

2019 HIV/AIDS SUSTAINABILITY INDEX AND DASHBOARD: RWANDA

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 125 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

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

Rwanda Overview: Rwanda has made significant and remarkable progress in reaching the UNAIDS Fast Track 90-90-90 Goals following the genocide of 1994. The Government of Rwanda (GOR) has demonstrated strong leadership and vision in crafting a national HIV/AIDS strategy and coordinating the response. However, Rwanda still remains highly dependent on donors to fund its HIV response, particularly PEPFAR and the Global Fund. Those donor contributions are declining, which poses a significant risk to the long-term sustainability of the national HIV program, and to the great successes Rwanda has achieved. The Government of Rwanda is taking strides to find and treat remaining positives through targeted outreach and testing models focusing on key and priority populations and key geographic areas, to provide immediate treatment for PLHIV under the fully implemented Treat All program, to optimize service delivery models, and to find ways to absorb the costs of administering the national HIV program even though Rwanda is a low income country.

SID Process: The fourth of Rwanda's SID day-long workshop was co-convened with UNAIDS Rwanda and organized jointly with GOR and the Ministry of Health (MOH) in September 2019 and was attended by more than 30 participants from more than 10 organizations working in the national HIV program. Participants included representatives from the MOH, Rwanda Biomedical Center (RBC), UNAIDS, WHO, as well as local civil society organizations and PEPFAR implementing partners' staff. After opening remarks by PEPFAR Coordinator and the UNAIDS Country Representative for Rwanda, the participants broke into four groups around each of the domains and jointly answered the questions and provided source data and notes for the final 2019 SID. After the day-long meeting, the 2019 SID was circulated among participants and further feedback was incorporated into the final 2019 SID.

Sustainability Strengths: All 2019 SID domains were identified as sustainable, approaching, or emerging sustainability with notable strength in the domain "Governance, Leadership, and Accountability."

- **Public Access to Information (8.33, light green):** This score reduced from 9.00 to 8.33 from SID 3.0 to 2019 SID due clarifications in the reporting schedule. The GOR widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges toward achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, etc.) related to HIV/AIDS. Information is readily available on GOR websites. GOR reports internally on a quarterly basis but the reports are made public on an annual basis (one later than one month following the close of the fiscal year).

- **Quality Management (7.76, light green)**: Because quality improvement (QI) and quality management (QM) is integrated in the national health budget and significant improvements in QI/QM has occurred since SID 2.0, SID 3.0 shows a much stronger quality management system in Rwanda.
- **Financial/Expenditure Data (9.17, dark green)**: Rwanda maintained the Financial/Expenditure score from SID 3.0 to 2019 SID. Rwanda continues to provide consistent quality expenditure reporting data

Sustainability Vulnerabilities:

- **Technical and Allocative Effectiveness (6.56, yellow)**: Technical and allocative effectiveness remains a vulnerability to the sustainability of the Rwandan HIV response. There is limited domestic budget to fund the HIV program, and donor funding, including PEPFAR funding, is reducing. Both PEPFAR and Global Fund have invested substantially in Rwanda's HIV response, and both funding sources are reducing at a significant pace and rate. Nearly 50% of PEPFAR funding and all GF support are delivered through the government, which demonstrates the high capacity of the GOR and MOH systems. However, the lack of domestic resources continues to pose a challenge to the long-term sustainability of the national HIV response when donor funding has reduced.
- **Epidemiological and Health Data (6.18, yellow)** Epidemiological and health data are collected, analyzed, and made available to the public in some cases, including size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, limited data on viral load and AIDS-related mortality rates. Surveys and surveillance activities are conducted to measure both general population and key populations, but the Government provided minimal funding for these activities.
- **Data for Decision-Making Eco-system (6.33, yellow)** The Government of Rwanda has demonstrated commitment to advancing the use of data to inform government decisions and cultivate an informed, engaged civil society. The capacity and use of existing and nascent systems are still in varied stages of development. The main reason that this score is not higher is the lack of a nationally rolled out unique identification system in Rwanda, though the system is in development and is planned for full implementation by September 2020.

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

Sustainability Analysis for Epidemic Control: Rwanda

Epidemic Type: Generalized

Income Level: Low income

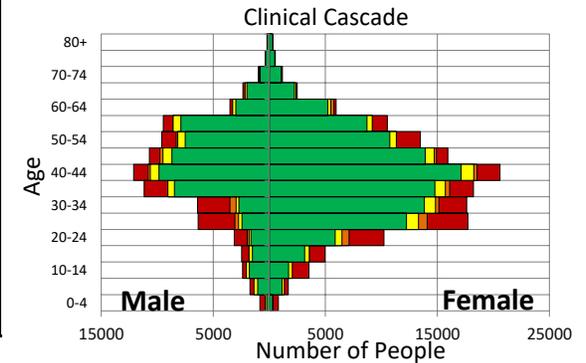
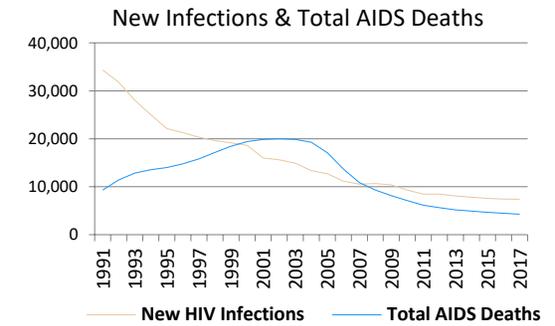
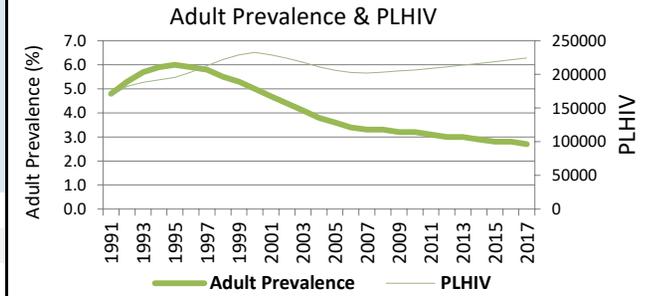
PEPFAR Categorization: Long-term Strategy

