HIV	83.7	17.0	14.2	1.0	0.3	4.2
Clinical management of pediatric HIV	83.8	18.6	13.8	1.1	0.2	4.3
PMTCT	84.2	17.5	13.4	0.6	0	4.2
Diagnosis and treatment of TB for HIV+ patients	85.9	18.2	13.8	1.3	0	4.8
Diagnosis and treatment of other OIs for HIV+ patients	83.3	19.1	15.0	1.3	0	4.9
Diagnosis and treatment of STIs	74.6	30.6	18.7	0	0.7	0

3.2.6 INTEREST IN RECEIVING TRAINING AND WILLINGNESS TO PAY

Those providers who had not received training in HIV and related areas were asked if they were interested in receiving such training and, further, whether they would be willing to pay for the training. As shown in Table 3.8, providers' interest in training across the different topics was universally high. One exception was training in home-based care, for which providers indicated slightly less interest. It is important to note that interest in receiving HIV training was highest among lower and medium clinic practitioners, suggesting that these providers may have had the least access to training.

TABLE 3.8: PERCENTAGE OF PROVIDERS WHO ARE INTERESTED IN RECEIVING TRAINING

	Lower clinic	Medium clinic	Higher clinic	Hospital
HIV counseling and testing	99.3	95.1	88.1	75.0
Antiretroviral therapy	95.3	96.0	94.6	85.0
Home-based care	76.4	61.3	47.4	61.8
Clinical management of adult HIV	97.5	95.1	90.4	84.0
Clinical management of pediatric HIV	97.6	94.2	91.3	87.5
PMTCT	97.2	96.8	90.0	77.3
Diagnosis and treatment of TB for HIV+ patients	96.2	97.4	93.1	78.3
Diagnosis and treatment of other OIs for HIV+ patients	97.4	97.0	83.1	86.7
Diagnosis and treatment of STIs	87.0	70.2	82.9	66.7

Note: Results reflect interest among providers who have not received training

The study examined the willingness of providers who had not received training to pay for future training. Table 3.9 shows that more than half of health providers from clinics and 44 percent from hospitals were willing to pay for CT training. Up to 65 percent of health practitioners from hospitals and more than half from clinics were willing to pay for ART training. Respondents expressed a strong willingness to pay for other related training as well.

TABLE 3.9: PERCENTAGE OF PRIVATE HEALTH PROVIDERS WILLING TO PAY FOR TRAINING BY TYPE OF FACILITY

	Lower clinic	Medium clinic	Higher clinic	Hospital
Voluntary HIV counseling and testing	58.5	52.3	60.1	44.4
Antiretroviral therapy	56.0	49.7	57.9	64.7
Home-based care	45.4	30.7	35.9	38.1
Clinical management of adult HIV	54.9	41.6	39.2	57.1
Clinical management of pediatric HIV	54.8	41.4	39.3	52.4
PMTCT	55.8	47.5	36.8	64.7
Diagnosis and treatment of TB for HIV+ patients	54.9	44.4	26.7	38.9
Diagnosis and treatment of other OIs for HIV+ patients	56.6	36.9	26.2	38.5
Diagnosis and treatment of STIs	45.0	22.9	31.5	62.5

Note: Results reflect interest among providers who have not received training

Finally, Table 3.10 shows the median amounts that private health providers reported they would be willing to pay for each type of training. Providers employed at hospitals were willing to pay the most for training while providers in lower clinics were willing to pay the least. The range of reported amounts providers were willing to pay for CT training was between 20 and 1500 Birr (0.20 to 155 USD). Providers were willing to pay more for ART training—up to 500 Birr (51 USD)—with hospital providers willing to pay the highest average (410 Birr).

TABLE 3.10: MEDIAN AMOUNTS PRIVATE HEALTH PROVIDERS ARE WILLING TO PAY FOR TRAINING (IN BIRR)

	Lower clinic	Medium clinic	Higher clinic	Hospital
Voluntary HIV counseling and testing	100	200	175	200
Antiretroviral therapy	100	200	200	200
Home-based care	50	200	200	200
Clinical management of adult HIV	100	175	175	200
Clinical management of pediatric HIV	100	150	150	250
PMTCT	100	138	150	200
Diagnosis and treatment of TB for HIV+ patients	100	150	250	200
Diagnosis and treatment of other OIs for HIV+ patients	100	125	200	100
Diagnosis and treatment of STIs	100	88	150	150

To summarize the training findings, overall a large percentage of private health providers have received training in at least one HIV-related area, with CT being the most prevalent. By and large the type of services for which they have received training is consistent with Ethiopian regulations (e.g., lower and medium clinics are not authorized to provide ART, and thus one would not expect them to have received training in this area). Even without changing the regulations, however, it is possible to increase the number of providers, particularly in lower and medium clinics, trained in properly diagnosing TB and OIs and in providing counseling and referrals for HIV testing. Not tapping into these cadres of clinics represents a missed opportunity in terms of the potential contributions of lower level clinics in mitigating HIV.

Furthermore, the strong interest in training among those providers who have not yet been trained indicates a willingness among private health providers to increase their role in preventing and treating HIV. Although the fact that private providers reported a high willingness to pay for training underscores this interest, these results should be further verified by assessing actual *ability* to pay among private providers. It should be noted that even without paying outright for training, private providers would be contributing indirectly, in terms of the costs to participate (i.e., sustaining lost income while in training or needing to replace workers while some providers participate in training).

3.3 SERVICE DELIVERY: HIV/AIDS AND RELATED SERVICE PROVISION

The training results serve as a foundation for the next area of inquiry: the actual HIV and related services provided by private health facilities. In each facility, health providers familiar with HIV services were asked about their practices and experiences providing CT, HIV prevention and treatment, treatment of related illnesses, record keeping, patient referrals, and post-exposure prophylaxis. The results are presented in the following sections.

3.3.1. OVERVIEW OF HIV AND RELATED SERVICE PROVISION

Private clinicians familiar with HIV services were asked about the types of HIV and related services provided at their facilities. The results, as presented in Table 3.11, show that few clinics at the lower end of the spectrum offer CT, whereas about half of higher clinics and all private hospitals do. Pre-ART care, ART, and PMTCT are not commonly provided by private clinic health providers. In private hospitals, about 50 percent of health providers offer pre-ART care and ART to adults, 18 percent of them offer ART to children, and about 55 percent offer PMTCT.

Diagnosis of TB is commonly offered in all clinics aside from the lower clinics, although only one in five higher clinics and private hospitals offer TB treatment. Prior to the establishment of the *PPM-DOTS Implementation Guidelines* written by the FMOH in August 2006, treatment of TB was allowed only in government facilities. When providers in the private sector diagnosed TB, they would refer cases to the public sector for treatment. With the inception of the PPM-DOTS guidelines, the private sector began to play a bigger role in TB treatment. Since the PPM implementation of TB/DOTS in 2007, program sites currently number close to 100.

In general, all levels of private clinics and hospitals provide diagnosis and treatment of other STIs. One area in which lower and medium clinics appear to be adding value is in the provision of family planning services. Nearly all clinics at these levels provide family planning services, compared with 63 percent of higher clinics and 84 percent of hospitals. Condom promotion is also considerable across all facility types. No significant regional differences exist in terms of provision of HIV-related services in the same type of facility.

TABLE 3.11: PERCENTAGE OF PRIVATE HEALTH FACILITIES OFFERING HIV AND RELATED SERVICES

	Lower clinic	Medium clinic	Higher clinic	Hospital
HIV counseling and testing	1.1	12.4	53.2	100.0
Pre-ART HIV care	0	0.4	9.4	50.0
Antiretroviral therapy for adults	0	0	1.7	47.7
Antiretroviral therapy for children	0	0	1.7	18.2
PMTCT	0	0.7	1.7	54.6
Diagnosis of TB	9.9	75.1	89.6	93.2
Treatment and follow up of TB	0.4	0	18.4	20.5
Diagnosis and treatment of STIs	78.9	92.0	90.4	97.7
Condom promotion	86.0	72.3	57.1	81.8
Family planning	90.6	95.7	63.0	84.1
N	**133**	**82**	**62**	**44**

The PPM-DOTS policy has allowed the private health sector to play a much greater role in TB service provision, as compared to HIV/AIDS service provision. Since Ethiopia's early days of ART provision (2002–2003), primarily public hospitals and certain public sector health centers were allowed to provide ART. Aside from a few exceptional cases in which private hospitals and NGO clinics had received authority from DACA to prescribe antiretrovirals (ARVs),[3] the public sector shouldered the burden of ART provision. Between 2003–2004, exceptional waivers were granted to more private hospitals to allow ART service provision.

By July 2005, national implementation guidelines for ART recognized that private hospitals were already providing "a large part of the fee-based" provision of ART. The August 2007 federal FHAPCO *Guidelines for HIV Care/ART Clinical Mentoring in Ethiopia* indicated that "some 10 private hospitals" had already been included in the free, nationally based ART program. It also indicated that after the success of the private hospitals delivering the free ART had been evaluated that "most private hospitals and private higher clinics are expected to be included in free ART program."[4]

An assessment of the Addis Ababa private higher clinic readiness to provide ART (August 2008) indicated that "private higher clinics remain a largely untapped resource" for providing ART services. Although the policy framework in Ethiopia supports the extension of free ART services to for-profit higher clinics, more information on private higher clinic capacity and willingness to provide ART was needed. That assessment concluded that the private sector indeed had high capacity and willingness to provide ARV services. It also identified gaps and improvements to be made in the private sector in order for scale up to take place. The full report offers concrete recommendations that the private sector can immediately address (Kombe et al. 2008).

3.3.2 HIV TESTING

A cornerstone to curbing the epidemic is effective counseling and accurate testing for HIV. National guidelines for HIV counseling and testing state: "It is a basic responsibility of health care providers to recommend HIV testing and counseling to clients presenting with symptoms or signs of illness possibly attributable to HIV…To identify unrecognized or unsuspected HIV infection in persons attending health facilities, providers may therefore recommend HIV testing and counseling to patients who do not exhibit obvious HIV-related symptoms and signs."

On average, 96 percent of health providers reported *ever* encouraging a patient to be tested for HIV (ranging from 94 percent in lower clinics to 100 percent in hospitals). It should be noted that this encouragement might have been in the form of referring the patient elsewhere for testing. Figure 3.3 indicates the circumstances under which respondents would encourage a patient to get tested for HIV. Although World Health Organization (WHO) guidelines recommend that in a generalized epidemic all patients testing positive for an STI should be tested for HIV, our survey found that only 21percent of providers recommended an HIV test for patients with STIs. In addition, despite WHO guidelines for testing pregnant women for HIV as early as possible to avoid transmission to infants, only 13 percent of surveyed providers made such a recommendation.

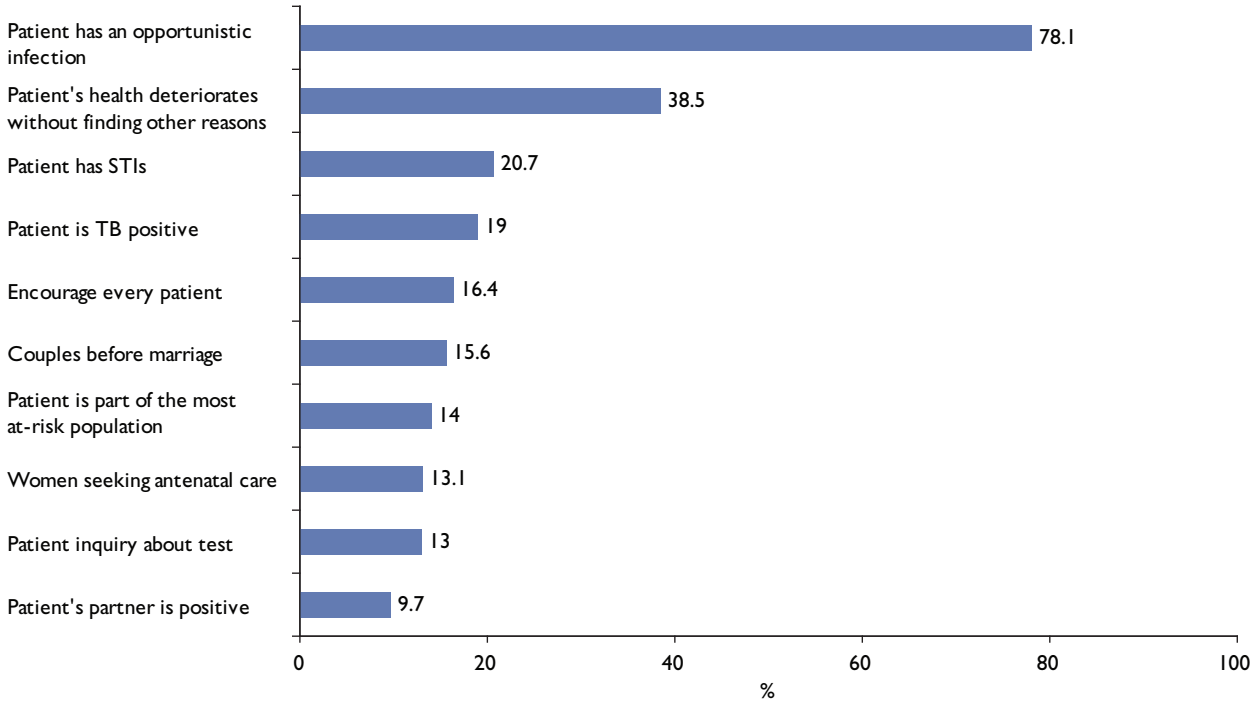
Most at-risk populations are deemed at high risk for contracting HIV, given their propensity for behaviors associated with transmission. Among providers surveyed, only 14 percent had recommended

[3] At that time, patients would have their prescriptions filled by specially approved pharmacies run by the Addis Ababa municipality.
[4] As of August 2008, 14 private hospitals were reportedly providing ART.

HIV testing for patients considered most at risk. Although partners of people living with HIV/AIDS are known to have among the greatest risk of contracting the disease, only 10 percent of surveyed providers had recommended an HIV test for partners of people living with HIV (FHAPCO & World Bank, 2008).

Approximately 19 percent of providers had ever advised a client who had tested positive for TB to get tested for HIV. The results underscore the fact that private providers are missing many opportunities to encourage patients in several high-risk categories to get tested, perhaps because they lack training or information about universal recommendations. In 2006, 1.9 million people received CT in Ethiopia, and in 2007, this amount increased to 4.5 million. Although this represents a dramatic upsurge from previous years (564,000 in 2005 and 10,000 in 2002), it also reveals the need to mobilize additional resources to reach Ethiopia's goal of testing 9.27 million people by 2010 (FHAPCO 2007). Extending training to private providers may be one way to ensure that testing opportunities are not missed.

FIGURE 3.3: REASONS FOR ENCOURAGING A PATIENT TO GET TESTED FOR HIV AS REPORTED BY PRIVATE HEALTH PROVIDERS



The FHAPCO Multisectoral Plan of Action calls for expanding CT to approximately 3,518 clinics, training 17,000 staff, and conducting 21 million CT sessions in both the public and private sectors from 2007–2010 (FHAPCO, 2007). The results of this survey indicate that private facilities could be contributing to a greater extent, with government support and training opportunities.

Respondents who indicated their facility performs CT were queried about the method of testing. As shown in Table 3.12, the majority of lower and medium clinics refer the patient elsewhere for HIV testing; however, higher clinics were more likely to perform the test on-site (65 percent) as opposed to referring the patient elsewhere (32 percent). All private hospitals collect blood samples and perform the test on-site.

TABLE 3.12: DISTRIBUTION OF HIV TESTING PRACTICES BY PRIVATE HEALTH FACILITIES

	Lower clinic	Medium clinic	Higher clinic	Hospital
Collect blood sample and test at this facility	0.0	11.0	64.5	100.0
Collect blood sample and send to outside lab	0.8	0.0	3.2	0.0
Refer patient to an outside lab for testing	99.2	89.0	32.3	0.0
N	**133**	**82**	**62**	**44**

Rapid testing was the most common method private health facilities used. Less than 10 percent of higher clinics and 27 percent of private hospitals reported use of ELISA to test for HIV. Given the small number of medium clinics that conduct HIV testing, this group was combined with higher clinics for all subsequent results. Among respondents who reported conducting tests on-site, providers were nearly as likely to ask a counselor or nurse to report the results to the patient as they were to inform the patient themselves (see Table 3.13). Few providers reported notifying patients of HIV test results in writing.

TABLE 3.13: COMMUNICATION METHODS FOR RELAYING HIV TEST RESULTS AMONG PRIVATE HEALTH PRACTITIONERS WHO CONDUCT TESTS ON-SITE

	Medium/higher clinic	Hospitals
Present the results verbally	57.6	50.0
Instruct a counselor/nurse to tell the results	49.9	52.3
Present written results to client	2.8	2.3
N	**49**	**44**

* Among providers who conduct HIV tests on-site

Respondents were asked what action they have taken when a patient tests positive for HIV. The range of responses is presented in Table 3.14. A majority of providers reported they provided counseling to the patient—more than 80 percent for all facility types. Of these providers, 86 to 95 percent reported following the national guidelines for provision of CT. About 73 percent of providers from medium or higher clinics and 77 percent from hospitals reported referring patients for further testing such as CD4 counts. Less than one-third of health providers would initiate further testing such as pre-ART testing and testing to determine the stage of disease. Some providers in higher clinics or hospitals also reported referring patients to other facilities for counseling and psychosocial support.

TABLE 3.14: PRIVATE PROVIDER RESPONSES TO PATIENTS WHO TEST POSITIVE FOR HIV

	Medium/higher clinic	Hospital
Counsel the patient	83.4	81.8
Refer the patient to another facility for counseling	9.2	13.6
Refer to other organization for psychosocial support	13.6	11.4
Screen for TB	4.9	4.6
Screen for other OIs	14.8	29.6
Refer patient for further testing (e.g., CD4 count)	73.1	77.3
Initiate further testing (Pre-ART)	37.4	29.6
Order lab tests to determine stage of disease	20.6	31.8
N *	**49**	**44**

Note: Due to multiple responses being allowed, columns do not add to 100.

Respondents were asked the number of patients they tested for HIV in the past six months, according to their official registries. As presented in Table 3.15, hospital staff reported testing a larger number of patients than did medium or higher clinics. Nearly one-quarter of hospital providers said they had tested more than 1,000 patients during this time period. In medium clinics, about three-quarters of providers reported testing fewer than 100 patients. The large volume of HIV testing in hospitals was attributed to hospitals identifying more patients with HIV-positive test results, although medium clinics reported a greater proportion of positive test results than did hospitals. Most providers from medium clinics tested 10 or fewer positive patients in the six-month period. The results for medium clinics should be interpreted with caution, however, given the small sample size.

