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Prospective Country Evaluation

Guatemala

2018 ANNUAL COUNTRY REPORT

Commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund

CIESAR
Salud Sexual y Reproductiva Para Siempre
IHME
PATH

DISCLAIMER

Views expressed in this report are those of the author. The author has been commissioned by the Technical Evaluation Reference Group (TERG) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to conduct an assessment to provide input into TERG's recommendations or observations, where relevant and applicable, to the Global Fund. This assessment does not necessarily reflect the views of the Global Fund or the TERG.

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Abbreviations

ASI	Asociación de Salud Integral
CCM	Country Coordinating Mechanism
CDC CAR	Center for Diseases Control in Central America
CEP	Country Evaluation Partner
CIESAR	Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva
CSW	Commercial Sex workers
CT	Country Team
EPA	Eligibility and Performance Assessment
FPM	Fund Portfolio Manager
GDP	Gross Domestic Product
GEP	Global Evaluation Partner
HRH	Human Resources for Health
IBBS	Bio-Behavioral Surveillance
ICEFI	Instituto de Estudios Fiscales
IHME	Institute for Health Metrics and Evaluation
INCAP	Instituto de Nutrición de Centroamérica y Panamá
KII	Key Informant Interviews
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MIS	Modelo Integral de Salud
MoF	Ministry of Finance
MoH	Ministry of Health
MSM	Men who have Sex with Men
PCE	Prospective Country Evaluation
NFM	New Funding Model
NGO	Nongovernmental Organization
NSP	National Strategic Plan
PAHO	Pan American Health Organization
PCE	Prospective Country Evaluation
PEPFAR	US President's Emergency Plan for AIDS Relief
PR	Principal Recipient
RCA	Root Cause Analysis
RSSH	Resilient and Sustainable Systems for Health
SEGEPLAN	Ministry of Finance and the Presidency Programming and Planning Secretariat
STC	Sustainability, transition and co-financing
SR	Sub-recipient
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
ToC	Theory of Change
TRP	Technical Review Panel
UAI	Integral Care Units
UNAIDS	Joint United Nations Program on HIV and AIDS
WHO	World Health Organization

Executive Summary

The Prospective Country Evaluation (PCE) is a novel approach to understand in depth the Global Fund processes at ground level and provide results in real time, as they are taking place. The PCE is tailored and focused to local needs. This principle allows for the production of country specific and actionable recommendations. Independent evaluators who report to the Global Fund Technical Evaluation Review Group (TERG) are responsible for conducting the PCE.

The Evaluation Framework is based on country priorities for the three Global Fund diseases, HIV, malaria, and tuberculosis. The PCE in Guatemala started in May 2017 and is implemented by the *Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva* (CIESAR) as the Country Evaluation Partner (CEP) in collaboration with its Global Evaluation Partner (GEP), the Institute for Health Metrics and Evaluation (IHME) and PATH.

The initial phase (inception phase) took place from May to September 2017 and was successful in priming stakeholders on the details of the PCE process and securing the level of cooperation and trust required from stakeholders in the Country Coordinating Mechanism (CCM), government, and technical partners. During this time, the team completed a comprehensive mapping of key stakeholders, established contacts with stakeholders, identified channels to access secondary data, and obtained approval from a certified ethics committee prior to collection of primary data.

The evaluation followed the inception phase, starting in October 2017. During this period, relevant qualitative information was collected from relevant stakeholders through key informant interviews (KIIs).A total of twenty stakeholders from various groups, including the CCM members (board, technical secretary and assembly), technical and government partners, and other closely related parties, were selected through a systematic process and interviewed. In parallel to KIIs, the PCE team continued to document the funding request process through observations of CCM meetings and assemblies, and review of relevant documents.

The findings of the present report will be specific to the August 2017 HIV funding request (window 3), which was ongoing at the time the PCE was launched. In October 2017, the Global Fund's Technical Review Panel (TRP), informed the CCM that the funding request was sent to iteration, an infrequent remedial event; during 2017, only 8.5% of funding requests were sent to iteration. The TRP Review contained 10 "Areas of Concern, Gaps and Weaknesses" to be addressed in the iteration. The findings described in the report focus on the process of the initial 2017 funding request,seek to better understand why it received an iteration outcome and describe responses to the iteration to date.

Context during the funding request process

The environment for the HIV funding request was complex due to many changing political and process factors converging during the time of the request. Firstly, approximately seven years had passed since the CCM was required to present a full-review funding request. Therefore, the 2017

HIV funding request was the first time many stakeholders experienced the New Funding Model (NFM) and the new application tools and templates. Prior Global Fund HIV grant performance remained relatively stable with grants receiving the following ratings:A1 - A2 (PR HIVOS 2015-2016), B1 (PR MoH 2013- 2015), and B2 from 2016 to the last rating in December 2017 as published in the latest Grant Performance Report (Dec. 2017). Even as the MoH experienced performance challenges in the last two years, the HIV program had remained stable and positive programmatic results had developed, such as substantial increase in ARV coverage compared to 2010.In addition, advances in HIV care coverage were achieved with the opening and operationalization of 19 HIV clinics (denominated Integrated Care Units - UAI in Spanish). Consequently, the CCM and country stakeholders felt confident that the funding request process would be straightforward.

However, at the time of drafting the 2017 HIV funding request, the prevailing political environment was unstable with numerous changes of the Minister of Health. Moreover, with each new Minister came newly appointed Vice Ministers and key staff. The HIV National Program underwent three changes in coordination, which stalled or delayed technical and financial-administrative decisions. For example, the HIV National Strategic Plan (NSP) was not approved during 2016 as planned, nor during 2017,as it required further technical work such as a lack of cost estimations for programmatic interventions, among other issues. It was not until February 2018 that the Ministry of Health (MoH) finally approved the NSP under the current Minister of Health.

Initial Findings

As requested by the TERG, the PCE focused on investigating the funding request and grant-making process during the first phase of the evaluation. The PCE found that although there were improvements seen by stakeholders on the New Funding Model application processes, the 2017 funding request faced technical, process and coordination issues, which led to an overall inefficient procedure and the outcome of a request for iteration. Country stakeholders emphasized the gaps in technical documentations, such as the NSP, which were missing and the void in specific gender and human rights expertise needed for a successful application.

The process for the HIV funding request was inclusive and transparent, as evidenced by attendance lists comprising more than 100 persons in initial meetings. However, attendance was inconsistent throughout the process and became increasingly limited as the funding request development proceedings were lengthy and required frequent meetings. At the end of the process, less than half of initial participants attended more than 50% of meetings. Participants were distributed into three working groups, which required close coordination, clear guidelines [as to expected outcomes] and follow up. Stakeholders reported that they did not receive clear guidance related to outcomes and tasks from the CCM. They claimed that board members were often not present during coordination meetings, reportedly due to issues related with full work agendas, lack of time, location of meetings and overall workload.

