Angola Sustainability Index and Dashboard Narrative (SID)

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool that is completed every two years in Angola by PEPFAR teams and partner stakeholders to sharpen the understanding of Angola's HIV 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 in relation to:

1. Governance, Leadership and Accountability
2. National Health System and Service Delivery
3. Strategic Investments, Efficiency and Sustainable Financing and
4. Strategic Information.

Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information as follows:

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)**

Green and light green scores are seen as sustainable and approaching sustainable, requiring little to no investment. Red and yellow scores are seen as sustainability risks and are areas that need to be addressed. As the SID is completed over time, it allows stakeholders to track progress and gaps across these key components of sustainability.

SID Process: On February 7th, 2018, a multi-disciplinary group of Angolan stakeholders convened to complete the SID tool. Led by the Instituto Nacional de Luta Contra a SIDA (INLS), the group consisted of over 35 colleagues from, but not limited to the Luanda Health Directorate, UN bodies, EU, CSOs, Angolan Armed Forces, the private sector PEPFAR supported sites and PEPFAR. The group was divided into four pre-assigned domain groups (Governance, Health System, Strategic Investments, and Strategic Information). A week prior to the workshop, members of each domain were emailed the SID tool in order to be prepared for the workshop. The following paragraphs will highlight the 2018 SID results in comparison to the 2016 SID results.

Results:

	2015 (SID 2.0)	2017 (SID 3.0)
Governance, Leadership, and Accountability		
1. Planning and Coordination	10.00	8.90
2. Policies and Governance	7.82	7.40
3. Civil Society Engagement	6.43	3.92
4. Private Sector Engagement	1.60	2.86
5. Public Access to Information	7.00	6.00
National Health System and Service Delivery		
6. Service Delivery	3.24	4.54
7. Human Resources for Health	5.25	5.19
8. Commodity Security and Supply Chain	2.93	5.99
9. Quality Management	2.95	4.52
10. Laboratory	2.92	4.75
Strategic Investments, Efficiency, and Sustainable Financing		
11. Domestic Resource Mobilization	5.83	4.05
12. Technical and Allocative Efficiencies	6.45	6.93
Strategic Information		
13. Epidemiological and Health Data	6.49	4.52
14. Financial/Expenditure Data	2.50	1.67
15. Performance Data	6.94	6.48

Governance Leadership and Accountability:

- **Planning and Coordination (decreased from 10.0 to 8.90 Green):**
  - **Results:** A decrease is noted in the process elements for planning and coordination. There were several reasons for the decrease, for example the plan does not explicitly and specifically include activities to mitigate HIV impact on vulnerable children and key populations. The group also identified that two out of three national coordination bodies are now either inactive or need a more active role to effectively plan and coordinate the HIV response. Also, the Government of Angola (GRA) had less information about private sector activities.
  - **Discussion of Results**: The national HIV strategy is developed through key stakeholder involvement and coordinated by the national government. During the National HIV planning sessions and annual forums, civil society and the private sector are invited to participate in the plan development and annual forums. The 2016 SID results pointed to an engaged private sector, whose HIV activities were mapped out by the government and there was substantial coordination between the private sector and the government. Unfortunately this was not the case in 2018 as the private sector's involvement is currently limited.

- **Policies and Governance (decreased from 7.82 to 7.4 Light Green)**
  - **Results:** A slight decrease in this element is noted. The change in score is largely due to the national Test and Treat policy. Other policies do exist to create an enabling environment;

however better dissemination is needed to improve effectiveness and operation. Non-discriminatory policies for key population are not implemented with the exception of prisoners.

- **Discussion of Results**: There are many existing policies in Angola that create an enabling environment. They include the National Child Protection Commitment, the Law for HIV/AIDS 8/04; the HIV Treatment Protocol for stable patients, The National Counsel for Social Action and the Ministerial decree (11/8 of 2011) on task-shifting of doctors/nurses that allowed nurses to dispense ARV's at small sites without doctors. Licensed clinical nurses may dispense ARVs at all sites except national hospitals. Unfortunately there are very few licensed nurses in the public health clinics. There are no policies or legislation for ARV dispensation at the community level. There are generic policies for non-discrimination of People Living with HIV (PLHIV), however there are no specific policies for the protection of orphans and vulnerable children (OVC). Even though audits are regularly conducted, the results are not publically available except upon written request.