PEPFAR COP 19 Planning Level: \$ 74,505,966

SUSTAINABILITY DOMAINS and ELEMENTS

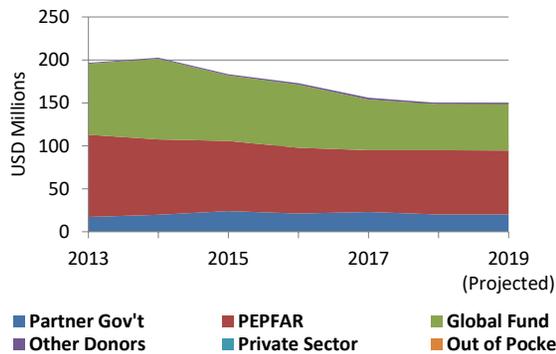
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.50	10.00	10.00	
2. Policies and Governance	8.63	9.19	8.50	
3. Civil Society Engagement	7.67	8.33	8.33	
4. Private Sector Engagement	6.11	9.22	9.50	
5. Public Access to Information	10.00	9.00	8.33	
National Health System and Service Delivery				
6. Service Delivery	6.67	6.67	7.06	
7. Human Resources for Health	8.50	8.24	8.13	
8. Commodity Security and Supply Chain	7.30	6.06	7.36	
9. Quality Management	7.38	8.05	8.05	
10. Laboratory	7.36	6.67	7.22	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	6.94	8.25	8.25	
12. Technical and Allocative Efficiencies	6.43	5.56	6.56	
13. Market Openness	N/A	N/A	9.75	
Strategic Information				
14. Epidemiological and Health Data	6.27	6.56	6.18	
15. Financial/Expenditure Data	7.50	9.17	9.17	
16. Performance Data	7.94	8.11	8.00	
17. Data for Decision-Making Ecosystem	N/A	N/A	6.33	

CONTEXTUAL DATA

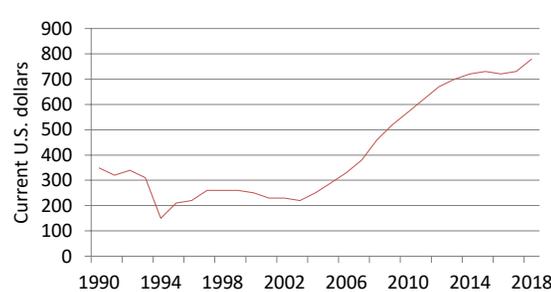


CONTEXTUAL DATA

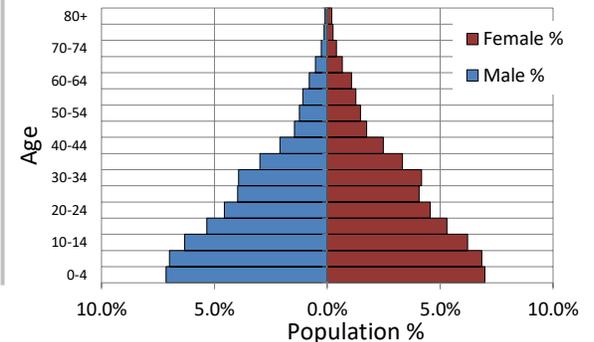
Financing the HIV Response



GNI Per Capita (Atlas Method)



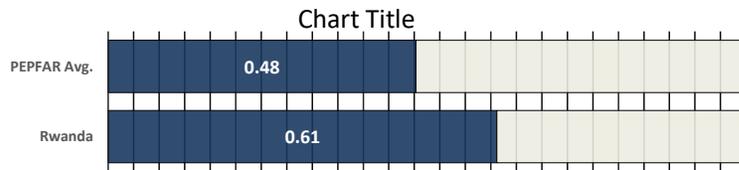
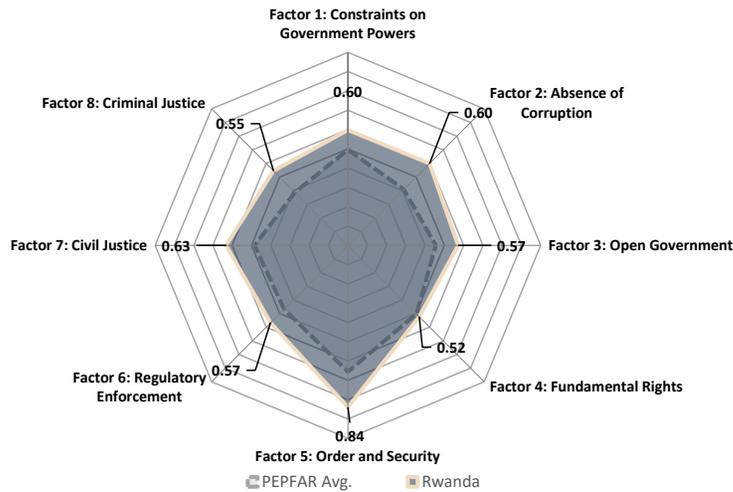
Population Pyramid (2019)



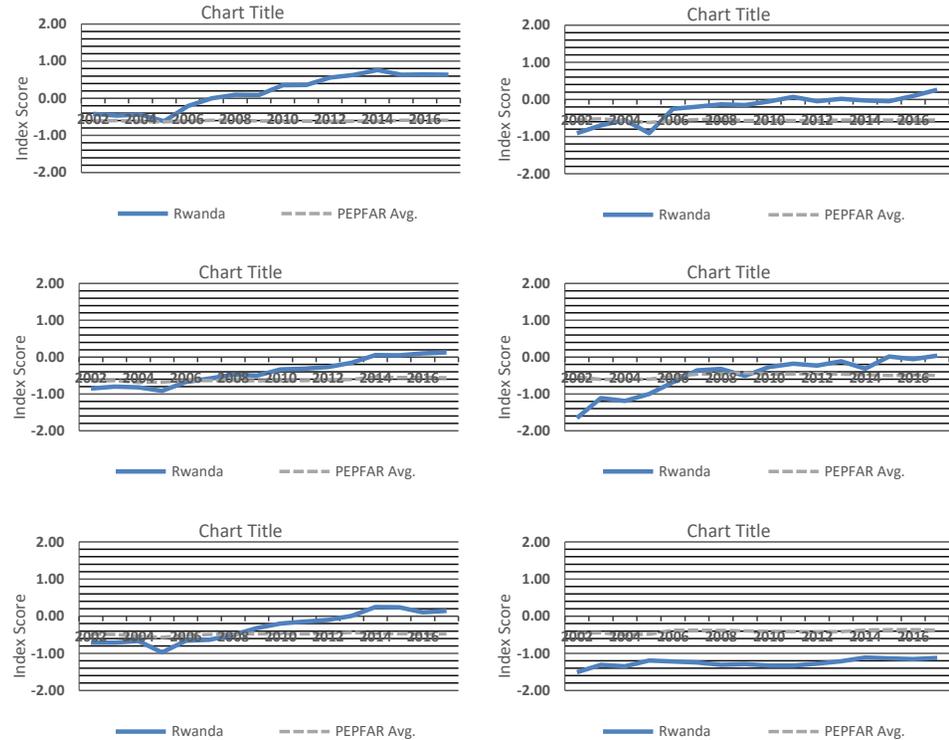
Sustainability Analysis for Epidemic Control: Rwanda

Contextual Governance Indicators

Rule of Law Index (World Justice Project)



Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

- 1. Constraints on Government Powers:** Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.
- 2. Absence of Corruption:** Government officials in all branches of government do not use public office for private gain.
- 3. Open Government:** Citizens have open access to government information and data, complaint mechanisms, and civic participation.
- 4. Fundamental Rights:** There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.
- 5. Order and Security:** Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.
- 6. Regulatory Enforcement:** Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.
- 7. Civil Justice:** Civil justice is accessible and free of discrimination, corruption and improper government influence.
- 8. Criminal Justice:** Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: <https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019>