TABLE 3.15: DISTRIBUTION OF HIV TESTING AND TEST RESULTS AMONG PRIVATE HEALTH FACILITIES IN THE PAST SIX MONTHS

	Medium clinic	Higher clinic	Hospital
Number of patients tested for HIV			
<=100	76.7	9.1	25.0
101-1000	23.2	56.7	34.1
>1000	0	17.9	22.7
Don't know	0	16.3	18.2
Number of patients tested positive for HIV			
<=10	89.9	1.8	15.9
11-100	6.2	29.4	34.1
>100	0	21.7	29.6
Don't know	3.9	47.1	20.5
Proportion of patients tested positive			
Mean	17.6	20.8	15.6
Range	0-40	0-80	1.8-66.7
N	**9**	**40**	**44**

3.3.3 PRIVATE PROVIDER INTEREST IN DELIVERING HIV/AIDS AND RELATED SERVICES

Although as noted earlier, private clinics provide a relatively low level of HIV services, when private health providers were asked if interested in offering such services in the future, the response was extremely positive. Table 3.16 shows that private clinics had a near universal interest in providing these services in the future. Although there may be valid reasons why some services (such as ART) would not be appropriate for all types of facilities, these results provide useful information concerning private provider interest and willingness to offer essential HIV and related services. Overall, the high level of interest in HIV service provision coupled with strong interest in training in these areas supports expansion of HIV services throughout the private sector, particularly since a majority of these providers own the facility and, as such, would be in a position to make changes in services offered (discussed further in Section 3.7).

TABLE 3.16: PERCENTAGE OF HEALTH PROVIDERS WILLING TO PROVIDE SELECT SERVICES IN THE FUTURE, AMONG THOSE NOT CURRENTLY PROVIDING SERVICE

	Lower clinic	Medium clinic	Higher clinic	Hospital
HIV counseling and testing	94.6	95.8	95.2	N/A*
Pre-ART HIV care	90.5	98.3	90.2	100.0
Antiretroviral therapy for adults	90.5	98.3	91.1	100.0
Antiretroviral therapy for children	90.5	98.3	91.1	94.4
PMTCT	91.3	97.3	91.1	100.0
Diagnosis of TB	92.3	92.0	100.0	100.0
Treatment and follow up of TB	88.1	89.8	89.3	52.3
Diagnosis and treatment of STIs	90.4	100.0	100.0	100.0
Condom promotion	100.0	87.1	74.2	87.5
Family planning service	85.2	69.7	78.3	100.0

*All hospitals provide CT services

3.3.4 FACTORS ENABLING HIV/AIDS TREATMENT AND RELATED SERVICE PROVISION

Providers in facilities not currently offering HIV and related services who were willing to provide these services in the future cited several factors that would facilitate their provision. Table 3.17 presents the most commonly reported factors, which include additional training, equipment, staff, and supplies. The majority of providers across all levels of clinics, ranging from 78 to 84 percent, desired additional training and equipment. Approximately one in five respondents cited that more favorable government policies and regulations would encourage private provision of HIV and related services. The study found no significant regional variations in providers' responses.

TABLE 3.17: FACTORS THAT WOULD ENABLE PROVISION OF SPECIFIC SERVICES, AS REPORTED BY PRIVATE HEALTH PROVIDERS

	HCT	Pre-ART Care	Adult ART	Pediatric ART	PMTCT
Additional training	79.1	82.1	83.6	84.3	82.0
Additional equipment	79.6	81.6	82.5	79.1	77.6
Additional supplies	26.0	28.2	27.8	26.9	26.1
More facility space	8.3	7.2	6.0	6.8	9.3
Additional staff	32.8	31.2	31.2	37.0	35.6
More favorable gov't policies/regulations	17.5	20.9	20.9	18.3	20.1
N*	**220**	**274**	**280**	**292**	**274**

* Among those who don't offer service currently but would be willing to provide services in the future

Notably, the *Multisectoral Plan of Action* strives to achieve universal access: 100 percent (397,000) of people living with HIV/AIDS on ART by 2010 (up from 32 percent in 2007). To reach this goal, the Multisectoral Plan of Action calls for 111 private health clinics to begin providing ART by 2010.

In addition to scaling up CT and ART capacity in the private sector, FHAPCO seeks to integrate PMTCT in approximately 3,014 facilities (both public and private), training four staff per facility, and procuring and distributing ARVs to 166,914 mothers between 2007–2010, through both public and private clinics. Ultimately, FHAPCO is striving to have 80 percent of HIV-positive pregnant women (estimated at 72,167 women) receiving PMTCT by 2010. Expanding the number of public and private sites, providing training, and distributing necessary supplies are requirements for scaling up these services.[5] Additionally, five health workers per ART facility (both public and private) are to be trained in comprehensive HIV and TB/DOTS care. The FMOH and RHBs have been identified as primary trainers for both the public and private sectors.

3.4 AWARENESS OF STANDARDS OF CARE FOR ART, TB/DOTS, AND STI SERVICES

Combined with an understanding of the extent to which private health providers offer HIV and related services, it is important to ascertain the extent to which private providers are aware of and adhere to national treatment protocols. Standards of care guide the provision of patient treatment and care based on the best scientific knowledge and clinical expertise.

Because of the guidelines and restrictions on ART and TB treatment, it would not be expected that health workers from lower clinics would be knowledgeable about the standard of care relative to these services. The survey corroborates this finding, with providers from hospitals reporting very high awareness of standards of care for ART, and lower clinics reporting poor awareness of the standards. Because criteria for STI treatment are less restrictive, most respondents from all levels of clinics and hospitals were aware of standards of care for STI diagnosis and treatment. Detailed results are presented in Table 3.18.

[5] FHAPCO, pp. 14-15. http://www.etharc.org/publications/eth_multi_plan_action2007.pdf

TABLE 3.18: PERCENTAGE OF PROVIDERS WHO ARE AWARE OF STANDARDS OF CARE FOR HIV AND RELATED SERVICES

	Lower clinic	Medium clinic	Higher clinic	Hospital
ART	16.1	51.8	64.5	81.8
TB diagnosis and treatment	48.3	80.0	78.0	88.6
STI diagnosis and treatment	64.6	78.4	72.3	90.9

Respondents who were aware of the standards were then asked to cite the specific manuals for each of the three treatment areas: ART, TB, and STI. As evidenced by Table 3.19, awareness of the actual documents containing standards of care was consistently high. It is interesting to note that although medium clinics are not authorized to provide ART, and providers in these clinics have largely not received training in these areas, awareness of specific documents containing ART standards of care is high among this group.

TABLE 3.19: PERCENTAGE OF PRIVATE HEALTH PROVIDERS WHO COULD CITE ACTUAL DOCUMENTS CONTAINING THE STANDARDS OF CARE

	Lower clinic	Medium clinic	Higher clinic	Hospital
ART	94.2	100.0	95.4	100.0
TB diagnosis and treatment	90.9	90.9	94.2	94.9
STI diagnosis and treatment	89.3	85.3	93.8	92.5

Actual adherence to standards of care, as reported by the subset of providers who were aware of standards, varied by type of facility and service, as shown in Table 3.20. At the time of the survey, only private hospitals were allowed to offer ART, thus it is not surprising that while hospital adherence to ART standards was 100 percent, other private clinics were not adhering to standards for this service. Adherence to standards for TB diagnosis and treatment was poorer for lower and medium clinics than for higher clinics and hospitals. Adherence to standards for STI care was higher on average.

TABLE 3.20: PERCENTAGE OF PROVIDERS WHO REPORT FOLLOWING STANDARDS OF CARE

	Lower clinic	Medium clinic	Higher clinic	Hospital
ART*	0	0	0	100.0
TB diagnosis and treatment	33.1	52.6	89.9	90.9
STI diagnosis and treatment	75.2	82.8	87.7	95.5

*ART was not provided in clinics

3.5 ENSURING CONTINUOUS STOCKS OF MEDICINE, SUPPLIES, AND EQUIPMENT

Another prerequisite to delivering quality HIV/AIDS services is continuous availability of necessary medicine, supplies, and equipment. The President's Emergency Plan for AIDS Relief (PEPFAR), Management Sciences for Health's Rational Pharmaceutical Management Plus Program, and John Snow International have been key to strengthening supply chain management related to ARV provision in private hospitals and public facilities. Despite these improvements, reports of stockouts and supply interruptions still occurred, as reported by facility admininstrators.

Table 3.21 shows that few private health facilities reported stock of ARV drugs, CD4 test reagents, or TB drugs. In fact, only private hospitals reported any stocks of these drugs. Stocks of HIV tests varied by type of facility. Whereas, overall, less than 10 percent of private facilities stocked the test kits, 96 percent of hospitals and 43 percent of higher clinics reported stocking HIV test kits. Public sector entities, including FMOH, RHBs, and the Pharmaceutical & Medical Supplies Import & Wholesale Share Co. (PHARMID), were reported as the main sources of these medical supplies, although a few hospitals reported obtaining HIV test kits and CD4 test reagents from private suppliers. With FHAPCO's effort to scale up HIV testing and treatment through public and private collaboration, the level of HIV test and drug stocks is expected to increase. Stockouts in the private sector may have been due to supply chain issues, particularly in response to the rapid rise in testing between 2006 and 2007 (an increase of nearly 3 million tests).

Stockouts for HIV tests were common, with medium clinics (52.6 percent), higher clinics (41.9 percent), and hospitals (27.3 percent) reporting stockouts due primarily to shipment delays from suppliers. The small number of facilities carrying ARVs and TB medicines prevented an analysis of stockouts for these commodities.

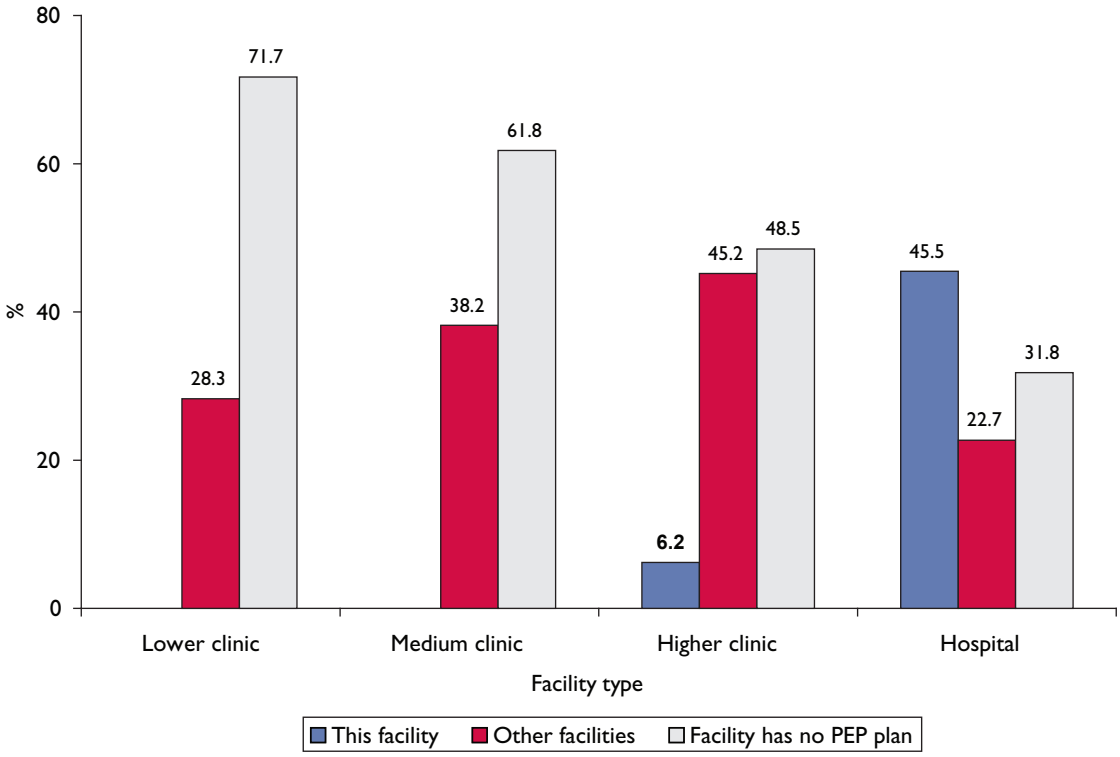
TABLE 3.21: PERCENTAGE OF PRIVATE FACILITIES STOCKING HIV AND TB DRUGS OR SUPPLIES BY SOURCES

Medical supplies	In stock	Source of supply			Not stocked
		Public	Private	NGO	
HIV test kits	9.7	6.8	5.5	0.9	90.3
TB drugs	1.7	1.7	0.5	0.4	98.3
ARV drugs	1.0	0.9	0.2	0.5	99.0
CD4 test reagent	1.7	1.1	1.3	0.4	98.3
N	**280**	**280**	**280**	**280**	**280**

3.5.1 POST-EXPOSURE PROPHYLAXIS

Post-exposure prophylaxis (PEP) has been shown to decrease the transmission of HIV infection after an occupational exposure to HIV, and thus is an important protection for health workers. Figure 3.4 shows that access to PEP services is largely associated with the level of the facility. In higher clinics, 6 percent of workers have on-site access to PEP, whereas almost 46 percent of hospital workers have access to the treatment. The majority of health providers from lower clinics must access PEP from another facility, mainly government hospitals.

FIGURE 3.4: ACCESS TO PEP REPORTED BY PRIVATE HEALTH FACILITIES



These findings have relevance for national plans to scale up HIV service provision through the private sector and underscore the importance of increasing awareness and ensuring access to PEP for health workers in the private sector.

3.5.2 MEDICAL WASTE MANAGEMENT

Hazardous medical waste, including biohazards (e.g., bandages and bodily fluids) and sharp waste (e.g., syringes and needles), must be managed effectively to ensure the safety of health workers and patients. Burning waste in an incinerator is considered the optimal way to dispose of most medical waste. Our survey found that although management of medical waste generally improved with the level of private facility, there is room for improvement across all facility types. As shown in Table 3.22, 57 percent of private hospitals, 53 percent of higher clinics, and 45 percent of medium clinics burned sharp waste in an incinerator. Only 19 percent of lower clinics followed this practice. Waste management practices for biohazards were also questionable, with the percentage of facilities following best practices ranging from 17 to 46 percent. About 20 percent of all types of facilities threw sharp waste in the trash or latrine. Similar to access to PEP, waste management is another important area to address in expanding provision of HIV services to private health facilities. The practices could be improved by offering training to private providers and further supported through outreach and education by professional associations.

TABLE 3.22: MEDICAL WASTE DISPOSAL BY TYPE OF WASTE AND FACILITY

	Lower clinic	Medium clinic	Higher clinic	Hospital
Disposal of medical objects (e.g. needles and syringes)				
Burned in incinerator	18.5	44.5	52.9	56.5
Burned and buried	61.5	41.7	42.9	34.8
Burned and removed to offsite dump	11.7	10.3	4.2	0.0
Others	8.3	3.4	0.0	8.7
Disposal of potential biohazards				
Burned in incinerator	17.3	39.7	45.6	43.5
Burned and buried	44.3	30.2	23.3	26.1
Burned and removed to offsite dump	9.8	5.8	4.2	0.0
Thrown in trash/open pit/latrine	21.9	18.9	21.9	21.8
Others	6.8	5.4	5.0	8.7
N	**133**	**81**	**42**	**24**

3.6 GOVERNMENT REGULATION AND OVERSIGHT

In many countries, as in Ethiopia, the government provides regulatory oversight of private health facilities. This oversight includes facility guidelines and accreditation and standards of practice for and certification of private providers. In addition, many governments have a provision for supervisory or site visits to ensure private facilities and practitioners meet the regulations. However, facing insufficient personnel or budgets, an inability to enforce the regulations, and tensions between the two sectors, many developing countries are struggling to fulfill their oversight role of the private sector.

To assess private facilities understanding of regulations, administrators were asked about government oversight of their facility. All private health facilities reported they were regulated by the government, reporting an average of 2.7 supervision visits in the previous year.

Generally, hospital and higher level clinics reported being supervised by higher level government entities, as shown in Table 3.23. About 35 percent of hospitals said they were supervised by the FMOH, whereas 57 percent were supervised by RHBs, and 26 percent by zonal health offices. Most lower clinics reported they fell under woreda health office regulation. Medium clinics reported being regulated primarily by zonal and woreda health offices, while higher clinic oversight was somewhat equally split among RHBs, zonal health offices, and woreda health offices.

In accordance with Ethiopian regulations governing private health facilities, regional variation was also noted. The majority of private clinics in Oromia and Amhara reported being regulated by woreda health offices, whereas clinics in Addis Ababa indicated they were regulated primarily by zonal health offices (also known as subcity health offices), as well as by the Addis Ababa RHB. The Addis facility findings reflect the fact that whereas private clinics are officially regulated by zonal health offices, day-to-day supervision is also carried out by the Addis Ababa RHB. Hospitals reported being regulated by either the FMOH or RHB, although they reported that in Amhara, the zonal health office had oversight over hospitals. All of these findings corroborate Ethiopian regulatory policies with one exception – some

lower, medium, and higher clinics indicated they were regulated by FMOH, which is contrary to existing regulations. One possible explanation is that these were PPM pilot sites, which were initially supervised by the FMOH.

TABLE 3.23: PERCENTAGE OF FACILITIES SUPERVISED BY DIFFERENT GOVERNMENT BODIES BY TYPE OF FACILITY

Government supervision bodies	Lower clinic	Medium clinic	Higher clinic	Hospital
Federal Ministry of Health	3.4	5.1	12.6	34.8
Regional Health Bureau	4.4	14.4	34.3	56.5
Zona/Kifle-ketema health office	34.4	46.7	51.1	26.1
Woreda health office	82.7	51.0	34.1	4.4
N	**133**	**81**	**42**	**24**

3.6.1 REFERRING PATIENTS FOR HIV/AIDS AND RELATED SERVICES

In viewing the various health sectors as part of the total health care system, it is important to identify linkages between the sectors, as well as potential barriers. Patients transferring between the public and private sectors for the receipt of health care services, otherwise called referrals, form a necessary link between the sectors. Very little information has been documented about patients moving between the public and private health sectors for HIV/AIDS care, yet anecdotal evidence suggests this occurs. Our survey asked private health providers about their referral practices, which most likely occur for services that are not offered in their own facilities.

Table 3.24 presents referral results for each HIV or related service of interest, by type of facility and referral destination. For CT, a clear relationship exists between type of facility and referrals, in that whereas nearly 98 percent of health providers from lower clinics referred patients out for CT, this percentage decreased significantly with the level of the facility, such that only 2 percent of hospitals referred patients out for CT. Health providers from all clinic levels reported substantial referrals for PMTCT and ART, while providers from hospitals reported relatively lower referrals. A high percentage of all types of health facilities referred patients out for TB treatment at public facilities, which reflects the relatively nascent state of private sector involvement in treating TB at the time of the survey. Providers made most referrals for HIV and related services to government facilities, although up to 20 percent of health providers from higher clinics and hospitals reported referrals to private for-profit facilities. A small percentage of health providers referred patients to NGOs.

The most commonly stated reasons for referring patients out for HIV related services were "not offering service here" and "not authorized/allowed to provide the service." The FMOH July 2005 *Guidelines for Implementation of Antiretroviral Therapy in Ethiopia* allowed ART in private sector hospitals but not in higher clinics.[6] In December 2007, however, the FHAPCO *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support* included private higher clinics in it's expansion plan for both ART and TB services. This suggests momentum towards expanding provision of ART through private facilities, and in fact was a topic of discussion in a recent task force led by FHAPCO.

[6] For guidelines, see http://www.etharc.org/arvinfo/ethARTguide.pdf

Notably, about 66 percent of health providers working in hospitals and 38 percent from higher clinics reported to have received HIV-positive patients referred from other facilities or organizations. The HIV-positive patients were mainly referred from public facilities and other private for-profit facilities.

