2016 Sustainability Index and Dashboard Summary: Guatemala

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

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

The workshop was held in Guatemala City on April 14, 2016 with the participation of 25 representatives from Government, Civil Society, Academic Institutions and NGOs. There was a preliminary review of several documents that provided information about the four areas assessed by the SID tool.

Guatemala is a country classified as low median income, and has a concentrated HIV epidemic. It is the largest country in population and number of PHIV in the Central America Region.

The country shows an emergent sustainability in most of the index areas that will require some investment. The results are presented by Domain from the highest to the lowest score:

Governance, leadership and accountability: The country has made important advances in the areas of policy and governance (6.61), Planning and Coordination (6.53), Civil Society Participation (6.12) and Public Access to Information (6.00), however the lower score from the domain and from the index is the Private Sector Participation (1.46) that shows no sustainability and will require and important support.

National Health System and service provision: In this domain the assessment shows a midway to sustainability with advances in Improvement of the Logistics System capacity (5.17), Quality management (4.90) and Service Provision 4.68. However, Human Resources for Health (3.83) still in an emergent sustainability and also will require important support as well as Laboratory (3.33).

Strategic investment, efficiency and sustainable financing: The assessment recognized the advances in health sector technical efficiencies 6.23, and recognized the need to improve the mobilization of national financial resources (5.28).

S**trategic information**: The assessment shows some advances related to performance evaluation (6.38) and Financial and expenditure analysis needs to be improved (6.38). However, epidemiological data (5.0) still need improvement and support to make it sustained

Sustainability Analysis for Epidemic Control: Guatemala

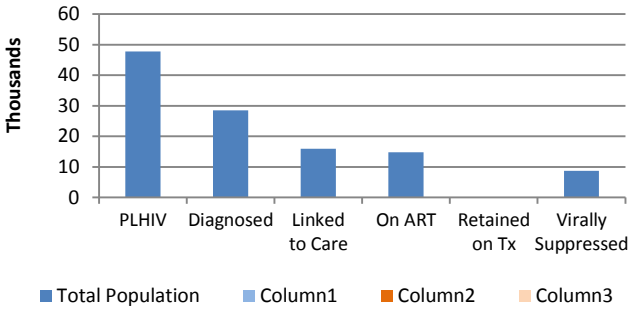
Epidemic Type: Concentrated
Income Level: Lower-middle income
PEPFAR Categorization: Targeted Assistance (Cent. America Regional)
PEPFAR COP 16 Planning Level: $21,614,000

SUSTAINABILITY DOMAINS and ELEMENTS

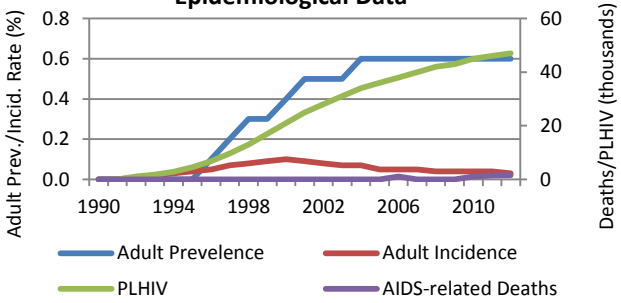
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	6.53			
2. Policies and Governance	6.61			
3. Civil Society Engagement	6.12			
4. Private Sector Engagement	1.46			
5. Public Access to Information	6.00			
National Health System and Service Delivery				
6. Service Delivery	4.68			
7. Human Resources for Health	6.33			
8. Commodity Security and Supply Chain	5.17			
9. Quality Management	4.90			
10. Laboratory	3.33			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.28			
12. Technical and Allocative Efficiencies	6.23			
Strategic Information				
13. Epidemiological and Health Data	5.00			
14. Financial/Expenditure Data	7.50			
15. Performance Data	6.38			

CONTEXTUAL DATA

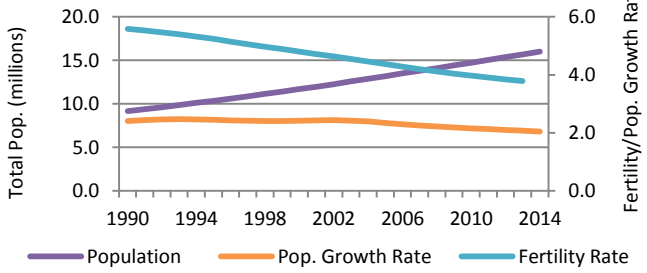
National Clinical Cascade



Epidemiological Data

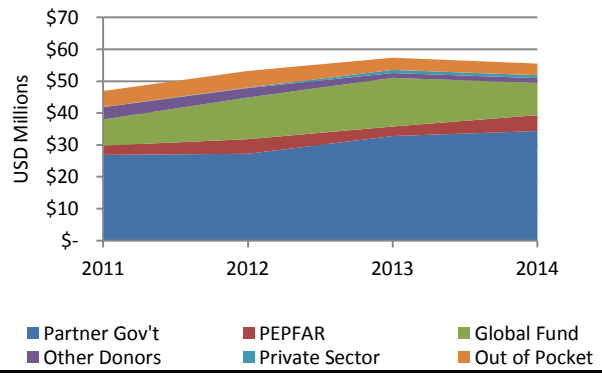


Population and Fertility

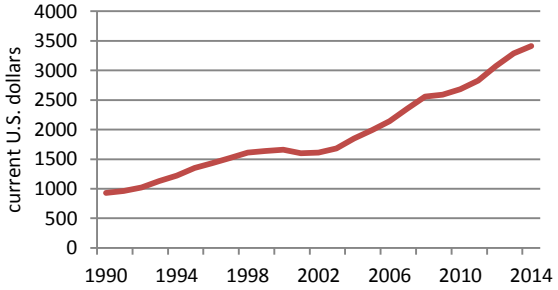


CONTEXTUAL DATA

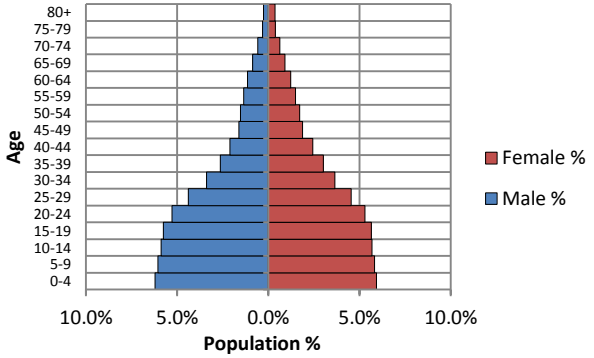
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