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

- 1. Control of Corruption:** captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.
- 2. Government Effectiveness:** measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.
- 3. Rule of Law:** captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.
- 4. Political Stability and Absence of Violence:** measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.
- 5. Regulatory Quality:** Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.
- 6. Voice and Accountability:** captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: <https://info.worldbank.org/governance/wgi/>

Domain A. Governance, Leadership, and Accountability

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

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.	Data Source	Notes/Comments
<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 checked="" type="checkbox"/> Strategy (or separate document) includes considerations and activities related to sustainability</p>	<p>1.1 Score: 2.50</p> <p>Rwanda HIV/AIDS National Strategic Plan, Updated 2018 to 2024</p>	<p>Updated</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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Its development was led by the host country government <input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy <input checked="" type="checkbox"/> Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy <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) <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>1.2 Score: 2.50</p>	<p>NSP 2018-2024 minutes of NSP developpement workshop and list of participants</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> <ul style="list-style-type: none"> <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. <input checked="" type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> civil society organizations <input checked="" type="checkbox"/> private sector (including health care providers and/or other private sector partners) <input checked="" type="checkbox"/> donors <input checked="" 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. <input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations. <input checked="" type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed. 	<p>1.3 Score: 2.50</p>	<p>RBC annaul report , minute of TWG meetings, donor site vist report</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>Monthly report for district hospitals and Health facilities, quarterly for civil society</p>	<p>National indicators all partners are required to report on</p>
<p align="center">Planning and Coordination Score: 10.00</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., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens for each of the following: A. Adults (>19 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No B. Pregnant and Breastfeeding Mothers <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No C. Adolescents (10-19 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No D. Children (<10 years) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2.1 Score: 0.91	National Guideline	Guidelines are updated every 2 years to review and incorporate new scientific evidence and WHO guidelines

<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 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 checked="" type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS <input checked="" type="checkbox"/> Policies that permit HIV self-testing <input checked="" type="checkbox"/> Policies that permit pre-exposure prophylaxis (PrEP) <input checked="" type="checkbox"/> Policies that permit post-exposure prophylaxis (PEP) <input checked="" 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: 0.83</p>	<p>National Strategic Plan (2018 -2024) and National HIV and Care & Treatment Guidelines</p>	<p>TLD guideline updated in August 2019, to be adopted in the updated guidelines. Children as young as 12 can be tested with out parental consent based on mental capaity assessed by health care provider</p>
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<p>2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for <u>any</u> HIV services in the public sector: clinical, laboratory, testing, prevention and others?</p> <p>Note: "Formal" user fees are those established in policy or regulation by a government or institution.</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> No, neither formal nor informal user fees exist.</p> <p><input type="checkbox"/> Yes, formal user fees exist.</p> <p><input type="checkbox"/> Yes, informal user fees exist.</p>	<p>2.3 Score: 0.91</p>	<p>Group agreement and participation</p>	
<p>2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for <u>any</u> non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others?</p> <p>Note: "Formal" user fees are those established in policy or regulation by a government or institution.</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> No, neither formal nor informal user fees exist.</p> <p><input checked="" type="checkbox"/> Yes, formal user fees exist.</p> <p><input type="checkbox"/> Yes, informal user fees exist.</p>	<p>2.4 Score: 0.23</p>	<p>Based on the Health Insurance Policy of Rwanda (Mutuelle - community health insurance)</p>	
<p>2.5 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> <p><input checked="" type="checkbox"/> Govern the collection of patient-level data for public health purposes, including surveillance</p> <p><input type="checkbox"/> Govern the collection and use of unique identifiers such as national ID for health records</p> <p><input checked="" type="checkbox"/> Govern the privacy and confidentiality of health outcomes matched with personally identifiable information</p> <p><input checked="" type="checkbox"/> Govern the use of patient-level data, including protection against its use in criminal cases</p>	<p>2.5 Score: 0.68</p>	<p>Rwanda Constitution, Penal Code, other legal rules and regulations</p>	<p>Unique ID is not universally used, ID numbers are used for TracNet to track HIV positive patients on treatment. Unique ID in development</p>

<p>2.6 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> <p><input checked="" type="checkbox"/> Constitutional prohibition of discrimination based on gender diversity</p> <p><input checked="" type="checkbox"/> Prohibitions of discrimination in employment based on gender diversity</p> <p><input type="checkbox"/> A third gender is legally recognized</p> <p><input type="checkbox"/> Other non-discrimination provisions specifying gender diversity (note in comments)</p> <p>Men who have sex with men (MSM):</p> <p><input checked="" type="checkbox"/> Constitutional prohibition of discrimination based on sexual orientation</p> <p><input type="checkbox"/> Hate crimes based on sexual orientation are considered an aggravating circumstance</p> <p><input checked="" type="checkbox"/> Incitement to hatred based on sexual orientation prohibited</p> <p><input checked="" type="checkbox"/> Prohibition of discrimination in employment based on sexual orientation</p> <p><input type="checkbox"/> Other non-discrimination provisions specifying sexual orientation</p> <p>Female sex workers (FSW):</p> <p><input checked="" type="checkbox"/> Constitutional prohibition of discrimination based on occupation</p> <p><input type="checkbox"/> Sex work is recognized as work</p> <p><input type="checkbox"/> Other non-discrimination protections specifying sex work (note in comments)</p>	<p>2.6 Score: 0.51</p>	<p>Rwanda Constitution, Penal Code, other legal rules and regulations</p>	<p>Constitution protects all Rwandan citizens from gender diversity, sexual orientation etc. discrimination however does not mention LGBTQ specifically.</p>
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	<p>People who inject drugs (PWID):</p> <p><input type="checkbox"/> Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments)</p> <p><input checked="" type="checkbox"/> Explicit supportive reference to harm reduction in national policies</p> <p><input type="checkbox"/> Policies that address the specific needs of women who inject drugs</p>			
<p>2.7 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> <p><input checked="" type="checkbox"/> General criminal laws prohibiting violence</p> <p><input checked="" type="checkbox"/> Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population</p> <p><input checked="" type="checkbox"/> Programs to address intimate partner violence</p> <p><input checked="" type="checkbox"/> Programs to address workplace violence</p> <p><input checked="" type="checkbox"/> Interventions to address police abuse</p> <p><input checked="" type="checkbox"/> Interventions to address torture and ill treatment in prisons</p> <p><input checked="" type="checkbox"/> A national plan or strategy to address gender-based violence and violence against women that includes HIV</p> <p><input checked="" type="checkbox"/> Legislation on domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for violence against children</p>	<p>2.7 Score: 0.91</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. Source: Rwandan Constitution and Penal Code</p>	<p>Rwandan Constitution protects the general population. Key Populations not specifically mentioned in protections.</p>

