Baseline Assessment of HIV Domestic Resource Mobilization and Sustainability in Ethiopia

MARCH 2020

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH-ETHIOPIA

Acknowledgments

The HIV domestic resource mobilization and sustainability baseline assessment and preparation of the baseline assessment report was led by the Federal HIV/AIDS Prevention and Control Office's (FHAPCO's) Projects and Grant Management Coordination Directorate in collaboration with members of the HIV Domestic Resource Mobilization and Sustainability Task Force.

FHAPCO would like to express its gratitude to the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief, for providing financial and technical support for producing this baseline assessment report. Particular thanks are due to Thomas Fagan, Elise Lang, and Amaha Haile. Cover photos are courtesy of UNICEF.

FHAPCO also would like to extend its heartfelt thanks to the following list of members of the Domestic Resource Mobilization and Sustainability Task Force and other contributors/participants in the baseline assessment.

HIV Domestic Resource Mobilization and Sustainability Task Force members:

Mr. Hayelom Assefa, FHAPCO
Mr. Abdeta Atomsa, FHAPCO
Mr. Yeworkwuha Abate, Ministry of Finance
Mr. Desta Moges, FHAPCO
Mr. Andarge Abie, Ministry of Health
Mrs. Alemtsehay Abebe, Ministry of Health
Mrs. Tsigehiwot w/Agegnehu, Ministry of Revenue
Dr. Subrata Routh, USAID
Mr. Samson Oli, USAID
Dr. Ester Aceng-Dokutum, World Health Organization
Dr. Seble Abate, World Health Organization
Mr. Emmanuel Baingana, Joint United Nations Programme on HIV/AIDS (UNAIDS)
Mr. Getachew Worku, Health Financing Improvement Project
Mr. Abebe Bezabih, Project HOPE
Mr. Bayissa Challa, Network of Networks of HIV Positives in Ethiopia

Other contributors:

Mr. Yared Asgedom, FHAPCO
Mr. Teferi Flate, FHAPCO
Mr. Weldesenbet Emagnaw, FHAPCO
Mrs. Belaynesh Debel, FHAPCO
Mr. Rahmeto Juhar, FHAPCO
Mr. Kifle Mitiku, FHAPCO
Dr. Girmachew Mamo,
Mr. Getachew Aberra, ICAP
Dule Yitagessu, FHAPCO
Alehegn Kertema, Ministry of Health
Mr. Kifle Tadesse, PSI Ethiopia
Dr. Demissew Asegid, Network of Networks of HIV Positives in Ethiopia (NEP+)
Mr. Amanuel Assegid, Consortium of Christian Relief and Development Associations
Sr. Kedija Zeynu, UNICEF

Zelalem Gizachew
Federal HIV/AIDS Prevention and Control Office
Projects and Grant Management Coordination Directorate Director

Table of Contents

List of Tables

List of Figures

Acronyms

ART	antiretroviral therapy
CBHI	community-based health insurance
CCCs	community care coalitions
ETB	Ethiopian birr
FHAPCO	Federal HIV/AIDS Prevention and Control Office
HAPCO	HIV/AIDS Prevention and Control Office
HP+	Health Policy Plus
MOH	Ministry of Health
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SDGs	Sustainable Development Goals
SHI	social health insurance
SNNPR	Southern Nations, Nationalities, and Peoples' Region
$	U.S. dollars
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development

Executive Summary

Ethiopia has made significant progress in responding to the country's HIV epidemic. The annual number of both new infections and AIDS-related deaths have declined by more than 80% since their peaks in the 1990s and early 2000s. These achievements have been largely financed by external donor resources and development partners. In the past five years, external resources for HIV have declined sharply. Between 2011 and 2016, such resources for the HIV program averaged nearly US$350 million per year. This amount has since declined by half, to less than US$175 million in 2019.

Mobilization of domestic resources for the HIV program previously has not been a significant priority. Efforts to measure and mobilize these resources typically have focused on the contribution of Ethiopia's health system strengthening efforts through investments in infrastructure and human resources for health. The *National AIDS Spending Assessment* for 2011/12 and *Ethiopia Health Accounts* for 2010/11 and 2013/14 provide highly variable estimates of the value of domestic resources spent on HIV. They do not provide a detailed look at the sources and use of this expenditure.

This baseline assessment provides an in-depth examination of current domestic spending and resource mobilization efforts for HIV. It is the first stage in developing a comprehensive HIV domestic resource mobilization and sustainability strategy; it identifies successes, challenges, and future recommendations for domestic resource mobilization initiatives that will guide strategic initiatives and objectives. The assessment also provides baseline estimates of resource mobilization, by source, against which future achievements can be measured.

The assessment found that, overall, mobilization of domestic resources for HIV have been limited. In 2019, an estimated US$11 million in public or otherwise pooled (i.e., excluding out-of-pocket and corporate spending) domestic resources were mobilized for HIV. Of these resources, roughly half came from the health sector (i.e., the Ministry of Health, the Federal HIV and AIDS Prevention and Control Program, regional health bureaus, and woreda health offices). Although sampling from woredas was limited, available data indicate that as much as 75% of domestic health sector spending on HIV occurs at the woreda level.

HIV mainstreaming—the allocation of resources from non-health sectors to HIV programming—has previously been a central focus of HIV domestic resource mobilization efforts. However, this assessment found that the success of mainstreaming has been extremely limited, primarily due to a lack of (1) a legal basis for enforcing mainstreaming; (2) clear guidelines for how mainstreamed funds should be spent, tracked, and reported; and (3) capacity to deploy mainstreamed funds in an effective manner that aligns with national initiatives and priorities. The total value of resources mobilized through mainstreaming in 2018 is estimated to be approximately US$1 million—a substantial decrease from the US$3 million mobilized during the first year of mainstreaming implementation, according to the 2011/12 *National AIDS Spending Assessment* (FHAPCO, 2013).

However, there are promising examples of domestic resource mobilization initiatives currently underway. The Ethiopia Roads Authority requires the integration of HIV programming in all road contracts. The annual estimate for 2018 and 2019 was US$2 million in domestic resources allocated for HIV through this mechanism. This model could be replicated in other infrastructure sectors.

At the community level, community care coalitions have mobilized substantial resources for HIV. In 2018, 468 coalitions raised approximately US$1.2 million in cash and in-kind contributions for people living with HIV and HIV orphans and vulnerable children. The proposed scale-up of community care coalitions to cover the country's more than 17,000 kebeles as part of Ethiopia's *Growth and Transformation Plan* presents a promising opportunity for expansion of this approach.

Lastly, the AIDS Fund, which collects voluntary payroll contributions from public sector employees, has been an underutilized but promising way to mobilize resources. In the Amhara region, more than US$100,000 is already being pooled and allocated to support HIV orphans and vulnerable children. Respondents interviewed for this assessment noted that there is a lack of guidance as to how these resources should be collected and used, but cited employees' willingness to contribute.

Although several resource mobilization mechanisms for HIV already exist and funds allocated for HIV have demonstrated high execution rates, most stakeholders said that funds were not used properly or effectively. A lack of tracking, reporting, and oversight in the use of funds mobilized for HIV results in a significant share of funds being used for repetitive training and meetings, rather than high-impact interventions aligned with priorities outlined in the national *HIV/AIDS Strategic Plan*. Focusing on key efforts to strengthen resource mobilization and ensure sustainability for Ethiopia's HIV program should ensure that the proper legal, regulatory, and accountability mechanisms are in place, and that any future resources mobilized will contribute directly to the priorities and objectives of the strategic plan.

1. Introduction

1.1 Background

Through government leadership and commitment to country ownership, Ethiopia has made immense strides in its HIV response. Over the last two decades, Ethiopia has witnessed a marked reduction in AIDS morbidity and mortality. According to the most recent projections by the Joint United Nations Programme on HIV/AIDS (UNAIDS), AIDS-related deaths have fallen from 61,000 in 2003 to 11,000 in 2018 (UNAIDS, 2019). New infections also declined sharply, from a peak of 120,000 in 1993 to 23,000 in 2018 (UNAIDS, 2019).

To achieve these results, Ethiopia developed a strong HIV policy framework—including national policies, technical guidelines, and multisectoral implementation plans—aimed at unifying and guiding the overall national response. Cognizant of the health, social, economic, and demographic impacts of the epidemic, an HIV policy was issued in 1998. This policy was followed by the establishment of the National AIDS Council in 2000 and the Federal HIV/AIDS Prevention and Control Office (FHAPCO) in 2002, creating a platform for leadership and coordination of the multisectoral response in the country. Since 2000, the Government of Ethiopia has developed and implemented a series of five-year strategic plans to strengthen the multisectoral response to HIV, including the current *HIV/AIDS Strategic Plan 2015–2020 in an Investment Case Approach* (see box).

HIV/AIDS Strategic Plan 2015–2020

Strategic objectives

- Implement high-impact and targeted prevention programs
- Intensify targeted HIV testing and counseling services
- Attain virtual elimination of mother-to-child transmission of HIV
- Optimize and sustain quality care and treatment

Goals

- Prevent 70,000–80,000 new HIV infections over the investment period
- Save 500,000–550,000 lives over the investment period

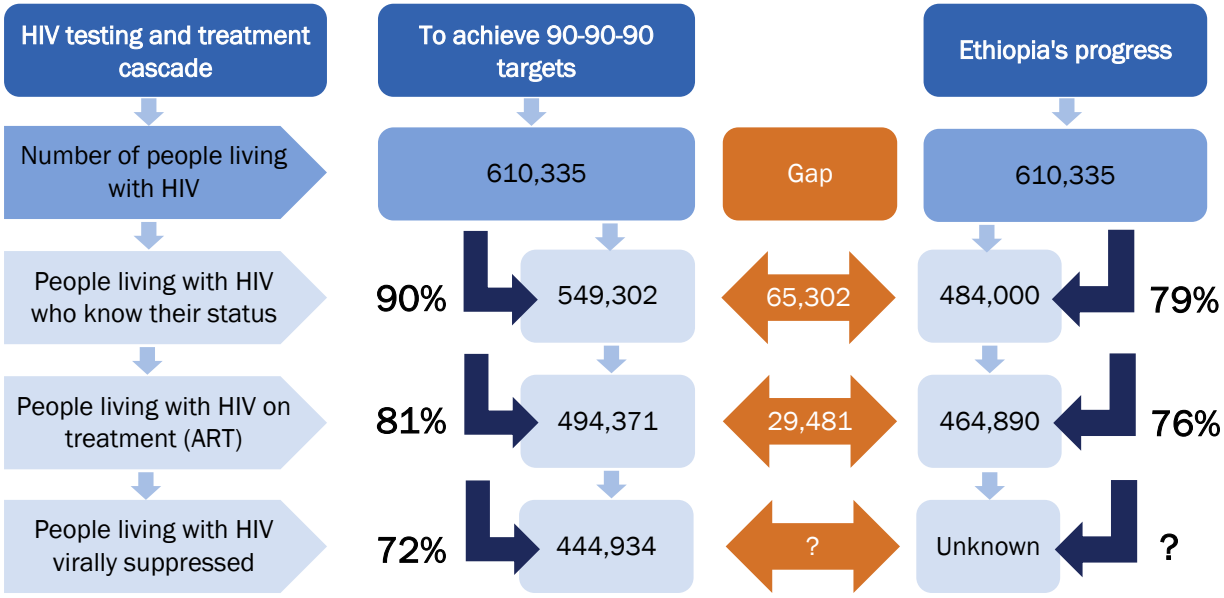
The country has made significant progress on scaling up HIV testing and counseling services, especially through the catch-up campaign and partner services targeting high-risk population groups. A *Mid-Term Review of the National HIV/AIDS Strategic Plan* indicated that there are more than 3,000 HIV testing 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). A policy of test and treat—referring all HIV-positive patents for treatment, regardless of CD4 count—was launched in October 2017. By mid-2019, there were 464,890 people living with HIV receiving ART, treatment coverage for prevention of mother-to-child transmission was 59%, and coverage of viral load testing was at 50% (MOH and FHAPCO, 2018; FHAPCO, 2019).

In developing the current national HIV/AIDS Strategic Plan, the government of Ethiopia has adopted UNAIDS's 90-90-90 targets: 90% of people living with HIV know their status, 90% of people living with HIV who know their status are on treatment (ART), and 90% of people living with HIV on treatment have attained viral suppression. Ethiopia has made significant progress toward achieving these goals, particularly regarding treatment and viral suppression (see Figure 1). As of 2019, 96% of people living with HIV who knew their status were on ART; as of 2018, 86% of those on ART who received viral load testing were virally

suppressed (MOH and FHAPCO, 2018; FHAPCO, 2019), indicating that the HIV program has been highly successful in linking patients to treatment and achieving viral suppression. Virally suppressed patients no longer transmit the disease, which makes this attainment a key goal of the HIV response.

However, more progress needs to be made to reach 90% of people living with HIV who know their status. As of 2018, an estimated 79% of people living with HIV knew their status, resulting in important gaps in the achievement of targets for treatment and viral suppression. To reach the 90-90-90 treatment targets, which require 81% of people living with HIV to be on treatment, Ethiopia must achieve 494,371 people on ART—an increase of nearly 30,000 over the current number of ART patients (see Figure 1). ART is a major cost driver of the HIV response—increasing the number of patients means that the cost of the HIV response will continue to rise. Scaling up viral load testing coverage to monitor viral suppression will be another significant need going forward.

Figure 1. Ethiopia's Progress on 90-90-90 Targets



Adapted from MOH and FHAPCO, 2018

Although the number of new infections has decreased dramatically over two decades, it has remained stable at 23,000–24,000 new infections a year since 2013 (UNAIDS, 2019). The *Ethiopia Demographic and Health Survey 2016: HIV Report* shows that HIV prevalence for adults (ages 15–49) is less than 1% nationally, however, the epidemic is heterogeneous by sex, geography, and population group (CSA and ICF, 2018). According to the report, HIV prevalence is:

- Twice as high among women (1.2%) than men (0.6%)
- Seven times higher in urban areas (2.9%) compared to rural areas (0.4%)
- Substantially higher than the national average in the regions of Gambella (4.8%), Addis Ababa (3.4%), Dire Dawa (2.5%), and Harari (2.4%)

As part of its HIV response, Ethiopia has defined key and priority populations that face high risk of HIV infection, limited access to services, and stigma and discrimination. HIV prevalence is highest among female sex workers (23%), distance drivers (5%), prisoners (4%), and divorced and widowed women (4% and 11%, respectively) (EPHI et al., 2013;

UNODC and Federal Prison Administration, 2013; CSA and ICF, 2018). Programmatic gaps remain in addressing these inequities and continuing challenges. The *Mid-Term Review of the National HIV/AIDS Strategic Plan 2015–2020* highlighted that HIV prevention interventions have been inadequate in coverage and quality, with only a limited focus on key and priority populations (MOH and FHAPCO, 2018). Prevention programs were not regularly evaluated for efficiency and effectiveness to guide prioritization of population groups and selection of effective prevention interventions. The mid-term evaluation also noted that targeted HIV testing is not being fully implemented in health facilities or communities, and the systems for linking HIV-positive clients to care are weak. Furthermore, efforts to reach targets to increase the proportion of pregnant women who are tested for HIV and receive their results, and to decrease the proportion of HIV-infected infants born to HIV-positive women, have made very little progress. Similarly, progress toward *HIV/AIDS Strategic Plan* targets related to pediatric ART were not on track.

1.2 Rationale and Objectives

To fill these gaps and maintain current achievements in prevention and treatment, Ethiopia's HIV response faces a growing resource need. The estimated resource requirement to achieve the objectives of the *National HIV/AIDS Strategic Plan 2015–2020* has increased annually, from US$242 million in 2015 to $311 million in 2020.[1] At the same time, financial support from external donors, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), has declined by 60% (Global Fund, 2019; HP+, 2018; PEPFAR, 2019).

Cognizant of these declines, in 2018 FHAPCO identified domestic resource mobilization as a flagship initiative. As part of this initiative, FHAPCO intends to develop and implement a strategy for mobilizing domestic funding for HIV to sustain and further advance gains made in reducing new infections and AIDS-related mortality over the past two decades. To oversee this initiative, FHAPCO established the HIV Domestic Resource Mobilization and Sustainability Task Force, composed of representatives from FHAPCO, the Ministry of Health (MOH), the U.S. Agency for International Development (USAID), PEPFAR, UNAIDS, and the World Health Organization.[2]

The task force identified conducting a baseline assessment as a first step to inform the development of an HIV resource mobilization and sustainability strategy. The objective of the baseline assessment is to determine the current sources and trends for HIV financing, with a focus on current domestic financing, and assess current challenges and future opportunities to mobilize and use these resources effectively. This baseline assessment will advise on the strategies proposed in the overall resource mobilization strategy and provide baseline estimates of domestic resource mobilization for HIV against which future achievements can be measured.

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

[2] Recently, the task force has expanded to include representatives from the Ministry of Finance, Ministry of Revenue, Ethiopia Health Insurance Agency, Network of Networks of HIV Positives in Ethiopia, and the USAID- and PEPFAR-funded Health Financing Improvement Program and Health Policy Plus project.

