2016 Sustainability Index and Dashboard Summary: Ethiopia

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed periodically by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) (sustainable and requires no additional investment at this time)
Light Green Score (7.00-8.49 points) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 points) (emerging sustainability and needs some investment)
Red Score (<3.50 points) (unsustainable and requires significant investment)

Country Overview: The HIV/AIDS situation in Ethiopia continues to be characterized by a low intensity mixed epidemic According to the latest Ethiopian National AIDS Spending Assessment (NASA) report for 2011/12, total annual HIV/AIDS categorical spending was $405 million of which 86% (US$ 350 million) came from external donors, 13% came from public revenue (US$ 55 million) and less than one percent (US$ 680 thousand) came from the private sector. The Government of Ethiopia (GoE) maintains the AIDS Mainstreaming Fund to which every Ministry voluntarily contributes 2% of their annual budget.

Ethiopia's policies and programming related to HIV/AIDS are in response to its Investment Case Framework, recently updated for 2015 to 2020. In general, policies, mandates, and mechanisms exist to adequately support the HIV/AIDS response. However, as is true everywhere, the implementation of those policies and adherence to those mandates are variable. With a trajectory of decreased PEPFAR and Global Fund funding, and with Ethiopia's economy showing consistent strong growth, it is increasingly critical for the GoE (at all levels from federal to woreda) to focus on (1) ensuring that mechanisms are operational and responsive in order to increase efficiencies, (2) strengthening planning and coordination at the national and regional levels in order to improve health system and service delivery, and (3) commit to a trajectory of increasing domestic contribution toward HIV categorical funding. It is not expected that all external

funding will be supplanted by domestic funding in the near or medium term. However, it will be an important indicator of GoE resolve to set that positive trajectory while at the same time moving aggressively to stop transmission and control the epidemic, so that the "mortgage" of lifelong ART ultimately required in Ethiopia is set to the lowest possible level.

SID Process: As a preliminary step for annual planning in COP16, PEPFAR Ethiopia convened a SID workshop with stakeholder representatives from government, donors, CSOs, and private sector firms in February 2016 to complete the dashboard exercise. The SID workshop was held offsite to allow wide participation from stakeholder groups. Participants included representatives from the Ministry of Health (national and regional representation), Civil Society (5 organizations representing the largest civil society groups in the health sector, also CCM members), UNAIDS, WHO, UNHCR, DfID, private sector, faith-based organizations, and PEPFAR implementing partners. The morning began with opening remarks from the Office of the State Minister (representing the Minister of Health), an overview of PEPFAR 3.0 and the SID process given by the Acting PEPFAR Coordinator, and remarks by the UNAIDS Country Director. Participants were then divided into 4 groups to discuss and complete the SID domains. Participants reconvened for an hour, during which domain facilitators presented outcomes from the group discussions. The SID workshop closed with remarks given by the Deputy Chief of Mission.

Sustainability Strengths:

- **Planning and Coordination (8.37, light green):** Similar to COP15, the COP16 SID characterizes Ethiopia as having strong planning and coordination. The government has developed and oversees a costed multiyear national strategy, although it does not include detailed plans and activities to address the needs of all key populations. Per its mandate, the role of the Federal HIV/AIDS Prevention and Control Office (F/HAPCO) is to ensure implementation of related policies, programming, and to coordinate the overall HIV/AIDS response; however, HAPCO has had challenges with fulfilling their defined role. During the SID workshop, there were conflicting opinions on some responses in this section. In general, Domain A participants felt that while planning and coordination is well defined, plans and coordination are not well implemented.
- **Public Access to Information (7.0, light green):** Surveillance, expenditure, and performance reports are made available to key stakeholders via different channels including reports and review meetings. However, the materials are not routinely available to the general public through widely-disseminated publications or on websites of responsible government agencies.

Sustainability Vulnerabilities: Given PEPFAR Ethiopia's increased efforts to support the GoE to attain the 90-90-90, and taking into consideration decreasing donor funding, the following are priorities for COP16:

- **Service delivery (Score 4.40):** To achieve the 90-90-90 target and thereby epidemic control and for the implementation of standard high-quality, less-

expensive patient-centered HIV service delivery models strengthening health facilities capacity, establishing a strong community based platforms and improving linkage between community and facility based services will be of paramount importance. Although GoE is committed to provide comprehensive services to PLHIV, it needs substantial technical assistance on issues such as program management, providing service to key and priority population and effectively engaging civil society and the private sector in this endeavor. PEPFAR can provide technical assistance to build the capacity to achieve the ambitious 90-90-90 target and sustainable epidemic control.