TABLE 3.24: PERCENTAGE OF PRIVATE HEALTH PROVIDERS REFERRING PATIENTS FOR SELECTED SERVICES BY REFERRAL DESTINATION

	Lower clinics to				Medium clinics to			
	Public	Private	NGO	Total	Public	Private	NGO	Total
HIV counseling and testing	97.0	8.8	4.7	98.3	85.0	23.7	7.9	89.6
PMTCT	80.5	7.3	3.9	84.7	86.1	10.2	4.0	89.3
Pre-ART HIV care	74.1	7.3	3.7	75.2	81.4	8.2	2.0	84.6
ART for adults	76.4	7.3	3.7	78.5	83.7	9.2	4.0	86.9
ART for children	74.6	7.3	3.7	76.7	82.0	9.2	4.0	85.2
Home-based care				36.9				30.8
Screening for TB for HIV+	78.9	6.7	3.1	81.6	47.1	5.0	4.0	47.1
Treatment and follow up of tuberculosis for HIV+ patients	81.6	7.3	0	84.3	92.4	8.3	0	93.7
Diagnosis and treatment of other OIs for HIV+ patients	69.7	7.5	2.8	73.6	53.0	6.6	4.9	55.3
Diagnosis and treatment of STIs	33.9	5.6	1.4	34.7	13.6	6.0	2.0	15.6
Lab service	70.7	30.0	4.3	84.7	47.3	30.4	3.0	58.2

	Higher clinics to				Private hospitals to			
	Public	Private	NGO	Total	Public	Private	NGO	Total
HIV counseling and testing	27.3	12.1	3.4	32.6	0	2.3	0	2.3
PMTCT	82.7	19.9	8.0	85.4	38.6	15.9	0	45.5
Pre-ART HIV care	85.8	18.2	5.6	90.8	40.9	13.6	5.6	50.0
ART for adults	90.2	17.6	7.4	93.0	43.2	13.6	7.4	52.3
ART for children	84.2	17.6	7.4	87.8	68.2	20.5	0	80.0
Home-based care				36.1				29.6
Screening for TB for HIV+	13.9	4.5	1.7	13.9	6.8	0	4.6	6.8
Treatment and follow up of tuberculosis for HIV+ patients	71.7	13.1	0	76.9	65.9	6.8	0	75.0
Diagnosis and treatment of other OIs for HIV+ patients	20.2	4.5	0	22.0	9.1	9.1	0	11.4
Diagnosis and treatment of STIs	0.7	0	0	0.7	0	0	0	0
Lab service	12.8	15.2	1.7	21.1	2.3	6.8	0	6.8

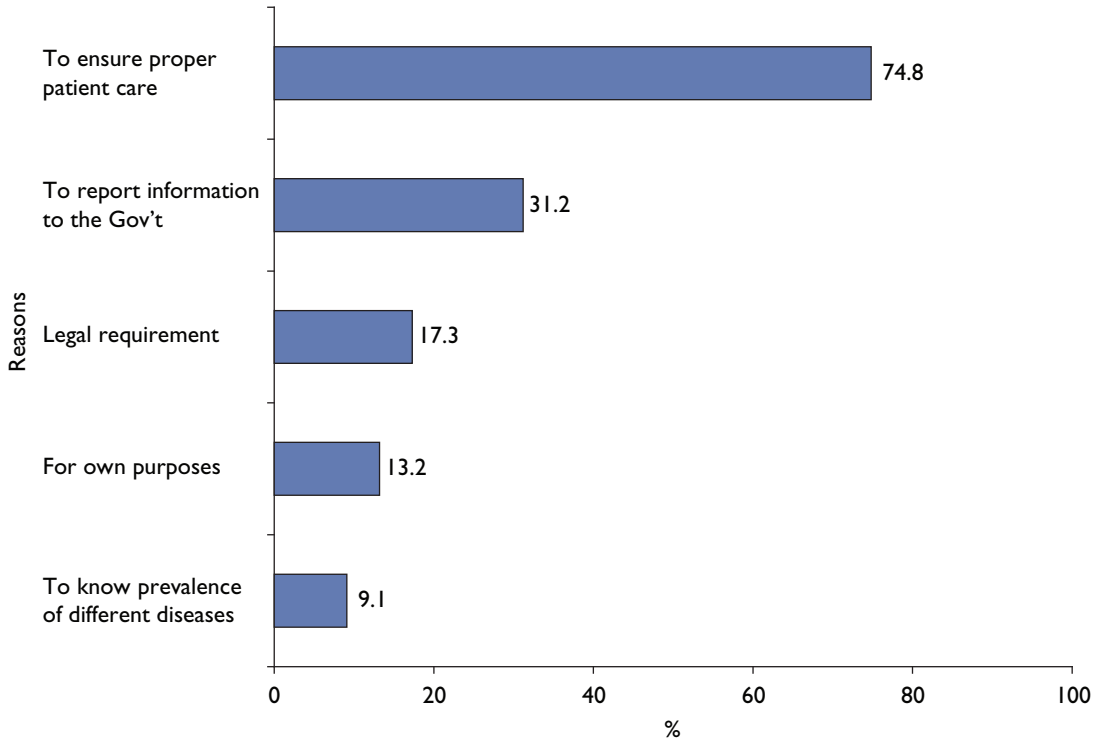
Referral destination percentages may add to more than "Total" column due to multiple response

3.6.2 MEDICAL RECORDS

Ensuring effective continuity of care and treatment for HIV-positive patients is another way that the public and private health sectors may intersect. Private health providers were asked about their record-keeping practices and under what circumstances they share patient records with other health providers.

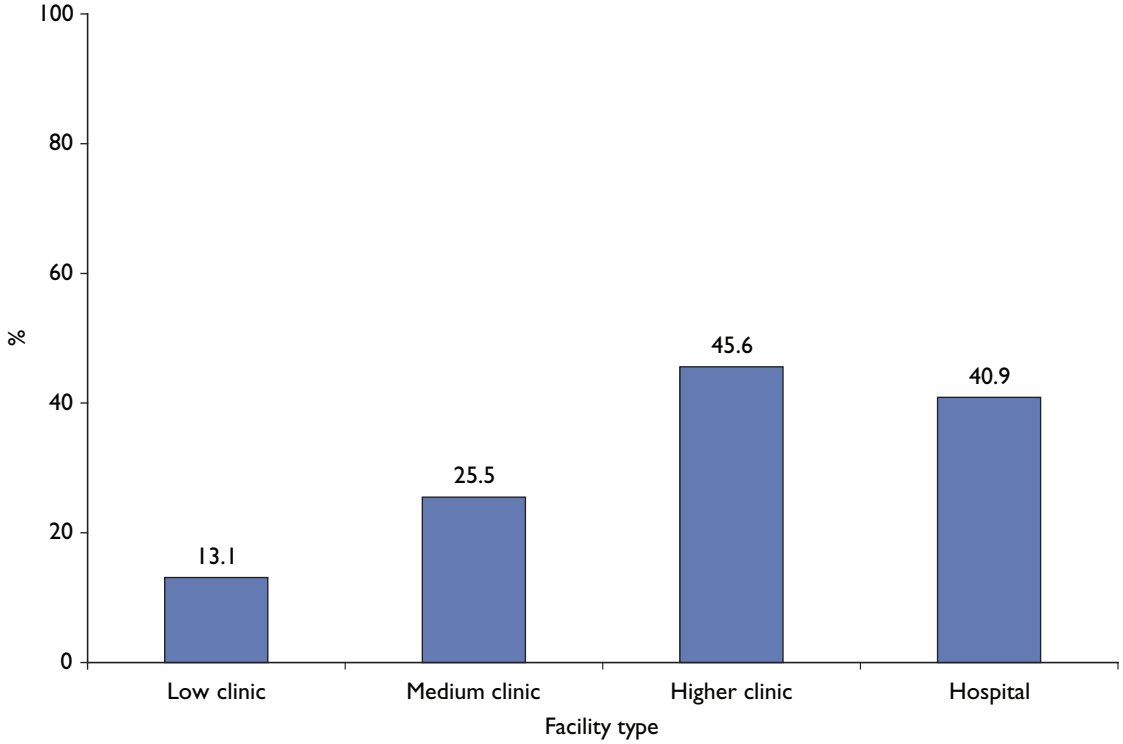
Almost all private facilities reported that they keep individual medical records on patients. The most commonly reported reason across all types of facilities for doing so was to ensure proper patient care (Figure 3.5). All hospital respondents and more than 75 percent of private clinic respondents reported sharing medical records or patient statistics with the relevant government oversight entity, including the FMOH, RHB, or zonal or woreda health office.

FIGURE 3.5: PERCENTAGE OF RESPONDENTS REPORTING VARIOUS REASONS FOR KEEPING INDIVIDUAL MEDICAL RECORDS



As Figure 3.6 indicates, about 41 percent of hospital respondents and 46 percent of higher clinic respondents reported sharing patient records. The majority of respondents from clinics shared patient records with public facilities, while 33 percent of respondents from hospitals shared records with other private for-profit facilities, and 69 percent shared records with private not-for-profit facilities.

FIGURE 3.6: PERCENTAGE OF PRIVATE HEALTH PRACTITIONERS SHARING MEDICAL RECORDS OF HIV-POSITIVE PATIENTS WITH OTHER HEALTH PROVIDERS



The major mechanism for record sharing was using the standard referral form. More than 90 percent of all facilities reported using this form.

The measures providers reported using to ensure confidentiality of medical records included sharing results only with patients, keeping test results only accessible to facility staff, and obligating staff to maintain patient confidentiality.

3.7 THE BUSINESS OF PRIVATE SECTOR HEALTH PROVISION

As noted earlier, the survey was comprised of two components: an administrator module and a health practitioner module. In the majority of cases (61 percent), the person responding to the administrator and health provider modules was one and the same (see Table 3.25). Of particular interest is the overlap between facility ownership and direct service provision. This dual role of owner/practitioner was most common in lower clinics (77 percent of facilities) and diminished with the level of facility: 64 percent for medium clinics, 36 percent for higher clinics, and 17 percent for private hospitals. These findings are relevant in terms of health provider autonomy, such that if a health provider is also a facility owner, he/she is more likely to be able to make decisions affecting the facility, such as whether to partake in training opportunities or which services to offer. The results indicate that lower and medium health providers are more likely to be in this position, whereas higher clinic and hospital health workers may have less say in these matters. Of course, training first has to be offered for providers to avail themselves of its benefits.

TABLE 3.25: PERCENT DISTRIBUTION OF RESPONDENTS AT PRIVATE HEALTH FACILITIES

	Lower clinic	Medium clinic	Higher clinic	Hospital
Owner/manager only	3	6	9	13
Health provider only	5	6	38	61
Health provider and manager	15	22	17	9
Health provider and owner	13	9	7	4
Health provider, manager and owner	64	56	28	13
N	**133**	**81**	**42**	**23**

Respondents of the administrator module were primarily men (89 percent) with an average age of 41 years. Respondents were asked about their business and management training, challenges they face in administering/managing the facility, and their experience with accessing credit.

3.7.1 TRAINING IN BUSINESS AND FINANCIAL MANAGEMENT

Business and financial management training is critical to effectively operating a private health facility. Generally, administrators/owners of private facilities reported low to moderate levels of training on business and management, as shown in Table 3.26. Training in health facility administration was highest across all types of facilities. Facility managers employed in private hospitals and higher clinics on average received more business and financial training than their counterparts in medium and lower clinics. Few respondents had received training on how to obtain loans or accessing credit.

TABLE 3.26: PERCENTAGE OF FACILITY MANAGERS TRAINED IN BUSINESS AND MANAGEMENT

Training	Lower clinic	Medium clinic	Higher clinic	Hospital
Business management	13.1	12.9	32.1	34.8
Information technology	13.3	19.8	22.8	47.8
Records administration/data management	19.9	24.2	40.7	47.8
Accessing financing/loans	1.6	1.7	7.6	4.4
Health facility administration/ management	39.8	45.9	29.3	47.8
N	**133**	**81**	**42**	**24**

3.7.2 SOURCES OF TRAINING FOR BUSINESS AND FINANCIAL MANAGEMENT

Respondents were asked where they obtained business and financial management training. As Table 3.27 indicates, university/college and private institutes were the predominant sources of training. Private institutes were most frequently mentioned for information technology and access to finance training, whereas universities/colleges were cited as the top source of training for business management, records administration, and health facility administration. FMOH was least frequently cited as a source of training in these areas.

TABLE 3.27: SOURCES OF BUSINESS AND FINANCIAL MANAGEMENT TRAINING

Training \ Source	University/college	Private training institute	Ministry of Health
Business management	46.0	31.0	9.6
Information technology	34.8	52.6	10.2
Records administration/data management	41.1	25.4	20.2
Accessing financing/loans	11.1	66.9	0
Health facility administration/ management	47.5	11.6	28.9

3.7.3 GAUGING INTEREST AND WILLINGNESS TO PAY FOR FUTURE TRAINING IN BUSINESS AND FINANCING

Among those respondents who had not received prior training, interest in receiving business and management training in the future was high. As presented in Table 3.28, results demonstrate a strong interest in all of the business training topics. A general trend is that interest in training was strongest in the lower clinics and diminished slightly as the level of facility increased. This makes sense in that physicians and other highly trained health professionals often have more access to a variety of training, and these health providers are more likely to be concentrated in hospitals and higher clinics.

TABLE 3.28: GAUGING INTEREST AND WILLINGNESS TO PAY FOR FUTURE TRAINING IN BUSINESS FINANCING

Training	Lower clinic	Medium clinic	Higher clinic	Hospital
Business management	85.0	83.6	78.0	81.3
Information technology	85.2	88.8	78.5	76.9
Records administration/data management	76.8	68.8	67.8	61.5
Accessing financing/loans	76.7	67.0	58.4	69.6
Health facility administration/management	86.9	92.0	77.9	76.9

The findings underscore a keen interest in accessing these types of trainings and highlight a potential barrier to growing the private health sector's role in addressing HIV/AIDS needs.

Respondents who indicated interest in receiving business training were asked if they would be willing to pay for such training and, if so, how much. As demonstrated in Table 3.29, administrators expressed a strong willingness to pay for training, which seems to correspond loosely with the level of facility (i.e., lower clinics indicating strongest interest and hospitals showing less interest). More than half of administrators in low and medium clinics reported they would be willing to pay for training in business management, information technology, and facility administration.

TABLE 3.29: PERCENTAGE OF PRIVATE FACILITY ADMINISTRATORS WILLING TO PAY FOR TRAINING

Training	Lower clinic	Medium clinic	Higher clinic	Hospital
Business management	54.4	59.7	44.1	46.2
Information technology	58.2	66.5	45.4	40.0
Records administration/data management	40.3	41.8	26.5	50.0
Accessing financing/loans	49.9	43.6	32.1	43.8
Health facility administration/management	57.1	53.1	36.2	40.0

Note: Among administrators who have not received training

A relatively smaller proportion of clinics were willing to pay for training in records administration management, although this type of training was of particular interest to hospital administrators. Among those who were willing to pay for training, 49 to 64 percent of administrators suggested they would pay less than 100 Birr (equivalent to 10 USD) for various trainings; 21 to 41 percent of facilities were willing to pay between 100 to 1000 Birr (equivalent to 10 USD to 100 USD); no respondents were willing to pay more than 1000 Birr (100 USD) for any type of business training. Results of the median amounts administrators were willing to pay are presented in Table 3.30. Not surprisingly, median amounts increase with level of facility, in line with estimated earnings.

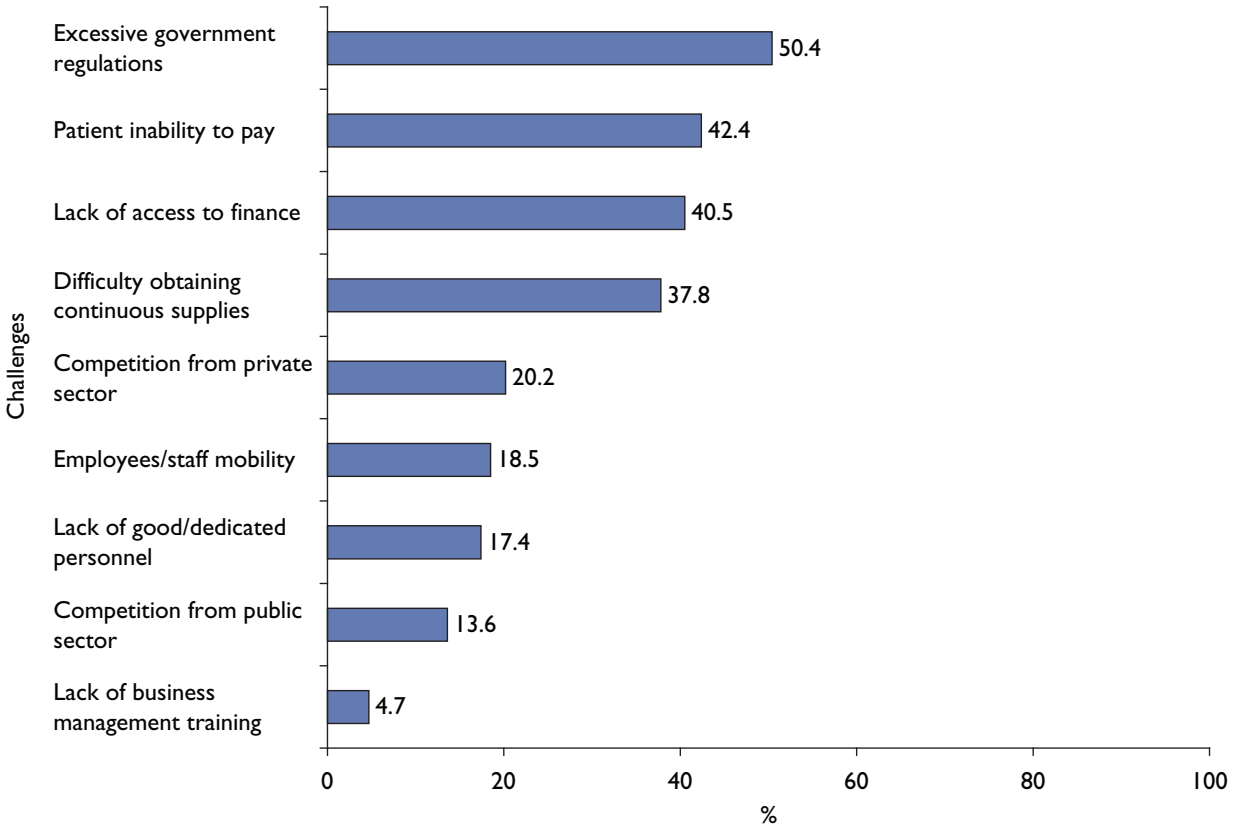
TABLE 3.30: AMOUNTS ADMINISTRATORS ARE WILLING TO PAY FOR VARIOUS BUSINESS TRAINING TOPICS BY TYPE OF FACILITY (MEDIAN AMOUNTS IN BIRR)

Training	Lower clinic	Medium clinic	Higher clinic	Hospital
Business management	100	200	225	300
Information technology	100	200	100	250
Records administration/data management	50	100	300	200
Accessing financing/loans	100	100	150	200
Health facility administration/management	100	200	200	225

3.7.4 ADMINISTRATIVE CHALLENGES

The study sought to discover any challenges administrators face in managing private health facilities, and Figure 3.7 displays their responses. Excessive government regulation was the most commonly reported challenge across all types of facilities. Other challenges such as patient inability to pay, lack of access to financing, and difficulty obtaining continuous medical supplies were also reported with some frequency. Staff turnover was a particular concern for hospital administrators, with 43 percent of respondents citing this problem.

