

2016 Sustainability Index and Dashboard Summary: Zimbabwe

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed periodically by the PEPFAR Zimbabwe 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. This year was the second year that the tool was completed with partner stakeholders. It was a collaborative process and co-convened by UNAIDS. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with other contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

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

Zimbabwe Overview: Zimbabwe has an estimated HIV prevalence of 14.7% amongst the adult population, combined with a challenging economic environment and inadequate human resources have created difficult circumstances to address the HIV epidemic. Even with such circumstances, Zimbabwe has made progress toward epidemic control. The Government Zimbabwe (GOZ) has demonstrated leadership in crafting a national HIV/AIDS strategy and coordinating the response. An additional note of success is the AIDS Levy that has mobilized domestic resources to address the HIV epidemic and funded purchase of ARVs, community-based HIV prevention programming, and monitoring and evaluation.

In the last four years, there has been significant progress in the expansion of ART initiation, however, the major gap in achieving high ART coverage and epidemic control is insufficient funding for ARVs. Insufficient funds for ARV is indicative of greater funding limitations and the country remains highly dependent on donors to fund its HIV response and broader health sector. For example, test kits are completely funded by the Global Fund and PEPFAR, condoms by PEPFAR, the majority of laboratory services by Global Fund and PEPFAR, and significant PEPFAR funding to strengthen the supply chain and logistics. Further complicating the situation is a severe water shortage and looming drought impacting the Southern Africa Region that may threaten treatment adherence and retention, and care and support for vulnerable populations, especially children in food insecure areas and households. The PEPFAR program is increasing efforts to implement new service delivery models for care and treatment, and strengthening efficiencies within existing programming working towards sustained epidemic control.

SID Process: On February 19 and 24 the PEPFAR team met with the Ministry of Health and Child Care (MOHCC) and National AIDS Council (NAC) to orientated and pre-populate the SID tool. On February 22, PEPFAR representatives also met with the Clinton Health AIDS Initiative (CHAI) who has taken a leadership role in sustainable financing and to assist with pre-populating relevant questions. On February 26 UNAIDS and PEPFAR co-convened a stakeholder validation meeting with participants from the MOHCC, NAC, Global Fund Country Coordinating Mechanism (CCM) members, implementing partners, civil society, and other development partners. After an introductory address and clarification regarding the purpose of the SID from UNAIDS and PEPFA, the participants broke into four domain subgroups to discuss and validate the SID questionnaire based on the data and information assembled. The subgroups had a facilitator from PEPFAR, UNAIDS, and/or CHAI to validate agreed upon scores, record data sources, and document points of clarification and context. Upon completion of subgroup discussion, the full group then reconvened at the end of the day to review the completed tool, discuss the findings and validate the conclusions.

Sustainability Strengths:

- **Planning and Coordination (9.33, dark green):** The MOHCC effectively leads the coordination of the HIV response in Zimbabwe. A multi-year, costed national strategy exists, including specific activities and strategies to minimize the impact of HIV on vulnerable populations. The MOHCC also continues to effectively lead the implementation of the National HIV Implementation. The MOHCC has made great effort to ensure the development of the national strategy is an inclusive process.
- **Quality Management (8.67, dark green):** The GOZ has institutionalized quality management systems and plans to ensure quality improvement methodologies are applied to managing and providing HIV/AIDS services. For example, peer-learning opportunities are being developed and will be available by the end of 2016. Additionally, HIV program performance measurement data are used to identify areas of patient care and service that can be improved through national decision-making, policy, and priority setting.

Sustainability Vulnerabilities:

- **Private Sector Engagement (2.71, red):** The private sector engagement needs increased attention. For example, the private sector does not actively engage with the GOZ as part of the policy and budget decision for HIV/AIDS programs. Additionally, the legal framework and regulatory framework makes limited provisions for the needs of private businesses.
- **Domestic Resource Mobilization (3.06, red):** The GOZ continues to remain highly dependent on outside donors to fund their national HIV response. Current resource mapping shows around 20% of total funding is from the GOZ.
- **Epidemiological and Health Data (3.87, yellow):** Zimbabwe requires additional capacity to lead and manage planning and implementation of epidemiological survey and surveillance activities. Additionally, key population epidemiological survey and behavioral surveillance activities are not funded or conducted by the MOH, but external agencies, organization, and institutions. Lastly, there is a lack of reporting for viral load data and viral load testing is not done routinely at clinics.
- **Laboratory (4.72, yellow):** Like many other components of service delivery, there are strategies in place, but not fully operationalized at all levels of the system. The entire

network of laboratories and point of care testing to regulate and monitor quality is not covered. There remain large gaps in capacity of laboratory workforce, viral load infrastructure, and domestic funds for laboratories as a whole.

- **Commodity Security and Supply Chain (6.14, yellow):** ARV funding for future years is uncertain given that planning for the Global Fund beyond 2017 is currently unknown. Furthermore, as ART coverage is expected to increase with the introduction of Test and Start, ARV needs will increase while overall funding is expected to remain stable or decrease. Supply chain systems are relatively strong, but still heavily reliant on support from outside donors.

Additional Observations: Commodity shortages, especially for ARVs and viral load instrument and reagents, remain an area of concern that requires immediate attention.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Zimbabwe, please contact Mark Troger at mtroger@state.gov.

Sustainability Analysis for Epidemic Control: Zimbabwe

Epidemic Type: Generalized

Income Level: Low-income

PEPFAR Categorization: Long-term Strategy

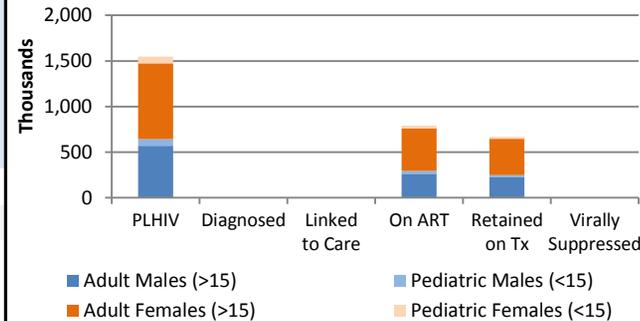
PEPFAR COP 16 Planning Level: 95,000,000

SUSTAINABILITY DOMAINS AND ELEMENTS

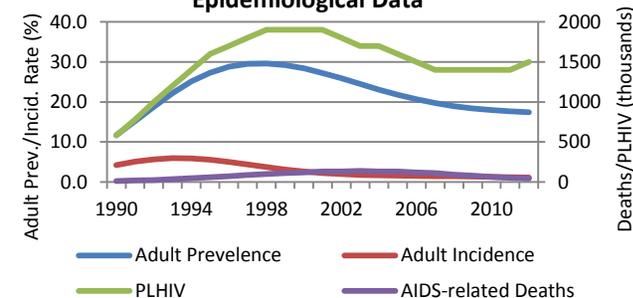
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.33			
2. Policies and Governance	7.16			
3. Civil Society Engagement	6.17			
4. Private Sector Engagement	2.71			
5. Public Access to Information	8.00			
National Health System and Service Delivery				
6. Service Delivery	7.22			
7. Human Resources for Health	8.42			
8. Commodity Security and Supply Chain	6.14			
9. Quality Management	8.67			
10. Laboratory	4.72			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	3.06			
12. Technical and Allocative Efficiencies	6.70			
Strategic Information				
13. Epidemiological and Health Data	3.87			
14. Financial/Expenditure Data	7.08			
15. Performance Data	7.34			

