

End Line Evaluation of the Private Health Sector Project in Ethiopia Executive Summary



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Data for Impact

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Executive Summary

Background

Ethiopia is the second most populous country in Africa and has one of the continent’s fastest growing economies. In Ethiopia’s current health landscape, some of the most pressing health issues are HIV, tuberculosis (TB), and malaria, accounting for a combined 85 percent of Ethiopia’s disease burden (Tiruneh, McLelland, & Plummer, 2020; Misganaw, et al., 2017). In 2017, the maternal mortality rate was 401 per 100,000 live births, ranking Ethiopia twenty-sixth in the world for this indicator (Central Intelligence Agency, 2020).

The Government of Ethiopia (GOE) developed its Health Sector Transformation Plan (HSTP) for 2015 to 2020 after the Health Sector Development Plans (HSDPs) I to IV that were prepared between 1997 and 2015. The GOE set new goals for the period from 2015 to 2020 in the HSTP. The Joint Consultative Forum (JCF), which is the governance body tasked with overseeing the implementation of the HSTP, lists the private sector as a member. Although the HSTP gives increased attention to private health sector engagement, it does not define the composition of the private health sector.

Ethiopia has had achievements and faced challenges in its mixed delivery system. In 2017, the Ministry of Finance and Economic Cooperation (MOFEC) published the Public-Private Partnership (PPP) Policy, which outlined the need for private sector involvement in all sectors for economic growth, increased innovation, improved quality, and reduction in delays in service delivery.

To advance the potential of the private sector in Ethiopia, the United States Agency for International Development (USAID) mission in Ethiopia awarded a five-year Cooperative Agreement (October 2015–October 2020) to Abt Associates Inc. for the Private Health Sector Project (PHSP).

In 2020, USAID/ Ethiopia asked Data for Impact (DAI) to evaluate the PHSP’s achievements, challenges, and sustainability to inform future investments in strengthening the private health sector. This report presents the methodology, findings, and recommendations from the DAI end line evaluation.

PHSP’s strategy focused on developing and implementing the public-private mix (PPM) for diseases of significant public health importance. Key partners that implemented and facilitated the PPM were the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), other government bodies, seven regional private health facility associations (PHFAs), and private health facilities (PHFs). The goal and primary purposes of the PHSP are given in Box ES1.

Box ES1. PHSP goal, purposes, and sub-purposes

Project Goal: To contribute to the mitigation of the impact of diseases of public health importance

Project Purpose 1: Enabling environment for private sector engagement in health improved

- 1.1: Improved supportive policy and legal frameworks
- 1.2: Enhanced oversight and implementation of public-private partnership in health
- 1.3: Strengthened capacity of regulatory bodies

Project Purpose 2: Access to quality services for diseases of public health importance increased

- 2.1: Increased demand creation
- 2.2: Increased uptake of services
- 2.3: Enhanced implementation of quality management strategies of PHFs
- 2.4: Strengthened referral linkages

Project Purpose 3: Private healthcare system strengthened

- 3.1: Enhanced capacity of local institutions
- 3.2: Increased access to resources
- 3.3: Improved enrollment in accreditation
- 3.4: Enhanced supply chain management and rational drug use

Project Purpose 4: Program learning and innovative ventures enhanced for the private health sector

- 4.1: Improved evidence-based decision making
- 4.2: Strengthened health management information system implementation
- 4.3: Innovative ventures

Evaluation Methods

Evaluation purpose:

- To document and learn from the PHSP’s experiences, achievements, and challenges in Ethiopia.
- To provide insights on the reach, relevance, implementation, effectiveness, and potential sustainability of the PHSP’s intervention strategies implemented to date.
- To inform USAID on future investments for strengthening the private health sector in Ethiopia.

Evaluation questions:

1. To what extent has the project achieved its three primary purposes: (1) an improved enabling environment; (2) increased access to quality services; and (3) a strengthened private healthcare system?
2. How were the project’s learning and innovative ventures developed and used during project implementation and how will they continue to be used after the project?
3. What strategies did the PHSP use to ensure sustainability? Which strategies were most successful or are most promising? What are the remaining challenges and opportunities for ensuring sustainability of the gains achieved in strengthening the private health sector?
4. What areas need further improvement for strengthening the private sector?
5. What lessons from the PHSP should inform USAID decisions for ongoing and future investments in strengthening the private health sector in Ethiopia?