Furthermore, most stakeholders interviewed reported low engagement from the Ministry of Health specific to providing leadership on technical aspects and strategic decision making

related to the HIV funding request. The Ministry of Finance was also absent from key processes and discussions on budgeting for the development of the application.

A Country Dialogue preceded the drafting of the 2017-2021 NSP, which took place in August 2015 in two locations outside the capital city to facilitate attendance of diverse stakeholders, as well as two meetings in Guatemala City. It was a one-time event, and was followed by discussion in the CCM Assembly. It is unclear to the PCE team the extent to which the Country Dialogue provided inputs to the funding request process due to lack of evidence in this regard. A Country Dialogue report was developed, but there is no specific reference to the report during CCM meetings or KIIs. The report is listed as a reference for the NSP (Ref No. 46), but no specific inputs are mentioned in the actual plan. Stakeholders and document review pointed to strong participation by key and vulnerable populations in the funding request. Although there was strong participation by different key and vulnerable groups, there was a large technical gap relating specific strategies and approaches to address key populations in the submitted 2017 funding request. So it is quite possible that the participation of various population groups in initial discussions in fact had limited influence on the final funding request, which would represent a troubling outcome.

The role of technical partners in the funding request was perceived as useful and necessary as it became evident that the working groups were not generating technically sound deliverables. Technical assistance from partners helped to develop a more solid proposal, particularly for the iteration as they became a part of the iteration committee.

Summary of Key Initial Findings Statements:

Finding 1: The New Funding Model application process was found to be more streamlined, as fewer documents were required, but overall changes in the new application templates were not well known or understood by most stakeholders.

Finding 2: Technical, process, and coordination issues led to inefficiencies in the funding request development.

Finding 3: The NFM provided more flexibility to better address country needs, but also required a higher level of analysis and strategic planning that could not be met due to technical gaps.

Finding 4: Country stakeholders perceived the funding request process to be open, inclusive and transparent; however, sustained participation was a challenge, and notable gaps were identified regarding human rights and gender expertise.

Finding 5: Stakeholders perceived low government engagement during the funding request development.

Finding 6: The sustainability, transition and co-financing (STC) policy is new, but government and CCM stakeholders are in the early stages of addressing STC issues in Guatemala

Finding 7: There was strong participation from key and vulnerable populations in the initial phases of the application process; however, the differentiated strategies needed to address the specific prevention and treatment needs of key populations were not adequately addressed in the resulting 2017 funding request.

Root Causes

A root cause analysis was developed by the PCE team to illustrate the underlying causes of key process and challenges, which led to the iteration outcome. The following issues were identified as root causes, and are congruent with the findings mentioned above: 1) issues of country ownership, 2) the lack of a technically sound, costed and approved HIV National Strategic Plan, and 3) challenges with CCM leadership and coordination of the application process.

Iteration Process

In response to the request for iteration, the CCM, with guidance from the Country Team, undertook the following actions to improve the process and achieve approval of the iteration:

- Change in methodology from large work groups to a smaller, 18-member group, the Iteration Committee. Rules were established to communicate and provide feedback from stakeholders to the committee. The CCM Assembly agreed to delegate authority to the Iteration Committee to make technical decisions in a timely manner and prevent delays and misunderstandings within the CCM. In the prior modality, decision-making was difficult and slow.

- To ensure transparency, updates on the funding request were posted periodically online to make information publically available. Contributions from stakeholders could be sent via email for the Iteration Committee to consider and review.

- The CCM hired a new consultant (third in the process) with experience in Global Fund grants to compile, review, and organize contributions from the Iteration Committee and write the iteration application. Technical partners provided funds for consultants during the funding request process.

- Stronger involvement from the new Minister of Health and high-level authorities within the ministry has already proven helpful to advance the iteration.

- Inclusion of the newly selected Principal Recipient (PR) in the funding request process has been made mandatory, as absence of one of the PRs during 2017 funding request process was detrimental to the application.

- Balanced participation of technical partners and other stakeholder groups within the Iteration Committee.

- Use of lessons learned from the prior experience to streamline and improve the process and management of data.

Challenges and Opportunities for the PCE

Initially, the Guatemala CEP team encountered some challenges in gaining the trust of stakeholders and being invited to all CCM meetings. It was necessary to continuously engage with the CCM and other stakeholders to be included in the invitation list for all relevant meetings. The Global Fund Secretariat also provided support in facilitating initial discussions with the CCM and other stakeholders. The CEP team has built and maintained relationships with key stakeholders by cultivating rapport and following certain conditions, such as not including more than one consultant in CCM meetings, and always maintaining the role of objective observers.

The comprehensive mapping of stakeholders was an excellent way to start the PCE as it allowed the team the opportunity to better understand the ecosystem of players in the Global Fund processes. In addition, the stakeholder mapping exercise provided a natural introduction process for the CEP to the CCM board and assembly members. This process also allowed the team to set up preliminary interviews to sensitize key informants on the PCE and promote the first PCE workshop, which took place in August 2017. The inception report contains a detailed description of the mapping process.

Dissemination Workshop

The second PCE workshop took place on April 11, 2018 in Guatemala City with the purpose of disseminating findings to date. The workshop included the participation of 82 stakeholders, which included members from all stakeholder groups. The aim of the dissemination workshop was to provide stakeholders with updates on the PCE process, initial PCE findings, and provide a platform to receive feedback and recommendations moving forward. The workshop began with presentations by the GEP and TERG members, providing information on the evaluation methodology and global progress to date. Following these presentations, the CEP presented the key initial findings from the first phase of the evaluation. The workshop then transitioned into nine small working groups, which were structured to included representatives from various sectors, to discuss specific findings and provide input on the root causes and recommendations. Each group designated a facilitator and rapporteur to document the discussion and recommendations. At the conclusion of the workshop, each group presented their feedback regarding the key findings and provided recommendations moving forward with the PCE.

The nine groups confirmed the main findings and conclusions presented by the PCE. The working groups provided the following key feedback and recommendations:

1) Government representatives on the CCM need to have due authority to make timely decisions based on technically sound expertise.

2) There is a need for better balance on the CCM board of technical and non-technical participants, and for clear technical leadership in working groups.

3) There is critical need of a costed national strategic plan.

4) More expertise on gender, indigenous people, and human rights is needed.

5) Any changes made in the Global Fund application process require hands on training for stakeholders.

In terms of sustainability, the discussions focused on the government´s role and the need to assume financing of civil society organizations, which are currently dependent on the Global Fund. It was recognized that steps towards sustainability are nascent and the STC policy is relatively new to the country so results are not evident yet.

