2016 HIV/AIDS SUSTAINABILITY INDEX AND DASHBOARD: RWANDA

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)

Rwanda Overview: Rwanda has made significant and remarkable progress in reaching the UNAIDS Fast Track 90-90-90 Goals following the genocide of 1994. The Government of Rwanda has demonstrated strong leadership and vision in crafting a national HIV/AIDS strategy and coordinating the response. However, Rwanda remains highly dependent on donors to fund its HIV response, particularly PEPFAR and the Global Fund. Those donor contributions are sharply declining, which poses a significant risk to the long-term sustainability of the national HIV program, and to the great successes Rwanda has achieved. The Government of Rwanda is taking strides to develop and implement cost efficiencies by rolling out Test and START for all PLHIV beginning in 2016, optimizing service delivery models, and by finding ways to gradually absorb the costs of administering the national HIV program.

SID Process: The second year of Rwanda's SID 2.0 day-long workshop was again organized jointly with GoR/MOH in January 2016 and was attended by more than 50 participants from more than 25 organizations working in the national HIV program. Participants included representatives from the MOH, Rwanda Biomedical Center (RBC), UNAIDS, UNFPA, WHO, UNICEF, as well as local civil society organizations and PEPFAR implementing partners' staff. After opening remarks by the Deputy Chief of Mission of the U.S. Embassy in Kigali and the HIV Division Manager of the RBC, the participants broke into four groups around each of the domains and jointly answered the questions and provided source data and notes for the final SID 2.0. After the day-long meeting, the SID 2.0 was circulated among all stakeholders in the national HIV response, including invitees who were not able to attend the in-person meeting, and further feedback was incorporated into the final SID 2.0.

Sustainability Strengths: All SID 2.0 domains were identified as sustainable, approaching, or emerging sustainability with notable strength in the domain "Governance, Leadership, and Accountability."

- **Public Access to Information (10.0, dark green):** Notably, the GoR widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges toward achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, etc.) related to HIV/AIDS. Information is readily available on GoR websites.

- **Policies and Governance (8.63, dark green):** At the time of completing SID 2.0, the GoR had adopted but not yet implemented Test and START and is working on the development and

implementation of new service delivery models to create efficiencies within the national HIV program and for ART patients. The expectation is that the next version of SID in Rwanda will find a higher score in this element due to the efficiencies adopted and implemented in 2016, after the publication of SID 2.0.

- **Human Resources for Health (8.50, dark green):** Beginning in COP16, PEPFAR no longer provides support to HRH program activities. The MOH has been working on an HRH sustainability plan to implement the transition. Additional monitoring of this element will be important in future years to ensure that HRH remains a dark green category.

Sustainability Vulnerabilities: After the collapsing of four elements of SID (2015) into two elements in SID 2.0 (2016), the SID element of Domestic Resource Mobilization: Resource Commitments, previously identified as the only unsustainable element requiring significant focus, is now identified as emerging sustainability needing some improvement.[1] Other components identified as emerging sustainability and needing further investment were Private Sector Engagement, Service Delivery, Technical and Allocative Efficiencies, and Epidemiological Health Data

- **Domestic Resource Mobilization (6.94, yellow):** SID 2.0 collapsed two elements in the prior year version into one element, "Domestic Resource Mobilization." In the 2015 SID, the only element identified as red and "unsustainable" requiring significant investment in order to ensure the sustainability of the national HIV program was Domestic Resource Mobilization: Resource Commitments. Because this element was combined with another element that was previously identified as light green and "approaching sustainability" needing little or no investment, the red and light green scoring of two separate elements has resulted in a yellow score for the current SID 2.0. The placeholder question in 11.4 in the next version of SID is expected to help better capture Rwanda's financial ability to pay for the HIV response. It is agreed among stakeholders that Rwanda's domestic resource mobilization is directly dependent on the ability to pay, rather than on a willingness or desire to pay.

Additional Observations: There is limited domestic budget to fully fund the HIV program, and donor funding, including PEPFAR funding, is rapidly reducing. Both PEPFAR and Global Fund have invested substantially in Rwanda's HIV response, and both funding sources are reducing at a significant pace and rate. Nearly 50% of PEPFAR funding and all GF support is delivered through the government, which demonstrates the high capacity of the GoR and MOH systems.

Contact: For questions or further information about PEPFAR efforts to support sustainability of the HIV response in Rwanda, please contact Tracy Burns, Interim PEPFAR Country Coordinator for Rwanda, at BurnsT@state.gov.

[1] In the 2015 SID, the other element, Domestic Resource Mobility: Resource Generation, currently combined with the previously identified unsustainable element was previously identified as "approaching sustainability needing little or no investment."