FIGURE 3.7: PERCENTAGE OF FACILITIES REPORTING VARIOUS ADMINISTRATIVE CHALLENGES



Regarding the administrative challenge of patient inability to pay, administrators in all types of facilities reported that the majority (80 percent) of their clients pay for services out-of-pocket. About 90 percent of facilities reported that they had reduced or eliminated service fees, on a case-by-case basis, to treat patients who could not afford to pay for their health care.

3.7.5 FINANCING

Private health facilities' access to financing is particularly important to ensure quality improvement, staffing, facility upgrades, and overall expansion of the private health sector. According to the International Finance Corporation (2007), loans can strengthen the overall health system while being engines of economic growth in Africa. Access to financing was spontaneously cited as an administrative challenge by 41 percent of respondents, who were further queried on the topic.

Surveyed private facilities in all regions had limited access to financing. Although about one-third of hospitals and higher clinics reported being financed with credit, less than 10 percent of medium and lower clinics were financed with credit. Commercial banks were the major source of financing for both higher clinics and hospitals. A few lower and medium clinics (less than 5 percent) obtained credit from micro-finance institutions. We found no regional differences with respect to financing history for each type of facility.

As indicated in Table 3.31, facility administrators from all facility types expressed interest in taking out a loan; lower clinic administrators were particularly interested in pursuing financing opportunities. Private clinics and hospitals cited the major reason they were interested in such a loan was to expand or renovate facilities, and a secondary reason was to purchase medical equipment. Lower clinics indicated an interest in using loans to hire staff and offer new services.

TABLE 3.31: FINANCING HISTORY AND FUTURE INTENTIONS AMONG PRIVATE HEALTH OWNERS/ADMINISTRATORS

	Lower clinic	Medium clinic	Higher clinic	Hospital
Financing History and Interest				
Financed with credit	8.3	8.6	28.0	33.3
Interested in taking a loan in the future	62.1	52.9	40.4	29.2
None of above	29.7	38.5	31.6	37.5
Intended Uses for Loan*				
Expand or renovate facility	68.9	58.9	67.6	41.7
Train or hire more staff	22.3	10.8	9.8	0
Purchase medical equipment	32.9	29.8	37.8	25.0
Offer new services	21.9	26.2	24.2	8.3
Computerize records	2.4	3.0	4.9	0
N	**133**	**81**	**42**	**24**

* Among owners/administrators reporting interest in future loans

Based on the high interest involved in accessing credit, it may be advisable to revise banking and lending policies for the health sector to extend affordable financing to private health facilities. Training in financing and business management paired with attractive lending conditions for the private health sector could go a long way toward maximizing the potential of this sector to address priority health needs in the country.

4. PRIVATE PHARMACY FINDINGS

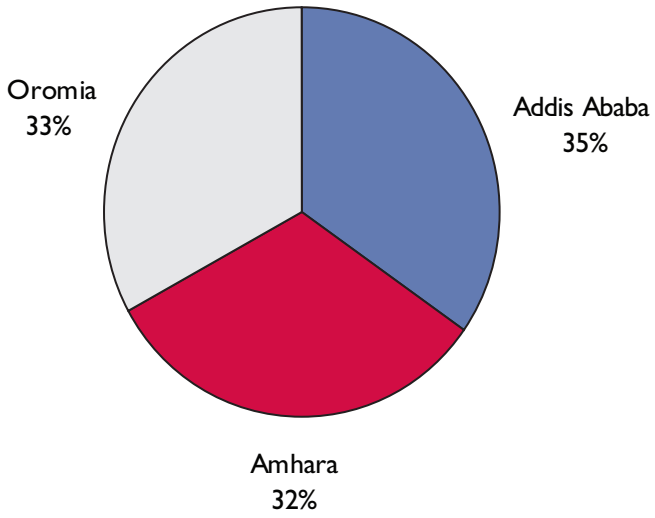
In many countries, private pharmacies play a vital role in the overall health system, as they are often the first source of care for people who are ill (International Finance Corporation, 2007). Likewise, private pharmacies are considered to play an important role in Ethiopia, although little documentation exists on the extent to which these pharmacies are involved in delivering drugs and services related to HIV. This study seeks to better understand the current and potential role of private pharmacies in responding to the HIV/AIDS epidemic in Ethiopia.

Similar to the private health facility survey, the pharmacy survey instrument consisted of two modules: one for owners/administrators and one for drug dispensers. Results follow the same sequence as for private health facilities, beginning with general characteristics of the sample, followed by findings related to training, drug stocks and referrals, and ending with the business of dispensing drugs.

4.1. GENERAL CHARACTERISTICS OF PRIVATE PHARMACIES

The sample included a total of 121 pharmacies and drug stores in the three study regions, distributed as shown in Figure 4.1. Among pharmacies surveyed, 70 percent were open every day, and 5 percent were open 24 hours a day. The daily number of customers ranged from 6 to 350, with an average of 92 customers per day. Half of all pharmacies reported 60 or more customers per day.

FIGURE 4.1: GEOGRAPHIC DISTRIBUTION OF SAMPLED PRIVATE PHARMACIES (N=121)



4.2 CHARACTERISTICS OF PRIVATE PHARMACISTS

A total of 121 respondents (pharmacists or drug dispensers) were interviewed in terms of HIV and related drug dispensing, training received, and awareness of standards of care. Nearly three-quarters (72 percent) of respondents were men, and the median age was 40 years, with a range of 22–68 years. About 72 percent of respondents were pharmacists, 19 percent were druggists, and 7 percent were pharmacy technicians.

Two-thirds of respondents (66 percent) reported being a member of a professional association, the majority being affiliated with the Ethiopian Pharmaceutical Association. Interestingly, membership was highest among pharmacists in Addis Ababa and lowest among their counterparts in Amhara.

4.2.2 TRAINING

Pharmacy staff responsible for dispensing drugs were asked about the kinds of training they had received. Despite the fact that most private pharmacies were not authorized to dispense ARVs at the time of the survey, more than half of respondents reported they had received training in dispensing ARV and STI drugs, and 39 percent were trained in dispensing TB drugs.

DACA was commonly reported as the source of training for managing ARV and STI drugs, while FMOH was the major source of training for TB drugs. Most pharmacists obtained their training through in-service training, while a smaller percentage had been trained as part of their formal degree program. Full training results are presented in Table 4.1.

Respondents most often reported lack of opportunity and lack of awareness of training offerings as the reasons for not attending training. Cost was not reported as a barrier.

TABLE 4.1: PERCENTAGE OF RESPONDENTS TRAINED BY SOURCES AND TIMING OF TRAINING

	Total	Sources of training				Type of training		
		FMOH	RHB/ DACA	NGO	Others	Pre-service	In-service	Both
ARV drugs dispensing	52.0	6.9	22.4	12.4	15.0	2.3	45.4	2.3
TB drugs dispensing	39.4	16.5	8.9	3.8	10.6	14.5	20.4	4.0
STI drugs dispensing	51.6	10.1	16.9	4.8	21.9	17.1	29.8	4.7
N	**121**							

4.2.3 INTEREST IN RECEIVING TRAINING AND WILLINGNESS TO PAY

Among pharmacists who had not received training, at least 90 percent reported interest in attending training in dispensing ARV, TB, and STI drugs. For those expressing interest, more than half indicated they would be willing to pay for such training. Surveyed pharmacists reported a willingness to pay 100 Birr for ARV training, 200 Birr for TB training, and 175 Birr for STI training (median amounts). Full results are presented in Table 4.2. As noted in the private health facility chapter, the amounts that pharmacists report they would be *willing* to pay should be further validated by determining *actual* ability to pay.

TABLE 4.2: INTEREST AND WILLINGNESS AMONG PRIVATE PHARMACISTS TO PAY FOR FUTURE HIV-RELATED TRAINING

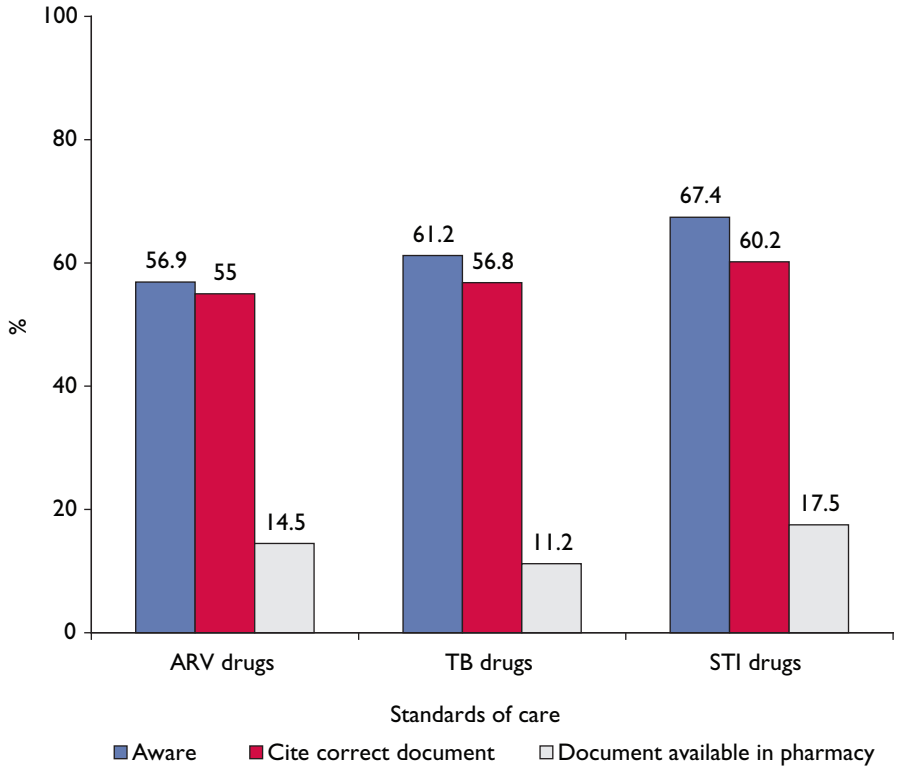
	Interested in future training[1]	Willing to pay for future training[2]	Median amount willing to pay (in Birr)[3]
ARV drugs dispensing	89.8	55.2	100
TB drugs dispensing	90.7	50.0	200
STI drugs dispensing	92.5	53.4	175

Notes: 1, among those not trained
2, among those interested in future training
3, among those willing to pay

4.2.4 AWARENESS AND KNOWLEDGE OF STANDARDS OF CARE AMONG PRIVATE PHARMACISTS

Among surveyed pharmacists, 57 percent were aware of written standards of care for the dispensing of ARV drugs. Of these, almost all knew that these standards were contained in the *Guideline for Implementation of Antiretroviral Therapy in Ethiopia* (MOH 2005), and 29 percent reported that they had the guidelines in the pharmacy. About 61 percent reported awareness of standards of care for dispensing TB medicines – almost all knew that the TB drug dispensing guidelines were contained in the *National TB and Leprosy Control Manual* (FMOH) and 21 percent reported availability of the manual in the facility. Awareness of written standards of care for dispensing STI drugs was reported by 67 percent of respondents. Of this group, 94 percent cited the source of these standards as the *Guideline for Syndromic Management of STI* (FMOH) and 31 percent reported the manual was available in the facility.

FIGURE 4.2: AWARENESS AND KNOWLEDGE OF STANDARDS OF CARE FOR DISPENSING ARV, TB, AND STI DRUGS AMONG PRIVATE PHARMACISTS



4.3 STOCKING HIV/AIDS AND TB DRUGS AND OTHER MEDICAL SUPPLIES

The survey questioned pharmacy managers about their drug stocks related to HIV/AIDS and TB, and results are shown in Table 4.3. Few pharmacists in the private sector – only three among the entire sample – reported dispensing ARV drugs. Only 7 percent of the surveyed pharmacies reported having a current stock of ARV drugs. The sources of their ARV drugs included FMOH, RHBs, PHARMID, and private suppliers.

The most commonly reported reason for not dispensing ARV and TB drugs was "not authorized to dispense." No pharmacy respondents reported stocking TB drugs, a finding in line with current national regulations. The *Policy on Antiretroviral Drug Supply and Use in Ethiopia* (FMOH 2002) indicates that ARVs "shall be dispensed in authorized retail outlets by trained personnel." To date, few pharmacies are involved in dispensing ARVs.

TABLE 4.3: PERCENTAGE OF PHARMACIES STOCKING HIV AND TB DRUGS BY SOURCES

Medical supplies	In stock	Source		No stock
		Public	Private	
HIV test kits	5.4	5.0	5.3	94.6
TB drugs	—	—	—	100.0
ARV drugs	6.6	5.2	3.3	94.6
CD4 test reagent	3.3	3.3	3.3	96.7
N	**121**	**121**	**121**	**121**

Note: Supplies could be obtained from multiple sources

Recently, some private hospitals have been designated to distribute ARV drug regimens. Hospitals have on-site pharmacies, which are allowed to dispense free ARV drugs. At the time of the survey, stand-alone pharmacies were not allowed to stock ARV drugs. However, private pharmacies are now allowed to dispense certain ARVs, such as *Atripla*, a single daily dose triple-therapy drug for which clients must pay. At the time of this report, FHAPCO and Addis Ababa Health Bureau were in the process of developing a policy to permit dispensing free ARVs from private higher clinics.

With the exception of *Atripla*, ARVs in Ethiopia are generally procured with assistance from the Global Fund, PEPFAR, and the Clinton Foundation HIV/AIDS Initiative and, according to national policy, must be distributed free of charge to the patient. Despite the fact that these drugs cannot be sold, as much as 88 percent of all surveyed pharmacists expressed an interest in dispensing ARVs in the future.

A few pharmacies reported stocking CD4 test reagent, an interesting finding since the supply channel for CD4 test reagent is through a medical equipment supplier, not a pharmaceutical supplier.

4.4 PATIENT REFERRALS

To better understand the role pharmacists play in addressing HIV/AIDS services, our survey asked whether customers sought information on various topics related to HIV/AIDS, and, if so, how the pharmacist responded to such queries. Table 4.4 reveals that a high percentage of pharmacists reported being asked about HIV testing. Their responses varied: 63 percent of pharmacists provided counseling and 84 percent referred the customer elsewhere for care. About 58 percent of pharmacists had been asked about ART from their customers, and, of those, 60 percent offered counseling to clients and 77 percent referred clients to other facilities. Pharmacists reported being asked frequently about TB treatment, and 81 percent of those asked referred clients to other facilities. In all cases, customers were primarily referred to public facilities for care.

TABLE 4.4: PERCENTAGE OF PHARMACISTS ASKED ABOUT HIV AND RELATED SERVICES AND ACTIONS TAKEN

	HIV testing	ART	TB treatment
Being asked questions on	70.5	57.6	64.6
N	121	121	121
Actions taken (among those being asked questions)			
Dispense medicine	NA	7.5	10.4*
Offer counseling	63.4	60.4	46.3
Made referrals	83.8	76.5	81.3
N	84	69	80
Referral destination			
Public facility	89.4	93.8	94.9
Private not-for-profit	26.0	7.9	1.6
Private for-profit	23.0	16.7	13.9
N	72	55	65

*Although at the time of the survey private pharmacies were not authorized to distribute TB drugs, six pharmacists who were asked about TB by a customer did report that they dispersed medicine. Since other data indicate no pharmacies stocked TB drugs, it is likely that this figure reflects non-TB drugs.

4.5 GOVERNMENT REGULATIONS

All pharmacy managers reported that they were regulated by the government, and on average they reported 2.5 regulatory visits per year. The majority (82 percent) of pharmacies reported being regulated by DACA, whereas 27 percent said they were regulated by the RHB. Regional variations were apparent, in that pharmacies in Addis Ababa reported universally being regulated by DACA, whereas 90 percent of pharmacies in Oromia and 92 percent in Amhara reported oversight by their RHB.

These findings are in accordance with Ethiopian regulations, which specify that DACA regulates Addis Ababa pharmacies, but RHBs in other regions, including Oromia and Amhara, have regulatory oversight over pharmacies.

4.6 BUSINESS PRACTICES OF PRIVATE PHARMACIES

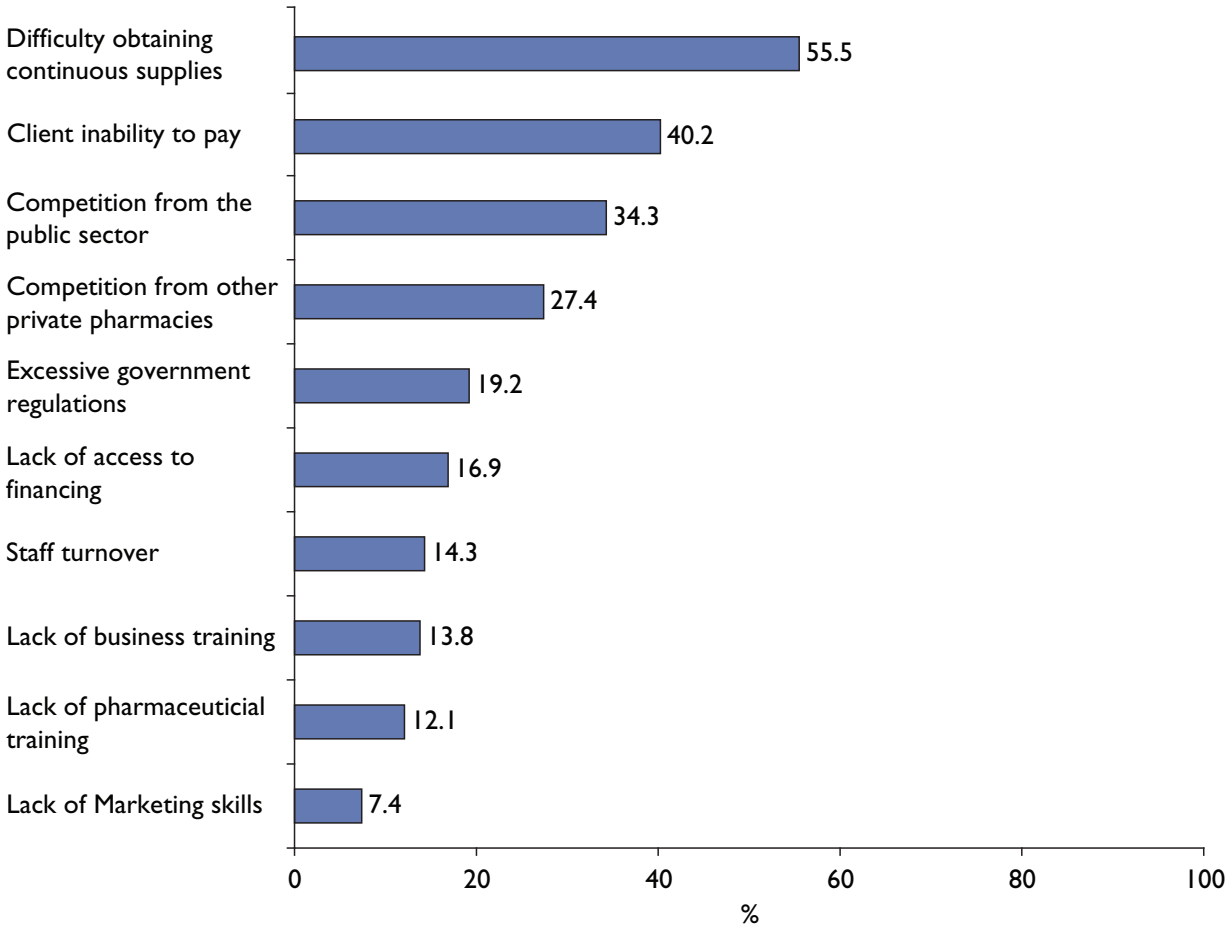
Similar to the private health facility survey, a high percentage of pharmacists also either managed or owned the pharmacy. For more than 80 percent of the surveyed pharmacies, the respondent answering the owner/administrator module also responded to the drug dispenser module. In slightly more than half of the pharmacies, the pharmacist owned the facility, with ownership more likely in Oromia than the other two study sites.