CONTEXTUAL DATA

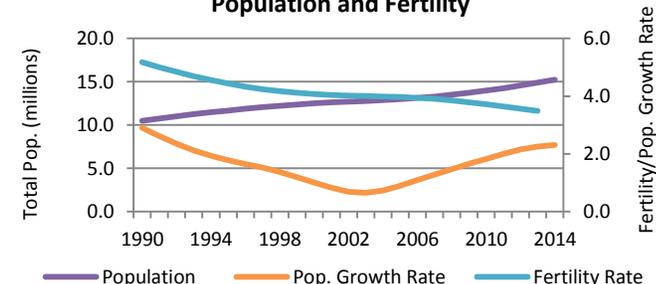
National Clinical Cascade



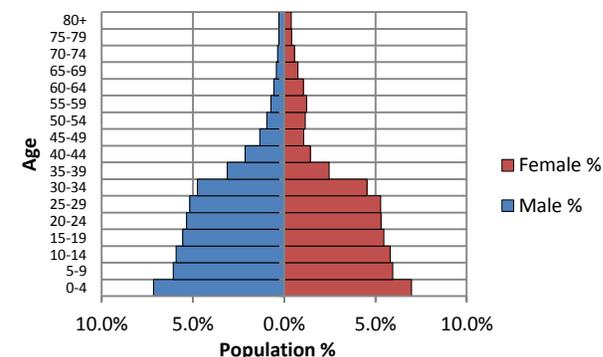
Epidemiological Data



Population and Fertility

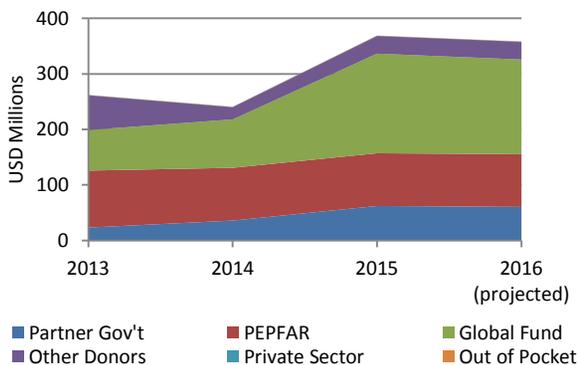


Population Pyramid (2015)

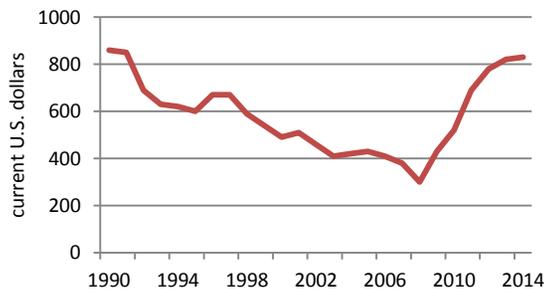


CONTEXTUAL DATA

Financing the HIV Response



GNI Per Capita (Atlas Method)



Domain A. Governance, Leadership, and Accountability

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

	Data Source	Notes/Comments
<p>1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.</p>		
<p>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p>1.1 Score: 2.50</p>	<p>Zimbabwe National HIV/AIDS Strategic Plan (ZNASP), 2015-2018</p> <p>Yes, it was costed. In order to submit a concept note to the GF, a costed National Strategy was required. (The strategy document has been shared however stakeholders have not seen a costed ZNASP)</p>
<p>1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?</p>	<p>1.2 Score: 2.50</p>	<p>Zimbabwe National HIV/AIDS Strategic Plan (ZNASP), 2015-2018</p> <p>MOHCC makes great effort to ensure active participation in the development.</p>

<p>1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?</p>	<p>Check all that apply:</p> <p><input type="checkbox"/> There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.</p> <p><input checked="" type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of:</p> <p><input checked="" type="checkbox"/> civil society organizations</p> <p><input type="checkbox"/> private sector</p> <p><input checked="" type="checkbox"/> donors</p> <p><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.</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations.</p> <p><input checked="" type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.</p>	<p>1.3 Score: 1.83</p>	<p>Ministry of Health and Child Care (MOHCC) Technical Working Group (TWG) minutes; CMM minutes; MOHCC annual planning and review minutes; National AIDS Council (NAC) reports; Terms of Reference for Partnership Forum</p>	<p>MOHCC, through CHAI, is conducting donor mapping of HIV services that are funded by multiple donors (60-70% completed) and will assist in efforts of coordination, de-duplication, and identifying gaps. There is a strategy for engage private sector for implementation and M&E reporting. That engagement is not yet operationalized the M&E system. TWG and partnership forum are the convening for other donors. Private sector is not as engaged to the extend of the public sector (general practitioners, private clinics, and providers). Private sector not reporting directory to MOHCC. There is not a full or comprehensive information to the MOHCC. MOHCC is able to gather and collect some information through health insurance. Though if private practitioners do not accept medical aide cards, if people are not accessing services through medical insurance, or if patients are paying with cash, the health insurance do not collect information, and it isn't passed to MOHCC. For example, about 8,000-10,000 patients accessing ARVs through private sector and MOHCC is unable to accurately track those patients. MOHCC is better able to track CSO (through NAC and GF) as they are sub-recipients of GF.</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 B and C)</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. Sub-national units have performance targets that contribute to aggregate national goals or targets.</p> <p><input type="radio"/> C. The central government is responsible for service delivery at the sub-national level.</p>	<p>1.4 Score: 2.50</p>	<p>Annual District Integrated Plans; Annual NAC Reports</p>	<p>An Example of MOHCC target setting and division to SNU: ART, VMMC, HTS - divide targets by the SNU, population, burden. SNUs report monthly or every three months—depending on program area—through DHIS2. Proposed targets are at SNU level are tracked and followed-up at national and SNU-level.</p>
<p>Planning and Coordination Score:</p>		<p>9.33</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
<p>2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?</p>	<p>For each category below, check <u>no more than one box</u> that reflects current national policy for ART initiation:</p> <p>A. Adults (>19 years)</p> <p><input type="checkbox"/> Test and START (current WHO Guideline)</p> <p><input checked="" type="checkbox"/> CD4 <500</p> <p>B. Pregnant and Breastfeeding Mothers</p> <p><input checked="" type="checkbox"/> Test and START/Option B+ (current WHO Guideline)</p> <p><input type="checkbox"/> Option B</p> <p>C. Adolescents (10-19 years)</p> <p><input type="checkbox"/> Test and START (current WHO Guideline)</p> <p><input checked="" type="checkbox"/> CD4<500</p> <p>D. Children (<10 years)</p> <p><input checked="" type="checkbox"/> Test and START (current WHO Guideline)</p> <p><input type="checkbox"/> CD4<500 or clinical eligibility</p>	<p>2.1 Score: 1.07</p>	<p>National Operational Plan</p> <p>Test and start is already rolled out for pregnant women, discordant couples, TB co-infected patients, and children under 5 years of age. The country has started the ART guidelines 2015 adaptation process.</p>