2. Study Design and Implementation

2.1 Methods

The baseline assessment was carried out using a combination of both quantitative and qualitative methods. Three structured questionnaires were developed to collect data from federal public institutions, regional and woreda sector offices (e.g., health, education, and finance), and the private sector. The public sector (federal, regional, and woreda level) questionnaire was used to obtain data on institutions' overall annual budgets and HIV-specific budget allocations and expenditures from 2014–2019.[3] Unless otherwise noted, all quantitative data (i.e., budget and expenditure) presented in this report was collected through this process (cited as "baseline assessment survey" throughout the report). In addition, questionnaires asked respondents which areas HIV funding was allocated to (treatment, prevention, monitoring and evaluation, etc.). For the private sector, the questionnaire collected data on annual revenues and budgets for HIV programs, and well as willingness to commit funds for HIV in the future. Quantitative data were cleaned and entered into the Statistical Package for Social Sciences (SPSS). Data then were exported into Microsoft Excel for further cleaning and analysis. All HIV budget and spending data were reported in nominal terms and are reported as such in this report unless otherwise specified.

Key informant interviews were conducted with management staff from each participating institution using an open-ended question guide. These interviews explored the informants' understanding of the current context of HIV financing, existing practices in domestic resource mobilization, and informants' opinions on opportunities and challenges for future resource mobilization efforts. Each key informant interview session was recorded, then transcribed and coded using Atlas-ti 5.0 and summarized along key thematic areas.

The USAID- and PEPFAR-funded Health Policy Plus (HP+) project supported FHAPCO in the design of the overall study and data collection tools, as well as analysis and preparation of the final report. HP+ also provided a desk review of HIV financing trends and resource needs.

2.2 Data Collection

Baseline data collection was conducted between February 20 and March 10, 2019, at the federal level, in six regions (Afar, Amhara, Gambella, Oromia, Southern Nations, Nationalities, and Peoples' Region [SNNPR], and Tigray), and Addis Ababa city administration. These regions account for approximately 88% of regional government spending, 93% of Ethiopia's population, and 94% of people living with HIV. Therefore, while not fully comprehensive, this assessment likely captures the vast majority of HIV spending at the regional level.

In addition, data was collected from sector offices in 12 woredas, two from each of the six regions, and two sub-cities of Addis Ababa city administration. This represents an extremely small sample (approximately 1% of the country's 1,000 woredas) and should not be interpreted to be–nor is it intended to be–nationally representative. Therefore, all estimates

[3] For purposes of alignment across different fiscal and calendar years, unless otherwise specified, all annual data are reported according to the Gregorian calendar year in which the reporting institutions' fiscal year ends. For example, 2019 (Gregorian calendar year) corresponds to U.S. Government fiscal year 2019 and Ethiopian calendar year and fiscal year 2011.

at the woreda level are indicative and conclusions drawn from them should be considered preliminary.

Twenty-four staff from FHAPCO, MOH, and other organizations participating in the HIV Domestic Resource Mobilization and Sustainability Task Force conducted data collection. There were two to three people available for field work in each of the six regions and Addis Ababa city administration. The federal-level data collection team was composed of six people. Field workers were trained for one day by HP+ and the FHAPCO team on data assessment rationale, objectives, and data collection methods and instruments. Key informant interviews were organized with senior management at each of the institutions, during which field workers explained the assessment rationale and objectives to participants and conducted interviews after obtaining informed consent. Structured questionnaires were administered with finance and HIV focal persons.

Participating Federal Sector Offices

- Ethiopian Health Insurance Agency
- Ethiopian Roads Authority
- FHAPCO
- Ministry of Health
- Ministry of Labor and Social Affairs
- Ministry of Women, Children, and Youth
- Ministry of Agriculture
- Ministry of Communication and Information Technology
- Ministry of Education
- Ministry of Finance

A total of 92 organizations participated in the baseline assessment. Of these, 77 were government offices, 12 were private and parastatal companies, and three were partners and civil society organizations. At the federal level, 10 sector offices participated (see box). At the regional level, 45 offices participated (Table 1). In all regions and city administrations surveyed, these offices included the regional bureaus of health, education, finance, labor and social affairs, and women, children and youth affairs. In addition, regional HAPCOs were surveyed in the four regions where they are distinct from the regional health bureau. Six other regional government offices were also surveyed, including two regional transport bureaus, one water and irrigation bureau, a regional House of People's Representatives, two regional councils on social affairs, and one office of the regional president.

Table 1. Participating Government Offices, by Region

Region	Regional Bureaus	Woreda Offices	Total
Addis Ababa	6	2	8
Afar	6	2	8
Amhara	6	6	12
Gambella	8	2	10
Oromia	6	4	10
SNNPR	7	4	11
Tigray	6	2	8
Total	**45**	**22**	**67**

At the woreda level, 22 offices participated, including those for health (11), education (3), finance (5), labor and social affairs (2), and women, children, and youth affairs (1). One zonal health department also participated. Participating private and parastatal companies included those registered at the federal level and those registered at the regional level across a range

of sectors, including banking and finance, construction, manufacturing, telecommunications, energy, and agriculture.

Limitations

During the data collection process, challenges occurred in retrieving financial data for the preceding five years from some institutions. Few private sector respondents were willing to disclose their profits or comment on their willingness to allocate funds for HIV. Less than 25% of institutions interviewed, either public or private, could reliably report financial data disaggregated by different HIV program areas.

In addition, the extremely small number of woredas included in this assessment limits the accuracy of estimates of HIV funding at this level. Where possible, the study team has attempted to provide broad estimates to provide insight into the relative role of woredas in funding the HIV response. However, these estimates should not be taken as nationally representative; actual levels of HIV financing across woredas may vary significantly from the values observed in this assessment. Given this limitation, the study team recommends that additional comprehensive data collection from the woreda level occur prior to undertaking any further woreda-focused resource mobilization efforts.

2.3 Key Indicators

Data was collected for key indicators that are used to summarize the current HIV financing landscape in Ethiopia. These indicators are divided into three areas: external HIV financing trends, domestic resource mobilization for HIV, and use of domestic HIV resources. The funding landscape indicators summarize the current external financing situation, highlighting the need for mobilization of additional resources. The indicators of domestic resource mobilization summarize the primary sources and current levels of domestic financing for HIV, and the indicators of use of domestic resources summarize targeting and use of these resources. These domestic indicators are intended to serve as baseline indicators against which future improvement in domestic resource mobilization and use will be measured. This baseline assessment report is structured around these three sets of indicators, which are summarized in Table 2.

Table 2. Key HIV Financing Indicators

Category	Indicator	Value	Data Source
External HIV Financing Trends	**1. Trend in external financing for HIV (2011–2019)**	Declined from $440 million to $177 million	Estimates based on PEPFAR dashboard (2019), Global Fund funding landscape (2019), *Ethiopia Health Accounts, 2013/2014* (MOH, 2017),* and *Ethiopia National AIDS Spending Assessment Report: 2011/12* (FHAPCO, 2013)
Domestic Resource Mobilization for HIV	**2. Government health sector budget for HIV (2019)**	**Less than $7 million**	Baseline assessment survey**
	2a. Federal HIV budget (MOH and FHAPCO)	$750,000	Baseline assessment survey
	2b. Regional HIV budgets	$1 million	Baseline assessment survey
	2c. Woreda HIV budgets	$5 million***	Baseline assessment survey
	3. HIV mainstreaming budget† (government budget allocation from non-health sectors) (2019)	**Less than $1 million**	Baseline assessment survey
	3a. Federal HIV mainstreaming budgets	$200,000	Baseline assessment survey
	3b. Regional HIV mainstreaming budgets	$250,000	Baseline assessment survey
	3c. Woreda HIV mainstreaming budgets	< $500,000	Baseline assessment survey
	4. Resources mobilized through innovative financing for HIV (2019)	$2–3 million	Baseline assessment survey
	5. Community resources mobilized for HIV (2018)	More than $1.2 million	Report on Community Care Coalitions (CCCs) in Ethiopia (FHI 360, unpublished)
	6. Corporate and enterprise financing for HIV (2018)	Negligible	Baseline assessment survey
	7. HIV expenditure from insurance	Unknown	N/A
	8. Out-of-pocket expenditure on HIV (2014)	$3 million	*Ethiopia Health Accounts, 2013/2014* (MOH, 2017)
Use of Domestic HIV Resources	**9. Government HIV program budget execution (2014–2018)**	> 90%	Baseline assessment survey
	9a. Health sector budget execution	> 90%‡	Baseline assessment survey
	9b. Mainstreaming budget execution	> 90%	Baseline assessment survey
	10. Prioritization of key populations: percentage of prevention resources spent on HIV priority populations	18%	*Ethiopia National AIDS Spending Assessment Report: 2011/12* (FHAPCO, 2013)

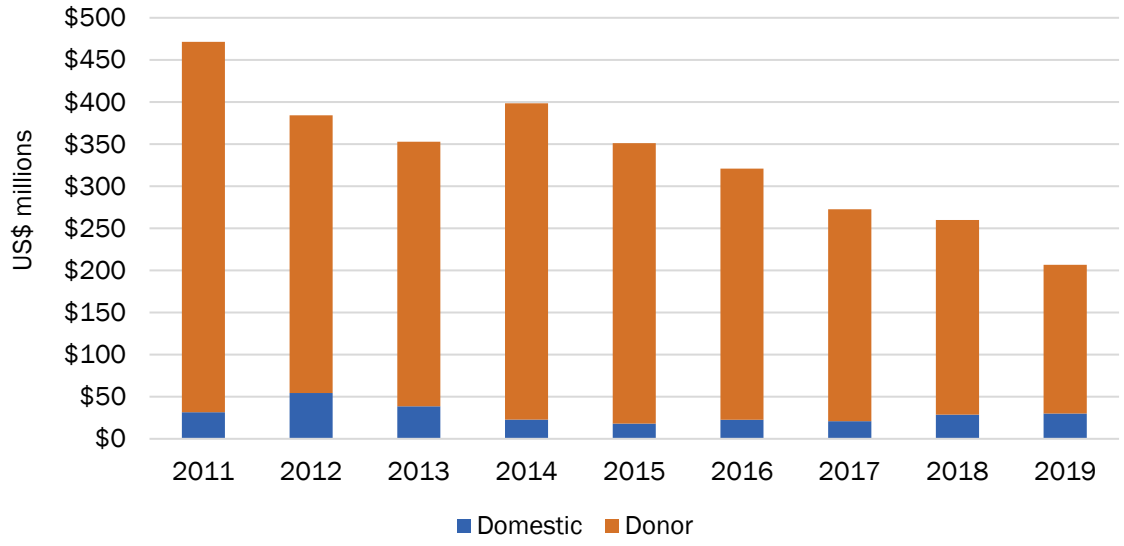
* Data for the *Ethiopia Health Accounts, 2013/2014* was collected in 2015/2016.
** Data cited as from the baseline assessment survey was collected during key informant interviews through a structured questionnaire. In most instances, source documents were not made available to the study team and figures could not be independently verified.
*** Estimated based on a sample of seven woredas.
† Mainstreaming is defined as the allocation of resources from non-health sectors to HIV programming. Mainstreamed funds are managed by individual sector offices and are used primarily for HIV promotion, awareness, and prevention.
‡ MOH budget was an outlier for 2017 and 2018, at 12% and 14%, respectively.

3. Findings

3.1 HIV Funding Landscape

Over the past two decades, financing of Ethiopia's HIV response has been primarily dependent on external resources. Between 2011 and 2019, external funding accounted for 91% of the total funding for HIV; however, in recent years there has been a decline in the absolute amount and share of external funding (Figure 2). According to previous estimates, the value of domestic resources increased over the past five years, from 5% of total HIV financing in 2015 to 15% in 2019. Despite the recent increases in domestic contributions to HIV financing, Ethiopia has experienced an overall decline in total HIV funding due to the decline in donor funding. Recent, marginal increases in domestic resources have not been sufficient to offset the significant declines in external resources.

Figure 2. Source of HIV Funding, by Domestic or Donor (2011–2019)



Source: Estimates based on PEPFAR, 2019; Global Fund, 2019; MOH, 2014 and 2017; and FHAPCO, 2013

A substantial share of donor resources has been allocated and executed through government structures, strengthening the ability of the government to plan, manage, and execute funds for HIV. However, to some extent, this situation has made it difficult to accurately measure funding by source, as multiple funding streams are mixed at execution. This report attempts to unpack these sources of funding by considering the different funding channels used by the Government of Ethiopia and its development partners.

Funding Flows

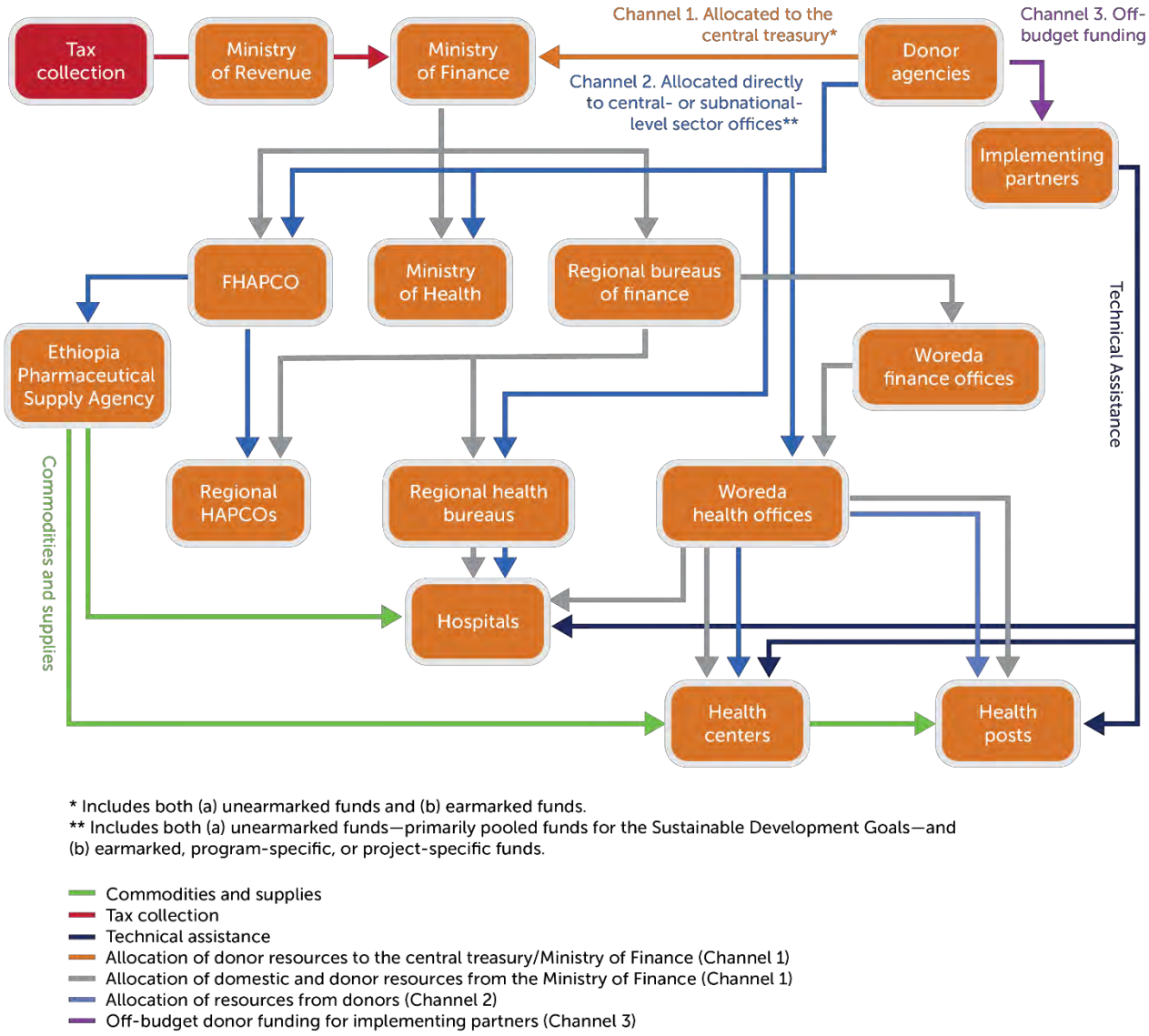
Funding from external sources is disbursed through three different channels (Figure 3). Channel 1 is general budget support for the Government of Ethiopia and includes all funding transferred to the Ministry of Finance's general treasury. These funds may be allocated either (a) at the full discretion of the Ministry of Finance or (b) earmarked for specific purposes.

Channel 2 refers to all funds allocated directly by donors to implementing government agencies, including the MOH, FHAPCO, regional health bureaus, woreda health offices, and other government institutions. This includes (a) unearmarked funds and (b) funds

earmarked for specific programs and projects. Channel 2a consists primarily of funds pooled for the achievement of the Sustainable Development Goals.[4] Many bilateral donors, with the notable exception of the U.S. Government, disburse funds through channel 2b. However, these funds have not played a particularly large role in financing the HIV response. Channel 2b includes all support from the Global Fund allocated to FHAPCO and, in turn, to the Ethiopia Pharmaceutical Supply Agency for procurement of antiretroviral drugs and other commodities. PEPFAR support for regional health bureaus is also included in this category.

Lastly, Channel 3 refers to funding not channeled through any government structure or institution. These funds are allocated by donors to nongovernmental implementing partners. This channel accounts for the largest share of PEPFAR funding and includes laboratory reagents and all other commodities procured independently by PEPFAR.

Figure 3. Funding Flows for HIV



* Includes both (a) unearmarked funds and (b) earmarked funds.
** Includes both (a) unearmarked funds—primarily pooled funds for the Sustainable Development Goals—and (b) earmarked, program-specific, or project-specific funds.

- Commodities and supplies
- Tax collection
- Technical assistance
- Allocation of donor resources to the central treasury/Ministry of Finance (Channel 1)
- Allocation of domestic and donor resources from the Ministry of Finance (Channel 1)
- Allocation of resources from donors (Channel 2)
- Off-budget donor funding for implementing partners (Channel 3)

[4] Although these funds must be used to achieve the Sustainable Development Goals, they are not earmarked for a specific program or project.