2.8 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

2.8 Score:

0.80

Rwanda Constitution, Penal Code, other legal rules and regulations

New law introduced to criminalize those knowingly transmitting HIV to partners (classified as any incurable disease)

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 checked="" type="checkbox"/> No</p>			
<p>2.9 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, adolescents, 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>2.9 Score: 0.91</p>	<p>RBC guidelines and guidance; National Strategic Plan (2018-2024)</p>	<p>Each district has a public lawyer to assist in these matters</p>
<p>2.10 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>2.10 Score: 0.91</p>	<p>National Strategic Plan (2018 -2024)</p>	<p>Audit is conducted 1 to 2 times a year</p>
<p>2.11 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>2.11 Score: 0.91</p>	<p>Organic Law on State finances and property 2013: Legal document on roles and responsibilities of the Chief Budget Manager</p>	<p>Issue tracking report on quarterly basis (actions taken and status) signed by CBM</p>
Policies and Governance Score:		8.50		

3. Civil Society Engagement			
<p>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.</p>		Data Source	Notes/Comments
<p>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?</p>	<p><input type="radio"/> A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response.</p> <p><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.</p> <p><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.</p>	<p>3.1 Score: 1.67</p>	<p>Group concurrence, penal code</p>
<p>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)?</p>	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. There are no formal channels or opportunities.</p> <p><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.</p> <p><input checked="" type="radio"/> C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p> <p><input checked="" type="checkbox"/> Involvement on government HIV/AIDS program evaluation teams</p> <p><input checked="" type="checkbox"/> Involvement in surveys/studies</p> <p><input checked="" type="checkbox"/> Collecting and reporting on client feedback</p> <p><input checked="" type="checkbox"/> Service delivery</p>	<p>3.2 Score: 1.67</p>	<p>Group concurrence, Cabinet Manual, Prime Minister's Office, Planning and Budgeting Call Circular (issued annually by Minicofin)</p> <p>Civil Society are members of national HIV technical working groups</p>

<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>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 type="radio"/></p> <p>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 checked="" 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 checked="" type="checkbox"/> In HIV/AIDS basket or national health financing decisions</p>	<p>3.3 Score: 1.67</p>	<p>Group Concurrence and Participation; RBC Guidance</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>A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input type="radio"/></p> <p>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"/></p> <p>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 checked="" type="radio"/></p> <p>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"/></p> <p>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><input type="radio"/></p>	<p>3.4 Score: 1.67</p>	<p>Cabinet Manual, Prime Minister's Office; Planning and Budgeting Call Circular (issued annually by MINICOFIN), RGB law governing civil society</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>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 government that goes to CSOs).</p> <p><input type="radio"/></p> <p>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 checked="" type="checkbox"/> Competition is open and transparent (notices of opportunities are made public)</p> <p><input checked="" type="checkbox"/> Opportunities for CSO funding are made on an annual basis</p> <p><input checked="" type="checkbox"/> Awards are made in a timely manner (within 6-12 months of announcements)</p> <p><input checked="" type="checkbox"/> Payments are made to CSOs on time for provision of services</p>	<p>3.5 Score: 1.67</p>	<p>Regulation by GOR RGB</p>	
<p>Civil Society Engagement Score: 8.33</p>				

4. Private Sector Engagement			
		Data Source	Notes/Comments
<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.</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> <p><input checked="" type="checkbox"/> Corporations</p> <p><input checked="" type="checkbox"/> Employers</p> <p><input checked="" type="checkbox"/> Private training institutions</p> <p><input checked="" type="checkbox"/> Private health service delivery providers</p> <p>ii. Stakeholders contribute in the following ways (check all that apply):</p> <p><input checked="" type="checkbox"/> The private sector contributes technical expertise into HIV program planning</p> <p><input checked="" type="checkbox"/> Data and strategic input into supply chain management for HIV commodities</p> <p><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</p> <p><input checked="" type="checkbox"/> Data on staffing in private health service delivery providers</p> <p><input checked="" 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</p> <p><input checked="" type="checkbox"/> For technical advisory on best practices and delivery solutions</p>	<p>4.1 Score: 2.50</p>	<p>National Strategic Plan specifies the role of the private sector</p>
<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>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 checked="" 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 checked="" 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 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 checked="" 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>National Strategic Plan specifies the role of the private sector</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 checked="" type="checkbox"/> HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes</p> <p><input checked="" 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><input type="checkbox"/> Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.</p>	<p>4.3 Score: 2.50</p>	<p>Group agreement and participation</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>Group agreement and participation</p>	
<p>Private Sector Engagement Score:</p>		<p>9.50</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 Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance 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 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 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 data available to stakeholders and the general public within six months.</p>	<p>5.1 Score: 1.00</p>	<p>RBC guidelines and report</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 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 checked="" 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: 2.00</p>	<p>HRTT from Ministry of Health, disseminating of quarterly expenditure report at quarterly CCM meetings</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>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>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>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>At what level of detail is this performance data reported? [CHECK ALL THAT APPLY]</p> <p><input checked="" type="checkbox"/> National</p> <p><input checked="" type="checkbox"/> District</p> <p><input checked="" type="checkbox"/> Site-Level</p>	<p>5.3 Score: 1.33</p>	<p>Ministry of Health Annual report</p>	<p>Interanally MOH reports monthly, review quarterly and made available to stakeholders annually</p>
<p>5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?</p>	<p>A. The host country government does not make any HIV/AIDS procurements.</p> <p>B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.</p> <p>C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.</p> <p>D. The host country government makes HIV/AIDS procurements, and both tender and award details available.</p>	<p>5.4 Score: 2.00</p>	<p>E-Procurement, Coordination Procurement and Distribution System (CPDS) quantification</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>Law establishing RBC</p>	
<p>Public Access to Information Score: 8.33</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

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.

			Data Source	Notes/Comments
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV	<input checked="" type="checkbox"/> Public facilities are able to tailor services to accommodate demand (e.g., modify or add) <input checked="" type="checkbox"/> Public facilities are able to situate services in proximity to high-HIV burden locations or <input checked="" type="checkbox"/> There is evidence that public facilities in high burden areas and/or serving high-burden	6.1 Score:	0.95	National HIV Strategic Plan 2018 - 2024; HSSP IV and HRH; HIV Annual Report 2018/19
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	The host country has standardized the following design and implementation <input checked="" type="checkbox"/> Formalized mechanisms of participation by communities, high-burden populations and/or <input checked="" type="checkbox"/> National guidelines detailing how to operationalize HIV/AIDS services in communities <input type="checkbox"/> Providing official recognition to skilled human resources (e.g. community health <input checked="" type="checkbox"/> Providing financial support for community-based services <input type="checkbox"/> Providing supply chain support for community-based services <input checked="" type="checkbox"/> Supporting linkages between facility- and community-based services through	6.2 Score:	0.63	National HIV Guideline 2016 and circulars including community component and peer educator module; National Strategic Plan 2018-2024
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)?	<input type="radio"/> A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services <input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of <input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of <input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of <input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery	6.3 Score:	0.83	National Strategic Plan 2018-2024; HIV Annual Report 2018/19; Health Resource Tracking Tool (HRTT)