<p>2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART <input checked="" type="checkbox"/> A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) <input checked="" type="checkbox"/> Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready <input checked="" type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS 	<p>2.2 Score: 1.43</p>	<p>National AIDS Council Act of 1998, Statutory instrument 202 (workplace policy), Children's Act (get the details). Letter written by PS outlining task-shifting (specific to VMMC). Document (scaling up/decentralization of HIV services - nurses to initiate) for decentralization of ART services (Tx can be provided by nurses--check with Dr. Apollo). (Constitution of Zimbabwe section 76 - right to health, ZNASP 3, units in government ministries and departments)</p>	<p>HIV/AIDS Policies exist, but harmonization remains a gap. Specifically, a task shifting policy exist in the form of written guidance (VMMC) and document for scaling up/decentralizing HIV services and ART initiation to allow nurses to initiate, HTS taskshifted to lay providers. [Check with Dr. Apollo for specific form of documentation]. Medical and Dental Practitioners Act and Organization of District Health Services (early 1980s) state that facilities are run under the direction of the DMO and DMO has authority to delegate duties to specific cadres. As for CHW to disperse ARVs, the preference at this point is for a member of an adherence clubs (one patient from adherence clubs) to collect the ARVs every 6 months for distribution to other club members. Delayed introduction of the public health bill in parliament)</p>
<p>2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)</p>	<p>Check all that apply:</p> <p>Adults living with HIV (women):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Law/policy exists <input checked="" type="checkbox"/> Law/policy is fully implemented <p>Adults living with HIV (men):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Law/policy exists <input checked="" type="checkbox"/> Law/policy is fully implemented <p>Children living with HIV:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Law/policy exists <input checked="" type="checkbox"/> Law/policy is fully implemented <p>Gay men and other men who have sex with men (MSM):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Law/policy exists <input type="checkbox"/> Law/policy is fully implemented 	<p>2.3 Score: 1.03</p>	<p>This question aligns with the revised UNAIDS NCPI (2015). ART guidelines, VMMC guidelines, HTS guidelines for adults and children. Service delivery manuals used at facility level. Statutory instrument 202</p>	<p>Where laws and policies are available they may not be fully implemented e.g. Constitution of Zimbabwe section 76 - limits the right of health to availability of resources. NCPI will be completed by end of March for Zimbabwe (31 March, 2016). Prisoners have policy that allows access to treatment however this is not comprehensive because other preventive strategies are not available. but there are questions if the policy is actually implementation. CSW, not policy exists and there was a recent court ruling that CWS should not be targeted for loitering without clear evidence. CSW continue to be persecuted.</p>

Migrants:

- Law/policy exists
- Law/policy is fully implemented

People who inject drugs (PWID):

- Law/policy exists
- Law/policy is fully implemented

People with disabilities:

- Law/policy exists
- Law/policy is fully implemented

Prisoners:

- Law/policy exists
- Law/policy is fully implemented

Sex workers:

- Law/policy exists
- Law/policy is fully implemented

Transgender people:

- Law/policy exists
- Law/policy is fully implemented

Women and girls:

- Law/policy exists
- Law/policy is fully implemented

2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)

Check all that apply:

Criminalization of sexual orientation and gender identity:

Law/policy exists

Law/policy is enforced

Criminalization of cross-dressing:

Law/policy exists

Law/policy is enforced

Criminalization of drug use:

Law/policy exists

Law/policy is enforced

Criminalization of sex work:

Law/policy exists

Law/policy is enforced

Ban or limits on needle and syringe programs for people who inject drugs (PWID):

Law/policy exists

Law/policy is enforced

Ban or limits on opioid substitution therapy for people who inject drugs (PWID):

Law/policy exists

Law/policy is enforced

Ban or limits on needle and syringe programs in prison settings:

Law/policy exists

Law/policy is enforced

Ban or limits on opioid substitution therapy in prison settings:

Law/policy exists

Law/policy is enforced

2.4 Score: 0.77

This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question.

PWID fall under the drugs use population, though in Zimbabwe there is no evidence of PWIDs.

Ban or limits on the distribution of condoms in prison settings:

Law/policy exists

Law/policy is enforced

Ban or limits on accessing HIV and SRH services for adolescents and young people:

Law/policy exists

Law/policy is enforced

Criminalization of HIV non-disclosure, exposure or transmission:

Law/policy exists

Law/policy is enforced

Travel and/or residence restrictions:

Law/policy exists

Law/policy is enforced

Restrictions on employment for people living with HIV:

Law/policy exists

Law/policy is enforced

<p>2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</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 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 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>2.5 Score: 0.71</p>	<p>Constitution of Zimbabwe; Health Care Act 2013; Public Health Act 2013</p>	<p>The key populations have varied reach and policies available - PWD have non-discriminatory laws, however prisoners, SWs and MSM remain with discriminatory laws and policies. The education is tokenistic Young people - ambiguity and non alignment of laws e.g. age of marriage is 18 however age of sexual consent is 16, youths do not have access to comprehensive SRH services - policies were available are not fully implemented</p>
<p>2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?</p>	<p><input type="radio"/> A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.</p> <p><input checked="" 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 type="radio"/> C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.</p>	<p>2.6 Score: 0.71</p>	<p>Annual NAC report</p>	<p>Yes, audit occurs and is available on NAC website, through other types of media, and a printed report is disseminated. Program audits done - data verification, program reviews, data quality audits</p>
<p>2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?</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>2.7 Score: 1.43</p>	<p>MOHCC</p>	<p>The biggest challenges of the audit finding implementation is the legal framework which does not change as required.</p>
<p>Policies and Governance Score: 7.16</p>				

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>Zimbabwe National HIV/AIDS Strategic Plan (ZNASP), 2015-2018</p> <p>CSO are active members of CCM</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>3.2 Score: 1.67</p>	<p>MOHCC TWG meetings/minutes, CCM meetings/minutes, MOHCC strategy reports give a participants list. Board member of Zimbabwe AIDS Network (ZAN).</p> <p>"functional" - regular basis, organized, own groups, and has organized coordination forum.</p>

<p>3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?</p>	<p><input type="radio"/> A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS.</p> <p><input checked="" type="radio"/> B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply):</p> <p><input checked="" type="checkbox"/> In advocacy</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>CCM minutes, Annual NAC reports, MOHCC TWG minutes</p>	<p>MOHCC consults CSO prior to budget submission to Ministry of Finance. CSO is the largest implementer of NAC programs. CCM representation. Decisions are made by government e.g. CSOs were involved in the public health act but it has taken government long to table this in parliament.</p>
<p>3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)?</p> <p>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)</p>	<p><input checked="" type="radio"/> A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input type="radio"/> B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input type="radio"/> C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).</p>	<p>3.4 Score: 0.00</p>	<p>CSO Consultation</p>	<p>Majority of resources for CSO is not domestic funding, but outside donors. AIDS Levy provides a small portion to CSO.</p>
<p>3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?</p>	<p><input type="radio"/> A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy</p> <p><input checked="" type="radio"/> B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that apply):</p> <p><input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs</p> <p><input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs</p> <p><input type="checkbox"/> Open competition among CSOs to provide government-funded services</p> <p><input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change</p> <p><input type="checkbox"/> There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.</p>	<p>3.5 Score: 1.17</p>	<p>CSO Consultation</p>	<p>At one point there were tax quotations (tax deduction) given to business if you funded NGOs/CSOs, hospitals, and/or social services. This will require further investigation if still exist. AIDS Levy is manifestation of CSO advocacy. There is a forum where GoZ engages CSO, but not private sector could receive additional efforts for engagement.</p>
<p>Civil Society Engagement Score:</p>		<p>6.17</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>4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p><input type="radio"/> A. There are no formal channels or opportunities</p> <p><input checked="" type="radio"/> B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback</p> <p><input type="radio"/> C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply:</p> <p><input type="checkbox"/> Corporate contributions, private philanthropy and giving</p> <p><input type="checkbox"/> Joint (i.e. public-private) supervision and quality oversight of private facilities</p> <p><input type="checkbox"/> Collection of service delivery and client satisfaction data from private providers</p> <p><input type="checkbox"/> Tracking of private training institution HRH graduates and placements</p> <p><input type="checkbox"/> Contributing to develop innovative solutions, both technology and systems innovation</p> <p><input type="checkbox"/> For technical advisory on best practices and delivery solutions</p>	<p>4.1 Score: 0.83</p>	<p>Private Sector Board Terms of Reference. Business coalition and private practitioners isn't as formalized and ad hoc.</p>	<p>Private Sector Board and Zimbabwe Business (College of Primary Care Physician) are channels for private sector engagement and coordination. Currently, there is effort to develop a public-private partnership policy for structured engagement with the private sector health delivery systems. MOHCC agrees that engagement could and should be enhanced.</p>