The evaluation used a mixed-methods, end line only cross-sectional design without comparison areas. It focused on the national level and in the regions and areas where PHSP implemented programming in the private sector. D4I collected data in partnership with the Addis Continental Institute of Public Health (ACIPH) located in Addis Ababa, Ethiopia. Due to the COVID-19 pandemic, all primary data collection was conducted remotely.

Document review	<ul style="list-style-type: none"> • Reviewed quarterly, annual, and end-of-project (EOP) reports, workplans, technical proposals, and assessments conducted by the PHSP.
Key informant interviews	<ul style="list-style-type: none"> • Conducted 50 key informant interviews (KIIs) with different stakeholders at national, regional, and facility levels remotely by telephone using open-ended semi-structured guides. • Key informants were representatives from the FMOH, RHBs, PHFAs, PHSP, private health facilities, farm owners, the Development Credit Authority (DCA), and regulatory agencies
Health facility assessment	<ul style="list-style-type: none"> • Collected data in October 2020 from 106 PHFs over the telephone. • The health facilities were located in eight regions (Afar, Amhara, Benishangul Gumuz, Gambella, Oromia, Southern Nations, Nationalities, and Peoples’ Region [SNNPR], Tigray, and Addis Ababa); various types of health facilities and various supported service areas (TB; malaria; maternal, newborn, and child health [MNCH]; and/or family planning [FP]).
Secondary analysis of program data	<ul style="list-style-type: none"> • PHSP shared quarterly routine program monitoring data covering the past five years • D4I identified indicators for analysis in coordination with USAID • D4I analyzed priority indicators across health areas by quarter, year, and region • D4I used Excel to analyze the data and construct graphs

Evaluation Findings

To what extent has the project achieved its three primary purposes: (1) an improved enabling environment; (2) increased access to quality services; and (3) strengthened private healthcare system?

Project Purpose 1: Enabling environment for private sector engagement in health improved

Structures to strengthen public-private partnership in health (PPPH) implementation: The PHSP supported the FMOH to establish a PPPH unit in the Partnership and Collaboration Directorate in 2018 to strengthen the implementation of the [2013 PPPH strategic framework](#). The project also supported the FMOH to prepare supporting documents to justify the rationale for running PPP projects in the health sector using the national PPP proclamation by the MOFEC.

PPM guidelines for priority health areas: A key approach of the PHSP was to employ a PPM. The PHSP supported the FMOH to develop, revise, and finalize PPM guidelines, including:

- Supported the National Tuberculosis Program to revise the PPM-TB implementation guideline in 2018 (3rd edition).
- Supported the FMOH's Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Directorate to finalize the PPM implementation guidelines for RMNCAH (including FP), which the FMOH formally endorsed in January 2020.
- Supported the Malaria Directorate to develop the PPM implementation guideline for malaria.
- PPM implementation guidelines for HIV were not developed. However, the PHSP advocated with the FMOH to allow specialty clinics to provide antiretroviral therapy (ART) services, including clinics without a pharmacy. The FMOH shifted the task of handling and dispensing ART drugs from a pharmacist to nurses.

Integrated Pharmaceutical Logistics System (IPLS) incorporated in PHFs: The PHSP advocated to include PHFs in the IPLS to access drugs and supplies for FP, HIV, malaria, MNCH, and TB services. As a result of this advocacy, the annual national quantification of drugs and supplies for FP, HIV, malaria, MNCH, and TB and the annual distribution plan now includes PHFs.

Private sector included in the national laboratory quality assurance program: PHFs with laboratories offering diagnostics for HIV, malaria, and TB were included in the national External Quality Assurance (EQA)¹ Program that ensures the quality of laboratory diagnostics.

Transportation of PHF laboratory samples and referral linkages with regional laboratories: The PHSP supported the inclusion of the private sector in the national laboratory sample transportation system to bring laboratory samples (HIV viral load, CD4, Gene Xpert testing, and drug resistant testing for TB) to a network of government regional laboratories.

Revisions to regulatory standards: The PHSP facilitated coordination among the FMOH, the Food, Medicine and Health Care Administration and Control Authority (FMHACA, later named the Ethiopian Food and Drug Administration [EFDA]), and the PHFAs, which resulted in the FMOH revising 20 of 39 health facility regulatory standards (for example, number of rooms, number of trained professionals) to reduce onerous regulations for PHFs.