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	<input type="radio"/> A. HIV/AIDS services are primarily delivered by external agencies, organizations, or <input type="radio"/> B. Host country institutions deliver HIV/AIDS services but with substantial external <input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services with some external technical <input type="radio"/> D. Host country institutions deliver HIV/AIDS services with minimal or no external	6.4 Score: 0.63	National Strategic Plan 2018-2024; HIV Annual Report 2018/19; Health Resource Tracking Tool (HRTT)	
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.	<input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of <input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of <input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of <input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of <input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for	6.5 Score: 0.83	National Strategic Plan 2018-2024; HIV Annual Report 2018/19; Health Resource Tracking Tool (HRTT)	
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	<input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, <input type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with <input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some <input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or	6.6 Score: 0.63	National Strategic Plan 2018-2024; HIV Annual Report 2018/19; Health Resource Tracking Tool (HRTT)	
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery	<input type="radio"/> A. No, there is no entity. <input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient <input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. <input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.63	National Authority Exists as Rwanda Biomedical Center (RBC)	

<p>6.8 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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level <input checked="" type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service <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 	<p>6.8 Score: 0.95</p>	<p>National Policy for Human Resource Management (IPPIS)</p>	<p>The planning assessment of current and future staffing is done nationally and not limited to HIV/AIDS program</p>
<p>6.9 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 <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level <input checked="" type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service <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 	<p>6.9 Score: 0.95</p>	<p>National Strategic Plan 2018-2024; HSSP IV; Administrative District Operational Plans for Health facilities; HIV Annual Report 2018/19</p>	
<p>Service Delivery Score</p>		<p>7.06</p>		

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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				
			Data Source	Notes/Comments
7.1 Health Workforce Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: <input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply <input type="checkbox"/> The country's clinical health workers are adequately deployed to, or distributed <input type="checkbox"/> The country has developed retention schemes that address clinical health worker <input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply	7.1 Score: 0.48	HRH Sustainability Agenda for action; HRH Strategic Plan	the retention schemes are developed but not implemented
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: <input checked="" type="checkbox"/> There is a national community-based health worker (CHW) cadre that has a defined <small>1-1</small> Data are made available on the staffing and deployment of CHWs, including non- <input checked="" type="checkbox"/> The host country government officially recognizes non-formalized CHWs delivering	7.2 Score: 0.95	National HIV Guidelines; National Strategic Plan 2018-2024	Community-based health workers are peer educators providing defined scope of service mentioned in national guidelines
7.3 Health Workforce Transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation?	<input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers <input type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to <input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not <input checked="" type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and <input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally	7.3 Score: 0.71	Country Operational Plans and Cooperative Agreements; Prime Minister's Order determining the structure of Health facilities	

<p>7.4 Domestic Funding for Health Workforce: 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><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries <input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries <input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries <input checked="" type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries <input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker</p>	<p>7.4 Score: 2.50</p>	<p>HSSP IV; HRH Strategic Plan; National Strategic Plan 2018-2024; MIFOTRA</p>	
<p>7.5 Pre-service Training: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments</p>	<p><input type="radio"/> A. Pre-service education institutions do not have HIV content, or HIV content used by <input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years <input checked="" type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS- <input checked="" type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS <input checked="" type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLHIV <input checked="" type="checkbox"/> Institutions track student employment after graduation to inform planning</p>	<p>7.5 Score: 0.95</p>	<p>HRH strategic plan; HRH sustainability Agenda for Action</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? (if exact or approximate percentage known, please note in Comments column)</p>	<p>Check all that apply among A, B, C, D: <input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training <input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service <input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related <input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service <input type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service <input checked="" type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS <input checked="" type="checkbox"/> B. The host country government has a national plan for institutionalizing <input checked="" type="checkbox"/> C. The host country government requires continuing professional development, a <input checked="" type="checkbox"/> D. The host country government maintains a database to track training for HIV/AIDS,</p>	<p>7.6 Score: 0.95</p>	<p>National Mentorship Guideline; HRH Information System; E-Health/ Learning; CPD Providers and Medical/ Allied Health Professional Councils</p>	<p>In-Service training plan is available and updated every year. On top of this, a database of Health Care Providers trained on HIV/AIDS is available and maintained by the National Program.</p>

<p>7.7 Health Workforce 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>	<p><input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected</p> <p><input type="radio"/> B. There is no HRIS in country, but some data is collected for planning and management</p> <p><input type="checkbox"/> Registration and re-licensure data for key professionals is collected and used for</p> <p><input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment)</p> <p><input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health</p> <p><input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and</p> <p><input checked="" type="checkbox"/> The HRIS is primarily financed and managed by host country</p> <p><input checked="" type="checkbox"/> There is a national strategy or approach to interoperability for HRIS</p> <p><input checked="" type="checkbox"/> The government produces HR data from the system at least</p> <p><input checked="" type="checkbox"/> Host country institutions use HR data from the system for planning</p>	<p>7.7 Score:</p>	<p>0.95</p>	<p>HRH Information System; IPPIS (Integrated Payroll and Personnel Information)</p>	
<p>7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor,</p>	<p><input type="radio"/> A. No, there is no entity.</p> <p><input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient</p> <p><input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</p> <p><input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.</p>	<p>7.8 Score:</p>	<p>0.63</p>	<p>Administrative entity exists as MIFOTRA</p>	
<p>Health Workforce Score:</p>		<p>8.13</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
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)	<input type="radio"/> A. This information is not known. <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.21	CPDS Forecasting and Reports
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)	<input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.21	CPDS Forecasting and Reports
8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? <i>Note: The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community</i>	<input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.21	CPDS Forecasting and Reports

<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</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: 1.67</p>	<p>CPDS Forecast and Reports; MOH Supply chain management SOPs;</p>	<p>The plan that includes training is available and integrated in the annual/budgeted action 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,</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 type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input checked="" 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: 0.62</p>	<p>HSSP IV; National Strategic Plan 2018-2024; CPDS Forecast and Reports;</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 <input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum) <input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal delay <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 in external systems <input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government 	<p>8.6 Score: 1.67</p>	<p>CDPS Forecast and Stock Reports; Stock Reports from eLIMS; MOH Logistics Management Office (LMO)</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</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 below 80%. <input checked="" type="radio"/> C. A comprehensive assessment has been done within the last three years and the score was above 80%. 	<p>8.7 Score: 1.67</p>	<p>National Supply Chain Assessment Report</p>	
<p>8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No, there is no entity. <input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. <input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. <input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget. 	<p>8.8 Score: 1.11</p>	<p>Administrative entity exists as RBC/Medical Production and Procurement Division (MPPD)</p>	
<p>Commodity Security and Supply Chain Score:</p>		<p>7.36</p>		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services		Data Source	Notes/Comments
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	<input type="radio"/> A. The host country government does not have structures or resources to support site- <input checked="" type="radio"/> B. The host country government: <input checked="" type="checkbox"/> Has structures with dedicated focal points or leaders (e.g., committee, focal <input checked="" type="checkbox"/> Has a budget line item for the QM program <input checked="" type="checkbox"/> Supports a knowledge management platform (e.g., web site) and/or peer	9.1 Score: 2.00	Rwanda Healthcare Quality Management Policy and Strategic Plan 2012;
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	<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 checked="" type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific <input type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	Rwanda Healthcare Quality Management Policy and Strategic Plan; Operational plans at Health facilities
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	<input type="radio"/> A. HIV program performance measurement data are not used to identify areas of patient <input checked="" type="radio"/> B. HIV program performance measurement data are used to identify areas of patient <input checked="" type="checkbox"/> The national quality structure has a clinical data collection system from which <input checked="" type="checkbox"/> There is a system for sharing data at the national, SNU, and local level, with <input checked="" type="checkbox"/> There is documentation of results of QI activities and demonstration of national	9.3 Score: 2.00	Rwanda HMIS; Data Quality Assurance and Management SOPs