Chapter 1: Introduction and establishing the PCE

1.1 Introduction

Presently, Guatemala is implementing a Prospective Country Evaluation (PCE) of Global Fund grants. The PCE is an independent evaluation commissioned by the Global Fund's Technical Evaluation Reference Group (TERG). The TERG is an independent evaluation advisory group, accountable to the Global Fund Board through its Strategy Committee for ensuring independent evaluation of the Global Fund business model, investments and impact. The PCE aims to evaluate the Global Fund's business model, investments, and impact. By generating evidence in real-time, the PCE will inform global, regional, and country stakeholders on the progress towards meeting the Global Fund's Strategic Objectives: i) Maximize impact against HIV, TB and malaria; ii) Build Resilient and Sustainable Systems for Health; iii) Promote and Protect Human Rights and Gender Equality; and iv) Mobilize Increased Resources (1).

The TERG selected eight countries for the PCE: Cambodia, Democratic Republic of the Congo, Guatemala, Mozambique, Myanmar, Senegal, Sudan and Uganda. These countries were selected based on the following criteria: 1) grants in the three diseases; 2) long standing implementation and funding, i.e. Guatemala has implemented Grants since 2005 for more than $170 million; and 3) representative of a region in the world, i.e. Latin America. The TERG contracted three Global Evaluation Partners (GEP) for the eight countries. The consortium formed by IHME/PATH was chosen for Guatemala, Uganda and the Democratic Republic of Congo. In each country, the GEP selected a Country Evaluation Partner (CEP). In Guatemala, IHME/PATH selected the *Centro de Investigación Epidemiológica en Salud Sexual y Reproductiva, CIESAR,* a research center with more than 23 years of experience in the country, recognized for its work in research and evaluation of sexual and reproductive health initiatives.

This report describes the progress made to-date on the PCE and initial findings of the 2017 HIV funding request process, which was sent to iteration by the Technical Review Panel (TRP) in October 2017. During 2017, the Global Fund Secretariat received 165 new funding requests. Of these, 151 (91.5%) were recommended for grant-making and 14 (8.5%) were sent for iteration. Of the 14, eight were revised and then recommended for grant-making; six were in progress as of February 2018 (2).Guatemala submitted the iteration on February 7, 2018.

1.2 Country Background

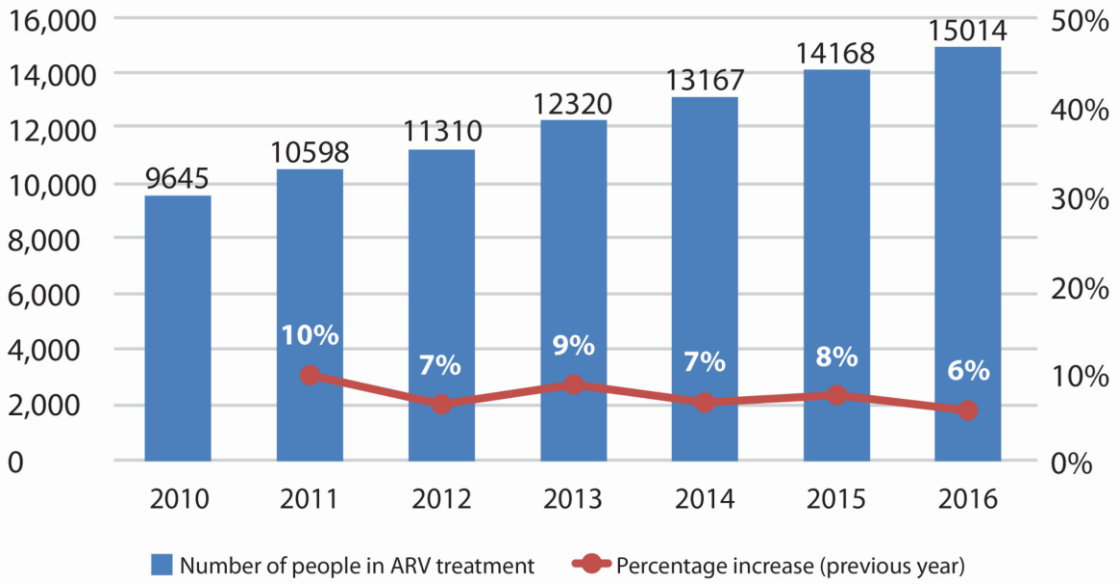
With nearly 17.3 million people estimated for year 2018 (3), Guatemala has the largest population in Central America and a diverse cultural heritage that includes 25 sociolinguistic groups. Classified by the World Bank as a low middle-income country, it has been one of the strongest economic performers in Latin America in recent years, with a GDP growth rate of 3.0 percent since 2012(4).Nevertheless, the country bears some of the highest inequality rates in Latin America, specifically within measures of poverty, malnutrition, and maternal and child mortality, which are particularly pronounced in rural and indigenous populations. Government figures also indicate an increasing trend in poverty rates, with a reported 59.3% in 2014 and even higher rates among indigenous populations (65.7-66.4%)(5).In addition, of those living in poverty, 52% are indigenous. Women tend to be poorer and are disproportionately less likely to

own land in comparison with men. The prevailing patriarchal culture influences customs and attitudes. For example, women are often excluded from inheriting land, and in most families the male head of household makes all major decisions concerning land-use, health, and finances (6–8).

An equally important shift has been a steady national progress towards equitable access to health and education services. Since the signing of the Peace Accords in 1996, Guatemala has seen a decrease in the primary education gender gap, increased access and utilization of primary health care services, and a private sector that is more engaged in social development.

The country has also seen advances in reducing the burden of the HIV/AIDS, malaria, and tuberculosis epidemics (9,10). Access to care and treatment has improved since the opening of HIV Integrated Care Units throughout the country (UAI). Consequently, the number of persons in ARV treatment has increased steadily since 2010, exhibiting a fluctuating annual increase between 10% in 2011 to 6% in 2016(Figure 1).

Figure 1. Number of persons in ARV treatment and annual increase



Source: Ministry of Health, cohort 2010 to 2016 Guatemala, taken from iterated funding request

Since 2004, Guatemala has received support from the Global Fund to fight AIDS, tuberculosis and malaria. The first Global Fund award (2004-2010) was for HIV and administered by World Vision as the Principal Recipient (PR). One year after the HIV grant was approved, the Global Fund approved a grant for malaria and two years later, a grant for tuberculosis. All initial grants had the same PR, World Vision, who decided not to participate in the next grant application in 2010. Two new PRs were then selected: HIVOS (Humanist Institute for Cooperation with Developing Countries) and the Ministry of Health (MoH) for the following period, which ended in September 2016. Guatemala was granted a 15-month extension until the end of 2017 through a simplified concept note application process. The CCM submitted a funding request in window

3, to be presented in August 2017. A summary of the Global Fund grants in Guatemala is shown in Table 1 below.