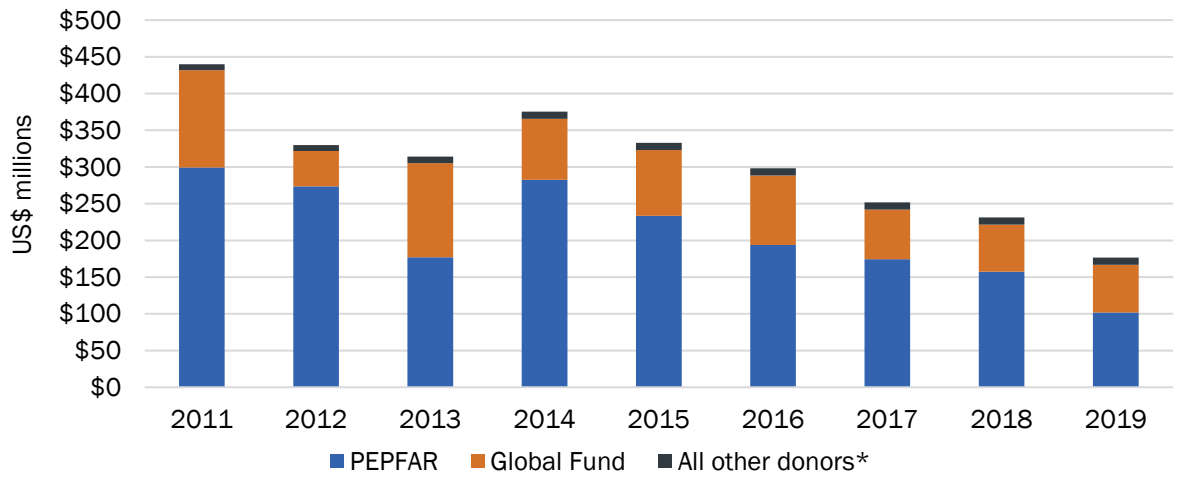
Domestic funds allocated to HIV-specific activities and spent on HIV include those allocated directly by the Ministry of Finance to FHAPCO and the MOH. In addition, regions and woredas allocate their own funds to the HIV program through their respective health and HIV offices. These funds, both from internally generated resources (i.e., collected at the regional level) and subsidies, are given in the form of block grants from the federal level.

Health facilities, including hospitals, health centers, and health posts, then receive resources—in the form of financing for salaries, commodities and supplies, and technical assistance (i.e., training and capacity building)—from a variety of sources.

External Financing Trends

The HIV response has been a major donor priority in Ethiopia. Since the early 2000s, Ethiopia has received more than $4 billion in external financing for its HIV program—an average of more than $250 million per year (Figure 4). Donor financing support peaked between 2010 and 2011 at well over $400 million annually but has since declined by more than half. In 2019, only around $170 million was allocated by donors for the HIV response.

Figure 4. External Financing for HIV



Source: Estimates based on PEPFAR, 2019; Global Fund, 2019; MOH, 2017; and FHAPCO, 2013.
* Extrapolated from MOH, 2017 and FHAPCO, 2013 data.

PEPFAR has historically been the largest donor, contributing approximately $2.9 billion to Ethiopia's HIV response during 2004–2019. However, PEPFAR funding has declined dramatically compared to other donors, from more than $300 million annually during 2008–2011 to just $102 million for 2019—a reduction of two-thirds. This reduction has corresponded to a strategic pivot—refocusing funds to high-prevalence areas with funding reductions primarily concentrated in areas of low prevalence–as well as a shift away from support for broader health systems.

The Global Fund has contributed only about half of the amount that PEPFAR has—approximately $1.4 billion over 2005–2019. However, the reduction in funding from the Global Fund has followed a similar trend to that of PEPFAR, from an average annual disbursement of $125 million during 2007–2011 to an anticipated $65 million a year for 2019. This annual reduction is almost half of what was previously received from Global Fund.

"We've had a sudden cut in donor funding, which is seriously affecting the program. We were supposed to have time for a strategic phase-out from donor support. Now we need to urgently look for domestic funds and other sources."

–Key informant, Ministry of Health

"HAPCO itself is just starting to comprehend the situation, as lately the problem has become bigger and deeper … HAPCO was supposed to communicate the situation early to key stakeholders and we haven't done that job."

–Key informant, HAPCO

"We used to have funding from donors for the HIV program. Now there is almost no funding from donors, and many programs are interrupted due to funding shortages, especially prevention programs such as peer education, community conversation, etc. Moreover, an association established by PLHIV [people living with HIV] in the woreda could not function due to lack of funds."

–Key informant, Woreda Health Office, Amhara Region

External support has been the sole source of financing for key components of the HIV response, including all commodities for HIV testing and treatment. In 2017, the Global Fund spent $60 million on antiretroviral drugs and rapid test kits, and PEPFAR spent $11 million, primarily on laboratory commodities and reagents (PEPFAR, 2018). With further funding reductions, the procurement of these commodities likely will be unable to keep pace with growing need and current procurement levels may be threatened.

Stakeholders' Understanding of Trends in External Financing

Despite these substantial reductions in external funding, awareness and understanding of the current HIV financing situation was mixed among key stakeholders interviewed. Program staff whose activities had acutely felt reductions in donor funding tended to be well aware of the situation. However, many key decision-makers were not well informed of recent reductions or were only beginning to understand the implications of these cuts.

Program staff at the federal, regional, and woreda levels by and large understood that donor funding is declining, and most have felt the impact of these reductions on the HIV program. However, at the federal level, key stakeholders noted that funding reductions have been sudden and there has not been an adequate period of transition and preparation to assume program costs using domestic resources. Some institutions were in the early stages of understanding the consequences and severity of these reductions.

At the local level, donor funding cuts also have been felt acutely. These reductions seem to have had a particularly significant impact on community-level programs. As further cuts occur and donor funding consolidates around procurements and treatment, funding reductions at the community level are likely to be exacerbated even more.

However, despite how acutely these funding cuts are being felt by HIV program activities and staff, many key decision-makers at the federal and regional levels outside of the program were unaware of them. Most key informants believe that there has been little effort to communicate these reductions to decision-makers, particularly to finance institutions (i.e., Ministry of Finance, regional bureaus of finance, and woreda finance offices) and among elected officials. They emphasized that these decision-makers, who are key players in the

"We have not communicated the amount of budget spent on the program and current situation. Decision-makers don't know of the situation."

–Key informant, Tigray Regional Health Bureau

"Stakeholders don't know the amount of funding invested in the HIV program. They don't have any idea how big the investment is and the impending funding crisis. It is urgent to communicate to the decision-makers the amount of budget needed and the current decline of donor funding."

–Key informant, Tigray Region

"We generally know there is declining donor funding for many programs … but we didn't have information that the HIV program is in such a critical position in terms of funding. There should have been communication from the Ministry of Health or HAPCO."

–Key informant, Ministry of Finance

budget approval process, did not understand the amount of money required for HIV programming.

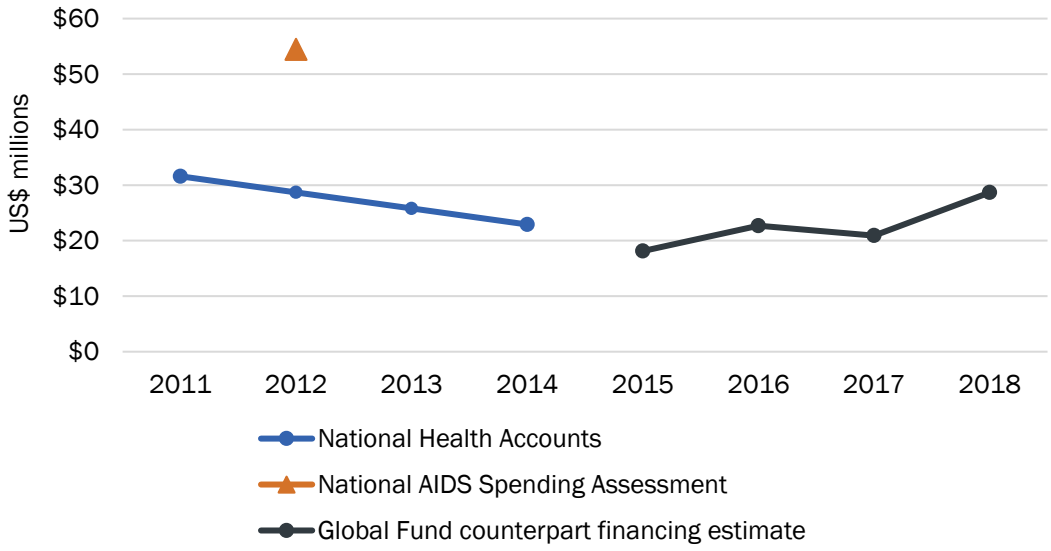
To address this information gap, there was a consensus among stakeholders around the need for greater evidence to inform decision-making for domestic HIV resource mobilization efforts and for wide-scale communication and advocacy efforts at all levels to convey the severity and impact of reductions in external financing. Stakeholders underscored that the development and implementation of a domestic resource mobilization strategy should occur in parallel with, or include, these efforts.

Historical Estimates of Domestic Financing for HIV

Although no comprehensive strategy for domestic resource mobilization for HIV has existed previously, domestic resources have played a crucial role in the HIV response. The Government of Ethiopia, through investments in the overall health system, including health infrastructure and human resources, has significantly contributed to improving access to HIV services. These contributions have been captured in previous estimates of total HIV spending, based on the share of human resources for health, infrastructure, and other overhead costs used in the delivery of HIV services.

Although previous assessments for domestic financing for HIV employ similar, survey-based methodologies, they have produced highly variable estimates (Figure 5). The *Ethiopia Health Accounts*, conducted in 2010/11 and 2013/14, found that government revenue spent on HIV through the health sector declined (in U.S. dollars) over that period, going from $32 million to $23 million (MOH, 2014 and 2017). In contrast, the *National AIDS Spending Assessment,* conducted in 2011/12, estimated that the Government of Ethiopia spent $54 million of its own resources on the HIV response, including resources spent by non-health sector institutions, which are not included in the *Ethiopia Health Accounts* (FHAPCO, 2013). More recent estimates used to measure achievement of Ethiopia's Global Fund counterpart financing obligations are more in line with the findings of the *Ethiopia Health Accounts*, showing an increase from $18 million to $29 million over 2015–2018. However, this trend is predicated on a constant share of health system costs (for human resources, infrastructure, etc.) being attributable to HIV.

Figure 5. Historical Estimates of Government HIV Expenditure



Sources: MOH, 2014 and 2017; FHAPCO, 2013; Global Fund, 2019
Note: National Health Accounts estimate excludes non-health sector resources. National AIDS Spending Assessment data was not available for review by the study team.

Although the health system costs included in these estimates make up an important component of the HIV response, they are not directly attributable to the HIV program and not part of the resource estimate for the *HIV/AIDS Strategic Plan 2015–2020*. For the Government of Ethiopia to demonstrate a clear commitment to the HIV response and ensure that all aspects of the response are adequately financed, it will be necessary to increase the contribution of domestic resources to HIV program-specific costs. At the same time, the Global Fund is changing its counterpart financing guidelines to count only program-specific costs toward the requirements. This move further emphasizes the need to both have accurate estimates of these contributions and focus on increasing them.

Therefore, in contrast to previous estimates, this baseline assessment aims to estimate the value of domestic resources being allocated and spent directly on the HIV program (excluding nonprogram-specific human resources, infrastructure, equipment, and other overhead costs). These values align with, and can more easily be compared to, the HIV program costs estimated in the *HIV/AIDS Strategic Plan 2015–2020, Health Sector Transformation Plan 2015/16–2019/20*, and future updated plans. The amounts provided in this report represent the best available estimate of the current financial sustainability of the HIV response, given sample and data availability, as well as a baseline against which future improvements in domestic financing of the program can be measured.

3.2 Domestic Resource Mobilization for HIV

Health Sector Financing for HIV

Ethiopia's health sector is highly decentralized, with the MOH, regional health bureaus, and woreda health offices all playing key roles in the delivery, management, and financing of health services. In addition, FHAPCO and regional HAPCOs, where they exist, manage separate budgets allocated directly by the Ministry of Finance and regional finance bureaus. This baseline assessment examined the amount of funding allocated to and spent on HIV by each of these institutions at each administrative level.

Federal Level

Ministry of Health: The MOH's HIV unit is responsible for health worker training and supervision; development of technical guidelines, tools, standards; and monitoring and evaluation of the provision of clinical HIV services. Funding for these functions comes primarily from external resources, although the Government of Ethiopia previously has allocated a share of its own domestically generated resources.

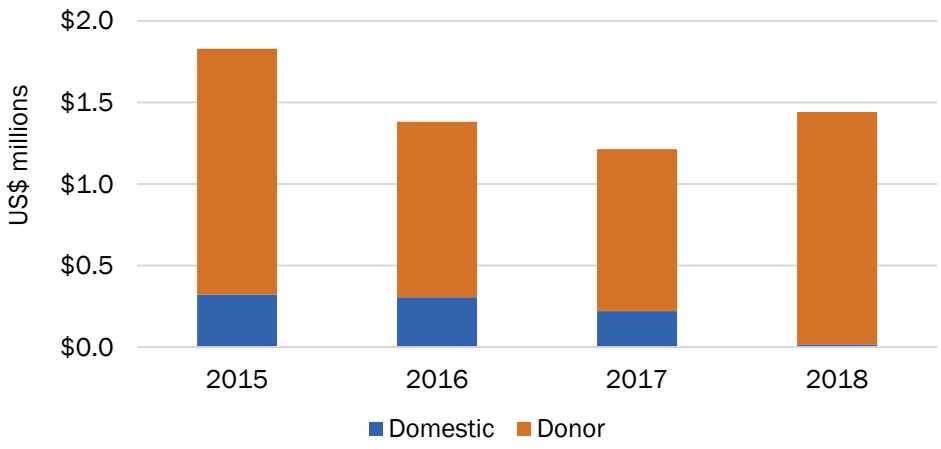
Key Finding

The nominal value of domestically generated resources allocated by the MOH for HIV declined to just $17,000 annually in 2018 and 2019, representing less than 0.1% of the MOH's domestically generated budget.

Between 2016 and 2018, the MOH's total health budget increased from ETB 5.3 billion ($243 million) to ETB 8.9 billion ($321 million). Donor resources increased significantly during that period—from ETB 5.0 billion ($231 million) to ETB 7.8 billion ($283 million). Similarly, the allocation of domestic resources increased—from ETB 257 million ($12 million) in 2016 and 2017 to ETB 1.1 billion ($38 million) in 2018. As a result, the share of the MOH's budget from domestic resources increased from less than 5% in 2016 and 2017 to 12% in 2018.

Data on the MOH's budget for the HIV program were available only for fiscal years 2015–2018. During this period, the total budget fluctuated significantly, declining in nominal terms from 38 million Ethiopian birr (ETB) in 2015 to ETB 28 million in 2017, before increasing sharply to ETB 40 million in 2018. In U.S. dollars, this fluctuation translates to a decrease from $1.8 million to $1.2 million, and then an increase to $1.4 million in fiscal year 2018 (Figure 6). (See Annex A for the exchange rate by year for U.S. dollars and Ethiopian birr.)

Figure 6. MOH HIV Program Budget, by Source

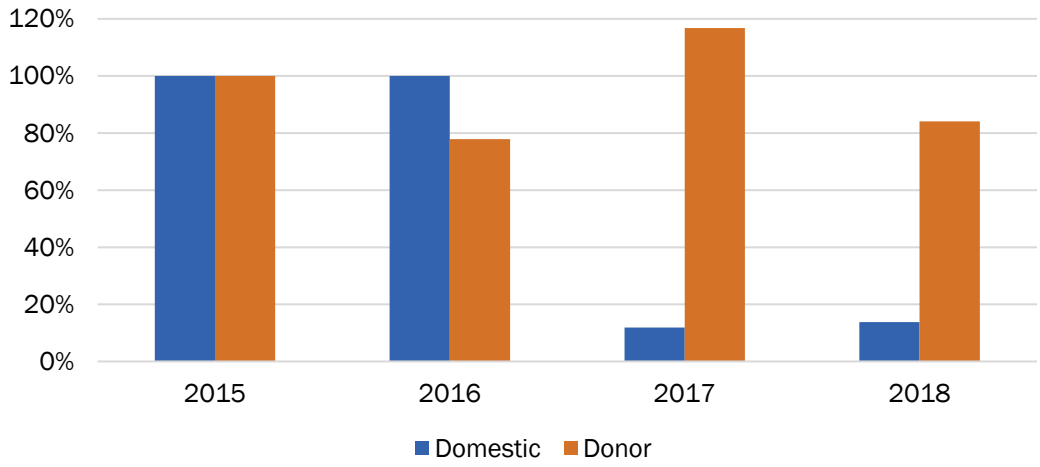


Source: Baseline assessment survey

Despite an uptick in the MOH's HIV program budget in 2018 due to an increase in donor funding, the nominal value of domestic resources allocated by the MOH to HIV declined, first from ETB 6.6 million (approximately $315,000) annually in 2015 and 2016 to ETB 5.1 million ($221,000) in 2017 and then sharply to just ETB 0.5 million ($17,000) annually in 2018 and 2019. This decline was particularly marked when the value of the MOH's domestic resources for HIV are considered both as a share of the value of resources for HIV (including external funding) and as a share of the overall value of domestic resources managed by the

MOH. While domestically generated resources had represented 21–28% of the MOH's HIV budget over 2015–2017, by 2018 they accounted for just 1%. And, while the MOH allocated 2.6% of its domestically generated budget to HIV in 2016 and 1.8% in 2017, in 2018 it allocated just 0.04% (Figure 7).