<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</p>	<p><input type="radio"/>A. There is no training or recognition offered to build health workforce competency in</p> <p><input checked="" type="radio"/>B. There is health workforce competency-building in QI, including:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in <input type="checkbox"/> National in-service training (IST) curricula integrate quality improvement training 	<p>9.4 Score: 1.00</p>	<p>HRH Strategic Plan</p>	<p>Need to consult the teaching institutions and seek if there is a process for data source including medical school, nursing school, public health, health</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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provides oversight to ensure continuous quality improvement in HIV/AIDS care <input type="checkbox"/> Regularly convenes meetings that include health services consumers <input checked="" type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and <p>Sub-national QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provide coordination and support to ensure continuous quality improvement in <input checked="" type="checkbox"/> Regularly convene meetings that includes health services consumers <input checked="" type="checkbox"/> Routinely review national, sub-national and clinical outcome data to identify and <p>Site-level QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Undertake continuous quality improvement in HIV/AIDS care and services to 	<p>9.5 Score: 1.71</p>	<p>Data reports into RHMIS; QM/ QI Plans at Health facilities; Quality Improvement Policy Accreditation for Health facility</p>	<p>Performance indicators are aligned to quality improvement of clinical outcomes; The QM structure, providing oversight to ensure continuous quality improvement in HIV/AIDS care and services, functions are implemented by RBC through the regular Integrated Supportive Supervision coupled with Data Quality Assessment.</p>
<p>Quality Management Score:</p>		<p>8.05</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
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	<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	10.1 Score: 1.33	National Lab Strategic Plan 2015-2020
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance -	<input type="radio"/> A. No, there is no entity. <input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient <input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. <input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.89	National Lab Strategic Plan 2015-2020
10.3 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?	<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 <input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories <input type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and <input checked="" type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and <input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of	10.3 Score: 1.00	National Lab Strategic Plan 2015-2020; Lab Annual Reports
10.4 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	<input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic <input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key <ul style="list-style-type: none"> <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 <input checked="" type="checkbox"/> TB diagnosis 	10.4 Score: 1.33	Lab Annual Reports Qualified lab personnel exists however still have inadequate number of staff at complex laboratory testing including VL testing hub

<p>10.5 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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Sufficient HIV viral load instruments <input checked="" type="checkbox"/> All HIV viral load laboratories have an instrument maintenance program <input checked="" type="checkbox"/> Sufficient supply chain system is in place to prevent stock out <input type="checkbox"/> Adequate specimen transport system and timely return of results 	<p>10.5 Score: 1.00</p>	<p>National Lab Strategic Plan 2015-2020; Lab Annual Reports</p>	<p>Established systems for specimen transportation and timely return of results still need support for sustained epidemic control</p>
<p>10.6 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 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 checked="" 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>10.6 Score: 1.67</p>	<p>National Lab Strategic Plan 2015-2020; Lab Annual Reports</p>	
<p>Laboratory Score:</p>		<p>7.22</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

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?	16.5%	HSSP III Mid Term Review, 2015	
2. What is the per capita health expenditure all sources?	\$57	WHO Global Health expenditure database, 2015	Check in HSSP IV if information is available
3. What is the total health care expenditure all sources as a percent of GDP?	7.50%	WHO Global Health expenditure database, 2015	
4. What percent of total health expenditures is financed by external resources?	61%	Health Resource Tracking Tool report (MoH, 2018)	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	26%	WHO Global Health expenditure database, 2015	An OOP health study (using EICV5 datasets) was just launched and the assignment will be completed by December 2019

<p>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.</p>	<p>Data Source</p>	<p>Notes/Comments</p>
<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:</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> <p style="text-align: right;">11.1 Score: 0.87</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 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 checked="" type="checkbox"/> It covers more than 75% of the population. <p><input checked="" 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 checked="" type="checkbox"/> Non-ARV care and treatment services are covered. <input checked="" type="checkbox"/> Prevention services are covered (specify in comments). <input checked="" type="checkbox"/> It includes public subsidies for the affordability of care. 	<p>Prevention services under the CBHI scheme include circumcision and some other services.</p>	

<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>Group Agreement</p>	
<p>11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?</p>	<p><input type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget</p> <p><input checked="" type="radio"/> B. There are HIV/AIDS goals/targets articulated in the national budget.</p> <p><input checked="" type="checkbox"/> The goals/targets are measurable.</p> <p><input checked="" type="checkbox"/> Budget items/programs are linked to goals/targets.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during budget execution.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during the development of the budget.</p>	<p>11.3 Score: 0.95</p>		<p>RBC should verify this information as our group was not entirely sure about this.</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>RBC HIV division annual report 2017/18</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><input type="radio"/> 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><input type="radio"/> B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</p> <p><input checked="" type="radio"/> 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>HRTT collects all donor and government expenditure on an annual basis, by programme and sub-programme based on the MTEF</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><input type="radio"/> A. None (0%) is financed with domestic funding.</p> <p><input type="radio"/> B. Very little (approx. 1-9%) is financed with domestic funding.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) is financed with domestic funding.</p> <p><input type="radio"/> D. Most (approx. 50-89%) is financed with domestic funding.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) is financed with domestic funding.</p>	<p>11.6 Score: 1.67</p>	<p>RBC HIV division annual report 2017/18, GoR contributed 15% as a share of total expenditure (the rest is covered by GF, PEPFAR and One UN)</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><input type="radio"/> A. There is no budget for health or no money was allocated.</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>11.7 Score: 0.95</p>	<p>Joint Health Sector Review report, FY 2018/19</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><input type="radio"/> A. There is no system for funding cycle reprogramming.</p> <p><input type="radio"/> B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.</p> <p><input type="radio"/> 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><input checked="" type="radio"/> 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>Public Finance Management Law and regulations</p>	
<p>Domestic Resource Mobilization Score:</p>		<p>8.25</p>		

