

2017 Sustainability Index and Dashboard Summary: Ethiopia

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

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

Ethiopia Country Overview: The HIV/AIDS situation in Ethiopia continues to be characterized by a low intensity mixed epidemic. According to the latest Ethiopian National AIDS Spending Assessment (NASA) report for 2011/12, total annual HIV/AIDS categorical spending was \$405 million, of which 86% (\$350 million) came from external donors, 13% came from public revenue (\$55 million) and less than one percent (\$680,000) came from the private sector. The Government of Ethiopia (GoE) maintains the AIDS Mainstreaming Fund to which every Ministry may voluntarily contribute 2% of their annual budget. Ethiopia's policies and programming related to HIV/AIDS are in response to its Investment Case Framework, recently updated for 2015 to 2020. In general, policies, mandates, and mechanisms exist to adequately support the HIV/AIDS response. However, the implementation of those policies and adherence to those mandates vary. With a trajectory of decreased PEPFAR and Global Fund funding, and with Ethiopia's economy showing consistent strong growth, it is increasingly critical for the GoE (at all levels from federal to woreda) to focus on (1) ensuring that mechanisms are operational and responsive in order to increase efficiencies, (2) strengthening planning and coordination at the national and regional levels in order to improve health system and service delivery, and (3) commitment to increasing its domestic contribution toward HIV categorical funding. It is not expected that all external funding will be replaced by domestic funding in the near or medium term. However, it is critical for the GoE to continue implementing and exploring additional options for domestic resource mobilization.

SID Process: PEPFAR Ethiopia co-convened a SID workshop with UNAIDS on October 12, 2017. Participants included representatives from the Ministry of Health (national and regional), Ministry of Finance, Ethiopian Public Health Institute, Civil Society Organizations, WHO, UNHCR, UNFPA, private sector, faith-based organizations, and PEPFAR implementing partners and USG agencies. The morning began with opening remarks from UNAIDS, followed by an overview of PEPFAR SID3.0 and the process. The PEPFAR Team used this opportunity to present PEPFAR's Quarter 3 performance results. Lastly, participants were divided into 4 groups to discuss and complete the SID domains. Participants reconvened for one hour during which domain facilitators presented outcomes from the group discussions.

Sustainability Strengths:

- **Private Sector Engagement (8.39, light green):** Private sector engagement has shown significant improvement, a sharp increase from 4.44 (SID 2.0). This increase is partially attributed to active engagement of the private sector facilities in sector plans; specifically planning with FMOH and the Pharmaceuticals Fund and Supply Agency (PFSA) to ensure that private facilities are included in the quantification and distribution process of HIV commodities especially test kits.
- **Laboratory (5.42, yellow):** The difference from SID 2.0 is insignificant, however GoE has focused on implementing regulations and recruiting skilled laboratory personnel. Ethiopia is aggressively implementing its viral load scale-up plan which led to an increase in VL testing from 5% to 54% within one year.

Sustainability Vulnerabilities: GoE is committed to increasing efforts to reach sustained epidemic control in spite of declines in donor funding. Priorities for consideration in COP18:

- **Public Access to Information (6.0, yellow) and Epidemiological and Health Data (4.90, yellow):** This is a decrease from 7.0 (SID 2.0) and increase from only 4.48 (SID 2.0) respectively. Although surveillance, expenditure, and performance reports are shared, dissemination is not timely. Program and funding decisions are therefore based on old data, which creates a huge challenge in tailoring interventions to the location and populations with the highest disease burden.
- **Quality Management (6.67, yellow):** Despite a low score, this score improved from 1.62 (SID 2.0). GoE has established an HIV Quality Improvement Framework which includes monitoring tools specific to HIV service delivery.

Additional Observations:

- PEPFAR-E is well positioned to improve service delivery by supporting the GoE to target resources that will increase case detection and improve linkage to care and treatment services.
- Usage of local and national systems data has shown slight improvement, however, there is still a gap in accessing granular and disaggregated data at the lowest SNU level. PEPFAR-E will continue providing technical assistance to increase data availability, quality and use at all levels.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Ethiopia, please contact the PEPFAR-E Coordinator at NgongL@state.gov.

Sustainability Analysis for Epidemic Control: Ethiopia

Epidemic Type: Generalized

Income Level: Low income

PEPFAR Categorization: Long-term Strategy

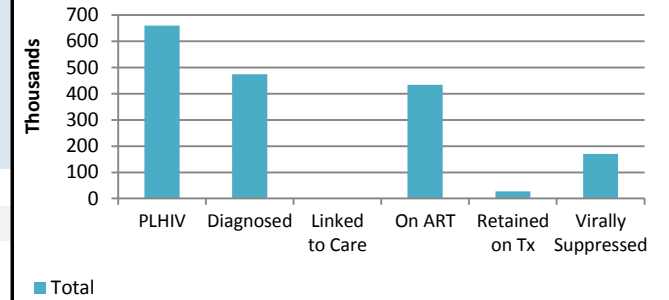
PEPFAR COP 17 Planning Level: \$ 157,328,750

SUSTAINABILITY DOMAINS AND ELEMENTS

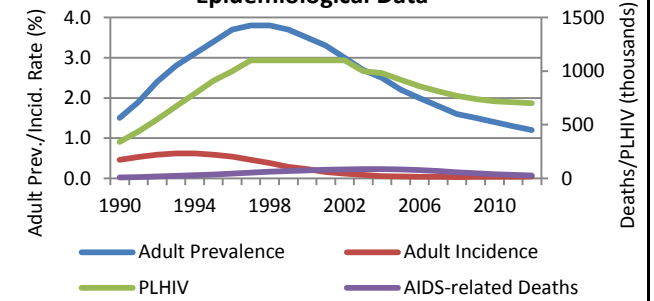
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.87	9.29		
2. Policies and Governance	6.58	8.08		
3. Civil Society Engagement	4.00	5.17		
4. Private Sector Engagement	4.44	8.39		
5. Public Access to Information	7.00	6.00		
National Health System and Service Delivery				
6. Service Delivery	4.40	5.32		
7. Human Resources for Health	6.00	6.06		
8. Commodity Security and Supply Chain	7.08	7.08		
9. Quality Management	1.62	6.67		
10. Laboratory	5.51	5.42		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	2.78	6.94		
12. Technical and Allocative Efficiencies	1.11	5.56		
Strategic Information				
13. Epidemiological and Health Data	4.48	4.90		
14. Financial/Expenditure Data	3.75	6.67		
15. Performance Data	4.74	5.97		