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

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☑ Strategy includes explicit plans and activities to address the needs of key populations. ☐ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 2.20	National Strategic Plan for the Prevention,Care and Control of STI and HIVAIDS (NSP). Guatemala 2011-2015. Cost evaluation of the National Strategic Plan for the Prevention, Care and Control of STI and HIV AIDS (NSP). Report of results; description of calculations; documentation of sources that were used. Public Policy 638 - 2005 in relation to prevention of sexuallly transmitted infections (STI) and response to the ZIKA virus. This policy has not been updated, but is still in force; it was last assessed by SEGEPLAN in January 2012, when it became evident that it was necessary to harmonize this policy and the NSP. The Ministry of Public Health (MPH) has continued to use the NSP 2011-2015, which was granted an extension and is being used as a basis for the new version of the NSP.	The last NSP was formulated for 2011-2015. The previous government proposed officially extending its term until 2016; however, political crisis and the Ministry of Public Health (MoH) in office influenced negatively on its implementation. Current government is focusing on creating the new NSP 2016-2021. USAID/PASCA LMG are coordinating with the MoH and will provide technical assistance to develop the new strategic plan. The strategy does not include male circumcision. However, the official extension of the NSP 2011 - 2015 needs to be validated so the country and responsible actors may have a backup strategy. Information provided by the Coordinator of the National AIDS Program.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☐ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☐ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 1.50	National Strategic Plan for the Prevention, Care and Control of STI and HIV AIDS (NSP). Guatemala 2011-2015.	Private clinics and laboratories have not participated in the elaboration of the NSP. The corporate sector participated in CONASIDA and some of their foundations have incorporated HIV policies (Fundacion Fernando Iturbide, APIB and Fundabanano) and implemented actions using NSP parameters. External agencies have participated and provided technical assistance in the development of the NSP.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☐ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☑ civil society organizations ☐ private sector ☑ donors ☐ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☐ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 0.33	Decree No. 27 - 2000. General Law for the Fight against HIV AIDS and for the Promotion, Protection and Defense of Human Rights of Persons living with HIV AIDS. The Ministry of Public Health (MoH) monitors health related issues only; other government ministries don't get involved. The Ministry of Public Health (MoH) of Guatemala has an Annual Operative Plan (AOP).	Although the HIV AIDS Law includes CONASIDA, a multisectoral national commission for the prevention of STI/VIH AIDS that is responsible of coordinating and implementing the policies of the MPH, this mechanism has not been functional. Its functions include planification and evaluation of programs. A mapping of organizations at a national level does exist, but there is no routine tracking of their activities. However, measurements by MEGAS provide a mechanism to monitor activities through expenditure tracking. Duplications and gaps have been identified in the execution of Global Fund grants.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	The Annual Operative Plan (AOP) of the Ministry of Public Health (MoH) identifies actions, supplies, human resources Sub national units of the MoH, such as Regional Offices and hospitals	In the health environment, the mechanism is the AOP of the MoH ; however, there's a gap between other government institutions and the planning mechanism for HIV actions.
		Planning and Coordination Score: 6.53		

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☑ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 D. Children (<10 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 or clinical eligibility	2.1 Score: 0.89	33 Treatment Guide for antirretrovirals and for opportunistic infections in Guatemala , 2013. In the case of children,there is an ongoing discussion about age.	Presently, the MoH applies the ART protocol, and it has considered updating it to incorporate treatment as a strategy of prevention. This requires a projection of needs and securing funding sources; and ideally, that it gets included in the 2016 Annual Operation Plan. Eventually, the strategy would give priority to key populations.

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☐ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS	2.2 Score: 0.41	DecreeNo. 27 - 2000 General Law for the Fight against HIV AIDS and for the Promotion, Protection and Defense of Human Rights of Persons living with HIV AIDS. Treatment Guide for antirretrovirals and for opportunistic infections in Guatemala , 2013.	Presently ARV medications are provided for periods of one to three months, depending on stock available in the different health facilities and based on individual medical evaluations of cases. For pregnancy cases in the PMTCT Program, ARVs are started the same day.
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☐ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☐ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☐ Law/policy is fully implemented Gay men and other men who have sex with men (MSM): ☐ Law/policy exists ☐ Law/policy is fully implemented	2.3 Score: 0.48	This question aligns with the NCPI of UNAIDS (2015). If your country completed the new NCPI, you may use it as a source of data to answer this question. Political Constitution of the Republic of Guatemala. HIV Law 27-2000 Decree 90-97 Health Code; Decree 57-2002 Reform of the Criminal Code; Decree 42-2001 Law of Social Development; Legislative Decree 36-2006 Prison Regime Law; Decree 330 Work Code; Law for Integral Protection of Children and Adolescents; Law of Educational Promotion against Discrimination; Law against sexual violence, exploitation and human trafficking; Law to prevent and erradicate intrafamiliar violence; Law against feminicide and other forms of violence against females; Law for attention to people with discapacities; Law for the dignity and integral promotion of women. Objectives in the Ombudsman's Office	It is necessary to discuss what criteria to apply in order to determine if the Law or Policy has been fully implemented. Law 27-2000

