HIV Domestic Resource Mobilization and Sustainability Strategy 2020–2025

FEBRUARY 2020

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH-ETHIOPIA

Acknowledgements

The Federal HIV/AIDS Prevention and Control Office (FHAPCO) would like to thank the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development and U.S. President's Emergency Plan for AIDS Relief, for its continual financial and technical assistance for the realization of this *HIV Domestic Resource Mobilization and Sustainability Strategy*.

FHAPCO also extends its appreciation to all members of the HIV Domestic Resource Mobilization Task Force from government sectors and partners for their contributions to enriching and strengthening the document. Our office is delighted to acknowledge the regional health bureaus/regional HAPCOs and other regional bureaus for their contributions during the baseline assessment and help in enriching the strategy.

FHAPCO also warmly appreciates the contributions of Thomas Fagan, Elise Lang, and Dr. Amaha Haile (consultant) of HP+, all of whom played a key role in developing the strategy.

FHAPCO also recognizes the great work done by its Projects and Grant Management Coordination Directorate colleagues. In particular, FHAPCO extends its great appreciation to Director Zelalem Gizachew for his strong role in leading the development of the document and to Senior Program Officer Hayelom Assefa for his role in facilitating the coordination of task force members and in developing and finalizing the domestic resource mobilization strategy.

The overall leadership and coordination role played by FHAPCO staff in developing the document was pivotal and very much appreciated.

Tsigereda Kifle (MD, MPH)
Director General, Federal HIV/AIDS Prevention and Control Office

Contents

Abbreviations

ART	antiretroviral therapy
BOLSAs	Bureaus of Labour and Social Affairs
BWCYAs	Bureaus of Women, Children and Youth Affairs
CBHI	community-based health insurance
CCCs	community care coalitions
DRMS	Domestic Resource Mobilization and Sustainability
EFY	Ethiopia fiscal year
EHIA	Ethiopia Health Insurance Agency
ETB	Ethiopian birr
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GDP	gross domestic product
HAPCO	HIV/AIDS Prevention and Control Office
HCFS	Health Care Financing Strategy
HIV	human immunodeficiency virus
HPR	House of Peoples' Representatives
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MOR	Ministry of Revenue
PCD	Partnership and Cooperation Directorate
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RHAPCO	Regional HIV/AIDS Prevention and Control Office
RHB	regional health bureau
SHI	social health insurance
TOR	terms of reference
TWG	technical working group
US$	U.S. dollar
USAID	U.S. Agency for International Development
USG	U.S. Government

Executive Summary

The Federal HIV/AIDS Prevention and Control Office (FHAPCO) and the Ministry of Health (MOH) have recognized the need to strengthen the mobilization of domestic resources to achieve national programmatic targets and ensure the long-term sustainability of the HIV response. Although Ethiopia has made significant contributions to the provision of HIV services through investments in health workers and infrastructure, in the context of declining external support for the HIV program, domestic resources will be required to fund core elements of the HIV program, including prevention, community-level interventions, provider training, monitoring and evaluation, and commodity procurement.

However, mobilization of domestic resources for HIV in a way that promotes the sustainability of the response and the transparent, efficient, and cost-effective use of resources for priority interventions requires a clear vision and strong leadership. Previous efforts to mobilize domestic resources for HIV have been fragmented and lacked clear guidelines and oversight. Thus, the FHAPCO and MOH developed this HIV Domestic Resource Mobilization and Sustainability Strategy to coordinate and govern all domestic resource mobilization efforts. The strategy covers the 2020–2025 period. The initial year of implementation, 2020, is considered a preparatory period, with resource mobilization to occur over 2021–2025 in alignment with the forthcoming national HIV/AIDS Strategic Plan 2021–2025.

The overall goal of the strategy is to finance 30 percent of the cost of the 2021–2025 national HIV/AIDS Strategic Plan from domestic sources by 2025. This goal is part of a larger vision to progressively increase domestic financing for HIV to complement donor funding. This will help improve levels of service coverage and quality and achieve epidemic control. The strategy consists of 10 strategic initiatives, detailed below, to promote (1) public resource mobilization, (2) prepayment and private sector financing options, and (3) sustainability and capacity building.

Public Resource Mobilization Initiatives

1. Increase allocation of general government revenue to health, and specifically HIV, at federal and regional levels. FHAPCO, the MOH, regional HAPCOs (RHAPCOs), and regional health bureaus will strengthen advocacy and negotiation efforts to secure an increase in budget allocations for the HIV program from the Ministry of Finance (MOF) and regional finance bureaus. Annual budgets should increase progressively over 2020–2025, from US$0.7 million to US$9.1 million at the federal level and US$1.2 million to US$7.3 million at the regional level.
2. Strengthen participation in and management and pooling of the AIDS Fund for public and private sector employees. In coordination with FHAPCO, government sector offices and private employers will achieve 65 percent and 40 percent, respectively, of employees participating voluntarily in the AIDS Fund. The recommended contribution will be 0.2 percent of pre-tax salary, generating an estimated US$36 million over 2021–2025.
3. Improve management and targeting of funds mainstreamed for HIV within priority sectors. Government offices in 10 strategic sectors will allocate at least 0.2 percent of their budgets to HIV, including from the contract value of infrastructure projects. This will generate approximately US$32 million over 2021–2025, which will be used to target the beneficiary populations of each sector—rather than employees—with services, including comprehensive HIV prevention, testing, and linkage to care and treatment.
4. Strengthen and scale up community care coalitions to increase funding for community-based care. A comprehensive package for HIV prevention and support

will be integrated into the activities of 1,300 community care coalitions in 200 high-burden woredas by 2025. This integration will mobilize the equivalent of US$14 million for HIV programming over the 2021–2025 period.

5. Implement an earmarked tax on the profits of large public and private enterprises. To ensure consistent allocation of funding toward HIV, a new tax on large public and private enterprises will be implemented and specifically earmarked for the HIV program. The tax will apply to companies with an annual income of ETB 100 million or more and be equivalent to 0.2 percent of taxable income, mobilizing an estimated US$93 million over 2021–2025.

Prepayment and Private Sector Financing Initiatives

6. Strengthen private sector engagement in the provision of HIV testing, counseling, and treatment services. Increasing the number of HIV patients able and willing to seek services in the private sector will reduce the saturation of public facilities and financial burden on the government. Developing mechanisms for private sector facilities and patients to provide at least partial cost sharing for commodities can provide a more sustainable source of commodity financing.
7. Explore the potential for eventual integration of HIV services into social and community-based health insurance benefits packages. Expansion of health insurance coverage is a central component of Ethiopia's ongoing health financing reforms and proposed Health Care Financing Strategy. Integration of HIV and other exempted services into the benefits packages of prepayment schemes is critical to ensure their long-term financing. However, further investigation into the implications for the scheme's financial sustainability is needed.

Sustainability and Capacity-Building Initiatives

8. Strengthen government stewardship to effectively implement the Domestic Resource Mobilization and Sustainability Strategy by building capacity for transparent management, coordination, and advocacy. FHAPCO, in coordination with other key partners, will strengthen capacity at all levels of government and across sectors to implement the strategy. High-level coordination, including with broader health financing efforts and donors, also will be critical to ensure the success of the strategy.
9. Ensure evidence-based decision making for efficient use of HIV resources. Resources mobilized by the strategy will be allocated to the regions, populations, and interventions of greatest need and cost-effectiveness, as determined in the national HIV/AIDS Strategic Plan, to maximize impact.
10. Promote transparency and accountability in the collection, allocation, and execution of HIV funding by improving resource tracking and monitoring. FHAPCO and the MOH will develop a standardized tool for tracking HIV allocations and expenditures. They will also develop an online dashboard and storage platform for HIV financing and programmatic data and reporting.

Implementation of these 10 strategic initiatives will be overseen by FHAPCO and its partners, guided by an implementation road map, which defines a set of activities and responsible parties to implement each initiative. Through full implementation of these activities and initiatives, an estimated US$241 million in domestic resources will be mobilized for the HIV response over 2021–2025. The initiatives to be pursued under this strategy will represent a critical step in achieving self-sufficiency and long-term sustainability for Ethiopia's HIV program.

1. Introduction

1.1 Purpose of the Strategy

The Federal HIV/AIDS Prevention and Control Office (FHAPCO) and Ministry of Health (MOH) have acknowledged a trend of steady reductions in external financing for the HIV program in Ethiopia. Since 2011, external funding has declined by approximately 60 percent (Global Fund, 2019; PEPFAR, 2019). These declines have threatened the continuation of critical activities and are already being felt acutely at the program level (FHAPCO and MOH, 2019). At the same time, Ethiopia requires steadily increasing resources to meet its programmatic targets, particularly related to identifying people living with HIV and ensuring that those on treatment are virally suppressed and can no longer transmit HIV.

Given this context, FHAPCO and the MOH have recognized the need to strengthen domestic resource mobilization for HIV to ensure the sustainability of Ethiopia's HIV response. Furthermore, FHAPCO has made domestic resource mobilization and sustainability a flagship initiative. This initiative aims to establish the political commitment, legal framework, and overall coordination needed to ensure steady increases in HIV financing to meet the program's long-term needs.

The development of the HIV Domestic Resource Mobilization and Sustainability (DRMS) Strategy is a critical first step in this initiative. Previous efforts to mobilize additional domestic resources for HIV in Ethiopia have been fragmented, uncoordinated, and lacked clear guidelines for implementation and mechanisms for enforcement (FHAPCO and MOH, 2019). This strategy aims to standardize, scale, and optimize these existing fragmented domestic resource mobilization initiatives, as well as implement new innovative financing mechanisms. It establishes a clear vision and commitment for the mobilization of new domestic resources by identifying sources of new funding, annual targets for each source, and key actions for implementation.

The strategy is structured around 10 strategic initiatives. There are five public resource mobilization initiatives, which build on existing sources and practices for domestic resource mobilization and adopt and apply international experiences and best practices for innovative financing of the HIV response. Two additional prepayment and private sector financing initiatives aim to improve integration of HIV financing into overall health financing reforms. Finally, three sustainability and capacity-building initiatives will improve stewardship, efficiency, and resource tracking to further strengthen sustainability in the HIV response.

The strategy also establishes implementation milestones and a monitoring framework to ensure compliance with and measurable progress toward its resource mobilization targets. In this way, the strategy also serves as an important instrument in the overall governance and multisectoral coordination of the HIV/AIDS response. All initiatives and activities defined in the strategy will be implemented from 2020 to 2025. Resource mobilization will occur over 2021–2025 in alignment with the forthcoming national HIV/AIDS Strategic Plan 2021–2025.

Although FHAPCO, the MOH, and their partners recognize there will be a continuing need for donor support for Ethiopia's HIV response, this strategy forms part of a larger vision to fully and sustainably finance the response. Through the 10 proposed strategic initiatives, Ethiopia will increase its domestic contribution to financing the HIV response to gradually complement and eventually replace the current level of external support. This strategy document will govern all such HIV DRMS initiatives in Ethiopia over the period 2020–2025, starting from the date of its approval by the Council of Ministers.

1.2 Strategy Development Process

This strategy was developed under the guidance and leadership of the HIV Domestic Resource Mobilization and Sustainability Task Force. The Task Force is led by FHAPCO and comprises members from the MOH, Ministry of Finance (MOF), Ministry of Revenue (MOR), Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), U.S. Agency for International Development (USAID), U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Centers for Disease Control and Prevention, Network of Networks of HIV Positives in Ethiopia (NEP+), and the USAID-funded Health Financing Improvement Program and Health Policy Plus project.

Before the strategy's development, a baseline assessment of domestic resource mobilization was conducted between January and May 2019. The baseline assessment identified current domestic resource mobilization efforts and strategies in consultation with a range of stakeholders from government, development partners, civil society, and the private sector. It collected quantitative data on current levels of domestic budget allocations and spending on HIV, and additional qualitative input from stakeholders on successes and challenges regarding existing domestic resource mobilization efforts and potential future initiatives. An additional literature review was conducted regarding the experience with and proposed strategies for domestic resource mobilization for HIV of other developing countries, particularly in eastern Africa, including Uganda and Kenya.

The strategy development occurred between June and October 2019 in close consultation with key stakeholders. Throughout the data collection and strategy development process, a series of consultative sessions was held with the task force and additional key stakeholders to define the goal, objectives, and guiding principles of this strategy and identify its strategic pillars for achieving DRMS. The Health Policy Plus project supported the task force in drafting the HIV DRMS Strategy, as well as data collection and analysis for resource mobilization projections. The draft strategy document has been reviewed in various consultative workshops with national and regional stakeholders. The final strategy has incorporated the feedback and inputs of key stakeholders at all levels.

As part of the strategy, an implementation road map of key subsequent actions was developed. Implementation of the strategy should follow this road map (included as Section 6.2 of the strategy) and occur in accordance with proposed timelines. FHAPCO, the MOH, and their partners acknowledge that ongoing review and regular updates of this road map is required to reflect changes in the political, economic, and programmatic context of strategy implementation.

2. Situation Analysis

2.1 Ethiopia's HIV Response

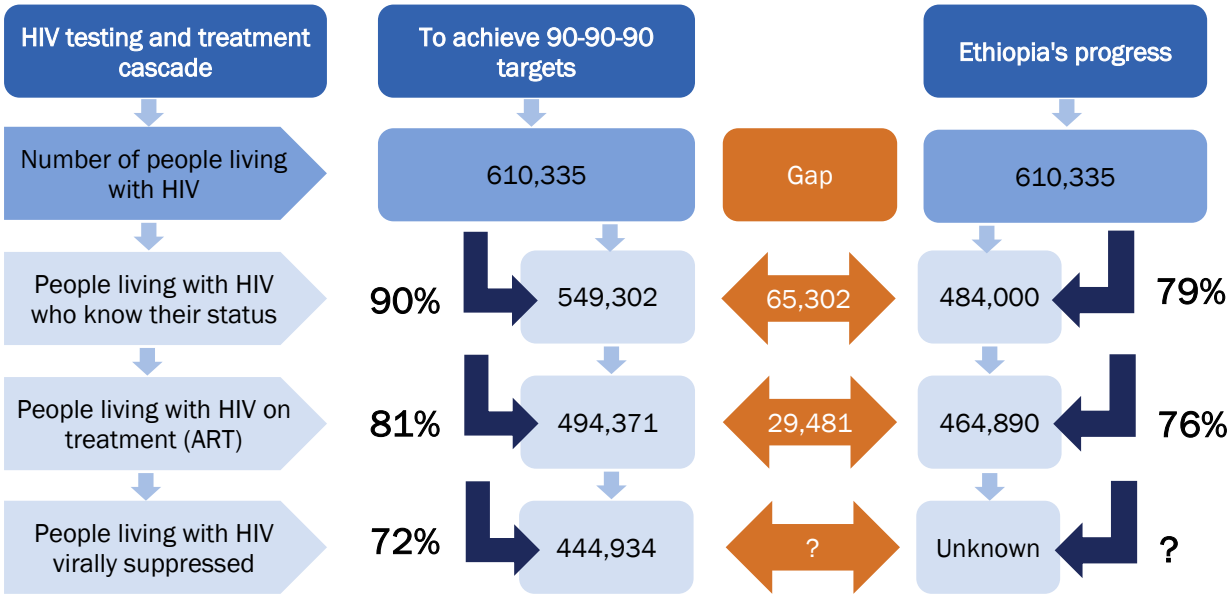
Programmatic Achievements

Ethiopia's HIV response has achieved immense progress in containing the epidemic and mitigating its impact on public health and human welfare. Over the past two decades, the efforts of FHAPCO, the MOH, and their development and technical partners have led to a decline of 90 percent in the number of new annual infections and 80 percent in the number of AIDS-related deaths (UNAIDS, 2019). At the same time, HIV prevalence has fallen from 3 percent in the late 1990s to less than 1 percent in 2017, and there are now an estimated 610,335 people living with HIV in the country, compared to 1.1 million in 2000 (UNAIDS, 2019; FHAPCO, 2019).