- **Civil Society Engagement (decreased from 6.43 to 3.92 Yellow)**
  - **Results:** There is a slight decrease in the score for this element. This is due to the fact that CSOs do not have substantial impact on financial decisions related to HIV AIDS.
  - **Discussion of Results** Formal channels for CSO engagement exist. They include annual planning and program reviews, policy development and involvement in surveys. Furthermore, Civil Society occupies strategic positions such as Vice president of the Global Fund Subvention Mechanism (MCN); Coordinator of the MCN Strategic Supervisory Committee. However, due to limited resources civil society cannot be effective in their supervisory role.

- **Private Sector Engagement (increased from 1.60 to 3.86 Red)**
  - **Results:** The score for this element doubled from 2016 to 2018. The increase in score is mainly due to having a legal framework for the private health sector, and having a standardized process for developing public private partnerships and regulations for private providers to adhere to the national ART guidelines. The private sector is part of the Country Coordinating Mechanism (CCM) Executive Committee (represented by Chevron).
  - **Discussion of Results:** The red score reflects that there is still limited private public partnership engagement. There is no active participation from the private sector on policy and budget planning for HIV. The government has relied on a consortium of approximately six businesses (CEC) as its main interlocutors. Unfortunately, CEC has turned inactive due to the majority of its member companies downsizing in the wake of the economic downturn and eliminating many Corporate Social Responsibility (CSR) departments. PEPFAR Angola, however, is prioritizing efforts to find a new approach to private sector engagement through companies that remain strong players, such as the cellphone networks.

- **Public Access to Information (stayed the same at 6.00 Yellow)**
  - **Results:** The result for this element stayed the same. The annual HIV report is available to the public and stakeholders in the year that it is released and the HIV expenditure report is available to within 1 to 3 years of publication.
  - **Discussion of Results:** Availability of the expenditure report was questioned in the group discussion. It was stated that that the expenditure report and procurement reports are available upon written request to the government.

National Health System and Service Delivery

- **Service Delivery (increased from 3.24 to 4.54 changing from Red to Yellow)**
    - **Results**: There was a significant increase in the score for this element that resulted in a change in color from red to yellow. The increase in score is largely due to using epidemiologic and programmatic data to ensure effective planning and management of HIV services at both the national and subnational levels and that high HIV burden populations have access to provider services.
    - **Discussion of Results**: The government facilitates planning and management of HIV services, access to and linkages between facility- and community-based HIV services. However, there are no specific services for KPs. KP's remain a relatively new target population for GRA (included in concept note to GFATM). Outreach to KPs is done through NGOs with support of external donors. Initiation of Test and Start in Luanda Province in 2018 may continue to move this from yellow to green by simplifying protocols, increasing job aids and, thus, positively impacting service delivery by making oversight and service delivery at the facilities much simpler.

- **Commodity Security and Supply Chain (increased from 2.93, Red to 5.99 Yellow)**
    - **Results**: There was a significant increase in the score for this element that resulted in a change in color from red to yellow. The change in score was due to several reasons that include; a percentage increase in the domestic resources allocated for ARVs, condom procurement and supply chain planning and to significant improvements in data-driven, HIV commodity quantification and timely visibility of ARV stock on hand at the facility. Facilities are stocked according to a plan and supply chain data are maintained within the Ministry and not solely by donor projects.
    - **Discussion of Results:** Stock outs of HIV testing supplies existed in 2016 and 2017 and are anticipated in 2018. In Luanda, there are insufficiencies with commodities at both the pharmacy and laboratory levels due to poor planning and a distribution plan that is not always based on principals of supply and demand or need at the facility. However, due to significant improvements to HIV commodity quantification, which is forecasted every quarter and includes a data-based distribution plan, we anticipate this section to continue on the trajectory towards green. The group making commodity supply decisions has timely visibility into stock on hand.

- **Quality Management (increased from 2.95, Red to 4.52 Yellow)**
    - **Results:** There was a significant increase in the score for quality management that resulted in a change from red to yellow. The change in score was due to several reasons including having documentation of QI activities and data to document National HIV Program improvement in QI activities. QI in-service training has resulted in improved health worker capacity, and improved QM supervision and coordination.
    - **Discussion of Results:** In 2016 PEPFAR pivoted from a national geographic scope to provision of quality, daily mentorship at nine key facilities in Luanda with a focus on data collection and use for HIV service delivery improvement. Although the country lacks 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, activities written in the INLS' Plano de Accao 2017 and Nota Conceptual HIV, 2016-2018, funded by external partners, highlight continuous quality improvement in HIV care and services at the national, sub national and site level. With the uptake of a new DHIS2 platform, improved data collection tools, simplified SOPs and job aids and a continuous quality improvement approach now being used, this section should continue toward sustainability.