	Migrants: ☑ Law/policy exists ☐ Law/policy is fully implemented People who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully implemented Prisoners: ☐ Law/policy exists ☐ Law/policy is fully implemented Sex workers: ☐ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☐ Law/policy exists ☐ Law/policy is fully implemented Women and girls: ☑ Law/policy exists ☐ Law/policy is fully implemented		(human rights of sexually diverse persons, women, children and adolescents, disabled persons, victims of human trafficking and malpractice) Presidential Bureau for Women SEPREM; Bureau against violence and human trafficking, SVET ; Youth National Council CONJUVE. HIV policies in Work Environment	

2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of sex work: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced	2.4 Score: 1.26	This question aligns with the NCPI of UNAIDS (2015). If your country completed the new NCPI, you may use it as a source of data to answer this question. HIV Law Decree 27 - 2000. Observance No. 15 of Article 24 of the Convention of the Rights of the Child. Articles 25 of VET Law (related to article 151 of the Criminal Code) Article 24 of the HIV Law establishes that it is compulsory to inform your partner about your serological state. Article 301 of the Criminal Code sanctions the intentional propagation of contagious diseases. Difference between criminal offence and misconduct. Drugs and manifestations of affection. Review use of drugs in the criminal code. The criminal code of 2015 penalizes actions actions commited under the influence of drugs but does not penalize drug consumption. Law against Narcoactivity in its article 23 penalizes possesion of drugs for use .	Although no specific legislation exists, in June 2013 the state of Guatemala presented legal reserves to ratify the Interamerican Convention against all kinds of discrimination and intolerance including discrimination based on sexual orientation and gender identity. Although Guatemalan legislation does not penalize sexual work, certain laws such as Decree 9-2009 do penalize the promotion, facilitation or fostering of prostitution in the case of exploitation and trafficking. Article 23 of the HIV Law prohibits HIV testing on minors. However, observance No. 15 of Article 24 of the Convention on the Rights of the Child recommends that children have access to therapies and services (including HIV) with no need of consent from their parents or tutors if the health professional deems HIV testing is required. The law does not set limits to the employment and hiring of persons with HIV; however, HIV continues to be a barrier for said purpose.

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

- [ ] Law/policy exists
- [ ] Law/policy is enforced

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

- [x] Law/policy exists
- [ ] Law/policy is enforced

Criminalization of HIV non-disclosure, exposure or transmission:

- [x] Law/policy exists
- [ ] Law/policy is enforced

Travel and/or residence restrictions:

- [ ] Law/policy exists
- [ ] Law/policy is enforced

Restrictions on employment for people living with HIV:

- [ ] Law/policy exists
- [ ] Law/policy is enforced

2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☐ To educate PLHIV about their legal rights in terms of access to HIV services ☐ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☑ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.5 Score: 0.71	Law 27-2000 The PDH (Ombudsman Office) educates government entities and key populations on the subject of their rights (project financed by Norway) The Military Medical Center does it from a clinical point of view, for patients under treatment. Any victim of discrimination can go the Public Attorney's Office or to the PDH to initiate legal proceedings.	Article 14 of the HIV Law emphasises privacy and confidentiality. Through the public law offices of the national university (Bufete Popular/ USAC), the government provides legal services and assigns public defenders.
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 1.43	In 2015 the government initiated an audit that was not concluded nor made official due to lack of funds. Nonetheless, WF audits were conducted using Local Fund Agent (LFA) reports and those of the National Comproller's Bureau. The MoH conducts internal audits on a yearly basis; and the MoH is audited annualy by the National Comptroller's Bureau.	Last one 15 days ago, and the one before in December 2015. See National Comptroller's webpage.
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 1.43	Organic Law of the National Comptroller's Bureau. Decree 31-2002	The National Comptroller's Bureau requires tracking of audit findings, sets times to do it and establishes sanctions for affected officials.
		Policies and Governance Score: 6.61		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			Data Source	Notes/Comments
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ○ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ◉ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 1.67	They don't exist at a national level, but they do intervene in specific issues when interests are at stake. They are continously tracked from the perspective of access to medication and through Citizens Observatory. Citizens follow up but with limited access to financial information. The law stipulates 10 days to provide required information.	The participation of civil society is important; however, in reality few organizations get involved and their feedback is not effective because systematic tracking mechanisms are lacking. There are discussion tables on Women and on AIDS.
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☐ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☐ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	3.2 Score: 0.95	There is a government approved structure for a Tracking and Evaluation Committee, but said Committee is not operating and hasn't met over the past two years. Example of technical groups. Meeting to update ARV norms and others issues related to medication and HIV patients.	Mainly during structural planning Civil society organizations participate in the development of norms and relevant protocols, for example, guides for care for transgender population and sex workers. Some civil society organizations track issues such as quality of care and provison of ARVs medications and supplies (ITPC, ICW and REDCA)

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☑ In advocacy ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☑ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.67	Focused programmatic decision making. Strategies for trans and sex workers. In the package of health services. Growth of funding for HIV is attributed to medication costs. Civil society advocates for treatment. In HIV/AIDS basket, focus is on treatment.	TRANS population has participated actively in the drafting and approval of the HIV Protocol for Trans population ; advocacy for a Guide for Sex Workers; community follow-up to guarantee adherence to treatment and ARV.
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).	3.4 Score: 0.83	Guatemalan National Revenue and Expenditure Budget 2015 Joint HIV programs with the private sector.	$Q14,000,000 contribution to Hospicio San José The area where Fundacion Marco Antonio is located is government-owned property (Zone 3)
3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	○ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ◉ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that apply): ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☐ Significant tax exemptions for not-for-profit CSOs ☐ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change ☐ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 1.00	Political Constitution of the Republic Tax Update Law, Decree 10-2012	The income tax law grants tax deductions on contributions. However, very few CSOs are authorized to receive these tax deductable donations. In Guatemala, civil society organizations are exempt from income tax. Recently, CSO services financed by the government were temporarily shut down. CSOs in Guatemala advocate and act with freedom.
		Civil Society Engagement Score: 6.12		

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	◉ A. There are no formal channels or opportunities ○ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ○ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☐ Corporate contributions, private philanthropy and giving ☐ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☐ Tracking of private training institution HRH graduates and placements ☐ Contributing to develop innovative solutions, both technology and systems innovation ☐ For technical advisory on best practices and delivery solutions	4.1 Score: 0.00		Participation of Private Sector in NASA (HIV AIDS expenditure measurements), NSP, national dialogues. Because of lack of initiatives to strengthen transparency, private sector avoids financing government activities.