CONTEXTUAL DATA

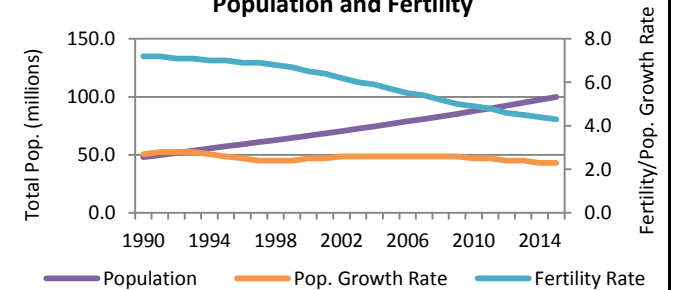
National Clinical Cascade



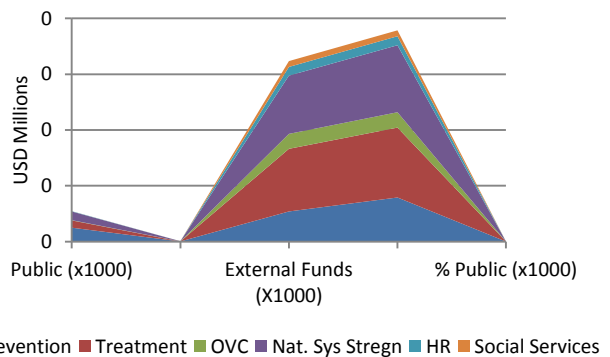
Epidemiological Data



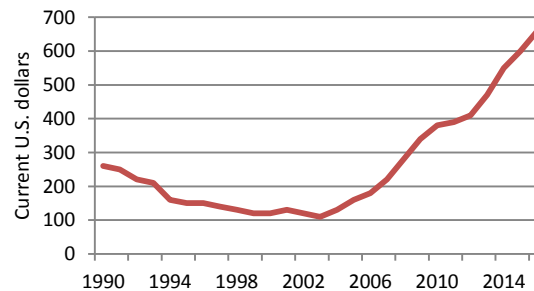
Population and Fertility



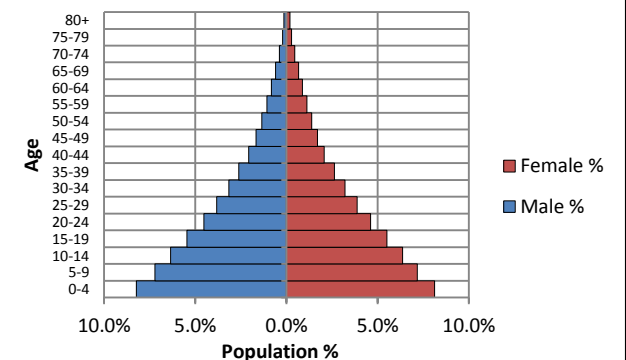
Financing the HIV Response



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.

		Data Source	Notes/Comments
<p>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.</p>			
<p>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. There is a multiyear national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> It has measurable targets.</p> <p><input checked="" type="checkbox"/> It is updated at least every five years</p> <p>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)</p> <p><input checked="" type="checkbox"/> Strategy includes explicit plans and activities to address the needs of key populations.</p> <p><input checked="" type="checkbox"/> Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children</p> <p><input type="checkbox"/> Strategy (or separate document) includes considerations and activities related to sustainability</p>	<p>1.1 Score: 2.29</p>	<p>2015-2020 Ethiopia HIV /AIDS prevention care and treatment Strategic plan</p> <p>KPs are addressed in the investment case however based on the global definition of KPs, not all addressed</p> <p>Impact of OVCs is very well elaborated in the investment case, however no clear division of labor or ownership defined</p>
<p>1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?</p>	<p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. The national strategy is developed with participation from the following stakeholders (check all that apply):</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p> <p><input checked="" type="checkbox"/> Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy</p> <p><input checked="" type="checkbox"/> Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)</p> <p><input checked="" type="checkbox"/> External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy</p>	<p>1.2 Score: 2.50</p>	<p>Private sector Partnership in Health Strategic Framework 2014, CCM meeting</p> <p>Private sector is involved however the CSR component is weak and is not implemented. No Specific data source to show CSO engagement in such discussion.</p>

<p>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?</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.</p> <p><input checked="" type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of:</p> <p><input checked="" type="checkbox"/> civil society organizations</p> <p><input checked="" type="checkbox"/> private sector (including health care providers and/or other private sector partners)</p> <p><input checked="" type="checkbox"/> donors</p> <p><input type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations.</p> <p><input checked="" type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.</p>	<p>1.3 Score: 2.00</p>	<p>* 2015-2020 Ethiopia HIV /AIDS prevention care and treatment Strategic plan</p> <p>* Proclamation for establishment of HAPCO</p> <p>* Annual multi-sectoral response plan</p> <p>* Reports from Joint Review Meetings</p> <p>* National guidelines for economic strengthening</p> <p>* Global Fund tools for planning</p>	
<p>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)</p>	<p><input type="radio"/> A. There is no formal link between the national plan and sub-national service delivery.</p> <p><input checked="" type="radio"/> B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.)</p> <p><input checked="" type="checkbox"/> Sub-national units have performance targets that contribute to aggregate national goals or targets.</p> <p><input type="checkbox"/> The central government is responsible for service delivery at the sub-national level.</p>	<p>1.4 Score: 2.50</p>	<p>Woreda Based Health Sector Annual Plan and the National Health Sector Transformation Plan (HSTP) IV 2010/11 - 2014/15 FMOH</p>	
<p>Planning and Coordination Score:</p>		<p>9.29</p>		

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?	<p>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:</p> <p>A. Adults (>19 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>B. Pregnant and Breastfeeding Mothers</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>C. Adolescents (10-19 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>D. Children (<10 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>2.1 Score: 1.11</p>	<p>*Supplemental guidelines for Test and Start/Treat</p> <p>*Revised national HIV prevention, care and treatment guidelines</p>