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><input type="radio"/> A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.</p> <p><input checked="" type="radio"/> 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>RBC to confirm</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 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 checked="" 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: 1.00</p>	<p>RBC/CDC to confirm</p>

<p>12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used 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 DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services.</p> <p><input type="radio"/> B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning.</p> <p><input checked="" type="radio"/> C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for budgeting or planning purposes for the following services (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><input type="checkbox"/> PrEP</p>	<p>12.3 Score: 2.00</p>	<p>National HIV annual report, 2017/18</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 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 checked="" 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 checked="" 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>12.4 Score: 1.56</p>	<p>RBC to confirm this information and data sources</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 (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)</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>	<p><input checked="" type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year.</p> <p><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.</p> <p><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.</p> <p><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.</p> <p><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>	<p>12.5 Score: 0.00</p>	<p>Group Agreement</p>	
<p>Technical and Allocative Efficiencies Score:</p>		<p>6.56</p>		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.			
		Data Source	Notes/Comments
<p>13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?</p>	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies:</p> <p>A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>C. Grant exclusive rights to government institutions for providing health service training?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>	<p>13.1 Score: 0.36</p>	<p>Group agreement</p>
<p>13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?</p>	<p>A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE]</p> <p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities.</p> <p><input type="checkbox"/> Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities.</p> <p>B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE]</p> <p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions.</p> <p><input type="checkbox"/> Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.</p>	<p>13.2 Score: 0.36</p>	<p>Group agreement</p>

<p>13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?</p>	<p>National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services:</p> <p><input type="checkbox"/> Prevention</p> <p><input type="checkbox"/> Testing and Counseling</p> <p><input checked="" type="checkbox"/> Treatment</p>	<p>13.3 Score: 0.24</p>	<p>Group agreement</p>	<p>Not any clinic can provide ARVs because GoR needs to monitor</p>
<p>13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?</p>	<p>A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]:</p> <p><input checked="" type="checkbox"/> ARVs</p> <p><input checked="" type="checkbox"/> Test kits</p> <p><input type="checkbox"/> Laboratory supplies</p> <p><input type="checkbox"/> Other</p> <p>D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>13.4 Score: 0.22</p>	<p>Group Discussion and Agreement</p>	<p>Question A to be checked by RBC</p>

<p>13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?</p>	<p>A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards?</p> <p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p>B. [IF YES] For which of the following is local manufacturing restricted?</p> <p><input type="checkbox"/> ARVs</p> <p><input type="checkbox"/> Test kits</p> <p><input type="checkbox"/> Laboratory supplies</p> <p><input type="checkbox"/> Other</p>	<p>13.5 Score: 0.36</p>	<p>Group agreement</p>	
<p>13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?</p>	<p>Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>13.6 Score: 0.36</p>		
<p>13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?</p>	<p>A. Are certain geographical areas restricted to only government or donor-supported HIV service providers?</p> <p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p>B. [IF YES] Which of the following are geographically restricted?</p> <p><input type="checkbox"/> Supplying HIV supplies and commodities</p> <p><input type="checkbox"/> Supplying HIV services or health workforce labor</p> <p><input type="checkbox"/> Investing capital (e.g., constructing or renovating facilities)</p>	<p>13.7 Score: 0.36</p>	<p>Group agreement</p>	
<p>13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services?</p> <p>[Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]</p>	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>	<p>13.8 Score: 0.63</p>	<p>Group Discussion , Annual Report of HIV Division 2017/2018</p>	

<p>13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?</p>	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY]</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, government service providers are held to higher standards than nongovernment service providers</p> <p><input type="checkbox"/> No, FBOs/CSOs are held to higher standards than government service providers</p> <p><input type="checkbox"/> No, private sector providers are held to higher standards than government service providers</p>	<p>13.9 Score: 0.63</p>	<p>Group Agreement</p>	
<p>13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?</p>	<p>Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES]</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>	<p>13.10 Score: 0.63</p>		<p>RBC to provide sources</p>
<p>13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?</p>	<p>A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p>	<p>13.11 Score: 0.63</p>	<p>Group Agreement</p>	
<p>13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-</p>	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services?</p>	<p>13.12 Score: 1.25</p>	<p>Group Discussion</p>	

regulatory regime?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	<p>A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]:</p> <input type="checkbox"/> HIV service caseload <input type="checkbox"/> Procurement of HIV supplies/commodities <input type="checkbox"/> Expenses <p>B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]:</p> <input type="checkbox"/> Distribution <input type="checkbox"/> Sales/Revenue <input type="checkbox"/> Production costs	13.13 Score: 1.25		None Apply under A and B
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose:</p> <p>A. Which HIV service providers they use?</p> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p>B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	13.14 Score: 1.25	Group agreement	
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	<p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider?</p> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13.15 Score: 1.25	Group agreement	

Market Openness Score: 9.75

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.

14. 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
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. <u>Select only ONE answer.</u>	<input type="radio"/> No, there is no entity. <input type="radio"/> Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget <input checked="" type="radio"/> Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. <input type="radio"/> Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.56	National Strategic Plan
14.2 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 surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	<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	14.2 Score: 0.42	RPHIA; CBS; Acquired and Pre-treatment Resistance Surveys; DHS 2014/15 RPHIA and CBS, two major survey/surveillance activities, were led and funded by external agencies during the period of note.
14.3 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.)?	<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 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 checked="" 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	14.3 Score: 0.63	FSW & MSM Size Estimations BSS (FSW) BSS (MSM in Kigali)

<p>14.4 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>	<p><input type="radio"/> A. No HIV/AIDS general 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 (90% +) is provided by the host country government</p>	<p>14.4 Score: 0.42</p>	<p>RPHIA; CBS; Acquired and Pre-treatment Resistance Surveys; DHS 2014/15</p>	
<p>14.5 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>14.5 Score: 0.42</p>	<p>FSW & MSM Size Estimations BSS (FSW) BSS (MSM in Kigali)</p>	

<p>14.6 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>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 checked="" 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 checked="" 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 checked="" 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 checked="" 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>14.6 Score: 0.83</p>	<p>DHS 2014/15 RAHIS 2013 RPHIA</p>	<p>KPs (prevalence): FSW, MSM PPs (prevalence): AGYW, Clients of Sex workers</p> <p>KPs (incidence): FSW SNU (incidence): National & Kigali</p>
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<p>14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV?</p> <p>(if exact or approximate percentage is known, please note in Comments column)</p>	<p><input type="radio"/> A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load coverage data (answer both subsections below):</p> <p>Government collects/report viral load coverage data 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 checked="" type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners)</p> <p><input checked="" type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)</p> <p>For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following):</p> <p><input type="checkbox"/> Less than 25%</p> <p><input type="checkbox"/> 25-50%</p> <p><input type="checkbox"/> 50-75%</p> <p><input checked="" type="checkbox"/> More than 75%</p>	<p>14.7 Score: 0.83</p>	<p>RHMIS</p>	<p>KPs: FSW, MSM PP: AGYW, Clients of sex workers</p>
<p>14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and 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 (or other integrated behavioral surveillance) for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" 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>Size estimation studies for (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Female sex workers (FSW)</p> <p><input checked="" 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>14.8 Score: 0.42</p>	<p>FSW PSE; MSM Size Estimation; BSS</p>	<p>The Priority Populations box under selection B/IBBS was not checked this year, as compared to 2017. For SID 3.0 (2017), data were published regarding truck drivers in 2013, fisherfolk in 2013, the Military by DoD, and PWID (cross-border). Similar data were not collected during the period of note for SID 2019, which explains why the score decreased.</p>