Table 1. Summary of prior and active Global Fund grants in Guatemala

Disease	Stage/ Classification	Start Date	Principal Recipient	Total Amount (USD) Signed*	Total Amount disbursed (USD)	Status
HIV/AIDS	Concentrated Epidemic	2004 2010 2011 2018 2018	WV HIVOS MSPAS HIVOS INCAP	41.1 million 46.2 million 35.4 million 4.9 million 14.7 million	41.1 million 45.5 million 29.5 million 1.7 million Pending	Closed In Closure In Closure Active TRP approved
Malaria	Seeking elimination	2005 2011 2018	WV MSPAS MSPAS	12.7 million 29.2 million 5.8 million	12.7 million 23.6 million Pending	Closed Active Iteration
TB	Concentrated in vulnerable populations MDR cases	2007 2010 2016	WV MSPAS MSPAS	3.5 million 3.4 million 6.5 million	3.5 million 3.4 million 2.0 million	Closed Closed Active
Total		**11 grants**		**203.4 million**	**163.0 million**	

Source: The Global Fund Website/GRANTS / Guatemala

*Or allocated for unsigned grants

Another important contextual factor to be considered in the case of Guatemala is the political instability, exacerbated in 2015 when a major corruption scandal caused a drastic change in the highest authorities of the government. The Ministry of Health was affected by the political swings, undergoing several changes in leadership in recent years, the last one occurring in August of 2017.In the aftermath of the government crisis, the MoH faced a serious "financial paralysis" that affected execution of ongoing grants.

Furthermore, during 2016 and until August 2017, the MoH launched a new model, focused in primary health care in rural communities (first level of care). The design of the *Modelo Integral de Salud*, MIS, was not akin to national programs organized by disease; thereby not much support or attention was provided to Global Fund projects implemented under HIV, malaria and TB programs. During this time, a suboptimal performance of national programs occurred and financial execution dropped to unprecedented low levels. Stakeholders interviewed for this evaluation perceive that the current Minister of Health, who came after the former resigned, has a different perspective and has proved supportive of national programs and Global Fund grants. It is expected that under this new leadership, the performance of grants will recover.

1.3 Establishing the PCE at country-level

The Guatemala PCE was launched in May 2017 with a five-month inception phase for planning and designing the PCE, although preparatory activities had been occurring since February 2017. CIESAR assembled an evaluation team comprised of professionals with expertise in public health, anthropology, quantitative and qualitative research, M&E, Global Fund initiatives, finances, and communications. To gain an understanding of the general landscape, CIESAR explored the history of Global Fund activities within the three disease areas, and mapped key stakeholders.

Determining Priority Evaluation Questions

A consultation workshop was held August 5, 2017, which brought together 44 experts from all sectors[1] previously recorded in the stakeholder mapping: MoH, key and vulnerable populations, technical partners, and representatives from the Social Security Institute, the private sector and the Global Fund Country Team (CT). The purpose of the workshop was to solicit stakeholder feedback in identifying priority evaluation areas for the PCE in Guatemala. Country-specific questions were developed in a participatory manner through the workshop, focusing on identifying implementation challenges and bottlenecks related to the three disease areas within four main thematic domains: 1) Grant-making process; 2) Implementation challenges and impact; 3) Finance & sustainability; and 4) Governance/partnership. Through an iterative process between IHME/PATH and CIESAR, evaluation questions were developed, refined, and mapped on to the Global Fund's strategic objectives. Preliminary questions were grouped into broad themes, each with numerous embedded sub-questions. The team also examined where the proposed questions fit into a Theory of Change (ToC), which the PCE consortia are using to guide the overall evaluation, to ensure the proposed questions were relevant to the Global Fund business model, and determine where the questions aligned with four key thematic areas of interest: partnerships, value for money, country ownership, and sustainability. The global ToC is described in the annexes of this report. The identified country-specific questions were then combined with prioritized evaluation questions from the PCE framework to have a common basis to compare with other PCE countries.

Protocol Development and Internal Review Board (IRB) Approval

In October 2017, the evaluation phase was officially launched. IHME/PATH and CIESAR developed an Evaluation Protocol for the PCE and submitted it to an independent ethics committee (what is known in other countries as IRB) for approval. The Latin American Ethics Committee granted the approval in mid-November 2017, including approval of the Informed Consent form to conduct key informant interviews. The Evaluation Protocol was subsequently submitted to the National Ethics Committee of the Ministry of Health, which also approved the evaluation protocol.

[1]Invitation to the workshop was broad and included more than 60 stakeholders to ensure representativeness.

Advisory Panel

In September 2017, CIESAR proceeded to establish an Advisory Panel to provide guidance and expertise to the PCE. The Centers for Disease Control and Prevention in Central America (CDC CAR), renowned for its work in HIV/AIDS in alliance with PEPFAR, and *Asociación de Salud Integral* (ASI), a pioneering, high-level association for HIV, accepted the invitation to become Guatemala´s PCE Advisors. Both organizations have had a long-standing working relationship with the CIESAR team and fulfilled the terms of reference provided by the TERG. Criteria to select the Advisory Panel were the following: a) proved expertise in the three epidemics; b) renowned and respected organization; c) complementary disciplines in the group; and d) long trajectory and knowledge of the Global Fund grants. The Advisory Panel is comprised of local members from the CDC CAR team and ASI. The expertise of the group covers a range of fields, from public health and HIV to laboratory, strategic information systems (for the Central America region), health economics, care and treatment, tuberculosis, and opportunistic infections.

On March 22, 2018, the Advisory Panel and CIESAR held its first meeting to review preliminary PCE findings. The PCE progress to-date is summarized in Table 2 below.

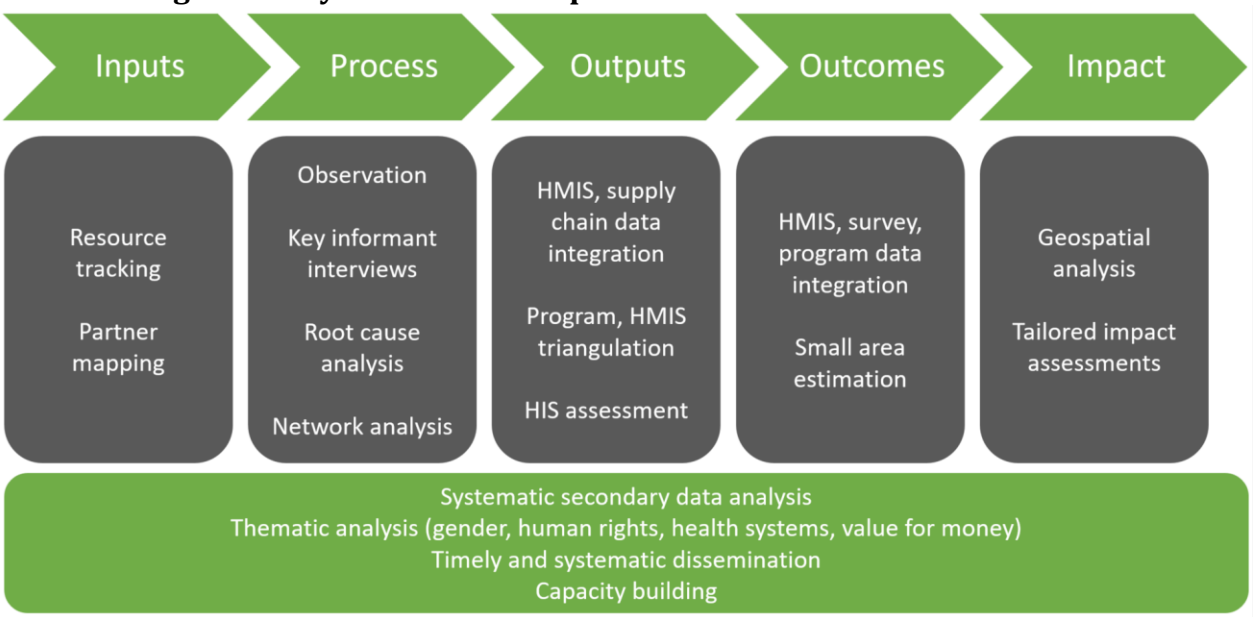
Table 2. Progress PCE Guatemala to February 2018