- **Human Resources for Health (6.0, yellow):** The transition to Test and Start requires training health care workers on the new guidelines and ensuring that mechanisms are developed or strengthened to increase staff retention. PEPFAR will provide technical assistance to strengthen task-shifting, and will facilitate pre-service and in-service training. Accurate data is still needed on the number of available health care workers and the gap. Findings from site visits, assessments, and the PEPFAR HRIS assessment framework show that HRIS is performing low. HRIS is one of the flagship programs in the MOH's HRH Strategy therefore PEPFAR can provide technical assistance to improve the functionality of the HRIS so that HRH information is accurately captured. PEPFAR's support will directly focus on further building the capacity of MOH, regional health bureaus, health education institutions to coordinate the HRIS system for long-term country ownership.
- **Quality Management (1.62, red):** Despite low achievement in this domain, GOE is currently developing an HIV Quality Improvement Framework. PEPFAR plans to assist in the development and implementation of the framework, particularly on the inclusion of monitoring tools specific to HIV service delivery and its roll out to health facilities.
- **Domain C: Domestic Resource Mobilization (2.78, red) and Technical Allocative Efficiencies (1.11, red):** Increased allocation of funding to HIV/AIDS needs to be discussed. PEPFAR, through increased engagement with Civil Society, will support efforts to build the capacity of community groups to raise awareness, and to contribute to finalizing the national Health Sector Financing Strategy and Social/Community Based Insurance.

Additional Observations: PEPFAR is well positioned to improve Service Delivery and the National Health System, by supporting GoE in addressing relative weaknesses such as:

- Distribution of resources at the sub-national level: There is a strong principle of "equity" that governs allocation decisions for sub-national units as opposed to based on burden of HIV disease. Rectifying this mis-allocation of resources is key to improving performance for the first "90" and requires PEPFAR to strongly advocate for changing the allocation formula for test kit distribution.
- Linkage to care and treatment services: The linkages between community services and facility services are weak. There is no national system for monitoring referrals within a facility, between facilities or between community and facility. PEPFAR's

approach to strengthening referral linkages is to provide points of contact both at the facility and community level and to utilize telephone technology to enhance both the making of referrals and the provision of feedback. Additionally, a para-social worker cadre is being trained utilizing PEPFAR support that will provide case management services for OVCs.

- Generating demand for HIV services: The Federal Ministry of Health has launched a campaign to promote Compassionate and Respectful Care for all people served in the public sector. The Ministry also has very successfully capitalized on the Health Development Army to promote ANC services and institutional delivery for pregnant women. With assistance from PEPFAR, the GoE can tailor its promotion of compassionate and respectful care to encourage high risk populations to know their status and seek HIV services at public facilities.

Contact: For any questions regarding Ethiopia's SID, please contact Acting PEPFAR Coordinator, Shoa Girma at girmas@state.gov.

Sustainability Analysis for Epidemic Control: Ethiopia

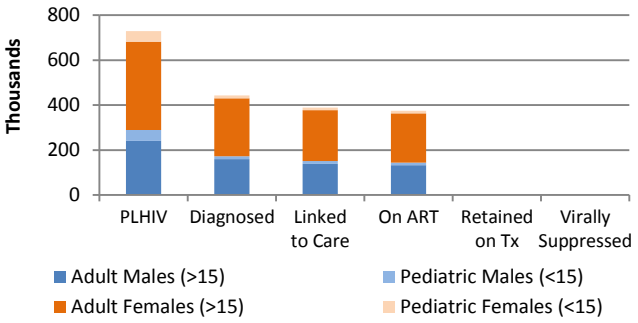
Epidemic Type: Generalized
Income Level: Low-income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 16 Planning Level: 174,500,000