¹ Under the EQA program, the PHFs retain samples of lab results (blood film for malaria, sputum smear for TB, blood sample for HIV). Experts from the regional laboratories periodically collect a sample from the PHFs and recheck it (blindly). The regional laboratories then provide written feedback to the PHFs.

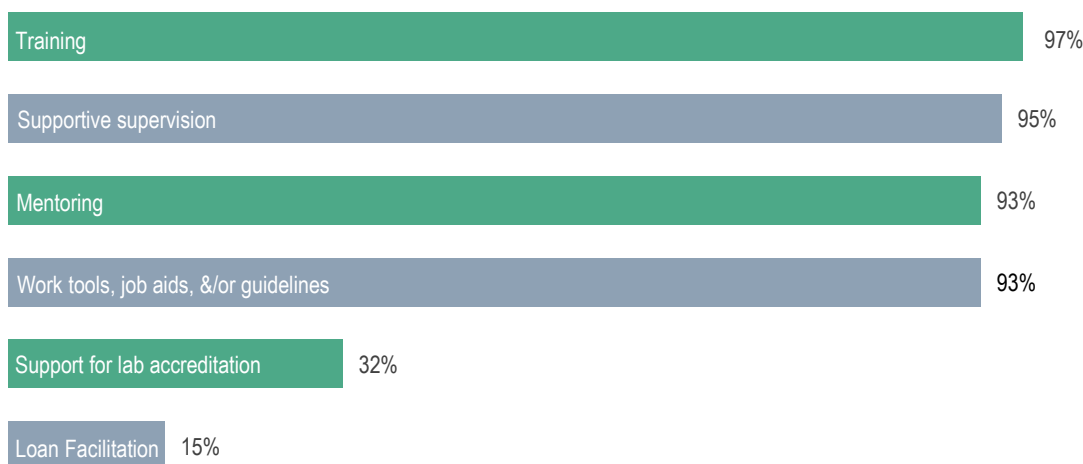
Monitoring and supervision of standards: The PSHP supported the FMHACA/EFDA to develop and implement a modernized health standards monitoring system with digital equipment, and it trained the EFDA’s local inspectors on the regularity of inspections and professional ethics.

Inclusion of PHFs in the national health management information system (HMIS): The PHSP trained approximately 350 people at PHFs in HMIS reporting and arranged with the Woreda health offices (WoHOs) and town health offices (THOs) to equip the PHFs with reporting forms. The PHSP actively ensured that the PHFs supported by the project reported to the WOHOs and THOs in timely and complete manner.

Project Purpose 2: Access to quality services for diseases of public health importance increased

Overall, the PHSP supported 862 for-profit PHFs to implement the PPM guidelines to provide TB, HIV, malaria, FP, and/or MNCH services over the life of the project. This represents about 10 percent of all PHFs in Ethiopia, including primarily for-profit and a fewnot-for-profit facilities. The PHSP provided training, supervision, mentoring, and linkages to referral systems and supply chains to increase the uptake of services, enhance quality, and strengthen referral linkages (Figure ES1).

Figure ES1. Types of support provided by the PHSP reported by the 106 PHFs surveyed in October–November 2020



Increased access and uptake of quality TB diagnosis, referral, and treatment services: The PHSP trained 1,079 providers, and supported and equipped the PPM-TB program at 239 PHFs to provide TB services. Over the life of project (LOP), 80,379 patients were diagnosed with TB, 69,610 confirmed cases were referred, and the rest were treated at the PHFs. In the health facility assessment (HFA) conducted by the evaluation team in late 2020, among the 75 PHFs surveyed that were engaged by the PHSP in the PPM-TB program, almost all reported providing TB diagnosis (100%), referral to other facilities for TB treatment (99%), treatment of TB (92%), HIV testing of TB patients (95%), and contact tracing (92%). Fewer facilities reported requesting a Gene Xpert test for all TB cases for drug-susceptibility testing (DST) (57%).

Expanded access to quality malaria services: The PHSP provided technical assistance for malaria case management to 178 PHFs and 46 workplace health facilities, and malaria services for mobile and migrant workers (MMW). Almost all (nearly 100% in the PHSP final EOP report) confirmed cases at the PHFs were reportedly treated. Over the LOP, 1,696,811 suspected malaria cases were investigated and 316,261 were confirmed.