<p>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?</p> <p>Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART <input checked="" type="checkbox"/> A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) <input checked="" type="checkbox"/> Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready <input type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS <input type="checkbox"/> Policies that permit HIV self-testing <input type="checkbox"/> Policies that permit pre-exposure prophylaxis (PrEP) <input checked="" type="checkbox"/> Policies that permit post-exposure prophylaxis (PEP) <input type="checkbox"/> Policies that allow HIV testing without parental consent for adolescents, starting at age 15 <input checked="" type="checkbox"/> Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent 	<p>2.2 Score: 0.74</p>	<p>1998 National AIDS Policy</p> <ul style="list-style-type: none"> * Taskshifting guidelines * The national HIV prevention and treatment guidelines 	<p>Guidelines for the Differentiated Service Delivery Models is currently under finalization</p> <ul style="list-style-type: none"> *PrEP included in the new guidelines for Prevention, Treatment and Care *Ethiopia endorsed the Global HIV Prevention road map which includes PrEP for KPs
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<p>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?</p>	<p>The country has policies in place that (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Govern the collection of patient-level data for public health purposes, including surveillance <input checked="" type="checkbox"/> Govern the collection and use of unique identifiers such as national ID for health records <input checked="" type="checkbox"/> Govern the privacy and confidentiality of health outcomes <input checked="" type="checkbox"/> Govern the use of patient-level data, including protection 	<p>2.3 Score: 1.11</p>	<p>National Health Information System (HMIS) Data base</p>	<p>We could only confirm availability of patient level data on HIV/AIDS but no data for other health</p>
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<p>2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?</p>	<p>Check all that apply:</p> <p>Transgender people (TG):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on gender diversity <input type="checkbox"/> Prohibitions of discrimination in employment based on gender diversity <input type="checkbox"/> A third gender is legally recognized <input type="checkbox"/> Other non-discrimination provisions specifying gender diversity (note in comments) <p>Men who have sex with men (MSM):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on sexual orientation <input type="checkbox"/> Hate crimes based on sexual orientation are considered an aggravating circumstance <input type="checkbox"/> Incitement to hatred based on sexual orientation prohibited <input type="checkbox"/> Prohibition of discrimination in employment based on sexual orientation <input type="checkbox"/> Other non-discrimination provisions specifying sexual orientation <p>Female sex workers (FSW):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constitutional prohibition of discrimination based on occupation <input type="checkbox"/> Sex work is recognized as work <input type="checkbox"/> Other non-discrimination protections specifying sex work (note in comments) <p>People who inject drugs (PWID):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) <input type="checkbox"/> Explicit supportive reference to harm reduction in national policies <input type="checkbox"/> Policies that address the specific needs of women who inject drugs 	<p>2.4 Score: 0.00</p>	<p>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.</p>	
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<p>2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?</p>	<p>The country has the following to protect key populations and people living with HIV (PLHIV) from violence:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> General criminal laws prohibiting violence <input checked="" type="checkbox"/> Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population <input checked="" type="checkbox"/> Programs to address intimate partner violence <input checked="" type="checkbox"/> Programs to address workplace violence <input checked="" type="checkbox"/> Interventions to address police abuse <input type="checkbox"/> Interventions to address torture and ill treatment in prisons <input checked="" type="checkbox"/> A national plan or strategy to address gender-based violence and violence against women that includes HIV <input checked="" type="checkbox"/> Legislation on domestic violence <input checked="" type="checkbox"/> Criminal penalties for domestic violence <input checked="" type="checkbox"/> Criminal penalties for violence against children 	<p>2.5 Score: 1.00</p>	<p>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. National HIV AIDS Policy 1998 and Federal Criminal Code</p>	<p>*Legal provision is in the National HIV policy to protect PLHIV but not Key Population</p>
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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: 0.79

Federal Criminal Code

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

	<p>Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?</p> <p><input type="checkbox"/> Yes, promotion ("propaganda") laws</p> <p><input type="checkbox"/> Yes, morality laws or religious norms that limit LGBTI freedom of expression and association</p> <p><input type="checkbox"/> No</p>			
<p>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?</p>	<p>There are host country government efforts in place as follows (check all that apply):</p> <p><input checked="" type="checkbox"/> To educate PLHIV about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> To educate key populations about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> National law exists regarding health care privacy and confidentiality protections</p> <p><input checked="" type="checkbox"/> Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>2.7 Score: 1.11</p>	Ethiopian HIV/AIDS Policy 1998	
<p>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)?</p>	<p><input type="radio"/> A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.</p> <p><input type="radio"/> B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more.</p> <p><input checked="" type="radio"/> C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.</p>	<p>2.8 Score: 1.11</p>	The Health Development Program (HSDP) 2011-2012 B.7 - MONITORING & AUDIT. SECTION "C"	*These are general audits not exclusive to HIV
<p>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?</p>	<p><input type="radio"/> A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted.</p> <p><input type="radio"/> B. The host country government does respond to audit findings by implementing changes as a result of the audit.</p> <p><input checked="" type="radio"/> 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.</p>	<p>2.9 Score: 1.11</p>	General Federal Audit reports and The Health Development Program (HSDP) 2011-2012 B.7 - MONITORING & AUDIT. SECTION "C"	
Policies and Governance Score:		8.08		

3. Civil Society Engagement				
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?	<input type="radio"/> A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. <input type="radio"/> 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. <input checked="" type="radio"/> C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 1.67	No data source available	* There is no law restricting and there is no law permitting CSOs to access government funding
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: <input type="radio"/> A. There are no formal channels or opportunities. <input type="radio"/> B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. <input checked="" type="radio"/> C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: <input checked="" type="checkbox"/> During strategic and annual planning <input checked="" type="checkbox"/> In joint annual program reviews <input checked="" type="checkbox"/> For policy development <input checked="" type="checkbox"/> As members of technical working groups <input checked="" type="checkbox"/> Involvement on government HIV/AIDS program evaluation teams <input checked="" type="checkbox"/> Involvement in surveys/studies <input checked="" type="checkbox"/> Collecting and reporting on client feedback <input checked="" type="checkbox"/> Service delivery	3.2 Score: 1.67	Opinion from PLHIV Association	Local civil societies mainly engagment in HIV/AIDS and other health issues are part of the HIV/AIDS forum chaired by FMOH/FHAPCO but this is not inclusive of all CSOs in the country.

<p>3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?</p>	<p><input type="radio"/> A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS.</p> <p><input checked="" type="radio"/> B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply):</p> <p><input checked="" type="checkbox"/> In policy design</p> <p><input type="checkbox"/> In programmatic decision making</p> <p><input checked="" type="checkbox"/> In technical decision making</p> <p><input checked="" type="checkbox"/> In service delivery</p> <p><input type="checkbox"/> In HIV/AIDS basket or national health financing decisions</p>	<p>3.3 Score: 1.00</p>	<p>Opinion from PLHIV Association; FHAPCO/FMOH Joint Annual Planning Meetings, GIPA Principles (Greater Involvement of People Living with HIV)</p>	<p>Local civil societies mainly engagement in HIV/AIDS and other health issues are part of the HIV/AIDS forum chaired by FMOH/FHAPCO but this is not inclusive of all CSOs in the country.</p>
<p>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)?</p> <p>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)</p>	<p><input type="radio"/> A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input checked="" type="radio"/> 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).</p> <p><input type="radio"/> 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).</p> <p><input type="radio"/> 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).</p> <p><input type="radio"/> 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).</p>	<p>3.4 Score: 0.83</p>	<p>Opinion from PLHIV Association; Charity and Societies Agency Proclamation No. 621/2009</p>	<p>There is no law restricting for CSOs to access private sector or self generated funds but government funds are not accessed by all CSOs.</p>
<p>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)?</p> <p>Note: This sometimes referred to as "social contracting" or "social procurement."</p>	<p><input checked="" type="radio"/> A. There is no law, policy, or regulation 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</p> <p><input type="radio"/> 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:</p> <p><input type="checkbox"/> Competition is open and transparent (notices of opportunities are made public)</p> <p><input type="checkbox"/> Opportunities for CSO funding are made on an annual basis</p> <p><input type="checkbox"/> Awards are made in a timely manner (within 6-12 months of announcements)</p> <p><input type="checkbox"/> Payments are made to CSOs on time for provision of services</p>	<p>3.5 Score: 0.00</p>	<p>PLHIV Associations opinion; Charity Society Charity and Societies Agency Proclamation No. 621/2009</p>	<p>* There is no law restricting and there is no law permitting CSOs to access government funding. The Charities and Societies guideline states that CSOs can only generate 10% internally but 90% of their funding should be from external donors.</p>
<p>Civil Society Engagement Score: 5.17</p>				