SUSTAINABILITY DOMAINS and ELEMENTS

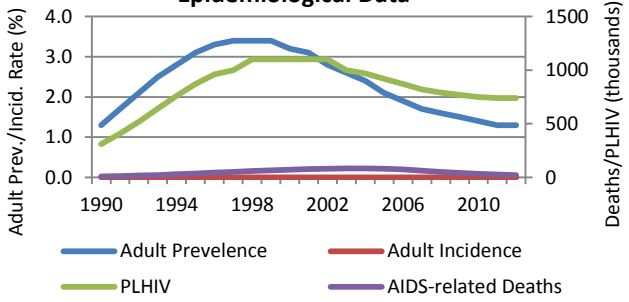
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.87			
2. Policies and Governance	6.58			
3. Civil Society Engagement	4.00			
4. Private Sector Engagement	4.44			
5. Public Access to Information	7.00			
National Health System and Service Delivery				
6. Service Delivery	4.40			
7. Human Resources for Health	6.00			
8. Commodity Security and Supply Chain	7.08			
9. Quality Management	1.62			
10. Laboratory	5.51			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	2.78			
12. Technical and Allocative Efficiencies	1.11			
Strategic Information				
13. Epidemiological and Health Data	4.48			
14. Financial/Expenditure Data	3.75			
15. Performance Data	4.74			

CONTEXTUAL DATA

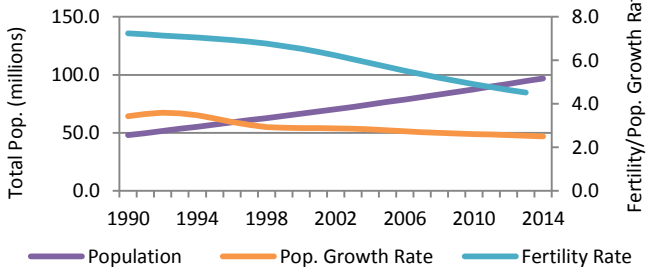
National Clinical Cascade



Epidemiological Data

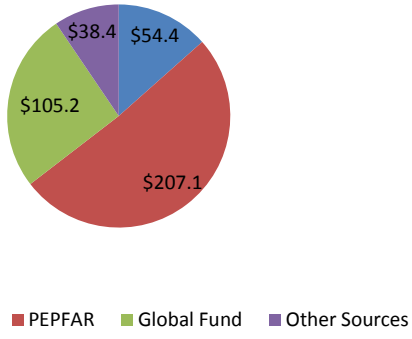


Population and Fertility

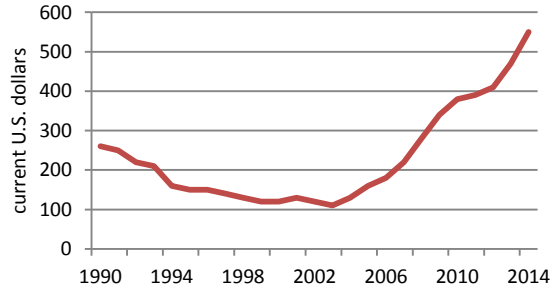


CONTEXTUAL DATA

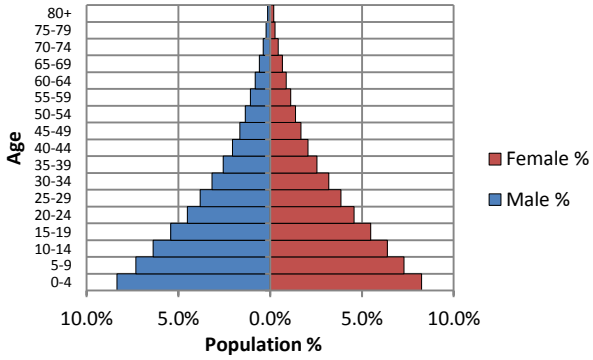
Financing the HIV Response (2011/12)
(USD millions)