<p>4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?</p>	<p>A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS.</p> <p><input checked="" type="radio"/> A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS.</p> <p><input type="radio"/> B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> In patient advocacy and human rights <input type="checkbox"/> In programmatic decision making <input type="checkbox"/> In technical decision making <input type="checkbox"/> In service delivery for both public and private providers <input type="checkbox"/> In HIV/AIDS basket or national health financing decisions <input type="checkbox"/> In advancing innovative sustainable financing models <input type="checkbox"/> In HRH development, placement, and retention strategies <input type="checkbox"/> In building capacity of private training institutions <input type="checkbox"/> In supply chain management of essential supplies and drugs 	<p>4.2 Score: 0.00</p>	<p>They influence policy but not budget.</p>
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<p>4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?</p>	<p>The legislative and regulatory framework makes the following provisions (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Systems are in place for service provision and/or research reporting by private sector facilities to the government. <input checked="" type="checkbox"/> Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. <input checked="" type="checkbox"/> Tax deductions for private health providers. <input type="checkbox"/> Tax deductions for private training institutions training health workers. <input type="checkbox"/> Open competition for private health providers to compete for government services. <input type="checkbox"/> General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. <input checked="" type="checkbox"/> Freedom of private providers to advocate for policy, legal, and regulatory frameworks. <input checked="" type="checkbox"/> Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers. 	<p>4.3 Score: 1.04</p>	<p>PPP strategy</p>	<p>Private Sector reports to both MOHCC and NAC, though MOHCC stated that it depends on which private facility. For example, Mission Hospitals are private not for profit but in terms of service delivery, they are part of public sector. Mission Hospital (but not all private health sector) do not adhere to the entirety of the legislative and regulatory framework.</p>
<p>4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?</p>	<p>The legislative and regulatory framework makes the following provisions (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). <input type="checkbox"/> Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. <input type="checkbox"/> Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. <input type="checkbox"/> Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. <input type="checkbox"/> Workplace policies support HIV-related services and/or benefits for employees. <input type="checkbox"/> Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs. 	<p>4.4 Score: 0.00</p>		

<p>4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?</p>	<p><input type="radio"/> A. There are no enablers for private health service provision for lower and middle-income HIV patients.</p> <p><input checked="" type="radio"/> B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply):</p> <p><input checked="" type="checkbox"/> Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs.</p> <p><input type="checkbox"/> The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.</p>	<p>4.5 Score: 0.83</p>		<p>NAC has gone into an arrangement with Private pharmacists and this has supported PLWHIV who access treatment from private providers</p>
<p>4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?</p>	<p><input checked="" type="radio"/> A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector.</p> <p><input type="radio"/> B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply):</p> <p><input type="checkbox"/> HIV-related services/products are covered by national health insurance.</p> <p><input type="checkbox"/> HIV-related services/products are covered by private or other health insurance.</p> <p><input type="checkbox"/> Adequate risk pooling exists for HIV services.</p> <p><input type="checkbox"/> Models currently exist for cost-recovery for ART.</p> <p><input type="checkbox"/> HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.</p>	<p>4.6 Score: 0.00</p>		
<p>Private Sector Engagement Score:</p>		<p>2.71</p>		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.				
			Source of Data	Notes/Comments
<p>5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?</p>	<p><input type="radio"/> A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection.</p> <p><input type="radio"/> B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years.</p> <p><input checked="" type="radio"/> C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.</p>	<p>5.1 Score: 2.00</p>	<p>ZDHS (Every five years), Annual HIV/AIDS Estimates, ANC/PMTCT survey (Every 2 years), HIVDR Survey (Pretreatment and Acquired) (annual) EWI</p>	<p>ZDHS information is released. National HIV/AIDS Estimates are released quickly per the MOHCC. HIVDR Survey (Pretreatment and Acquired) on annual rotational basis. Early Warning Indicators Survey retrospective yearly</p>
<p>5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?</p>	<p><input type="radio"/> A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures.</p> <p><input type="radio"/> B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures.</p> <p><input checked="" type="radio"/> C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.</p>	<p>5.2 Score: 2.00</p>	<p>National AIDS Spending Assesment (NASA) every two years.</p>	<p>Data is highly summarised for the public - it is therefore difficult for the public to see actual expenditure.</p>
<p>5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?</p>	<p><input type="radio"/> A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming.</p> <p><input type="radio"/> B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming.</p> <p><input checked="" type="radio"/> C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .</p>	<p>5.3 Score: 2.00</p>	<p>NAC website; NAC 2014 report; MOHCC website not kept up to date, but regular publications go out to all health facilities through Health Matters Magazine.</p>	<p>Yes, the host country government makes available but likely not same year</p>

<p>5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?</p>	<p><input type="radio"/> A. Host country government does not make any HIV/AIDS procurements.</p> <p><input type="radio"/> B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.</p> <p><input checked="" type="radio"/> C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.</p> <p><input type="radio"/> D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.</p>	<p>5.4 Score: 1.00</p>	<p>Public Tenders (aderts in papers)</p>	
<p>5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?</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 checked="" 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 checked="" type="checkbox"/> Civil society</p> <p><input checked="" type="checkbox"/> Media</p> <p><input checked="" type="checkbox"/> Private sector</p> <p><input 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: 1.00</p>		<p>NAC is responsible coordination all partners and some of the partners educate the public. MOHCC said that NAC previously did provide education, but they were told they were treading into implementation. MOHCC has recommended that it could be explored to pull that responsibility back to the MOHCC/NAC to be the conduit for public information.</p>
<p>Public Access to Information Score: 8.00</p>				

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

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

	Data Source	Notes/Comments
<p>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.</p>		
<p>6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)</p>	<p>6.1 Score: 1.11</p>	<p>MOHCC Consultations</p> <p>Public facilities are not able to increase staff as hiring for additional workers has been frozen by the government. Demand generation is typically coordinated by facilities and partners.</p>
<p>6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?</p>	<p>6.2 Score: 1.11</p>	<p>MOHCC Consultations</p> <p>The government does not have nationalized guidelines around structuring engagement within communities, but has however incorporated recommendations into different guidelines and SOPs, including the HTS, and the operational and service delivery manual.</p> <p>Bi-directional referral system guidelines are under development.</p>
<p>6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>6.3 Score: 0.83</p>	<p>National Health Funding Reports</p> <p>Significant domestic resources are contributed to HR, infrastructure, and running cost. Minimal to procurement and supply chain, outside donors are primary contributors. [per MOHCC and Resrouce Mapping (CHAI/WB)]. The AIDS trust fund contributes almost 15% of HIV/AIDS budget.</p>