Half of pharmacies employed one or two full-time staff and less than 10 percent had five or more full-time staff. Survey responses indicate it is common practice for pharmacies to employ part-time staff.

4.6.1 ADMINISTRATIVE CHALLENGES

The administrative challenge that pharmacy owners/administrators most commonly reported was difficulty in obtaining continuous supplies. As reported in Figure 4.3, a number of pharmacies reported facing other challenges as well, such as client inability to pay, competition from both public and private pharmacies, and excessive government regulations.

FIGURE 4.3: PERCENTAGE OF PHARMACIES REPORTING ADMINISTRATIVE CHALLENGES



4.6.1 ACCESS TO FINANCE

Relatively fewer (17 percent) pharmacy owners/administrators cited lack of access to financing as an administrative challenge. Further probing on this topic revealed that 21 percent of pharmacies had been financed with credit, and all of these had obtained credit from commercial banks. Among those that had not previously received a loan, 37 percent reported interest in taking out a future loan. Respondents cited expanding the pharmacy as the major reason they were interested in accessing credit.

Given the considerable levels of training of private pharmacists, their interest in providing information and drugs related to HIV/AIDS, and their potential role as an entry point into the health system for counseling, testing, and other critical HIV services, the government may wish to explore how to more efficiently engage this cadre of providers.

5. DISCUSSION AND RECOMMENDATIONS

5.1 DISCUSSION

The survey findings offer valuable information about current practices and future potential of the private health sector in HIV/AIDS service delivery. This study provides an unprecedented assessment of Ethiopia's private sector involvement in HIV and related service provision. It quantitatively explores issues pertaining to facility management, stock of HIV drugs and supplies, HIV counseling and testing, and HIV and TB treatment, training, referrals, and record keeping. Including both health facilities and pharmacies in the sample provides a richer and more comprehensive picture of the total private health sector role in HIV/AIDS and related service delivery than would addressing either of the two segments individually.

Most importantly, the study reveals the gaps in public-private collaboration that can be addressed to help Ethiopia fulfill its goal of scaling up access to prevention, treatment, care, and support of HIV and related services. The study findings and recommendations of this report can be used to inform the FMOH and FHAPCO in building public-private partnerships to increase access to quality HIV/AIDS care and related treatment services. The recommendations based on the findings cover the following categories: strengthening the Public-Private Partnership (PPP) unit, elevating awareness and operationalizing GOE plans to work with the private sector, addressing policy and regulatory barriers, enhancing collaboration among the constellation of all providers involved in HIV/AIDS service delivery, addressing quality issues and increasing private sector engagement through various incentives.

5.2 RECOMMENDATIONS

5.2.1. STRENGTHEN PUBLIC-PRIVATE PARTNERSHIP UNIT TO ENGAGE THE PRIVATE SECTOR ON BEHALF OF FMOH

By creating a PPP unit within the FMOH, Ethiopia sends a message to both its own staff and to the private health sector that it is ready to engage the private sector. In fact, many developing countries throughout the region and elsewhere (e.g. India) have established either a PPP unit or have PPP advisers for the express purpose of creating a policy body. PPP staff are equipped with unique skills to engage the private health sector to carry out PPPs. The following are examples of PPP initiatives, from new to more mature and established units:

- New – Ethiopia, Kenya
- Emerging – Ghana, Nigeria, Utter Pradesh state (India)
- Mature – South Africa

An example of a PPP unit that has been particularly effective in the region includes South Africa's PPP unit. The unit has been designed to be a model for the region and includes a website with toolkits and accompanying legislation that has been enacted to empower the unit.[7]

[7] Public-Private Partnership Unit, South Africa. See http://www.ppp.gov.za/

There are many steps the FMOH can take to strengthen its PPP unit, including the following:

- Elevate the authority and visibility of the PPP unit creating direct lines of communication to senior policymakers within the FMOH.
- Define the terms of reference for the PPP unit that will include the mission and functions of the unit as well as a description of the roles and responsibilities of the unit staff.
- Draft a PPP policy framework to confer authority to the PPP unit to represent the FMOH with the private health sector. This will enable the PPP unit to establish common ground with the private sector through dialogue, joint problem-solving, and the development of an actionable framework for collaboration.
- Build the PPP unit skills to work with the private health sector by offering them training in key skill areas (e.g., formulation of policy and regulatory frameworks, private sector mapping, health financing, legal/regulatory analysis) and by supporting their travel to observe successful PPP units in other countries.

PPP Unit Objective in Uttar Pradesh

The overall objective of the PPP unit is to strengthen the health delivery systems in the state of Uttar Pradesh with capabilities and full participation of the private for-profit and not-for-profit health sectors to maximize the attainment of the health goals in rural and urban areas as envisioned by the government of Uttar Pradesh. The PPP unit in Uttar Pradesh views tapping the potential of the private health sector as critical to expanding coverage to quality services.

5.2.2. RAISE AWARENESS AND OPERATIONALIZE GOVERNMENT'S PLAN TO WORK WITH THE PRIVATE SECTOR

Although Ethiopia's Multisectoral Plan of Action clearly includes the private health sector in its goals for scaling up HIV/AIDS services, many residual myths and uncertainties continue to exist regarding the policies affecting private sector collaboration. Since the private sector has clearly become more central to HIV/AIDS service delivery through the FMOH mandate, the private and public health sectors must be made aware of their respective roles in contributing to national HIV/AIDS strategies.

Disseminate government strategies and plans, such as the Multisectoral Plan of Action, to encourage greater collaboration with private providers and pharmacists. Through the Multisectoral Plan of Action, the government has articulated strategies to include the private sector in its efforts to scale up testing and treatment for HIV/AIDS and related services. While the Multisectoral Plan of Action has been disseminated, what may be lacking are concrete plans to operationalize its goals with respect to the private sector. The FMOH has a captive audience with its own staff and could publicize widely and frequently its intention to work more closely with the private sector. Disseminating the key findings of this private facility survey offers an opportunity for the FMOH to discuss with its staff, RHB heads, and FMOH department heads the current capacity of the private sector, as well as opportunities for collaboration. It also serves as a tool to identify common barriers to further expanding the role of the private sector as envisioned by the Multisectoral Plan of Action. As presented in Box 1, the recent PPM-DOTS experience could serve as a guide for involving the private sector to accomplish national goals.

Box 1. PPM/DOTS Experience in Ethiopia

In 2006, PSP-Ethiopia (PSP-E) supported a policy process led by the FMOH to extend the provision of DOTS services using a Public-Private Mix (PPM) model. PSP-E initiated this process by convening a consensus-building meeting that included all partners working on TB in Ethiopia in April 2006. Following this consensus-building meeting, a technical working group was formed to guide the development of national PPM-DOTS guidelines and plan the piloting of services. Technical working group members included WHO, German Leprosy and TB Relief Association, Medical Association of Physicians in Private Practice-Ethiopia (MAPPP-E), Drug Administration and Control Authority, Medico Legal Department, FMOH, Ethiopian Health and Nutrition Research Institute, and the RHBs of Addis Ababa and Oromia. MAPPP-E represented the private sector, although the PPM-DOTS initiative was driven by the FMOH. The technical working group developed national PPM-DOTS guidelines and selection criteria for private health facilities. The guidelines were finalized in August 2006 and officially launched in March 2007 with a national meeting convened by the State Minister of Health to formally endorse the guidelines and call upon the regions to dramatically expand the number of PPM-DOTS sites.

FMOH has several institutions with whom it could partner to raise awareness of the private sector's capacity for providing expanded HIV/AIDS services. More than 20 percent of all private health professionals interviewed are members of a professional association. The FMOH could work with these associations to disseminate a strategic plan to collaborate with the private health sector. In Guatemala, the professional medical associations were a driving force for raising awareness of the current and potential contribution to HCT. Using a similar provider survey, 10 professional associations, ranging from general practitioners to obstetrician-gynecologists, to pharmacists, to biological lab technicians, worked together to disseminate the findings among their membership and to use their country's provider study results for dialogue with the Guatemalan Ministry of Health and HIV/AIDS program. This dialogue enabled both sectors to address specific barriers to private-public collaboration, including private sector access to service and quality guidelines, inclusion in FMOH trainings, and improvement of referrals of HIV/AIDS patients between sectors.

5.2.3. ADDRESS POLICY AND REGULATORY BARRIERS

As the study revealed, some of the barriers to greater participation of the private health sector in delivering HIV/AIDS services and products stem from the current legal and regulatory environment. For example, one ongoing issue preventing ART provision in private higher clinics is the requirement that a pharmacy professional dispense ARVs. Recently, FHAPCO led a policy task force to address this barrier by exploring the feasibility of using nurses trained in the national ART curriculum to dispense ARVs. This example demonstrates how creative, yet workable, solutions can be found by bringing divergent health actors (private clinicians, facility owners, FMOH, FHAPCO, and DACA) together for a compromise that will expand quality service delivery with Ethiopia's available resources, both public and private.

Private providers and pharmacists indicated that administrative and policy challenges, such as perceived or actual lack of authority to provide treatment or care, excessive government regulations, and lack of continuous supplies, impede their ability to provide HIV/AIDS drugs and services. Although policies and regulations are designed to ensure quality of care, if such regulations are excessive, they may actually decrease access to health services, and in the case of HIV/AIDS services, may prevent the country from achieving its national goals.

Reconcile policy regulations to address expressed challenges and barriers faced by private facilities and pharmacies. An important step to increasing private sector participation would be to conduct a systematic review of the norms, regulations, and guidelines governing HIV/AIDS services and products, which could then inform a policy framework outlining the role of the private sector.

The FMOH could embark on a new initiative in this area by forming a working committee comprised of the different stakeholder groups to (1) identify the key barriers related to the norms, guidelines, and standards; (2) prioritize the barriers; and (3) identify solutions to address the barriers. Critical representation from professional associations and the private sector should be included to ensure that these groups' capacities are fully maximized.

A participatory process similar could produce many benefits in addition to reconciling the laws and regulations. A working group comprised of both the public and private sectors would help overcome the mistrust and lack of information by providing for regular contact and information exchange. For example, the survey revealed that private providers listed "excessive regulations" as a key challenge to operations in Ethiopia. Ongoing public-private policy forums, perhaps informed by focus group discussions with private providers, could offer the FMOH an opportunity to explain the rationale for some of the regulations while, at the same, offering private providers the chance to explain how some of the requirements create barriers to offering HIV/AIDS services and drugs. Through direct dialogue, compromises can be reached quickly and efficiently.

Empower pharmacists with training and authority to collaborate effectively in HIV/AIDS service provision. Pharmacists are a gateway to the health system for many people, including the poor. In Ethiopia, private pharmacies comprise 65 percent of all pharmacies. Because most ARVs and TB drugs must be distributed for free, private pharmacists have not been trained to provide these services. Since the poor often turn first to private pharmacists to address their family's health care needs (especially when no doctors are available), it is essential that these providers be seen as allies in HIV/AIDS service delivery (International Finance Corporation 2007). Although almost all ARVs continue to be free in Ethiopia, pharmacists surveyed still expressed an interest in dispensing these drugs. FMOH can explore with private pharmacists the appropriate roles and strategies needed to harness the extensive network of private pharmacies. In Vietnam, the MOH established a training program in three provinces to allow pharmacists to provide counseling and referrals for HIV testing and to better diagnose and treat STIs and OIs among people living with HIV/AIDS. This strategy has been effective in reaching high-risk groups in Vietnam, who often do not seek health services for HIV/AIDS and STIs in the public sector, but turn to private pharmacists to address symptoms.

5.2.4 SHORE UP COLLABORATION AMONG THE CONSTELLATION OF PROVIDERS OFFERING HIV/AIDS AND RELATED SERVICES

The large and diverse constellation of providers involved in the continuum of HIV/AIDS-related services (e.g., lab technicians, pharmacists, counselors, physicians, nurses, data clerks) requires careful tracking and sharing of patient information and records to ensure that patient care, support, and statistics are carefully monitored for quality, consistency, and health planning purposes. The range of recommendations that follows would help create a more integrated health system within and between the public and private sectors.

Manage and utilize a database of private providers. The difficulty of compiling a list of private health facilities and pharmacies for this survey highlights the need for a comprehensive database of the private health sector. Currently, FMOH is establishing such a database to enable efficient management, planning, resource distribution, and future research. MAPPP-E is also in the process of developing a facilities directory of private practices. While the first edition focuses primarily on private facilities, pharmacies, laboratories, and specialists in Addis Ababa, subsequent editions will offer expanded information about private facilities beyond the capitol.

Utilize professional associations to reach out to private providers. Private provider membership in professional associations is prominent in Ethiopia, particularly among the more advanced level facilities. These associations should be viewed as instruments for public-private collaboration. Professional associations can mobilize, educate, and communicate new policies to the private sector and can advocate for the needs of providers, enabling them to practice more effectively. MAPPP-E could play a prominent role, particularly if it expands membership to include other cadres of providers in the private sector.

Strengthen referral system between public and private providers: The continuum of HIV/AIDS services requires comprehensive care by a variety of providers. Pharmacists, lab technicians, counselors, nurses, physicians, and obstetricians are all involved in this continuum, ensuring that patients receive education, prevention, testing, counseling, and consistent access to treatment. This constellation of providers requires a well-planned, seamless referral system to ensure that patients do not fall through the cracks between each stage of service. This challenge is particularly acute when patients move between the public and private sectors, requiring transparent information sharing within and between the public and private health sectors. Disease reporting, referral cards, and awareness of the operating hours, locations, and costs of the clinics, labs, and pharmacies are all central to this referral system. Job aids to ensure appropriate and timely referral completion need to be circulated among all providers. Reporting and information sharing can monitor the success of this referral network. As presented in Box 2, the recently launched advocacy workshops to improve referrals between public and private clinics in Ethiopia could serve as a basis for further strengthening collaboration between the sectors.

Improve private sector reporting to appropriate government entities. While the survey found that all private hospitals and over 75 percent of private clinics report service statistics to the relevant government authority, there is still room for improvement. The FMOH of Ethiopia could work with a core group of health care providers and pharmacists to identify the constraints to health reporting and, together, determine solutions that meet both sectors' needs. This process could inform the planned health management information system, which will eventually require private providers to report on service statistics.

Box 2. Advocacy Workshops to Strengthen Partnership and Referral Networks Between Public and Private Health Facilities

Advocacy workshops to strengthen the partnership and referral networks between public and private clinics providing TB and/or HIV services began in Amhara and Oromia regions in 2008. With support from PSP-E, the RHBs convened a series of advocacy workshops in the Amhara and Oromia regions in response to problems encountered in the referral system to support TB/HIV services. The advocacy workshops bring together representatives from public and private clinics, woreda health offices (WoHOs), and RHBs to make participants aware of the services provided by both public and private facilities, fostering a dialogue between facilities and establishing a referral linkage system. Laminated cards with a directory of private PPM-DOTS facilities are distributed to each public health facility for posting to increase awareness of the community and public health workers about the TB services provided at the private clinics. Defaulter tracing is discussed in the advocacy workshops to identify a collaborative solution for this issue. Private clinics will first attempt to trace defaulters using telecommunications. If this is not successful, the private provider will report defaulters to the focal person in the woreda health office. This person will then engage kebele leaders and community health extension workers affiliated with public health posts to assist with defaulter tracing. As a result of the workshops, the referral system between public and private clinics will be strengthened, leading to improved TB outcomes at the patient, regional, and national levels.

Better manage coordination between public and private health services. The steps described above will provide the FMOH with the type of data needed to plan effectively and coordinate the different stakeholder groups in the health system. With these data, the FMOH, in dialogue with the NGOs and private commercial sector, can discuss what type of services should be targeted to specific socioeconomic groups in need. The provider survey reveals that many health care providers experience not only competition with other private health care providers (21 percent) but also from public sector services (14 percent). This may reflect possible duplication and overlap of services. Moreover, 40 percent of private health providers and 55 percent of pharmacists stated they had difficulty accessing a continuous supply of products and drugs needed to deliver quality services. This constraint could be explored as part of the public-private dialogue suggested in Section 5.2.3, with the goal of identifying root causes and potential solutions.

5.2.5. ADDRESS QUALITY ISSUES IN THE PRIVATE SECTOR

While this study did not assess quality of care comprehensively, in terms of reported awareness and adherence to accepted standards of care and HIV testing procedures, the findings suggest some room for improvement. Awareness of standards of care for ART, TB and STI care were lowest among lower clinic providers, and highest for hospital providers. These findings reflect the fact that lower level clinics are not expected to play a role in TB or ART service provision. Among those providers who were aware of standards, compliance with these standards was strong in higher clinics and hospitals, but weaker in lower and medium clinics. Reported reasons for encouraging patients to be tested for

HIV were also found lacking. Two strategies the FMOH can employ to close the gap in private sector performance and compliance are to widely disseminate the norms and guidelines throughout all private facilities and invite private providers to participate in related training sessions.

Lack of training among private sector providers remains one of the biggest barriers to quality service delivery. Staff in higher clinics and hospitals had greater access to training on a wide array of topics related to HIV/AIDS, TB, and STIs than did staff in medium and lower clinics. There were, however, gaps in training among these higher clinics, particularly concerning management of adult and pediatric HIV and the diagnosis and treatment of TB for people living with HIV/AIDS. The number of staff in medium and lower clinics trained in HIV/AIDS and related service provision is very low. Although two-thirds were trained to diagnosis and treat STIs, less than one-quarter of staff in these facilities received training in all other health topics listed.

Provide more appropriate, tailored HIV/AIDS and related training opportunities to private providers. The findings showed that private providers were eager for more training in HIV/AIDS services. Yet the majority of private providers interviewed indicated that lack of opportunity was the major reason for not receiving training. Fortunately, RHBs and other stakeholders in Ethiopia are well equipped to provide the necessary training to private sector providers. There are many precedents in East Africa for including the private sector in public health service training. Kenya, Uganda, and Tanzania, for example, routinely include private providers in their trainings. This training is offered directly by the FMOH (as in Kenya) and through certified NGOs (as in Uganda).