- **Laboratory (increased from 2.92, Red to 4.75 Yellow)**
  - **Results:** There was a significant increase in the score for laboratory services that resulted in a change from red to yellow. The change in score is due to the development and approval of a national laboratory strategic plan and to the fact that nearly all lab services are financed by domestic resources.
  - **Discussion of Results:** There is a need for more qualified laboratory personnel (human resources [HR]) in the public sector, adequate program prioritization and realistic reagent and consumable forecast, in order to sustain key laboratory functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression. The areas on laboratory workforce capacity and viral load infrastructure were rated at "0" both in 2016 and in 2018 and must be improved in order to further improve sustainability of laboratory services. Furthermore, Angola lacks sufficient infrastructure to test for viral load to reach sustained epidemic control. Although, the Ministry is piloting viral load systems in Luanda, it is a slow and expensive process.

Strategic Investments, Efficiency, and Sustainable Financing

- **Domestic Resource Mobilization (decreased from 5.83 to 4.05 Yellow)**
  - **Results:** There was a slight decrease in the score for domestic resource mobilization. This is due to the fact that the percentage of goals and targets funded in Angola's national HIV budget decreased and that information on budget execution is not available.
  - **Discussion of Results:** Angola's national HIV budget is available publicly through the Ministry of Finance website. However, tracking specific line items is not possible due to the fact that the entire budget is under one unique line item that captures all planned funding. It is estimated that the government covers approximately 75% of the costs of the health system that includes the response to HIV/AIDS but the investment is not enough to meet the goals and targets of the HIV Program and has been decreasing over the past 2 years. The devaluation of the national currency and inflation in the last years also compromises the real value of the percentage funded by the state. The AIDS institute budgets for its HIV/AIDS response and makes adjustments on resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control on a yearly basis. The AIDS institute estimates that less than 50% of the planned national health funding is executed on; obtaining accurate data, however, is challenging as the government does not make detailed spending data available to the public. Significant work needs to be done in the area of budget execution in order to make this section sustainable.

- **Technical Allocative Efficiencies (increased from 6.45 to 6.93 Yellow)**

- **Results:** There was a slight increase in the score for this element which is due to the fact that there is an increase in the number of procedures or policies to assure quality of service delivery data.
- **Discussion of Results:** New/multiple data points have become available to the government (DHS+, PEPFAR, spectrum) and geographic priorities are well identified although these are not necessarily reflected in the budget. The Ministry of Finance has the national budgets available going back approximately ten years but, execution data is only at a very general, high level. Of note, however, is the INLS' use of UN global pricing to procure HIV commodities, significantly lowering procurement costs and bringing Angola in line with international benchmark pricing.

Strategic Information

- **Epidemiological and Health Data (decreased from 6.49 to 4.68 Yellow):**
  - **Results:** There was a significant decrease in the score for epidemiological and health data. The change in score is mainly due to the fact that the National AIDS Program no longer conducts ANC surveys. The surveys provided estimates for incidence data.
  - **Discussion of Results:** Nearly all general population surveillance studies and key populations (KPs) studies are funded by the donor community. Comprehensive HIV prevalence data was collected for the first time through the 2015/2016 DHS+. The GRA is actively leading the way for the next DHS+ to be carried out in 2020. Overall, there is a general need to improve data collection, analysis and availability in order to reach sustainability.

- **Financial/Expenditure Data (decreased from 2.50, Red to 1.67 Red)**
  - **Results:** There was a decrease in the score for the area of financial/expenditure data.
  - **Discussion of Results:** The SID question may have been understood differently in 2016. Although there is a standardized tool to collect expenditure data and software that tracks expenditure at the national level, tracking of specific HIV expenditures is not done; general expenditure data is available publically. Lack of fiscal transparency regarding specific expenditure is a significant issue in all sectors and Angola has committed to address this issue.