<p>6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.</p>	<p>6.4 Score: 0.74</p>	<p>Annual Report</p>	
<p>6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas.</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas.</p> <p><input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas.</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas.</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.</p>	<p>6.5 Score: 0.83</p>	<p>National Health Funding Reports</p>	<p>There is a partial data for CSW but no clarity on denominator on this population or other key populations. Challenges remain in identifying key populations. Exact quantification is difficult.</p>
<p>6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?</p>	<p><input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</p>	<p>6.6 Score: 0.74</p>	<p>National Health Funding Reports</p>	<p>There is a partial data for CSW but no clarity on denominator on this population or other key populations. Challenges remain in identifying key populations. Services to key populations may largely be provided though general services and not necessarily as targeted services for key populations. But exact figures are unknown.</p>
<p>6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?</p>	<p>The national MOH (check all that apply):</p> <p><input checked="" type="checkbox"/> Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.</p> <p><input checked="" type="checkbox"/> Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.</p> <p><input type="checkbox"/> Assesses current and future staffing needs based on HIV/AIDS program goals and</p> <p><input checked="" type="checkbox"/> Develops sub-national level budgets that allocate resources to high burden service delivery locations.</p> <p><input checked="" type="checkbox"/> Effectively engages with civil society in program planning and evaluation of services .</p> <p><input checked="" type="checkbox"/> Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.</p>	<p>6.7 Score: 0.93</p>	<p>Partner Consultations</p>	<p>MOHCC does factor staffing in the planning and management, but told there are constraints around hiring new positions at all levels and planning is not specific to HIV needs. Community health center committees and district committees are run by community/CSO. Limited resources prevent planning and management capabilities.</p>

<p>6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?</p>	<p>Sub-national health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <input type="checkbox"/> Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship. 	<p>6.8 Score: 0.93</p>	<p>Partner Consultations</p>	<p>Same constraints exist at sub-national level as at the national level.</p>
<p style="text-align: right;">Service Delivery Score</p>		<p style="text-align: right;">7.22</p>		

7. Human Resources for Health			Data Source	Notes/Comments
7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.				
<p>7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?</p>	<p>Check all that apply:</p> <p><input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers</p> <p><input type="checkbox"/> The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden</p> <p><input checked="" type="checkbox"/> The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas</p> <p><input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children</p>	<p>7.1 Score: 1.00</p>	<p>No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p>	<p>The MOHCC has undertaken a study to review the current staff establishment (SARA). A Workload Indicator of Staffing Needs study is currently under way. The current HRIS data does not allow analysis of adequate staff because it is based on an establishment that has not been reviewed since 1981 and disease burden and population size have both increased since then.</p> <p>The country has a freeze on hiring which results in clinicians and social workers are being trained but not employed despite vacancies. In addition, anecdotal evidence indicates inadequate staffing at health facility level.</p> <p><u>MOHCC:</u> Bullet 1 – There is an adequate mix, but there is room for improvement. Nurses and doctor curriculum and the amount of time provided for lectures around HIV/AIDS and STIs versus amount of time in other health related components, there are additional opportunities to increase HIV/AIDS information to increase workers capability. Post-graduate training is still required to increase their skills (i.e. initiate children on ARV) due to changing policies and some lack of specific HIV training during graduate studies. Bullet 2 – Staff are distributed, but a challenge is that high burden district may not have adequate staff. Bullet 4 - institution capacity exist, but financial capacity is limited.</p>
<p>7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support</p> <p><input checked="" type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>7.2 Score: 0.67</p>	<p>HDF and Global Fund</p>	<p>A plan and inventory has been developed and agreed, but exact timing of the transition is still unknown due to funding constraints.</p>

<p>7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?</p>	<p><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries</p> <p><input checked="" type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries</p>	<p>7.3 Score: 3.33</p>	<p>Government budget and accounts.</p>	<p>Health Worker retention plan for GF Dec 2014 gives an overview of expenditures on HR. Other reference includes the national budget document released Dec 2014. Note that GOZ expenditure on wages was approximately \$176 million (90%) in 2014 and donor contribution an additional 10%.</p> <p>More retention funding coming from HDF than GF.</p>
<p>7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input type="radio"/> A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS content</p> <p><input type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLWHA</p> <p><input type="checkbox"/> Institutions track student employment after graduation to inform planning</p>	<p>7.4 Score: 1.00</p>	<p>Q4 Score: 2.2 RN Curriculum Review Workshop 2013; Updated Guidelines Training for RN Tutors 2014</p>	<p>When new guidance emerge (WHO or other bodies), MOHCC shares with institutions to incorporate.</p> <p>HIV content is basic, and the majority of capacity building is provided as part of in-service training.</p>
<p>7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p>Check all that apply among A, B, C, D:</p> <p><input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training in the country (check ONE):</p> <p><input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service training</p> <p><input type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS</p> <p><input checked="" type="checkbox"/> C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians</p> <p><input checked="" type="checkbox"/> D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)</p>	<p>7.5 Score: 1.25</p>	<p>MOHCC Training plans. Trainsmart database.</p>	<p>From last year: All PEPFAR training is guided by the MOHCC training plans that are decentralized to Provincial and District levels. There is no system in place for separate PEPFAR trainings to be planned or implemented.</p>

<p>7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?</p>	<p><input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management</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 planning and management</p> <p><input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment) is collected and used</p> <p><input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health facility and/or community sites</p> <p><input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:</p> <p><input type="checkbox"/> The HRIS is primarily financed and managed by host country institutions</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 annually</p> <p><input checked="" type="checkbox"/> Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)</p>	<p>7.6 Score: 1.17</p>	<p>National HRIS SOP and framework</p>	<p>Significant donor support. PEPFAR.</p>
<p align="center">Human Resources for Health Score</p>		<p align="center">8.42</p>		
<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.</p>			<p align="center">Data Source</p>	<p align="center">Notes/Comments</p>
<p>8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources</p> <p><input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.1 Score: 0.21</p>	<p>GOZ contribution was 10% in 2013 and 12% in 2014. From LSU procurement and forecasting reports. Last available report August 2014. GF NFM gap analysis 2013. Health budget statement Dec 2014.</p>	<p>Last year response: GOZ contribution is coming from NAC through the AIDS Levy. The DPS Logistics Unit reports stock status of ARV, RTK and condoms on a bimonthly basis at the PSM meetings. In 2015 domestic funding for ARVs was about \$10m (total \$160m) Pediatrics has 0% coming from domestic financing and the majority of adult ARVs are funded externally.</p>
<p>8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known</p> <p><input type="radio"/> B. No (0%) funding from domestic sources</p> <p><input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.2 Score: 0.21</p>	<p>Same as above. GOZ contribution 30% in 2013 and 15% in 2014.</p>	<p>RTK are funded by the GF. Some test kits procured by USAID and HDF.</p>