Sustainability Analysis for Epidemic Control: Rwanda

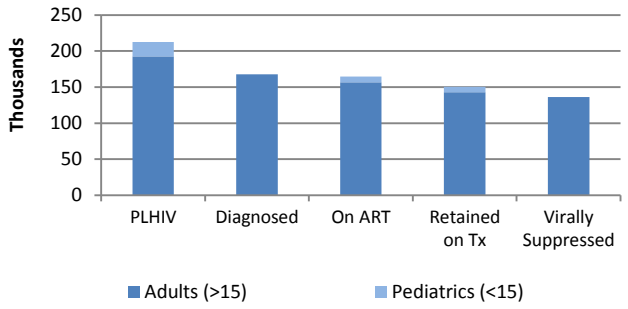
Epidemic Type: Generalized
Income Level: Low-income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 16 Planning Level: 72,000,000.00

SUSTAINABILITY DOMAINS and ELEMENTS

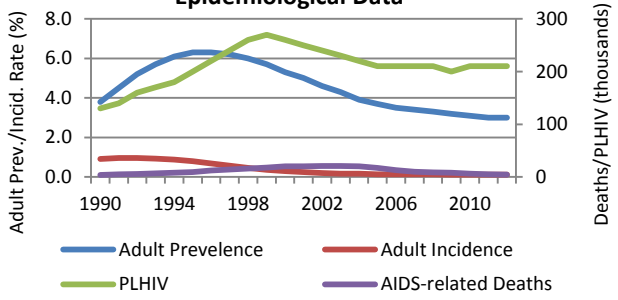
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.50			
2. Policies and Governance	8.63			
3. Civil Society Engagement	7.67			
4. Private Sector Engagement	6.11			
5. Public Access to Information	10.00			
National Health System and Service Delivery				
6. Service Delivery	6.67			
7. Human Resources for Health	8.50			
8. Commodity Security and Supply Chain	7.30			
9. Quality Management	7.38			
10. Laboratory	7.36			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	6.94			
12. Technical and Allocative Efficiencies	6.43			
Strategic Information				
13. Epidemiological and Health Data	6.27			
14. Financial/Expenditure Data	7.50			
15. Performance Data	7.94			

CONTEXTUAL DATA

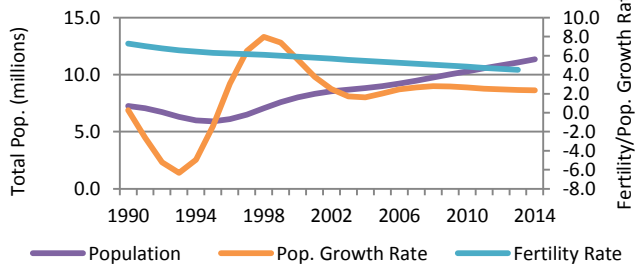
National Clinical Cascade



Epidemiological Data

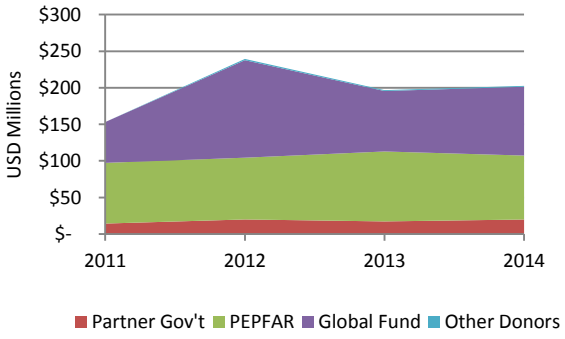


Population and Fertility

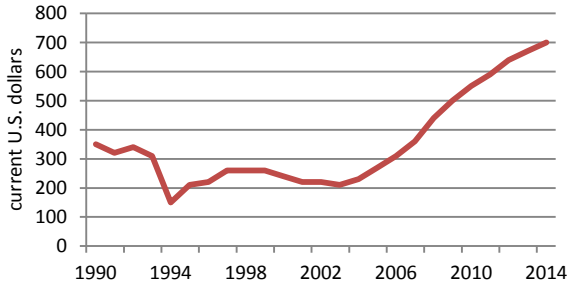


CONTEXTUAL DATA

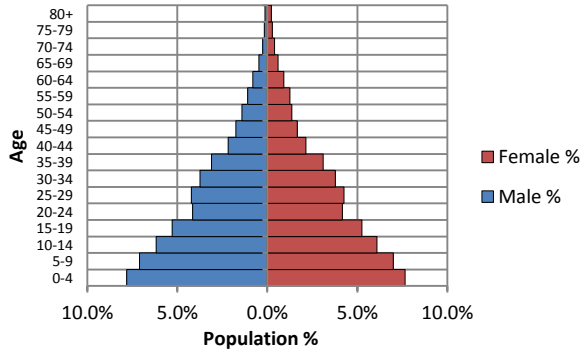
Financing the HIV Response



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: 2.50	NSP 2013-2018	
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: 2.50	Group concurrence	There is need to increase and improve participation of business, corporate sector and civil society.