- **Performance Data (decrease from 6.94 to 6.48 Yellow)**
  - **Results:** There was a slight decrease in the score for this element due to the fact that the National AIDS Program no longer has national data available to report on orphans and vulnerable children, priority populations or AIDS- related mortality. Also, the host country government does not routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates) by population, program and geographic area.
  - **Discussion of Results:** Service delivery data is not collected for Key population (Men who have Sex with Men, Female Sex Workers, Trans Gender). All facilities are supposed to report service delivery data; however, it is only disaggregated by age and sex. In general, reporting is not timely and it is incomplete. Not all community sites report service delivery data. There is an ongoing effort to improve reporting through improved data collection tools, simplified SOPs and job aids and adoption of a health information system (DHIS2 platform) to improve the timeliness and accuracy of data.

Sustainability Analysis for Epidemic Control: Angola

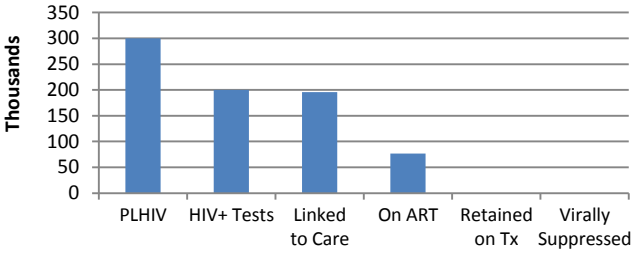
Epidemic Type: Generalized
Income Level: Lower middle income
PEPFAR Categorization: Targeted Assistance (Co-finance)
PEPFAR COP 17 Planning Level: $17,700,000

SUSTAINABILITY DOMAINS and ELEMENTS

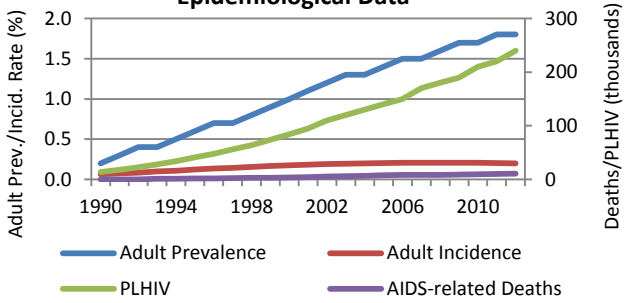
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	10.00	8.90		
2. Policies and Governance	7.82	7.40		
3. Civil Society Engagement	6.43	3.92		
4. Private Sector Engagement	1.60	2.86		
5. Public Access to Information	7.00	6.00		
National Health System and Service Delivery				
6. Service Delivery	3.24	4.54		
7. Human Resources for Health	5.25	5.19		
8. Commodity Security and Supply Chain	2.93	5.99		
9. Quality Management	2.95	4.52		
10. Laboratory	2.92	4.75		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.83	4.05		
12. Technical and Allocative Efficiencies	6.45	6.93		
Strategic Information				
13. Epidemiological and Health Data	6.49	4.52		
14. Financial/Expenditure Data	2.50	1.67		
15. Performance Data	6.94	6.21		