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	◉ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ○ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☐ In patient advocacy and human rights ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery for both public and private providers ☐ In HIV/AIDS basket or national health financing decisions ☐ In advancing innovative sustainable financing models ☐ In HRH development, placement, and retention strategies ☐ In building capacity of private training institutions ☐ In supply chain management of essential supplies and drugs	4.2 Score: 0.00		Experience with the private sector in work related HIV policies reflects a public-private alliance in the provision of services. (Coordinations between the MoH and private sector organizations such as APIB, Funcafe and Azasgua in HIV testing and adherence to treatment) Corporate contributions to the social security system through the Guatemalan Social Security Institute (IGSS) a semi-autonomous entity that uses its own norms and protocols. Through the National Commission of Occupational Security (CONASO) the role of the private sector could be further strengthened with feedback on IGGS policies and programs.

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☐ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☐ Tax deductions for private health providers. ☑ Tax deductions for private training institutions training health workers. ☐ Open competition for private health providers to compete for government services. ☐ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☑ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☐ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 0.63	The Health Code stipulates compulsory notification. Pharmaceutical industries must provide protocols and report to the MoH. There are systems of reporting standards, but these are not applied rigorously. The norm of lab reporting exists, but it is not followed. There are mechanisms, but these are no guarantee. Programs such as the National Program against AIDS (NPA - PNS in Spanish) or the Integrated Health Care System (SIAS) should be in charge of supervising and certifying private clinics. The available private services lack supervision and are only supervised if someone files a lawsuit against them.	Even though insurance companies must submit financial reports to the Bank Superintendency (SIB), the provision of services is not actually reported. Regarding private labs and blood banks, they have the obligation to report any cases identified as reactive. Some municipalities have reached agreements for inter-institutional coordination through their public services or human resources, in order to support MoH services. Memorandums of understanding do exist: such is the case of Fundacion Marco Antonio. But it is a very rare case. Private universities don't pay the value added tax (IVA)
4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☑ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☐ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☐ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☑ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 0.83	HIV policies of trade associations (APIB, ASAZGUA, VESTEX, ANACAFE).	There are official norms to register pharamceutical products, but they are very burocratic. There are some examples of private-public alliances, among them the usufruct of state property granted by the MoH to Fundación Marco Antonio for its clinics and offices and the financial support that Congress approved for its operations. 42 Businesses in Guatemala have adopted HIV policies in work premises with the help of public-private alliances for prevention of HIV. Guatemala has hosted two regional forums and national dialogues about HIV at work premises. The Ministry of Labor updated its Health and Occupational Security Regulations, incorporating the subject of HIV in in private sector.

4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	◉ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ○ B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply): ☐ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs. ☐ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 0.00	National Revenue and Expenditure Budget 2015	Two examples would be Fundación Marco Antonio and Hospicio San José, which receive financial support from the government to cover of its budget.
4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00	Epidemiological Bulletin, May 2015, National Center of Epidemiology (NCE) No statistics about HIV care in the private sector.	Of the 33,862 HIV cases reported at a national level, 4,500 were cases treated at the Guatemalan Social Security Institute (IGSS). This total may include the cases treated by private practitioners.
		Private Sector Engagement Score: 1.46		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ◉ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 2.00	Epidemiological Bulletin, June 2015	Every semester the MoH distributes basic data to participants of the response to HIV in Guatemala through the publication of an epidemiological bulletin.
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures. ◉ B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.	5.2 Score: 1.00	Management and Accountability Report - budget implementation , fiscal year 2015, Ministry of Public Finances	The MoH report, which includes a section concerning the HIV budget, was presented as a summary one year later. The MoH collects the information but the reports are made public two years later.
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?	◉ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ○ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .	5.3 Score: 0.00	234 Annual Reports are public. Webpage of Aids National Program Law of Access to Information.	Officially, the Annual Report for 2015 is unavailable or it was not published.

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements. ○ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ◉ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ○ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 1.00	Guatecompras Website	Procurement and acquisition operations are available for the public to see at the Guatecompras website. However, some purchases are direct to avoid risk of shortage.
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	Guide for Comprehensive Management of Sexually Transmitted Infections of the National Aids Program (NPA - PNS in Spanish) National Aids Program (PNS), 2007.	The MoH is in charge of promotion and education activities in health services and in outside organizations that request them. The IGGS educates its affiliates and the Ministry of Education is in charge of STI/HIV/AIDS education in schools and universities.
		Public Access to Information Score: 6.00		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

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

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☐ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☐ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.37	Report by *Monitoreo Ciudadano* on Integrated Care Units : "Community Movilization to Effectively Implement The Global Fund Grant, Managing and Reducing Risks and increasing Access to HIV Treatment in Guatemala and Nicaragua" There is response capacity, but no government actions to generate demand.	The Integrated Care Units (ICUs) show high demand. The Director of the HIV Clinic at one of the two main referral hospitals (Roosevelt Hospital -HR), Dr. Mejia, estimated that only 6 out of 18 ICUs comply with the responsibility of generating demand. Services provide attention spontaneously to the public and not in a programmed way. There is risk of regression in sustainability. Some centers that provide services don't have enough staff to handle the demand that could be generated.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☐ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☐ National guidelines detailing how to operationalize HIV services in communities ☐ Providing official recognition to skilled human resources (e.g. community health ☐ Providing financial support for community-based services ☐ Providing supply chain support for community-based services ☐ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.00	Much gets done through the WF. It is done but not standarized. It is done within the framework of the WF program. Done with the support of external cooperation (CAPACITY) and other programs like Fundamaco. It is standarized. No option was marked.	There are unstandarized methods, for example a pilot project in Alta Verapaz and Quiché for community work, presently focusing on the elimination of mother-child transmission, a joint project with UNICEF y PAHO. The present reproductive health system offers opportunities to distribute ARVs at the community level.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 1.25	Measurement of Expenditure Report MEGAS , Guatemala 2013	Most of the investment goes to attention of HIV and is provided by the government. The investment in prevention is minimum and most of it is provided by cooperation.