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
<p>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?</p> <p>(If option B is true, check all subsequent boxes that apply.)</p>	<p><input type="radio"/> A. There are no formal channels or opportunities for private sector engagement.</p> <p><input checked="" type="radio"/> B. There are formal channels or opportunities for private sector engagement.</p> <p>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):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Corporations <input checked="" type="checkbox"/> Employers <input checked="" type="checkbox"/> Private training institutions <input checked="" type="checkbox"/> Private health service delivery providers <p>ii. Stakeholders contribute in the following ways (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The private sector contributes technical expertise into HIV program planning <input checked="" type="checkbox"/> Data and strategic input into supply chain management for HIV commodities <input checked="" type="checkbox"/> Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning <input type="checkbox"/> Data on staffing in private health service delivery providers <input type="checkbox"/> Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning <input checked="" type="checkbox"/> For technical advisory on best practices and delivery solutions 	<p>4.1 Score: 1.67</p>	<p>Private Health Sector Partnership Strategic Framework, October 2014</p>	<p>There is reference to public Private partnership.</p>

	<p>iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. <input type="checkbox"/> A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan <input type="checkbox"/> 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. 			
<p>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?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 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). <input type="checkbox"/> 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). <input checked="" type="checkbox"/> The host country government has standards for reporting and sharing data across public and private sectors. <input checked="" type="checkbox"/> 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). <input checked="" type="checkbox"/> There are strong linkage and referral networks between on-site workplace programs and public health care facilities. 	<p>4.2 Score: 2.00</p>	<p>Ethiopian Tax Revenues</p>	<p>There are linkages but not strong</p>

<p>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?</p> <p>Note: Full score possible without checking all boxes.</p>	<p><input type="radio"/> A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.</p> <p><input type="radio"/> B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.</p> <p><input checked="" type="radio"/> C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):</p> <p><input checked="" type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.</p> <p><input checked="" type="checkbox"/> Joint (i.e., public-private) supervision and quality oversight of private facilities.</p> <p><input type="checkbox"/> The government offers tax deductions for private facilities delivering HIV/AIDS services.</p> <p><input type="checkbox"/> The government offers tax deductions for private training institutions.</p> <p><input checked="" type="checkbox"/> The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores</p> <p><input checked="" type="checkbox"/> The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.</p> <p><input type="checkbox"/> HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes</p> <p><input type="checkbox"/> There are open competitions for private health care providers to compete for government service contracts</p> <p><input checked="" type="checkbox"/> 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</p> <p><input checked="" type="checkbox"/> The government effectively regulates the flow of subsidized commodities into the private sector.</p>	<p>4.3 Score: 2.22</p>	<p>Private Health Sector Partnership Strategic Framework, October 2014</p>	<p>Private sector can access ARV and test kits from government</p>
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<p>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?</p>	<p> <input type="radio"/> A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. </p> <p> <input type="radio"/> B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. </p> <p> <input checked="" type="radio"/> C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): </p> <p> <input checked="" type="checkbox"/> Market opportunities that align with and support the national HIV/AIDS response </p> <p> <input checked="" type="checkbox"/> 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) </p> <p>4.4 Score: 2.50</p>	<p>Private Health Sector Partnership Strategic Framework, October 2014</p>	
<p>Private Sector Engagement Score: 8.39</p>			

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
<p>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?</p>	<p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months.</p> <p><input type="radio"/> C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.</p>	<p>5.1 Score: 1.00</p>	<p>Information is shared during annual joint review meetings</p>
<p>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?</p>	<p><input type="radio"/> A. The host country government does not track HIV/AIDS expenditures.</p> <p><input checked="" type="radio"/> 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.</p> <p><input type="radio"/> 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.</p> <p><input type="radio"/> D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.</p>	<p>5.2 Score: 0.00</p>	<p>Ethiopian National AIDS Spending Assesment Report EFY 2013/14</p>
<p>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?</p>	<p><input type="radio"/> 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.</p> <p><input type="radio"/> 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.</p> <p><input checked="" type="radio"/> 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 .</p>	<p>5.3 Score: 2.00</p>	<p>Information is shared during annual joint review meetings</p>

<p>5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?</p>	<p><input type="radio"/> A. The host country government does not make any HIV/AIDS procurements.</p> <p><input type="radio"/> B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.</p> <p><input checked="" type="radio"/> C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.</p> <p><input type="radio"/> D. The host country government makes HIV/AIDS procurements, and both tender and award details available.</p>	<p>5.4 Score: 1.00</p>	<p>Pharmaceuticals Fund and Supply Agency (PFSA)</p>	
<p>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?</p>	<p><input type="radio"/> A. There is no government institution that is responsible for this function and no other groups provide education.</p> <p><input type="radio"/> B. There is no government institution that is responsible for this function but at least one of the following provides education:</p> <p><input type="checkbox"/> Civil society</p> <p><input type="checkbox"/> Media</p> <p><input type="checkbox"/> Private sector</p> <p><input checked="" type="radio"/> C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.</p>	<p>5.5 Score: 2.00</p>	<p>Ethiopian Public Health Institute</p>	
<p>Public Access to Information Score:</p>		<p>6.00</p>		

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
<p>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.)</p>	<p><input checked="" type="checkbox"/> 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)</p> <p><input checked="" type="checkbox"/> Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics)</p> <p><input checked="" type="checkbox"/> There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services</p>	<p>6.1 Score: 1.11</p>	<p>Participants' opinion from program experience</p>
<p>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.)</p>	<p>The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):</p> <p><input checked="" type="checkbox"/> Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services</p> <p><input type="checkbox"/> National guidelines detailing how to operationalize HIV/AIDS services in communities</p> <p><input checked="" type="checkbox"/> Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities</p> <p><input type="checkbox"/> Providing financial support for community-based services</p> <p><input checked="" type="checkbox"/> Providing supply chain support for community-based services</p> <p><input type="checkbox"/> 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)</p>	<p>6.2 Score: 0.56</p>	<p>Participants' opinion from program experience</p> <p>There are gaps in standardization of community based services, some of the guidelines exist but are not operationalized, the Urban Health Extension Workers contribution is not adequate to support HIV (an assessment conducted)</p>
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services</p> <p><input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services</p>	<p>6.3 Score: 0.83</p>	<p>National Health Account 2010/2011</p>

<p>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?</p>	<p><input type="radio"/> A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions.</p> <p><input checked="" type="radio"/> B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance.</p> <p><input type="radio"/> C. Host country institutions deliver HIV/AIDS services with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.</p>	<p>6.4 Score: 0.37</p>	<p>SIMS visit report</p>	
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input checked="" type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.</p>	<p>6.5 Score: 0.42</p>	<p>Federal HAPCO Annual Report</p>	
<p>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?</p>	<p><input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.</p> <p><input checked="" type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.</p> <p><input type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</p>	<p>6.6 Score: 0.37</p>	<p>PEPFAR SIMS visit report</p>	
<p>6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?</p>	<p>National health authorities (check all that apply):</p> <p><input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.</p> <p><input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.</p> <p><input checked="" type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.</p> <p><input type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations.</p> <p><input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services.</p> <p><input checked="" type="checkbox"/> 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.</p>	<p>6.7 Score: 0.93</p>	<p>Participants' opinion from program experience</p>	