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☐ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 2.20	HIV/AIDS STRATEGIC PLAN 2015-2020, AN INVESTMENT CASE APPROACH, FHAPCO, DEC.2014	Group participants had not received the costed strategy, but GoE representative insisted that a costed strategy is available. The strategy does not include plans and activities to address the needs of all key populations, only Female Sex Workers (FSWs).
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☐ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.00	HIV/AIDS STRATEGIC PLAN 2015-2020, AN INVESTMENT CASE APPROACH, FHAPCO, DEC.2014	There was limited representation of private health sector facilities and providers.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☐ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.17	Proclamation to establish the Federal HIV/AIDS Prevention and Control Office (F/HAPCO).	Important to note that mechanisms DO EXIST, but are not effective. F/HAPCO's role is clearly defined but the institutional capacity needs to be strengthened and the mandate reviewed. The current mandate has been ignored in recent years, for example, coordination and council meetings are not held. In recent years aspects of the HIV response have been split between F/HAPCO and the MoH; F/HAPCO coordinates the non-clinical aspects of the HIV/AIDS response, and the MoH coordinates clinical aspects. This sometimes creates confusion in roles or duplication of efforts. The host country government routinely tracks 70-90% of donor activities and tracks less than 25% of civil society activities.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	Annual Review Meeting (ARM) report Woreda based planning meetings	
	Planning and Coordination Score: 7.87			

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☑ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 D. Children (<10 years) ☑ Test and START (current WHO Guideline) ☐ CD4<500 or clinical eligibility	2.1 Score: 1.07	National HIV/AIDS Control policy	

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☐ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS	2.2 Score: 0.61	HIV/AIDS guidelines; Labor law, Family law	There is an umbrella legistlation for the protection for women and children, however it is not specific to HIV/AIDS (even though implied in the documents).
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☐ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☐ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☐ Law/policy is fully implemented	2.3 Score: 0.48	This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. HIV/AIDS National policy document (1988)	There are implementation challenges to the laws such as cultural barriers. There are no non-discrimination laws for FSWs, the HIV/AIDS policy does include provision of services to FSW.

	Gay men and other men who have sex with men (MSM): ☐ Law/policy exists ☐ Law/policy is fully implemented Migrants: ☐ Law/policy exists ☐ Law/policy is fully implemented People who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully implemented Prisoners: ☑ Law/policy exists ☐ Law/policy is fully implemented Sex workers: ☐ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☐ Law/policy exists ☐ Law/policy is fully implemented				

	Women and girls: ☑ Law/policy exists ☐ Law/policy is fully implemented			
2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of sex work: ☑ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced	2.4 Score: 1.21	This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. Article 269 of the Criminal Code of Ethiopia (for criminalization of sexual orientation). Criminal code of Ethiopia (2004), article 634 for FSW and article 525 for narcotics.	

	Ban or limits on needle and syringe programs in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on the distribution of condoms in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on accessing HIV and SRH services for adolescents and young people: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of HIV non-disclosure, exposure or transmission: ☑ Law/policy exists ☐ Law/policy is enforced Travel and/or residence restrictions: ☐ Law/policy exists ☐ Law/policy is enforced Restrictions on employment for people living with HIV: ☐ Law/policy exists ☐ Law/policy is enforced			

2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☐ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☑ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.5 Score: 1.07	National HIV/AIDS policy; Ethiopia anti-discrimination guidelines; Greater Involvement of Persons with AIDS	Financial support is not provided, but free legal services are provided by the government.
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 1.43	Government audit records (Office of General Audit)	
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ◉ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ○ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 0.71	Government audit records (Office of General Audit)	
	Policies and Governance Score:	**6.58**		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ○ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 0.83	Ministry of Health Mandate, Ethiopian Civil Socitey Law CSA 2011	
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ◉ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ○ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☐ During strategic and annual planning ☐ In joint annual program reviews ☐ For policy development ☐ As members of technical working groups ☐ Involvement on government HIV/AIDS program evaluation teams ☐ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	3.2 Score: 1.67	Ethiopian Civil Socitey Law CSA 2011	

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☐ In advocacy ☐ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 0.67	Global Fund for TB, Malaria and AIDS-GFTAM Country Coordination Mechanism (CCM)- TOR #301	
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).	3.4 Score: 0.83	There is no data source. Decision reached by consensus.	