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: 2.00		
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		
		Planning and Coordination Score: 9.50		

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: 0.89	Rwanda Biomedical Center National guidelines for prevention and Management of HIV, STI & Other Blood Borne Infections, NSP 2013-2018	The MOH has adopted the policy of universal test and start. Test and start already exists for SFW and MSM. For children test and start is for less than 5 years.

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: 0.82	Task shifting Policy, Rwanda Biomedical Center National guidelines for prevention and Management of HIV, STI & Other Blood Borne Infections.	Challenges remain on implementation of policy that permit patients stable on ART to have reduced pickups (i.e., every 3-6 months).
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 Gay men and other men who have sex with men (MSM): ☑ Law/policy exists ☑ Law/policy is fully implemented	2.3 Score: 1.43	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. Constitution, NSP and penal code.	The exiting law does not specify HIV, However it ensures protection to all without any discrimination.

	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 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	2.4 Score: 1.21	This question aligns with the revised UNAIDS NCPI (2015). Constitution, NSP and penal code.	There is no law that criminalizes sexual orientation.

	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: 1.43		
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		
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: 1.43		
		Policies and Governance Score: 8.63		

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: 1.67		The questions B and C are extremes. There are no laws that restrict CSOs in providing oversight but does not happen to the degree to which it should occur. Capacity strengthning of CSOs is an important element.
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	Cabinet manual (Chapter 5: Guidelines for Policy Development), Prime Minister Office Planning and Budgeting Call Circular, (issued annualy by MINECOFIN).	In the cabinet Manual in the guidelines for policy development, which is approved by the Cabinet, it is directed to consult the stakeholders (including civil societies and private sector among others) in the process of policy development. For the annual operational plan, the Ministry of Finance issues the Planning and Budgeting Call Circular in which it is highlighted to make consultation with stakeholders including civil societies , during the planning process.

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: 1.33		
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: 1.67	The government contributes 11% toward the HIV Program.	
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: 1.33		PPPs need to be improved.
		Civil Society Engagement Score:	**7.67**	

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: 0.56		

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: 0.37		

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: 1.46		Medical equipment for training is tax exempt
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: 1.39		Some have and some do not have workplace policies. No formal forum exist though individual efforts are made.

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		
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: 0.67		Models currently exist for cost recovery for ART. HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.
		Private Sector Engagement Score: 6.11		

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: 2.00	GoR websites (MOH and RBC)	
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: 2.00	GoR websites (MOH and RBC)	
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: 2.00	GoR websites (MOH and RBC)	

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		
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		
		Public Access to Information Score: **10.00**		

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: 0.74	Rwanda's National HIV Annual Report, 2014-2015	Budget reductions from external donors impact Rwanda's ability to be more responsive to the HIV demand in our facility-based services. The extent to which public facilities can accomodate demand is dependant on the location of where those services are provided (e.g. rural areas vs. urban areas, and overall patient volume at the facility).
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	Rwanda's National HIV Strategic Plan 2013-2018 Rwanda's Health Sector Strategic Plan 2013-2018	Although there is a plan outlined in the national strategic plan, the country is still working on guidelines to operationalize community-based HIV service. In practice, there are skilled workers who provide care in the community (peer educators and community health workers).
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	National Strategic Plan 2013-2018	

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: 0.74	National Strategic Plan 2013-2018 Annual HIV Report 2015	
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: 0.83	National Strategic Plan 2013-2018. Rwanda's Health Resource Tracking Tool FY13-15	Funding HIV control in key populations is well integrated into the overall funding for HIV program.
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: 0.74	National HIV annual report 2015	
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: 1.11	HIV National Strategic Plan National HIV Guidelines, HRH Strategic Plan, Global AIDS Response Progress Reporting 2014	

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: 0.93	National HIV Strategic Plan Rwanda's Elimination of Mother-to-Child Transmission Plan (EMTCT) 2012 Health Sector Strategic Plan 2013-2018 Paris Declaration and Accra Agenda for Action 2005 Kigali City HIV Response Plan 2012 NGO Forum Strategic Plan	
		Service Delivery Score **6.67**		
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: 1.00	HRH Strategic Plan 2011-2016	The MOH forecasts HRH projections integrating HIV. HRH planning is for the entire health sector. The Ministry of Health is designing motivation and incentive packages beyond retention contracts to encourage health care workers to be retained in the public and private sector.
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: 1.00	HRH Sustainability Agenda for Action (not yet endorsed)	There is a HRH sustainaiblity plan, which will inform the transition plan. Its implementation is ongoing