<p>14.9 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, or a national 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>14.9 Score: 0.83</p>	<p>National Strategic Plan (includes M&E Plan)</p>	<p>Note: Timeline for FSW, MSM, GP, AGYW. No standalone survey for clients of sex workers, but they are included in the FSW surveys</p>
<p>14.10 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>14.10 Score: 0.83</p>	<p>RBC Website Rwanda National Ethical Committee National Health Scientific Review</p>	
<p>Epidemiological and Health Data Score:</p>		<p>6.18</p>		

			Data Source	Notes/Comments
15. 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.				
15.1 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?	<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 checked="" 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	15.1 Score: 3.33	HRTT 2018	HRTT development was supported by external agencies *Muhammed will contact Ismael to confirm
15.2 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?	<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): <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 type="checkbox"/> Sub-nationally	15.2 Score: 2.50	HRTT 2018	Expenditure Data is not collected at the sub-national level.
15.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	<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 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 checked="" type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	15.3 Score: 3.33	HRTT 2018	
Financial/Expenditure Data Score:			9.17	

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			
	Data Source		Notes/Comments
<p>16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?</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>16.1 Score: 1.33</p>	<p>RHMIS LMIS</p>
<p>16.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)</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 type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input checked="" 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>16.2 Score: 1.67</p>	<p>Group agreement</p> <p>Exact percentages are not available, but financing of the collection of service delivery data is split between PEPFAR, Global Fund, and GoR, with GoR providing less than 50% of funding.</p>

<p>16.3 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 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 checked="" type="checkbox"/> By key population (FSW, PWID, MSM, TG, prisoners) <input checked="" 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>16.3 Score: 1.33</p>	<p>OVC data collected through PEPFAR DATIM -NCC collects OVC data, but not HIV-specific -Mortality is estimated for all PLHIV, but not necessarily AIDS-related deaths</p>	
<p>16.4 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>16.4 Score: 1.33</p>	<p>RHMIS</p>	<p>Collected monthly</p>

<p>16.5 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, viral suppression, 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> <ul style="list-style-type: none"> <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, and viral load <input checked="" type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM, ITG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load <input checked="" type="checkbox"/> Results against targets <input checked="" type="checkbox"/> Coverage or recent achievements of key treatment & prevention services (ART, PMTCT, VMMC, etc.) <input checked="" type="checkbox"/> Site-specific yield for HIV testing (HTC and PMTCT) <input type="checkbox"/> AIDS-related mortality rates <input checked="" type="checkbox"/> Variations in performance by sub-national unit <input checked="" type="checkbox"/> Creation of maps to facilitate geographic analysis 	<p>16.5 Score: 1.00</p>	<p>RHMIS</p>	<p>#NAME?</p>
<p>16.6 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> <ul style="list-style-type: none"> <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 <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 <input checked="" type="checkbox"/> Standard national procedures & protocols exist for routine data quality checks at the point of data entry <input checked="" type="checkbox"/> Data quality reports are published and shared with relevant ministries/government entities & partner organizations <input checked="" 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>16.6 Score: 1.33</p>	<p>National Strategic Plan (M&E Plan) DQA (NSP) MOH Data Quality Guide</p>	
<p>Performance Data Score:</p>		<p>8.00</p>		

				Data Source	Notes/Comments
<p>17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.</p>					
<p>17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?</p>	<p><input type="radio"/> A. No, there is not a CRVS system.</p> <p><input checked="" type="radio"/> B. Yes, there is a CRVS system that... (check all that apply):</p> <p><input checked="" type="checkbox"/> records births</p> <p><input checked="" type="checkbox"/> records deaths</p> <p><input checked="" type="checkbox"/> is fully operational across the country</p> <p>[IF YES] How often is CRVS data updated <u>and</u> made publically available (select only one)?</p> <p><input checked="" type="checkbox"/> A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection.</p> <p><input type="checkbox"/> B. The host country government makes CRVS data available to the general public within 6-12 months.</p> <p><input type="checkbox"/> C. The host country government makes CRVS data available to the general public within 6 months.</p>	<p>17.1 Score: 1.00</p>	<p>System governed by the Noncommunicable Disease Division supported by JHU Bloomberg</p>		
<p>17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?</p>	<p>Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services?</p> <p><input checked="" type="radio"/> A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services.</p> <p><input type="radio"/> B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services.</p> <p><input type="radio"/> C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services.</p> <p>[IF YES TO B OR C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>17.2 Score: 0.00</p>		<p>A national UID system is in development (ETA September 2020 for full implementation)</p>	

<p>17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?</p>	<p><input type="radio"/> A. No, there is no central integration of HIV/AIDS data with other relevant administrative data.</p> <p><input checked="" type="radio"/> B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following:</p> <p><input checked="" type="checkbox"/> a. TB</p> <p><input checked="" type="checkbox"/> b. Maternal and Child Health</p> <p><input checked="" type="checkbox"/> c. Other Health Data (e.g., other communicable and non-communicable diseases)</p> <p><input type="checkbox"/> d. Education</p> <p><input checked="" type="checkbox"/> e. Health Systems Information (e.g., health workforce data)</p> <p><input type="checkbox"/> f. Poverty and Employment</p> <p><input type="checkbox"/> g. Other (specify in notes)</p>	<p>17.3 Score: 1.33</p>	<p>RHMIS</p>	
<p>17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?</p>	<p><input type="radio"/> A. No, the host country government does not collect census data at least every 10 years</p> <p><input type="radio"/> B. Yes, the host country government regularly collects census data, but does not make it available to the general public.</p> <p><input checked="" type="radio"/> C. Yes, the host country government regularly collects census data and makes it available to the general public.</p> <p>(IF YES TO C only) Data that are made available to the public are disaggregated by:</p> <p><input checked="" type="checkbox"/> a. Age</p> <p><input checked="" type="checkbox"/> b. Sex</p> <p><input checked="" type="checkbox"/> c. District</p>	<p>17.4 Score: 2.00</p>	<p>NISR</p>	<p>Also by Sector</p>
<p>17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?</p>	<p><input type="radio"/> A. No, the country's subnational administrative boundaries are not made public.</p> <p><input type="radio"/> B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes.</p> <p><input checked="" type="radio"/> C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.</p>	<p>17.5 Score: 2.00</p>	<p>NISR</p>	
<p>Data for Decision-Making Ecosystem Score:</p>		<p>6.33</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D