CONTEXTUAL DATA

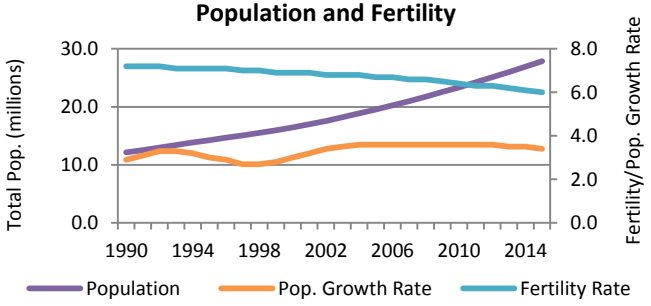
National Clinical Cascade



Epidemiological Data

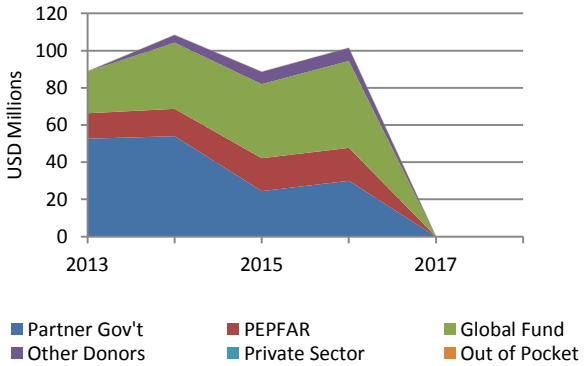


Population and Fertility

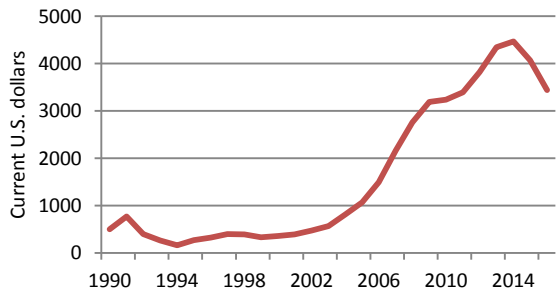


CONTEXTUAL DATA

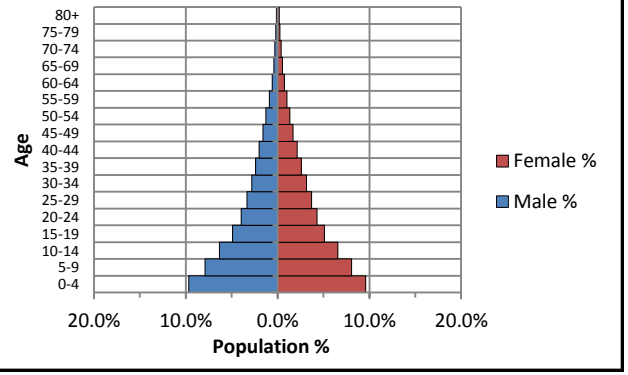
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2017)



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, create space for and promote participation of the private sector, 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 has measurable targets. ☑ 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 ☑ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.07	Revise the 5th National Strategic Plan (PEN: 2014-2018)	Male circumcision as prevention intervention is not applicable in the case of Angola. According to the IMMS 2016, 96% of men are circuncised. Sustanability activities are mirrored in the national strategy.
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	PEN-ITS	

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented 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 (including health care providers and/or other private sector partners) ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.83	Governance manual of MCN	The National Commission for the fight against AIDS and large endemics, implanted by a presidential decree was established in 2003; met twice from 2003 to 2017. It needs to be more functional. The country leads the mechanism for coordinating the grants of FG. MCN meetings need to be more frequent. At the level of the INLS, there is a national group of monitoring and evaluation that meets quarterly.
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 either checkbox under option B)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☑ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☐ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	Plano de Aceleração da resposta ao VIH/sida	Sub-national goals exist but need to be updated and evaluated |
		Planning and Coordination Score: 8.90		

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 WHO guidelines for initiation of ART, i.e. Test and START for all populations?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 1.11	National Protocol	Test and treat in relation to to pregnant women and breastfeeding, Option B is from 2012. The test and treat will be deployed in a phased manner from Luanda in 2018.

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? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	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 ☐ Policies that permit HIV self-testing ☑ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☐ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.65	Law 8/04 mentions the free treatment of HIV for PLHIV. Despacho ministerial 11/8 de 2011 (mudança de tarefa médicos / enfermeiros) Normas de TARV / Protocolo de tratamento (pacientes estavéis)	The National Council of Social Action is created by decree. The legal diploma that creates the CNAS in its objective 7 contemplates questions regarding HIV/AIDS. Law 8/04 is the legislation on HIV/AIDS, with generic clauses, not specific to private groups such as children.

2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☐ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes ☐ Govern the use of patient-level data, including protection	2.3 Score: 0.56	This issue aligns with the ' National Policy and commitments tool (NCPI, 2015). If your country has completed the new NCPI, you can use it as a data source to answer this question. Law 8/04 Codigo Penal Codigo da Familia	The Law 8/04 protects in a generic way the PLHIV, without discriminating by categories. The law is not yet regulated. An assessment of the legal environment of Angola in relation to the needs of the key populations in terms of sexual health and reproduce was started in 2017, with the support of the UNDP.
2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☐ Constitutional prohibition of discrimination based on gender diversity ☐ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☐ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☐ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☐ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.4 Score: 0.00	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.	Anti-homosexuality law dating to colonial times exists, but is not enforced.

	People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☐ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☑ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☑ Programs to address workplace violence ☐ Interventions to address police abuse ☐ Interventions to address torture and ill treatment in prisons ☐ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.5 Score: 0.78	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.	

2.6 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?	**For each question, select the most appropriate option:** Are transgender people criminalized and/or prosecuted in the country? ☐ Both criminalized and prosecuted ☐ Criminalized ☐ Prosecuted ☐ Neither criminalized nor prosecuted Is cross-dressing criminalized in the country? ☐ Yes ☐ Yes, only in parts of the country ☐ Yes, only under certain circumstances ☐ No Is sex work criminalized in your country? ☐ Selling and buying sexual services is criminalized ☐ Selling sexual services is criminalized ☐ Buying sexual services is criminalized ☐ Partial criminalization of sex work ☐ Other punitive regulation of sex work ☐ Sex work is not subject to punitive regulations or is not criminalized. ☐ Issue is determined/differs at subnational level	2.6 Score: 0.97	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.	Anti-homosexuality law dating to colonial times exists, but is not enforced. Even tough there are no law prohibiting sex work, it is common to police to arrest sex workers and detain them.