Figure 7. MOH HIV Budget Execution, by Funding Source (2015–2018)



Source: Baseline assessment survey

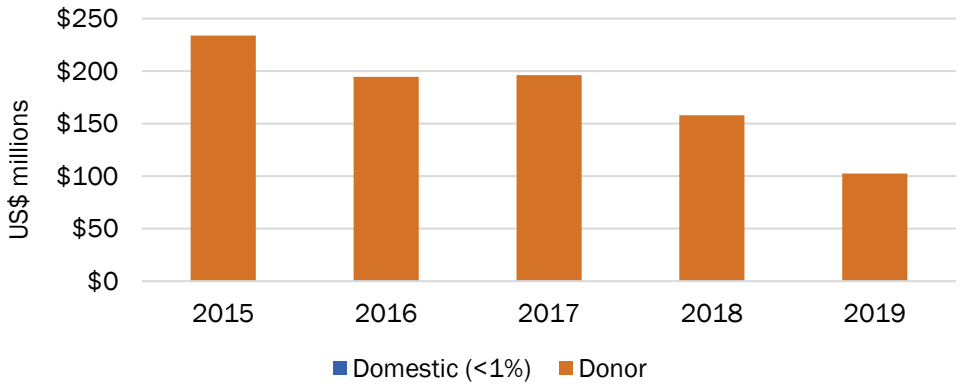
Furthermore, although the MOH fully executed the domestically generated resources allocated to it for HIV in 2015 and 2016, the MOH reported that in 2017 and 2018 its execution rate for these funds was only 12% and 14%, respectively. In contrast, the budget execution rate for external HIV resources managed by the MOH has been at least 78% for the past four years (average of 95% over the four-year span). *Budget execution is discussed further in section 3.3 of this report (Use of Domestic Resources).*

MOH staff were largely not aware of these declining trends in both allocation and execution of domestic resources for HIV. This highlights the focus on international donors as the primary source of funding for the HIV program and the need for improved awareness and tracking of domestic resource allocations to HIV.

Federal HIV/AIDS Prevention and Control Office: FHAPCO is primarily responsible for coordinating the multisectoral response to HIV. This includes developing partnerships with and mobilizing resources from other government sectors, communities, and development partners and managing external funds for HIV (primarily from the Global Fund), including those for commodity procurement.

FHAPCO's budget has decreased by more than half over the past five years, from $234 million in 2015 to $102 million in 2019 (Figure 8). FHAPCO was originally established to coordinate Ethiopia's multisectoral HIV response. This role includes leadership of efforts to mobilize donor and domestic resources for the response; as part of its responsibilities, FHAPCO has been the principal recipient for and in charge of the management and implementation of Global Fund resources. Accordingly, the decline in FHAPCO's budget has been driven by sharp reductions in external financing, primarily from the Global Fund.

Figure 8. FHAPCO Budget, by Source

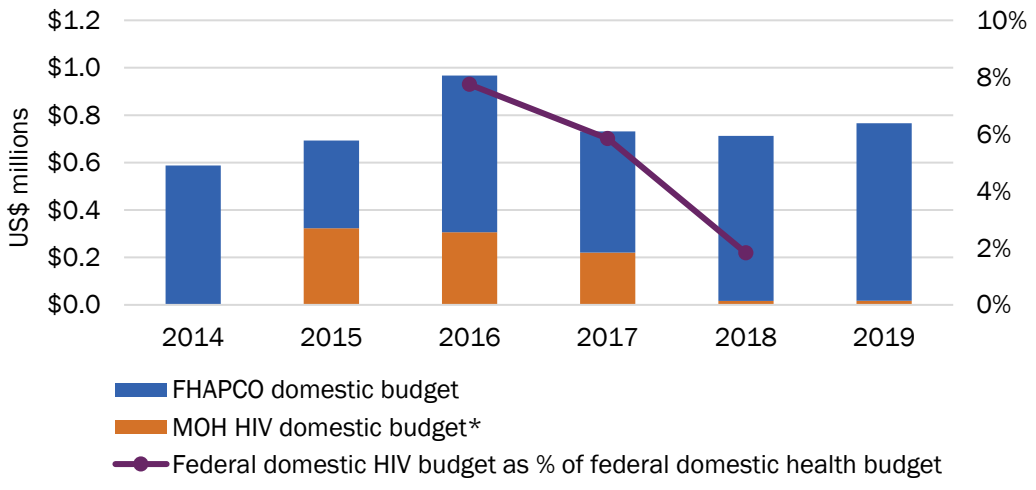


Source: Baseline assessment survey

However, over this time period, the amount of domestically generated resources allocated to FHAPCO has increased steadily. In ETB terms, the value of domestic resources allocated to FHAPCO nearly tripled, from ETB 7.6 million in 2015 to ETB 21.8 million in 2019. Given exchange rate depreciation, in U.S. dollar terms these resources doubled, from approximately $370,000 to $749,000. However, even with this increase—along with simultaneous decreases in external support—domestically generated resources still represent less than 1% of FHPACO's budget.

The total federal government allocation of domestic resources to HIV across both FHAPCO and the MOH has remained reletaively consistent across 2015–2019, at less than $1 million annually. However, the share of the total federal domestically generated health budget allocated to HIV has fallen sharply, from nearly 8% in 2016 to less than 2% in 2018 (Figure 9). Domestically generated federal health sector resources allocated to HIV are used exclusively for salaries and overhead costs (e.g., office space, supplies, and utilities). All financing for programs (including training and technical assistance) and commodities (including procurement and suppy chain) have come from external sources, principally the Global Fund.

Figure 9. Federal Government Domestic Resource Allocation to HIV (MOH and FHAPCO)



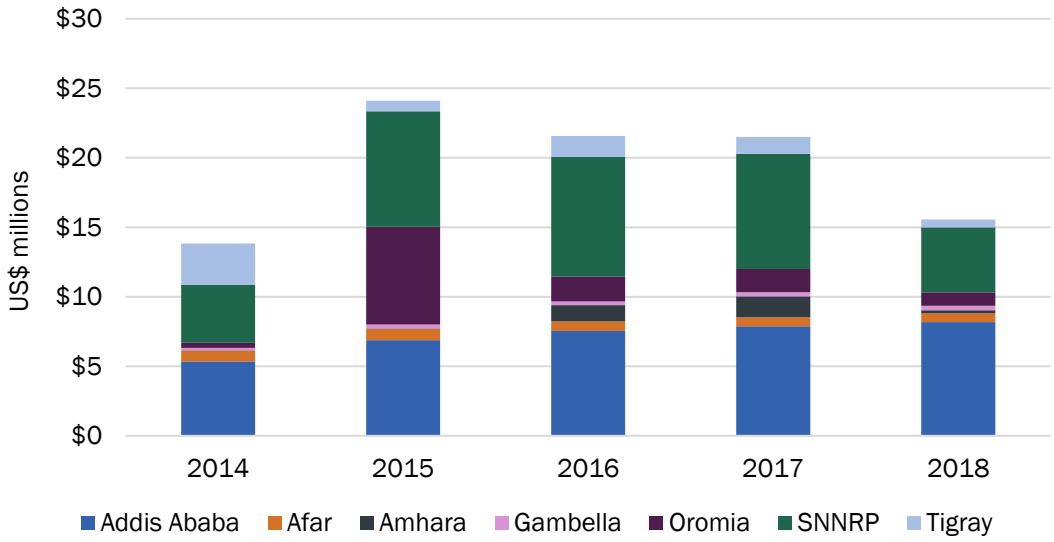
*MOH data not yet available for 2019.
Source: Baseline assessment survey

Regional Level

At the regional level, the HIV response is managed by either the regional HIV/AIDS Prevention and Control Office (regional HAPCO) or the regional health bureau in regions without a regional HAPCO. HIV budget and expenditure data were collected from three regional HAPCOs (Addis Ababa, Afar, and Gambella) and four regional health bureaus (Amhara, Oromia, SNNPR, and Tigray) as part of the baseline assessment survey. These regions represent 96% of people living with HIV and have an adult HIV prevalence (weighted average) of 1.0%, slightly above the national prevalence of 0.9% (CSA and ICF, 2018).[5]

The value of all resources (including from external sources) allocated to HIV by these entities declined steadily from 2015 to 2018, from $24 million in 2015 to $16 million in 2018 (Figure 10). The majority of this funding comes from external sources—approximately 94% over the 2014 to 2018 period.

Figure 10. Regional Health Sector HIV Budget for Surveyed Regions

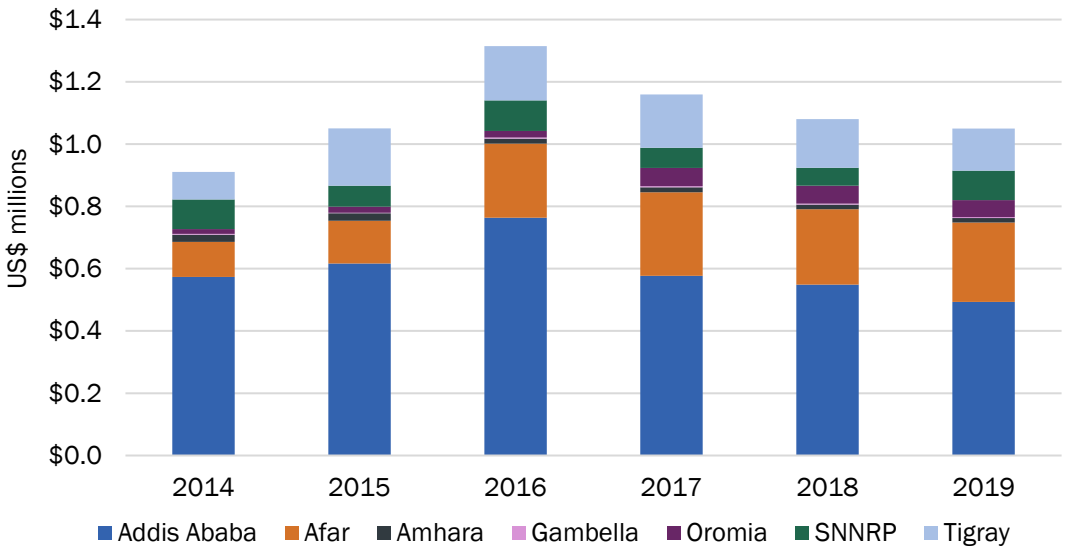


Source: Baseline assessment survey

The value of domestically generated resources allocated to HIV within the health sector at the regional level averaged just $1.1 million annually over 2014–2019. Although nominal allocations increased steadily, from ETB 18 million in 2014 to ETB 31 million in 2019, in U.S. dollars, allocations peaked at $1.3 million in 2016 and have since declined steadily (Figure 11). On average, Addis Ababa accounted for 55% of the domestic funds allocated for HIV, followed by Afar at 19%. Only three of the seven regions (Addis Ababa, Afar, and Tigray) allocated at least $100,000 annually for HIV, on average. For regions that reported both their total health and HIV budgets (Amhara, Gambella, Oromia, and SNNPR), the share allocated to HIV was extremely low—just 0.5% annually (unweighted average).

[5] Benishangul-Gumuz, Somali, and Harari regions and Dire Dawa City Administration, which were not part of this baseline assessment, collectively account for only an estimated 12% of regional spending, 7% of the population, and 4% of people living with HIV.

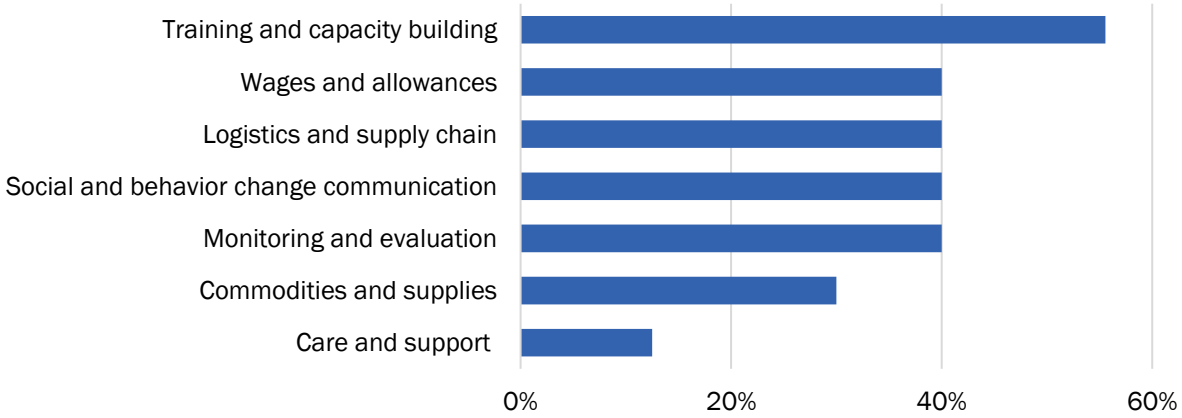
Figure 11. Regional Health Sector Expenditure on HIV for Surveyed Regions (Domestically Generated)



Source: Baseline assessment survey

Staff at regional health bureaus and regional HAPCOs reported using domestic funds for a broad range of HIV-related purposes. Although most were not able to provide data on the value of expenditure by use, they did indicate the categories of HIV expenditure for which they used domestic resources. Figure 12 presents the share of responding regional institutions (regional health bureaus and HAPCOs) that reported using domestic funds for different programmatic areas or costs.[6] Of the respondent regions, 56% (five of nine) reported using domestic funds for training and capacity building, and 40% (four of 10) reported spending domestic resources on monitoring and evaluation, social and behavior change communication, logistics and supply chain, and wages and allowances. Use of funds was lower for commodities and supplies (30%) and care and support (13%).

Figure 12. Share of Regional Health Bureaus and HAPCOS That Reported Using Domestic Resources, by Category of Use (2018)



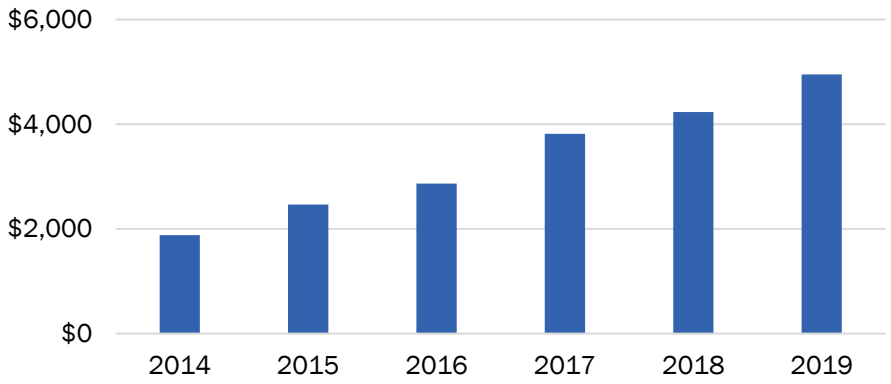
Note: Figure shows the frequency of responses, not the share of total expenditure.
Source: Baseline assessment survey

[6] Due to limitations in expenditure data available at the regional level, share of expenditure by each programmatic area is not available.

Woreda Level

Staff from woreda health and HIV/AIDS prevention and control offices were interviewed in nine woredas across seven regions (eight woreda health offices and one woreda HAPCO). Data collected demonstrates that allocation of funding to HIV programming does occur at the woreda level. Seven offices provided HIV budget data for at least three of the past five years. In responding woredas, the average annual allocation of domestically generated resources increased from ETB 36,843 ($1,881) in 2014 to ETB 144,382 ($4,951) in 2019 (Figure 13).

Figure 13. HIV Budget per Woreda (Domestic Resources)

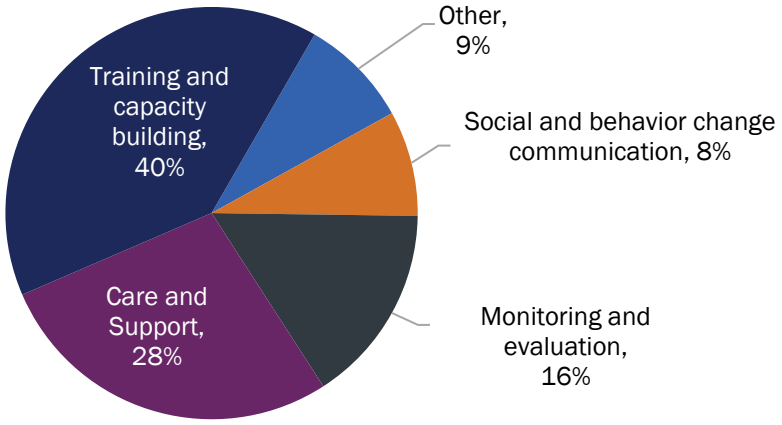


Source: Baseline assessment survey

On average, woreda health offices reported allocating 0.5% of their budgets to HIV activities. If this amount—about ETB 144,382 ($4,951)—were allocated for HIV across all of Ethiopia's approximately 980 woredas, approximately ETB 144 million ($5.0 million) would be budgeted. It is important to note the small number of responding woredas, which is not nationally representative. Only nine of the country's approximately 1,000 were included in the study, with seven providing relevant data.