The country has also made significant progress in scaling up HIV testing and counseling services, and improving HIV treatment affordability and access, driven by the exemption of HIV services from user fees in all public facilities and through the Health Extension Program. In addition, a policy of test and treat—referring all HIV-positive patients for treatment, regardless of CD4 count—was launched in October 2017. As of 2018, there were more than 3,000 HIV testing and counseling sites, 1,250 antiretroviral therapy (ART) sites, and approximately 3,000 prevention of mother-to-child transmission sites across the country (MOH and FHAPCO, 2018).

Ethiopia has made significant progress along the HIV treatment cascade, particularly regarding treatment and viral suppression. As of 2019, of all estimated people living with HIV in Ethiopia, 79 percent knew their status and 76 percent were on ART (96 percent of those who knew their status) (Figure 1) (MOH and FHAPCO, 2018; FHAPCO, 2019). This progress puts Ethiopia well on the way to achieving the UNAIDS 90-90-90 and 95-95-95 targets, which call for 81 percent of people living with HIV to be on treatment by 2020 and 90 percent by 2030. Although coverage of viral load testing was at just 50 percent, 86 percent of those on ART who were tested were virally suppressed (MOH and FHAPCO, 2018).

Figure 1. Ethiopia's Progress and Remaining Gaps for 90-90-90 Targets



Adapted from MOH and FHAPCO, 2018

Continuing Needs

Although Ethiopia's HIV program has achieved impressive success over the past two decades, the new challenge for the response is ensuring that this success does not lead to complacency. The declining burden of HIV—in incidence, prevalence, and mortality—does not mean there is a lesser need to prioritize HIV programming and treatment. Those gains are made possible only through significant and sustained investments in HIV prevention, testing, and treatment. Even as the disease burden of HIV declines, its financial burden rises. As of 2019, there are 464,890 people on ART in Ethiopia—an increase of 125,000, or nearly 37 percent, since 2014 (FHAPCO, 2019; UNAIDS, 2019).

Ethiopia is continuing to pursue an ambitious scale-up of HIV testing and ART. In its most recent HIV/AIDS Strategic Plan (2016–2020), the government of Ethiopia adopted UNAIDS's 90-90-90 targets: 90 percent of people living with HIV know their status, 90 percent of people living with HIV who know their status are on treatment (ART), and 90 percent of people living with HIV on treatment have attained viral suppression (UNAIDS, 2014). The current number of patients on ART represents 76 percent of the estimated 610,335 people living with HIV. Therefore, to reach the 90-90-90 treatment goal, an estimated additional 30,000 people living with HIV will need to be linked to and sustained on treatment by 2020 (Figure 1). This will bring the number of people living with HIV on ART in Ethiopia, requiring life-long treatment, to nearly 500,000.

As treatment needs continue to increase, prevention cannot be forgotten. Even with the HIV program's impressive achievement of reducing new infections by 90 percent since the mid-1990s, there is a risk of regression. Between 2014 and 2017, the estimated number of new annual infections increased from 14,000 to 16,000 (UNAIDS, 2019). This increase is due, at least in part, to reduced prioritization of and funding for prevention activities. Being cognizant of this fact, FHAPCO developed the HIV Prevention Road Map, which sets a target to reach 90 percent of key and priority populations, including adolescent girls and young women, with combination prevention by 2020 (FHAPCO, 2018). Prevention of mother-to-child transmission through scale-up of ART for women of reproductive age or pregnant or breastfeeding, as well as pediatric treatment, also remain significant programmatic gaps.

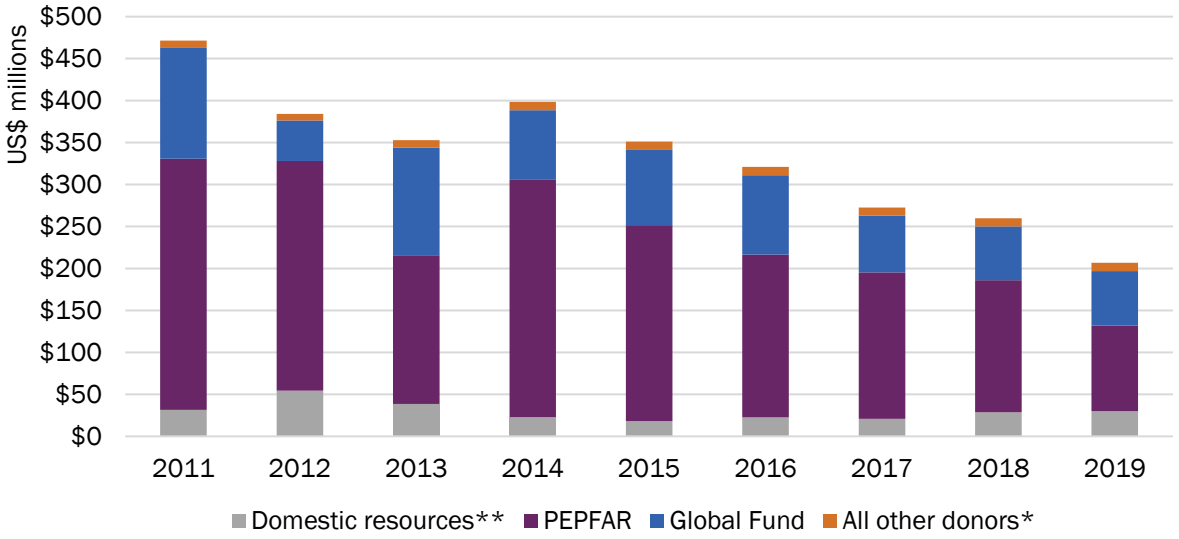
2.2 Financing the Response

Financing Trends

Ethiopia's HIV program has historically been heavily dependent on external resources. Between 2011 and 2019, the U.S. Government, through PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), accounted for more than 95 percent of estimated spending on HIV-specific commodities and programs in Ethiopia (Figure 2). Between 2004 and 2019, PEPFAR spent approximately $2.9 billion on HIV programming in Ethiopia.[1] (See Annex A for the exchange rates by year for U.S. dollars and Ethiopian birr.) However, PEPFAR's financial support has declined by roughly 80 percent, from as much as $300 million per year to just $60 million in 2018/19. The Global Fund, which contributed approximately $1.4 billion over 2005–2019, has also consistently reduced its support in recent years, from an average of $96 million annually over 2011–2016 to $66 million a year over 2017–2019. These reductions are part of a long-term global trend of flattening and ultimately declining donor financing for HIV.

[1] All currency is in nominal, U.S. dollars unless stated otherwise.

Figure 2. HIV Financing Trends in Ethiopia (2011–2019)



Estimates based on PEPFAR, 2019; Global Fund, 2019; MOH, 2017; and FHAPCO, 2013.
*Extrapolated from FHAPCO, 2013 and MOH, 2017 data. **Domestic resources for HIV were estimated using a different methodology in 2010/11–2011/12 and 2012/13.

Donor support has allowed for HIV services to be exempted from user fees in public health facilities and provided free of charge to all clients. The status of HIV services as being exempted from user fees has been key to accelerating scale-up, promoting retention, and ensuring equitable access to key prevention and treatment services, particularly among poor and economically vulnerable populations. However, the absence of user fees makes HIV services particularly vulnerable to potential funding reductions by external donors.

As Ethiopia has experienced declines in external financing for HIV, it has not achieved meaningful gains in the level of domestic resource mobilization for the response. Past estimates through the 2011/12 National AIDS Spending Assessment and 2010/11 and 2013/14 National Health Accounts have found low levels of funding for HIV (FHAPCO, 2013; MOH, 2014 and 2017). Furthermore, the calculated contributions have consisted primarily of health systems resources—including human resources and infrastructure—used to provide HIV services, rather than direct financing contributions to the HIV program.

Sources of Domestic Financing

The baseline assessment conducted before development of the DRMS Strategy sought to better understand the current levels and sources of domestic financing for HIV, and current challenges and future potential for domestic resource mobilization efforts. Although this baseline assessment was not fully comprehensive, data were collected from identified priority government offices at the federal level and in seven (of 11) regions and city administrations that account for roughly 90 percent of regional government spending, population, and people living with HIV. Sampling of woreda-level offices was limited to only nine woredas, representing a significant limitation in understanding the total value and use of resources mobilized at this level. However, estimates of the total value of resources mobilized from different sources and levels of government were extrapolated based on available data (Table 1). These estimates will serve as a baseline against which strategy progress will be measured.

Table 1. Sources of Domestic Financing According to the Baseline Assessment

Source of Financing	Value (US$)
Health sector budget for HIV (2019)	**Less than $7 million**
Federal HIV budget (MOH and FHAPCO)	$750,000
Regional HIV budgets	$1 million
Woreda HIV budgets	$5 million
HIV mainstreaming budget (2019)	**Less than $1 million**
Federal HIV mainstreaming budgets	$200,000
Regional HIV mainstreaming budgets	$250,000
Woreda HIV mainstreaming budgets	< $500,000
Resources mobilized through innovative financing for HIV (2019)	$2–3 million
Community resources mobilized for HIV (2018)	More than $1.2 million
Corporate and enterprise financing for HIV (2018)	Negligible
HIV expenditures from insurance	Unknown
Household (out-of-pocket) expenditures on HIV (2014)	$3 million

More broadly, the baseline assessment identified seven current sources and mechanisms for domestic HIV financing, challenges to their implementation, and potential for scale-up. These findings informed the strategic initiatives selected as part of this strategy. For each financing mechanism identified in the baseline assessment, its structure, achievements, and challenges are summarized briefly below (Table 2).

Table 2. Financing Mechanisms

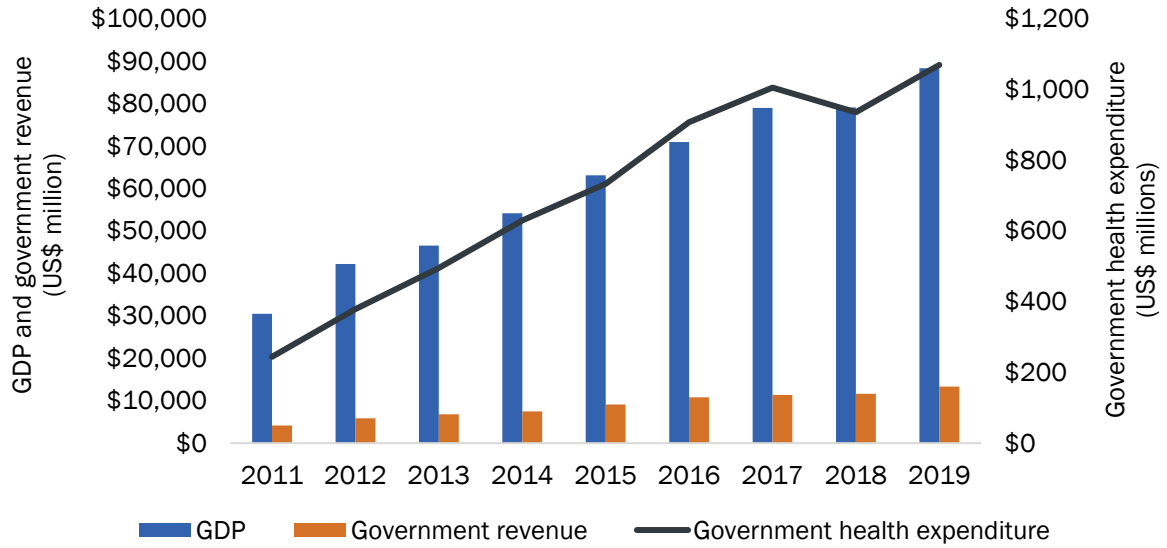
Funding source	Structure and Institutionalization	Achievements and Opportunities	Challenges and Limitations
Health sector Budgets	Allocations from general tax revenue to HAPCOs or the MOH, regional health bureaus, and woreda health offices for HIV-specific activities	Seven of nine woreda health offices surveyed reported spending directly on HIV. The average allocation increased from less than $2,000 in 2014 to nearly $5,000 in 2019. *Although based on a limited sample, this finding suggests that the approximately 1,000 woredas in the country may spend as much as $5 million annually on HIV.*	Total domestic resources spent on HIV at the federal level averaged just $750,000 from 2014 to 2019. Modest increases in domestic funding for FHAPCO have been offset by reductions to the MOH HIV Unit. Regional spending on HIV averaged $1.1 million over 2014–2019 but has declined steadily since 2016. In total, government health sector spending on HIV represents just 4% of total spending on HIV.
HIV mainstreaming budgets	Funds budgeted and executed by non-health sector offices for HIV programming in accordance with FHAPCO's 2011 guidelines	Nearly all education; labor and social affairs; and women, children, and youth affairs offices are implementing HIV mainstreaming. The average allocation was approximately 0.2% of the total institutional budgets.	The lack of a legal enforcement mechanism and unique account codes provides little incentive for institutions to reach the 2% target established by FHAPCO. Resources were poorly tracked, and funded activities were not of high impact or aligned with HIV/AIDS Strategic Plan priorities.
Community resources	Funds raised at the community level by community care coalitions (CCCs) through voluntary contributions and allocated to HIV and orphans and vulnerable children programming	A total of 468 CCCs supported by the USAID Caring for Vulnerable Children project mobilized $300,000 in cash and in-kind contributions for HIV orphans and vulnerable children over three months.	CCCs are not institutionalized and lack professional management and capacity for planning, coordination, and implementation of high-impact HIV interventions.
Innovative financing	Voluntary contributions by public sector employees to AIDS Funds managed either by the sector office or pooled by administrative level and used for HIV awareness and prevention, and orphans and vulnerable children support	In the Amhara region, more than $100,000 annually is collected through the AIDS Fund and used to support HIV orphans.	AIDS Fund resources are under-utilized; also, accountability and transparency in their use are lacking, and standard guidelines are absent.
Innovative financing	HIV programming included as a core part of all road contracts, with subcontractors implementing risk-mitigation actions, including HIV prevention and awareness, for laborers and local communities	Roads contractors spent a total of an estimated $24 million on HIV from 2014 to 2019, with approximately 75% coming from domestic resources, although annual expenditures declined in the past two years due to fewer active road contracts.	The monitoring and documentation of HIV programming through road contracts is poor. Improved oversight and coordination are needed to ensure alignment with HIV/AIDS Strategic Plan priorities.
Private sector	Expenditures by public and private enterprises on HIV awareness and prevention activities for employees or communities	Many public and private enterprises have corporate social responsibility programs to implement health- and HIV-related activities.	Overall expenditures on HIV by these enterprises is extremely low, poorly tracked, and not aligned with priorities in the national HIV/AIDS Strategic Plan.
Insurance	Expenditures or reimbursements by public and private insurance schemes for HIV-related services obtained from either public or private providers	Community-based health insurance (CBHI) now covers 22 million people, or 22% of the population. Social health insurance (SHI), when implemented, will cover an additional estimated 11% of Ethiopians.	Public health insurance schemes (CBHI and SHI) do not cover services currently provided free of charge to the user in public health facilities. Private health insurance coverage is less than 1%, and benefits packages typically do not cover services provided free of charge in public facilities.
Households	Out-of-pocket expenditures by households on HIV-related services in private for-profit or not-for-profit facilities	Selected higher-level private facilities, particularly in urban areas, are providing HIV services to those who prefer and are willing to switch to private providers.	Limited private provision of services offered free of charge in public facilities restricts access to preferred providers to those with the ability to pay.