In the HFA conducted in late 2020, almost all facilities surveyed (96%) reported malaria screening for all fever cases with blood film. Ninety-six percent of the facilities conducted internal quality control (IQC) either always or sometimes, and 88 percent reported to Public Health Emergency Management (PHEM) system weekly. A high

percentage (78%) of the facilities mentioned experiencing a stockout of at least one malaria drug in the six months before the survey.

Expanded access and uptake of FP services and referral linkages, with an emphasis on long-acting methods:

The number of PHSP-supported PHFs providing FP services with an emphasis on long-acting family planning (LAFP) methods increased from 98 at baseline to 113 in Year 5. The PHSP trained 110 providers in the delivery of FP services in accordance with national guidelines over the LOP. During the project, 23,248 women opted for LAFP and the percentage of LAFP method acceptors among all modern contraceptive users increased from 9 percent in Year 1 to 20 percent in Year 4². Among the 54 PHFs supported by the PHSP to provide FP services surveyed in late 2020, almost all health facilities reported providing injectables (100%), oral contraceptive pills (98%), condoms (96%), and implants (94%); 80% provided the intrauterine contraceptive device (IUCD).

Increased capacity to provide quality MNCH services: By Year 5, the PHSP had supported 59 PHFs and trained 173 providers in comprehensive MNCH—only 35 percent of the target of providers to be trained. This outcome was potentially the result of cuts in funding from the President’s Emergency Plan for AIDS Relief (PEPFAR) in Year 3, although USAID’s MNCH program continued to provide some funding. Approximately 153,000 pregnant women received at least one antenatal care visit (ANC1) at PHSP-supported PHFs over the LOP. The ANC1–ANC4 dropout rate (DOR) decreased from 59 percent in the Year 1 to 55 percent in Year 4. Over the LOP, there were a total of 60,771 deliveries at the PHSP-supported PHFs. The number of deliveries at the PHFs, and the proportion of caesarian section deliveries, increased over time. In the HFA, among the 36 PHFs surveyed, 67 percent reported a provider trained in basic emergency obstetric and newborn care (BEmONC). More than 90 percent of the PHFs reported providing folic acid, syphilis screening, and treatment during ANC, whereas only 54 percent reported tetanus toxoid (TT) immunization.

Increased access to HIV services and ART: The PHSP supported HIV programming at PHFs until PEPFAR terminated funding in 2017. By Year 3, the PHSP supported 235 facilities to provide HIV testing services, 43 facilities to provide prevention of mother-to-child transmission (PMTCT) services, and 70 facilities to provide ART. The proportion of HIV-positive patients linked to ART increased from 62 percent in Year 1 to 89 percent in Year 3. Over the LOP, approximately 750,000 clients received testing and counseling services, 4,453 new HIV patients enrolled in ART, and 78,122 pregnant women were provided PMTCT services during antenatal care (ANC).

Improved quality of laboratory services through the inclusion of PHFs in the regional EQA system: The PHSP supported the inclusion of PHFs in the regional EQA system for assessing the quality of laboratory services provided at the PHFs. The majority of PHFs (92%) surveyed in late 2020 reported receiving an EQA for lab samples maintained for TB and malaria, and more than one-half had had an EQA in the past six months. All (100%) PHFs surveyed that received an EQA reported getting feedback from the EQA.

Project Purpose 3: Private healthcare system strengthened

Enhanced capacity of local institutions in the oversight and support of the private health sector: The PHSP provided financial and technical assistance to eight PHFAs³ that its predecessor project helped established in 2014. The project supported the PHFAs to establish offices, including providing vehicles and training staff (e.g., administrative, financial, and accounting). The project also advocated and encouraged RHBs to support the associations and engage them in planning, reviewing, and monitoring health activities in the private sector. However, the degree of acceptance of and commitment to engage the associations varied by RHB.

In the HFA, 65 percent of the 106 PHSP-supported PHFs surveyed in late 2020 reported belonging to some type of PHF network or group. About half of the PHFA members reported paying membership fees. Among the PHFA members, about 40 percent thought that the PHFA was an important organization, 60 percent noted that

² Monitoring data was not available for year 5 beyond the first two quarters during the time of this analysis. As such, for some analysis, year 5 data were not included.