The growing experience in training private sector providers reveals a need to modify and adapt the training curriculum for the unique needs of this target audience. The most salient factor in private sector training is that private health providers are also business owners or employees of a for-profit facility. Unlike public sector providers, who continue to receive their salary while attending training courses, private providers forgo revenue when they are away from their practice. This can be particularly problematic when the provider is a sole practitioner, which our survey found was extremely common in lower and medium clinics and also in pharmacies, as this lost revenue cannot easily be recovered. Private providers must weigh the potential benefits of training against this opportunity cost. A PSP-*One* Primer, based on eight country experiences, identifies six considerations that must be taken into account to ensure maximum training impact among private providers (Averbug & Segall 2008).

PSP-E's recent experience with PPM-DOTS training revealed that private facility owners find it very difficult to send providers to lengthy in-service training. The off-site training courses burden the private facility owner with the salary costs for both the worker being trained and the substitute worker. In cases where the owner and practitioner are one and the same, which is common in lower and medium clinics, an interruption of service delivery may occur. As a result of these challenges, PSP-E is currently exploring new modalities of delivering TB and HIV/AIDS trainings in collaboration with the RHBs. Based on principles of adult and experiential learning, the proposed modality offers a more time-efficient training approach and includes three major components: self study, classroom training, and practicum. The new training modality would reduce the length of off-site classroom training without compromising content and quality and would reduce the total training costs by minimizing the need for lodging, meals, and per diem, allowing resources to focus on practicum training. In addition, this new modality would allow PSP-E and the RHBs to offer rolling training to a large pool of private providers.

The notable interest in training among private providers in our survey, combined with the new HIV rapid test kit algorithm that does not require venipuncture or refrigeration, suggests that if the government of Ethiopia were to increase opportunities for lower and medium clinic health workers to get trained in CT following the proposed training modality, these clinics could begin to offer point-of-care testing. This could have major impacts for reaching national CT goals, as uptake of HIV testing is higher when the tests are provided on site (WHO et al. 2008).

Factors to consider when developing trainings for private health providers

1. Strategies to identify and access private providers.
2. Mechanisms to assess training needs.
3. Range of incentives to encourage attendance.
4. Training methodologies appropriate for private providers.
5. Tips to maximize attendance.
6. Strategies to ensure sustainability.

5.2.6. FURTHER ENGAGE THE PRIVATE SECTOR THROUGH A VARIETY OF INCENTIVES

One of the main constraints to delivering certain services in the private health sector is cost. Private providers cannot always recuperate costs by providing HIV/AIDS, TB, family planning/reproductive health, and other primary health care services. Nearly all facilities (90 percent) reported having reduced or waived service fees to treat the poor on a case-by-case basis, while 42 percent of the private providers stated that patients' inability to pay was the biggest management challenge they confronted.

Explore a range of incentives (discounted laboratory services; donated supplies, equipment, and medicines; training; financing mechanisms) to encourage private sector collaboration. The FMOH may cost-effectively expand its reach by using incentives to encourage private sector service provision. There are a variety of incentives to encourage private sector provision of HIV/AIDS services. One model for consideration is the Gold Star Network in Kenya. Gold Star is a collaborative effort between Family Health International (FHI) and the Kenya Medical Association (KMA) to engage private practitioners in Kenya in the delivery of HIV/AIDS treatment services. Members are private physicians who have been trained and agree to abide by quality standards set by FHI and KMA for the delivery of ARV treatment services, with the approval of the government of Kenya. Gold Star was launched in 2006 by FHI primarily as a program to help employers support ART services for their HIV-positive employees. Gold Star providers assess patients' ability to pay for ARVs and match them with one of two sources of lower cost drugs available through the program. The network purchases low-cost ARV drugs, as well as OI drugs, through Pharm Access Africa Limited, a logistics management organization. Patients who cannot afford even these lower cost drugs can access the free drug supply from the public sector. Membership in the network provides access to lower cost and subsidized sources

Incentives to Expand Private Sector Service Delivery

1. Provide training opportunities to private sector staff.
2. Empower nurses and pharmacists to offer more services, thereby increasing service access points and freeing up scarce physician resources.
3. Utilize vouchers to offer services to the poor in the private sector.
4. Contract out to private providers to offer a defined set of services.

of drugs and test kits as well as negotiated group rates at a nationally recognized reference laboratory for CD4, CD8, and viral load testing. Gold Star receives PEPFAR funding, operates in four provinces, and currently includes 190 providers in the network. Gold Star developed a customized training for private providers based on a curriculum developed by the National STD and AIDS Control Program. In addition to training and access to low-cost drug supply, Gold Star offers other services to support private physicians' treatment of HIV patients:

- A hotline for ART patients to call in with questions.
- A system to identify patients who are delinquent on their prescriptions refills and to follow up with phone reminders.
- A mentoring program in which experienced HIV/AIDS providers are available to answer questions from those who are newer to this type of practice. (Barnes et al. 2009)

Financial incentives could address the commonly reported challenges of client inability to pay and lack of financing that many facility administrators and pharmacists reported. Contracting between Ministries of Health and private providers is a mechanism that enables the government to define, monitor, and compensate private providers to deliver high-quality public health services (Abramson 2004, Islam 2006). Professional associations could potentially play a role in organizing private providers and serving as the point of contact for the FMOH. Output-based aid or vouchers could also be used to target defined services for specific groups of people. Both are powerful financing mechanisms that the government may use to carve out a greater role for the private sector in the provision of HIV/AIDS and related services.

5.2.6. IMPROVE ACCESS TO CREDIT

The private health sector's access to financing is particularly important for quality improvement, staffing, facility upgrades, and expansion of the private health sector. The International Finance Corporation (2007) has suggested that loans can strengthen the overall health system while also generating economic growth in Africa. Yet private providers throughout sub-Saharan Africa routinely state that lack of access to capital is one of the largest barriers to growing or improving their practices.

Increase private sector access to finance complemented by business training. Ethiopia is no exception to this regionwide trend. Approximately one-third of private providers in hospitals and higher clinics—the most organized and best capitalized strata of the private sector – stated they had access to credit. This percentage drops dramatically, to less than 10 percent, among medium and lower clinics. Yet all categories of facilities indicated a strong desire to have greater access to credit. The need was greatest among lower and medium clinics, where as much as two-thirds wanted access to some form of financing compared with 30 to 40 percent of hospitals and higher clinics. All categories of health facilities indicated they would use the loans to do things that would improve the quality of their services: expand or renovate the facility and purchase needed equipment were the two main motivational factors associated with financing.

Given these findings, it is essential that the FMOH be aware of ongoing activities carried out by Banking on Health (BOH) project in Ethiopia. BOH is a USAID-funded project that seeks to increase access to

financing for the private health sector in developing and emerging economies worldwide. BOH takes a two-pronged approach to increasing access to financing by working with local financial institutions to promote health sector lending and by improving credit-readiness among private providers. In Ethiopia, BOH is working with four banks to expand lending opportunities for the private health sector. The project disseminates market information and provides training to banks on marketing, product development, and credit techniques for lending to private health providers. As banks become more comfortable with the business models, risks, and opportunities inherent to lending to the private health sector, they tend to increase lending and outreach efforts. BOH is working with the USAID mission to structure a Development Credit Authority Loan Portfolio Guarantee with two banks that supports lending to the sector. The Development Credit Authority provides the banks a 50-percent loan loss guarantee for all qualifying loans to the private health sector, thus mitigating the risks for the banks. The banks have agreed to lower collateral requirements for private clinics under the guarantee, which should serve to increase lending to the sector by helping potential borrowers overcome the barrier of real estate collateral requirements. The Development Credit Authority guarantee contains provisions that encourage lending to facilities based outside of Addis Ababa, which should serve to increase access for this particularly underserved subgroup of health care businesses. BOH will sponsor the first-ever private health sector business fair in 2009, providing a forum for private providers to access information and updates from banks, medical suppliers, business support service providers, and the FMOH.

The PSP-Ethiopia project addresses another business barrier faced by private health facilities seeking access to finance: lack of business and management skills among facility administrators and owners. As the provider survey illustrates, very few of the staff across all levels of private facilities have received training in these areas. Slightly more than one-third of respondents in hospitals and higher clinics had received some form of business training in areas such as management, administration, and information technology, and even fewer (less than 10 percent) had received training in financial management. When compared with staff in medium and lower clinics, the percentage with training drops even further; between 13–20 percent had training in management, records and data management, and information technology. Meanwhile, the percentage of staff trained in financial management was less than 2 percent.

Because demonstrating a solid grasp of these business skills is a prerequisite to accessing finance from local banks, business training expansion should go hand-in-hand with other strategies to reform banking and lending policies for the health sector.

5.3 CONCLUSION

The findings from the private provider survey in Ethiopia quantify the current role of the private health sector in HIV/AIDS and TB services, a solid foundation upon which further public-private collaboration can be achieved. Plans for scaling up private sector engagement in HIV/AIDS care in the country have already been articulated, as reflected by the *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support*, and with a clearer understanding of private sector practices, these plans can be operationalized.

The private health sector still remains a relatively untapped resource that can be harnessed to increase access to quality HIV/AIDS services. The private sector offers longer hours and more access points for service delivery, which may be appealing and convenient for certain clients. The private sector's human resources are also not being fully maximized. Many capable nurses, physicians, laboratory technicians,

and pharmacists operate in the private sector. They express a willingness and interest in providing HIV/AIDS and related services, but they need training and opportunities to do so.

Many immediate barriers can be addressed to unleash the potential of the private sector in providing essential services. Recommendations for overcoming these barriers include the following:

Expand collaboration between and within the public and private health sectors: Sharing resources, supplies, equipment, and training materials and shoring up referral networks require regular dialogue between and within the public and private health sectors. Professional associations can assist with information dissemination and should be viewed as a resource for mobilizing private and public sectors. Technology such as the private sector database, the health management information system, and regular reporting mechanisms for epidemiological surveillance can also be used to shore up public-private collaboration.

Empower and maximize the human resource potential of private health sector staff: By increasing efficient training opportunities for the private sector, and by reexamining prohibitive policies that restrict health professionals from providing services, human potential can be maximized. This can in turn increase job satisfaction, improve quality, and retain professionals working in the field of HIV/AIDS.

Encourage innovative incentives and access to credit: There are a variety of ways to incentivize the private sector to provide necessary HIV/AIDS services. In addition to expanding opportunities for training, other options include providing discounted supplies or medicines to private providers, increasing access to credit to improve their facilities, and compensating private providers for delivering health services to the poor through contracting or voucher mechanisms. In the case of pharmacists and private sector health professionals, this may include formalizing the consulting fees (on a progressive scale determined by patient's income) that practitioners can charge for providing ART, TB, or related services.

Address the attitudinal barriers to public-private collaboration: Without doubt, embarking on new PPPs involves a paradigm shift in traditional thinking. Much of this attitudinal shift has already occurred, as revealed in recent discussions on extending ART into private higher clinics. Lessons learned from other experiences within Ethiopia (e.g. PPM-DOTS) and beyond demonstrate that it is possible to address critical health needs through public-private collaboration. Through operationalizing proposed plans to engage the private sector, Ethiopia will continue to make progress toward achieving its goal of universal access to HIV/AIDS prevention, treatment, and care.

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ANNEX A:

POLICY TIMELINE OF PRIVATE SECTOR COLLABORATION FOR HIV/AIDS AND RELATED SERVICES

Date	Event	Impact
2002	The Policy on Antiretroviral Drug Supply and Use in Ethiopia indicates that ARVs "shall be dispensed in authorized retail outlets by trained pharmacists/ personnel."	Despite authority for private pharmacists to distribute ARVs, many pharmacists still believe that lack of authority prevents them from doing so.
January 2005	*Guideline for Implementation of Antiretroviral Therapy in Ethiopia*	Fee-based ARV service is allowed in private hospitals.
2007	The Public Private Partnership (PPP) Unit is created within the FMOH Health Service Department.	Clear lines of communication between the FMOH and senior-level authority figures are needed to give the PPP Unit clear goals and authority to utilize financial mechanisms, other incentives, and shared information to effectively facilitate PPPs.
December 2007	The FHAPCO Multisectoral Plan of Universal Action to HIV/AIDS Prevention, Treatment, Care and Support in Ethiopia is released.	The private sector is fully listed as a partner in ARV and TB service provision.

ANNEX B: FINAL SURVEY INSTRUMENTS (ENGLISH)

The Amharic version of the questionnaire is available upon request. If you would like to receive a copy, please email: info@psp-one.com.

Private Health Facility Survey

SECTION A: INTRODUCTION

INTERVIEWER READ: Hello. My name is_____, and I work for SuDCA Development Consultants, an Ethiopian research firm. We are collecting information on behalf of Private Sector Partnerships-*One*, a health project whose goal is to increase private sector involvement in the provision of healthcare. We are interviewing personnel at private health facilities to better understand how they deliver health services and the extent to which they offer HIV/AIDS and TB services. The information will be used to assist the Federal Ministry of Health (FMOH), donors, and professional associations in identifying current practices, areas of concern, and suggestions for expanding the delivery of HIV/AIDS and related services. You have been randomly selected to participate in this survey from a registry of private facilities obtained from the Federal Ministry of Health.

Please be assured that all of the information you share with us will be kept confidential. Any identifying information (e.g. name of clinic, address, etc) will be removed from the data and will not be included in the final report. Your participation in the survey is voluntary. Therefore, you will not be obliged to answer any questions that you do not want to, and you may end the survey any time. There are also no repercussions for not participating in the survey. The interview will take about 45 minutes.

The information you provide will be used to facilitate the involvement of private providers in health service delivery, and thus improve the overall health system in Ethiopia. Therefore, your participation in this survey would be greatly appreciated. At the conclusion of the interview I will provide contact information on the Private Sector Partnerships/Ethiopia project, in case you are interested in learning more about the activities and how you might benefit.

SECTION B: STUDY CONTACT INFORMATION

If you have any questions about this study, you may contact **info@psp-one.com.**

SECTION C: INFORMED CONSENT

May I continue?	***YES***	→ CONTINUE	GO TO SECTION D
	NO	→ END INTERVIEW AND THANK RESPONDENT	COMPLETE SECTION D AND RETURN TO SUPERVISOR

Unique Facility ID

FINAL RESULT
(circle one response)

1 Completed
2 Partially Completed
3 No longer in business
4 Refused
5 Other (Specify)_____

SECTION D: IDENTIFICATION

District kk

1. Region
ADDIS ABABA 1
OROMIA 2
AMHARA.....3

2. Zone/Kifle Ketema

3. Woreda

4. Type of Health Facility
LOW CLINIC.....1
MEDIUM CLINIC 2
HIGHER CLINIC 3
SPECIAL CLINIC 4
HOSPITAL 5

5. Name of Health Facility

Facility Management Respondent

6. Name of Respondent

7. Gender of Respondent
MALE.....1
FEMALE 2

8. Age of Respondent

9. Profession of the Respondent

10. Current Position in the Facility

11. Ownership of the Health Facility by the Respondent
NOT OWNER 1
SOLE PROPRIETOR 2
SHAREHOLDER..... 3
OTHER (SPECIFY)..... 96

12. Involvement of the respondent in health service provision.
(If yes, mark the profession of the respondent under health service provider, if not involved fill the ID and proceed to the questions.)

13. Facility Management Respondent ID ☐☐

Health Service Provider

14. Name of Health Provider Respondent

15. Gender of Health Provider Respondent
MALE.....1
FEMALE 2

16. Age of Health Provider Respondent

17. Profession of Health Provider Respondent
GENERAL PRACTITIONER 1
INTERNIST 2
GYNECOLOGIST.....3
PEDIATRICIAN 4
HEALTH OFFICER 5
NURSE - BSC.....6
NURSE- DIPLOMA.....7
NURSE - CERTIFICATE 8
MIDWIFE.....9
HEALTH ASSISTANT 10
OTHER (SPECIFY) 96

18. Health Provider Respondent ID ☐☐
[IF SAME AS ADMINISTRATOR, ENTER SAME ID HERE]

SECTION 1: MANAGEMENT

I would appreciate if you would answer a few questions about the management of this facility.
For Interviewer: This section is to be asked for the facility owner or manager. This person may or my not be health professional.

Time Started:	Time Ended:	Total Time in Minutes:

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q001	Do you manage administrative activities for this facility?	YES NO	1 2	
Q002	What days of the week is this facility open?	EVERY DAY EVERY DAY EXCEPT SUNDAY MONDAY TO FRIDAY EVERYDAY EXCEPT FRIDAY DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 88 96	
Q003	Is this facility open 24 hours/day?	YES NO	1 2	If NO, Skip to Q005
Q004	For how many days in a week does the facility open for 24 hours)	EVERY DAY EVERY DAY EXCEPT SUNDAY MONDAY TO FRIDAY EVERYDAY EXCEPT FRIDAY DON'T KNOW OTHER(SPECIFY) _____	1 2 3 4 88 96	
Q005	In total, how many health service providers work at this facility (part time and full time, excluding administrative/support staff)?	PT STAFF FT STAFF	_____ _____	
Q006	Which government body regulates/supervises this facility?	FEDERAL MINISTRY OF HEALTH REGIONAL HEALTH BUREAU ZONAL/KIFLE-KETEMA HEALTH OFF WOREDA HEALTH OFFICE DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 88 96	
Q007	Has this facility ever had a supervision visit from this government body?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO Q009
Q008	On average, how many supervision visits does the facility receive in a **year**?	VISITS/YEAR	_____	
Q009	On average, how many patients are seen for health care services at this facility each **day**?	PATIENTS/DAY DON'T KNOW	_____ 88	
Q0010	In terms of payments, what proportion of your patients is fee-for-service (e.g. pay out-of-pocket) versus credit (e.g. fees covered by their employer)?	FEE FOR SERVICE CREDIT DON'T KNOW OTHER(SPECIFY) _____	_____ _____ 88 96	

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q0011	Have you ever reduced your fees or provided free treatment for patients who cannot afford to pay full price?	YES NO DON'T KNOW	1 2 88	
Q0012	What would you say are some of the administrative challenges for this facility? **(Read List. Circle all that apply. If no challenges, circle None.)**	LACK OF ACCESS TO FINANCING LACK OF BUSINESS MANAGEMENT TRAINING COMPETITION FROM PUBLIC SECTOR COMPETITION FROM OTHER PRIVATE FACILITIES LACK OF GOOD/DEDICATED EMPLOYEES/STAFF MOBILITY (TURNOVER) DIFFICULTY OBTAINING SUPPLIES LACK OF CONTINUOUS SUPPLIES STOCK OUTS PATIENT INABILITY TO PAY EXCESSIVE GOVERNMENT REGULATIONS NOTHING OTHER (SPECIFY) _____	1 2 3 4 5 6 7 8 9 10 11 96	
Q0013	Was this facility financed with credit?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO Q0015
Q0014	From where/which institution was the credit obtained?	**MICRO-FINANCE INSTITUTIONS** OROMIA CREDIT AND SAVING INSTITUTE. ADDIS CREDIT AND SAVING INSTITUTE. AMHARA CREDIT AND SAVING INSTITUTE **COMMERCIAL BANKS** ABYSSINIA BANK AWASH BANK DASHEN BANK NIB BANK COMMERCIAL BANK OF ETHIOPIA DEVELOPMENT BANK OF ETHIOPIA OTHER (SPECIFY) _____	 1 2 3 4 5 6 7 8 9 96	
Q0015	Would you be interested in taking out a loan in the future to improve your facility/medical practice?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO Q0018
Q0016	For what purpose/s would you use the loan? **(Do NOT read. Circle all mentioned.)**	EXPAND FACILITY RENOVATE FACILITY BUY ANOTHER FACILITY CONSTRUCT NEW FACILITY PURCHASE LAND PURCHASE MEDICAL EQUIPMENT PURCHASE GENERAL MEDICAL SUPPLIES HIRE ADDITIONAL STAFF TRAIN STAFF OFFER NEW SERVICES OFFER HOME-BASED SERVICES COMPUTERIZE RECORDS OTHER (SPECIFY) _____	1 2 3 4 5 6 7 8 9 10 11 12 96	

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q0017	How much would you be interested in borrowing?	UP TO 10,000 BIRR 10,001 - 50,000 BIRR 50,001 – 100,000 BIRR 100,001 – 500,000 BIRR 500,001-1,000,000 BIRR 1,000,001- 5,000,000 BIRR MORE THAN 5,000,000 BIRR	1 2 3 4 5 6 7	
Q0018	How does this facility primarily dispose of sharp medical objects such as needles and syringes?	BURNED IN INCINERATOR BURNED AND BURIED BURNED AND REMOVED TO OFFSITE DUMP BURNED AND NOT BURIED THROWN IN TRASH/OPEN PIT THROWN IN PUT LATRINE REMOVED OFFSITE DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 5 6 7 88 96	
Q0019	How does this facility primarily dispose of potential biohazards such as bandages and bodily materials? **(Do NOT read. Single response)**	BURNED IN INCINERATOR BURNED AND BURIED BURNED AND REMOVED TO OFFSITE DUMP BURNED AND NOT BURIED THROWN IN TRASH/OPEN PIT THROWN IN PUT LATRINE REMOVED OFFSITE DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 5 6 7 88 96	

MEDICAL SUPPLIES

INTERVIEWER: ASK Q101 FOR ALL ITEMS. THEN PROCEED ACROSS ROW FOR EACH YES ANSWER.