2.3 Context of Future HIV Financing

Achieving the 90-90-90 targets—and eventually the 95-95-95 targets—while maintaining critical prevention programs will require increased investment in the HIV response. However, funding for HIV has instead been declining steeply since its peak a decade ago. At less than $140 million, the total estimated value of available resources for HIV in 2018/19 was just one-third of what it was in 2010/11, at approximately $440 million. This declining trend in external financing is expected to continue, and Ethiopia cannot expect that donor support will be adequate to meet this growing need. If donor resources decline by half over 2020–2025, there will be a financing gap of more than $80 million for the HIV program compared to current spending levels. Therefore, new domestic resources must be mobilized to ensure sustainability of the response.

Ethiopia's economic situation provides a promising context for increasing domestic resources. Although Ethiopia remains a low-income country, it has one of the world's fastest growing economies. Gross domestic product (GDP) has grown by fourfold since 2003—an average increase of more than 10 percent annually—and is expected to continue to grow by more than 7 percent annually over the next five years (IMF, 2018). As a result of both this economic growth and improved tax collection (as a percentage of GDP) over the past decade, government revenues have increased sharply, doubling in real terms since 2012. This development has led to a significant increase in government fiscal space for key development priorities, including health. Since 2012, government spending on health has increased by an estimated two-and-a-half times (Figure 3).

Figure 3. Macroeconomic and Fiscal Growth (2012–2019)



Source: IMF, 2018; World Bank, 2019.

Despite this increase in health spending, the resource gap to meet Ethiopia's health sector targets remains immense. The country's Health Sector Transformation Plan (2015–2020) calls for at least ETB 95 billion (approximately $3.3 billion) to be spent on health in 2019—more than three times the estimated government expenditure in 2019 of ETB 31 billion ($1.1 billion) (Figure 3). To address this gap, the MOH has led the development of the Health Care Financing Strategy 2017–2025 (HCFS), which is awaiting approval by the Council of Ministers. This strategy aims to build on the success of the 1998 HCFS to meet the ambitious new targets for health outlined in the Health Sector Transformation Plan and Growth and Transformation Plan, and advance Ethiopia's goal of achieving universal health coverage.

The HFCS specifically recognizes the need to strengthen financing for exempted health services, including HIV, and implement innovative financing mechanisms in its HCFS 2017–2025 (see box) as core principles of the HIV DRMS Strategy. The HIV DRMS Strategy also adopts the HCFS's principles of sustainability, financial risk protection, equity, and efficiency, recognizing that they are critical to goals of the HIV program. In this way, the goals, initiatives, and approach of the HIV DRMS Strategy are explicitly linked with those of the HCFS.

Health Care Financing Strategy: Selected Strategic Initiatives Linked to HIV Resource Mobilization

Strategic Initiative 1.1: Increase government budget allocation to health

Strategic Initiative 1.2: Generate additional finances from innovative financing mechanisms

Strategic Initiative 2.2: Strengthen the mechanism for exempting health services

The HCFS has highlighted as a health financing priority the continued exemption of key health services, including those for HIV, from user fees and mobilization of adequate resources to ensure their availability. The HIV DRMS Strategy aims to ensure that the government of Ethiopia has adequate financing and resources to provide HIV services, including testing, counseling, and treatment, free of charge to all patients seeking them in the public health sector (i.e., government health facilities), as well as comprehensive prevention interventions to key and priority populations. Without these resources, declining donor financing threatens to stall—or even reverse—the impressive progress Ethiopia has made against the HIV epidemic.

Critical to achieving Ethiopia's overall health sector goals is to ensure that the country can meet the needs of the HIV program by mobilizing new domestic resources in a way that does not jeopardize the sustainability of other critical health and development priorities. Mobilizing these resources and achieving sustainability in the HIV response requires country ownership of and commitment to financing the program. To this end, the HIV DRMS Strategy has been developed in line with the strategic initiatives and principles of the country's overall health financing. The strategy is pivotal to the government's efforts to ensure it can fulfill its promise to provide HIV prevention, testing, counseling, and treatment as exempted services, and sustain and further scale up coverage rates to achieve its national targets.

3. Core Principles of the Strategy

3.1 Vision Statement

Progressively increase domestic financing for HIV to complement and eventually replace donor funding to improve levels of service coverage and quality and achieve epidemic control.

3.2 Strategic Goal

The country will finance 30 percent of the cost of the HIV program (national HIV/AIDS Strategic Plan) from domestic sources by 2025.

3.3 Strategic Objectives

1. Progressively increase budget allocations from the government treasury for the HIV program to $9.1 million at the federal and $7.3 million at the regional level by 2025.

2. Increase AIDS Fund participation to 65 percent of public sector employees and 40 percent of private sector employees by 2025, with an average contribution of 0.2 percent of salary, and pool these funds across sectors as a dedicated source of financing for HIV programming led by federal and regional HAPCOs (RHAPCOs)/regional health bureaus (RHBs).

3. Strengthen prevention funding for key and priority HIV populations by mainstreaming at least 0.2 percent of the total budget from 10 strategic sectors—including from infrastructure contracts—at the federal, regional, and woreda levels.

4. Strengthen funding for community-level prevention by integrating a package of high-impact prevention interventions into the activities of 1,300 community care coalitions by 2025.

5. Implement a new earmarked tax of 0.2 percent of taxable income on large public and private enterprises to mobilize at least $20 million annually by 2025 as a dedicated source of revenue for FHAPCO-led HIV programming.

3.4 Guiding Principles

Equity. Funds will be mobilized in a progressive manner (i.e., according to ability to pay) and allocated based on need to ensure that all people, particularly poor and vulnerable populations, have access to HIV prevention, testing, counseling, treatment, and care and support services.

Financial protection. Resource mobilization will support efforts to reduce out-of-pocket payments, which produce financial barriers to access (particularly for poorer households) and reduce uptake and retention for HIV services; it will also support the continued exemption of HIV services from user fees in public facilities.

Efficiency. Prioritization of high-impact interventions and most-at-risk and vulnerable populations, and the establishment of clear guidelines, standards, and respective accountability mechanisms to ensure compliance, will ensure that the execution of funds and service delivery maximizes the impact of HIV investments.

Accountability and transparency. Systems and mechanisms will be established to ensure that resources for HIV are tracked, responsibility is clearly defined, and incentives exist to promote the mobilization and appropriate use of resources for HIV.

Sustainability and country ownership. Resources will be mobilized from domestic sources that are economically and politically viable in the long term and strengthen domestic governance and management structures from the federal to the kebele level.

Alignment and harmonization. HIV resource mobilization initiatives will complement efforts to ensure adequate resources for the health sector as a whole, particularly other priority and exempted services, and align with other health financing and public financial management reforms.

Partnership and collaboration. Resource mobilization and sustainability initiatives will be designed, implemented, and monitored in coordination with all relevant public, private, and nongovernmental partners, including civil society and faith-based organizations, donor and technical partners, and local communities and people living with HIV.

4. Strategic Initiatives

The HIV DRMS Strategy defines 10 strategic initiatives (see Table 3) to strengthen domestic financing for HIV and promote the long-term sustainability of the HIV response. These strategic initiatives are subdivided into the following areas:

- Public resource mobilization initiatives define strategies to mobilize new domestic resources for HIV and increase domestic financing for the forthcoming HIV/AIDS Strategic Plan 2021–2025.
- Prepayment and private sector financing initiatives identify potential future strategies to be further explored during the strategic period for diversifying HIV funding sources and integrating HIV financing into broader health financing reforms to ensure adequate long-term financing for the HIV response.
- Sustainability and capacity-building initiatives identify key areas for building domestic capacity for HIV financing and ensuring accountability in domestic resource mobilization efforts.

Table 3. HIV DRMS Strategy Strategic Initiatives

Area	Strategic Initiative
Public resource mobilization	1. Increase allocation of general government revenues to health, and specifically HIV, at federal and regional levels
	2. Strengthen participation in and management and pooling of the AIDS Fund for public and private sector employees
	3. Improve management and targeting of funds mainstreamed for HIV within priority sectors
	4. Strengthen and scale up community care coalitions to increase funding for community-based care
	5. Implement an earmarked tax on the profits of large public and private enterprises
Prepayment and private sector financing	6. Strengthen private sector engagement in the provision of HIV testing, counseling, and treatment services
	7. Explore the potential for eventual integration of HIV services into social and community-based health insurance benefits packages
Sustainability and capacity strengthening	8. Strengthen government stewardship to effectively implement the DRMS Strategy by building capacity for transparent management, coordination, and advocacy
	9. Ensure evidence-based decision making for efficient use of HIV resources
	10. Promote transparency and accountability in the collection, allocation, and execution of HIV funding by improving resource tracking and monitoring

4.1 Public Resource Mobilization Initiatives

The government of Ethiopia has acknowledged that to provide adequate financing for the national HIV response, new sources of domestic financing must be identified and mobilized. FHAPCO, the MOH, and their partners acknowledge that no single strategy or source will be adequate to fully mobilize the necessary resources. Furthermore, the broad range of activities within the HIV program and their implementation at varying levels of government and the healthcare system necessitate diverse sources of funding and strategies to mobilize them.

The following strategic initiatives have been selected by the HIV DRMS Task Force as those to be pursued over the period 2020–2025. For each strategy, a defined resource mobilization target (i.e., the quantity of funding to be mobilized), program use (i.e., prevention, treatment, monitoring, etc.), and management structure are identified.

SI 1: Increase allocation of general government revenues to health, and specifically HIV, at federal and regional levels

The DRMS baseline assessment and other recent reports indicate that woredas constitute the predominant source of domestic financing for HIV, despite having limited fiscal space (Alebachew et al., 2015). Therefore, there is a need to focus on the mobilization of additional resources at the federal and regional levels to ensure the continued provision of HIV services free of charge to users at the facility level.

Given Ethiopia's strong economic growth and performance in tax administration, its government budget and fiscal space are growing rapidly. The total government budget (nominal) is estimated to have nearly doubled from 2016 to 2020 and is projected to more than double again by 2025. The government must ensure that within this budget, health broadly and HIV specifically are appropriately prioritized to meet national targets and the growing needs of the population. Given that health accounts for a much lower budget share at the federal and regional levels than the woreda level, despite greater fiscal space at those levels, health and HIV within federal and regional budgets should be prioritized (Alebachew, 2015).

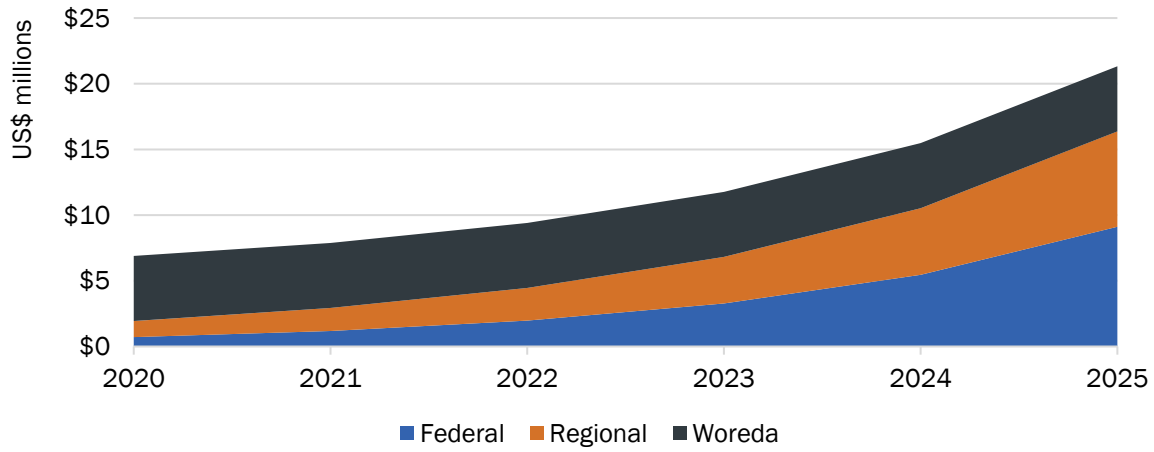
At the federal level, the budget allocated from the government treasury (i.e., the discretionary budget, excluding all earmarked taxes) will increase progressively from a baseline estimate of ETB 22 million ($700,000) in 2020 (Ethiopia fiscal year [EFY] 2012) to ETB 359 million ($9.1 million) by 2025 (EFY 2017), or by approximately 75 percent each year. This estimate is based on an increase in health as a percentage of the overall federal budget (domestic resources *only*) from a baseline of 0.5 percent to 1.3 percent by 2025, and an increase in HIV as a percentage of the federal health budget from 1.7 percent to 4.7 percent over the same period. By 2025 (EFY 2017), the federal budget for the HIV program, including both FHAPCO and the MOH, should be at least ETB 359 million (approximately $9.1 million).

At the regional level, the total budget allocated should increase progressively from a baseline estimate of ETB 38 million ($1.2 million) in 2020 (EFY 2012) to ETB 286 million ($7.3 million) by 2025 (EFY 2017), or by 50 percent each year. This development would correspond to an estimated increase in total regional health budgets as a share of total regional budgets (domestic resources *only*) from 2.2 percent to 4 percent, and of HIV as a share of regional domestic source health budgets from a baseline of 2.0 percent to 3.7 percent by 2025. The distribution of the budget target across regions should reflect HIV disease burden, such that each region and city administration will increase its HIV budget per person living with HIV from ETB 63 in 2020 to ETB 475 by 2025. Specific targets for each region and city administration are established in the monitoring framework (Section 6.3 of this strategy).

Woreda health offices are expected to continue allocating budgetary resources to HIV in a manner that maintains the total estimated baseline contribution of approximately $5 million at the woreda level. This allocation will require a contribution of approximately $5,000 annually per woreda. However, budgetary allocations for HIV by specific woredas should consider population, available resources, and HIV burden. In addition to targets for regional-level HIV budgets, the monitoring framework of this strategy establishes aggregate woreda-level HIV budget targets for each region and city administration based on the current distribution of people living with HIV. Regions should develop woreda-specific

targets to reach these people, with a particular emphasis on ensuring budget allocation in HIV priority woredas.

Figure 4. Projection of Government Budget Allocated to HIV, by Administrative Level (2020–2025)



Across all three administrative levels (i.e., federal, regional, and woreda) the amount of domestically generated resources allocated to HIV from the government budget should increase from an estimated ETB 212 million ($6.9 million) in 2020 to ETB 841 million ($21.3 million) in 2025 (Figure 4).

The government budget allocation for HIV at the federal level will be allocated directly to FHAPCO, to be managed and distributed according to HIV/AIDS Strategic Plan priorities, particularly for procurement of commodities, through the respective government structure, including the MOH, HAPCO, and the Ethiopian Pharmaceuticals Supply Agency (EPSA). Regional government budget allocations for HIV will be directed to those RHAPCOs where an office exists or to the regional health bureau where there is no RHAPCO structure. The woreda-level budget will be allocated to and managed by woreda health offices. In coordination with the MOF, budget codes will be created at all levels to track resource allocations to HIV. This effort will coordinate closely with the implementation of program-based budgeting at all levels within the health sector.

Objectives

- Secure commitments from the MOF, in coordination with the MOH, to increase federal funding for HIV by 75 percent annually from 2020 to 2025 to reach a target of $9.1 million by 2025.
- Secure commitments from all regional finance bureaus to comply with HIV budget allocation targets based on HIV burden, as elaborated in Section 6.3.
- Achieve at least 90 percent disbursement for HIV budgets at both the federal and regional levels.
- Achieve at least 90 percent budget execution for disbursed funds for HIV at the federal and regional levels.

Strategic actions

- FHAPCO will conduct consultative and consensus-building workshops with the MOF, House of Peoples' Representatives (HPR) social standing committee, Prime Minister's Office, Council of Ministers representatives, and regional governments.