3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	◉ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ○ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that apply): ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☐ Significant tax exemptions for not-for-profit CSOs ☐ Open competition among CSOs to provide government-funded services ☐ Freedom for CSOs to advocate for policy, legal and programmatic change ☐ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 0.00	Ethiopian Civil Soceity Law CSA 2011	
		Civil Society Engagement Score:	**4.00**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. There are no formal channels or opportunities ◉ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ○ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☐ Corporate contributions, private philanthropy and giving ☐ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☐ Tracking of private training institution HRH graduates and placements ☐ Contributing to develop innovative solutions, both technology and systems innovation ☐ For technical advisory on best practices and delivery solutions	4.1 Score: 0.83	National Health policy; Health Sector Transformation plan (as included in the Growth and Transformation Plan)	

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	◉ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ○ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☐ In patient advocacy and human rights ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery for both public and private providers ☐ In HIV/AIDS basket or national health financing decisions ☐ In advancing innovative sustainable financing models ☐ In HRH development, placement, and retention strategies ☐ In building capacity of private training institutions ☐ In supply chain management of essential supplies and drugs	4.2 Score: 0.00	Participants' Consensus	

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☑ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☐ Tax deductions for private health providers. ☐ Tax deductions for private training institutions training health workers. ☐ Open competition for private health providers to compete for government services. ☑ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☐ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 0.83	FMHACA Guideline on Private Health Facilities Standard for service delivery, National Guidelines for comprehensive HIV prevention, care and treatment(2014), MOUs between regional health bureaus and public and private providers, National HIV/AIDS Policy(1993)	Abt is working on processes to establish PPP and MOU between public and private providers.

4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☑ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☐ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☑ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 1.11	FMHACA Regulation # 189/2010, FHAPCO AND the Confederation of Ethiopian Trade Union(CETU) workplace HIV/AIDS policy, The Ethiopian Business Coalition against HIV/AIDS	
4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	○ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ◉ B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply): ☑ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs. ☑ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 1.67	Health Sector Transformation Plan (HSTP) 2015/16-2019/20	ART is procured only by the government.

4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00	FMOH/FHAPCO Annual Review Meeting (ARM) reports	Note that this is the same in public institutions, that is, the percentage of people accessing HIV services is also lower than the other curative services.
	Private Sector Engagement Score: 4.44			

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ○ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 1.00	Surveillance reports (sentinel, ANC surveillance reports, etc.); and by consensus	
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures. ◉ B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.	5.2 Score: 1.00	Joint Planning and Review meeting (Federal HAPCO)	report is only available to stakeholders, not to the public.
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .	5.3 Score: 1.00	Federal HAPCO Joint Review Meeting Reports	

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements. ○ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 2.00	Ethiopia Pharmaceuticals Fund and Supply Agency (PFSA) national tender/bid guidelines and documents	
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	FMOH/FHAPCO, Federal Ministry of Education	
		Public Access to Information Score: 7.00		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☐ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☐ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.37	Ethiopia Investment Case Framework	The question is too broad (does not apply to facilities. There are few number of facilities but not a widely spread practice) 2. Investment case is in favor in expanding health services and existing health facilities are located following the disease burden. Public health facilities have generally not worked to generate demand for HIV services. However, the Federal Ministry of Health has launched a campaign to promote Compassionate and Respectful Care for all people served in the public sector. The Ministry also has very successfully capitalized on the Health Development Army to promote ANC services and institutional delivery for pregnant women. With assistance from PEPFAR, the GoE can tailor its promotion of compassionate and respectful care to encourage high risk populations to know their status and seek HIV services at public facilities.

6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services ☐ Providing supply chain support for community-based services ☐ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.74	Health Development Army Guidelines, MARPs minimum package, Community level care and services delivery for PLHIV and affected families guideline.	Not all community services. E.g Commodity is supported by donors. Six tools exists but monitoring is poor. A third key weakness is that while formalized mechanisms exist that allow for civil society engagement in the oversight of services at public facilities, the linkages between community services and facility services are weak. At the facility level case managers provide the link to community based services for HIV-infected patients, but bi-directional flow of information is inconsistent. There is no national system for monitoring referrals within a facility, between facilities or between community and facility. PEPFAR's approach to strengthening referral linkages is to provide points of contact both at the facility and community level and to utilize telephone technology to enhance both the making of referrals and the provision of feedback. Additionally, a para-social worker cadre is being trained utilizing PEPFAR support that will provide case management services for OVCs.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 0.83	NASA, National HIV/AIDS sub account	