<p>8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? <i>Note:</i> The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not known</p> <p><input checked="" type="radio"/> B. No (0%) funding from domestic sources</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources</p> <p><input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources</p> <p><input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources</p>	<p>8.3 Score: 0.00</p>	<p>N/A</p>	<p>USG provides majority of condoms in public health domain.</p> <p>Global Fund and UNFPA procures for key populations.</p>
<p>8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?</p>	<p><input type="radio"/> A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).</p> <p><input checked="" type="radio"/> B. There is a plan/SOP that includes the following components (check all that apply):</p> <p><input checked="" type="checkbox"/> Human resources</p> <p><input checked="" type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input checked="" type="checkbox"/> Reverse Logistics</p> <p><input checked="" type="checkbox"/> Waste management</p> <p><input checked="" type="checkbox"/> Information system</p> <p><input checked="" type="checkbox"/> Procurement</p> <p><input checked="" type="checkbox"/> Forecasting</p> <p><input checked="" type="checkbox"/> Supply planning and supervision</p> <p><input checked="" type="checkbox"/> Site supervision</p>	<p>8.4 Score: 2.22</p>	<p>MOHCC procurement plan and other SOPs (quantification, stock management, etc).</p>	
<p>8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. This information is not available.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources.</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources.</p> <p><input checked="" type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input type="radio"/> E. Most (approx. 50-89%) funding from domestic sources.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funding from domestic sources.</p>	<p>8.5 Score: 0.42</p>	<p>Donor and domestic funding mapping.</p>	<p>Per MOHCC: Lower side of 10-49%</p>

<p>8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities <input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time <input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal external assistance: <ul style="list-style-type: none"> <input type="checkbox"/> Decision makers are not seconded or implementing partner staff <input checked="" type="checkbox"/> Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects <input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government 	<p>8.6 Score: 1.98</p>	<p>MOHCC procurement plan and staffing data.</p>	
<p>8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. A comprehensive assessment has not been done <input type="radio"/> B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments <input checked="" type="radio"/> C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment 	<p>8.7 Score: 1.11</p>	<p>COMPREHENSIVE ASSESSMENT OF THE SUPPLY CHAIN FOR HEALTH COMMODITIES IN THE PUBLIC SECTOR IN ZIMBABWE - March 2014 - Euro Health Group</p>	
<p>Commodity Security and Supply Chain Score:</p>		<p>6.14</p>		
<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</p>			<p>Data Source</p>	<p>Notes/Comments</p>
<p>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?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. The host country government does not have structures or resources to support site-level continuous quality improvement <input checked="" type="radio"/> B. The host country government: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement <input checked="" type="checkbox"/> Has a budget line item for the QM program <input type="checkbox"/> Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions 	<p>9.1 Score: 1.33</p>	<p>MOHCC 2016 National plan for Quality Improvement.(QI/QM)</p>	<p>Peer learning opportunities are being developed and will be available by the end of 2016</p>

<p>9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)</p>	<p><input type="radio"/> A. There is no HIV/AIDS-related QM/QI strategy</p> <p><input type="radio"/> B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years)</p> <p><input checked="" type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy</p>	<p>9.2 Score: 1.33</p>	<p>2016 National Plan for Qi/QM. National Quality Improvement Strategy 2015-2018.</p>	
<p>9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?</p>	<p><input type="radio"/> A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting.</p> <p><input checked="" type="radio"/> B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply):</p> <p><input checked="" type="checkbox"/> The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement</p> <p><input checked="" type="checkbox"/> There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities</p> <p><input checked="" type="checkbox"/> There is documentation of results of QI activities and demonstration of national HIV program improvement</p>	<p>9.3 Score: 2.00</p>	<p>DHIS and National HIV/TB Annual Reports</p>	
<p>9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?</p>	<p><input type="radio"/> A. There is no training or recognition offered to build health workforce competency in QI.</p> <p><input checked="" type="radio"/> B. There is health workforce competency-building in QI, including:</p> <p><input checked="" type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in curricula</p> <p><input checked="" type="checkbox"/> National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services</p>	<p>9.4 Score: 2.00</p>	<p>Training plan and HIV/TB Annual Reports</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 and services <input checked="" type="checkbox"/> Regularly convenes meetings that includes health services consumers <input checked="" type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement <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 HIV/AIDS care and services <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 prioritize areas for improvement <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 identify and prioritize areas for improvement 	<p>9.5 Score: 2.00</p>	<p>National QI Guide</p>	
Quality Management Score:		8.67		
<p>10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.</p>			Data Source	Notes/Comments
<p>10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?</p>	<ul style="list-style-type: none"> <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 checked="" 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 	<p>10.1 Score: 1.25</p>	<p>Lab Strategy</p>	<p>Approved end 2015. Currently being printed (Feb 16). Not yet costed.</p>
<p>10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. Regulations do not exist to monitor minimum quality of laboratories in the country. <input type="radio"/> B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). <input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated). <input type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). <input checked="" type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). <input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated). 	<p>10.2 Score: 1.25</p>	<p>Lab system reporting system shows implementation at >50%.</p>	

<p>10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?</p>	<p><input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control</p> <p><input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key functions:</p> <ul style="list-style-type: none"> <input type="checkbox"/> HIV diagnosis in laboratories and point-of-care settings <input type="checkbox"/> TB diagnosis in laboratories and point-of-care settings <input type="checkbox"/> CD4 testing in laboratories and point-of-care settings <input type="checkbox"/> Viral load testing in laboratories and point-of-care settings <input type="checkbox"/> Early Infant Diagnosis in laboratories <input checked="" type="checkbox"/> Malaria infections in laboratories and point-of-care settings <input type="checkbox"/> Microbiology in laboratories and point-of-care settings <input checked="" type="checkbox"/> Blood banking in laboratories and point-of-care settings <input checked="" type="checkbox"/> Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings 	<p>10.3 Score: 0.56</p>	<p>Verify vacancy rates in laboratories. SARA survey. According to HSB there is a 44% vacancy rate for Laboratory and pharmacy combined. The national system is failing to retain highly trained laboratory scientists.</p>	<p>Other cadres such as microscopists, primary care counselors, and nurses are carrying out testing in light of inadequate laboratory staffing. Significant number of laboratory staff are donor supported (esp. EID and Viral Load).</p>
<p>10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?</p>	<p><input checked="" type="radio"/> A. There is not sufficient infrastructure to test for viral load.</p> <p><input type="radio"/> B. There is sufficient infrastructure to test for viral load, including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sufficient viral load instruments and reagents <input type="checkbox"/> Appropriate maintenance agreements for instruments <input type="checkbox"/> Adequate specimen transport system and timely return of results 	<p>10.4 Score: 0.00</p>	<p>MOHCC viral load coverage reports</p>	<p>Current VL coverage is 5%. A VL scale-up plan exists and capacity exists to expand.</p>
<p>10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input 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>10.5 Score: 1.67</p>	<p>Donor and Government funding mapping.</p>	
Laboratory Score:		4.72		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

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

	Data Source	Notes/Comments
<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>11.1 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. <input checked="" type="radio"/> B. There is explicit HIV/AIDS funding within the national budget. <input type="checkbox"/> The HIV/AIDS budget is program-based across ministries <input checked="" type="checkbox"/> The budget includes or references indicators of progress toward national HIV/AIDS strategy goals <input type="checkbox"/> The budget includes specific HIV/AIDS service delivery targets <input type="checkbox"/> National budget reflects all sources of funding for HIV, including from external donors </p>	<p style="text-align: center;">11.1 Score: 1.39</p> <p>2016 National Budget</p> <p>2016 was the first year for program based budgeting which aligns the budgeting to programs. Domestic sources of funding are from the National Budget and from NAC.</p>
<p>11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)</p>	<p> <input checked="" type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget <input type="radio"/> B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. <input type="radio"/> C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. <input type="radio"/> D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. <input type="radio"/> E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. <input type="radio"/> F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached. </p>	<p style="text-align: center;">11.2 Score: 0.00</p> <p>2016 National Budget</p> <p>The national budgets does not reflect targets but the MoHCC has national targets</p>