- FHAPCO, RHAPCOs/RHBs, and woreda health offices will prepare annual costed plans and funding landscapes based on the national HIV/AIDS Strategic Plan to justify and negotiate the budget allocation through finance offices at all levels.
- FHAPCO, RHAPCOs/RHBs, and woreda health offices will request, negotiate, and secure budget funding from the government treasury at the federal, regional, and woreda levels, in line with the HIV DRMS Strategy and HIV/AIDS Strategic Plan.
- FHAPCO, RHAPCOs/RHBs, and woreda health offices will track budget allocation and use for the HIV program at all levels on a biannual basis to ensure adherence to this resource mobilization strategy.

SI 2: Strengthen participation in and management and pooling of the AIDS Fund for public and private sector employees

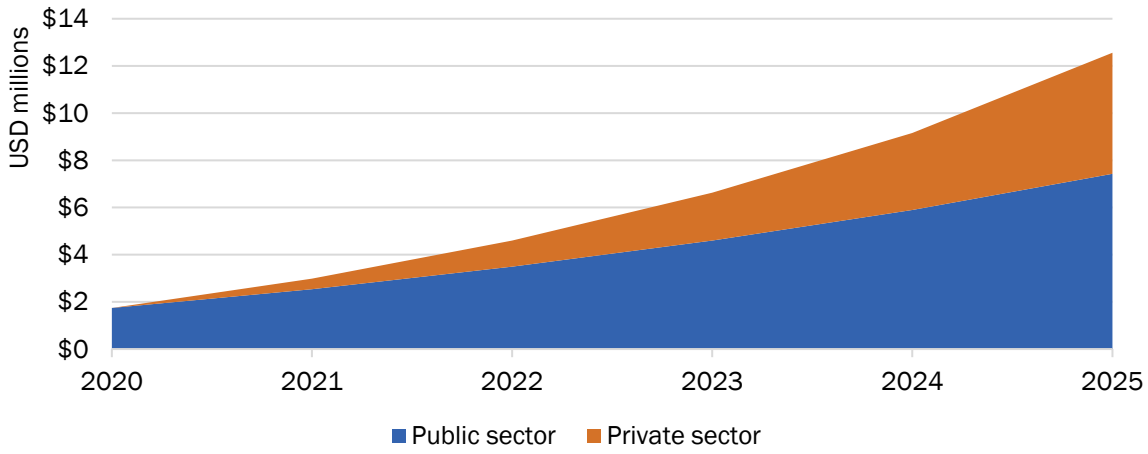
Despite historical limitations, the AIDS Fund presents significant potential for resource mobilization. Were the AIDS Fund to be universally implemented across sector offices with a high rate of voluntary—or mandatory—participation, even a low level of contribution could result in substantial revenue generation. There were 1,742,404 public sector employees in 2018 (EFY 2010), and the total wage bill for public sector employees was ETB 75.4 billion in 2018. The average annual growth rate of public sector employees was 9 percent in the five-year period from 2014 to 2018.

Contribution to the AIDS Fund will remain voluntary, but government offices should promote AIDS Fund participation and be expected to achieve a target of 65 percent participation by 2025. Offices should actively seek to enroll employees and provide new employees the opportunity to enroll at the time of hiring. The recommended contribution will be equivalent to 0.2 percent of pre-tax salary and be collected via automatic payroll deduction. These deductions will be transferred to accounts at the federal and regional levels managed by the respective HAPCO level.

Implementation of the AIDS Fund should also be expanded to the private sector. The MOR will support private employers in establishing processes for payroll deductions, which will be transferred to the same HAPCO-managed accounts. Private employers should encourage participation from employees to achieve 40 percent participation by 2025. The recommended contribution rate of 0.2 percent also will be the same for the private sector.

At these participation and contribution levels, the estimated resources mobilized annually by 2025 will equate to $7.4 million in the public sector and $5.1 million in the private sector (Figure 5). Over the strategic period (2020–2025), it is estimated that the total value of resources mobilized through the AIDS Fund will be $36 million. Of this amount, $21 million (59%) will come from the public sector and $15 million (41%) from the private sector.

Figure 5. Resources Mobilized by AIDS Fund, by Public and Private Sectors (2020–2025)



The pooling of funds in accounts managed by federal and regional HAPCOs will be a change from the common current practice, whereby AIDS Fund resources are managed by individual sector offices. However, the model of pooling funds across sector offices at each administrative level (i.e., federal, regional, or woreda) has been applied in some regions, such as Amhara. Using this model and transferring management of the pooled fund to HAPCO will ensure that funds are used in line with HIV/AIDS Strategic Plan priorities.

Ensuring alignment with HIV/AIDS Strategic Plan priorities is particularly important for the AIDS Fund because the use of its resources has previously been marked by inefficiencies. Similar to mainstreaming, AIDS Fund resources have often targeted only public employees. Public and other formal sector employees generally do not overlap significantly with defined key and priority populations in the HIV response.[2] Therefore, AIDS Fund resources will be retargeted to beneficiaries beyond its contributors to ensure both efficiency in resource use and alignment with HIV/AIDS Strategic Plan objectives.

In the long term, the potential integration of the AIDS Fund into social health insurance (SHI) will be considered. Although SHI has yet to be implemented, if and when it is, its contributory mechanism (i.e., automated payroll deductions) will be similar to that proposed herein for the AIDS Fund. It will be key to avoid redundancies (i.e., separate payroll deductions for HIV and SHI) to both reduce inefficiencies and elicit public support. A potential merger of the AIDS Fund and SHI payroll deductions might consider setting aside a portion of a single deduction as ring-fenced funding for purchasing HIV commodities. With a potential merger of the AIDS Fund into SHI, there also would be an opportunity to use these resources to procure commodities for private sector facilities, where many SHI enrollees are expected to seek services.

Objectives

- Achieve 65 percent engagement in the AIDS Fund by employees in the public sector (i.e., 65% of employees contributing) by 2025.
- Achieve 40 percent engagement in the AIDS Fund by employees in the private formal sector (i.e., 40% of employees contributing) by 2025.

[2] Key and priority populations are defined according to the HIV Prevention Road Map as female sex workers; prisoners; widowed and divorced urban women; distance drivers; mobile and resident workers in hotspot areas; and adolescent girls, young women, and their partners.

- Achieve an average monthly contribution by participating employees equivalent to 0.2 percent of pre-tax salary, or an estimated ETB 14 per participating employee per month, by 2025.
- Shift management of AIDS Fund resources to relevant HAPCOs.

Strategic actions

- FHAPCO will develop and support the passage of a proclamation or policy to establish a legal basis for the AIDS Fund.
- FHAPCO, with support from the MOR and MOF, will develop operational manuals for enrolling employees in the AIDS Fund, deducting contributions from payrolls, and transferring them to HAPCO accounts.
- Sector offices will use mainstreamed funds to promote the AIDS Fund, encourage employee participation, and establish and monitor targets for participation and contribution.
- FHAPCO will work through private sector associations to engage private sector employers and employees and encourage their participation in the AIDS Fund as well as provide them with the needed technical assistance and resources (i.e., operations manuals, etc.) to do so.
- Sector offices will promote participation in the AIDS Fund through workplace HIV awareness and promotion activities, including World AIDS Day activities, using mainstreamed funds.
- FHAPCO will promote the AIDS Fund through media (e.g., TV and radio) advocacy campaigns.
- FHAPCO will develop guidelines on using and reporting AIDS Fund resources for use by RHAPCO branches.
- Federal and regional HAPCOs will produce biannual updates on the use and impact of AIDS Fund resources to be disseminated to contributing offices and employees, including the numbers of commodities procured and number of people reached.
- Support for orphans and vulnerable children and people living with HIV currently being provided through the AIDS Fund will be transitioned to civil society organizations, government safety net programs, and woreda women and children affairs offices.

SI 3: Improve management and targeting of funds mainstreamed for HIV within priority sectors

Universal mainstreaming (i.e., by all government sector offices) has faced substantial limitations and in most cases has not been successful or effective in generating and targeting resources for priority HIV programs. However, the baseline assessment did show that certain sectors have made significant contributions to the HIV response. Furthermore, FHAPCO acknowledges that specific sectors are well positioned to reach priority populations in the HIV response. Integrating HIV programming into the core activities of relevant sector offices can be an effective way to deliver HIV services, improve the health and well-being of beneficiary populations, and support the achievement of sector objectives.

To leverage this opportunity, current mainstreaming guidelines will be revised and further developed to implement a targeted mainstreaming approach. HIV mainstreaming will be implemented in the 10 strategic sectors shown in Table 4 and linked directly to key and priority populations.

The strategy establishes a minimum contribution from all relevant sector offices at the federal, regional, and woreda levels. In seven sectors (identified in Table 4 as "Direct mainstreaming"), offices should directly allocate a minimum of 0.2 percent of their total annual budgets (both recurrent and capital) to implement HIV activities targeting key and priority populations linked with the sectors specified in the table. At the woreda level, efforts to promote mainstreaming will focus on education offices in 200 high-burden woredas.[3] The 0.2 percent threshold is based on historical contribution rates from key and strategic sectors.

Within the sectors associated with large infrastructure projects for roads, construction, mining, energy, and water, mainstreaming should follow the model currently being implemented by the Ethiopian Roads Authority. Within this model, mainstreaming should be integrated into contracts (referred to as "Infrastructure mainstreaming" in Table 4). HIV programming should be a core part of all contracts, with a minimum of 0.2 percent of the total contract value designated for HIV-related activities. These sectors should target workers (especially mobile workers, day laborers, and female sex workers) in project catchment areas.

Table 4. Strategic Sectors and Key and Priority Populations for Targeted Mainstreaming

Mainstreaming Type	Strategic Sector Office	Key and Priority Populations
Direct mainstreaming	Ministry of Labour and Social Affairs (MOLSA); regional bureaus and woreda offices	Workers in hotspot areas;* people living with HIV
	Ministry of Women, Children, and Youth Affairs; regional bureaus and woreda offices	Adolescent and young girls Female sex workers; widowed and divorced women
	Transport Authority; regional bureaus and woreda offices	Distance drivers
	Federal and regional prison administrations	Prisoners
	Ministry of Education; regional bureaus and woreda offices; Ministry of Science and Higher Education and technical and vocational training agency; colleges	Adolescent girls and young women
	Government Development Enterprises Agency and its entities (Sugar Corporation, Construction Corporation, Design Works and Supervision, Metal and Engineering Corporation)	Workers in hotspot areas and female sex workers in their project catchments
Infrastructure mainstreaming	Ethiopian Roads Authority; regional offices	Workers in hotspot areas and female sex workers in their project catchments
	Ministry of Construction and Urban Development and its projects and line offices	Workers in hotspot areas and female sex workers in their project catchments
	Ministry of Mines, Petroleum, and Natural Gas; regional offices	Workers in hotspot areas and female sex workers in their project catchments
	Ministry of Water, Irrigation, and Electricity	Workers in hotspot areas and female sex workers in their project catchments

* Hotspot areas are defined as workplaces with an HIV prevalence above 1.5 percent.

[3] The 200 high-burden woredas are those defined in the HIV Prevention in Ethiopia National Road Map 2018–2020 (FHPACO, 2018).

Within all targeted mainstreaming sectors, mainstreaming funds should be used for activities related to HIV awareness and prevention, testing and patient identification, and linkage to care and other support services. The HIV prevention interventions implemented through mainstreaming should include comprehensive behavioral change communication and condom promotion, demonstration, and distribution. An annual mainstreaming contribution of 0.2 percent of total budget or contract value from all sector offices within the 10 identified strategic sectors will generate an estimated $32 million over 2021–2025 (Table 5). Of this amount, the majority (83%) will come from contracts for infrastructure mainstreaming. An additional 5 percent will come from other federal-level sector offices; 4 percent will come from regional-level sector offices. Woredas will account for 7 percent, based on a presumed contribution of $250 annually from education offices in each of the 200 high-burden woredas.

Table 5. Budget to Be Allocated to HIV Program Through HIV Mainstreaming at Federal, Regional, and Woreda Levels, 2020—2025 (US$ millions)

Level of government	Type of mainstreaming	2020 (baseline)	2021	2022	2023	2024	2025
Federal	Direct	$0.23	$0.26	$0.30	$0.33	$0.37	$0.42
	Infrastructure	$3.65	$4.10	$4.65	$5.22	$5.90	$6.64
Regional	Direct	$0.18	$0.21	$0.23	$0.26	$0.30	$0.33
Woreda	Direct	$0.45	$0.45	$0.45	$0.45	$0.45	$0.45
Total	–	**$4.51**	**$5.02**	**$5.63**	**$6.26**	**$7.02**	**$7.84**

Objectives

- Achieve an average mainstreaming contribution of at least 0.2 percent across strategic sectors and levels of government.
- Reach 75 percent or more of federal strategic sector offices mainstreaming at least 0.2 percent of their budgets for HIV.
- Achieve 75 percent or more of strategic sector offices in each region mainstreaming at least 0.2 percent of their budgets for HIV.

Strategic actions

- FHAPCO will develop a proclamation and revised mainstreaming guidelines for both strategic sectors and infrastructure mainstreaming as well as develop a supportive legal framework to mandate and standardize the practice across sectors.
- The MOF will assign an account code and expenditure title to HIV mainstreaming.
- FHAPCO and RHAPCOs/RHBs will conduct advocacy meetings at the federal and regional levels with strategic sectors to engage them in continuing or initiating mainstreaming.
- FHAPCO will revise and standardize organizational structures and staffing norms for coordination of HIV mainstreaming within the strategic sectors, and staff and train HIV mainstreaming staff at federal- and regional-level offices to coordinate HIV mainstreaming.
- FHAPCO will create a platform and opportunities for experience sharing, annual performance reviews, and recognition of best performing sectors and regions.

SI 4: Strengthen and scale up community care coalitions to increase funding for community-based care

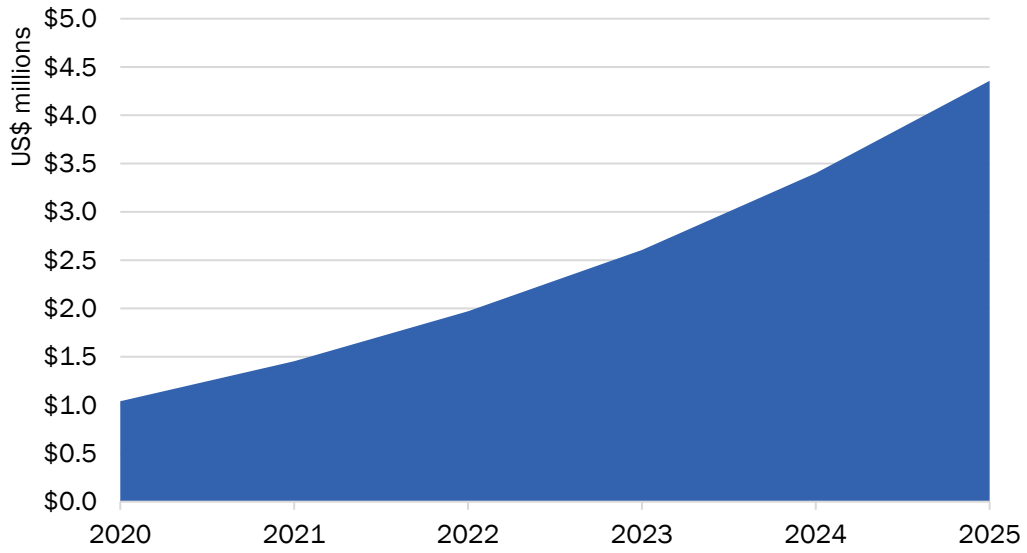
The baseline assessment showed that community care coalitions (CCCs) have already made a substantial contribution to HIV funding and programming by successfully leveraging a culture of social solidarity in Ethiopia to generate new resources at the community level. Historically, resources mobilized by CCCs have been used to promote social protection. Because people living with HIV and AIDS orphans are often among the most vulnerable groups, a large share of mobilized resources have been directed toward them. Although CCCs receiving technical assistance for HIV resource mobilization have also raised substantial resources specifically for HIV, low coverage of CCCs and limited efforts to track the mobilization and use of resources for HIV suggest that their potential is significantly greater.