In addition to general health resources that benefit service delivery for HIV, health bureaus and HAPCOs at the woreda level, like those at the regional level, reported using domestic funds for a variety of purposes. However, unlike at the regional level, most woreda-level institutions were able to report on the value of funds used for each purpose. Therefore, Figure 14, reports actual shares of expenditure, unlike the previous Figure 12. Eight of nine surveyed reported expenditure by category for the past fiscal year. Of the reported HIV-related spending of domestically generated resources, 40% was for training and capacity building, 28% for care and support, 16% for monitoring and evaluation, and 8% for social and behavior change communication.

Figure 14. Share of Woreda Domestic HIV Expenditure, by Category (2018)

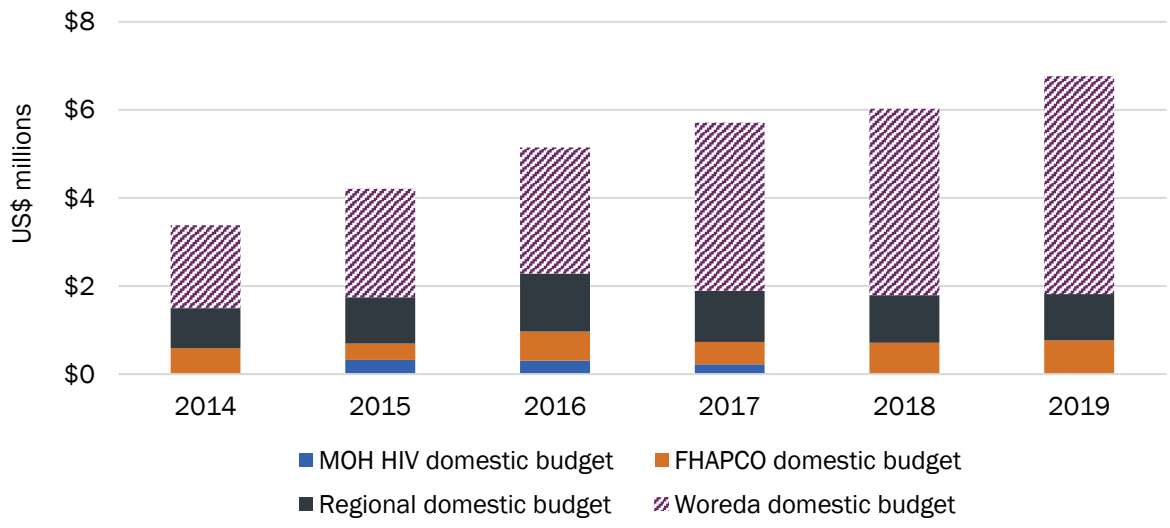


Source: Baseline assessment survey

Key Takeaways

Overall, the use of domestic funding for HIV within government health sector institutions is limited. At the federal level, less than 2% of domestically generated resources for health are allocated to HIV, whereas allocations at the regional and woreda levels are around 0.5% of the health budget. Based on available data, it is estimated that total domestic budget allocations for HIV from the health sector increased from less than $4 million in 2014 to nearly $7 million in 2019 (Figure 15). However, most of this estimated increase came from the woreda level, where estimates were based on an extremely small sample and are not nationally representative. Therefore, actual increases may have been substantially lower.

Figure 15. Health Sector Domestic Resource Budget Allocations for HIV, by Level



Note: Woreda estimates were extrapolated from a small sample of just seven woredas (1% of all woredas).
Source: Baseline assessment survey

At the federal level, budgets for HIV almost exclusively cover operational costs, including staff salaries, office rent, utilities, and vehicles, whereas subnational health and HIV offices reported using domestic funds for other HIV program costs. These primarily included costs associated with training and capacity building, monitoring and evaluation, and social and behavior change. At the regional level, wages and allowances were cited as a frequent use of domestic funds; notably, however, key informants indicated that funds mobilized at the regional level were also frequently used for HIV logistics and supply chain, and occasionally for procurement of HIV commodities and supplies to complement those provided from the national level.

Stakeholders at all levels indicated that low levels of government resources for HIV were, at least in part, due to a lack of effort in requesting, justifying, and advocating for additional HIV budget funds from the government treasury.

> *"We ourselves have the attitude of depending on donors and have not done enough to secure the government budget for the program."*
>
> *–Key informant, FHAPCO*

> *"HIV has never been [on] an agenda during regional budget allocation meetings. There was dependence on donor funding."*
>
> *–Key informant, Regional Finance Bureau*

Non-health Sector Financing: HIV Mainstreaming

Apart from funds budgeted and executed by health sector institutions, HIV mainstreaming is one of the primary ways through which non-health government funds are allocated to HIV programming. Mainstreaming consists of non-health sector government institutions allocating a portion of their budget for HIV-related activities. The purpose of mainstreaming is to reach employees (i.e., "internal mainstreaming") or the beneficiary population (i.e., "external mainstreaming") of the institution with HIV prevention and impact mitigation activities. Although any public institution may mainstream funds for HIV, some are better positioned to reach key and priority populations in the HIV response, such as adolescent girls and young women (e.g., the Ministry of Education and Ministry of Women, Children, and Youth Affairs) or prisoners (e.g., the Federal Prison Administration) because these groups comprise or overlap significantly with their beneficiary populations.

In 2011, FHAPCO published guidelines for how institutions (including nongovernment institutions) could mainstream funds for HIV (FHAPCO, 2011). Under these guidelines, sectors were expected to allocate up to 2% of their recurrent budgets to the HIV program, although key informants noted that, in practice, this expectation was interpreted as 2% of the non-salary recurrent budget. In addition to this budget allocation, the guidelines state that each institution should assign an HIV focal person to implement activities. The guidelines also include recommendations for specific HIV-related activities that should be promoted within different sectors and established the responsibility of employers—both public and private—to conduct HIV prevention, control, and surveillance activities in the workplace.

The *National AIDS Spending Assessment*, conducted in 2011/12, found that $3.5 million was mobilized for HIV through mainstreaming, representing less than 1% of total HIV funding (FHAPCO, 2013). Of this amount, approximately $3 million (87%) was spent. However, subsequent efforts to estimate the value of mainstreaming funds have been extremely limited and sporadic. This study represents the first effort to collect comprehensive quantitative data on HIV mainstreaming in Ethiopia since 2010/11. Data on resources budgeted for HIV mainstreaming over 2014–2019 are disaggregated at the federal, regional, and woreda levels and presented in the following sections.

Federal Mainstreaming

The study team interviewed and collected data from two federal ministries about HIV mainstreaming—the Ministry of Education and the Ministry of Women, Children and Youth Affairs. The selection of institutions to interview considered key and priority populations identified in FHAPCO's 2018 *HIV Prevention in Ethiopia National Road Map 2018–2020* and the federal institutions that were appropriately positioned to directly reach them. Additional federal institutions were selected based on their potential fiscal space for resource mobilization (i.e., the size of their budgets) and perceived awareness of the importance of HIV financing (e.g., the Ethiopia Health Insurance Agency and Ethiopia Public Health Institute) (see Table 3). Response rates among federal institutions were low, with many not responding to multiple requests for interviews. Among those that did participate, many noted that the lack of an account code for HIV mainstreaming made reporting difficult as there was no formal system in place for tracking the HIV budget and expenditure.

In addition to the Ministry of Education and the Ministry of Women, Children and Youth Affairs, the Ethiopia Roads Authority provided information on funds budgeted for HIV. Findings are summarized in the *Innovative Financing for HIV* section of this report due to the unique mechanism used for allocating and executing those funds.

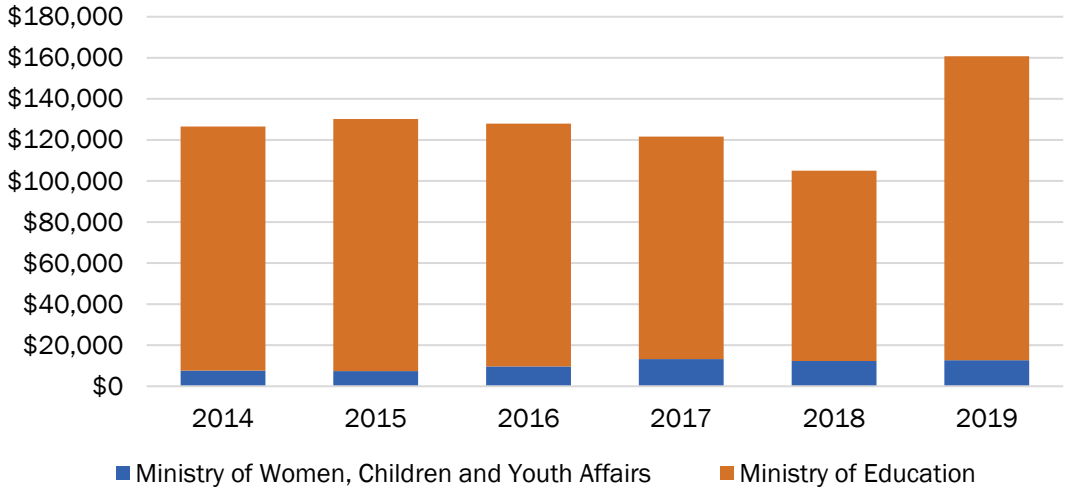
Stakeholders suggested that most federal institutions are participating in HIV mainstreaming, with an assigned focal person and employee training. However, the contribution of federal institutions beyond those captured in this assessment was likely small and restricted to internal mainstreaming.

Table 3. Institutions Identified for Federal HIV Mainstreaming and HIV Key and Priority Populations

Key or Priority Population	Relevant Government Institution
Female sex workers	FHAPCO; MOH; Ministry of Women, Children and Youth Affairs; Ministry of Labor and Social Affairs
Prisoners	Federal Prison Administration
Widowed and divorced urban women	Ministry of Women, Children and Youth Affairs
People living with HIV and partners	FHAPCO, MOH, Ministry of Labor and Social Affairs
Distance drivers	Ministry of Transport
Mobile and resident workers in hotspot areas	Ethiopia Roads Authority; Ministry of Water Irrigation and Electric Power; Ministry of Mines, Petroleum, and Natural Gas
Adolescent girls, young women, and their partners	Ministry of Education; Ministry of Women, Children and Youth Affairs
Other	Pharmaceuticals Fund Supply Agency; Ethiopia Public Health Institute; Ethiopia Health Insurance; Ministry of Science and Higher Education; Ministry of Agriculture and Natural Resources; Ministry of Communication and Information Technology; Revenues and Customs Authority; Ministry of Foreign Affairs; Ministry of Finance and Economic Cooperation; Government Development Enterprises Corporation

The total value of mainstreamed funds for the two ministries surveyed at the federal level increased from ETB 2.5 million ($127,000) in 2014 to ETB 4.7 million ($161,000) in 2019. Of these two ministries, the Ministry of Education accounted for 92% of the funds mobilized for HIV over 2014–2019. In 2019, it increased its allocation to HIV programming sharply to ETB 4.3 million ($148,000) from ETB 2.6 million ($93,000) in 2018, a 60% increase. This increase corresponded to a similar 67% increase in the overall budget for the Ministry of Education. However, funds mainstreamed for HIV accounted for only 0.2% in 2019, a share unchanged over the past three years. The Ministry of Women, Children and Youth Affairs allocated a greater share of its budget—0.8% in 2019—to HIV programming, and although the total value of this allocation increased by two and a half times over 2014–2019, the total allocation in 2019 was just ETB 370,000 ($13,000) (Figure 16).

Figure 16. Funds Mobilized through HIV Mainstreaming at the Federal Level



Source: Baseline assessment survey

Federal funds reported as being mainstreamed for HIV were used primarily for monitoring and evaluation of the program (ETB 841,000) and social and behavior change communication (ETB 856,000) in roughly equal proportions. All funds mainstreamed by the Ministry of Women, Children and Youth Affairs (ETB 340,000) were used for monitoring and evaluation, whereas the Ministry of Education used the largest share of its mainstreamed funds for social and behavior change communication (ETB 856,000) and a smaller share for monitoring and evaluation (ETB 501,000). Only ETB 18,000 were reported as being used for commodities and supplies, whereas nearly half of allocated resources were not classified as being dedicated to a specific purpose.

Regional Mainstreaming

At the regional level, the study team collected data from institutions aligned with those identified and surveyed at the federal level, including regional bureaus of education; finance; labor and social affairs; and women, youth and children affairs. In addition, data from an unpublished report by the Dire Dawa regional HAPCO on HIV mainstreaming for 2016–2018 is included in this assessment. This inclusion is important because the *National AIDS Spending Assessment* identified Dire Dawa as the largest source of mainstreaming in 2011/12, accounting for 53% of all mainstreamed funds (FHAPCO, 2013). Although Dire Dawa was not included in the overall baseline assessment data collection, the HIV mainstreaming estimates for that city administration are reported in this section.

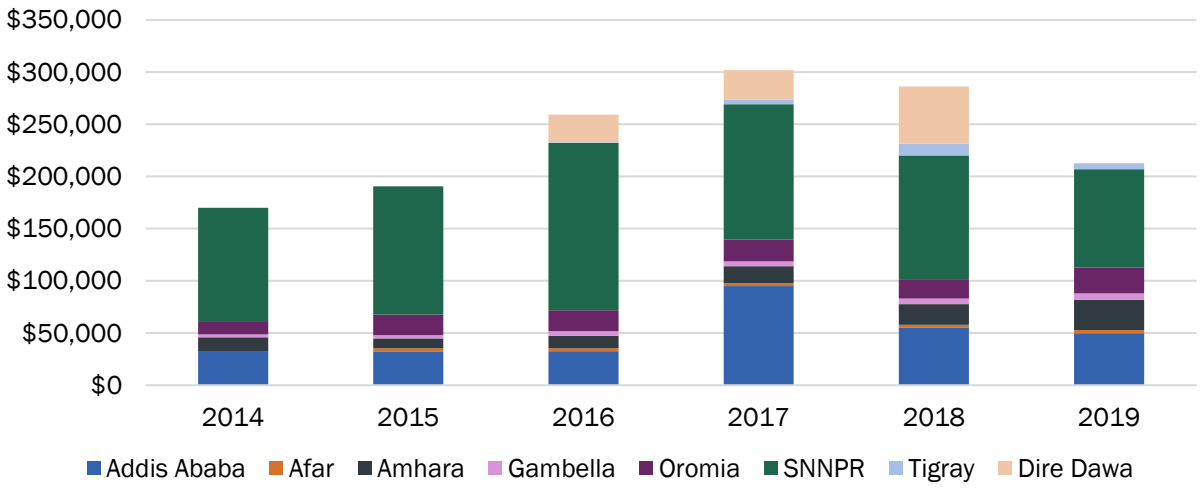
Overall, the total value of resources budgeted for HIV mainstreaming activities in the regions surveyed increased steadily from ETB 3.3 million (approximately $170,000) in 2014 to ETB 6.3 million ($274,000) in 2017 (Figure 17). However, since then allocations have been generally flat, at ETB 6.4 million in 2018 ($231,000) and ETB 6.2 million ($212,000) in 2019, and declined in U.S. dollar terms due to the continued devaluation of the birr. In Dire Dawa, allocations more than doubled from approximately ETB 600,000 ($27,000–28,000) in 2016 to ETB 1.5 million ($55,000) in 2017.

Regional Disparities in Mainstreaming

Over 2014–2019, 55% of funds mainstreamed for HIV at the regional level were in SNNPR, despite the region accounting for only 8% of people living with HIV.

SNNPR accounted for 55% of the mainstreaming funds mobilized over the six years surveyed (2014–2019) and 48% in the years for which data from Dire Dawa are included. These findings are similar to those of the *National AIDS Spending Assessment* for 2011/12, in which SNNPR accounted for 47% of mainstreaming funds among regions surveyed, although the remaining share is now distributed more evenly across other regions (FHAPCO, 2013).

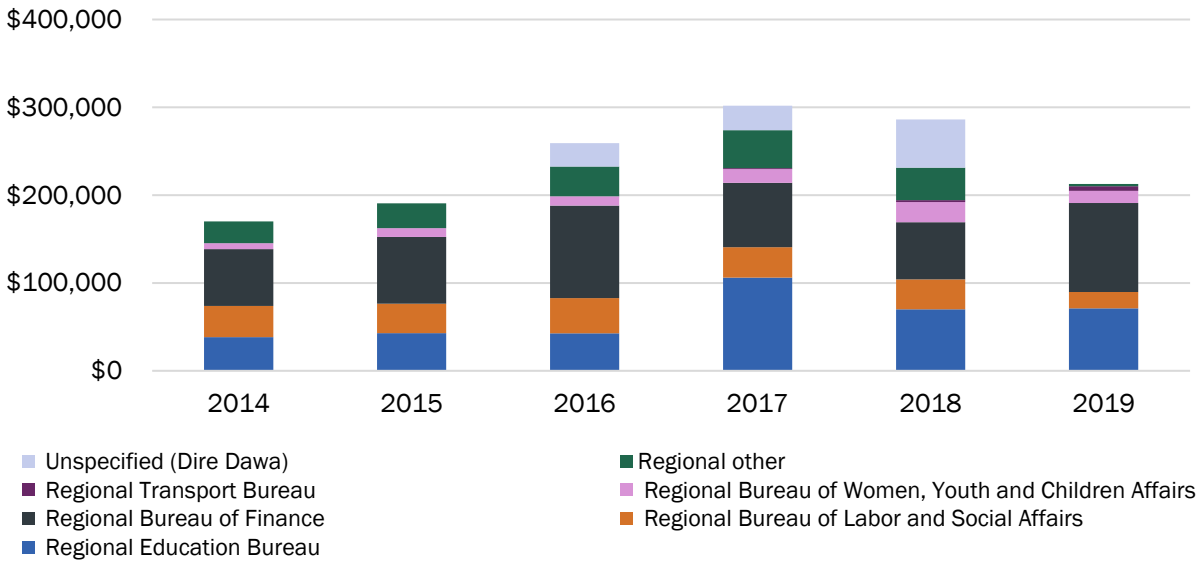
Figure 17. HIV Mainstreaming Budget for Surveyed Regions



Note: Dire Dawa data unavailable for 2014, 2015, and 2019.
Source: Baseline assessment survey

Across regions, the largest share of HIV mainstreaming resources came from regional bureaus of finance. Over 2014–2019, these regional bureaus contributed approximately ETB 11.6 million ($486,000) in total, accounting for 37% of funds allocated by the surveyed regional institutions for HIV mainstreaming activities (Figure 18). Annual contributions ranged from ETB 1.3–3.0 million ($65,000–105,000), accounting for 27–48% of funds allocated by the surveyed regional institutions for HIV mainstreaming activities. Regional education bureaus accounted for the second largest share of mainstreaming funds mobilized over the survey period—ETB 9.0 million ($371,000) in total and ETB 0.75–2.4 million ($38,000–106,000) annually. These funds accounted for 29% (18–39% annually) of all regional mainstreaming funds. Collectively, regional bureaus of finance and regional education bureaus accounted for ETB 20.5 million ($857,000) or 66% of mainstreamed funds over the period and institutions surveyed. Regional bureaus of labor and social affairs and women, youth and children affairs also make notable contributions to HIV mainstreaming. Collectively, the greatest contribution from these two institutions was ETB 1.6 million ($57,000) in 2018.