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.37	MEGAS Report, Guatemala 2013 Does not refer to funding but to technical assistance. Attention is financed mostly by government while prevention is cooperation-funded. It refers to key populations, and services eMoHasize PTMI.	The staff of Units of Integrated Care, providing have received external technical assistance. According to the NASA report 2013, PEPFAR and the Global Fund (GF) contribute with 32.62% of HIV funding; the rest is provided by the government. According to priorities of the country, Coatepeque, Roosevelt Hospital HIV Clinic, San Juan de Dios Hospital HIV Clinic (ASI) and IGSS are considered high burden clinics. They basically function with national financing and receive help from external/international sources to cover specific items. Nevertheless, the country as a whole depends on financial help. Dr. Mejia recommends following up on the weak points of each facility identified in the study performed by USAID-Capacity: HIV Cascade in Guatemala.
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 0.83	MEGAS Report, Guatemala 2013 Attention to FSW is generally covered by the government, while MSM and Trans by cooperation. Putchase of ARVs is government funded It is approximately 49%.	
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	MEGAS Report, Guatemala 2013	The Global Fund plays an important role in Guatemala. The involvement of civil society organizations in attracting and linking key populations to health services. has been important in the response to the epidemic. The GF finances 26.6% of the total HIV expenditure in Gutemala. Universidad del Valle (UVG) representatives informed that there is a mapping of activities performed by NGOs for key populations.

6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assesses current and future staffing needs based on HIV/AIDS program goals and ☐ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engages with civil society in program planning and evaluation of services . ☑ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.74	Each area has an epidemiologist. The GF used information to prioritize geographical areas. Each DAS has an HIV coordinator. Test performed by the MoH are not focused on MSM, they are mainly directed to screening pregnant women, informs Dr. Mejia. The MEGAS report indicates that more is spent in other populations than in key populations Situational Rooms for HIV data analysis should be better utilized to guarantee follow-up actions based on information.	Each Health Area Office (DAS in Spanish) has a person who is responsible for HIV and who elaborates the respective operative plans (HIV Area Coordinator). There are also multisectoral networks that develop local plans jointly with the MoH. Each DAS has an Epidemiology Unit that analyzes HIV information through the situational room tool and other methods. Although needs in staff resources are being evaluated, there have been layoffs due to budget cuts. The UVG representatives expressed that they do not know about a formal cost-effectiveness analysis, but the group argues that some effectiveness has indeed been measured. In regard to training, Dr. Mejia believes there is no total compliance, because each ICU works according to their own capacities. *Capacity* affirms there are initiatives for a national plan that will evaluate health care workers. The second level of attention is less developed, according to *Capacity* .

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score:	0.74	It is necessary to prioritize key populations and work to reduce the gap in stigma and discrimination.	In some areas, there are multisectoral networks that have elaborate work plans. When health areas require human resources, they address their requests to the MoH. Although the different Health Area Offices elaborate their own annual budget, the allocation of funds depends on Congressional approval and the budget share the MoH will effectovely receive from the Ministry of Finances. Each Health Area Office manages its budget allocation for their department (geo political organization of the country is by *departments*). The national budget for training programs is limited, and capacity building is mostly coordinated by foreign cooperation. At the departmental level, it is the HIV Coordinator who plans training programs and takes them to his/her districts; sometimes Capacity participates. In regard to performance, it is assessed in programs where Capacity is present, otherwise, at a national level performance is only partially assessed. Each area manages its own resources with hotels and other donors, and organizes its own workshops. The tool should evaluate timely payment of salaries to health personnel. Each network has a work plan and participates at a subnational level. Subnational plans exist but in every day practice the priority is implementation. The tool does not reflect the problem of corruption in personnel selection, management and planification.
	Service Delivery Score		**4.68**		

7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.00	Universities are producing health professionals and technicians without adequate capacities for HIV management.	The Integrated Care Units (ICUs) have faced a staff reduction for HIV attention because of budget cuts in the MoH. There are efforts going on in inter-university discussion tables, but no measures have been adopted yet at the university level. Nurses seem to be more acquainted with HIV- more than medical students, who have limited knowledge on the subject. There is a gap between existing needs and the number of prepared technicians, and between health personnel and service demand. The Ministry spends one million quetzales to educate a Specialist physician, and then they are hired by the IGGS and the private sector. The provision of health personnel lacks coordination. A national formation and hiring plan is required.
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ◉ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.2 Score: 1.00	Obligations assumed by the government in HIV subvention agreements with the GF PEPFAR does not help with human resources, but the GF does. The transition has started. The personnel of large clinics was registered in an inventory. The process stopped during the government transition because of budget cuts. Some of the staff was laid off, but the new authorities have resumed the hiring process of those no longer in the GF budget.	Initially the GF provided financial resources for hiring personnel; this activity is now assumed and financed by the MoH, except for staff paid by the grant at the central level, soon to finalize. The GF offered to absorb some of the job positions they were initially financing to help in government transitions.

7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 2.50	National Revenue and Expenditure Budget 2016 The GF is investing in human resources for health promotion. The MoH is now financing said resources, but the GF still covers 10%.	The MoH pays for most of its staff
7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ Institutions maintain process for continuously updating content, including HIV/AIDS content ☑ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score: 1.00		No available information
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden	7.5 Score: 0.83	Government invests from 10% to 20%. In theory, point C applies to physicians. The law exists but it is not applied.	No available information Representatives of the National Program for STI/HIV/AIDS (NPA) expressed that the MoH does respond to training programs based on comprehensive plans. The obligation of professional education in the medical bar does not include HIV.