To strengthen resource mobilization for HIV through CCCs, HAPCO will lead efforts to integrate and strengthen HIV programming into CCCs' work and better track HIV resources to ensure their alignment with HIV/AIDS Strategic Plan priorities. These efforts will leverage the proposed scale-up of CCC coverage to all kebeles by 2020 as part of the Growth and Transformation Plan II and aim to reach 1,300 CCCs in the 200 high-burden woredas with an integrated package of HIV services by 2025, focusing specifically on kebeles in these high-burden woredas.

The range of HIV-related interventions to be supported will be determined by an inter-ministerial working group. However, it will consider the care and support of orphans and vulnerable children as donor funding in this area decreases, as well as community-level awareness building and HIV prevention activities, including educational sessions, condom distribution, and testing referrals. HAPCO will work with the Ministry of Labour and Social Affairs (MOLSA) to establish targets for contributions and their collection, hold regular "town halls" to agree on community needs and priorities, and report on activities. Engagement with CCCs will be led by regional and woreda HAPCO branches in collaboration with the MOLSA and its relevant subnational offices.

Through implementation of this package of HIV services, an estimated $14.8 million (ETB 539 million) will be mobilized for HIV programming over the period 2020–2025, reaching $4.4 million annually by 2025 (Figure 6).

Figure 6. Projected HIV Resources for the National HIV/AIDS Strategic Plan Mobilized through CCCs, 2020–2025



Objectives

- Introduce a package of comprehensive HIV prevention activities into the activities of at least 1,300 CCCs in 200 high-burden woredas by 2025.
- Achieve an average allocation of $4,800 (ETB 190,000) annually in cash and in-kind contributions for HIV prevention and support for orphans and vulnerable children per supported CCC.

Strategic actions

- FHAPCO and the MOH will work in collaboration with the MOLSA to identify a package of HIV/AIDS care and support and prevention services for implementation by CCCs.
- FHAPCO and the Attorney General will provide input to the MOLSA on developing a legal framework to integrate CCCs formally into the government system; they also will set standards for leadership, oversight, governance, and financial management, which are critical for addressing existing challenges in CCC operations and ensuring effective and efficient use of resources.
- FHAPCO will support the MOLSA and partners to increase the capacity of existing CCCs to effectively implement HIV activities and mobilize, plan, and track resources allocated to HIV.
- RHAPCOs will support regional bureaus of labour and social affairs (BOLSAs) in scaling up CCCs to additional kebeles, focusing on those in HIV priority woredas—especially those also supported by other community-based programming and/or development partners.
- RHAPCOs and regional BOLSAs will conduct annual performance reviews of CCCs.

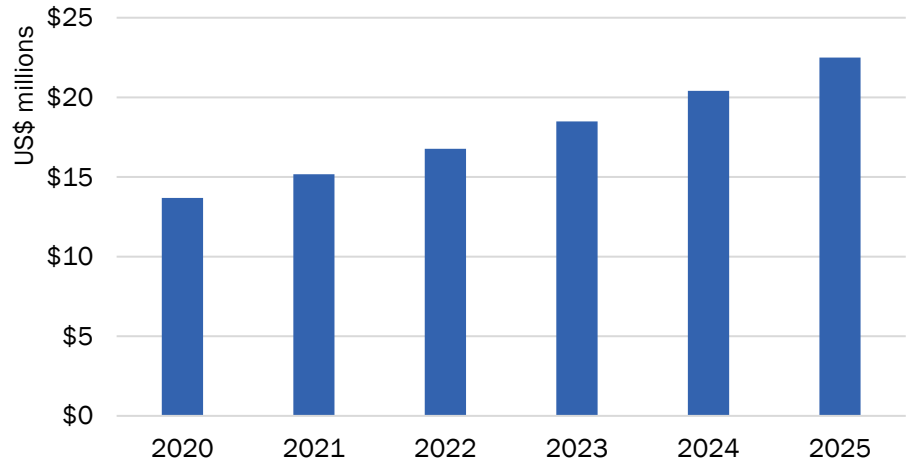
SI 5: Implement an earmarked tax on the profits of large public and private enterprises

Currently, there are no dedicated sources of government revenue for the HIV response. Given that prioritization of HIV within the general budget has fallen steadily in recent years, particularly at the federal level, there is a need to ensure a consistent allocation to HIV. To achieve this goal, a new tax on large public and private enterprises will be implemented and earmarked for the HIV program.

This tax will be imposed on public and private enterprises with annual revenues of ETB 100 million or more. The tax rate will be 0.2 percent, levied on all taxable income (i.e., profit). The tax will be in addition to all existing taxes and will be applied to pre-tax income (i.e., on the same reported income as all other applicable taxes). The exact tax liability for each company/enterprise will be calculated by the MOR (or its regional offices) based on the company's annual financial statement. Taxes will be collected by the MOR and transferred to an account managed by FHAPCO to finance HIV/AIDS Strategic Plan priority interventions and commodities.

In 2018, there were 1,133 public and private enterprises with an annual revenue above ETB 100 million—an increase from 709 in 2014. They reported a total annual profit of ETB 152.9 billion in 2018—an average of ETB 135 million each, compared to ETB 72 million in 2014. Given these trends, projected taxable income among qualifying companies (i.e., those with an annual revenue of ETB 100 million or more) will grow from a baseline of ETB 210.2 billion in 2020 to ETB 443.4 billion in 2025. Therefore, the annual amount of revenue raised through the proposed earmarked tax would increase from ETB 420.4 million (approximately $13.7 million) in 2020 (if immediately implemented) to ETB 886.7 million (approximately $22.5 million) in 2025 (Figure 7).

Figure 7. Projected Annual Revenue Generated by HIV Earmark (2020–2025)



Legislation and financial procedures will be drafted and approved by responsible legislative bodies in the country to enforce mandatory application of this contribution. The legislation will also define detailed roles and responsibilities of the MOR and FHAPCO in collecting and using these funds. If implementation of the earmark to targeted companies is successful, expansion of the earmark to additional enterprises (i.e., those at a lower profit threshold) will be considered.

Objectives

- Achieve full compliance by qualifying public and private enterprises, with 100 percent of such enterprises paying the appropriate amount of tax.
- Achieve less than 5 percent annual variation between the amount collected through the earmarked tax and the amount projected.
- Ensure that 100 percent of the projected annual revenue from the earmarked tax is transferred from the MOR to the HIV program (either to FHAPCO, the MOH, or EPSA for HIV-specific line items).

Strategic actions

- FHAPCO, the MOH, and the MOR will conduct advocacy and consensus-building workshops with the leadership and owners of private companies and public enterprises with annual revenue of ETB 100 million or more.
- FHAPCO will work with the MOR to develop a legal framework, forecasting and reporting guidelines, and an implementation manual, as needed, for collection of the applicable tax contribution.
- The MOR will assign and train focal persons to coordinate with FHAPCO and ensure that designated revenues are being properly collected, transferred in a timely fashion, and used appropriately.
- FHAPCO and the MOR will produce and distribute a biannual fund use and accountability report to Parliament, the Council of Ministers, the MOF, private companies and public enterprises, and other applicable stakeholders.

4.2 Prepayment and Private Sector Financing Initiatives

The public resource mobilization initiatives will be the primary strategies pursued for mobilizing new domestic resources for HIV over the 2020–2025 strategic period. However, ensuring that adequate resources are available to meet the long-term needs of the HIV program will require diversifying funding sources and engaging insurance schemes and households as purchasers of HIV services so as to reduce reliance on the government and its development partners, and allow for better targeting of government-subsidized services and commodities.

The following prepayment and private sector financing initiatives will lay the groundwork for future mobilization of additional resources beyond the current strategic period from new, sustainable funding sources. For each initiative, a specific set of actions are identified to facilitate their contribution to HIV financing after 2025.

SI 6: Strengthen private sector engagement in the provision of HIV testing, counseling, and treatment services

Private health providers play a critical and increasing role in delivery of health services in Ethiopia. Although private providers account for an estimated 20 percent of facility visits nationally, they make up a significantly larger share in urban areas (35%), where they are heavily concentrated, than in rural areas (18%) (Ministry of Health, 2014). Currently, engagement of private providers in the provision of HIV services is limited (Fagan et al., 2019). As with other infectious diseases for which services are exempt from user fees in public facilities, provision of HIV-related services in the public sector primarily focuses on testing and diagnostics. However, for more than a decade, development partners have supported programs to pilot the provision of HIV services, including testing, counseling, and treatment, in private facilities. Between 2015 and 2018, the USAID-funded Private Sector Health Project (PSHP) supported more than 300 private facilities to provide HIV test services to 760,963 clients and identified and linked to care and treatment 18,975 people living with HIV (PSHP, 2019). The PSHP also facilitated expansion of comprehensive ART service delivery to 75 facilities; as of the end of September 2019, 8,776 people living with HIV were on ART in PHSP-supported facilities. A similar number of patients currently receive ART in facilities supported by the U.S. Centers for Disease Control and Prevention, bringing the total number of clients receiving ART in the private sector to approximately 16,000–17,000 (USAID key informant interview).

Expanding the provision of ART and other HIV services from the private sector can help reduce the burden on public facilities, both financially for commodities and in overcrowding of infrastructure and demand on health workers' time. Stakeholders acknowledge that many patients exhibit a preference for the private sector, due to concerns about both privacy and quality. In urban areas, an estimated one-third of family planning users elect to pay for contraceptives and services from the private sector rather than obtain them for free from the public sector (Fagan and Dutta, 2019). Although HIV treatment is significantly more costly, the willingness to pay for services in the private sector, as well as the success of previous private sector ART pilot programs, indicates that perhaps there is a market for partially subsidized private services. Furthermore, the HIV epidemic in Ethiopia is heavily concentrated in urban, wealthier areas. An estimated 61 percent of people living with HIV (69% of male people living with HIV and 57% of female people living with HIV) live in urban areas, and 60 percent (64% of male people living with HIV and 55% of female people living with HIV) belong to the wealthiest quintile (CSA and ICF, 2018). These data suggest that people living with HIV have a greater ability to pay for health services than does the general population.

Given this situation, the following initiatives will be undertaken to further engage private providers in HIV service provision and reduce the financial burden of HIV on the public sector.

Strategic actions

- Examine the willingness of people living with HIV to pay for key services, including testing and diagnostics, counseling, treatment, and laboratory work (i.e., CD4 and viral load testing).
- Establish a legal framework for provision of HIV services, including treatment, from the private sector.
- Develop a market segmentation strategy for HIV to better target subsidies to those most in need and leverage additional out-of-pocket resources from those with the ability to pay.
- Establish mechanisms for private facilities to purchase or receive either partially or fully subsidized HIV commodities, particularly antiretroviral drugs, including potentially promoting a private market for the import of commodities.
- Strengthen training, oversight, and monitoring (i.e., linkage to national reporting systems) within the private sector to ensure high-quality services and effective national surveillance.

SI 7: Explore the potential for eventual integration of HIV services into social and community-based health insurance benefits packages

Improving financial protection for health by expanding prepayment schemes is a central pillar of Ethiopia's proposed HCFS. The HCFS identifies the scale-up of these schemes as a key strategic initiative for resource mobilization for health and establishes the goal of achieving combined coverage under SHI, community-based health insurance (CBHI), and private health insurance of 40 percent by 2025.

In their current designs, both CBHI and SHI, once it is implemented, reimburse facilities for services based on user fee schedules. These user fees are intended to cover only the cost of commodities and consumables; the government budget pays for human resources, equipment and infrastructure, and other associated costs at the relevant administrative level. However, because HIV and other priority health services are designated as exempted from user fees, they are likewise excluded from reimbursement through CBHI and SHI. Therefore, although CBHI and SHI, once implemented, may show promise in mobilizing additional resources for health broadly, they will not, based on their current designs, directly contribute to sustainable financing for HIV or other exempted and priority health services.

In the long run, if SHI and CBHI are successfully implemented and scaled up, it will be necessary to integrate HIV and other priority health services into their benefits packages to ensure that these services can be sustainably financed. Therefore, in the short term, efforts will be undertaken to understand the costs of and potential barriers to potential integration and establish a conducive legal and regulatory framework.

Strategic actions

- Estimate the long-term costs to CBHI and SHI of integration of HIV services based on a range of possible HIV benefits packages (e.g., treatment, counseling, and testing) and reimbursement rates, considering service utilization rates, enrollment trends, and beneficiary population characteristics.
- Conduct stakeholder dialogue based on the results of the feasibility of developing consensus around and a strategy for HIV integration into CBHI and/or SHI.

- Define an HIV benefits package and reimbursements rates for SHI and/or CBHI based on the results of the feasibility analysis.
- Make necessary revisions to exempted services proclamations and policies that allow facilities to charge insurance schemes for HIV services provided to those clients who are enrolled.

4.3 Sustainability and Capacity-Building Initiatives

Mobilizing new public resources for HIV in the short term and strengthening prospects for long-term financing through prepayment schemes and the private sector are critical steps in ensuring the sustainability of the HIV response. In addition, implementing these initiatives and maximizing the impact they have on meeting the resource needs for HIV will require strengthening the capacity of key stakeholders to advocate for greater resources, plan and demonstrate the efficient use of resources, and track and report progress in resource mobilization efforts. To achieve these requirements, three sustainability and capacity-building strategic initiatives and an accompanying set of strategic actions for each were identified for pursuit during the 2020–2025 period.

SI 8: Strengthen government stewardship to effectively implement the DRMS Strategy by building capacity for transparent management, coordination, and advocacy

Implementation of the DRMS Strategy requires effective stewardship, particularly by FHAPCO and the MOH. The DRMS Strategy development process strengthened the ability of FHAPCO and the DRMS Task Force members to identify challenges in financing HIV and proposals for sustainably financing the HIV program in the long term. Efforts must be made to sustain and further strengthen this capacity, and continue coordination between health offices, ministries, and development partners on the task force at the national level. Capacity building must also occur at each administrative level of government and the healthcare system to effectively implement this DRMS Strategy. Apart from the work of the task force, there are currently numerous gaps in effective coordination between key HIV stakeholders, resulting in lack of accountability, duplication of efforts, ineffective and inefficient programming and use of funds, and delayed processes.

Continued central-level multisectoral coordination and consultation efforts will be needed to ensure the strategy's effective implementation. A national Advisory Board will be formed to lead and oversee implementation of the DRMS Strategy. FHAPCO will lead development of the terms of reference (TOR) for this Advisory Board, in consultation with the proposed members, and will serve as the secretariat of the national Advisory Board. The national Advisory Board will be chaired by the MOH and co-chaired by the MOF. The TOR of the current HIV DRMS Task Force will be revised to form a DRMS Technical Working Group (TWG), which will serve as the technical arm of the Advisory Board. Membership of both will build the current HIV DRMS Task Force; however, membership of the national Advisory Board will focus primarily on high-level political leadership and multisectoral representatives. The Advisory Board will hold regular quarterly meetings to promote accountability and transparency in strategy implementation. As part of these meetings, the DRMS Implementation Road Map will be also be regularly updated and communicated to key stakeholders. Advisory boards and TWGs will also be formed at the regional level to oversee implementation and coordination of the DRMS Strategy at the regional level.