2016-2017	Prep phase	Administrative agreements between CIESAR & IHME Initial resource tracking, mainly publications & documents
2017	Inception Phase	Launch of PCE
May		Initiation of contacts with CCM & specific HIV Stakeholders
Jun-Jul-Aug		Stakeholder engagement and mapping Observations of meetings & recording details of HIV funding request process
Aug		CE Workshop: Consensus with Stakeholders on country specific Evaluation Questions
Sept		Consortium meeting for analysis of Inception Phase Establishing of Advisory Group
Oct	Evaluation Phase	Design and validation of Key Informant Interview Instruments based on Evaluation Questions
Nov		Key Informant Interviews Transcription and codification (software)
Dec		In-depth analysis of all qualitative data using PCE analysis matrix
2018 Jan		Data aggregation and collection Consortium Workshop in Guatemala: data analysis and drafting presentation of findings for upcoming TERG meeting in Geneva and Annual PCE Report
Feb		Full Launch of Partnership Network Survey Focus on malaria funding request component Implementation of Dissemination Plan (2 strategies)

Chapter 2: Evaluation framework and methods

The PCE is utilizing an evaluation framework to track events as they occur and measure the four Global Fund strategic objectives for 2017-2022. The framework provides a conceptual model describing the processes and causal mechanisms that lead from investments and inputs to outputs and coverage, outcomes, and eventually impact on these three diseases (Figure 2).

Figure 2. Key evaluation components across the full results chain



The focus of the first six months of the PCE was to identify challenges, bottlenecks and positive aspects of the Global Fund funding request process. The timing of the PCE and the initial HIV funding request process was such that the CIESAR team was able to investigate the first HIV funding request submission and capture initial reactions and plans to respond to TRP review. Although the initial findings focus on the HIV grant application, elements of the malaria and TB grants were also tracked and observed.

To allow systematic, efficient synthesis of findings, the consortia developed an evaluation framework for the funding request evaluation. This framework includes key propositions (statements that set out intended benefits and outcomes expected if the funding request and grant-making process is implemented as expected in Global Fund documentation) and associated sub-questions that have been evaluated in six PCE countries. Prior to key informant interviews (KII), instruments were tested with selected stakeholders. Following this, instruments were adjusted and tailored to current contextual factors. The result of this process was a set of 17 sub-questions, distributed across four overarching "propositions:"

1. Changes in the grant application and review process (for the 2017-2019 funding cycle) enabled a more efficient and streamlined process, reduced transaction costs, and allowed more time to be spent on grant implementation and program quality compared to previous application processes.

2. A transparent, inclusive and country-led process is in place to confirm the program split, the funding request approach, and PR selection. The Country dialogue is ongoing.
3. There is a stronger focus on sustainability, transition and co-financing (STC) compared to previous funding cycles and application processes.
4. There is a stronger focus on key and vulnerable populations, human rights, and gender compared to previous funding cycles and application processes.

As instructed by the TERG, this initial phase of the evaluation focused on the funding request. At the time the evaluation started, the HIV funding request was to be submitted in window 3 and the other two diseases had not begun their funding request process. For this reason, the selection of respondents prioritized stakeholders who participated in the HIV funding request process.

The methodology used was predominantly qualitative, including observations, stakeholder consultations, and KIIs, supported by documents such as CCM minutes, National Strategic Plan, the funding request and others listed in the references. The initial work in quantitative research was focused on preliminary analysis of secondary data obtained to-date.

For the selection of the respondents, the evaluation team took care to assure that the sample was representative of all stakeholders who participated in the HIV funding request. The final sample consisted of 21 respondents in 20 interviews, a number considered appropriate based on the saturation achieved halfway through the process; after 12 KIIs, respondents were not providing additional information. The criteria to select key respondents were the following:

- Participation in the 2017 HIV funding request. As a measure of participation, CIESAR reviewed attendance at the work groups, rating it from high to low; those who had consistent attendance were chosen over persons who attended work groups irregularly(11).
- Availability to be interviewed in the period required.
- HIVOS (the PR) and members of the Local Fund Agent (LFA) were also included as key informants, even though they did not play a major role in drafting the funding request.

Table 3. Summary of Qualitative Methods of PCE

Method	Target Audience/respondents	No.
Stakeholder Consultations & Meetings:	CCM Selected technical partners National Program Grant Coordinator and financial assistant	8
Stakeholder Workshop	National Programs, CCM, KP sector representatives, technical partners (USAID & CDC), private sector representative	1 WS 44 pp
Observation of Meetings	HIV funding request preparatory & work meetings CCM Assemblies PR Selection process Global Fund Country team visits	38

Key Informant Interviews	Selected KI from Stakeholders Map, with representation of all sectors that comprise CCM Assembly: CCM Tech Secret & Board; PR HIVOS &Sub receptors (who represent key population sectors); MoH & Technical Partners Global Fund Secretariat Interviews	**20**

All interviews, which lasted approximately two hours, were audio recorded and transcribed. Transcripts were coded: coding correlated to Evaluation Questions, but codes were also assigned to emergent topics that were not originally considered, such as perceived problems regarding purchase of supplies[2]. The quality of information was appraised by comparing responses across different types of stakeholders and cross-referencing with observation notes and CCM minutes, when available. Given that observations were addressing diverse issues occurring at the time, they were not always relevant to the Evaluation Questions. In this phase, the opinions of respondents are not always supported by documents, which should not disqualify the information obtained in the interviews. Given the PCE design and prospective nature which allows for flexible, and adaptive data collection, the depth and breadth of the evidence will vary across findings, which is addressed through the strength of evidence ranking.