<p>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?</p>	<p>Sub-national health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <input checked="" type="checkbox"/> 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. 	<p>6.8 Score: 0.74</p>	<p>Participants' opinion from program experience</p>	
<p>Service Delivery Score</p>		<p>5.32</p>		

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
<p>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?</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers</p> <p><input type="checkbox"/> The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden</p> <p><input type="checkbox"/> The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas</p> <p><input type="checkbox"/> 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</p>	<p>7.1 Score: 0.28</p>	<p>HRH Strategic Plan, 2016-2020</p>	
<p>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?</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> 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).</p> <p><input type="checkbox"/> Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors.</p> <p><input type="checkbox"/> The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.</p>	<p>7.2 Score: 0.37</p>	<p>The current in-service training manuals; HRH Strategic Plan, 2016-2020</p>	
<p>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?</p> <p>Note in comments column which donors have transition plans in place.</p>	<p><input checked="" type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>7.3 Score: 0.00</p>	<p>HRH Strategic Plan, 2016-2020</p>	

<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries</p> <p><input checked="" type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries</p>	<p>7.4 Score: 3.33</p>	<p>Consolidated annual national health plan and Health & Health Related Indicators; National Health Accounts (6), published September 2017</p>	<p>E. Except for health extension workers, other health community workers are supported by donors</p>
<p>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?</p> <p>Note: List applicable cadres in the comments column.</p>	<p><input type="radio"/> 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)</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS content</p> <p><input checked="" type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLHIV</p> <p><input type="checkbox"/> Institutions track student employment after graduation to inform planning</p>	<p>7.5 Score: 0.83</p>	<p>Institutionalization of inservice training directives and implementation guideline (FMOH); HRH Strategic Plan, 2016-2020</p>	
<p>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?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>Check all that apply among A, B, C, D:</p> <p><input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training in the country (check ONE):</p> <p><input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service training</p> <p><input type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training</p> <p><input type="checkbox"/> B. The host country government has a national plan for institutionalizing</p> <p><input checked="" type="checkbox"/> (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS</p> <p><input type="checkbox"/> C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians</p> <p><input type="checkbox"/> 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</p>	<p>7.6 Score: 0.56</p>	<p>HRH Strategic Plan, 2016-2020, HRIS Assessment Framework</p>	<p>HRIS does not support the national community structure other than health extension workers.</p>

<p>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?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management <input type="radio"/> B. There is no HRIS in country, but some data is collected for planning and management <ul style="list-style-type: none"> <input type="checkbox"/> Registration and re-licensure data for key professionals is collected and used for planning and management <input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment) is collected and used <input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health facility and/or community sites <input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: <ul style="list-style-type: none"> <input type="checkbox"/> The HRIS is primarily financed and managed by host country institutions <input type="checkbox"/> There is a national strategy or approach to interoperability for HRIS <input type="checkbox"/> The government produces HR data from the system at least annually <input checked="" type="checkbox"/> Host country institutions use HR data from the system for planning and management (e.g. health worker deployment) 	<p>7.7 Score: 0.69</p>	<p>HRIS</p>	<p>HRIS exists but there are challenges</p>
<p>Human Resources for Health Score</p>		<p>6.06</p>		

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
<p>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)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known.</p> <p><input checked="" type="radio"/> B. No (0%) funding from domestic sources</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.1 Score: 0.00</p>	<p>Global Fund grant application and agreements</p>
<p>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)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known</p> <p><input checked="" type="radio"/> B. No (0%) funding from domestic sources</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.2 Score: 0.00</p>	<p>Global Fund grant application and agreements</p>
<p>8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? <i>Note:</i> The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known</p> <p><input checked="" type="radio"/> B. No (0%) funding from domestic sources</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.3 Score: 0.00</p>	<p>Global Fund grant application and agreements</p> <p>There are an estimated 100+ million condoms in country and in the procurement pipeline. The condoms are purchased (funded) by DfID, DKT, UNFPA, the Global Fund and USAID.</p>

<p>8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?</p>	<p><input type="radio"/> A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).</p> <p><input checked="" type="radio"/> B. There is a plan/SOP that includes the following components (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input checked="" type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision <input checked="" type="checkbox"/> Site supervision 	<p>8.4 Score: 2.22</p>	<p>Pharmaceutical Supply Transformation Plan</p>	
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not available.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources.</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources.</p> <p><input checked="" type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input type="radio"/> E. Most (approx. 50-89%) funding from domestic sources.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funding from domestic sources.</p>	<p>8.5 Score: 0.42</p>	<p>Participants' opinion based on program experience</p>	<p>The annual budget is approximately \$1 billion, of which \$300 million is from domestic resources (funds from PFSA, FMOH, revolving drug fund and facility retained funds)</p>

<p>8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities <input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time <input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal external assistance: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Decision makers are not seconded or implementing partner staff <input checked="" type="checkbox"/> Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects <input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government 	<p>8.6 Score: 2.22</p>	<p>Pharmaceutical Supply Transformation Plan</p>	<p>This is PfSA's mandate</p>
<p>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)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. A comprehensive assessment has not been done within the last three years. <input type="radio"/> 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 <input checked="" type="radio"/> 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 	<p>8.7 Score: 2.22</p>	<p>IPLS survey conducted (89%), 2014</p>	<p>The next survey results will be reviewed in January 2018</p>
<p>Commodity Security and Supply Chain Score:</p>		<p>7.08</p>		

			Data Source	Notes/Comments
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				
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?	<input type="radio"/> A. The host country government does not have structures or resources to support site-level continuous quality improvement <input checked="" type="radio"/> 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 <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/>	9.1 Score: 2.00	Health Sector Development Program IV 2010/11 - 2014/15 FMOH	
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	<input type="radio"/> A. There is no HIV/AIDS-related QM/QI strategy <input type="radio"/> B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized <input type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. <input checked="" type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully	9.2 Score: 2.00	Quality management framework for HIV & AIDS Services in Ethiopia (2008) Quality management framework for health care facilities (2017)	There will be a QM/QI plan developed for community structures
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?	<input type="radio"/> 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. <input checked="" type="radio"/> 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 <input checked="" type="checkbox"/> <input type="checkbox"/> 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 <input type="checkbox"/> 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	Quality management framework for HIV & AIDS Services in Ethiopia (2008) Quality management framework for health care facilities (2017)	There will be a QM/QI plan developed for community structures

<p>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?</p>	<p><input type="radio"/> A. There is no training or recognition offered to build health workforce competency in QI.</p> <p><input checked="" type="radio"/> B. There is health workforce competency-building in QI, including:</p> <p><input checked="" type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in curricula</p> <p><input checked="" type="checkbox"/> 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</p>	<p>9.4 Score: 2.00</p>	<p>As part of the Ethiopian Hospital Management Initiative (EHMI) program, the Master in Hospital and Healthcare Administration (MHA) program was first launched in Ethiopia in 2008 at Jimma University</p>	<p>It is in the Masters of Health Administration (MHA) curriculum but not included in all the curricula</p>
<p>9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?</p>	<p>The national-level QM structure:</p> <p><input type="checkbox"/> Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services</p> <p><input type="checkbox"/> Regularly convenes meetings that include health services consumers</p> <p><input type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement</p> <p>Sub-national QM structures:</p> <p><input type="checkbox"/> Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services</p> <p><input type="checkbox"/> Regularly convene meetings that includes health services consumers</p> <p><input type="checkbox"/> Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement</p> <p>Site-level QM structures:</p> <p><input type="checkbox"/> Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement</p>	<p>9.5 Score: 0.00</p>		<p>We were unable to confirm with the Medical Service Directorate of the Health Ministry</p>
<p>Quality Management Score:</p>		<p>6.67</p>		