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☐ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 1.00		Although the MoH has received technical assistance from donors for operation systems and professional training of health care workers , there has been no political will for maintenance and continuity, mainly as a result of the constant change of authorities. The system exists but whether there is a strategy is still to be verified. Each Health Area Office of the MoH uses IRIS, but it's not inter-operative and health organizations outside the MoH don't use it.
	Human Resources for Health Score	**6.33**		
8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ◉ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.63	NASA Report, Guatemala 2013, pp 26	According to NASA report 2013, public expenditure financed 57% of ARVs; the remaining 43% was financed by the GF. This year the MoH intends to cover the total cost.
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ◉ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.63	NASA Report, Guatemala, 2013	According to the NASA Report for 2013, 80% of the cost of purchasing tests was government funded. It is known that during years 2014 and 2015, the political situation of the country, with constant changes of authorities, brought this percentage down.

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ◉ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.21	NASA Report, Guatemala, 2013, pp 32	According to NASA Report for 2013, 8.7% of condoms are purchased with public funds. The other 91.3% comes from private and international sources. There is no knowledge about the way condoms are purchased. Most purchases are through the Reproductive Health program, for family planning purposes, not as a prevention measure for STIs. In some key populations such as the transgender, 100 units a month is considered insufficient. Health facilities distribute condoms among the general population and not specifically to key populations. For the general population, the Reproductive Health Program estimates 120 condoms per year per person. The needs are much higher for key populations. There is variable access to condoms through this program.
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☐ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 2.02	Logistics Plan. See SCMS	No information available A Guide of Supplies is being implemented nationwide. It starts out with a diagnosis, has minimum and maximum controls and a requisition system. It uses a specific form for Balance, Request and Inventory of Supplies denominated BRES, and a Cardex system. Part of the logistic cycle is documented in the guide, with special attention to the information system. At present, 8 ICUs are under supervision, and hospital and pharmacies are also being integrated.

8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ◉ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.21	NASA Report, Guatemala, 2013	There are no exact numbers of the percentage of public funding for the chain of supplies for HIV. According to data in NASA 2013, it is estimated that the country invests 27.6% of its total AIDS expenditure for the purchase of ARVs, reagents, lab materiasl and tests.
8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☐ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 1.48		The National Program for STI/HIV/AIDS (NPA) has a logistics team responsible for the chain of supplies and for inventory control. During the prior government, an ARV shortage ocurred in 2012. The Social Security Institute recently reported a shortage, and although they have the financial possibility of a public bidding, they have not acted.
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	◉ A. A comprehensive assessment has not been done ○ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00		No information available
	Commodity Security and Supply Chain Score:	**5.17**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			Data Source	Notes/Comments
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.67	Listings or letters by national committees and plans by the different units.	The Department of Regulations (Direccion de Regulación) is in charge of supervising quality. Quality in healthcare facilities is the responsibility of Health Area Directors and Hospital Directors. A national strategy has been formulated to ensure quality.
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 1.33	There are plans in clinics and hospitals, but not nationwide. Specific improvements through interventions.	No information available There are plans that include HIV for hospital clinics
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☐ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national ☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☑ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 1.33	Reports and Improvement Plans in Integrated Care Units	There are improvement plans that are measured every year, and local teams are capable of applying methodology. The system is implemented in the third level of attention, with gaps in first and second levels. *Hivos* has also established a citizen tracking system for HIV cases at Integrated Care Units.

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 1.00	Measurements and Curricula by *Capacity*	
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☐ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 0.57	The structure exists at a sub-national level.	Authority changes have caused delays. A Quality Unit that formerly existed has now been picked up by the Vice Minister. At a subnational level, it is implemented only in hospitals. Documented with QI plans and reports.
	Quality Management Score:	**4.90**		

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	◉ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed	8.1 Score: 0.00	There is a regional lab expansion plan Referral and counterreferral of tests. There is no general laboratory plan, but there exist plans for specific issues. Descentralization of national tests.	Laboratories don't develop strategic plans, they just participate in the elaboration of Annual Operative Plans (AOP - POA in Spanish)

10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	◉ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ○ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	8.2 Score: 0.00	The regulations exist but not the resources to do it. Performed in 9 clinics	No information available SCMS will send diagnosis to document this point.
10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	◉ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ○ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis in laboratories and point-of-care settings ☐ TB diagnosis in laboratories and point-of-care settings ☐ CD4 testing in laboratories and point-of-care settings ☐ Viral load testing in laboratories and point-of-care settings ☐ Early Infant Diagnosis in laboratories ☐ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☐ Blood banking in laboratories and point-of-care settings ☐ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	8.3 Score: 0.00	There may be quantity, but quality is not adequate due to high turnover of staff and other factors. A weak point in laboratories is their human resources.	The staff at the labs of the hospital network where the Integrated Care Units are located are qualified to do HIV testing and other required activities. Viral load testing and CD4 testing are centralized in three reference laboratories (Laboratorio Nacional de Salud, ICU of Hospitals Roosevelt and San Juan de Dios) The National Health Laboratory has worked to strengthen the lab network and has developed a pilot plan for Escuintla (a large deparment with high HIV burden in the southcoast). Presently it is evaluating the implementation of the plan at a national level. Availability of supplies for viral load and CD4 testing has been a problem; studies show that viral load testing has been insufficient.
10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	◉ A. There is not sufficient infrastructure to test for viral load. ○ B. There is sufficient infrastructure to test for viral load, including: ☐ Sufficient viral load instruments and reagents ☐ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	8.4 Score: 0.00	There are only three locations, which is not enough, but viral load testing gets done.	There are three locations performing these tests (National Health Laboratory , HIV Clinics of the Hospital Roosevelt and Hospital San Juan de Dios). They all have adequate infrastructure and supplies.