Does the country have laws criminalizing same-sex sexual acts?

- ☐ Yes, death penalty
- ☐ Yes, imprisonment (14 years - life)
- ☐ Yes, imprisonment (up to 14 years)
- ☐ No penalty specified
- ☐ No specific legislation
- ☐ Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- ☐ Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- ☐ Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- ☐ Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- ☑ No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- ☑ Yes
- ☐ No, but prosecutions exist based on general criminal laws
- ☐ No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- ☐ Yes
- ☑ No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☐ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☑ No			
2.7 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	2.7 Score: 1.11	Projetcts funded by donors (Global Fund, PEPFAR, PNUD) Lei 8/04; Documentos de ANASO.	
2.8 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.	2.8 Score: 1.11		
2.9 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.	2.9 Score: 1.11		
	Policies and Governance Score:	**7.40**		

3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ○ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 0.83		Civil society occupies strategic positions such as Vice president of the MCN; Coordinator of the MCN Strategic Supervisory Committee. the limited resources available does not allow civil society to have an effective supervisory role.
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 ☐ Service delivery	3.2 Score: 1.25		

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☐ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.00		
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 (not including Global Fund grants through government Principal Recipients). ○ 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 through government Principal Recipients).	3.4 Score: 0.83		
3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	◉ A. There is no law, policy, ore rgulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to ○ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply: ☐ Competition is open and transparent (notices of opportunities are made public) ☐ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 0.00		
		Civil Society Engagement Score:	**3.92**	

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 the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply): ☑ Corporations ☐ Employers ☐ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☑ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☐ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 0.83		The private sector is part of the MCN. One of the three Vice presidents of CCM represents the private sector. The private Sector is part of the CCM Executive Committee (represented by Chevron).).

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☐ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☐ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.			
4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?	Check all that apply: ☐ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). ☑ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). ☐ The host country government has standards for reporting and sharing data across public and private sectors. ☐ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). ☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 0.50		

4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☐ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☐ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☐ There are open competitions for private health care providers to compete for government service contracts ☐ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming ☐ The government effectively regulates the flow of subsidized commodities into the private sector.	4.3 Score: 1.53		

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	◉ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ○ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☐ Market opportunities that align with and support the national HIV/AIDS response ☐ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)	4.4 Score:	0.00		
		Private Sector Engagement Score:	**2.86**		

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 and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months. ◉ C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.	5.1 Score: 2.00		
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not track HIV/AIDS expenditures. ◉ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. ○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 0.00	Tribunal de contas	
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .	5.3 Score: 1.00		

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. The 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 providing scientifically accurate education to the public about HIV/AIDS?	○ 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: 1.00		
		Public Access to Information Score: 6.00		

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	Distribution plan for health unites. Site visit reports from INLS and Municipal reports	1. The testing units for treatment are integrated into the health units. Demand is greater than the offer. There are limited human resources in relation to the population density. 2. There are advanced teams of field workers and community health teams for smsall health stations. 3. There is no evidence
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS 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/AIDS 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: 0.56	PNDL, Manuais INLS	After the training participants received certificates of recognition.
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 (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 ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 0.83	PNDL, INLS	

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.74	INLS reports and MoH reports	
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 (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. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.00	INLS reports and MoH reports	
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 without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	INLS reports and MoH reports	
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	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 ☐ 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.	6.7 Score: 0.74	INLS,MINSA,ANASO	Policy of test and start initiated in Lujanda in a phased based approach based on national policies 2. SIS and DHS2. 3. The health needs of the population. 5. The plans are made but assessment of the services done are limited.