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
<p>10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?</p>	<p> <input type="radio"/> A. There is no national laboratory strategic plan <input type="radio"/> B. National laboratory strategic plan is under development <input type="radio"/> C. National laboratory strategic plan has been developed, but not approved <input type="radio"/> D. National laboratory strategic plan has been developed and approved <input type="radio"/> E. National laboratory plan has been developed, approved, and costed <input checked="" type="radio"/> F. National laboratory strategic plan has been developed, approved, costed, and implemented </p>	<p>10.1 Score: 1.67</p>	<p>Ethiopian Public Health Institute (EPHI) Strategic Planning and Management (SPM) document</p>
<p>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)</p>	<p> <input type="radio"/> A. Regulations do not exist to monitor minimum quality of laboratories in the country. <input type="radio"/> B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). <input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated). <input type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). <input checked="" type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). <input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated). </p>	<p>10.2 Score: 1.25</p>	<p>Participants' opinion from program experience</p>
<p>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?</p>	<p> <input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control <input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key functions: <input checked="" type="checkbox"/> HIV diagnosis by rapid testing and point-of-care testing <input checked="" type="checkbox"/> Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria <input checked="" type="checkbox"/> Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays <input checked="" type="checkbox"/> TB diagnosis </p>	<p>10.3 Score: 1.67</p>	<p>EPHI national lab workforce assessment data; assessment conducted by the National Laboratory Capacity Building Directorate. EPHI is the Ethiopian Public Health Institute; the technical agency under Federal Ministry of Health which oversees all laboratory related issues.</p> <p>However, there is high degree of lab work force turn over and attrition due to issues related with government remuneration system which lacks consideration for retention.</p>

<p>10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?</p>	<p><input type="radio"/> A. There is not sufficient infrastructure to test for viral load.</p> <p><input checked="" type="radio"/> B. There is sufficient infrastructure to test for viral load, including:</p> <p><input checked="" type="checkbox"/> Sufficient HIV viral load instruments</p> <p><input checked="" type="checkbox"/> All HIV viral load laboratories have an instrument maintenance program</p> <p><input type="checkbox"/> Sufficient supply chain system is in place to prevent stock outs</p> <p><input type="checkbox"/> Adequate specimen transport system and timely return of results</p>	<p>10.4 Score: 0.83</p>	<p>Strategic Plan for Scaling-up of HIV Viral Load testing in Ethiopia</p>	
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input checked="" type="radio"/> A. No (0%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> C. Some (approx. 10-49%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> D. Most (approx. 50-89%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.</p>	<p>10.5 Score: 0.00</p>	<p>Opinion of most lab program personnel and based on program experience</p>	<p>From experience and what the Lab program personnel say, government budget allocation for lab system is very poor, and usually merged with pharmacy budget</p>
Laboratory Score:		5.42		

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		Data Source	Notes/Comments
This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			
1. What percentage of general government expenditures goes to health?	11%	FMOH Health and health related indicators bulletin 2008E.C (2016) version one	WHO recommends 15%
2. What is the per capita health expenditure all sources?	\$28.65	NHA 2013/14	Who recommends \$60. It was \$4.5 in 1995/96. Draft HCF document: The per capita income of Ethiopia has increased from US\$255 in 2004/05 to US\$794 in 2015/16 and as a result the national poverty rate has declined from 44% in 2000 to 23% in 2014/15
3. What is the total health care expenditure all sources as a percent of GDP?	4.37%	NHA 2013/14	NHA 2013/14: A decline from 5.2 percent in 2010/11. Draft HCF document: The Gross Domestic Product (GDP) of the country has grown by nearly 11% per annum between 2003/4 and 2014/15. A very impressive performance compared to the growth rate of 5.4 percent for sub-saharan Africa in 2014.
4. What percent of total health expenditures is financed by external resources?	36%	NHA 2013/14	The share of spending by " the rest of the world" (bilateral and multilateral donors, and private philanthropists) has fallen from 50 percent in 2010/11 to 36 percent in 2013/14.
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	33%	NHA 2013/14	There is no significant pooling of household resources in the form of health insurance.

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
<p>11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?</p> <p>Check all that apply: 11.1 Score: 0.52</p> <p><input checked="" type="checkbox"/> 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):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> ARVs are covered <input checked="" type="checkbox"/> Non-ARV care and treatment is covered <input checked="" type="checkbox"/> Prevention services are covered <p><input checked="" type="checkbox"/> B. Yes, there is an affordable health insurance scheme available (check one of the following).</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> It covers 25% or less of the population. <input type="checkbox"/> It covers 26 to 50% of the population. <input type="checkbox"/> It covers 51 to 75% of the population. <input type="checkbox"/> It covers more than 75% of the population. <p><input type="checkbox"/> C. The affordable health insurance scheme in (B.) includes the following (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> ARVs are covered. <input type="checkbox"/> Non-ARV care and treatment services are covered. <input type="checkbox"/> Prevention services are covered. <input type="checkbox"/> It includes public subsidies for the affordability of care. 	DHS 2016; Health Care Financing Strategy, 2017-2025	

<p>11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?</p>	<p><input type="radio"/> A. There is no explicit funding for HIV/AIDS in the national budget.</p> <p><input checked="" type="radio"/> B. There is explicit HIV/AIDS funding within the national budget.</p> <p><input checked="" type="checkbox"/> The HIV/AIDS budget is program-based across ministries</p> <p><input checked="" type="checkbox"/> The budget includes or references indicators of progress toward national HIV/AIDS strategy goals</p> <p><input checked="" type="checkbox"/> The budget includes specific HIV/AIDS service delivery targets</p> <p><input checked="" type="checkbox"/> National budget reflects all sources of funding for HIV, including from external donors</p>	<p>11.2 Score: 0.95</p>	<p>Sector plans</p>	<p>Per the WHO Global TB Report (2013), most ministries including Health, Transport, and Education, have a 2% budget for HIV mainstream programming; however it is not properly used</p>
<p>11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?</p>	<p><input checked="" type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget</p> <p><input type="radio"/> B. There are HIV/AIDS goals/targets articulated in the national budget.</p> <p><input type="checkbox"/> The goals/targets are measurable.</p> <p><input type="checkbox"/> Budget items/programs are linked to goals/targets.</p> <p><input type="checkbox"/> The goals/targets are routinely monitored during budget execution.</p> <p><input type="checkbox"/> The goals/targets are routinely monitored during the development of the budget.</p>	<p>11.3 Score: 0.00</p>		<p>Although the national budget does not have a line item specific to HIV, each sector has specified budgets based on need and the lump sum received from parliament. The national and regional sectors have specific allocations for disease areas</p>
<p>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?</p> <p>(If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)</p>	<p><input type="radio"/> A. There is no HIV/AIDS budget, or information is not available.</p> <p><input type="radio"/> B. 0-49% of budget executed</p> <p><input type="radio"/> C. 50-69% of budget executed</p> <p><input type="radio"/> D. 70-89% of budget executed</p> <p><input checked="" type="radio"/> E. 90% or greater of budget executed</p>	<p>11.4 Score: 0.95</p>	<p>Health Service Utilization and Expenditure Survey Among PLHIV (2015/2016)</p>	<p>There is a need to get last year's budget amount as denominator and last year expenditure data as numerator from FMOH. If the data is not available the response will be A.</p>