10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ○ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ◉ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	8.5 Score: 3.33	Aproximately 90%	Funding of laboratory services is determined by the resources that Health Area Offices allocate to health facilities in their department. No specific data available on the subject of lab funding.
	Laboratory Score:	**3.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

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

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			Data Source	Notes/Comments
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☐ The HIV/AIDS budget is program-based across ministries ☐ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☑ The budget includes specific HIV/AIDS service delivery targets ☑ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.67	Revenue and Expenditure Budget of Guatemala, 2016	The national budget includes an expenditure on HIV/AIDS; however, it is not detailed. In general, the national budget does not describe specific illnesses or health conditions. The National Program for STI/HIV/AIDS (NPA) presents its budget proposal based on objectives and projections. Nevertheless, the budget allocations of the MoH depend on the resources that the Ministry of Public Finances ultimately assigns to the Health Ministry. The unitary cost is calculated on the basis of every individual who receives attention, which difficults surveillance of individual expenditures, given that financial reports reflect only global numbers.
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	◉ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ○ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ○ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 0.00	Revenue and Expenditure Budget of Guatemala, 2016	Budget is calculated based on the number of beneficiaries of health services, but it's not compared with the production of the services.

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. Information is not available ○ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ○ C. 1-9% ◉ D. 10-49% ○ E. 50-89% ○ F. 90% or greater	11.3 Score: 1.11	Budget execution by entity. Ministry of Public Finances (MINFIN). December, 2015 National Program for STI/HIV/AIDS (NPA) estimates it at around 49%. Web portal for fiscal transparency, MPH and NPA	The MINFIN provides quartely official information on budget execution. In the case of the Ministry of Public Health and Public Assistance (MoH), executed sums are presented only in a general way and the report doesn't break down the spent amounts as initially budgeted. The MoH can generate specific information about budget execution on HIV, usually in response to specific summons by Congress.
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				Social Assistance (MoH)
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very little (approx. 1-9%) is financed with domestic funding. ○ C. Some (approx. 10-49%) is financed with domestic funding. ◉ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding	11.6 Score: 2.50	Report on Measurement of HIV Expenditure - MEGAS 2013, page 18.	57% of the expenditure in AIDS is financed by the public sector, 7% by private national donors and 35% by international donors.
	Domestic Resource Mobilization Score:	**5.28**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 1.43	Projections and Estimates on HIV, Guatemala Spectrum 2015. Because approved budget differs from requested budget, the program continues to work with previous budget, and any variation must be justified. Estimates of the NPA for the MoH. Execution of the previous year is evaluated and funding is estimated on that basis. The budget is distributed according to needs. The allocation depends more on historic expenditure than actual data. Coverage data is used even more than Spectrum. Finance and Planification experts are needed.	The NPA uses projections and annual estimates generated by the Spectrum model in order to request from the MoH the allocation of funds.
12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ◉ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 0.36	Charts and tables in the 2013 NASA Report, Guatemala. Information by sites is not available. At site level, salaries and some other items. Purchases and other services are centralized. It is estimated at 9%.	The expenditure in AIDS for mentioned interventions corresponds to 62.5% of the total expenditure, but the allocation of resources takes place at service and site-level.

12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ◉ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 1.07	The greatest expense is on treatment. Resources have not been allocated to prevention. Likewise, in VICITS (KP-friendly) clinics for prevention, diagnosis and treatment.	Allocations to Integrated Care Units is based on the data generated in the Cuantimed system, which uses HIV cohorts. For HIV supplies, allocation to ICUs is based on estimated data by pipeline The specific percentage alloted to each ICU is unknown.
12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming ○ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ○ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ◉ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 1.43	The Ministry of Finance (MINFIN) does have a reprogramming system. However reprogramming is not an easy process; evidence has to be presented and it all depends on the paperwork.	Reprogramming is possible in the MoH and there's a regulation on how to request it from the Ministry of Public Finances. Generally, the papework requires knowing the system well and a continous and persevering follow-up of the case.
12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Care and Support ☑ ART ☑ PMTCT ☐ VMMC ☐ OVC Service Package ☑ Key population Interventions	12.5 Score: 1.43	HIV/AIDS Expenditure Budget 2016, detail by budget lines	Average unit costs are based on key interventions.

12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☐ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☐ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☐ Improved procurement competition ☑ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☐ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☐ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☐ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☐ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 0.16	Investment framework. Data is still unavailable according to UNAIDS.	Due to GF grants for TB and HIV, ARV treatment has been implemented in places for TB treatment, and viceversa (TB testing has been implemented in HIV clinics). The MoH has a nationwide institutional strategy for the Prevention of Mother to Child Transmission
12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ◉ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ○ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score: 0.36	Rough draft of the IV Comparative Study on Prices of Medicine. ITPC 2015. pp 26 Antirretroviral Treatments in the Spotlight PAHO 2013	For the study on investments, the Pharmaceutical Department of the Ministry of Health provided information of 2014 that could be useful. • Annual cost of first line regimen per patient, purchased in Guatemala in 2014 was equivalent to US$408.23 •Standard cost of first line treatment is equivalent to US$224/year • The price in Guatemala is 82% higher than the standard costs determined by PAHO/WHO 2013. Antirretroviral Treatments in the Spotlight: an analysis of public health in Latin America and the Caribbean, page 8. Expenditure per patient is based on benchmark prices and on the assumption that countries have access to these prices.
	Technical and Allocative Efficiencies Score:	**6.23**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

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

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.48	Maternal-Child Health National Survey (ENSMI) 2008-2009 BSS Study Intermediate Line	This survey includes some questions on the general population. There are studies of key populations (KP) . Notification of HIV cases, epidemiological bulletins, and passive vigilance by the Ministry of Public Health and Social Assistance (MoH)
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ◉ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.24	Summary of the data in the Sentinel Surveillance Strategy (VICITS). Guatemala 2015. Prevalence of sexually transmitted infections (STI) MSM, TRANS, SW and persons who live with HIV. Guatemala 2012-2013. Exploratory study of diagnosis, linkage and care experiences of TS, TRANS y MSM in health facilities. Guatemala 2014.	The key population groups MSM, TRANS, FSW and PLWH are generally studied by UVG, CDC, HIVOS, and USAID associates. with the approval of the Ethics Comittee of the MPH and the surveillance of the National Program for STI/HIV/AIDS (NPA).
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ◉ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.83	The government invests in the National Epidemiology Center (NEC - CNE). It is important to mention that the MoH does not always quantify its investments.	No accurate information available.