FHAPCO will also work to develop the capacity of other sectors to participate in implementation of the strategy. It will lead workshops with the identified strategic sectors for HIV mainstreaming to sensitize them to the DRMS Strategy and their roles and potential contributions. FHAPCO also will develop and train assigned focal point staff at sector offices to use mainstreaming operational manuals and reporting tools. As needed, FHAPCO will

provide technical assistance to each sector to identify priority populations and high-impact practices for efficient allocation and use of mainstreamed funds. It will also lead awareness-building workshops with public and private sector organizations to understand the AIDS Fund. FHAPCO will coordinate closely with the MOLSA in developing and expanding CCCs supporting HIV services.

To ensure sustainability, it is also essential that the HIV DRMS agenda complement and be part of the broader vision of DRMS for health—and particularly other exempted services—and that HIV be integrated into broader health financing reform efforts. To achieve this goal, FHAPCO and the MOH will strengthen integration and coordination between the HIV DRMS Task Force and the Health Financing TWG. Both institutions should have representation in both groups, and the task force should provide regular reports to the TWG on activities and progress, thus ensuring alignment with broader health financing initiatives. Likewise, the task force should ensure that the needs of the HIV problem are explicitly considered within these broader initiatives.

Coordination with development partners must also be strengthened to ensure that allocations are not duplicative and align with HIV programming financing gaps. Development partners will re-establish regular HIV Donor Coordination Working Group meetings to develop, follow, and monitor a coordinated long-term strategy for HIV financing, which both effectively meets program needs and provides appropriate incentives for domestic investment. At the federal level, FHAPCO will lead the development and execution of an advocacy strategy specifically targeting the MOF and MOR to ensure timely approval of the DRMS Strategy. This effort may also include advocacy to the House of Representatives and other members of Parliament for their sensitization to some of the strategies above that require new legislation, such as implementation of an earmarked tax.

At the regional level, FHAPCO and the MOH will jointly lead workshops to introduce the DRMS Strategy and discuss regional-level responsibilities related to implementation—particularly resource tracking—to ensure transparent fund management. FHAPCO will provide and train the RHAPCOs and regional health bureau offices on the related tools and operational manuals. It is essential that RHAPCOs and regional health bureaus also become stewards of this strategy at the regional level so focal points can be identified in each office to coordinate and monitor strategy implementation. In addition, FHAPCO will consult RHAPCOs and regional health bureaus to revitalize regional AIDS councils and ensure that a DRMS discussion regarding regional and woreda government budget allocations to health and HIV is a standing agenda item.

Strategic actions

- Create the national Advisory Board and TOR, and update TOR of the HIV DRMS Task Force to serve as the DRMS TWG; establish regular quarterly meetings.
- Conduct sensitization and advocacy workshops with key federal and regional stakeholders on the DRMS Strategy.
- Train and assign resource mobilization staff at regional health bureaus and RHAPCOs to support DRMS.
- Revitalize regional AIDS councils and make DRMS and regional and woreda government budget allocation a standing agenda item.
- Monitor, update, and revise the HIV Sustainability Road Map quarterly or as needed, and report to the national Advisory Board and regional advisory boards.
- Re-establish a regular HIV Donor Coordination Working Group to develop a coordinated long-term strategy for HIV financing.

- Strengthen integration of and coordination between the Advisory Board/DRMS TWG and the Health Financing TWG to ensure that HIV is positioned as a health financing priority and HIV-focused initiatives contribute to broader health financing reform.
- Revise FHAPCO's mandate to include responsibility for domestic resource mobilization by updating its proclamation and directive; assign the Projects and Grant Management Coordination Directorate responsibility for management and coordination of domestic resource mobilization efforts, rename it (Resource Mobilization and Grant Management Directorate), and establish a Domestic Resource Mobilization Unit within the directorate.

SI 9: Ensure evidence-based decision making for efficient use of HIV resources

Ensuring that the mobilized resources are used appropriately and efficiently (i.e., in a way that yields the greatest impact) is critical in ensuring that such resources are adequate to meet HIV program needs. Promoting both allocative efficiency (i.e., where resources are targeted and which interventions are funded) and technical efficiency (maximizing the outputs for given selected interventions or inputs) must be a critical part of efforts to ensure sustainability in Ethiopia's HIV response.

Notably, previous efforts to mobilize resources for HIV have not promoted efficient allocation and targeting of resources. For example, funds mobilized through the AIDS Fund and CCCs have been spent on care and support, which is not an HIV/AIDS Strategic Plan priority intervention. Also, the AIDS Fund and mainstreaming efforts have targeted prevention funds toward sector office employees rather than key and priority populations.

For example, although viral load suppression is a primary goal of treatment, previous studies have shown that less than half (45%) of patients initiated on ART demonstrated viral suppression 12 months from treatment initiation (Telele et al., 2018). This is in large part due to the fact that only about half of people living with HIV on ART had access to viral load testing in the first 12 months of treatment (MOH and FHAPCO, 2018). Of those who received viral load testing, 86 percent were found to be virally suppressed (MOH and FHAPCO, 2018). However, 21 percent of those who began treatment were lost to follow-up (including death) in the first 12 months (Telele et al., 2018). Other studies have similarly found rates of loss to follow-up greater than 15 percent (Seifu et al., 2018; Mekonnen et al., 2019). As initiating patients on ART carries a significant cost, including for detection, initial laboratory work, and prescribed antiretrovirals, this loss to follow-up represents a key inefficiency, with these investments not achieving their intended result—that is, viral suppression. Additional effort is clearly needed to ensure that a greater share of patients have successful treatment outcomes, thereby demonstrating the measurable impact of the resources allocated to testing and treatment.

To improve both allocative and technical efficiency, the use of resources mobilized by this strategy will be aligned with HIV/AIDS Strategic Plan targets. There will be significant efficiency gains through improved targeting of key and priority populations, and alignment of interventions with HIV/AIDS Strategic Plan high-impact and cost-effective priority interventions and needs in each region and woreda. During the strategic period, 2020–2025, mainstreaming efforts will focus on sector offices in 10 key sectors and their implementing agencies. These sector offices will allocate budget funds to implement HIV prevention interventions (principally condom distribution and social and behavioral change interventions). Money from the AIDS Fund will be pooled to cover the cost of ART—one of the four current national HIV/AIDS Strategic Plan priorities—for public employees. The scope of interventions covered by CCCs will be expanded to cover community-based HIV prevention interventions, such as community dialogue and vulnerability reduction, including economic strengthening for impoverished girls and young women.

In addition, technical efficiency will be promoted by continuing to push HIV service delivery, particularly for testing and ART at lower (and lower-cost) levels of care. Especially in urban areas, where many patients receive ART in hospitals, costs to the health system could be reduced by promoting access to ART at health centers and posts. Multi-month prescriptions and models of differentiated care for stable patients can also reduce health workers' interactions and frequency of contact with patients, and most travel to facilities, reducing costs to both the system and the patients.

The following key actions will be taken to ensure efficient allocation and utilization of resources:

Strategic actions

- Institutionalize annual planning from the federal to the woreda level and provide support to lower levels during the planning process to ensure that annual action plans are aligned with the national HIV/AIDS Strategic Plan and key and priority populations.
- Institutionalize annual and semi-annual joint supportive supervision and review meetings at all levels to ensure the implementation of action plans, adherence to national HIV/AIDS Strategic Plan priorities, and tracking of funds at federal, regional, and woreda levels.
- Train HAPCO and health program staff at federal, regional, and woreda levels, and in the 10 strategic sectors, on results-based planning, high-impact interventions, national HIV/AIDS Strategic Plan priorities, and resource tracking to improve allocative efficiency and effective use of resources.
- Conduct an assessment to identify areas of inefficiency and potential efficiency gains in HIV service delivery and procurement and identify key actions to improve efficiencies and cost-effectiveness.
- Review and revise how decisions are made about where to prioritize HIV commodity and funding allocations and targeting of technical assistance. Develop new processes or criteria for these decisions and integrate them into annual workplan and budget development processes.
- Improve resource targeting and promote strategic purchasing through implementation of social contracting within the MOH's public-private partnership framework.

SI 10: Promote transparency and accountability in the collection, allocation, and execution of HIV funding by improving resource tracking and monitoring

Having timely and accurate financial data on the availability and use of HIV/AIDS resources is critical to inform decision making. Ethiopia has historically struggled to collect, use, and report data on HIV/AIDS-related resources. There is no standard template or structure for reporting HIV/AIDS programming and commodity expenditure data on a regular basis. Resources available from donors, particularly for off-budget funding (Channel 3), are difficult to predict, and it can be challenging to monitor how these resources are used. Funding from the private sector and civil society remains uncoordinated, and the public sector lacks information on these contributions. In addition, what is collected may not be made available or shared with relevant stakeholders. The baseline assessment found that many MOF offices were not aware of the current funding situation for HIV/AIDS, including the decline in donor funding. Therefore, being able to regularly and comprehensively collect and share this information will be important in informing the government budget for HIV programming.

Thus, as part of the DRMS Strategy, FHAPCO, in coordination with the MOH, will develop a standardized process and necessary tools to institutionalize resource tracking and monitoring of HIV/AIDS-related resource allocations and expenditures. The process will be aligned and harmonized with other national data management systems and processes. FHAPCO will be responsible for oversight of this process and distribution of data collection templates to and collection of data from all relevant government offices at all levels of the healthcare system, as well as development partners, civil society, and other private sector entities, and aggregating the data at regional and federal levels. The data will track resources committed, allocated, and spent, and the programmatic areas funded. These data will allow FHAPCO and the MOH to determine if and how the resources are being used in line with the HIV/AIDS Strategic Plan, improve coordination among partners, increase efficiency of resource use, and make informed decisions for planning and advocacy.

Strategic actions

- Identify an existing system or develop a new tool for regularly tracking and reporting HIV funding allocations and expenditures, particularly for subnational reporting.
- Develop a set of indicators for tracking public allocation and expenditures for HIV.
- Create a single information platform (electronic storage) where all reports will be stored in the public domain.
- Ensure that all HIV budget and spending data are maintained in a single electronic platform or are data that can be easily shared and updated.

5. Summary of Resource Mobilization Targets

Of the 10 strategic initiatives identified in the DRMS Strategy, the first five, focused on public resource mobilization, are specifically intended to mobilize new domestic resources for HIV and increase the domestic contribution to financing the forthcoming HIV/AIDS Strategic Plan 2021–2025. The expected resources to be mobilized through these initiatives are summarized here. Greater detail on resource mobilization from each source, including targets for participation and contributions by sector offices and subnational units, is included in the monitoring framework (Section 6.3).

The total value of domestic resources to be mobilized over 2021–2025, corresponding to Ethiopia calendar and fiscal year 2013–2017, is estimated to be $241 million. This amount reflects an increase from $28 million in the baseline year (2020) to $69 million annually by 2025 (Table 6). The largest sources of domestic resources to support the HIV/AIDS Strategic Plan will be the HIV earmarked tax on large public and private enterprises ($93 million) and general government revenues allocated as part of the discretionary budget ($66 million); together, these sources account for two-thirds of the resources mobilized, or 39 percent and 27 percent, respectively. The AIDS Fund pooling contributions from public and private sector employees ($36 million, 15%), targeted mainstreaming in strategic sectors ($32 million, 13%), and HIV programming through CCCs ($14 million, 6%) will make up the remaining one-third of resources. Although the specific use of resources mobilized from each source will be determined by national HIV/AIDS Strategic Plan priorities, Table 6 identifies areas for appropriate potential use. Depending on the performance of each mobilization strategy, FHAPCO will need to adjust how each source of revenue is used to ensure that all priority components of the program are sufficiently funded.

Table 6. Public Resource Mobilization Targets, by Strategy and Use (2020–2025) (US$ millions)

	2020 (baseline)	2021	2022	2023	2024	2025	TOTAL (2021–2025)
General government revenues	$6.9	$7.9	$9.4	$11.8	$15.5	$21.3	$66.1
AIDS Fund(s)	$1.7	$3.0	$4.6	$6.6	$9.2	$12.6	$35.9
Targeted mainstreaming	$4.5	$5.0	$5.6	$6.3	$7.0	$7.9	$31.8
Community care coalitions	$1.0	$1.5	$2.0	$2.6	$3.4	$4.4	$13.8
Earmarked tax	$13.7*	$15.2	$16.8	$18.5	$20.4	$22.5	$93.4
TOTAL	**$27.9***	$32.6	$38.4	$45.8	$55.5	$68.6	$241.0

*The baseline reflects the amount that would be mobilized if the HIV earmark were to be in place in 2020 (EFY 2012); however, implementation of the earmark is not expected until 2021.

6. Management, Implementation, and Monitoring

6.1 Management Arrangement

The Projects and Grants Management Directorate of FHAPCO will be responsible for overall leadership, coordination, implementation, and monitoring and evaluation of the DRMS Strategy. A national Advisory Board will be formed to lead and oversee implementation of the DRMS Strategy, particularly collection, allocation, and use of resources. Broadly, the Advisory Board will ensure compliance with strategies and activities defined in the HIV Domestic Resource Mobilization and Sustainability Strategy while ensuring effective and appropriate use of mobilized resources. The functioning and specific activities of the Advisory Board will be defined in TOR, to be developed.

The general structure of the national Advisory Board will be as follows. The Advisory Board will be chaired by the MOF and co-chaired by the MOH; FHAPCO will serve as the secretariat. Membership of the national Advisory Board will focus primarily on high-level political leadership and multisectoral representatives. The TOR of the current HIV DRMS Task Force will be revised to form a DRMS TWG, which will serve as the technical arm of the Advisory Board. The National DRMS Advisory Board and TWG members will be from FHAPCO; the MOH; the HPR Social Standing Committee; the MOF; the MOR; government sector offices (the Ministry of Women, Children and Youth Affairs, MOLSA, the Ministry of Education, Roads Authority, the Ministry of Transport); representatives of public and private enterprises and employees (i.e., employees associations, Confederation of Ethiopian Trade Unions, and Chamber of Commerce); development partners and donors; and civil society organizations.

The national DRMS TWG (previously the DRMS Task Force) will provide technical support in implementing the strategy. Regional-level advisory boards and TWGs will be established by each region to oversee regional-level strategy implementation.

Accounts will be created to collect contributions, to be managed by the AIDS Fund at FHAPCO and RHAPCOs/RHBs. Another account will be created to collect contributions for the earmarked tax, to be managed by FHAPCO.