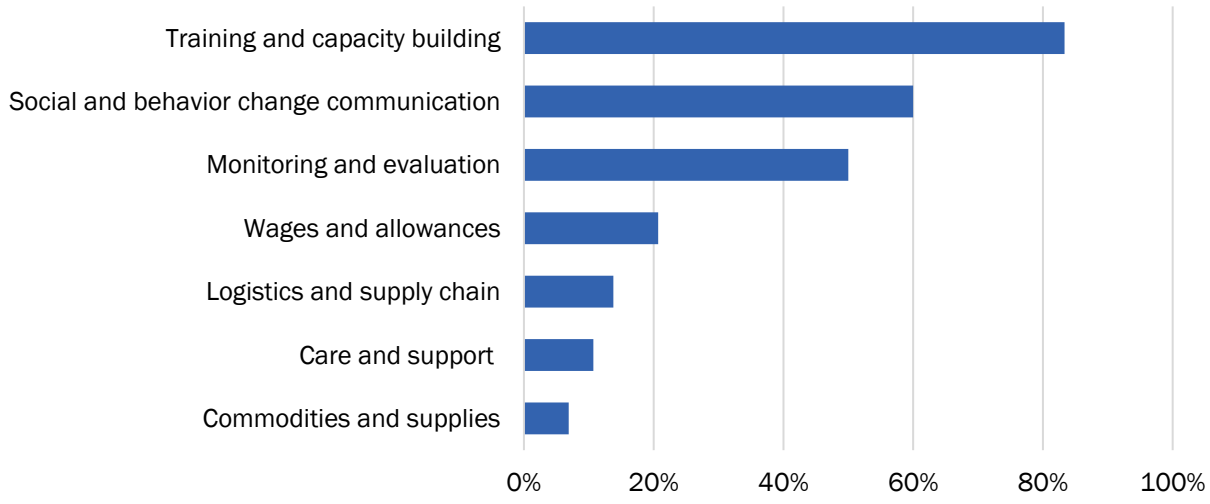
Figure 18. HIV Mainstreaming Budget for Surveyed Regions, by Sector Office



Note: Dire Dawa data unavailable for 2014, 2015, and 2019.
Source: Baseline assessment survey

Of the 34 regional institutions surveyed, 28 reported mainstreaming funds for HIV and 24 were able to provide data on the amount mainstreamed for HIV in at least one of the past five years (2014–2018). Nineteen reported mainstreaming funds in every year. On average, these institutions allocated 0.6% of their domestically generated budgets to HIV programming. Most regional non-health sector institutions were not able to report actual expenditure disaggregated by program area or category of use. As such, Figure 19 reports the share of responding institutions that reported spending at least some domestic funds on the respective programmatic area. Similar to the health sector, the top three uses of mainstreamed HIV funds at the regional level were training and capacity building, social and behavior change communication, and monitoring and evaluation.

Figure 19. Share of Regional Non-Health Sector Institutions That Reported Using Domestic Resources, by Category of Use (2018)



Note: Figure shows the frequency of responses, not the share of total expenditure.
Source: As reported by the Government of Ethiopia

Woreda Mainstreaming

HIV mainstreaming also occurs at the woreda level. As with regional ministries and bureaus at the federal and regional levels, woreda offices allocate funds to HIV-related activities. Due to the logistical challenges of data collection at the woreda level, the study team was able to collect quantitative data on HIV mainstreaming from just three non-health sector offices—one finance office and two education offices—across four different woredas. On average, these three offices allocated 0.2% of their total domestic budgets to HIV annually. However, there was significant variation in the share of each office's total budget allocated to HIV both across institutions/woredas and from year to year. Both education bureaus surveyed were relatively consistent in the share of their budgets allocated to HIV over a period of several years. However, one averaged 0.2% annually whereas the other averaged just one-tenth of that—0.02%. Notably, the higher allocation was in Amhara region, where adult HIV prevalence is estimated to be three times higher than in SNNPR, the other region represented. The sole finance office surveyed (in Gambella region) had allocated a greater share of its budget (0.8%) to HIV in 2014–2015 but ceased allocating any funding in subsequent years. Notably, Gambella has the highest burden of HIV nationally, with 4.8% adult prevalence (CSA and ICF, 2018).

The average annual HIV allocation from the two woreda education offices was just ETB 5,362 (approximately $237); the greatest allocation by a single office in a single year was ETB 9,121 ($420). Funds mainstreamed by education offices were allocated for training and capacity building in one responding woreda (SNNPR) and for behavior change communication in the other (Amhara region). The extremely small sample size for these findings (just 2 of approximately 1,000 woredas) highlights the need for more comprehensive data on HIV resources at the woreda level and that caution is needed when extrapolating this data for all woredas. Woreda offices, such as those for education, labor, social affairs, and women, children, and youth, are of key importance in mainstreaming efforts as they may be best able to directly reach beneficiary populations.

Key Takeaways

Implementation of mainstreaming varies significantly, mostly by sector. However, of 39 institutions queried outside of the health sector, 33 were implementing mainstreaming, whereas five were not (there was one nonresponse). Education institutions (i.e., the Ministry of Education, regional education bureaus, and woreda education offices) all implemented mainstreaming and 9 of the 10 institutions interviewed were able to provide regular data on the amount allocated for mainstreaming. Amounts mainstreamed were relatively small, with only one institution allocating more than 0.2% of its budget to HIV. However, in the absence of any formal proclamation or requirement for contribution, the fact that many sectors and offices were contributing to the HIV response is encouraging.

"To the best of my knowledge, there is no formal directive or letter about 2% budget allocations for HIV. The 2% budget for HIV has no budget code and expenditure title."

–Key informant, Amhara Regional Finance Bureau

"The mainstreaming budget is being misused on staff retreats and redundant trainings and discussion sessions. It will be better if the money goes to health and HAPCO to work on priority HIV program interventions."

-Key informant, SNNPR

Other institutions well positioned to provide services to key and priority HIV populations, such as those for labor and social affairs and women, children, and youth, were also nearly

unanimous in their implementation of mainstreaming, with 15 of 16 surveyed institutions at the federal and regional level reporting mainstreaming funds. Although less money was mobilized through mainstreaming by these institutions in comparison to education institutions (due to larger budgets for the education sector), they allocated a greater percentage of their budget to mainstreaming—0.6%, on average. However, there was greater variation across labor and social affairs offices and women, children, and youth affairs offices than across offices in the education sector. The majority of finance and transport institutions also implemented mainstreaming.

Given the focus of this study, the institutions surveyed deliberately represent those most likely to be implementing HIV mainstreaming. Therefore, we cannot and should not conclude that mainstreaming is being broadly implemented across most sectors. However, among priority sectors, the principal challenges to mainstreaming are related to the lack of clear guidelines for how mainstreamed funds should be spent, tracked, and reported, and the capacity to implement mainstreamed funds in an effective manner aligned with national initiatives and priorities. Furthermore, the lack of clear directives, account codes (i.e., budget line items), or legal enforcement mechanisms provides little incentive for institutions to fulfill the proposed 2% allocation. Lastly, most stakeholders believed that mainstreaming was not an effective strategy for addressing HIV program needs. They believed that mainstreaming funds would be better allocated directly to health and HIV offices for investment in priority interventions.

Innovative Financing for HIV

In addition to HIV mainstreaming, the Government of Ethiopia is already implementing two innovative financing mechanisms for HIV: a voluntary AIDS Fund for public employees and set-asides from road contracts for HIV prevention.

AIDS Fund

Use of AIDS Fund Resources

In Amhara region, 560 orphans received 400–500 birr each per month from the AIDS Fund, which are pooled across all sector offices.

Similar to mainstreaming, funds for the AIDS Fund are organized and managed separately at the level of individual government institution (e.g., by federal ministries, regional bureaus, and woreda offices). Funds are financed through employees of each institution via voluntary payroll deductions. The *National AIDS Spending Assessment* for 2011/12 found that $131,000 had been mobilized through the AIDS Fund, accounting for less than 0.1% of total HIV funding (FHAPCO, 2013). Of this amount, $107,000 (82%) had been spent. Although data on the amount of funding generated by the AIDS Fund was not collected as part of the current baseline assessment, key informants noted that funds were in place in most sector offices at all levels, from federal to woreda. Employee contributions were indicated as being in the range of 0.05–0.5% of salary.

"The staff is willing to contribute but it needs mechanisms for transparency and accountability."

–Key informant, Ministry of Women, Children and Youth Affairs

Resources mobilized through the AIDS Fund are used to provide care and support to HIV-positive employees and their families. However, stakeholders indicated that these funds are under-utilized because HIV-positive employees are reluctant to disclose their status, particularly to an employer. In addition, there are no guidelines for how these funds should be managed, disbursed, or monitored. As a result, there

is a lack of transparency and accountability, which in some instances creates concern and limits contributions.

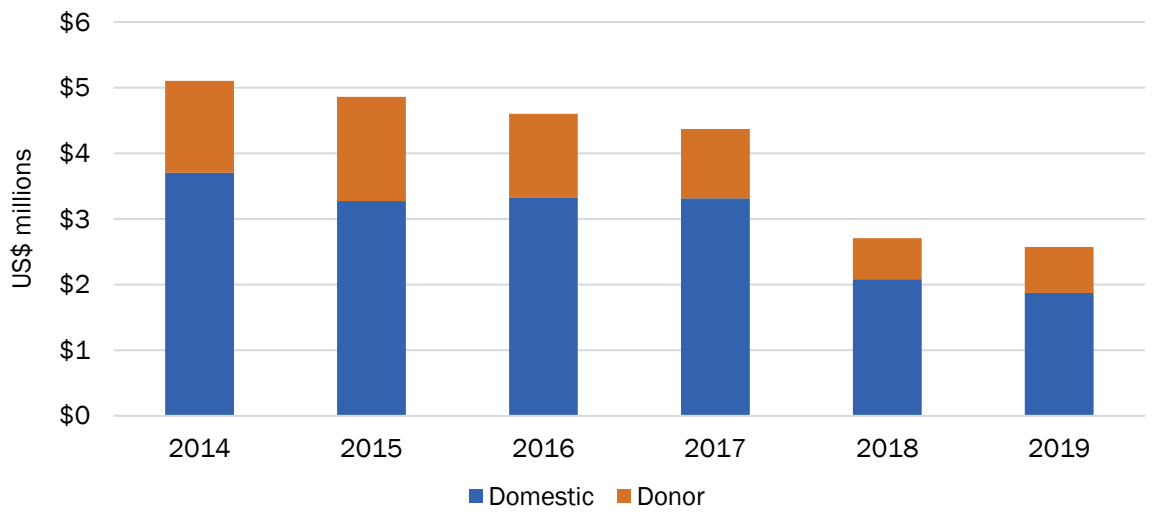
Roads Contracts

The Ethiopia Roads Authority regulation stipulates that all road construction contracts must include HIV prevention and treatment activities, which encompass peer education and condom distribution, testing, linkage to care, and care and support (e.g., nutritional support and counseling on hygiene and nutrition) that target construction staff and the communities in which construction projects are implemented. These activities are implemented by specialized private subcontractors with health expertise. The subcontractor is required to assign at least three full-time staff: a nurse, a sociologist, and an animator (promoter) from the local community.

Based on the baseline assessment survey and key informant interviews, Ethiopia Roads Authority projects are complying with this regulation, with approximately 200 roads projects allocating funds to HIV programming. The average allocation to HIV programming per road construction project was about ETB 500,000 per year ($22,000, based on the average annual exchange rate). With a typical length of three to five years per project, each road project mobilizes as much as ETB 2.5 million ($108,000) in total (author estimation), amounting to approximately 0.25% of the estimated average value of each contract.

Given the number of road contracts underway each year—200 each year for 2014–2016 and 150 during 2017 and 2018—Ethiopia Roads Authority staff estimated the total value of resources mobilized for HIV through this mechanism at ETB 550 million ($24 million) over 2014–2019. Annual allocations were reported to be ETB 100 million (approximately $4.4–5.1 million) each year from 2014 to 2017 and declined to ETB 75 million for 2018 and 2019 ($2.6–2.7 million) (Figure 20). From 2014 to 2019, an average of 73% of Ethiopia Roads Authority funding was domestic, with the remainder (27%) coming as grants from donors. There was minimal variation in these shares across years. Therefore, the amount of domestic spending on HIV through Ethiopia Roads Authority contracts was an estimated ETB 400 million ($17.6 million) over the six years, declining from ETB 73 million ($3.7 million) in 2014 to ETB 55 million ($1.9 million) in 2019.

Figure 20. HIV Funding from Road Construction Projects



Source: Baseline assessment survey

Ethiopia Roads Authority staff and implementing subcontractors noted poor monitoring, documentation, and communication regarding HIV programming as challenges. These challenges may limit effective implementation of HIV investments due in part to an inadequate amount of HIV program staff at the Ethiopia Roads Authority to supervise and monitor HIV programs.

Community Resource Mobilization for HIV

An additional source of domestic resources for HIV are those raised at the kebele level through community care coalitions (CCCs), which collect annual contributions from community members through kebele-level committees. Through these contributions, CCCs enable the community to solve its challenges with its own local resources and foster community ownership. Contributions can be cash or in-kind, and are used to support disadvantaged population groups, especially people living with disabilities, the elderly, people living with HIV, and orphans.

CCCs are currently being implemented in select regions consisting of Addis Ababa, Amhara, Dire Dawa, Oromia, SNNPR, and Tigray. As of 2016, there were 1,560 CCCs and the *National Growth and Transformation Plan* calls for the scale-up of CCCs to all of the country's 17,388 kebeles (MOLSA and UNICEF, 2018; NPC, 2016). Although CCCs operate at the kebele level, they are coordinated at the regional level by the regional bureaus of social and labor affairs and women, children and youth affairs.

Strengthening CCCs has been a focus of development partners—they have been at the forefront of USAID's Caring for Vulnerable Children project to improve services for HIV orphans and vulnerable children. FHI 360 reported that as of 2018, 468 CCCs were supporting Caring for Vulnerable Children activities. During only three months, these CCCs raised nearly ETB 8.6 million (approximately $300,000) in cash and in-kind contributions. FHI 360 staff further reported that, during a 12-month period, the total amount raised by CCCs was approximately ETB 34 million ($1.2 million), equating to about ETB 74,000 ($2,600) per CCC per year.[7] FHI 360 reported that more than half of these mobilized resources were in the form of in-kind contributions rather than cash. These contributions included, or were used to pay for, the provision of scholastic materials, school uniforms, food items, sanitation material, and free medical care/services.

Because the kebeles supported by Caring for Vulnerable Children represent just 3% of Ethiopia's 17,388 kebeles, the resource mobilization potential of CCCs is significantly greater than what has been measured to date. If every kebele in the country were to implement a CCC and mobilize, on average, the same amount for HIV programming as in the sample representing Caring for Vulnerable Children support, roughly ETB 1.1 billion ($39 million) would be generated in cash and in-kind resources for the HIV program annually. This amount compares favorably to the less than $15 million currently provided by PEPFAR and the Global Fund combined for activities for orphans and vulnerable children (PEPFAR, 2018). Although CCC resources are not dedicated specifically for orphans and vulnerable children or people living with HIV, and the costs associated with these populations are concentrated in certain high-prevalence areas, CCCs clearly provide a valuable opportunity to target domestically generated local resources to activities that directly benefit them. Key

[7] Raw data on CCC contributions, which was collected by FHI 360, was not available and not reviewed or validated by the study team.

informants noted that the use of CCC funds for impact mitigation only, rather than prevention, was one limitation with their current use.

CCCs also face challenges with effective implementation of their activities. They are managed by volunteer committees and are not institutionalized in the kebele administration management structure. These committee members often lack skills for planning, management, and accounting of funds, and there are high rates of turnover among members. As a result, there are often gaps in the collection of funds and a lack of transparency in their use.