In joint review of the data, CIESAR and IHME/PATH assessed and ranked the quality of the evidence against each key finding using a 4-point Strength of Evidence Ranking (Table 4), where 1 is the strongest evidence and 4 is the weakest. In the case of Guatemala, most rankings were 1 or 2; if ranking was 3 or 4, the CEP will continue to seek additional sources of evidence or discard the finding.

An analysis workshop between CEP/GEP was held in Guatemala City in mid-January 2018 to review the initial findings and assess data robustness and strength of evidence to support each finding. During this workshop, detailed evidence tables were created, pulling in data from the document review, observations, and KIIs. The evidence tables include succinct summaries of responses for each stakeholder plus document or observation data where applicable. These tables were used to assess patterns of convergence and divergence in the data, and ultimately to determine preliminary finding statements. Strength of evidence was rated according to these criteria: triangulation and quality of the data.

> Triangulation: refers to the breadth and depth of qualitative and quantitative data sources. Greater triangulation across multiple sources (different stakeholders or different data sources: interviews, reports, surveys, observations, minutes, etc.) equates to stronger findings. It is noted that many evaluation questions related to the funding request process are inherently perception-based. However, these findings can still be considered strong if they are supported by well-triangulated data across stakeholders and other evidence from document review and meeting observations.

[2]Initial coding began with pre-set codes. Preliminary data analysis provided codes that emerged from interview transcripts. These "emergent codes" are those ideas, actions, relationships or meanings that come up in the data and are different than those originally considered. In addition, as data are coded, the coding scheme will be refined, collapsing or expanding coding categories, especially the pre-set codes. The rule of thumb for coding is to make the codes fit the data, rather than trying to make data fit the set codes.

Quality of the data: High-quality data contribute to greater strength of evidence. Several indicators of quality were used in qualitative data, including recentness (for example timing of KII relative to the topics discussed to minimize recall bias); conditions of an interview (includes rapport with the respondent, appropriate pacing, interruptions, appropriate level of privacy for interview); and degree of proximity to topic or event in question (first-hand observation by the evaluation team or a respondent's first-hand experience participating in the funding request or grant making process vs. second-hand information).

The evidence tables include a few notes assessing qualitatively the strength of the evidence related to each sub-question. It was ranked using a four-point scale as a general guide for ranking findings and describing the rationale behind the ranking (Table 4). The evaluation team underwent a validation process, which included adding additional data to the evidence tables. Findings were further supported through triangulation with global-level interviews.

Table 4. Criteria for Ranking Strength of Evidence of PCE Key Findings

Ranking	Definition
1	The finding is supported by multiple data sources (good triangulation), which are of strong quality.
2	The finding is supported through (moderate triangulation) by multiple data sources of lesser quality, or by fewer data sources of higher quality.
3	The finding is supported by few data sources (limited triangulation) of lesser quality.
4	The finding is supported by very limited evidence (single source) or by incomplete or unreliable evidence. In the context of this prospective evaluation, findings with this ranking may be preliminary or emerging, with active and ongoing data collection to follow up.

Study Limitations

Findings from the PCE should be interpreted in the context of this evaluation and its prospective nature. As opposed to a retrospective evaluation, since its inception, the PCE was designed as an evaluation that moves forward in time while the countries implement different activities. This will allow the provision of feedback closer to the moment when activities take place, but also means that the PCE concentrates on the activities that are more relevant at a given point in time, in this case the elaboration of the funding proposal for HIV in Guatemala. However, the PCE is moving towards the evaluation of other activities and impact evaluation in the future.

Another important feature of the PCE that should be understood - linked to the broad aim of conducting a process and impact evaluation - is the use of quantitative and qualitative methodologies. The qualitative methodologies used in the process evaluation so far attempt to triangulate information from different sources (KIIs, observations, document review).It should be clear that stakeholders participating in different activities, in this case the preparation of the funding request, might experience a conflict of interest. This problem is unavoidable, since

participant stakeholders are the ones who can provide richer information. The PCE has tried to capture the diversity of stakeholders and describe the findings in this report while preserving the confidentiality of the information. As such, the information coming from KIIs should be interpreted in light of possible conflicts of interests.

Another limitation of this analysis is a potential recall bias, especially about the comparison of the most recent funding cycle to previous funding cycles, the last of which was seven years ago. Although the reporting of some details can be affected, we expect this bias will not influence the most relevant issues of the funding proposal process.

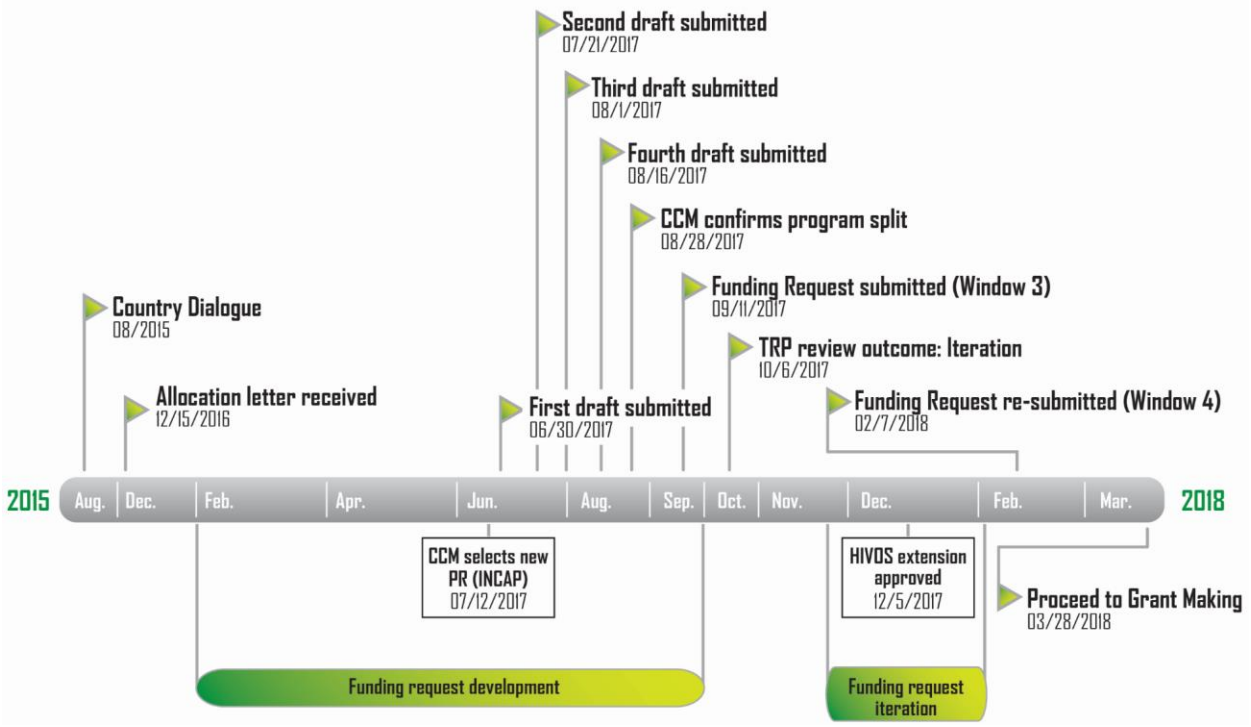
Chapter 3: The Global Fund Business Model in Practice