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☐ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score:	0.56	GABINETES PROVINCIAIS DE SAUDE, INLS	The budget depends on the municipal administrations and the budgets do not correspond to the needs of the population. 5. Ambiguous question, cannot evaluate the efficiency of a relationship without evidence.
		Service Delivery Score	**4.54**		

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 clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.00		Insufficient human resources
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: ☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☐ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.37		
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	◉ 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	7.3 Score: 0.00		

7.4 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)? (if exact or approximate percentage known, please note in Comments column)	○ 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	7.4 Score: 3.33		
7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	○ 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 PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.97	INLS	
7.6 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)	7.6 Score: 0.14	Annual reports INLS	

7.7 HR Data Collection and Use: Does the country systematically collect and use 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)	7.7 Score: 0.37		Does not reflect local reality
	Human Resources for Health Score	**5.19**		

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: 0.63	Government Overall Budget document (OGE)	The government has the responsibility to bear 60%
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: 0.63	Government Overall Budget document (OGE)	
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: 0.63	Government Overall Budget document (OGE)	

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: 0.40	INLS	There is a plan but it is not operationalized.
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: 0.63	MOH	

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	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: 1.98		
8.7 Assessment: Was an overall score of above 80% achieved on the 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 within the last three years. ◉ B. A comprehensive assessment has been done within the last three years 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 within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 1.11		
	Commodity Security and Supply Chain Score:	**5.99**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.67	MINSA/INSP	There exists a comission created to implement SQI
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 utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	INSP - PLANO ESTRATÉGICO DOS LABORATÓRIOS DE SAÚDE (PENLab) 2014 - 2017	
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 through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 0.67		

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		
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 include health services consumers ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 0.86	INLS - Plano de Acção 2017; Nota Conceptual VIH, 2016-2018;	
		Quality Management Score:	**4.52**	

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 ○ F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 1.00	MINSA	There is a strategic plan for laboratories approved but not budgeted.
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).	10.2 Score: 0.42	PENLAB 2014 - 2017	
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 by rapid testing and point-of-care testing ☐ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☐ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☐ TB diagnosis	10.3 Score: 0.00	MOH	There is not enough qualified laboratory technicians to respond on a national level.

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 HIV viral load instruments ☐ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock outs ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.00		
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.	10.5 Score: 3.33	MINSA/GEPE	
		Laboratory Score: **4.75**		

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.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	__%			
2. What is the per capita health expenditure all sources?	$__			
3. What is the total health care expenditure all sources as a percent of GDP?	__%			
4. What percent of total health expenditures is financed by external resources?	__%			
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	__%			

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 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☐ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply): ☐ ARVs are covered ☐ Non-ARV care and treatment is covered ☐ Prevention services are covered ☐ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☐ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☐ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☐ ARVs are covered. ☐ Non-ARV care and treatment services are covered. ☐ Prevention services are covered. ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.00		

11.2 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	11.2 Score: 0.71	Relatório anual do INLS.	There is funding for HIV/AIDS Mainly funded by the government, PEPFAR and Global fund. Not all ministries have a specific budget for HIV/AIDS. The Government budget is not aligned with the goals of the PEN. There was no consensus on whether the national budget reflects all sources of funding.
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☑ The goals/targets are measurable. ☑ Budget items/programs are linked to goals/targets. ☑ The goals/targets are routinely monitored during budget execution. ☐ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.83	Plano Anual de Actividades do INLS	There are annual objectives and goals of HIV/AIDS articulated in the latest national budget, and some were alocated (10-50%). There is need to confirm other sources of financing and performance evaluation from partners and verify existing reports.
11.4 HIV/AIDS 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. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ○ D. 70-89% of budget executed ○ E. 90% or greater of budget executed	11.4 Score: 0.00		There are no benchmarking reports of perofrmance for the public , thus we have no information about the average rate of implementation of the budgeted resources. However, according to INLS, the execution rates rarely exceed 50%.

11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?	◉ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ○ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.00		
11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (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: 2.50		It is estimated that the government covers approximately 75% of the costs of the health system that includes the response to HIV/AIDS. But the investment is not enough to fulfil the goals. Also consider the devaluation of Kwanza and inflation in the last years that compromises the real value of the percentage funded by the state.
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	◉ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ○ D. 70-89% of budget executed. ○ E. 90% or greater of budget executed.	11.7 Score: 0.00		
11.8 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 is seldom used. ○ C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, ○ 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.	11.8 Score: 0.00		
	Domestic Resource Mobilization Score:	**4.05**		

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? If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development) (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: 2.00	OGE	Although the government uses the Spectrum to inform targets and investments, there are constraints on the quality of the data. There is a need for more granular data. INLS is carrying out a patient audit to better inform the definition of targets (people in treatment) and necessary budgeting.
12.2 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.	12.2 Score: 0.00	DHIS2, MAT/FAS, etc.	Although geographic priorities are well identified by INLS, these are not necessarily reflected in the budget. Note that the government budget has transferred the scope of Municaplization without discriminating the amount to be allocated for specific programmes.