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: 2.50	MOH Annual Report 2015	
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: 1.33	HIV pre services curricula University of Rwanda College of Medicine and Health Sciences Master's of Medicine in Internal Medicine course - description and curriculum 2014	
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: 1.33	Training Database	

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: 1.33	Ministry of Health's Human Resources for Health Information System iHRIS	
	Human Resources for Health Score	**8.50**		
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: 0.21	Coordinated Procurement and Distribution System reports (annual)	
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: 0.21	Coordinated Procurement and Distribution System reports (annual)	

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		
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: 2.02	Coordination Procurement & Distributing System and tools National Supply Chain Strategic Plan 2014	
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	Coordination Procurement & Distributing System Quantification Report (annual) ; HIV NSP.	

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	Logistics Management Information Systems	
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	Rwanda National Supply Chain Assessment 2014	
	Commodity Security and Supply Chain Score:	**7.30**		
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: 1.33	Health Sector Strategic Plan III National Community Health Strategic Plan Rwanda Healthcare Quality Management Policy and Strategic Plan	Quality Improvement Management is integrated in the national health budget. At the district level, district officials meet monthly to share progress on QI iniatives.

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: 1.33	Rwanda Healthcare Quality Management Policy and Strategic Plan	
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: 2.00	Mentorship program for Quality Improvement Integrated Supervision and Data Quality Assessment Framework	
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: 1.00	HRH Strategic Plan	

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: 1.71	Quality Assurance (Assurance Qualite) Policy _ Rwanda Ministry of Health	
		Quality Management Score: **7.38**		
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: 1.67	National Laboratory Strategic Plan (2015-2019)	
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: 1.25	Medical Laboratories Norms and 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:	1.67	National Laboratory Strategic Plan (2015-2019); National HIV strategic Plan 2013-2018	
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	Viral load test and EID implementation plan (draft in progress) and Standardization of laboratory tests, techniques and Equipment policy	Rwanda recognizes the need to harmonize existing laboratory infrastructure (eg. Gene Xpert), scale-up Laboratory Information System and laboratory transportation network
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	National Laboratory Strategic Plan (2015-2019)	
		Laboratory Score:	**7.36**		

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: 1.67	National budget 2015/2016 NSP 2013-2018	National Strategic Plan for HIV/AIDS 2013-2018 includes costing and targets for service delivery and other indicators.
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: 2.22	HIV Annual Report 2014/2015	The 2014-2015 HIV Annual Report shows that all RBF annual targets were met.

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: 2.22	MOH Annual Reports and Budget execution reports2012-2015	2014/2015: 126% (domestic and external resources are missed) 2013-2014: 100% (HIV domestic resources) 2012-2013: 110% (disease prevention program domestic resources)
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: 0.83	GF Ability to Pay HIV Annual Report 2015 Annual Action Plan	Domestic budget Expenditure was at 9% with $19,877,495 from July 2014 to June 2015 according to the 2015 HIV Annual Report; The annual report is providing the % of annual expenditure for all MTEF programs in details.
	Domestic Resource Mobilization Score:	**6.94**		

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: 1.43	NSP JANS 2014 report for 2013-2018 NSP HIV Annual Report 2014-2015	One Health model has also been used.
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: 0.71	HIV Annual report, 2014-2015	The contribution of the GoR is based on MTEF programs. Apart from program specific financing, the estimation of GoR contribution takes into consideration all other health related programs costs, categorized as health systems strengthening costs like HRH, Infrastructures and equipments, quality of services. The GoR provides direct services to populations with domestic resources such as Voluntary Male circumcision (VMMC) example in Army weeks campaigns, EMTCT local leaders campaigns.

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		The contribution of the GoR is based on MTEF programs. Apart from program specific financing, the estimation of GoR contribution takes into consideration all other health related programs costs, categorized as health systems strengthening costs like HRH, Infrastructures and equipments, quality of services. The GoR provides direct services to populations with domestic resources such as Voluntary Male circumcision (VMMC) example in Army weeks campaigns, EMTCT local leaders campaigns.
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: 1.43	Organic Budget Law Budget Execution Report Budget Reprogramming Report	There is an annual reprogramming conducted once per year per the Organic Budget Law. Comparison of annual and revised budgets would demonstrate the frequency of reprogramming.
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: 1.43	NSP Detailed Costing Report	1) NSP HIV is well costed 2) PoA of HIV has unit costs 3)CPDS reports are based on unit costs for care, ARVs, Lab, Ois. Recent HIV NSP is containing updated unit costs which are utilizing for budgetting and planning processes .