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.37	SIMS visit results	Technical assistance is not specific enough. Substantial TA is needed for the community and private services but health facilities need some TA. In assessing the amount of external technical assistance required by the host country to provide HIV services both in high burden areas and to key populations, the focus group had to distinguish between "some" and "substantial" external technical assistance. The consensus was that "substantial" external TA was still being required. However, what should not be forgotten is that there has been a major shift in on-site supervision of HIV services with government taking from US based university partners. The level of external technical support for these activities is on a downward trajectory as Regional Health Bureaus increasingly are responsible for assuring the quality of HIV clinical services.
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ◉ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 0.42	FHAPCO annual report, Experts opinion	
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	FHAPCO annual report, Experts opinion	

6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assesses current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☐ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engages with civil society in program planning and evaluation of services . ☐ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.74	Joint steering community meeting, MOH annual meeting, MOH supportive supervision reports. MOH experts.	Regions allocate their own budget but the allocation is not aligned with disease burden. The regional bureaus, not natinal MoH, are mandated to plan and manage health care services. There is a strong principle of "equity" that governs allocation decisions for sub-national units. This is particularly an issue when it comes to distribution of test kits. When distributed "equitably" as opposed to based on burden of HIV disease, sub-national units with high need for testing tend to have test kit shortages resulting in setting priorities for whom to test that has likely resulted in "missed cases," while regions with low burden of disease are over-stocked with test kits, resulting in over-testing of low-risk populations. Rectifying this mis-allocation of resources is key to improving performance for the first "90" and requires PEPFAR to strongly advocate for changing the allocation formula for test kit distribution.

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☐ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score: 0.56	Key informant from Ministry of Health and FHAPCO joint review meeting documents	The first two options and the last option are not applicable to emerging regions. Sub-national health authorities engage with civil society but effectivness is questionable.
		Service Delivery Score **4.40**		
7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.00		None of the options apply
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.2 Score: 0.33	PEPFAR cooperative agreements	Data clerks and case managers are the only professions paid by PEPFAR thus answer is based on the two identified groups.

7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ○ D. Host country institutions provide most (approx. 50-89%) health worker salaries ◉ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 3.33	Consolidated annual national health plan and Health & Health Related Indicators	E. Except for health extension workers, other health community workers are supported by donors
7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☐ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score: 1.00	National curriculum, partners reports, SIMS findings	
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☑ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☐ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☐ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.5 Score: 0.50	Institutionalization of inservice training directives and implementation guideline (FMOH)	the team suggested approximately 50% and financial aspect was not considered

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☐ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☐ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 0.83	HRH strategy , HRIS Assesment Framework	HRIS does not support the national community structure other than health extension workers.
	Human Resources for Health Score	**6.00**		
8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.00	Data from NASA, NHA, PEPFAR Supply Chain Management IM; group consensus	
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.00	Data from NASA, NHA, PEPFAR Supply Chain Management IM; group consensus	

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	NHA, MOH, Condom assessment report; group consensus	
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 2.22	National supply chain plan/SOP:Pharm. Logistics Matter Plan 2008, FMOH; Integrated Pharmaceutical Logistics System (IPLS)	There is pharmaceuticals waste management directive from the regulatory side but it does not include SOPs on the disposal of pharmaceutical waste and medical supplies.
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ◉ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.42	By consensus	Includes dedicated time from staff of PFSA, RHB and Woreda health offices. There is also a supervision budget at RHB, Zone and Woreda health office from GOE.

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 2.22	2014 IPLS Assesment done by JSI; Logistics Management Information System bi-monthly Report; Report on additional assessment on availability of tracer commodities for HIV/AIDS	The group making the supply decisions includes deputy managers of major hubs, LMIS and distribution experts. There were varying opinions on the response to this question during the workshop. Representatives from government entities firmly stated that decisions were and are always made by the government employee, and that is the procedure in all government sectors. Per the government, the role of the seconded employees is to provide critical inputs and enable decision making, but not to make decisions.
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	○ A. A comprehensive assessment has not been done ○ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ◉ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 2.22	Quarterly Pharmaceutical Logistics Management Partners Meeting; Ethiopia National Survey of IPLS, Feb 2015 done by Pharmaceuticals and Funds Supply Agency and Deliver; Additional assessment on availability of tracer commodities for HIV/AIDS	
	Commodity Security and Supply Chain Score:	**7.08**		
9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	◉ A. The host country government does not have structures or resources to support site-level continuous quality improvement ○ B. The host country government: ☐ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.00	Health Sector Develpoment Program IV 2010/11 - 2014/15 FMOH	