Roles and responsibilities of key stakeholders will be as follows:

FHAPCO

- Lead, coordinate, monitor, and evaluate implementation of the DRMS Strategy
- Advocate and communicate the DRMS Strategy to all stakeholders at all levels
- Track collection, allocation, and use of domestic resources in accordance with the DRMS Strategy
- Build capacity for effective implementation of the DRMS Strategy at all levels
- Request, negotiate, and secure budget funds from the government treasury at the federal level, in coordination with the MOH
- Lead development of the legal framework and guidelines needed to support DRM mechanisms in the DRMS Strategy
- Serve as the secretariat of the national Advisory Board
- Produce quarterly reports on performance of DRMS Strategy initiatives

Ministry of Health

- Oversee and support implementation of the DRMS Strategy, in coordination with FHAPCO
- Ensure efficiency in the allocation of domestic resources through alignment with the HIV/AIDS Strategic Plan
- Support tracking, collection, allocation, and use of domestic resources per the DRMS Strategy
- Serve as the chair of the national Advisory Board

Ministry of Revenue and regional offices

- Build organizational capacity to support the implementation of HIV DRM mechanisms
- Collect contributions of private and public enterprises in an account created for the earmarked tax and managed by FHAPCO
- Collect contributions of public and private employees in an account created for the AIDS Fund and managed by FHAPCO
- Support monitoring of DRMS Strategy implementation
- Serve as a member of the DRMS Strategy Advisory Board

Ministry of Finance and regional offices

- Support FHAPCO and the Attorney General in developing a legal framework and guidelines for the implementation of DRM mechanisms
- Support tracking, collection, allocation, and use of domestic resources as per the DRMS Strategy
- Support requests and negotiation of budgets from the government treasury
- Serve as co-chair of the DRMS initiative Advisory Board
- Create an account code for the AIDS Fund at regional and federal levels, and for the earmarked tax at the federal level

Attorney **General's** Office

- Support drafting and endorsement of a legal framework to implement the DRMS Strategy
- Advise FHAPCO in implementation of the DRMS Strategy

Strategic sector ministries and regional and woreda offices

- Create an appropriate structure and assign staff and budget to implement targeted mainstreaming
- Plan, budget, implement, and monitor and evaluate targeted mainstreaming as per the revised guideline
- Document and report performance of targeted mainstreaming on a quarterly basis

Private companies and public enterprises

- Contribute 0.2 percent of annual profit through earmarked tax, per the DRMS Strategy

- Assign a representative and actively participate in the national Advisory Board

RHAPCOs/RHBs

- Lead, coordinate, and monitor and evaluate implementation of domestic resource mobilization at the regional level
- Advocate and communicate the DRMS Strategy at regional and woreda levels
- Track collection, allocation, and use of domestic resources in accordance with the DRMS Strategy at regional and woreda levels, and report to FHAPCO
- Build capacity for effective implementation of the DRMS Strategy at regional and woreda levels
- Provide technical support to regional- and woreda-level stakeholders
- Request, negotiate, and secure budget funds from the government treasury at regional and woreda levels
- Produce quarterly reports on performance of DRMS initiatives at regional and woreda levels

Woreda health offices

- Lead, coordinate, and monitor and evaluate implementation of the DRMS Strategy at the woreda level
- Advocate and communicate the DRMS Strategy at the woreda level
- Track collection, allocation, and use of domestic resources in accordance with the DRMS Strategy at the woreda level
- Build capacity for effective implementation of the DRMS Strategy at the woreda level
- Provide technical support to woreda-level stakeholders, including CCCs
- Request, negotiate, and secure budget funds from the government treasury at the woreda level
- Produce quarterly reports on performance of DRMS initiatives at the woreda level

Kebele administration

- Lead and oversee CCC activities
- Track collection, allocation, and use of domestic resources at the kebele level

Development partners and donors

- Participate in and provide strategic guidance through the Advisory Board
- Provide technical and financial support in implementation of the DRMS Strategy
- Support the development of regular HIV funding landscapes to identify and close HIV program funding gaps

6.2 Implementation Road Map

SI 1. Increase allocation of general government revenues to health, and specifically HIV, at federal and regional levels

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
1.1 Conduct a consultation workshop with the MOH; MOF; HPR Women, Youth and Social Affairs Standing Committee; the Prime Minister's Office; the Council of Ministers; and regional governments	Consensus on the responsibility of the government to increase budget allocation for the HIV program	X						FHAPCO	MOH, Advisory Board
1.2 Develop annual costed action plans and funding landscapes	Action plan and funding landscape developed	X	X	X	X	X	X	FHAPCO, RHBs and HAPCOs, woreda health offices	MOH, DRMS TWG
1.3 Request, negotiate, and secure budget funds from the government treasury at federal, regional, and woreda levels in line with HIV DRMS Strategy and HIV/AIDS Strategic Plan targets	Budget allocated for the HIV program	X	X	X	X	X	X	FHAPCO, MOH, RHBs/RHAPCOs, woreda health offices	U.S. Government (USG) partners, Global Fund, World Bank
1.4 Conduct a biannual review and report on budget allocation and use at federal, regional, and woreda levels	Biannual domestic budget allocation report produced and distributed		X	X	X	X	X	FHAPCO, MOH, RHAPCOs/RHBs	Advisory Board/DRMS TWG
1.5 Conduct an annual audit of budget allocation and use at federal and regional levels	Annual audit report		X	X	X	X	X	FHAPCO, MOH, RHAPCOs/RHBs, MOF	Advisory Board, Auditor General

SI 2. Strengthen participation in and management and pooling of the AIDS Fund for public and private sector employees

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
2.1 Establish a legal basis for the AIDS Fund through development and passage of an appropriate proclamation or policy	AIDS Fund legal framework developed	X						FHAPCO, MOH, TWG	MOF, MOR, Advisory Board, Attorney General, HPR
2.2 Develop operational manuals for enrollment of employees in the AIDS Fund, deduction of contributions from payrolls, transfer to HAPCO accounts, and guidelines for use and reporting of AIDS Fund resources	Operational manuals and guidelines developed	X						FHAPCO	DRMS TWG
2.3 Work with private sector associations to engage private sector employers and employees, encourage them to participate in the AIDS Fund, and provide them with needed technical assistance and resources	Advocacy campaigns to targeted private sector employers completed	X						FHAPCO	Advisory Board, Ethiopian Chamber of Commerce, and Central Ethiopian Trade Union
2.4 Promote the AIDS Fund through workplace HIV awareness and promotion activities using mainstreamed funds	Awareness created among employers and employees	X	X	X	X	X	X	Sector offices, RHAPCO/RHBs, FHAPCO	DRMS TWG
2.5 Conduct media advocacy campaigns through TV and radio	Awareness created among employers and employees	X	X	X	X	X	X	FHAPCO	DRMS TWG, media outlets
2.6 Establish and implement an AIDS Fund performance review and recognition mechanism for high-performing regions and institutions	High-performing institutions and regions recognized	X	X	X	X	X	X	FHAPCO	Advisory Board/DRMS TWG
2.7 Produce a biannual fund use and accountability report and distribute it to public and private employees	AIDS Fund report produced and distributed		X	X	X	X	X	FHAPCO	Advisory Board/DRMS TWG
2.8 Transition support for orphans and vulnerable children and people living with HIV, currently supported by public employees through the AIDS Fund, to civil society and nongovernmental organizations (CSOs/NGOs), safety net programs, and woreda women and children affairs office support programs	Orphans and vulnerable children and people living with HIV support transitioned to appropriate CSO/NGO/woreda program	X	X	X				RHAPCO/RHB and woreda health offices	Woreda women and children affairs offices, CSOs, NGOs

SI 3. Improve management and targeting of funds mainstreamed for HIV within priority sectors

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
3.1 Develop a proclamation and revised mainstreaming guidelines for the infrastructure sector and other strategic sectors; develop a supportive legal framework to mandate and standardize the practice across sectors; assign an account code and expenditure title for HIV mainstreaming	Mainstreaming proclamation approved, guidelines revised, legal framework developed, and account code and expenditure title created	X						FHAPCO, MOF, Attorney General	Advisory Board, MOR, Ethiopia Roads Authority
3.2 Conduct advocacy and consensus-building meetings with strategic sectors at federal and regional levels, focusing on those mainstreaming through infrastructure contracts	Consensus created on roles and responsibilities of strategic sectors	X						FHAPCO	MOH, Advisory Board
3.3 Revise organizational structures and staffing norms for the coordination of HIV mainstreaming within strategic sectors: assign and train HIV mainstreaming focal persons at federal, regional, and woreda levels to coordinate HIV mainstreaming	Mainstreaming focal points assigned and trained	X						Strategic sectors, FHAPCO, RHBs	DRMS TWG
3.4 Create a platform and opportunities for experience sharing, annual performance review, and recognition of best performing sectors and regions	Annual experience-sharing event; strategic sectors' performance improved			X				FHAPCO	DRMS TWG

SI 4. Strengthen and scale up community care coalitions to increase funding for community-based care

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
4.1 Identify a package of HIV/AIDS care and support and prevention services to be supported by CCC financing; update CCC guidelines	Expansion of CCC guidelines to include allocations to HIV care and support and prevention	X						FHAPCO, MOLSA, Ministry of Women, Children and Youth Affairs (MOWCYA)	MOH, USAID/FHI 360, community leaders
4.2 Develop a legal framework to integrate CCCs formally into the government system and set standards for leadership, oversight, governance, and financial management and reporting	Legal framework developed	X						MOLSA, FHAPCO, Attorney General, MOWCYA	USAID/FHI 360, FHAPCO
4.3 Develop reporting guidelines for CCCs to report financial and programmatic support for HIV services	Reporting guidelines developed for effective monitoring, evaluation, and resource tracking	X						FHAPCO	USAID/FHI 360, MOLSA, Bureaus of Women, Children and Youth Affairs (BWCYAs)
4.4 Increase the capacity of existing CCCs to effectively implement HIV activities and mobilize, allocate, and track resources allocated to HIV	CCCs have capacity to manage resources and support HIV-related activities	X	X	X	X	X	X	RHAPCO/RHB, BOLSAs, BWCYAs	USAID/FHI 360, community leaders
4.5 Provide technical assistance in the scale-up of CCCs, focusing on those in HIV priority woredas	Number of CCCs supporting HIV services increased		X	X	X	X	X	BOLSAs, RHAPCO, BWCYAs	United Nations, USG partners
4.6 Conduct annual performance reviews of CCCs at national and regional levels	Share lessons learned from performance review	X	X	X	X	X	X	FHAPCO, MOLSA, RHAPCO/RHB, BOLSA, BWCYAs	DRMS TWG, United Nations, USG partners

SI 5. Implement an earmarked tax on the profits of large public and private enterprises

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
5.1 Conduct sensitization workshops with leadership and owners of private companies and public enterprises qualifying for the earmarked tax	Private companies and public enterprises are aware of new tax, their responsibility, and reason for it	X						FHAPCO, MOR, MOF	AIDS Council, DRMS Task Force, Ethiopian Chamber of Commerce, Confederation of Ethiopian Trade Unions, regional bureaus of finance, RHAPCO/RHB
5.2 Draft and approve necessary legislation to implement the new earmarked tax	Legislation drafted and approved	X						Attorney General, FHAPCO, HPR, MOF	Advisory Board
5.3 Develop forecasting and reporting guidelines and an implementation manual for collection of the applicable tax	Forecasting and reporting guidelines and implementation manual developed	X						FHAPCO, MOR, and Attorney General	DRMS TWG
5.4. Assign and train focal persons at MOR federal and regional offices to ensure effective collection, transfer, and use of funds	MOR focal persons assigned and trained	X						FHAPCO, MOR	DRMS TWG
5.5 Produce and distribute a biannual fund use and accountability report to Parliament, the Council of Ministers, the MOF, private companies and public enterprises, and other applicable stakeholders	Reports disseminated promoting transparency and accountability	X	X	X	X	X	X	FHAPCO	MOR, MOF

SI 6. Strengthen private sector engagement in the provision of HIV testing, counseling, and treatment services

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
6.1 Examine willingness and ability of the community and people living with HIV to pay for key services, including testing and diagnostics, counseling, treatment, and laboratory work (i.e., CD4 and viral load testing), and identify determinants of private sector use	Evidence generated to guide decisions	X						FHAPCO, HP+/USG partners	FHAPCO, MOH, private sector providers and associations
6.2. Establish a legal framework for the provision of HIV services, including treatment, within the private sector	Legal framework developed to facilitate private HIV service provision	X	X					FHAPCO, MOH, and Attorney General	Private sector providers and associations, Food and Drug Administration, parliamentarians, MOH
6.3. Develop a market segmentation strategy for HIV to better target subsidies to those most in need; leverage additional out-of-pocket resources from those with the ability to pay	Strategy developed		X					FHAPCO	Private sector providers and associations, PSI, DKT
6.4. Establish mechanisms for private facilities to purchase or receive partially or fully subsidized HIV commodities, particularly ARVs	Private sector improved access to commodities		X	X				FHAPCO, MOH	United Nations, USG partners
6.5. Strengthen training, oversight, and monitoring (i.e., linkage to national reporting systems) within the private sector to ensure high quality of services and effective national surveillance	Private sector capacity built; improved monitoring and evaluation	X	X	X	X	X	X	FHAPCO, MOH, RHBs	Abt Associates/Private Health Sector Project

SI 7. Explore the potential for eventual integration of HIV services into social and community-based health insurance benefits packages

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
7.1 Estimate the long-term costs to CBHI and SHI of integration of HIV services based on a range of possible HIV benefits packages (e.g., treatment, counseling, and testing) and reimbursement rates, considering service utilization rates, enrollment trends, and beneficiary population characteristics	Integration feasibility analysis completed		X					Ethiopia Health Insurance Agency (EHIA), MOH, USG partners	FHAPCO, DRMS TWG
7.2 Conduct stakeholder dialogue based on results of the feasibility of developing consensus around and strategy for HIV integration into CBHI and/or SHI	Consensus developed on need for HIV insurance integration			X				EHIA, MOH, FHAPCO	DRMS Advisory Board and USG partners
7.3 Define an HIV benefits package and reimbursement rates for SHI and/or CBHI based on results of the feasibility analysis	Benefits package and reimbursement rates defined				X			FHAPCO, EHIA	Clinton Health Access Initiative, Health Financing Improvement Program, DRMS TWG
7.4 Make revisions to exempted services proclamations and policies to allow facilities to charge insurance schemes for HIV services provided to enrolled clients	Legal framework established					X	X	EHIA	MOH, FHAPCO

SI 8. Strengthen government stewardship to effectively implement the DRMS Strategy by building capacity for coordination, advocacy, and transparent management

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
8.1 Create the national Advisory Board and TOR, and update TOR of the HIV DRMS Task Force to serve as the DRMS TWG; establish regular quarterly meetings	Advisory Board and DRMS TWG membership and TORs defined and approved	X						FHAPCO, MOH, MOF	DRMS Task Force
8.2 Develop an advocacy and communications strategy, materials (flyers and posters), and media campaigns with key information on the HIV DRMS Strategy	Strategy developed and communicated to the public and stakeholders	X						FHAPCO	DRMS TWG, Broadcasting Corporation
8.3 Conduct sensitization and advocacy workshops with key federal and regional stakeholders on the HIV DRMS Strategy; develop regional targets and workplans for cascading	Consensus created on the role of stakeholders in strategy implementation	X						FHAPCO	Advisory Board
8.4 Facilitate endorsement and approval of the HIV DRMS Strategy	HIV DRMS Strategy approved by the Council of Ministers	X						FHAPCO	MOH, Advisory Board
8.5 Assign and/or train resource mobilization staff at RHBs and RHAPCOs to support the HIV DRMS Strategy	FHAPCO and RHAPCO/RHB capacity built	X						FHAPCO, RHAPCO/RHB, BOF, Civil Service Commission	DRMS TWG
8.6 Revitalize regional AIDS councils and make HIV DRMS and regional and woreda government budget allocations a standing agenda item	Regular convening of regional and woreda AIDS councils	X						FHAPCO, RHAPCOs/RHBs	Advisory Board, United Nations
8.7 Meet to review and monitor progress on the HIV DRMS Strategy, including updating and revising the HIV Sustainability Road Map at least quarterly, or as needed, and report to federal and regional advisory boards	HIV DRMS Strategy progress monitored and HIV Sustainability Road Map reviewed and revised as part of quarterly task force meetings	X	X	X	X	X	X	FHAPCO	Advisory Board

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
8.8 Re-establish regular quarterly HIV Donor Coordination Working Group meetings to develop a coordinated long-term strategy for HIV financing	Donor coordination meetings held quarterly	X						Development partners	Development partners
8.9 Strengthen integration of and coordination between the Advisory Board/HIV DRMS TWG and the Health Financing TWG to ensure HIV is positioned as a health financing priority and that HIV-focused initiatives contribute to broader health financing reform	Both working groups include members of the MOH Partnership and Cooperation Directorate (PCD) and FHAPCO, and share notes from each meeting	X						FMOH PCD, Advisory Board/DRMS TWG	MOH, FHAPCO, MOF
8.10 Revise FHAPCO's proclamation and directive to include domestic resource mobilization as part of its mandate and establish a Domestic Resource Mobilization Unit within the FHAPCO Projects and Grant Management Coordination Directorate	FHAPCO proclamation and directive revised; Domestic Resource Mobilization Unit created within the Projects and Grant Management Coordination Directorate	X						FHAPCO, Civil Service Agency	DRMS Advisory Board/DRMS TWG