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: 1.43	Restructuring MOH/RBC 2014. HRH Sustainability Agenda. Resource Management Commission doucmentation; use of GF-negotiated prices for commodities. National Procurement Law requires competition, price is a factor in evaluation of bids (with exception of single-source). NSP and SOPs re integrated care (need specific SOP if required by PEPFAR). Health Sector Policy, 2015. Health Financing and Sustainability Policy, 2015. Health Sector Sustainability Plan is being developped.	HIV services are reimbursed through CBHI, however commodities need not be reimbursed because they are received free by health facilities As an example of integrated new and efficient models of HIV testing, care, Test and Start is currently being integrated.
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		
	Technical and Allocative Efficiencies Score:	**6.43**		

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: 0.71	ANC Surveillance 2015, Drug Resistance Monitoring 2014, Early Warning Indicator 2014, Threshold Survey, DHS2015, Incidence 2014	Some are entirely locally managed (DHS, ANC) other had some support (Drug Resistance Monitoring etc)
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: 0.71	MSM BSS 2015, Sex worker BSS 2015	
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: 0.83	RAIHIS 2013/14 and DHS2015	

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: 0.00	MSM BSS 2015, Sex worker BSS 2015	
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: 0.83	DHS 2015, RAIHIS 2013/14	

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: 0.48	Viral load data has been reported to be between 87.6% and for 88.9% of PEPFAR-supported VL-eligible patients in 2015. PEPFAR reporting accounts for 55% of PLHIV on treatment, representing 48-49% of all VL-eligible patients in Rwanda. VL data is also collected nationally as needed for studies and surveys.	Data is collected universally at facilities, but reported regularly only through PEPFAR annual indicators for 53-55% (confirm) of patients on treatment.
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: 0.79	MSM BSS 2015, Sex worker BSS 2015, Truck drivers 2013, Fisherfolk 2013, DOD study for military	
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	Rwanda M&E Plan on HIV and AIDS 2013-2018 (RBC), Health Sector Research Policy	Policy doesn't include timelines, but M&E Plan does

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	Health Sector Research Policy 2014, Rwanda National Ethics Committee, National Research Committee (internal MOH technical review), Health Sector Research checklist	
	Epidemiological and Health Data Score:	**6.27**		
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: 1.67	HRTT 2015, NHA 2010	HRTT expenditure data is currently being collected, has not been reported out yet. HRTT development was supproted by external agencies, but implementation and analysis is by government
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: 2.50	Some components externally funding such as partner training.	

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: 1.67	HRTT 2015, data currently being collected, report not yet available	
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: 0.83	HRTT 2015, data currently being collected, report not yet available	HRTT 2015, data currently being collected, report not yet available. This is a new tool that is intended to be implemented annually. The initial report will represent two years of expenditure. Expenditure by funder is reported annually, but not detailed.
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	NSP costing 2013, Prevention of Mother-to-Child Transmission of HIV: Cost-effectiveness of Antiretroviral Regimens and Feeding Options in Rwanda. Binagwaho et al, PLoS ONE 8(2) 2013., "Male Circumcision at Different Ages in Rwanda: A Cost-effectiveness Study" Binagwaho et al. PLoS Med 7(1) 2010. 'HIV costing studies with RBC and SPH (2012 and 2013),	
	Financial/Expenditure Data Score:	**7.50**		
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: 1.00	National HMIS system. Some training support from USG (Chemonics, MSH)	

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: 2.50	Data managers are paid by Global Fund, some central support from PEPFAR/CDC	
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: 1.11		NCC collects OVC service data on OVC, but not HIV/AIDS specific service delivery data. HIV prevention - discordant couples, PEP are collected, but condom distribution and community-based prevention in not routinely collected. Facility-based mortality reported, but not necessarily AIDS-related. Data is collected from the private sector as well (reporting coverage is improving), but not all provide HIV services.
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	HMIS data is collected monthly	

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		District analysis conducted as needed to compare performance
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: 1.33	Rwanda M&E Plan on HIV and AIDS 2013-2018 (RBC), MOH Data Quality Guide 2014, Integrated Supervision Tools (RBC) including data audit process	Data Managers from the facilities have SOPs for data quality management. Data quality reports are shared internally and with Global Fund, some partners have had difficulty accessing reports.
		Performance Data Score: **7.94**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D