3.1. Funding request and grant-making processes

The Global Fund introduced changes to the overall funding request, review, grant-making and approval process for the 2014-2016 funding cycle. These changes were designed to increase flexibility to address country needs, improve efficiency in accessing funds, and allow for more time on implementation of existing grants. Guatemala's last Global Fund HIV application was in 2010 through a Rolling Continuation Channel, which extended through 2017. Therefore, the current HIV funding request was the first time most stakeholders experienced the New Funding Model (NFM). During the recent funding request and grant-making process, Guatemala went through significant political changes that affected overall functioning of the government and particularly the Ministry of Health. This socio-political environment has influenced Global Fund processes and provides context to the key findings included through the prospective evaluation.

This report focuses on the most recent HIV funding request, which did not receive approval upon first submission and underwent a second iteration (TRP review: Iteration). The timing of the PCE has allowed for review and analysis of both the funding request submitted and preliminary observations on the iteration processes. The iteration was submitted on February 7, 2018, and was approved on March 28.

Figure 3. Guatemala HV funding request Timeline



3.2 Country Dialogue

The Country Dialogue was held in August of 2015, in three different locations a novel modality to reach out to stakeholders residing outside the capital and spread around the country: Zacapa (east), Retalhuleu (south) and Guatemala City. The purpose of the Country Dialogue was to help reach agreements between the diverse groups of stakeholders regarding how to best respond to the HIV epidemic. In addition, the data collected and stakeholder inputs from the Country Dialogue were incorporated into the revised National Strategic Plan. Although the event was held as a one-time occurrence, stakeholders reported that it successfully captured the contributions and insights from most of the country stakeholders. After the main event, the Country Dialogue transitioned to a continued discussion between stakeholders during CCM Assemblies, and related meetings and workshops, including the work groups with the purpose of drafting the funding request.

3.3. The HIV Grant

The CCM Board invited the Assembly to begin working on the new HIV funding request following the invitation letter sent on December 15, 2016 by the Global Fund. The HIV grant under implementation was to be finalized in December 2017. The differentiated funding approach determined that Guatemala should present a Full Review request, given that strategic priorities needed to be comprehensively reviewed for the upcoming funding cycle. The funding request process was slow to start and there was a lag between receiving the allocation letter and initial work by the CCM. By January 30, 2017, the CCM called for an Assembly and informed that the National Strategic Plan was still in progress, as informed by the Technical Vice Minister of Health. The funding request was dependent on the NSP to be ready as established by the

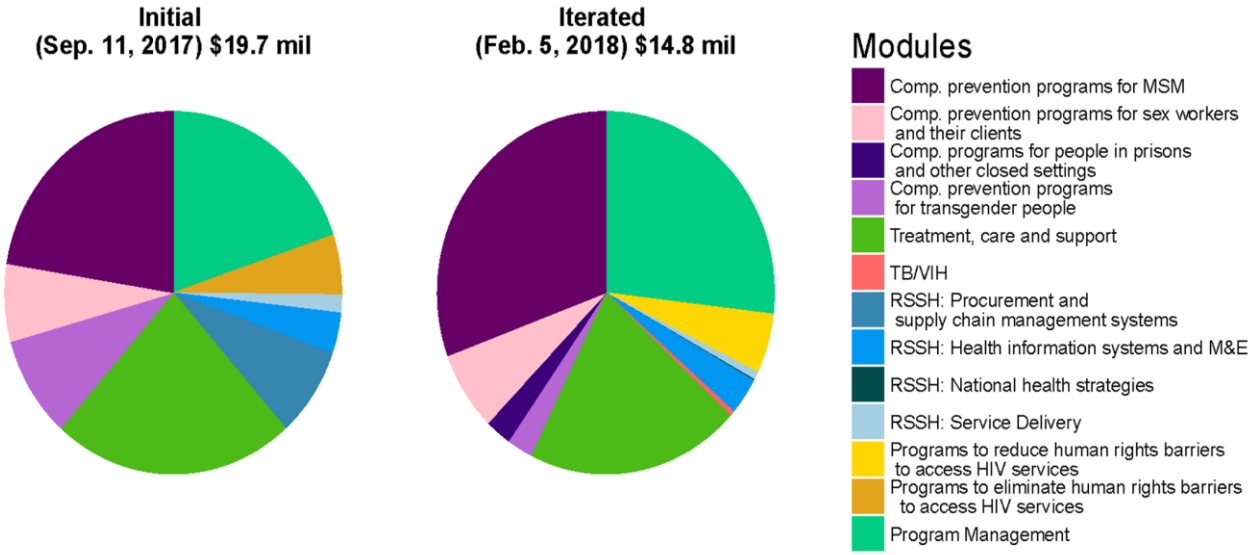
Global Fund. The funding request process did not advance during the subsequent two months awaiting for the NSP to be costed and more robust so it would be approved(12).

These series of delays caused the actual work on the funding request not to start until April 2017, with the NSP still pending approval. The NSP was finally signed by the Minister of Health more than a year after the first draft was published in October 2016.Furthermore, despite the considerable effort involved, by mid-May the working tables were not able to produce detailed strategies, as noted in the CCM minutes(13).

Additionally, the PR selection was late and further encumbered the funding request process, as described above. Due to the late PR selection, a majority of the funding request was developed without the PR's technical input. During this process, there was also a change in the Country Team. Even though the transition was considered prompt and efficient; it necessarily entailed a learning curve and adaptation from both sides (CCM and CT).

Figure 4below displays the allocation of resources in the HIV grant, comparing the initial submission and the iterated funding request. Resources in this figure have been categorized according to the modules as listed in the corresponding detailed budget.

Figure 4. Resource Allocation in Initial and Iterated HIV Budgets



Note: The total amounts ($19.7 million vs. $14.8 million) differ mostly because of the shortened time frame of the iterated budget. The initial submission spanned January 2018 to December 2020, while the iterated budget spans January 2019 to December 2020. The budget amount in 2018 corresponds to the extension of HIVOS as the PR for one more year.

3.4 HIV funding request Process: Key Findings

The PCE analysis of the funding request processes followed the PCE Evaluation Framework, organized by the four propositions described above. Unless specified otherwise, the opinions and statements presented in the findings below come from interviews with key stakeholders, meeting observations, and document review. Evidence utilized in this report is summarized in the methodology section above.