<p>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?</p>	<p>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.</p> <p>B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</p> <p>C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.</p>	<p>11.5 Score: 0.95</p>	<p>Health Sector Resource Mapping</p>	
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>A. None (0%) is financed with domestic funding.</p> <p>B. Very little (approx. 1-9%) is financed with domestic funding.</p> <p>C. Some (approx. 10-49%) is financed with domestic funding.</p> <p>D. Most (approx. 50-89%) is financed with domestic funding.</p> <p>E. All or almost all (approx. 90%+) is financed with domestic funding.</p>	<p>11.6 Score: 1.67</p>	<p>Ethiopian National AIDS Spending Assesment Report EFY 2013/14</p>	<p>It any be replaced with recent NASA version (54.6+679)/405.179)*100=13.6%</p>
<p>11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?</p>	<p>A. There is no budget for health or no money was allocated.</p> <p>B. 0-49% of budget executed.</p> <p>C. 50-69% of budget executed.</p> <p>D. 70-89% of budget executed.</p> <p>E. 90% or greater of budget executed.</p>	<p>11.7 Score: 0.95</p>	<p>PLHIV Health Service Utilization Expenditure 2015/2016</p>	<p>MOFEC Resource to be explored 2009 EC</p>
<p>11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprogramming domestic investments based on new or updated program data during the government funding cycle?</p>	<p>A. There is no system for funding cycle reprogramming.</p> <p>B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.</p> <p>C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data.</p> <p>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.</p>	<p>11.8 Score: 0.95</p>		<p>Require Validation</p>
<p>Domestic Resource Mobilization Score:</p>		<p>6.94</p>		

12. Technical and Allocative Efficiencies			
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	
<p>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?</p> <p>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)</p> <p>(note: full score achieved by selecting one checkbox)</p>	<p>A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.</p> <p>B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply):</p> <p><input type="checkbox"/> Optima</p> <p><input checked="" type="checkbox"/> Spectrum (including EPP and Goals)</p> <p><input type="checkbox"/> AIDS Epidemic Model (AEM)</p> <p><input type="checkbox"/> Modes of Transmission (MOT) Model</p> <p><input type="checkbox"/> Other recognized process or model (specify in notes column)</p>	<p>12.1 Score: 2.00</p>	<p>UNAIDS Estimates</p>
<p>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)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input checked="" type="radio"/> A. Information not available.</p> <p><input type="radio"/> B. No resources (0%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.</p>	<p>12.2 Score: 0.00</p>	<p>There are no direct allocation parameters for HIV. But the general allocation parameters are proxy like population size, equity, service coverage</p>

<p>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?</p> <p>(note: full score can be achieved without checking all disaggregate boxes).</p>	<p><input type="radio"/> A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs</p> <p><input checked="" type="radio"/> B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):</p> <p><input checked="" type="checkbox"/> HIV Testing</p> <p><input checked="" type="checkbox"/> Laboratory services</p> <p><input checked="" type="checkbox"/> ART</p> <p><input checked="" type="checkbox"/> PMTCT</p> <p><input checked="" type="checkbox"/> VMMC</p> <p><input checked="" type="checkbox"/> OVC Service Package</p> <p><input checked="" type="checkbox"/> Key population Interventions</p>	<p>12.3 Score: 2.00</p>	<p>PLHIV Health Service Utilization Expenditure 2015/2016</p>	<p>The government plans to use costing data, as required by the Global Fund.</p>
<p>12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies</p> <p><input checked="" type="checkbox"/> Reduced overhead costs by streamlining management</p> <p><input checked="" type="checkbox"/> Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc.</p> <p><input checked="" type="checkbox"/> Improved procurement competition</p> <p><input type="checkbox"/> Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)</p> <p><input type="checkbox"/> 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)</p> <p><input checked="" type="checkbox"/> 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)</p> <p><input checked="" type="checkbox"/> Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)</p>	<p>12.4 Score: 1.56</p>	<p>PFSA, GHSC-PSM and JSI, AIDS FREE Periodic Reports</p>	<p>Lower unit cost due to pooled procurement and improved procurement competitiveness also Tx at DICs, DSDM, target testing</p>

<p>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?</p> <p>(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)</p>	<ul style="list-style-type: none"> <input checked="" type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year. <input type="radio"/> 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. <input type="radio"/> 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. <input type="radio"/> 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. <input type="radio"/> 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. 	<p>12.5 Score: 0.00</p>		
<p>Technical and Allocative Efficiencies Score:</p>		<p>5.56</p>		

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
<p>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.)?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years <input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions <input checked="" type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies <input type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies <input type="radio"/> 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 	<p>13.1 Score: 0.48</p>	<p>PEPFAR and Global Fund supported surveys and surveillance activities</p>	
<p>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.)?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years <input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions <input checked="" type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies <input type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies <input type="radio"/> 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 	<p>13.2 Score: 0.48</p>	<p>PEPFAR and Global Fund supported surveys and surveillance activities</p>	<p>Examples of surveys, IDU, MARPs, CSW mapping and size estimation</p>
<p>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.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years <input type="radio"/> B. No financing (0%) is provided by the host country government <input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government <input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government <input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government <input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government 	<p>13.3 Score: 0.42</p>	<p>PEPFAR and Global Fund supported surveys and surveillance activities</p>	<p>No data on the actual spending but the government has cost sharing in the form of overhead (e.g. electricity, internet, salary, office rent etc.)</p>

<p>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.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (approx. 90%+) is provided by the host country government</p>	<p>13.4 Score: 0.42</p>	<p>PEPFAR and Global Fund supported surveys and surveillance activities</p>	
<p>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?</p> <p>(Note: Full score possible without selecting all disaggregates.)</p>	<p>Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data:</p> <p><input checked="" type="checkbox"/> A. The host country government collects at least every 5 years HIV prevalence data disaggregated by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input checked="" type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> Sub-national units <p><input type="checkbox"/> B. The host country government collects at least every 5 years HIV incidence disaggregated by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age (at coarse disaggregates) <input type="checkbox"/> Age (at fine disaggregates) <input type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non- <input type="checkbox"/> Sub-national units 	<p>13.5 Score: 0.38</p>	<p>EPHI spectrum estimate 2016</p>	<p>Subnational unit in this context is to mean regional level. We don't have the details beyond.</p>