9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ◉ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ○ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 0.67	Quality management framework for HIV & AIDS Services in Ethiopia (2008)	
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☐ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☐ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 0.67	Ethiopia Investment Case Framework, FHAPCO annual and semi annual M&E report, Bulletin of Annual Review Meeting of FMOH, HMIS, SIMS report, PEPFAR quarterly, semi annual and annual report, implememting partners report to FMOH/RHBs	
9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	◉ A. There is no training or recognition offered to build health workforce competency in QI. ○ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☐ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 0.00	The current in-service training materials does not specifically address modern quality improvement methods to HIV & AIDS care and services.	Although there is no training or recognition, initiatives are underway.

9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☐ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☐ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 0.29	SIMS visit & joint supportive supervision and mentoring reports	
		Quality Management Score: **1.62**		
10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ◉ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed	8.1 Score: 0.83	Ethiopian Public Health Institute (EPHI) Strategic Planning and Management (SPM) document	
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ◉ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ○ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	8.2 Score: 0.42	Ethiopian Food, Medicine and HealthCare Administration and Control Authority (FMHACA) standards	

10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	○ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ◉ B. There are adequate qualified laboratory personnel to perform the following key functions: ☑ HIV diagnosis in laboratories and point-of-care settings ☑ TB diagnosis in laboratories and point-of-care settings ☑ CD4 testing in laboratories and point-of-care settings ☑ Viral load testing in laboratories and point-of-care settings ☑ Early Infant Diagnosis in laboratories ☑ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☑ Blood banking in laboratories and point-of-care settings ☑ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	8.3 Score: 1.48	Stepwise laboratory improvement process towards WHO-AFRO accreditation site reports	Even though,there are adequate qualified laboratory personnel to perfom the selected tests, staff competency is still a challenge in some of the tests e.g. Malaria microscopy.
10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○ A. There is not sufficient infrastructure to test for viral load. ◉ B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient viral load instruments and reagents ☑ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	8.4 Score: 1.11	Strategic Plan for Scaling-up of HIV Viral Load testing in Ethiopia	
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ○ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ◉ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	8.5 Score: 1.67	Expert Opinion and group consensuses, no other data source	
	Laboratory Score:	**5.51**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☐ The HIV/AIDS budget is program-based across ministries ☐ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☐ The budget includes specific HIV/AIDS service delivery targets ☐ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.11	Annual National plan budget; Country Progress report NASA 2014	GOE allocates budget for FHAPCO for personnel, infrastructure etc. Drug and program costs are covered from donor resources. GOE institutions are required to allocate up to 2% of their budget for HIV/AIDS mainstreaming. Some Regional Governments (example Addis Ababa CA) also allocate an additional regional budget for HIV/AIDS multisectoral response.
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	◉ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ○ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ○ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 0.00	FHAPCO annual budget and RHB annual report with target and budget.	As there is no budget approved annually by the government no target is reflected. However the Health Sector Development Plan (HSDP IV) and other documents do include set targets.

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	◉ A. Information is not available ◯ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ◯ C. 1-9% ◯ D. 10-49% ◯ E. 50-89% ◯ F. 90% or greater	11.3 Score: 0.00	Group consensus	
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	◯ A. None (0%) is financed with domestic funding. ◯ B. Very little (approx. 1-9%) is financed with domestic funding. ◉ C. Some (approx. 10-49%) is financed with domestic funding. ◯ D. Most (approx. 50-89%) is financed with domestic funding. ◯ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 1.67	NASA EFY 2014	13% domestic public resources and less thank 1% from private sector resources. Huge range could distort information.
	Domestic Resource Mobilization Score:	**2.78**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	◉ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ○ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☐ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 0.00	Group consensus	
12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 0.00	Group consensus	

12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 0.00	Group consensus	
12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming ◉ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ○ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0.48	Group consensus	
12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	◉ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ○ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☐ HIV Testing ☐ Care and Support ☐ ART ☐ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions	12.5 Score: 0.00	Group consensus	