Q101 Do you stock the following items in your facility? **(If NO or DK, do NOT ask Q102-Q107.)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q102 From where do you obtain [item]? **(Read List and circle all that apply.)** PUBLIC SECTOR (MOH/RHB PHARMID) ..... 1 PRIVATE SUPPLIER ..... 2 NGO ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96			Q103 How many times per year do you order each item?	Q104 When you order this item, which best describes the systems to determine how much of each to order? **(Read entire list.)** ALWAYS ORDER SAME AMOUNT ..... 1 SUPPLIES ORDERED TO MAINTAIN CERTAIN STOCK LEVEL ..... 2 DON'T HAVE A SYSTEM ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96			Q105 Have you ever experienced a stock out of the items you stock in your facility? **(If NO or DK, skip to Q108.)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q106 What are the most common reasons for stock outs? **(Single response.)** DELAY IN SHIPMENT FROM SUPPLIER ..... 1 DELAYS DUE TO TRANSPORT PROBLEMS ..... 2 NO ONE MONITORS STOCK LEVELS AND STOCK-OUTS RESULT ..... 3 SUPPLIES NOT ORDERED ENOUGH IN ADVANCE TO AVOID STOCK-OUT ..... 4 DON'T KNOW ..... 88 OTHER (SPECIFY) 96	Q107 What do you do if you experience a stock-out? FIND ANOTHER SUPPLIER ..... 1 WAIT FOR SHIPMENT ..... 2 PATIENT PURCHASES PRODUCT OUTSIDE OF FACILITY ..... 3 PURCHASE PRODUCT FROM CHEMIST/SHOP ..... 4 CLOSE FACILITY ..... 5 NO ACTIONS TAKEN ..... 6 DON'T KNOW ..... 88 OTHER (SPECIFY) 96		
		A	**B**	**C**		**A**	**B**	**C**			**A**	**B**	**C**
a. HIV test kits													
b. TB drugs													
c. ARV drugs													
d. CD4 test reagent													
e. Antibiotics													

TRAINING AND EDUCATION

	Q108 Which of the following business or management topics have you been trained on? **(Read list. If YES, ask across the row. If NO, skip to Q111and continue with Q113-Q115.)** YES ..... 1 NO..... 2 DON'T KNOW..... 88	Q109 Was [training] provided through pre-service (formal education) or in-service (training) or both? PRE-SERVICE.....1 IN-SERVICE.....2 BOTH.....3	Q110 From which organization/ institution did you receive training on [topic]? **Go to next row as applicable. (Up to three responses and then skip to Q112.)** UNIVERSITY/COLLEGE...1 NATIONAL MANAGEMENT INSTITUTE.....2 REGIONAL MANAGEMENT INSTITUTE.....3 MOH.....4 RHB.....5 PRIVATE TRAINING INSTITUTE.....6 OTHER (SPECIFY).....96			Q111 Why have NOT received training on [topic]? **(Up to three responses and then skip to Q112.)** NOT AWARE OF TRAINING..... 1 TOO BUSY TO ATTEND..... 2 TOO EXPENSIVE ..... 3 DON'T NEED ..... 4 NOT APPLICABLE DUE TO NAT'L REGS..... 5 LACK OF OPPORTUNITY..... 6 OTHER (SPECIFY)..... 96			Q112 Would you be interested in receiving training in [topic]? **(If NO go to next row.)** YES..... 1 NO ..... 2 DON'T KNOW..... 88	Q113 Would you be willing to pay a fee to attend training in [topic]? **(If NO enter "0" in Q115 and go to next row.)** YES..... 1 NO..... 2 DON'T KNOW 88	Q114 How much would you be willing to pay for training on [topic]? **Amount in Birr**
			A	**B**	**C**	**A**	**B**	**C**			
1. Business management											
2. Information technology											
3. Records administration/ data management											
4. How to access financing/loans											
5. Health facility administration/management?											

INTERVIEWER: END INTERVIEW AND THANK THE RESPONDENT. PROCEED TO INTERVIEW HEALTH SERVICES PROVIDER.

SECTION 2: HEALTH SERVICES PROVIDER

If the manager/administrator is the same person with the health service provider, this section will be asked for the same respondent with out interruption where there is no need to record the time indicated below and identification section for the health service provider (as it is already recorded on the first page). However, if the manageger/admistrator is different from the respondent for health service provider, the identification for the health service provider under section D has to be completed and the time indicated below has to be recorded.

Time Started:	**Time Ended:**	**Total Time in Minutes:**

I would like to ask you a few questions about your background and your clients/patients.

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q201	For how many years have you worked in your profession?	YEARS	_____	
Q202	For how many years have you worked in the private health sector?	YEARS (Note: this number should be LESS than or equal to Q201)	_____	
Q203	What are the reasons you work in the private health sector? **(Do NOT read. Multiple response)**	BETTER SALARY/INCOME BETTER JOB OPPORTUNITIES (THAN PUBLIC SECTOR) UNABLE TO SECURE JOB IN PUBLIC SECTOR BETTER WORKING ENVIRONMENT SUPPLEMENT GOVT SALARY OTHER (SPECIFY) _____ NO RESPONSE	1 2 3 4 5 96 99	
Q204	Do you also work in the public sector?	YES NO NO RESPONSE	1 2 99	
Q205	Do you have a current professional license to practice medicine in Ethiopia?	YES NO DON'T KNOW	1 2 88	
Q206	Are you a member of a professional association?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO Q301
Q207	To which association/s do you belong? **(Circle all mentioned.)**	ETHIOPIAN MEDICAL ASSOC. MEDICAL ASSOC OF PHYSICIANS IN PRIVATE PRACTICE-ETHIOPIA ETHIOPIAN NURSES ASSOCIATION ETHIOPIAN MIDWIVES ASSOCATION PUBLIC HEALTH ASSOCIATION ETHIOPIAN GENERAL MEDICAL PRCTIONERS ASSOCIATION OTHER (SPECIFY) _____	1 2 3 4 5 6 96	

INTERVIEWER Read: Next I would like to ask you a couple of questions about your clients/patients			
Q301	Approximately what proportion of your patients is female?	PROPORTION FEMALE	_____
Q302	Thinking of all your patients, approximately what proportion is RICH? MIDDLE INCOME? POOR?	RICH MIDDLE INCOME POOR	_____ _____ _____
Q303	What proportion of your patients do children (ages 0-14) comprise? Adults (ages 15-49)? Older adults (50+)?	AGES 0-14 AGES 15-49 AGES 50+	_____ _____ _____
Q304	To your knowledge, approximately what proportion of your patients/clients is HIV positive?	PROPORTION HIV+	_____

HIV/AIDS SERVICES

Now I would like to ask you a few questions related to the HIV/AIDS services offer. Don't worry if you do not currently provide HIV/AIDS services – as a reminder - this is a baseline study, so we are trying to determine current levels of HIV/AIDS service provision among private providers.

Q401 Which of the following HIV/AIDS and related services do you provide? **(Read list. If NO or DK, Skip to Q403.)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q402 Have you provided [service] in past 6 months? **(If YES, go to next row. If NO or DK, skip to Q403.)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q403 Would you be willing to provide this service in the future? **(If YES, go to Q404. If NO or DK, go to next row.)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q404 What would enable you to provide [service] in the future? **(Up to three responses.)** ADDT'L TRAINING ..... 1 ADDT'L EQUIPMENT ..... 2 ADDT'L SUPPLIES ..... 3 MORE FACILITY SPACE ..... 4 ADDT'L STAFF ..... 5 MORE FAVORABLE GOV'T POLICIES/REGULATIONS ..... 6 DON'T KNOW ..... 88 OTHER (SPECIFY) 96		
				A	**B**	**C**
a. Voluntary counseling and testing						
b. Pre-ART HIV care						
c. Antiretroviral treatment for adults						
d. Antiretroviral treatment for children						
e. Prevention of mother to child transmission						
f. Diagnosis of TB						
g. Treatment and follow up of tuberculosis						
h. Diagnosis and treatment of sexually transmitted infections						
i. Condom promotion						
j. Family Planning Service						
k. Other (specify) _____						

POST EXPOSURE PROPHYLAXIS

Next, I am going to ask you few questions about Post Exposure Prophylaxis (PEP).

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q405	Can staff receive post-exposure prophylaxis (PEP) service at this facility?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO 501
Q406	From where do staffs get PEP?	THIS FACILITY ANOTHER FACILITY DON'T KNOW	1 2 88	IF 1 OR 88, SKIP TO Q501
Q407	If it is from another facility, where do you refer staff for PEP?	(SPECIFY)_____ _____ DON'T KNOW	 88	

HIV TESTING

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q501	Have you ever advised/encouraged a patient to be tested for HIV?	YES NO DON'T KNOW	1 2 88	IF NO OR DK, SKIP TO Q504
Q502	When do you encourage a patient to get tested for HIV? **(Do NOT read. Circle all mentioned.)**	I ENCOURAGE EVERY PATIENT TO RECEIVE HIV TESTING WHEN A PATIENT HAS AN OPPORTUNISTIC INFECTION WHEN A PATIENT HAS A SEXUALLY TRANSMITTED INFECTION WHEN A PATIENT'S HEALTH DETERIORATES & ANOTHER REASON CAN'T BE DETERMINED IF THE PATIENT IS PART OF THE MOST AT-RISK POPULATION WHEN A WOMEN SEEKS ANTENATAL CARE COUPLES BEFORE MARRIAGE WHEN PATIENT FOUND TO BE TB POSITIVE WHEN PATIENT INQUIRES ABOUT TEST WHEN PARTNER TESTS POSITIVE DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 5 6 7 8 9 10 88 96	
Q503	Have you ever encouraged a client that tested negative for TB to still get tested for HIV?	YES NO DON'T KNOW	1 2 8	

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q504	If a client agrees to be tested, what action do you take?	COLLECT BLOOD SAMPLE AND TEST AT THIS FACILITY COLLECT BLOOD SAMPLE AND SEND TO OUTSIDE LAB REFER PATIENT TO AN OUTSIDE LAB FOR TESTING DON'T KNOW OTHER (SPECIFY) _____	1 2 3 88 96	IF RESPONSE IS 1, SKIP TO Q506. IF 2, ASK 505 AND SKIP TO 507. IF 3, ASK 505 AND SKIP TO 601.
Q505	If you collect blood sample and send to outside lab or refer patient to outside lab, to which facility do you send blood samples/ refer patients?	PUBLIC PRIVATE NOT FOR PROFIT/NGO PRIVATE FOR PROFIT DON'T KNOW OTHER(SPECIFY) _____	1 2 3 88 96	
Q506	If blood sample is collected and lab test is done in this facility, which HIV testing techniques do you use?	RAPID TEST ELISA OTHER (SPECIFY) _____	1 2 96	
507	How do you normally inform your clients of HIV test result? **(Do NOT read. Circle all that apply.)**	PROVIDER TELLS PATIENT VERBALLY INSTRUCT A COUNSELOR/NURSE IN THIS FACILITY TO TELL CLIENT THE RESULTS PRESENT WRITTEN RESULT TO CLIENT DON'T KNOW OTHER (SPECIFY) _____	1 2 3 88 96	
Q508	If a patient tests positive for HIV, what action do you take? **(Unprompted. Check all that apply.)**	COUNSEL THE PATIENT REFER THE PATIENT TO ANOTHER FACILITY FOR COUNSELING REFER TO OTHER ORGANIZATION FOR PSYCHOSOCIAL SUPPORT SCREEN FOR TB SCREEN FOR OTHER OIS REFER PATIENT FOR FURTHER TESTING (E.G. CD4 COUNT) INITIATE FURTHER TESTING (PRE-ART) ORDER LAB TESTS TO DETERMINE STAGING NO ACTION TAKEN DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 5 6 7 8 9 88 96	
Q509	Do you follow the national guidelines for the provision of VCT?	YES NO DON'T KNOW	1 2 88	
INTERVIEWER: For the following questions, I would ask that you refer to your records related to HIV testing. This is the information that you would report to the government.				
Q510	How many patients/clients have you tested for HIV in the past 6 MONTHS?	PATIENTS	_____	

NO.	QUESTION	POSSIBLE RESPONSES	CODE
Q511	How many of these patients had TB?	PATIENTS [NOTE: THIS NUMBER SHOULD BE LESS THAN Q511]	_____
Q512	Of all the patients who were tested in the past 6 months, how many tested positive for HIV?	PATIENTS	_____

TRAINING AND EDUCATION

Q601 Which of the following topics have you ever received during pre-service or in-service? **(Read list. If YES, ask 602 and 603, then skip to next row. If NO, skip across row to Q604 and continue across row.)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q602 Was [training] provided through pre-service (formal education) or in-service (training) or both? PRE-SERVICE ... 1 IN-SERVICE ..... 2 BOTH 3	Q603 From which organization/ institution did you receive training on [topic]? **(Up to three responses.)** MOH ..... 1 RHB ..... 2 DACA ..... 3 NGO ..... 4 PRIVATE INSTITUTION ..... 5 OTHER(SPECIFY) 96			Q604 Why have NOT received training on [topic]? **(Up to three responses.)** NOT AWARE OF TRAINING ..... 1 TOO BUSY TO ATTEND ..... 2 TOO EXPENSIVE ..... 3 DON'T NEED ..... 4 NOT APPLICABLE DUE TO NAT'L REGS ..... 5 LACK OF OPPORTUNITY (NOT OFFERED) ..... 6 OTHER(SPECIFY) 96			Q605 Would you be interested in receiving training in [topic]? **(If NO, skip to next row.)** YES ..... 1 NO ..... 2 DK 88	Q606 Would you be willing to pay a fee to attend training in [topic]? **(If NO, enter "0" for Q607 and go to next row.)** YES ..... 1 NO ..... 2 DK 88	Q607 How much would you be willing to pay for training in [topic]? **Amount in Birr**
			A	**B**	**C**	**A**	**B**	**C**			
a. Voluntary HIV counseling and testing											
b. Antiretroviral treatment											
c. Home-based care											
d. Clinical Management of HIV infection in adult											
e. Clinical Management of HIV infection in children											
f. Prevention of mother to child transmission											
g. Diagnosis and treatment of tuberculosis for HIV-positive patients											
h. Diagnosis and treatment of other opportunistic infections for HIV-positive patients											
i. Diagnosis and treatment of sexually transmitted infections											
j. Family planning methods											
k. Other (specify)											

REFERRALS AND MEDICAL RECORDS

Next, I am going to ask you some questions related to referrals and record-keeping for HIV/AIDS and related services.

Q701 Do you refer patients to other facilities for HIV/AIDS services?	YES ..... 1 NO ..... 2 DON'T KNOW 88	IF NO OR DK, SKIP TO Q801

Q702 For which of the following HIV/AIDS and related services do you refer a patient to another facility/organization? **(Read list. If YES ask Q703, 704 and 705. If NO, skip to Q706 for that service.)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q703 To what type of facility do you refer patients for [service]? **(Select all applicable.)** PUBLIC FACILITY ..... 1 PRIVATE FOR-PROFIT ..... 2 PRIVATE NOT-FOR-PROFIT/NGO ..... 3 CBO (SUCH AS IDER) ..... 4 DON'T KNOW ..... 88 OTHER **(SPECIFY)** 96	Q704 Why do you refer patients there for [service]? **(Up to three major reasons)** DO NOT OFFER SERVICE HERE ..... 1 NOT AUTHORIZED/ALLOWED TO PROVIDE SERVICE ..... 2 OTHER FACILITY BETTER EQUIPPED ..... 3 FOR ADVANCED MANAGEMENT/CARE ..... 4 PATIENT PREFERENCE ..... 5 DON'T KNOW ..... 88 OTHER SPECIFY 96	Q705 Have any of your patients ever been refused treatment at that facility/organization for [service]? YES ..... 1 NO ..... 2 DON'T KNOW 88

		A	B	C	D	E	A	B	C	
1. Voluntary HIV counseling & testing										
2. Prevention of mother to child transmission										
3. Pre-ART HIV care										
4. Antiretroviral treatment for adults										
5. Antiretroviral treatment for children										
6. Home-based care										
7. Screening for TB in HIV positive patients.										
8. Treatment and follow up of tuberculosis for HIV-positive patients										
9. Diagnosis and treatment of other opportunistic infections for HIV-positive patients										
10. Diagnosis and treatment of sexually transmitted infections										
11. Lab services										
12. Other(specify)										

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q706	Have any HIV-positive patients been referred to you from another facility/organization?	YES NO DON'T KNOW	1 2 88	
Q707	From which type/s of facility have you received HIV-positive patients? **(Do NOT read. Circle all mentioned.)**	PUBLIC FACILITY PRIVATE FOR-PROFIT PRIVATE NOT-FOR-PROFIT/NGO DON'T KNOW OTHER (SPECIFY) _____	1 2 3 88 96	
Q708	Continuity of care is important for HIV positive patients. For your HIV positive patients, do you share patient records with other facilities that also provide/ have provided medical care to the patient?	YES NO DON'T KNOW	1 2 88	IF NO, SKIP TO Q712
Q709	With what type of facilities do you share patient records?	PUBLIC FACILITY PRIVATE FOR-PROFIT PRIVATE NOT-FOR-PROFIT/NGO DON'T KNOW OTHER (SPECIFY) _____	1 2 3 88 96	
Q710	What is the mechanism for sharing patient records with other facilities?	USE STANDARD REFERRAL FORM/PAPER TELEPHONE CALL WITH PROVIDER IN PERSON DISCUSSION WITH PROVIDER DON'T KNOW OTHER (SPECIFY) _____	1 2 3 88 96	
Q711	What problems, if any, have you encountered in sharing patient records for HIV positive patients?	NO PROBLEM CONCERN ABOUT BREAKING CONFIDENTIALITY DON'T KNOW OTHER (SPECIFY) _____	1 2 88 96	
Q712	Do you keep individual medical records on your patients?	YES NO DON'T KNOW	1 2 88	IF NO, SKIP TO Q714
Q713	What are the reasons that you keep medical records? **(Do NOT read. Circle all mentioned.)**	LEGAL REQUIREMENT FOR OWN PURPOSES TO ENSURE PROPER PATIENT CARE TO REPORT INFORMATION TO THE GOVT TO KNOW PREVELANCE OF DIFFERENT DISEASES DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 5 88 96	
Q714	Do you report medical record/service statistics data to the relevant government body (Woreda or Zonal/K.ketema Health Office/RHB/FMOH)?	YES NO DON'T KNOW	1 2 88	

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q715	How do you ensure confidentiality of medical records? **(Do NOT read. Circle all mentioned.)**	TEST RESULTS ARE NOT SHARED WITH ANYONE BUT THE PATIENT TEST RESULTS ARE KEPT IN AN AREA ONLY ACCESSIBLE TO FACILTIY STAFF FACILITY STAFF ARE OBLIGATED TO MAINTAIN PATIENT CONFIDENTIALITY CONFIDENTIALITY STANDARDS ARE ENFORCED BY THE HEAD OF THE FACILITY DON'T KNOW OTHER (SPECIFY) _____	1 2 3 4 88 96	

STANDARDS OF CARE

READ: The next section of the survey concerns standards of care." Standards of care" guide the provision of standard treatment and care service for patients/clients based upon the best scientific knowledge and clinical treatment and care service for the patients/clients based upon the best scientific knowledge and clinical expertise.