Corporate and Enterprise Financing for HIV

Various stakeholders have highlighted the private sector as a key current and potential source of resource mobilization for HIV. They believe that workplace and corporate social responsibility programs can play a significant role in financing HIV services. Of seven private and parastatal corporations interviewed for this assessment, all reported financing health and/or HIV services for either their employees or clients, and five had explicit corporate social responsibility policies. Four entities reported financing HIV-specific programs for clients, whereas two said they did not finance HIV activities (one did not respond). The only entity to provide data on HIV spending reported an average of approximately $8,600 annually over 2014–2018. The largest corporation (by reported revenue) interviewed reported spending approximately $280,000 annually on health over 2014–2018; however, it did not allocate any funds for HIV specifically and cited a declining focus on HIV.

"We have a CSR [corporate social responsibility] program but the focus was on chronic illness, IDP [internally displaced persons], elderly, and orphans—it has not been HIV at least for the past 5 years."

–Key stakeholder, private sector

"We understand HIV is a big threat to the workforce and budget is not a problem. We don't have the capacity to effectively coordinate HIV prevention programs. In addition, there is lack of commitment."

–Key stakeholder, private sector

Four of five responding key stakeholders believed that their company should finance HIV-related activities and suggested allocating between 0.1–2% of corporate profits for this purpose. However, most responding corporations still preferred the idea of an earmarked corporate tax to support HIV financing rather than managing the funds themselves. At the time, respondents tended to believe that the current tax rate of 30% was either appropriate or too high and therefore, would not be likely to support an increase in taxes for this purpose.

When corporations did allocate funds and implement HIV programs, they included HIV testing, information and education, and condoms. These services were often provided in conjunction with World AIDS Day, not on a regular basis. In addition, corporations often cited a lack of capacity to implement effective programs and of guidance or support (e.g., from HAPCOs) to engage in HIV prevention and impact mitigation.

Out-of-Pocket Expenditure on HIV

Due to the provision of HIV services, including testing, counseling, and treatment, free of charge from public facilities, out-of-pocket expenditure on HIV is limited. The *Ethiopia Health Accounts, 2013/2014* estimated that total household expenditure on HIV-related services was ETB 58 million ($3 million) (MOH, 2017). A major source of out-of-pocket expenditure on HIV is services obtained in the private sector. Through successive projects,

USAID and the U.S. Centers for Disease Control and Prevention have supported private facilities in providing these services and worked with the MOH to obtain formal approval of private HIV service provision. In 2019, an estimated 16,000–17,000 people living with HIV were accessing ART through private facilities, where they pay a consultation fee but receive free commodities (Private Health Sector Project key informant interview). Given the growth in private provision of HIV services over the last five years, total out-of-pocket expenditure on HIV services has likely increased substantially from the 2013/14 estimates.

HIV Financing through Health Insurance

To date, health insurance has not played a major role in HIV financing in Ethiopia. Both of the public schemes, community-based health insurance (CBHI) and the proposed but yet-to-be-implemented social health insurance (SHI), are currently designed to cover only user fees charged at the point of service in public facilities.[8] As all HIV services are exempted from user fees and provided free of charge in public facilities, no reimbursement rate for these services is established under the CBHI or SHI scheme. In limited cases where CBHI has contracted with private providers, who charge service fees, HIV services are not reimbursable because there is no established rate.

However, some stakeholders noted that insurance—particularly public schemes—could be a potential future source of funding for HIV. As of late 2019, CBHI, which began national scale-up in 2013, was enrolling households in roughly two-thirds of woredas (667) nationally, with 506 woreda-level schemes being active (i.e., having begun to process reimbursements). Overall, CBHI has achieved coverage of an estimated 22% of the population (July 2019)—one-third of the way to its goal of covering 80% of households in 80% of woredas, or roughly 64% of the population (as reported by the Ethiopian Health Insurance Agency). Although CBHI has been piloted in select urban woredas, it remains primarily focused in rural areas. As CBHI is not mandatory, there remain concerns about adverse selection among enrollees (i.e., that only the patients most likely to use services will enroll), which may have long-term implications on the financial sustainability of the schemes. SHI, when implemented, will cover an estimated additional 11% of the population, primarily civil servants and other formal sector workers and their dependents.

Both schemes face uncertainty regarding their financial sustainability; some woreda-level CBHI schemes are already running steep deficits, and SHI, in its current design, is projected to run a deficit immediately upon launch (EHIA, unpublished). Therefore, the potential inclusion of any additional services, including those for HIV, will require further analysis of their financial feasibility and sustainability.

The baseline assessment did not survey private insurance providers, but participants and a review of recent literature suggest that the potential contribution of this sector is small. Less than 1% of the population of Ethiopia has coverage from private insurance providers and, although these providers may cover consultation fees associated with accessing HIV services in the private sector, commodities are provided free of charge (CSA and ICF, 2016; Fagan et al., 2019).

[8] These user fees are only intended to cover the cost of commodities and supplies and not human resources, equipment, and other overhead costs that are paid for through the general government budget.

Cost of ART Commodities to CBHI

Previous studies by the Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy estimated the average cost of ART commodities and supplies provided in public health centers to be approximately $60 per patient per year (Berman et al., 2016; Alebachew et al., 2018).* The *Ethiopia Demographic and Health Survey 2016: HIV Report* estimated rural HIV prevalence to be just 0.4% (CSA and ICF, 2018).** If the CBHI-enrolled population faces a similar burden of HIV (i.e., not considering adverse selection or higher or lower rates of enrollment among specific subpopulations with different risk profiles), an estimated 1 out of every 250 CBHI enrollees will be HIV-positive and require ART. Therefore, the average cost of ART commodities per CBHI enrollee (for all enrollees, including those without HIV) would be approximately ETB 7 ($0.24) per year.

ART commodity cost for HIV patients	X	Proportion of CBHI enrollees requiring ART (HIV+) (0.4%)	=	HIV commodity cost per CBHI enrollee $0.24)

Considering the current annual premium rate of ETB 240 per household and an average household size of five (CSA and ICF, 2016), this would equate to approximately 15% of the annual contribution per enrollee. While this provides a rough estimate of the financial burden to CBHI (in its current form) of covering HIV treatment services, a comprehensive actuarial analysis of the financial implications of HIV service integration into insurance is required. Such an analysis for CBHI and SHI should take into account costs associated with provision of non-treatment HIV services (e.g., testing and laboratories), the non-commodity costs of service provision (e.g., human resources and overhead), and the demographic and risk profiles of enrolled members.

* In public primary hospitals, the cost of ART commodities and supplies was estimated to be substantially higher, at approximately $85, but only the cost for health centers was used in these calculations given the limited engagement of hospitals in CBHI schemes to date and the fact that most services reimbursed through CBHI are provided in health centers.

** Although CBHI was piloted in select urban areas, the vast majority of enrolled members live in rural parts of the country where HIV prevalence is 0.4% as opposed to 0.9% nationally and 2.9% in urban areas.

3.3 Use of Domestic Resources

Mobilization and increasing the availability of domestic funds for HIV programming are key steps in ensuring the sustainability of Ethiopia's HIV response. However, the mobilization of resources alone is not sufficient to ensure that resource needs are met. Improving efficiency in the use of funds through improved execution for high-impact priority programs and populations is critical to reducing dependence on external support while also ensuring that strategic programs have adequate resources. In contrast, if funds are poorly managed and targeted, domestic resource mobilization efforts may go to waste, with funds misused and allocated for unproductive activities.

Budget Execution

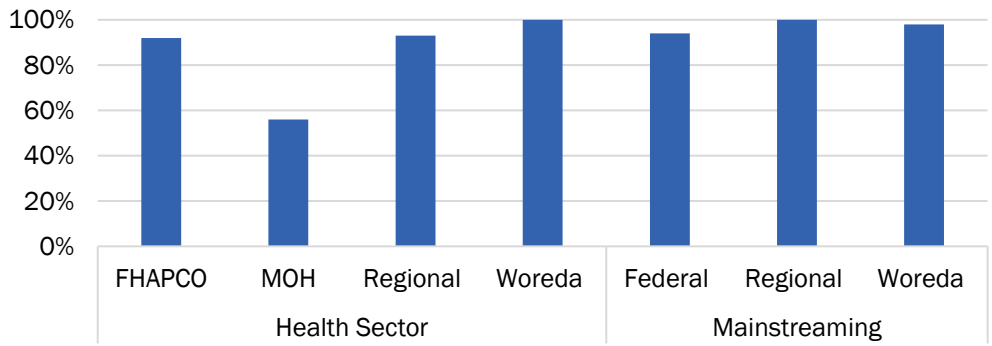
Once resources are identified and allocated to HIV activities, a critical first step is ensuring that these funds are executed. Historical data have shown that Ethiopia's health sector exhibits relatively high budget execution rates overall. Between 2008/09 and 2011/12, execution of the recurrent budget averaged 92% at the federal level, 91% at the regional level, and 96% at the woreda level (Kiringai et al., 2016).

Health Sector

The reported HIV budget execution for domestically generated resources by regional and woreda health sector institutions is reflective of this overall trend. The five regional HAPCOs and health bureaus that provided both HIV budget and expenditure data for domestically generated revenues reported an average annual execution rate of 93% over 2014–2018. The five woreda health offices that provided both sets of data reported an average annual execution rate of greater than 100% over the same period.[9]

At the federal level, the average execution rate for domestically generated resources for FHPACO was 92% over 2014–2018 and 56% for the MOH over 2015–2018 (Figure 21). Notably, MOH execution of domestic resources for HIV declined from 100% in both 2015 and 2016 to just 12% and 14% in 2017 and 2018, respectively. In absolute dollar terms, the unexecuted domestically generated MOH HIV funds were small—195,000 in 2017 and $15,000 in 2018—relative to the overall MOH budget for HIV, which was primarily donor funded. As previously mentioned, MOH staff were largely not aware of the declining trends in HIV domestic resource execution, highlighting a focus on donors as the primary source of funding for the HIV response but also suggesting a potential disconnect between the programmatic and budgetary aspects of the HIV program. Ensuring that the MOH's HIV unit understands and effectively executes its allocated domestic resources is critical to increasing allocations in the future.

Figure 21. Budget Execution Rate for Domestic HIV Resources, Annual Average (2014–2018)



Note: Regional includes Afar, Amhara, Gambella, Oromia, SNNPR, Tigray, and Addis Ababa City Administration.
Source: Baseline assessment survey

Mainstreaming

Reported execution of domestically generated funds mainstreamed by non-health sector institutions followed a similar trend. At the federal level, the average annual execution rate over 2014–2018 was 94%: 88% by the Ministry of Education and 100% by the Ministry of Women, Children and Youth Affairs. At the regional level, average annual budget execution was greater than 100% among 18 reporting institutions; at the woreda level, the rate was 98%, with three institutions reporting.

[9] Allocation over 100% could be due to inclusion of funds from the previous year, moved from other expenditure areas, or from a supplemental budget.

Efficiencies in Allocation of Resources

Even when funds are executed for HIV programming, they are not always used for efficient and productive purposes. Ensuring efficiency in the use of funds requires allocation to populations that have the greatest need and programs and activities that achieve the greatest impact and results (i.e., the most cost-effective).

Targeting Priority Populations

Past analyses have examined this concept in terms of the share of HIV expenditure benefiting key and priority populations. The 2011/12 *National AIDS Spending Assessment* showed that in 2011/12 82% of funding for prevention activities went to the general population, whereas just 18% went to all key and priority populations (FHAPCO, 2013). It also showed that female sex workers, among whom HIV prevalence is 23%, received just 0.1% of total funding for prevention.

However, the *HIV Prevention in Ethiopia National Road Map 2018–2020* establishes new priorities for targeting key and priority populations, including allocating 25% of prevention resources to female sex workers (FHAPCO, 2018). Overall, planned prevention spending on other key and priority populations is also significantly higher, including for widowed and divorced urban women (12%), adolescent girls and young women (12%), mobile workers (8%), people living with HIV and their partners (5%), and prisoners (1%).[10] In total, key and priority populations will account for 63% of prevention spending, while accounting for roughly 40% of all people living with HIV.

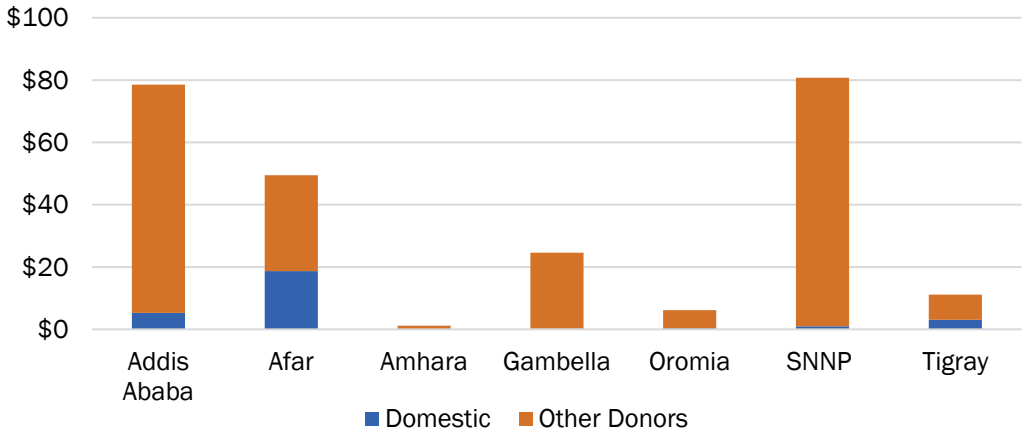
The improved targeting of resources to these higher-prevalence and at-risk groups promises to yield higher impact for the level of investment. Although the HIV prevention roadmap marks a significant step in improving efficiency and effectiveness in the use of resources for prevention, further gains could be made regarding how key and priority populations are defined.

Geographic Allocation of Resources

Another critical piece for ensuring that the impact of resources is maximized is aligning resource allocation and expenditure with disease burden. Based on HIV budget data collected at the regional level and the estimated number of people living with HIV by region (EPHI, 2018), regional HIV funding per the number of people living with HIV was calculated for 2018. These estimates show a significant variation in both domestic and donor funds across the regions surveyed. Regarding domestically generated funds, the Afar Regional Health Bureau and HAPCO allocated $19 per person living with HIV—nearly four times the allocation of the next highest region (Figure 22). Four of the five regions allocated less than $1 per person living with HIV.

[10] Distance drivers account for less than 1% of planned spending under the HIV prevention roadmap, despite having an HIV prevalence rate of 5%, as noted previously.

Figure 22. Regional HIV Budgets per Person Living with HIV, by Financing Source and Region (2018)



Source: Authors' calculation based on the baseline assessment survey and EPHI, 2018.

On-budget donor funding also varied significantly across regions, from more than $70 in Addis Ababa and SNNP to as little as $1 in Amhara (Figure 22).[11] Although these inequities do not take into account off-budget donor support (notably excluding the substantial financial contributions from PEPFAR) or amounts budgeted by federal or woreda offices within each region, they do highlight that HIV allocations are often not well aligned with needs, as they are much higher per person living with HIV in some regions than in others. Higher spending per person does not necessarily indicate inefficiencies, which may be due to the quantity or quality of services provided or economies of scale. However, further examination of spending in regions with low spending per person living with HIV could identify potential opportunities to expand low-cost interventions and achieve scale for high-impact activities.

High-Impact Interventions and Priority Setting

One significant issue around current domestic HIV expenditure, highlighted in the use of mainstreamed funds, is that they are used for low-impact and ineffective interventions. Such funds are often used for staff retreats and World AIDS Day celebrations, both of which are intended to promote awareness and facilitate a positive environment for employees to practice prevention and seek testing and counseling services. However, focusing efforts to mobilize mainstreamed funds through sector offices to promote high-impact interventions, such as condom distribution and behavior change communication among key and priority populations, may result in a greater impact than current broad-based mainstreaming efforts.

Similarly, funds currently mobilized through the AIDS Fund are used primarily for care and support, primarily nutritional supplementation and support for orphans and vulnerable children, which are not considered to be high-impact interventions according to the *HIV/AIDS Strategic Plan*. Reprogramming these funds for proven interventions—in particular, treatment for HIV-positive employees and family members—could yield greater returns.

For funds budgeted and executed through the health sector, *Ethiopia's Health Sector Transformation Plan 2015/16–2019/20* lays out the framework for sector priorities. It was

[11] On-budget donor funding excludes funding from PEPFAR but includes Global Fund resources.

prepared using the OneHealth Tool and Spectrum suite of models, which link interventions and costs to health outcomes. These tools were also used in costing the *HIV/AIDS Strategic Plan*. Furthermore, the *HIV Prevention in Ethiopia National Road Map 2018–2020* defines a set of high-impact, priority activities that should be pursued to reduce incidence among key and priority populations with a high HIV burden.

This sort of deliberate priority-setting is critical to ensure that Ethiopia's limited HIV resources are used effectively and explicitly linked to programmatic targets and achievements focused on populations with both the greatest needs and gaps along the HIV treatment cascade.

Technical Efficiency of Clinical Service Delivery

Once resources are allocated to specific delivery channels (i.e., facilities), services, and inputs, it is important that they are used in a way to maximize output. Inputs for clinical HIV services include a range of health system components, such as human resource, infrastructure, and administrative costs that are not directly attributable to the HIV program, and therefore not explicitly considered within with the national *HIV/AIDS Strategic Plan* or the country's HIV domestic resource mobilization goals. However, it is nonetheless important to consider how to reduce these costs by achieving greater technical efficiency in service delivery and use the cost savings to provide greater resources to other components of the HIV program.