³ Seven regional and one national PHFA.

the PHFA was highly or medium functional, and 43 percent mentioned receiving training from the PHFA as a benefit of being a member, whereas 20 percent did not perceive any tangible benefits.

Increased private health sector access to resources: In 2011, during the PHSP's predecessor project, USAID committed US\$13.4 million through the USAID Development Credit Authority (DCA) to two Ethiopian banks: Bank of Abyssinia S.C. and NIB International Bank S.C. The PHSP provided technical assistance and trained 29 bank branch managers and credit officers. Fifty-five PHFs received support for loan applications and 42 PHFs received loans. The PHFs benefited from the guidance received and they were able to conduct financial analyses to identify which service areas were yielding a high profit (for example, laboratories vs. outpatient vs. inpatient services).

Improved enrollment and practice of accreditation among PHFs: The PHSP's predecessor project supported 17 private facilities providing TB diagnosis and HIV treatment and care services to enroll in the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) and the International Organization for Standardization (ISO) accreditation. The PHSP initiated support to an additional 14 private laboratories. The activity stopped due to the termination of PEPFAR funding.

Enhanced supply chain management: Due to enrollment in the IPLS, the PHFs providing PPM received free drugs and supplies for FP, HIV, malaria, MNCH, and TB services. In the HFA, 65 percent of the PHFs providing FP services mentioned WoHOs as their source for contraceptive commodities. Stockouts were high at the PHFs providing malaria services (34% for chloroquine and 58% for artesunate in past six months).

Project Purpose 4: Program learning and innovative ventures enhanced for the private health sector

- **Malaria clinics for mobile and migrant workers:** The PHSP collaborated with the RHBs in Amhara, Benishangul-Gumuz, Gambella, and Tigray to establish 23 temporary clinics and to provide malaria diagnosis and treatment services to seasonal and MMW on farms in high malaria transmission areas. This initiative provided services to 74,000 people between Year 4 (Q2) and Year 5 (Q2).
- **Maternal Prenatal Death Surveillance and Response (MPDSR):** The project piloted the MPDSR at 18 PHFs in Addis Ababa, demonstrating its feasibility, and developed standard operating procedures (SOPs) for MPDSR at private facilities. In the HFA, 11 of 13 PHFs implementing the MPDSR reported that they had a trained MPDSR focal person and SOPs, and 11 reported an established rapid response team.
- **Provision of ART services at specialty clinics with no pharmacy services:** After almost seven years of advocacy, the PHSP established ART services at specialty private health clinics with no pharmacy services, which served as the basis for the PHSP PPM-HIV program.

The Most Successful Strategies

Establishment of government policies, procedures, and structures: The PHSP's efforts to codify the GOE's policies, procedures, and structures ensures sustainability. The national PPPH framework, guidelines, and operations manual demonstrate the government's commitment to PPPs in health and will continue after the LOP.

Inclusion of private health sector in government systems: The PHSP's efforts to include the private sector in government systems ensured some sustainability after the project closed out, notably the inclusion of PHFs providing PPMs in the IPLS, the regional laboratory EQA system, the sample transportation and referral system, and routine reporting to the RHBs for the national HMIS/DHIS2.

Fostering private-public relationships and building trust: The PHSP and its predecessor project conducted extensive advocacy and facilitation with the FMOH and relevant stakeholders to make the process of engaging PHFs formal and sustainable. This prolonged and sustained effort created a conducive environment in the FMOH, which now has a more positive view of the private health sector as partners.

Building ownership of RHBs and sub-regional offices: The PHSP worked in close collaboration with the RHBs and sub-regional offices, collaborating with them on the capacity building process for the PHFs, including training,

refresher training, mentoring, and joint supportive supervision (JSS). This continuous joint approach from the early stage of the project gave the RHBs ownership of the engagement with PHFs.

Remaining Challenges

PPPH structures and systems are not fully self-sustaining: The PPPH unit is in its early stages and relies on donor support, but progress has been made in defining the PPPH strategic framework, implementation guidelines, and operations manual.

Weaknesses in the integration of the private sector in existing government systems: Low coverage of PHFs in the EQA program, inefficiencies in the laboratory sample transport and referral system, the uneven reliability of drug and commodity supplies (especially for malaria), and incompleteness of reporting to the HMIS, are ongoing challenges.