Q801 Are you aware of written standards of care for the treatment and care services provided in the following areas? **(Read across row. If YES, ask Q802)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q802 What document contains the standard of care for [health issue]? ART IMPLEMENTATION GUIDELINE ..... 1 NATIONAL TB AND LEPROSY CONTROL MANUAL ..... 2 GUIDELINE FOR SYNDROMIC MANGEMENT OF STI ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96		Q803 Do you follow the standards of care for [health issue]? (**If NO, skip to next row.**) YES ..... 1 NO ..... 2 DON'T GIVE MEDICAL SERVICE ..... 3 DON'T KNOW 88
		Known	**Available at facility**	
a. Antiretroviral therapy				
b. Diagnosis and treatment of TB				
c. Diagnosis and treatment of STI				

INTERVIEWER: END INTERVIEW AND THANK THE RESPONDENT FOR THEIR TIME

Pharmacy Survey

SECTION A: INTRODUCTION

INTERVIEWER READ: Hello. My name is_____, and I work for SuDCA Development Consultants, an Ethiopian research firm. We are collecting information on behalf of Private Sector Partnerships-*One*, a health project whose goal is to increase private sector involvement in the provision of healthcare. We are interviewing pharmacy personnel to better understand how they dispense advice and drugs and the extent to which they offer HIV/AIDS-related medicines. The information will be used to assist the Federal Ministry of Health (FMOH), Drug Administration Control Authority (DACA), donors, and professional associations in identifying current practices, areas of concern, and suggestions for improvement in the delivery of HIV/AIDS and related services. You are randomly selected to participate in this survey from registries of private pharmacies obtained from DACA, Regional Health Bureaus and a local NGO.

Please be assured that all of the information you share with us will be kept confidential. Any identifying information (e.g. name of clinic, address, etc) will be removed from the data and will not be included in the final report. Your participation in the survey is voluntary. Therefore, you will not be obliged to answer any questions that you do not want to, and you may end the survey any time. There are also no repercussions for not participating in the survey. The interview will take about 25 minutes. The information you provide will be used to facilitate the involvement of private providers in health service delivery, and thus improve the overall health system in Ethiopia. Therefore, your participation in this survey would be greatly appreciated. At the conclusion of the interview I will provide contact information on the Private Sector Partnerships/Ethiopia project, in case you are interested in learning more about the activities and how you might benefit.

SECTION B: STUDY CONTACT INFORMATION

If you have any questions about this study, you may contact **info@psp-one.com.**

SECTION C: INFORMED CONSENT

May I continue?	***YES***	→ CONTINUE	GO TO SECTION D
	NO	→ END INTERVIEW AND THANK RESPONDENT	COMPLETE SECTION D AND RETURN TO SUPERVISOR

Unique Facility ID	**FINAL RESULT(circle one response)**
	1 Completed 4 Refused 2 Partially Completed 5 Other (Specify)_____ 3 No longer in business

Time Started:	**Time Stopped:**	**Time Elapsed (Min.):**
Enumerator **Name:**	Supervisor **Name**	Data Entry **Name**
Date **Month** **sign**	**Date** **Month** **sign**	**Date** **Month**

SECTION D: IDENTIFICATION

1. Region
ADDIS ABABA 1
OROMIA 2
AMHARA 3

2. Zone/K.ketema
.....

3. Woreda
.....

4. Type of Outlet
PHARMACY 1
DRUG STORE 2

5. Name of Outlet
.....

Facility Management Respondent

6. Name of Respondent

7. Gender of Respondent
MALE 1
FEMALE 2

8. Age of Respondent

9. Profession of the Respondent

10. Current position in the facility

11. Ownership of the Health Facility by the Respondent
NOT OWNER 1
SOLE PROPRIETOR 2
SHAREHOLDER 3
OTHER 96
(SPECIFY)_____

12. Involvement of the respondent in health service provision. (If yes, mark the profession of the respondent under health service provider, if not involved fill the ID and proceed to the questions.)

13. Management Respondent ID ☐☐

Dispensing Respondent

14. Name of Respondent

15. Gender of Respondent
MALE 1
FEMALE 2

16. Age of Respondent

17. Profession of Respondent
PHARMACIST 1
DRUGGIST 2
PHARMACY TECHNICIAN 3
JUNIOR PHARMACY TECHNICIAN 4
OTHER 96
(SPECIFY)_____

18. Dispensing Respondent ID ☐☐

[IF SAME AS ADMINISTRATOR, ENTER SAME ID HERE]

SECTION 1: MANAGEMENT

I would appreciate if you would answer a few questions about the management of this facility. This section is to be asked for the pharmacy owner or manager. This person may or may not be health professional

Time Started:	**Time Ended:**	**Total Time in Minutes:**

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q001	Do you manage administrative activities for this pharmacy?	YES NO	1 2	
Q002	What days of the week is this facility open? **(Circle days mentioned, or circle every day but Sunday or every day as appropriate)**	EVERY DAY EVERY DAY EXCEPT SUNDAY MONDAY TO FRIDAY EVERYDAY EXCEPT FRIDAY DON'T KNOW OTHER(SPECIFY) _____	1 2 3 4 88 96	
Q003	Is this facility open 24 hours/day?	YES NO DON'T KNOW	1 2 88	If NO, Skip to Q005
Q004	For how many days in a week does the facility open for 24 hours?	EVERY DAY EVERY DAY EXCEPT SUNDAY MONDAY TO FRIDAY EVERYDAY EXCEPT FRIDAY DON'T KNOW OTHER(SPECIFY) _____	1 2 3 4 88 96	
Q005	In total, how many staff (Excluding support staffs) work at this pharmacy (part time and full time)?	PT STAFF FT STAFF	_____ _____	
Q006	On average, how many customers do you have in a day?	CUSTOMERS/DAY DON'T KNOW	_____ 88	
Q007	Which government body regulates this pharmacy?	DACA MOH REGIONAL HEALTH BUREAU DON'T KNOW	1 2 3 88	
Q008	Have you ever received a supervision visit from this government body?	YES NO DON'T KNOW	1 2 88	If NO, Skip to Q009
Q009	On average, how many visits do you receive in a year?	VISITS/PER YEAR DON'T KNOW	_____ 88	
Q0010	What would you say are some of the administrative challenges for this pharmacy? **(Read list. Circle all that apply.)**	LACK OF BUSINESS TRAINING LACK OF ACCESS TO FINANCING COMPETITION FROM THE PUBLIC SECTOR COMPETITION FROM OTHER PRIVATE PHARMACIES LACK OF PHARMACEUTICAL TRAINING	1 2 3 4 5	

		CLIENT INABILITY TO PAY STAFF TURNOVER DIFFICULTY OBTAINING SUPPLIES EXCESSIVE GOVERNMENT REGULATIONS LACK OF MARKETING SKILLS LACK OF CONTINUOUS SUPPLIES STOCK OUTS OTHER (SPECIFY) _____	6 7 8 9 10 11 12 96	
Q0011	Was this facility financed with credit?	YES NO DON'T KNOW	1 2 88	
Q0012	From where/which institution was the credit obtained?	**MICRO-FINANCE INSTITUTIONS** OROMIA CREDIT AND SAVING INSTITUTE ADDIS CREDIT AND SAVING INSTITUTE. AMHARA CREDIT AND SAVING INSTITUTE **COMMERCIAL BANKS** ABYSSINIA BANK AWASH BANK DASHEN BANK NIB BANK COMMERCIAL BANK OF ETHIOPIA DEVELOPMENT BANK OF ETHIOPIA OTHER (SPECIFY) _____	 1 2 3 4 5 6 7 8 9 96	
Q0013	Would you be interested in taking out a loan in the future to improve your pharmacy?	YES NO DON'T KNOW	1 2 88	
Q0014	For what purpose would you use a business loan? **(Do NOT read. Check all that apply.)**	EXPAND PHARMACY RENOVATE PHARMACY BUY ANOTHER PHARMACY CONSTRUCT A PHARMACY PURCHASE LAND BUY EQUIPMENT HIRE STAFF TRAIN STAFF OFFER NEW PRODUCTS PURCHASE SUPPLIES OR DRUGS OFFER DOOR-TO-DOOR SERVICES OTHER (SPECIFY) _____	1 2 3 4 5 6 7 8 9 10 11 96	
Q0015	How much would you be interested in borrowing?	UP TO 10,000 BIRR 10,001 - 50,000 BIRR 50,0001– 100,000 BIRR 100,001 – 500,000 BIRR 500,001-1,000,000 BIRR 1,000,001- 5,000,000 BIRR MORE THAN 5,000,001 BIRR	1 2 3 4 5 6 7	

DRUGS AND SUPPLIES

[ASK Q101 FIRST, THEN CONTINUE ACROSS ROW FOR EACH ITEM]

	Q101 Do you stock the following items in your pharmacy? **(If NO or DK, skip to Q201)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q102 From where do you obtain [item]? **(Multiple response. Read list circle all that apply.)** PUBLIC SECTOR (MOH/RHB PHARMID) ..... 1 PRIVATE SUPPLIER ..... 2 NGO ..... 3 DON'T KNOW ..... 88 OTHER(SPECIFY) 96	Q103 How many times per year do you order [item]?	Q104 When you order [item], which best describes the process to determine how much to order? ALWAYS ORDER SAME AMOUNT ..... 1 SUPPLIES ORDERED TO MAINTAIN A CERTAIN LEVEL ..... 2 DON'T HAVE A SYSTEM ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96	Q105 Have you ever experienced a stock out of [item]? **(If NO skip to next row.)** YES ..... 1 NO ..... 2 DON'T KNOW 88	Q106 What is the main reason for stock out of [item]? **(Multiple response.)** DELAY IN SHIPMENT FROM SUPPLIER ..... 1 DELAYS DUE TO TRANSPORT PROBLEMS ..... 2 LACK OF MONITORING SYSTEM ..... 3 SUPPLIES NOT ORDERED IN ADVANCE TO AVOID STOCK-OUT ..... 4 LACK OF CONTINUOUS SUPPLY ..... 5 DON'T KNOW ..... 88 OTHER (SPECIFY) 96	Q107 What action do you take when you experience a stock-out of [item]? **(Multiple response.)** FIND ANOTHER SUPPLIER ..... 1 WAIT FOR SHIPMENT ..... 2 REFER PATIENT TO OTHER PHARMACY TO PURCHASE ..... 3 NO ACTIONS TAKEN ..... 4 DON'T KNOW ..... 88 OTHER (SPECIFY) 96
f. HIV test kits							
g. TB drugs							
h. ARV dugs							
i. CD4 test reagent							
j. Antibiotics							
k. Anti-malarial drugs							
l. ORS							
m. Condoms							
n. Injectable contraceptives							
o. Oral Contraceptives							

SECTION 2: DISPENSING MEDICINE

Time Started:	Time Ended:	Total Time in Minutes:

RESPONDENT BACKGROUND

If the manager/administrator is the same person with the dispensing respondent, this section will be asked for the same respondent with out interruption where there is no need to record the time indicated below and identification section for the dispensing respondent (as it is already recorded on the first page). However, if the manageger/admistrator is different from the respondent for dispensing, the identification for the dispensing respondent under section D has to be completed and the time indicated below has to be recorded.

I would like to ask a few questions about your background and work history.

NO.	QUESTION	POSSIBLE RESPONSES	CODE	SKIP INSTRUCTIONS
Q201	For how many years have you worked in your profession?	YEARS	_____	
Q202	For how many years have you worked in the private sector?	YEARS	_____	
Q203	Are you a member of a professional association?	YES NO DON'T KNOW	1 2 88	
Q204	What is the name of the association?	ETHIOPIAN PHARMACEUTICAL ASSOCIATION OTHER (SPECIFY) _____	1 96	
Q205	Do you have a current license to dispense medicine in Ethiopia?	YES NO DON'T KNOW	1 2 88	

HIV/AIDS AND RELATED DRUGS

Next, I am going to ask you about specific medications to treat HIV/AIDS and related illnesses.

[ASK Q301 FIRST, THEN CONTINUE ACROSS ROW FOR EACH ITEM NOT STOCKED]

Q301 Which of the following medicines do you currently dispense? **(Read list: If NO, ask Q302-303.)** YES .....1 NO.....2 DON'T KNOW.....88		Q302 Why don't you dispense [medication]? **(Multiple response.)** DRUG NOT AVAILABLE .....1 OFFERED FREE IN THE PUBLIC SECTOR.....2 DRUG DIFFICULT TO OBTAIN.....3 DRUG IS TOO EXPENSIVE .....4 NOT AUTHORIZED/ALLOWED TO DISPENSE .....5 STOCK OUT.....6 EXPIRED .....7 SUPPLIES NOT GUARANTEED .....8 DON'T KNOW.....88 OTHER (SPECIFY).....96			Q303 Would you be willing to provide [medication] in the future? YES ..... 1 NO ..... 2 DON'T KNOW..... 88
		A	**B**	**C**	
a. ARVs					
b. TB-drugs					
Anti-Malarial					
d. Coartem (Artemether + lumefantrine)					
e. Quinine					
f. Chloroquine					
g. Fansidar (Pyrimethamine + sulfadiazine) g..Primaquine					
Opportunistic Infection Drugs					
h. Cotrimoxazole					
i. Clindamycin					
j. Ganciclovir					
p. Acyclovir					

Q301 Which of the following medicines do you currently dispense? **(Read list: If NO, ask Q302-303.)** YES .....1 NO.....2 DON'T KNOW 88		Q302 Why don't you dispense [medication]? **(Multiple response.)** DRUG NOT AVAILABLE .....1 OFFERED FREE IN THE PUBLIC SECTOR.....2 DRUG DIFFICULT TO OBTAIN.....3 DRUG IS TOO EXPENSIVE .....4 NOT AUTHORIZED/ALLOWED TO DISPENSE .....5 STOCK OUT.....6 EXPIRED .....7 SUPPLIES NOT GUARANTEED .....8 DON'T KNOW.....88 OTHER (SPECIFY).....96			Q303 Would you be willing to provide [medication] in the future? YES..... 1 NO ..... 2 DON'T KNOW..... 88	
		A	**B**	**C**	
q. Foscarnet					
r. Trimethoprim					
s. Nystatin					
t. Miconazole					
u. Procaine Penicillin					
v. Benzathine penicillin					
w. Ampicillin					
x. Ciprofloxacin					
y. Clotrimazole					
z. Fluconazole					
aa. Doxycycline					
bb. Podophyllin					

TRAINING AND EDUCATION

Q305 Which of the following HIV/AIDS related topics have you ever received during pre-service or in-service? **(Read list. If YES, ask Q306 and Q307. If NO, skip to 308.)**		Q306 Was this pre-service or in-service, or both? PRE-SERVICE ..... 1 IN-SERVICE..... 2 BOTH 3	Q307 From which organization/institution did you receive training on [medicine]? **(Up to three responses.)** MOH.....1 RHB.....2 DACA.....3 NGO .....4 PRIVATE INSTITUTION 5			Q308 Why have you not received training on [topic]? **(Up to three responses.)** NOT AWARE OF TRAINING .....1 TOO BUSY TO ATTEND.....2 TOO EXPENSIVE .....3 DON'T NEED .....4 NOT APPLICABLE .....5 OTHER (SPECIFY) 96			Q309 Would you like to receive training on [topic]? **(If NO or DK, skip to Q312)** YES .....1 NO.....2 DON'T KNOW 88	Q310 Would you be willing to pay a fee to attend training on [topic]? **(If NO, enter '0' in Q311 and skip to Q312)** YES ..... 1 NO ..... 2 DON'T KNOW..... 88	Q311 **[If YES]** How much would you be willing to pay for training on [topic]? Amount in Birr
			A	**B**	**C**	**A**	**B**	**C**			
a. ART											
b. Treatment of TB											
c. Treatment for Malaria											
d. Treatment for STIs											
e. Treatment of other OIs											
f. Other (specify) _____											

Q312 Has a client ever asked you about the following health issues? **(Read across row. For each YES response, ask question Q315. If NO skip to Q401.)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q313 ***The last time*** a client asked you about this health concern, what did you do? **(Circle all that apply. If referred, ask Q315. All other responses skip to Q401.)** DISPENSED MEDICINE ..... 1 OFFERED COUNSELING ..... 2 REFERRED CLIENT TO HEALTH FACILITY ..... 3 DON'T KNOW ..... 88 OTHER(SPECIFY) 96				Q314 To where did you refer the client? PUBLIC FACILITY ..... 1 PRIVATE NOT-FOR-PROFIT FACILITY/NGO ..... 2 PRIVATE FOR-PROFIT FACILITY ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96		
		A	B	C	D	A	B	C
a. HIV testing								
b. Antiretroviral treatment								
c. TB treatment								

STADARDS OF CARE

Q401 Are you aware of written standard of care for the dispensing of medicines and supplies for the following areas? **(Read across row. If NO skip to next row.)** YES ..... 1 NO ..... 2 DON'T KNOW 88		Q402 What document contains the standard of care for [health issue]? ART IMPLEMENTATION GUIDELINE ..... 1 NATIONAL TB AND LEPROSY CONTROL MANUAL ..... 2 GUIDELINE FOR SYNDROMIC MANAGEMENT OF STIS ..... 3 DON'T KNOW ..... 88 OTHER (SPECIFY) 96		Q403 Do you follow the standards of care for [health issue]? **(If NO, skip to next row.)** YES ..... 1 NO ..... 2 DON'T DISPENSE ..... 3 DON'T KNOW 88
		Known	**Available in Pharmacy**	
a. Antiretroviral Drugs				
b. TB Drugs				
c. STI Drugs				