12.3 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 have/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 ☑ Laboratory services ☑ ART ☑ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions	12.3 Score: 1.60	Financial Reports	The government ully uses recent expenses for planning. Due to the context of financial crisis since 2015, the government has also sought alternatives marketand analyses to obtain estimated and unitarian costs in the purchase of inputs with less cost.
12.4 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)	12.4 Score: 1.33	Plano Estratégico & Actualização das Normas.	The relapsing of indirect costs and the quality of purchases are the result of theet. No. 5 refers to partnerships with the private sector (Multiprofile, CML, FAA). Improvement in HIV and SMI integration is not yet visible.

12.5 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.	12.5 Score:	2.00	Reports form the Finance Minstry	The INLS has acquired the ARVs through the UN for the purpose of acquiring lower market prices according to the agreement signed with the Angolan Government.
	Technical and Allocative Efficiencies Score:		**6.93**		

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	Estudo Seroprevalencia em mulheres Grávidas 2013. Estudo de Seroprevalência em MTS 2015. IIMS 2015/16	The 1st National Survey was the DHS 2015/16 of INE,with support from ICS/Macro, Unicef
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	IBBS (SADC-TS) 2016. IBBS Linkage 2016/17 (TS,HSH,TG) IBBS Militares 2015/16	
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.42		

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	Estudo Seroprevalencia em MTS, HSH (Estudo SADC, CDC)	
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.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☐ Age (at coarse disaggregates) ☐ Age (at fine disaggregates) ☐ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non- ☐ Sub-national units	13.5 Score: 0.48	Seroprevalence studies in SW, MSM;Pregnant women IIMS 2015/16	Prevalence data from IIMS 2015/16 and Spectrum estimates Incidence-there are no studies as a basis, it is calculated by Spectrum estimation

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, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV (select ONE of the following): ☑ Less than 25% ☐ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.36	Data from the Biol. Molecular lab.	About 20% of pacients in ART have done an exam of VL
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.) Please note most recent survey dates in comments section.	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) 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 (TG) ☐ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☐ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	13.7 Score: 0.48	Estudo seroprevalência em MTS, HSH;Estudo Seroprevalência em Gravidas 2013 IIMS 2015/16	

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: 0.48	There is a cronogram for Seroprevalence studies since 2004, and which are carried out each year; the last study in pregnant women was done in 2013; in the last few years Serocomportamentais studies have been done in the key populations (MTS and HSH).	In order to carry out population surveys, it is necessary to have approval from the ethics committee, INE and MOH.
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 all protocols.	13.9 Score: 0.48	There are regulatory and methodological documents for the production of official statistics and quality control of the data produced; There is also the ethics Committee for Revision of the study protocols (MTS).	The GEPE of MINSA is the organ that represents INE to enforce health standards in the study protocols. There is a national decree that directs INE as responsible for controlling investigations. Procedures and protocols are not shared.
	Epidemiological and Health Data Score:	**4.52**		

14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ◉ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ○ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 0.83	There was the first survey NHA done by GEPE in 2017 supported by (technical assistence) WHO	There has been no NASA done in the country specific to HIV
14.2 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	14.2 Score: 0.83		INLS and partners (and military) it is possible to separate the expenses according to programmatic area, but not at the level of the other Ministries and provinces
14.3 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	14.3 Score: 0.00		Ask INE about specific reports of HIV/AIDS (or other health) expenditures
		Financial/Expenditure Data Score: 1.67		

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	Electronic HIV System	In some provinces there are still old systems that are not functional
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	Relatórios do Programa e Relatórios Financeiros	

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, TG, prisoners) ☐ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☐ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 0.78	Trimester report from routine data	Study on multiple indicators included male circuncision in 2011

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		Problems with the readiness and complition of reports sent that create logistical problems. Decision-making at provincial level should be improved
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 (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), 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: 0.33	Mapa sanitário do MINSA	Not updated
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☐ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☐ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.27	Anuário Estatístico de Angola (GEPE/MINSA) Decreto Lei /13. Actas, Relatórios de Runiões e Visitas de Supervisões	There is no protocol for HIV, but there exists an integrated package for all diseases. The yearly statistics report includes several diseases. There are acceleration meetings; TWG neetings of technical in the provinces to supervise the quality of data produced. There is a GTNMeA with the participation of several partners that gathers quarterly, but only at the central level.
		Performance Data Score: **6.21**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D