SI 9. Ensure evidence-based decision making for efficient allocation of HIV resources

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
9.1 Conduct an assessment to identify areas of inefficiency and potential efficiency gains in HIV service delivery and procurement; identify key actions to improve efficiencies	Efficiency study completed and action plan developed	X	X					MOH, FHAPCO	HIV implementing partners, civil society, development partners
9.2 Review and revise how decisions are made about where to prioritize HIV commodity and funding allocations and targeting of technical assistance; develop new processes/criteria for these decisions and integrate them into annual workplan and budget development processes	Methodology/approach developed and integrated into annual workplan guidelines	X						MOH PCD and Policy and Planning Directorate	FHAPCO, RHAPCOs, MOH
9.3 Train FHAPCO, MOH, RHAPCO/RHB, and strategic sector staff on results-based planning, high-impact interventions, national HIV/AIDS Strategic Plan priorities, and resource tracking to improve allocative efficiency and effective use of resources	Key stakeholders trained in high-impact practices	X	X					FHAPCO	DRMS TWG
9.4 Integrate performance on the HIV DRMS Strategy in federal and regional HIV program joint supportive supervision and annual review meetings	Performance of HIV DRMS Strategy initiatives tracked; challenges identified and addressed		X	X	X	X	X	FHAPCO, MOH, RHAPCO/RHBs	DRMS TWG, partners and other stakeholders
9.5 Improve resource targeting and promote strategic purchasing through the implementation of social contracting within the MOH's public-private partnership framework	Public-private partnership guidelines for social contracting of nongovernmental organizations for HIV service provision developed		X					MOH, FHAPCO	MOLSA, civil society organizations, international organizations

SI 10. Promote transparency and accountability in the collection, allocation, and execution of HIV funding by improving resource tracking and monitoring

Activity	Outputs	Implementation Year						Responsibility	Collaborators
		1	2	3	4	5	6		
10.1 Conduct an inventory of current systems for reporting and tracking public expenditures, particularly for health	Summary of current financial reporting systems	X						FHAPCO, MOH, MOF	Auditor General, USG partners
10.2 Develop indicators for tracking public health expenditures on HIV	Indicator set developed and validated	X						FHAPCO, MOH, DRMS TWG	USG partners
10.3 Leverage and strengthen existing systems—or develop a new tool, if needed—for regularly tracking and reporting HIV funding allocations and expenditures, particularly for subnational reporting	Number of financing sources (ministries, regions, development partners, etc.) reporting HIV funding allocations and expenditures on an annual basis	X						MOH PCD, FHAPCO	FHAPCO, MOH
10.4 Create or update a website or public portal for all published reports	Information platform online and publicly accessible	X						FHAPCO, MOH	FHAPCO, MOLSA, MOWCYA, other mainstreaming ministries
10.5 Ensure that all regularly reported HIV budgets and expenditures are stored and maintained electronically in a single and consistent format	All regular budgets and expenditures maintained in an electronic database		X					MOH, FHAPCO	FHAPCO, development partners, RHBs
10.6 Ensure regular updating and maintenance of the online HIV financing dashboard; in coordination with the Aid Management Platform, update government data quarterly and donor data annually/semi-annually	HIV allocation and expenditure by source updated on an annual basis		X					MOH PCD, FHAPCO	FHAPCO, development partners, RHBs
10.7 Ensure that health management information systems are interoperable with the integrated financial management system to connect financial performance and health impacts	Online management platforms merged/synced		X					MOH	MOH, MOF

6.3 Monitoring Framework

SI 1. Increase allocation of general government revenues to health, and specifically HIV, at federal and regional levels

Indicator	Unit of Measurement	Target					
		2020 (baseline)	2021	2022	2023	2024	2025
1.1 Federal-level HIV budget (MOH and FHAPCO)	**ETB (millions)**	**22**	**38**	**67**	**117**	**205**	**359**
1.1.1 Federal health budget (MOH and FHAPCO) as a percentage of total federal government budget	Percentage	0.5%	0.6%	0.7%	0.8%	1.0%	1.3%
1.1.2 Federal HIV budget as a percentage of total federal health budget (MOH and FHAPCO)	Percentage	1.7%	2.1%	2.7%	3.5%	4.1%	4.7%
1.2 Sum of regional HIV budgets (RHBs and RHAPCOs)	**ETB (millions)**	**38**	**57**	**85**	**127**	**191**	**286**
1.2.1 Addis Ababa city administration HIV budget	ETB (millions)	6.5	9.8	14.7	22.0	33.0	49.5
1.2.2 Afar regional HIV budget	ETB (millions)	0.8	1.2	1.8	2.7	4.1	6.2
1.2.3 Amhara regional HIV budget	ETB (millions)	11.4	17.0	25.6	38.3	57.5	86.3
1.2.4 Benishangul-Gumuz regional HIV budget	ETB (millions)	0.3	0.5	0.8	1.1	1.7	2.6
1.2.5 Dire Dawa city administration HIV budget	ETB (millions)	0.7	1.0	1.5	2.2	3.3	5.0
1.2.6 Gambela regional HIV budget	ETB (millions)	0.8	1.2	1.9	2.8	4.2	6.3
1.2.7 Harari regional HIV budget	ETB (millions)	0.3	0.4	0.6	0.9	1.4	2.1
1.2.8 Oromia regional HIV budget	ETB (millions)	9.7	14.6	21.9	32.8	49.3	73.9
1.2.9 Southern Nations, Nationalities and Peoples' Region regional HIV budget	ETB (millions)	3.6	5.4	8.2	12.2	18.3	27.5
1.2.10 Somali regional HIV budget	ETB (millions)	0.4	0.6	0.8	1.3	1.9	2.8
1.2.11 Tigray regional HIV budget	ETB (millions)	3.2	4.8	7.1	10.7	16.1	24.1
1.3 Sum of woreda HIV budgets (woreda health offices and HAPCO)	**ETB (millions)**	**154**	**162**	**170**	**179**	**188**	**197**

SI 2. Strengthen participation in and management and pooling of the AIDS Fund for public and private sector employees

Indicator	Unit of Measurement	Target					
		2020 (baseline)	2021	2022	2023	2024	2025
2.1 Total value of AIDS Fund contributions from public sector employees	**ETB (millions)**	**53**	**82**	**119**	**165**	**222**	**293**
2.1.1 Public sector employees participating in the AIDS Fund	Number of employees (thousands) (percentage of all public sector employees)	501 (25%)	703 (33%)	932 (41%)	1,181 (49%)	1,452 (57%)	1,752 (65%)
2.1.2 Average monthly contribution of public sector employees	ETB	9	10	11	12	13	14
2.2 Total value of AIDS Fund contributions from private sector employees	**ETB (millions)**	**0**	**14**	**38**	**73**	**123**	**202**
2.2.1 Private sector employees participating in the AIDS Fund	Number of employees (thousands) (percentage of all private sector employees)	0 (0%)	177 (8%)	413 (16%)	714 (24%)	1,078 (32%)	1,589 (40%)
2.2.2 Average monthly contribution of private sector employees	ETB	0	7	8	8	9	11

SI 3. Improve management and targeting of funds mainstreamed for HIV within priority sectors

Indicator	Unit of Measurement	Target					
		2020 (baseline)	2021	2022	2023	2024	2025
3.1 Total value of funds mainstreamed by federal institutions	**ETB (millions)**	**7.1**	**8.4**	**10.1**	**11.9**	**14.1**	**16.6**
3.1.1 Value of funds mainstreamed by the Ministry of Education	ETB (millions)	4.2	5.0	6.0	7.1	8.4	9.9
3.1.2 Value of funds mainstreamed by MOWCYA	ETB (millions)	0.2	0.2	0.3	0.3	0.4	0.5
3.1.3 Value of funds mainstreamed by MOLSA	ETB (millions)	0.2	0.2	0.2	0.3	0.3	0.4
3.1.4 Value of funds mainstreamed by the Prison Administration	ETB (millions)	1.8	2.1	2.5	3.0	3.5	4.1
3.1.5 Value of funds mainstreamed by the Transport Authority	ETB (millions)	0.5	0.5	0.6	0.8	0.9	1.1
3.1.6 Value of funds mainstreamed by the Ministry of Science and Higher Education	ETB (millions)	0.3	0.3	0.4	0.5	0.6	0.7
3.2 Total value of funds mainstreamed through infrastructure contracts	**ETB (millions)**	**112**	**133**	**158**	**187**	**222**	**262**
3.2.1 Value of funds mainstreamed through the Ministry of Mines and Natural Gas contracts	ETB (millions)	0.2	0.3	0.3	0.4	0.4	0.5
3.2.2 Value of funds mainstreamed through the Ministry of Water, Irrigation, and Energy contracts	ETB (millions)	19	22	27	32	38	44
3.2.3 Value of funds mainstreamed through the Ethiopian Roads Authority	ETB (millions)	93	110	131	155	184	217
3.3 Total value of funds mainstreamed at the regional level	**ETB (millions)**	**5.7**	**6.7**	**8.0**	**9.4**	**11.2**	**13.2**

SI 4. Strengthen and scale up community care coalitions to increase funding for community-based care

Indicator	Unit of Measurement	Target					
		2020 (baseline)	2021	2022	2023	2024	2025
4.1 Total value of resources mobilized for HIV/AIDS Strategic Plan activities by CCCs	**ETB (millions)**	**32**	**47**	**67**	**93**	**128**	**172**
4.1.1 Number of CCCs in HIV priority woredas	Number of CCCs	946	1,105	1,263	1,422	1,580	1,739
4.1.2 Number of priority woreda CCCs implementing HIV activities aligned with the HIV/AIDS Strategic Plan	Number of CCCs	468	602	753	919	1,101	1,299
4.1.3 Average value of financial revenues generated for HIV/AIDS Strategic Plan activities, per woreda	ETB (thousands)	39	45	51	58	66	76
4.1.4 Average value of in-kind contributions generated for HIV/AIDS Strategic Plan activities, per woreda	ETB (thousands) *50% of total estimated value of in-kind contributions to HIV	29	33	38	44	50	57

SI 5. Implement an earmarked tax on the profits of large public and private enterprises

Indicator	Unit of Measurement	Target					
		2020 (baseline)	2021	2022	2023	2024	2025
5.1 Value of financial resources generated from earmarked tax	**ETB (millions)**	**420**	**491**	**571**	**663**	**768**	**887**
5.1.1 Number of qualifying enterprises (annual profit at or more than of ETB 100 million or more)	Number of companies	1,303	1,392	1,483	1,576	1,669	1,763
5.1.2 Average taxable income of qualifying companies	ETB (millions)	161	176	193	211	230	251

References

Alebachew, A., Y. Yusuf, C. Mann, and P. Berman. 2015. *Ethiopia's Progress in Health Financing and the Contribution of the 1998 Health Care and Financing Strategy in Ethiopia.* Boston, Massachusetts and Addis Ababa, Ethiopia: Resource Tracking and Management Project; Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy, PLC.

Central Statistical Agency (CSA) [Ethiopia] and ICF. 2018. *Ethiopia Demographic and Health Survey 2016: HIV Report*. Addis Ababa and Rockville, Maryland: CSA and ICF.

Fagan, T., and A. Dutta. 2019. *Opportunities for Achieving Sustainable Family Planning Financing in Ethiopia*. Washington, DC: Palladium, Health Policy Plus.

Fagan, T., E. Lang, and B. Lee. 2019. *Achieving Sustainable Health Financing in Ethiopia: Prospects and Advocacy Opportunities for Domestic Resource Mobilization*. Washington, DC: Palladium and the Global Fund.

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2013. *Ethiopia National AIDS Spending Assessment Report: EFY 2004, 2011/12*. Addis Ababa: FHAPCO.

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2018. *HIV Prevention in Ethiopia National Road Map 2018–2020*. Addis Ababa: FHAPCO.

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2019. Data provided by FHAPCO staff.

Federal HIV/AIDS Prevention and Control Office (FHAPCO) and Ministry of Health (MOH). 2019. *Baseline Assessment of HIV Domestic Resource Mobilization and Sustainability in Ethiopia.* Addis Ababa: FHAPCO and MOH.

Global Fund. 2019. "Ethiopia: Disbursements by Component." Available at: https://www.theglobalfund.org/en/portfolio/country/?k=5061c5f2-1100-4eed9cff83787e240c78&loc=ETH.

International Monetary Fund (IMF). 2018. "2018 Article IV Consultation-Press Release; Staff Report; and Statement by the Executive Director for The Federal Democratic Republic of Ethiopia." Washington, DC: IMF. Available at: https://www.imf.org/en/Publications/CR/Issues/2018/12/04/The-Federal-Democratic-Republic-of-Ethiopia-2018-Article-IV-Consultation-Press-Release-Staff-46434.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2014. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: UNAIDS.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2019. "Ethiopia." Available at: https://www.unaids.org/en/regionscountries/countries/ethiopia.

Mekonnen, N., M. Abdulkadir, E. Shumetie, A.G. Baraki, and M.K. Yenit. 2019. "Incidence and Predictors of Loss to Follow-Up among HIV Infected Adults after Initiation of First Line Anti-Retroviral Therapy at University of Gondar Comprehensive Specialized Hospital Northwest Ethiopia, 2018: Retrospective Follow up Study." *BMC Research Notes* 12(1): 111. doi:10.1186/s13104-019-4154-y

Ministry of Health (MOH). 2014. *Ethiopia Fifth National Health Accounts, 2010/2011*. Addis Ababa: Federal Ministry of Health.

Ministry of Health (MOH). 2017. *Ethiopia Health Accounts, 2013/2014*. Addis Ababa: Federal Ministry of Health.

Ministry of Health (MOH) and Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2018. *Mid-Term Review of the National HIV/AIDS Strategic Plan—2015–2020 in an Investment Case Approach and Baseline Assessment of the National Viral Hepatitis Program* [Final Report]. Addis Ababa: FHAPCO.

Private Sector Health Project (PSHP). 2019. *Quarterly Reports, 2015–2019*. Addis Ababa: PSHP.

Seifu, W., W. Ali, and B. Meresa. 2018. "Predictors of Loss to Follow Up among Adult Clients Attending Antiretroviral Treatment at Karamara General Hospital, Jigjiga Town, Eastern Ethiopia, 2015: A Retrospective Cohort Study." *BMC Infectious Diseases* 18(1): 280. doi:10.1186/s12879-018-3188-4

Telele, N.F., A.W. Kalu, G. Marrone, S. Gebre-Selassie, D. Fekade, et al. 2018. "Baseline Predictors of Antiretroviral Treatment Failure and Lost to Follow Up in a Multicenter Countrywide HIV-1 Cohort Study in Ethiopia." *PLoS ONE* 13(7): e0200505.

U.S. President's Emergency Plan for AIDS Relief (PEPFAR). 2019. "Dashboards." Available at: https://data.pepfar.gov/dashboards.

The World Bank. 2019. "Data." Available at: https://data.worldbank.org/.

Annex A. Exchange Rate

Year	Rate (ETB/USD)
2011	16.9
2012	17.7
2013	18.6
2014	19.6
2015	20.6
2016	21.7
2017	22.9
2018	27.7
2019	29.2
2020	30.7
2021	32.3
2022	34.1
2023	35.9
2024	37.6
2025	39.4

Source: World Bank

Cover photos courtesy of ©UNICEF Ethiopia