Interested, but overburdened and underfunded government structures for private sector engagement at regional and local levels: The RHBs and sub-regional offices were involved in the capacity building, mentoring, supervision, and monitoring of the PHFs. However, there were concerns that the RHBs were too overburdened and underfunded to be able to continue to provide robust support to the PHFs after the end of the PHSP.

Ongoing tension in private-public sector working relationship: During the PHSP, the working relationship between the public and private sectors improved, but tensions and reservations about working together still exist in certain technical and geographic areas.

Misaligned incentives for the provision and continuity of services at PHFs: Although the PHSP-supported PHFs appreciated receiving current and cutting-edge training on treatment protocols and access to free medicines, the majority of the PHFs are for-profit enterprises. The cost structure of the PPM specifies free treatment. The PHSP's experiences, and specifically, the PHFs that were supported, should be analyzed to develop better aligned incentives for the PHFs' profit in future projects or initiatives.

Ongoing challenges in delivering quality services: There was an overall increase in the provision of quality diagnostics and/or services for TB, malaria, FP, and MNCH in the private sector. However, the provision of high-quality services requires ongoing training and support. The gains achieved are threatened by high staff turnover, and insufficient training, mentoring, and supervision.

Variable capacity of PHFAs to engage and self-sustain: To increase sustainability, the PHSP aimed to build the organizational and technical capacity of the PHFAs through the allocation of resources and technical support. The outcomes of this support and the functioning of PHFAs remained variable, and their functioning diminished after the suspension of PEPFAR funding.

Innovative ventures—promising, but resource intensive: There are opportunities to build on the innovative approaches, but the ventures are resource intensive.

Opportunities for loans and financial support from banks, but a difficult process: The DCA endeavor demonstrated that when options for loans and financial support were made available, some PHFs benefitted from the opportunities. The application process needs to be more user friendly, and the options for collateral should be reasonable to encourage PHFs to apply for loans and financial support.

Recommendations

Improve the Policy Environment

All stakeholders, including the government, donors, and partners, should continue to advocate and promote government ownership and acceptance of working with the private sector at federal, regional, and lower levels.

- All stakeholders should continue the dialogue, advocacy, and networking for private-public health sector engagement. Private sector engagement (PSE) has increased in the health sector, through a long and continuous process of dialogue and advocacy with relevant parties, backed by evidence (where possible) and expert opinions, which should continue.
- Development partners should continue acting as intermediary agencies to support the FMOH and RHBs to engage the private health sector until it is fully operating as part of the national health system.
- With financial support from donors, intermediary agencies/partners should continue to support the PPPH unit and the PPPH technical working group (TWG), including resource mobilization for PPP initiatives through government (i.e., budgeting) and external sources.
- The government should consider establishing a dedicated PPM unit in the FMOH organizational structure and foster linkages between the PPPH unit and PPM supported by other FMOH programs.
- The government and its partners should continue to support the ongoing implementation of the TB, malaria, and RMNCAH PPM. The PHSP supported only a handful of PHFs (less than 10% of the estimated PHFs in the country), but its work demonstrated that there is demand for services at the PHFs.
- The government and its partners should leverage evidence from the successful PPM programs for TB and malaria to further demonstrate the need for PPP.
- The federal government and its partners should strengthen support for the RHBs to develop PPPH structures and implementation plans. Despite the RHBs spearheading PSE in health, they currently do not have any formal frameworks to guide them in their PPM efforts. As such, it is essential to have a regional-level framework that aligns with the federal-level PPPH policies and guidelines.
- Partners should support the strengthening of regulatory bodies and improving the regulatory environment. Ownership of regulatory responsibilities for the private sector has shifted from the EFDA to the FMOH and further capacity building of the new unit is required.

Improve and Increase Access to Quality Services

- The RHBs should continue to include PHFs in training, mentoring, and supervision activities. Government, donors, and partners can identify mechanisms to mobilize resources to strengthen training, mentoring, and supervisory support provided by the RHBs.
- All stakeholders should collaboratively develop mechanisms and approaches to ensure a high quality of care (e.g., reduction in cesarean sections), balanced with financial incentives. PHFs are ultimately profit-generating entities. There needs to be strong monitoring of the PHFs to ensure their adherence to quality service delivery standards.
- The RHBs and local health offices should develop and foster the linkage of PHFs with communities and public referral facilities.