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ◉ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.83	Report on Measurement of Expenditures, NASA 2013 Studies are paid by donors and the country is responsible of surveillance. Through the National STI/HIV/AIDS Program (NAP), the MoH participates and facilitates many of the surveillance activities and research.	Although the MoH invests in human resources of the Ethics Committee that approves protocols and support revison of preliminary and final reports, NASA reports do not reflect it.
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years sub-national HIV incidence disaggregated by: ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.48		When specific studies are performed by the GF, the criteria is met.

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	13.6 Score: 0.95	There is no viral load data. MANGUA (SI System) does have that information. There is compilation capacity but presently there is no information available. Some information of the two reference ICUs is available, but it is still incomplete.	Viral loads are are done in three locations: National Laboratory, Hospital Roosevelt and Hospital San Juan de Dios. Although the NAP collects viral load data, the information has to be specifically requested. These units report an average of 43 viral loads every month. Information is collected but there are no reports available. The Health Management Information System (SIGSA) collects information on viral loads.
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	◉ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ○ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☐ Female sex workers (FSW) ☐ Men who have sex with men (MSM)/transgender ☐ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☐ Female sex workers (FSW) ☐ Men who have sex with men (MSM)/transgender ☐ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.00	Final Report, Characterization and population estimate of TRANS women in Guatemala. 2015. Size estimation studies in vulnerable populations. Guatemala 2007-2015 Central American Survey on Surveillance of Sexual Behaviors and STI/HIV Prevalence in Vulnerable Populations. Guatemala 2012-2013. Final Evaluation Report. Global Fund HIV Grant, World Vision, 2010.	The investigation unit of the MoH support studies and research. The last study was performed in 2009.
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.95	Information is routinely sent to the National Center of Epidemiology, and a weekly epidemiological report is published. HIV requires compulsory notification. There is no timetable for studies.	In regard to surveillance, Vigilance Protocols establish the entry of data on a monthly basis (tracking of individual cases). In regard to investigation, a Research Unit through an Ethics Committee reviews and approves research protocols of health related investigations . In conclusion, no regulation establishes the obligation or need of periodical studies.

13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☐ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data ☐ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.24	Ministerial Agreementl 1082 - 2007. It creates the Research Unit of the MPH. The National Center of Epidemiology (CNE in Spanish) is in charge of assuring quality in studies.	The Research Unit of the MoH has a Technical Council made up the Technical Viceminister, representatives of the academic sector, Concyt and other research centers, and a Unit Director who defines the policies and strategies of the investigation and its priorities. Review surveillance protocols to determine data quality.
	Epidemiological and Health Data Score:	**5.00**		
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ○ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ◉ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 1.25	NASA Report, Guatemala 2013.	Directed by the NPA, which has a specific role in NASA.
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ◉ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 3.33	NASA Report, Guatemala 2013.	The NPA employs a person who is dedicated exclusively to the annual Measurement of Expenditures on HIV/AIDS (MEGAS Report). External agencies provide technical assistance for the elaboration of the report and to hold workshops of analysis and validation.

14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☑ Sub-nationally	14.3 Score: 1.67	NASA Report, Guatemala 2013. Information at subnational level is insufficient.	
14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ◉ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 0.83	NASA Report, Guatemala 2013 Even if new information is collected on a yearly basis, it's not available until much later.	Although data for the NASA reports are collected every year, the official reports are published two years later.
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉ B. The host country government conducts (check all that apply): ☑ Costing ☐ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☐ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☐ Market demand analysis	14.5 Score: 0.42	Costing of the National Strategic Plan for the Prevention, Care and Control of STI/HIV/AIDS in Guatemala.	The RNM tool was used for costing HIV Response. The country is concluding the Goals Model update and the Investment Framework exercise.
	Financial/Expenditure Data Score:	**7.50**		

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			Data Source	Notes/Comments
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ◉ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ○ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 0.33	Some of the systems are partially harmonized and some others are definitely not. USAID is providing technical assistance to harmonize systems. USAID health office has a platform that can read many systems. UNAIDS harmonizes HIV technical aspects.	The System of Information Management- SIM- officially captures information; however, there are no parallel information systems yet (NPA, CNE, and the ICU use MANGUA and function in solitary). No institution of the private sector reports; labs don't report; not even the Institute of Social Security (IGGS) reports. The lack of a unique code has negative effects. The information is not being used for decision making.
15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ◉ F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 3.33		The exact percentage of government funding is unknown.The government finances the SMI, the GF finances the collection of data that feeds the SMI; cooperation agencies finance the operations of MANGUA (SI system) and studies about key populations.

15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☐ Orphans and Vulnerable Children ☐ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM/transgender) ☑ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☐ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.11	Epidemiological Bulletin, National Center of Epidemiology (NCE - CNE in Spanish). Guatemala, June 2015. The subject of mortality is studied by RENAP, the National Registry of Persons. Sometimes reporting in private health facilities is skipped because of insurance policies. Only those who die are reported.	The Bulletin of the National Epidemiology Center reports every six months. Data collection about key populations has an inconvenience: they don't identify themselves as such. The private sector and civil society do not report thoroughly, even though the law mandates them to do so. CDC has a study on mortality and AIDS.
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	The bulletin is biannual. Service delivery data. Includes the GF. Some Health Area Offices HIV services delived in facilities in their department, periodically or monthly, for planification purposes.	

15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	◉ A. The host country government does not routinely analyze service delivery data to measure program performance ○ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☐ Results against targets ☐ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☐ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☐ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.00	Government does not analyze the treatment cascade on a routine basis.	Analysis is perfomred in the MoH units mostly during the elaboration of the Annual Operative Plan. This aspect should be a priority and it is now in process, in coordination with the GF, clinical records, process standardization.
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☐ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☐ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.27		There is a work format for MANGUA, a protocol to administrate data quality and an instrument to generate basic data. There is data quality control at entry level.
		Performance Data Score:	**6.38**	

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D