<p>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?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. The host country government does not collect/report viral load data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load data (answer both subsections below):</p> <p>According to the following disaggregates (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Age</p> <p><input checked="" type="checkbox"/> Sex</p> <p><input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners)</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>For what proportion of PLHIV (select ONE of the following):</p> <p><input type="checkbox"/> Less than 25%</p> <p><input checked="" type="checkbox"/> 25-50%</p> <p><input type="checkbox"/> 50-75%</p> <p><input type="checkbox"/> More than 75%</p>	<p>13.6 Score: 0.48</p>	<p>National Database (Group Presentation)</p>	
<p>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.)</p> <p>Please note most recent survey dates in comments section.</p>	<p><input type="radio"/> 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.).</p> <p><input checked="" type="radio"/> B. The host country government conducts (answer both subsections below):</p> <p>IBBS for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input type="checkbox"/> Men who have sex with men (MSM)</p> <p><input type="checkbox"/> Transgender (TG)</p> <p><input checked="" type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>Size estimation studies for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input type="checkbox"/> Men who have sex with men (MSM)</p> <p><input type="checkbox"/> Transgender (TG)</p> <p><input type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p>	<p>13.7 Score: 0.36</p>	<p>The IBBS is geographically limited for CSW. IDU only in Addis Ababa . Size estimate: for FSW Report of PWID October 2015 MARPS Survey BBS and Size estimation 2015</p>	

<p>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)?</p>	<p><input type="radio"/> A. There is no national HIV surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys</p> <p><input type="radio"/> 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</p> <p><input checked="" type="radio"/> 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</p>	<p>13.8 Score: 0.95</p>	<p>EPHI SPM2- 2015/16-2019/20, Road map for HIV Related surveys and surveillance system in Ethiopia, July 2015, EPHI</p>	
<p>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?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data <input checked="" type="checkbox"/> A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance <input checked="" type="checkbox"/> Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection <input checked="" type="checkbox"/> An in-country internal review board (IRB) exists and reviews all protocols. 	<p>13.9 Score: 0.95</p>	<p>The Ethiopian Public Health Institute (EPHI) is the lead institution for assuring the quality of surveys and surveillance data</p>	
Epidemiological and Health Data Score:		4.90		

14. Financial/Expenditure data			
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	
<p>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?</p> <p> <input type="radio"/> A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years <input type="radio"/> 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 <input type="radio"/> 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 <input type="radio"/> 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 <input type="radio"/> 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 </p>	<p>Ethiopian Health Account 2013/14</p>		<p>14.1 Score: 1.67</p>
<p>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?</p> <p> <input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years <input checked="" type="radio"/> B. HIV/AIDS expenditure data are collected (check all that apply): </p> <p> <input checked="" type="checkbox"/> By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> By expenditures per program area, such as prevention, care, treatment, health systems strengthening <input checked="" type="checkbox"/> By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel <input checked="" type="checkbox"/> Sub-nationally </p>	<p>NASA 2011/2012</p>		<p>14.2 Score: 3.33</p>
<p>14.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?</p> <p> <input type="radio"/> A. No HIV/AIDS expenditure data are collected <input type="radio"/> B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago <input checked="" type="radio"/> C. HIV/AIDS expenditure data were collected at least once in the past 3 years <input type="radio"/> D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures <input type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures </p>	<p>National Health Accounts (2013/14); National AIDS Spending Assessment (NASA) (2011/12)</p>		<p>14.3 Score: 1.67</p>
Financial/Expenditure Data Score:			6.67

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
<p>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?</p>	<p><input type="radio"/> A. No system exists for routine collection of HIV/AIDS service delivery data</p> <p><input type="radio"/> 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</p> <p><input type="radio"/> C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution</p> <p><input type="radio"/> 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</p> <p><input checked="" type="radio"/> E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government</p>	<p>15.1 Score: 1.00</p>	<p>HMIS</p>
<p>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.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No routine collection of HIV/AIDS service delivery data exists</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90% +) is provided by the host country government</p>	<p>15.2 Score: 0.83</p>	<p>National AIDS Spending Assessment (2011/12)</p>

<p>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.)</p>	<p>Check ALL boxes that apply below:</p> <p><input checked="" type="checkbox"/> A. The host country government routinely collects & reports service delivery data for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> Adult Care and Support <input checked="" type="checkbox"/> Adult Treatment <input checked="" type="checkbox"/> Pediatric Care and Support <input checked="" type="checkbox"/> Orphans and Vulnerable Children <input checked="" type="checkbox"/> Voluntary Medical Male Circumcision <input checked="" type="checkbox"/> HIV Prevention <input checked="" type="checkbox"/> AIDS-related mortality <p><input checked="" type="checkbox"/> B. Service delivery data are being collected:</p> <ul style="list-style-type: none"> <input type="checkbox"/> By key population (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> By age & sex <input checked="" type="checkbox"/> From all facility sites (public, private, faith-based, etc.) <input checked="" type="checkbox"/> From all community sites (public, private, faith-based, etc.) 	<p>15.3 Score: 1.33</p>	<p>MRIS HAPCO routine service delivery</p>	
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<p>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?</p>	<p><input type="radio"/> A. The host country government does not routinely collect/report HIV/AIDS service delivery data</p> <p><input type="radio"/> B. The host country government collects & reports service delivery data annually</p> <p><input type="radio"/> C. The host country government collects & reports service delivery data semi-annually</p> <p><input checked="" type="radio"/> D. The host country government collects & reports service delivery data at least quarterly</p>	<p>15.4 Score: 1.33</p>	<p>Health Management Information System Implementation guide, SOPs, Training Manuals</p>	
<p>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)?</p>	<p><input type="radio"/> A. The host country government does not routinely analyze service delivery data to measure program performance</p> <p><input checked="" type="radio"/> B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention</p> <p><input checked="" type="checkbox"/> Results against targets</p> <p><input checked="" type="checkbox"/> Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.)</p> <p><input checked="" type="checkbox"/> Site-specific yield for HIV testing (HTC and PMTCT)</p> <p><input type="checkbox"/> AIDS-related mortality rates</p> <p><input checked="" type="checkbox"/> Variations in performance by sub-national unit</p> <p><input type="checkbox"/> Creation of maps to facilitate geographic analysis</p>	<p>15.5 Score: 0.67</p>	<p>Health Management Information System Implementation guide, SOPs, Training Manuals</p>	
<p>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?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):</p> <p><input checked="" type="checkbox"/> A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance</p> <p><input checked="" type="checkbox"/> 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</p> <p><input checked="" type="checkbox"/> Standard national procedures & protocols exist for routine data quality checks at the point of data entry</p> <p><input type="checkbox"/> Data quality reports are published and shared with relevant ministries/government entities & partner organizations</p> <p><input type="checkbox"/> 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</p>	<p>15.6 Score: 0.80</p>	<p>Adopted from WHO assesment protocol and data quality and information use manual</p>	<p>LQAs and RDQA performance monitoring team</p>
<p>Performance Data Score:</p>		<p>5.97</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D