<p>11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level?</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. Information is not available</p> <p><input checked="" type="radio"/> B. There is no national HIV/AIDS budget, or the execution rate was 0%.</p> <p><input type="radio"/> C. 1-9%</p> <p><input type="radio"/> D. 10-49%</p> <p><input type="radio"/> E. 50-89%</p> <p><input type="radio"/> F. 90% or greater</p>	<p>11.3 Score: 0.00</p>	<p>2016 National Budget</p>	
<p>11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)</p>				
<p>11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)?</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>NASA Survey</p>	<p>Resource Mapping shows around 20% of total funding is from government. However, more information and verification is needed from NAC and UNAIDS on the private sector component. Based on NASA 2012 domestic resources were 29% - 11% Aids levy, 5% from for profit and NGOs, 13% OOP and Private Insurance</p>
<p>Domestic Resource Mobilization Score:</p>		<p>3.06</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>(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 checked="" type="checkbox"/> Other recognized process or model (specify in notes column)</p>	<p>12.1 Score: 1.43</p>	<p>MOHCC Consultations/MODO</p> <p>There is no direct link between data driven models and resource allocation, however at programming level there is a conscious reallocation of resources based on the spectrum model and hot spot mapping.</p>
<p>12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations?</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 (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.</p> <p><input checked="" type="radio"/> D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.</p> <p><input type="radio"/> E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.</p>	<p>12.2 Score: 0.71</p>	<p>NAC Annual Budget</p>

<p>12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)?</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>12.3 Score: 0.71</p>	<p>HMIS reports; Quarterly reports from DHIS 2</p>	<p>NAC allocates funding based on thematic areas as follows (2012) : 55% treatment, care and support, 11% prevention, 4% enabling environment, 5% M&E, Prog cordination and management, 25% program and logistics. When allocating to provinces, allocations are based on results from hot spot mapping</p>
<p>12.4 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 checked="" type="radio"/> B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used.</p> <p><input type="radio"/> C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</p> <p><input 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>Q3 Score: 0.48</p>	<p>MODO/GF review/ National review of RBF program/HTF review process e.g. JRM/NAC quarterly review meetings</p>	<p>NAC may have a more dynamic resource reallocation - NAC to verify</p>
<p>12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes?</p> <p>(note: full score can be achieved without checking all disaggregate boxes).</p>	<p><input type="radio"/> A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs</p> <p><input checked="" type="radio"/> B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):</p> <p><input checked="" type="checkbox"/> HIV Testing</p> <p><input type="checkbox"/> Care and Support</p> <p><input checked="" type="checkbox"/> ART</p> <p><input checked="" type="checkbox"/> PMTCT</p> <p><input checked="" type="checkbox"/> VMMC</p> <p><input type="checkbox"/> OVC Service Package</p> <p><input type="checkbox"/> Key population Interventions</p>	<p>12.5 Score: 1.14</p>	<p>Unit cost analysis report - UNAIDS . Global fund concept note. Investment case report</p>	<p>unit costs are not used in allocation of resources from the national budget but are used for applying for donor funds</p>

<p>12.6 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> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies <input checked="" type="checkbox"/> Reduced overhead costs by streamlining management <input checked="" type="checkbox"/> Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. <input type="checkbox"/> Improved procurement competition <input type="checkbox"/> Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) <input type="checkbox"/> Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) <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) <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) <input type="checkbox"/> Developed and implemented other new and more efficient models of HIV service delivery (specify in comments) 	<p>12.6 Score: 0.79</p>	<p>PMTCT cost effectiveness study was used to plan for PMTCT strategy; VMMC modelling study; insurance schemes serve 10-15% of population serving 200,000 (World Bank PHE analysis in draft form). Hot spot analysis for geographic targeting is in process.</p>	<p>VMMC strategies are informed by costed plans, ART are reviewing treatment options based on more efficient WHO guidelines, NATPHAM is introducing provincial warehouses to streamline distribution of medicines - USAID to provide more information on logistics and supply chain management</p>
<p>12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year. <input type="radio"/> B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. <input type="radio"/> C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. <input type="radio"/> D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. <input checked="" type="radio"/> E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen. 	<p>12.7 Score: 1.43</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	
<p>Technical and Allocative Efficiencies Score:</p>		<p>6.70</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

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

			Data Source	Notes/Comments
<p>13. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.</p>				
<p>13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years <input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions <input checked="" type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies <input type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies <input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies 	<p>13.1 Score: 0.48</p>	<p>ZDHS, ZIMPHIA and YAZ</p>	<p>ZDHS conducted with substantial TA from MACRO, ZIMPHIA with substantial TA from ICAP. YAZ in preparatory phase with TA from EGPAF and UNICEF</p>
<p>13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?</p>	<ul style="list-style-type: none"> <input checked="" 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 type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies <input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies 	<p>13.2 Score: 0.00</p>	<p>No existent surveys (ZNASP, states no data)</p>	<p>CSW, IDU, MSM - not included in targeted surveys and surveillance.</p>
<p>13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years <input type="radio"/> B. No financing (0%) is provided by the host country government <input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government <input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government <input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government <input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government 	<p>13.3 Score: 0.42</p>	<p>National AIDS Trust Fund</p>	

<p>13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input checked="" 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 type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (approx. 90%+) is provided by the host country government</p>	<p>13.4 Score: 0.00</p>	<p>N/A</p>	<p>External donors, however the surveys have yet to be conducted. Csw Size estimates to be implemented in 2016</p>
<p>13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (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 collects at least every 5 years HIV prevalence data disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM/transgender) <input type="checkbox"/> Priority populations (e.g., military, prisoners, young women & girls, etc.) <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 <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM/transgender) <input type="checkbox"/> Priority populations (e.g., military, prisoners, young women & girls, etc.) <input checked="" type="checkbox"/> Sub-national units 	<p>13.5 Score: 0.71</p>	<p>HIV Estimates</p>	<p>Some of the priority populations can be extracted from larger national surveys. Sub-national unit disaggregates started in 2015. Majority of data is to the SNU (province level).</p>