12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☐ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☐ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☐ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 0.63	Experience from monitoring visits to Regional Health Bureaus and clinics, Budget reports, National HCT guidelines	HIV/TB integration is happening but not with ART.
12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	◉ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ○ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score: 0.00	Global Fund reports	ART procured through Global Fund resources.
	Technical and Allocative Efficiencies Score:	**1.11**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.48	Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI	Does TA involve financial assistance? If financial assistance is included, then options C & D shoud be checked, and not only C. Level of effort needs to be quantified. The question lumps survey and surveillance but the response could differ based on survey and surveillance. We need a question on data quality. Even with substantial involvment of partners both financially and TA the quality of data is not optimal. The questionasks who leads teh task, however the responses contradict the question as they reference implementation.
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.48	Ethiopia Investment Case Framework Investment Case (2015-2020), Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI	Is key population defined in Ethiopia? CSW, IDU, Prisoners - defined as key/priority populations. There are attempts to define CSW,IDU, very limited effort on the key population survey. No external stakeholder has lead a survey in Ethiopia. What does leadership mean is also a point for discussion? The question assumes that data quality is good/better.

13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.42	NHA is a basis to estimate for DHS; EPHI SPM2- 2015/16-2019/20,	
13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	EPHI SPM2- 2015/16-2019/20, Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI	The question need to be posed directly. Who finance the activity? It is not equivalent to the prior question.

13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years sub-national HIV incidence disaggregated by: ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.48	EPHI spectrum estimate	

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	◉ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ○ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.00	Ethiopian MARPS report (Unpublished)	Not for all PLHIV. Not routine and not comprehensive. The indicator in viral load.
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☐ Men who have sex with men (MSM)/transgender ☐ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☐ Men who have sex with men (MSM)/transgender ☐ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.32	The IBBS is geographically limited for CSW. IDU only in Addis Ababa . Size estimate: for FSW	
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.95	EPHI SPM2- 2015/16-2019/20, Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI	A timeline is included in the strategy, but it is not adhered to. In addition the timeline for data collection is not relevant to all populations.

13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☑ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.95	EPHI SPM2- 2015/16-2019/20, Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI	The data quality measures are not comprehensive. Even with existence all elements there are issues with the quality of surveillance data. The measure should not be yes B to A. The measure should have other intermediate scale. Although the procedure exisits, the implementation of the procedure has limitations.
	Epidemiological and Health Data Score:	**4.48**		
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ◉ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 0.83	NASA	UNAIDS and USAID participated
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 0.83	NASA	

14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☐ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally	14.3 Score: 0.83	NASA	
14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ◉ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 0.42	NASA	For example, data was collected 2011 disseminated in 2012
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉ B. The host country government conducts (check all that apply): ☑ Costing ☐ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☑ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☐ Market demand analysis	14.5 Score: 0.83	NASA	Costing done for investment case. Cost benefit done for ART guideline adoption for CD4 500 or 350 (Risk benfit analysis)
	Financial/Expenditure Data Score:	**3.75**		

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ◉ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ○ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 0.33	Health Management Information System Implementation guide, SOPs, Training Manuals	In the COP15 SID, this element scored light green, but that was because it referred to data collection systems for the health sector. However, specific to HIV service delivery, the data management system is not robust, hence the decrease in score.
15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 0.83	Health Management Information System Implementation guide, SOPs, Training Manuals	We don't have exact value

15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☐ Orphans and Vulnerable Children ☐ Voluntary Medical Male Circumcision ☐ HIV Prevention ☐ AIDS-related mortality ☑ B. Service delivery data are being collected: ☐ By key population (FSW, PWID, MSM/transgender) ☐ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 0.78	Health Management Information System Implementation guide, SOPs, Training Manuals	Age and sex disaggregation for only health related response.
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	Health Management Information System Implementation guide, SOPs, Training Manuals	Timely

15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.67	Health Management Information System Implementation guide, SOPs, Training Manuals, FMOH Routine Data Quality manuals	Data use at point of data collection/generation is not strong. Reference to government includes all levels from nationa, regional to facility.
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☐ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☑ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☐ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.80	Health Management Information System Implementation guide, SOPs, Training Manuals, FMOH Routine Data Quality manuals	With RDQA for ANC is 96% the ANC coverage is 106%
		Performance Data Score: **4.74**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D