Two recent studies examined whether health services provided at the facility level in Ethiopia, including HIV services, are technically efficient—i.e., achieve maximum output for a given level of input (Mann et al., 2016; Bobo et al., 2018). Both of these studies found that half or more of surveyed health facilities were technically inefficient and could reduce inputs without negatively impacting the quality of services provided. Furthermore, these studies highlight the need for analyses of technical efficiency in the delivery of HIV services specifically, not only at the facility level but also for prevention and community-level activities. Efficient use of the current mix of inputs to reach more patients, or realizing cost savings that can be directed toward commodities or other key inputs, can be a critical strategy for unlocking fiscal space given the current limited resources for Ethiopia's HIV response.

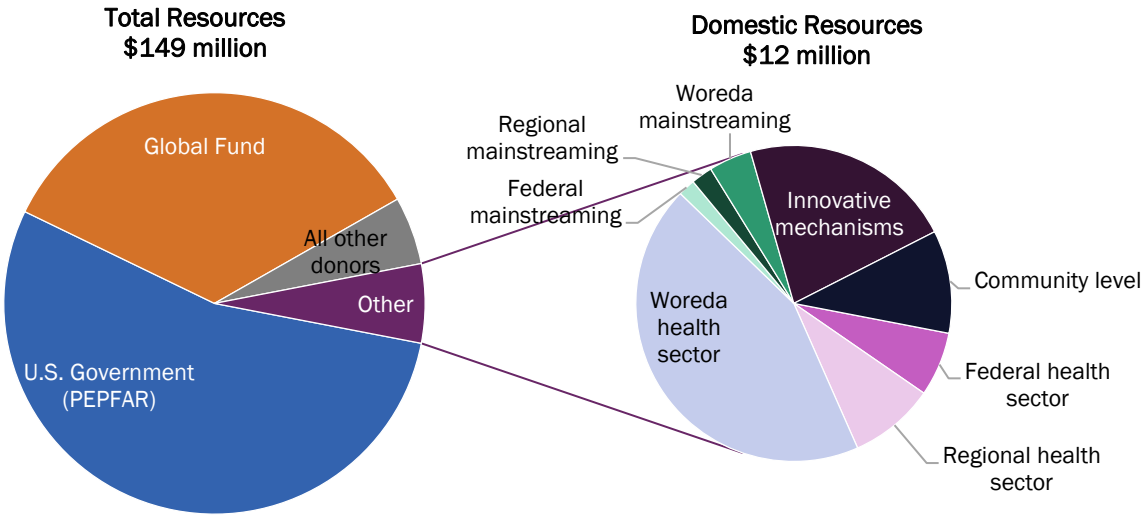
4. Conclusions and Recommendations

4.1 Conclusions

Ethiopia's HIV program has relied heavily on external donor funding. Previous estimates suggest that between 2011 and 2019, just 10% of funding came from domestic sources. Furthermore, this 10% consisted largely of funding for the general health system, such as for human resources and infrastructure, which contributes to the provision of HIV services. These contributions are critical to Ethiopia's achievements in improving access to and uptake of HIV services. However, ensuring the sustainability of the response will require the government and other domestic partners to take on a greater role in financing HIV-specific costs, including commodity and outreach activities to key and priority populations.

The steep decline in donor resources over the past five years has made this need even more urgent. Despite these declines, this baseline assessment finds that allocation of domestic resources for HIV has been relatively flat over recent years and has not increased in the proportion needed to offset reductions in donor funding. In 2019, only about 6% of direct funding (i.e., excluding human resources for health, infrastructure, and other inputs shared across health areas) for the HIV program, or about $11 million, came from public or otherwise pooled domestic sources (i.e., excluding out-of-pocket and enterprise spending) (Figure 23).

Figure 23. Estimated HIV Financing, by Source (2019)



Of this amount, less than $2 million came from federal and regional health sector budgets, including the MOH, FHAPCO, and regional health bureaus and HAPCOs. At the federal level, marginal increases in the value of domestic resources allocated to FHAPCO have been offset by cuts to the MOH. At the regional level, the value of allocations in U.S. dollars has declined steadily since 2015.

Although comprehensive data were not collected at the woreda level, anecdotal evidence suggests that woredas are the major source of domestic government financing for HIV services through their allocation of block grants received at the regional level. This conclusion may reflect the significant role woredas play in health financing, particularly for

recurrent expenditures. For example, from 2008 to 2012, woredas' share of recurrent health spending increased from 35% to 40%. In the responding woredas, the average annual expenditure on HIV-specific activities increased from approximately $1,900 in 2014 to $5,000 in 2019 (nominal terms), possibly related to the fact that although most stakeholders within the health sector were aware of the reductions in external support for HIV programs, the impacts of these cuts were felt and noted most acutely at the woreda level. Funds allocated for HIV services by woreda health offices had an average annual execution rate of 100% over the 2014–2018 period, compared to 93% at the regional level and 88% at the federal level.

Among stakeholders participating in the baseline assessment, there was a feeling of complacency regarding the HIV response—that HIV is no longer considered a serious problem or priority. At higher administrative levels, although stakeholders largely were aware of and understood the implications of reductions in external funding for HIV, there has been little or no communication of this situation to high-level decision-makers, including within the Ministry of Finance and regional bureaus of finance. HIV prevention and health sector offices have made little or no effort to request, justify, or advocate for more government funding for HIV programming. As a result, the amount of funding allocated for federal and regional HAPCOs, the MOH, and regional health bureaus has remained small and allocated only to salary, office, and transportation-related costs.

HIV mainstreaming—that is, the allocation of funds for HIV programming by government institutions outside of the health sector—has been a core strategy for HIV resource mobilization. However, the findings of this baseline assessment suggest that the total value of funds mobilized through mainstreaming has been small, at less than $1 million annually. Some sectors participated nearly across the board in mainstreaming, with offices at every level of government allocating funds for HIV. These sectors include education; finance; women, children and youth affairs; and labor and social affairs. However, most sectors did not participate. The fact that mainstreaming is not mandatory and lacks a legal mechanism for enforcement was cited as the primary reason for low participation. In addition, the lack of an account code (i.e., budget line item) made it difficult to track or hold institutions accountable for mainstreaming allocations.

Furthermore, even among sectors that did mainstream funds for HIV, almost all used them internally. That is, funds were used for activities targeted toward employees of the institution rather than the beneficiaries of its programs. Stakeholders noted that these internal activities often included ineffective or redundant training and staff retreats. Even though observed execution rates for mainstreaming funds were high at all levels of government—above 90%—most stakeholders considered the activities financed to be a waste of resources.

However, one promising practice has come from the roads sector. The Ethiopia Roads Authority requires that each contract it awards include HIV-related activities. The amount budgeted for these activities averages approximately ETB 500,000 per year, or 0.25% of the total value of the contract. The estimated total amount of funding mobilized for HIV programming through road contracts in 2018 amounted to approximately $1.9 million, or roughly 20% of all domestic funding for such programming.

Other innovative HIV funding mechanisms have achieved much more limited success. The AIDS Fund, to which public sector employees contribute voluntarily, lacks a clear structure and standardization. The lack of clear guidance on how funds should be used, and lack of transparency in their use, has contributed to low confidence in the effectiveness of these funds and led to low rates of participation.

Stakeholders identified a number of opportunities outside of the public sector to mobilize additional resources for HIV programming. Large private and public or parastatal enterprises were seen as a significant potential source of resources, although these institutions currently have very limited engagement with HIV programs.

On the other hand, there were strong examples of community engagement and resource mobilization efforts that have made significant contributions to the HIV response. With support from the USAID-funded Caring for Vulnerable Children project, in just 468 of Ethiopia's more than 10,000 kebeles, community care coalitions mobilized $300,000 for HIV-related activities over a three-month period. This achievement is highly promising in light of the country's efforts to scale up community care coalitions nationally.

4.2 Recommendations

FHAPCO, with the support of the HIV Domestic Resource Mobilization and Sustainability Task Force and HP+, convened a validation meeting and consultative session with baseline assessment participants to recommend future actions. The task force then consolidated these recommendations and, in a consultative session, selected the following eight for further investigation and consideration as part of the Domestic Resource Mobilization and Sustainability Strategy:

1. *Strengthen the capacity of HAPCOs and the health sector (e.g., the MOH and regional health bureaus) to generate evidence, analyze, and advocate for HIV funding at government budget allocation meetings.* Despite limited current allocations, health budgets at the federal and regional levels likely comprise the greatest potential sources of domestic funding for the HIV program in the short and medium term. The potential fiscal space at these levels needs to be further analyzed to develop evidence-based advocacy messages to increase allocations. In addition, there is a need to strengthen the capacity of HIV program staff to analyze budget data and trends to bridge the current disconnect from the budget process, particularly within the MOH, and improve monitoring of resource allocation and use.

> *"It is possible to secure regular budget, but it needs evidence-based advocacy. We need to cost the program, show the gap, and request the part of government."*
>
> *–Key informant, Regional Health Bureau*
>
> *"If mainstreaming has to continue it needs [to] focus on strategic sectors, clear guidance, enforcement mechanisms, and building capacity."*
>
> *–Key informant, Amhara region*

2. *Focus mainstreaming efforts on specific sectors that directly engage with key and priority populations in the HIV response, benefitting the population rather than sector employees).* These sectors should promote HIV education and awareness and provide combination prevention, linkage to care and treatment, and other support services as part of their core activities. All activities should be carried out in closer coordination and with oversight from the relevant HAPCO office to ensure accountability, best practices, and alignment with national guidance and priorities.
3. *Explore whether the model of HIV mainstreaming being implemented by the Ethiopia Roads Authority could be used by other sectors*. Energy, water, irrigation mining, and other sectors that award large-scale contracts, and may contribute to the creation of HIV hotspot areas, could adopt a similar model in which HIV

programming is included as a core component of awarded contracts.[12] However, for all such contracts, including those currently being awarded by the Ethiopia Roads Authority, coordination with and oversight by federal and regional HAPCOs must be strengthened to ensure that the activities being conducted are of high impact and use best practices for target populations.

4. *Leverage scale-up of community care coalitions and develop their capacity to implement an expanded package of HIV services, potentially including prevention activities.* As noted in previous studies (Alebachew et al., 2015; Alebachew and Mitiku, 2019), low overall government fiscal space for increased funding for health, and HIV programming specifically, highlights the need to create new sources of revenue and funding streams. Community care coalitions have demonstrated initial potential to collect and pool new resources while promoting community ownership, transparency, and accountability in resource use. At the same time, the capacity of community care coalitions must be strengthened to monitor and report on their HIV-related activities and to align their efforts with national priorities and targets.

5. *Address challenges associated with the AIDS Fund to successfully scale-up and serve as a source of funding for HIV treatment*. Implementation of the AIDS Fund has suffered from a lack of clear guidance, documentation, oversight, and accountability, but stakeholders believe that by addressing these challenges, it could be scaled up successfully and evolve into a significant source of financing. However, because the AIDS Fund relies on automatic payroll deductions from public sector employees, its similarity to the proposed SHI scheme—which has faced resistance from potential enrollees because of its contribution rate—should be noted. Broad support for the AIDS Fund would likely require low contribution rates and a clear linkage to benefits. The AIDS Fund should be considered as a potential source of funding for treatment, particularly in the case of increased private sector participation in providing HIV services. To reduce potential overlap or duplication, it may also need to be considered as a ring-fenced fund within social health insurance.

> *"If properly and uniformly implemented, the AIDS fund has big potential to mobilize resources. The budget for [the] salary of civil servants is about ETB 40 billion per year. If you take [a] fraction of this from payroll, you can raise hundreds of millions."*
>
> *–Key informant, Ministry of Finance*

6. *Implement tools and standardize regular processes for reporting on HIV budgets and spending.* In general, there was a lack systems and clear processes for tracking and reporting HIV budget allocations and expenditure. This severely limited the ability of the study team to obtain complete and reliable data on domestic funding for HIV, particularly at the woreda level. Making these data regularly available will allow FHAPCO and its partners to track progress on HIV resource mobilization and identify and address weaknesses and challenges in implementation of future domestic resource mobilization efforts.

[12] These sectors are represented at the federal level by the Ministry of Water, Irrigation, and Electricity; Ministry of Mines and Petroleum; and Government Development Enterprises Agency.

7. *Explore the potential role of private and parastatal enterprises as a source of funding for the HIV response*. Private sector participants in the baseline assessment generally preferred to pursue a corporate social responsibility strategy for supporting the HIV response over tax-based mechanisms. However, to date such corporate social responsibility strategies have not produced substantial, observable contributions to the response. Although a mandatory corporate social responsibility policy such as the one enacted in India in 2013, which requires large companies to donate 2% of their profits to charity, is an option, stakeholders should also consider tax-based mechanisms. Stakeholders should consider the financial and political feasibility of both approaches in future proposals for resource mobilization.

> *"We prefer to pursue a CSR [corporate social responsibility] program. We fund project proposals and we use the results for marketing."*
>
> *–Key informant, private sector*

8. *Adhere to the principles of efficiency, equity, and sustainability in all efforts to mobilize additional domestic resources*. Efforts should focus on regions and woredas with both the greatest need—regarding people living with HIV—and current financing gaps, and directly support high-impact interventions tied to national priorities and targets. All resource mobilization mechanisms should consider the financial means of potential contributors to mobilize funds in accordance with their ability to pay. Particular focus should be applied to mechanisms that have the potential to generate consistent and increasing resources in the long run, although a mix of all long-, medium-, and short-term sources will likely be needed to ensure adequate financing for the HIV response over the next five years (2020–2025).

References

Alebachew, A., and W. Mitiku. 2019. *Financing Exempted Services in Ethiopia - Policy Options.* Boston, Massachusetts and Addis Ababa: Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy, PLC.

Alebachew, A., W. Mitiku, C. Mann, and P. Berman. 2018. *Exempted Health Services in Ethiopia: Cost Estimates and its Financing Challenges.* Boston, Massachusetts and Addis Ababa, Ethiopia: Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy, PLC.

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*. Resource Tracking and Management Project. Boston, Massachusetts and Addis Ababa: Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy, PLC.

Berman, P., A. Alebachew, C. Mann, A. Agarwal, and E. Abdella. 2016. *Costs of Publicly Funded Primary Care Facilities, Departments, and Exempted Services in Ethiopia*. Boston, Massachusetts and Addis Ababa: Harvard T.H. Chan School of Public Health and Breakthrough International Consultancy, PLC.

Bobo, F.T., M. Woldie, M.A. Wordofa, G. Tsega, T. Alaro, et al. 2018. "Technical Efficiency of Public Health Centers in Three Districts in Ethiopia: Two-Stage Data Envelopment Analysis." *BMC Research Notes* 11(465) doi:10.1186/s13104-018-3580-6.

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

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

Dire Dawa HAPCO. Unpublished. *Dire Dawa Administration HIV Mainstreaming Report*.

Ethiopian Health Insurance Agency (EHIA). Unpublished. "Revisiting Financial Sustainability of Social Health Insurance in Ethiopia." Addis Ababa: EHIA.

Ethiopia Public Health Institute (EPHI). 2018. *HIV Related Estimates and Projections for Ethiopia*. Addis Ababa: EPHI.

Ethiopia Public Health Institute (EPHI), Ethiopian Public Health Association (EPHA), and Centers for Disease Control and Prevention (CDC). 2013. *Ethiopian National Key Population HIV Bio-Behavioural Surveillance Round-I, 2013 Report*. Addis Ababa: EPHI.

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.

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2011. *HIV and AIDS Mainstreaming Implementation Manual.* Addis Ababa: FHAPCO.

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). 2014. *HIV/AIDS Strategic Plan 2015-2020 in an Investment Case Approach*. 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.

FHI 360. Unpublished. "Report on Community Care Coalitions (CCCs) in Ethiopia."

Global Fund. 2019. "Ethiopia: Disbursements by Component." Available at: https://www.theglobalfund.org/en/portfolio/country/?k=5061c5f2-1100-4eed-9cff83787e240c78&loc=ETH.

Health Policy Plus (HP+). 2018. *Ethiopia's Emerging HIV Financing Gap: The Need for Increased Domestic Funding*. Washington, DC: Palladium, Health Policy Plus.

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

Kiringai, J., M. Geiger, M. Bezwada, and L. Jensen. 2016. *Ethiopia Public Expenditure Review* (English). Washington, DC: World Bank Group.

Mann, C., E. Dessie, M. Adugna, and P. Berman. 2016. *Measuring Efficiency of Public Health Centers in Ethiopia*. Boston, Massachusetts and Addis Ababa: Harvard T.H. Chan School of Public Health and Federal Democratic Republic of Ethiopia Ministry of Health.

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.

Ministry of Labor and Social Affairs (MOLSA) and United Nations Children's Fund (UNICEF). 2018. *Situation Analysis of Community Care Coalition Structures in Five Regions of Ethiopia*. Addis Ababa: MOLSA and UNICEF.

National Planning Commission (NPC). 2016. *Federal Democratic Republic of Ethiopia Growth and Transformation Plan II (GTP II) (2015/16–2019/20)*. Addis Ababa: NPC.

United Nations Office on Drugs and Crime (UNODC) and Federal Prison Administration. 2013. *Rapid Assessment of HIV Situation in Prison Settings in Ethiopia*. Addis Ababa: UNODC.

U.S. President's Emergency Plan for AIDS Relief (PEPFAR). 2018. *Ethiopia Country Operational Plan (COP/ROP) 2018 Strategic Direction Summary*. Washington, DC: PEPFAR.

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

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

Source: World Bank, 2019


USAID
FROM THE AMERICAN PEOPLE


PEPFAR


HP+
HEALTH POLICY PLUS