<p>13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. The host country government does not collect/report viral load data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load data (answer both subsections below):</p> <p>According to the following disaggregates (check ALL that apply):</p> <p><input checked="" type="checkbox"/> Age</p> <p><input checked="" type="checkbox"/> Sex</p> <p><input type="checkbox"/> Key populations (FSW, PWID, MSM/transgender)</p> <p><input type="checkbox"/> Priority populations (e.g., military, prisoners, young women & girls, etc.)</p> <p>For what proportion of PLHIV (select ONE of the following):</p> <p><input checked="" type="checkbox"/> Less than 25%</p> <p><input type="checkbox"/> 25-50%</p> <p><input type="checkbox"/> 50-75%</p> <p><input type="checkbox"/> More than 75%</p>	<p>13.6 Score: 0.36</p>	<p>HMIS</p>	<p>Lab capacities limitations. Majority of facilities are feeding VL samples to the provincial level labs and must report results back to lower level facilities. Is it about 5% of PLHIV who receive VL data.</p>
<p>13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)</p>	<p><input checked="" type="radio"/> A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.).</p> <p><input type="radio"/> B. The host country government conducts (answer both subsections below):</p> <p>IBBS for (check ALL that apply):</p> <p><input type="checkbox"/> Female sex workers (FSW)</p> <p><input type="checkbox"/> Men who have sex with men (MSM)/transgender</p> <p><input type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Priority populations (e.g., military, prisoners, young women & girls, etc.)</p> <p>Size estimation studies for (check ALL that apply):</p> <p><input type="checkbox"/> Female sex workers (FSW)</p> <p><input type="checkbox"/> Men who have sex with men (MSM)/transgender</p> <p><input type="checkbox"/> People who inject drugs (PWID)</p> <p><input type="checkbox"/> Priority populations (e.g., military, prisoners, young women & girls, etc.)</p>	<p>13.7 Score: 0.00</p>	<p>N/A</p>	<p>See 13.2 and 13.4 above.</p>
<p>13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?</p>	<p><input type="radio"/> A. There is no national HIV surveillance and surveys strategy, 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>13.8 Score: 0.95</p>	<p>ZNASP outlines entire list and timeline</p>	

<p>13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):</p> <p><input checked="" type="checkbox"/> A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data</p> <p><input checked="" type="checkbox"/> A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance</p> <p><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</p> <p><input checked="" type="checkbox"/> An in-country internal review board (IRB) exists and reviews reviews all protocols.</p>	<p>13.9 Score: 0.95</p>	<p>Medical Research Council of Zimbabwe (MRCZ) , Research Council of Zimbabwe and ZimStat</p>	
Epidemiological and Health Data Score:		3.87		
<p>14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.</p>	Data Source	Notes/Comments		
<p>14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?</p>	<p><input type="radio"/> A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years</p> <p><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</p> <p><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</p> <p><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</p> <p><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</p>	<p>14.1 Score: 1.67</p>	<p>NASA [currently underway every two years]</p>	<p>NASA and inprocess of being institutionalized wihtin NAC.</p>
<p>14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years</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 type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input checked="" 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>14.2 Score: 2.50</p>	<p>NASA</p>	<p>50% domestic and 50% external funding.</p>

<p>14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?</p>	<p><input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years</p> <p><input checked="" type="radio"/> B. HIV/AIDS expenditure data are collected (check all that apply):</p> <p><input checked="" type="checkbox"/> By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others</p> <p><input checked="" type="checkbox"/> By expenditures per program area, such as prevention, care, treatment, health systems strengthening</p> <p><input checked="" type="checkbox"/> By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel</p> <p><input checked="" type="checkbox"/> Sub-nationally</p>	<p>14.3 Score: 1.67</p>	<p>NASA</p>	<p>Yes it is by SNU (province and district level). Better utilization of the data would be benefit the national program.</p>
<p>14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?</p>	<p><input type="radio"/> A. No HIV/AIDS expenditure data are collected</p> <p><input type="radio"/> B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago</p> <p><input checked="" type="radio"/> C. HIV/AIDS expenditure data were collected at least once in the past 3 years</p> <p><input type="radio"/> D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures</p> <p><input type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures</p>	<p>14.4 Score: 0.83</p>	<p>NASA</p>	<p>Collected every two and captures previous two years of expenditures. Better use of data to inform program planning and budgeting decisions is recommended.</p>
<p>14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?</p>	<p><input type="radio"/> A. The host country government does not conduct health economic studies or analyses for HIV/AIDS</p> <p><input checked="" type="radio"/> B. The host country government conducts (check all that apply):</p> <p><input checked="" type="checkbox"/> Costing</p> <p><input type="checkbox"/> Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis)</p> <p><input type="checkbox"/> Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation)</p> <p><input type="checkbox"/> Market demand analysis</p>	<p>14.5 Score: 0.42</p>	<p>PMTCT Cost Efficiency Study (planned but not yet started), Investment Framework</p>	<p>Current economic evaluation and efficiency analysis is not adequate. It would be of greater benefit to have comprehensive economic evaluation and efficiency analysis, then disag to program areas.</p>
<p>Financial/Expenditure Data Score: 7.08</p>				
<p>15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.</p>			<p>Data Source</p>	<p>Notes/Comments</p>
<p>15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?</p>	<p><input type="radio"/> A. No system exists for routine collection of HIV/AIDS service delivery data</p> <p><input type="radio"/> B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions</p> <p><input type="radio"/> C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution</p> <p><input type="radio"/> D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution</p> <p><input checked="" type="radio"/> E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government</p>	<p>15.1 Score: 1.33</p>	<p>National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC</p>	

<p>15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p>	<p><input type="radio"/> A. No routine collection of HIV/AIDS service delivery data exists</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input 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>15.2 Score: 1.67</p>	<p>NASA</p>	<p>MOHCC - DHIS and NAC is funded by AIDS Levy</p> <p>GF provides significant resources.</p>
<p>15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)</p>	<p>Check ALL boxes that apply below:</p> <p><input checked="" type="checkbox"/> A. The host country government routinely collects & reports service delivery data for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> Adult Care and Support <input checked="" type="checkbox"/> Adult Treatment <input checked="" type="checkbox"/> Pediatric Care and Support <input checked="" type="checkbox"/> Orphans and Vulnerable Children <input checked="" type="checkbox"/> Voluntary Medical Male Circumcision <input checked="" type="checkbox"/> HIV Prevention <input type="checkbox"/> AIDS-related mortality <p><input checked="" type="checkbox"/> B. Service delivery data are being collected:</p> <ul style="list-style-type: none"> <input type="checkbox"/> By key population (FSW, PWID, MSM/transgender) <input type="checkbox"/> By priority population (e.g., military, prisoners, young women & girls, etc.) <input checked="" type="checkbox"/> By age & sex <input checked="" type="checkbox"/> From all facility sites (public, private, faith-based, etc.) <input type="checkbox"/> From all community sites (public, private, faith-based, etc.) 	<p>15.3 Score: 1.11</p>	<p>National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC</p>	<p>For some of KP (CSW), some data is being collected.</p>
<p>15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?</p>	<p><input type="radio"/> A. The host country government does not routinely collect/report HIV/AIDS service delivery data</p> <p><input type="radio"/> B. The host country government collects & reports service delivery data annually</p> <p><input type="radio"/> C. The host country government collects & reports service delivery data semi-annually</p> <p><input checked="" type="radio"/> D. The host country government collects & reports service delivery data at least quarterly</p>	<p>15.4 Score: 1.33</p>	<p>National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC</p>	<p>Monthly reporting</p>

<p>15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?</p>	<p><input type="radio"/> A. The host country government does not routinely analyze service delivery data to measure program performance</p> <p><input checked="" type="radio"/> B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention <input type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention <input checked="" type="checkbox"/> Results against targets <input checked="" type="checkbox"/> Coverage 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>15.5 Score: 0.83</p>	<p>National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC</p>	<p>The key word within the question is routinely. AIDS-related mortality rates are not collected and analyzed routinely.</p>
<p>15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?</p>	<p><input type="radio"/> A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):</p> <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 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>15.6 Score: 1.07</p>	<p>National QA/QI Strategy [date],</p>	
<p>Performance Data Score:</p>		<p>7.34</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D