Strengthen the Private Healthcare System

- The RHBs and local government should continue to strengthen support for the inclusion of the private health sector in government systems (EQA program, lab sample transport and referral system, IPLS/supply chain, and HMIS).
- Donors, government, and partners should continue strengthening the PHFAs and other associations. The PHSP engaged and strengthened the PHFAs. Future partners should support further strengthening of the organizational, technical, and financial capacity of the PHFAs.

- Donors and partners should consider alternative financing/incentive mechanisms for PSE to encourage PHFs. Stakeholders should explore mechanisms for incentivizing PHFs to provide public health services, such as community-based health insurance, which balances equity for recipients of services with incentives and/or marginal profits for providers.
- Donors and partners should continue their support for the currently enrolled banks and additional banks to provide loans to the PHFs in their efforts to expand their infrastructure, services, and portfolios. They should also continue to support financial education and loan processing for the PHFs.

Scale-Up Innovative Approaches

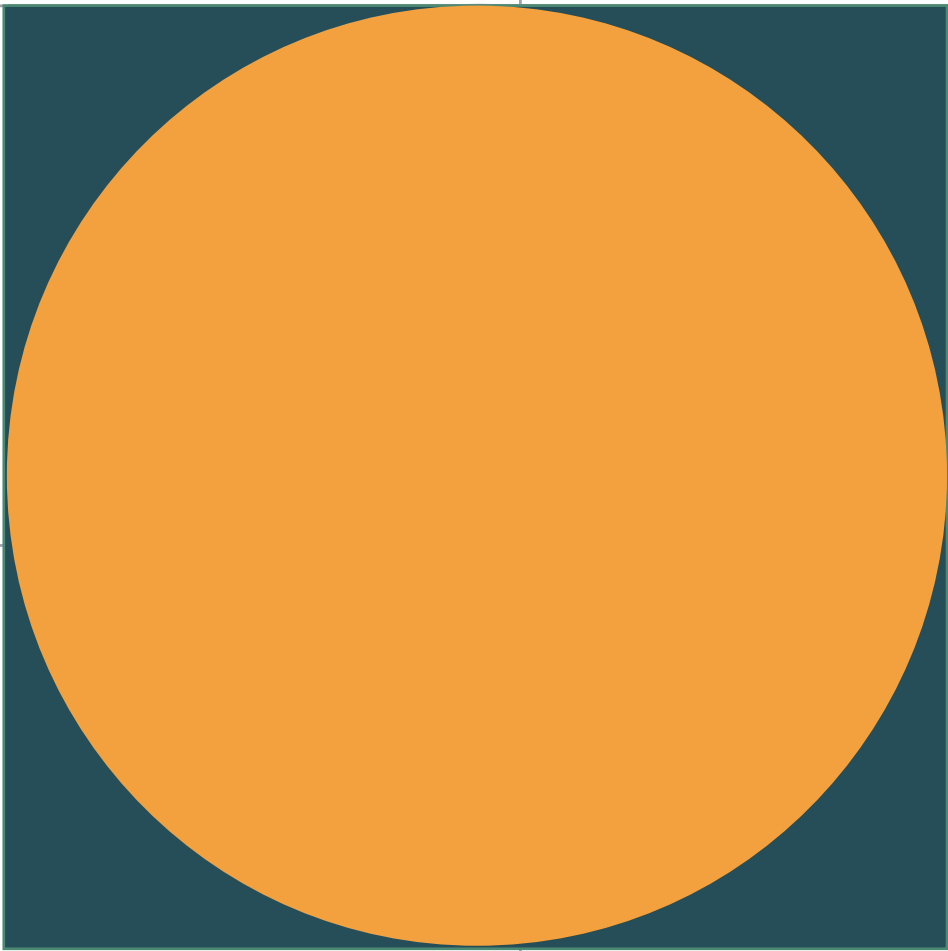
- The government and partners should support inclusion of the workplace approach in the national malaria program and the PPM-malaria; this approach should continue.
- The government and partners should work to scale up the MPDSR at all PHFs providing MNCH services.
- With support from partners, the government should finalize the PPM for HIV/ART to ensure implementation of ART services at PHFs without pharmacies.

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