Finding 1: The New Funding Model application process was found to be more streamlined, as fewer documents were required, but overall changes in the new application templates were not well known or understood by most stakeholders. The local CCM raised awareness of the changes early on and provided direction on the NFM, including strategic objectives. However, according to several stakeholders, detailed information on the new templates and how to fill them out was not disseminated clearly among all stakeholders when working groups began their discussions. As approximately seven years passed since the last full HIV application, this was the first time many stakeholders experienced the NFM approach. The CCM distributed a simplified version of the templates among working groups, so that only a few stakeholders were actually involved in filling the application templates(14).Stakeholders reported a different approach was observed later on during the malaria Country Dialogue in November 2017, where the forms to be used in the Funding Request were explained and a table was presented detailing which forms had to be submitted at specific times (15).

Those participating in the technical committee acknowledge that fewer documents were required in the new funding request cycle. For them, the new templates were more logical as they connected activities to specific outcomes, but more challenging to complete as they required the integration of numerous strategies and activities. The budgeting formats were found to be especially complicated.

> *"I like the new formats better because I find them more logical… before the focus was mostly on activities and several organizations had trouble going from activities to a logical sequence of cause and effect. So, for me, the new model demands a better definition of strategies to achieve desired effects, not only what, but also how."* ***KII, Technical Partner and member of the technical committee***

Strength of Evidence: (Ranking =2)

The finding is consistently supported across key informants regarding the preparation process of the 2017 HIV funding request, but most information comes from a few KIIs and application documents. Data quality is strong, as respondents had good, first-hand knowledge, but triangulation was limited due to few respondents who were directly involved in use of the new forms.

Finding 2: Technical, process, and coordination issues led to inefficiencies in the funding request development. All stakeholders stated that lack of clear instructions for working groups resulted in products that were not technically sound as early discussions tended to digress on tangential issues. Consensus among key populations was hard to reach across

representatives. The products coming out of these discussions were not useful for the consultants hired to draft the funding request. Interviews, observations and minutes from CCM meetings evidence a failure to grasp the technical side of the funding request and how the Global Fund would fit into the national response.

Stakeholders mentioned a gap in the leadership of the CCM during the funding request process, exacerbated by the political instability of the MoH at the time. As a consequence, participation in the working groups started to dwindle, products lacked technical definition and the budget was not even discussed. Moreover, crucial decisions were not taken in timely fashion.

> *"The job of the CCM is to lead and coordinate, not to act solely as an administrator of resources."* ***KII, Technical partner stakeholder***

> *"The problem was that the leadership was not well defined. Since the beginning, the role of the working groups was not laid out and neither was the role of the technical committee that was going to provide support. A lot of time was lost because sometimes the discussions were about the MoH situation and not necessarily about the funding request. "****KII, Key population stakeholder***

> "*The Global Fund wants a participative funding request and it assumes the CCM has the necessary leadership, but it does not. Moreover, the Global Fund expected the CCM to accomplish its mission, to exercise true leadership, but it didn´t happen."* ***KII, Civil Society Stakeholder***

Efficiency was further compromised by the high turnover of consultants. The first consultant responsible for the first draft was unable to complete the job failing to meet a critical deadline(16). For the third draft, two additional consultants were hired with a non-approval of the funding request, which was sent to iteration. The CCM hired a fourth consultant to lead the iteration. The transition of consultants during the process further delayed the process, as each new consultant needed time to get onboard and rekindle the process.

Due to poor understanding of the changes in the funding request and the lack of clear guidelines, stakeholders felt the process had been inefficient and required more time and resources than previous processes. In addition, there was insufficient strategic focus to achieve impact of the HIV response of the country, as stated by the TRP. Participants in the overall process considered the funding request was slower, not necessarily due to the changes brought in by the NFM, but due to incomplete guidance.

Some stakeholders reported that the process for creating the new funding request budget was too complicated, even though the CT provided guidance and asked for wider participation from stakeholders who were in absent from the process in July 2017. Suboptimal supervision from the CCM and lack of accountability on the consultants' work resulted in failure to effectively budget the funding request. The Global Fund Secretariat suggested to the CCM to request assistance from the finance officer of the Ministry of Health PR team to complete budgeting of the funding request.

CCM Board

Stakeholders reported that the CCM board had lost leadership in recent years. According to most respondents, the CCM board has become dysfunctional, with members consistently missing meetings. Even members of the CCM board interviewed for this evaluation agreed on this assessment.

Stakeholders called into question CCM functionality, claiming leadership and coordination were poor throughout the funding request process, noting that members of the Board were too busy in their full-time jobs, paying little attention to the CCM in general and the funding request in particular; others complained that their representative in the CCM assembly rarely consulted or communicated decisions already taken. The situation is not new. For example, in the orientation workshop provided to new members of the CCM elected in 2016, it was noted that out of the five members of the Board, four attended the first day, three the second day, and one of the members never attended. Comments from Board members confirmed that this person "seldom attended meetings."(10)Dissatisfaction was mostly aimed at the CCM board, but also aimed to the elected representatives of the CCM assembly. Many stakeholders did not feel represented, lamenting that their elected representatives failed to share information to the rest of members of their sector.

During the recent funding request process, most stakeholders lamented that the CCM Board's inattention led to poor planning and coordination of the working groups. It also failed to provide adequate guidance and follow-up to the consultants, upon whom were placed unrealistic expectations. Other factors impacting the CCM functionality were a poor relationship and communication with MoH decision-makers and the absence of an approved NSP to steer internal discussions. In the new iteration, stakeholders have reported improved communication with new MoH high authorities as there is new leadership following the prior Minister's resignation. The Global Fund has communicated the CCM that an Eligibility and Performance Assessment (EPA) should take place in the short term, conducted using the standard process to assess the CCM eligibility requirements and performance. Given the evidence that the CCM needs to be reformed, the Global Fund has also announced that it could finance extensive technical assistance to conduct an in-depth reform of the CCM should this approach be decided upon by the CCM. On March 19, 2018, the CCM agreed for a profound reform of the CCM followed by a standard EPA.

Strength of Evidence: (Ranking =1)

The finding is consistently supported across key informants across multiple stakeholder groups regarding the preparation process of the 2017 funding request. Additional document review of working group attendance records and meeting observations provide strong triangulation for this finding. Data quality is strong, and KII respondents were well informed as they participated directly in the 2017 funding request process.

Finding 3: The NFM provided more flexibility to better address country needs, but also required a higher level of analysis and strategic planning that could not be

met due to technical gaps. Several stakeholders acknowledged improvements in the new funding request planning tools, which supported alignment between activities, outcomes, and targets. However, there were critical challenges with the quality of the data, i.e. data is not disaggregated by Key Population, a national strategic plan not yet approved, and turnover of supporting consultants that hindered the ability of stakeholders involved in the funding request process to fully utilize the new flexible model. Specifically, there was difficulty in obtaining and integrating available data on HIV from the MoH and other key partners. Although data from technical partners existed, it was not always provided in a timely manner due to the lack of a shared data management system(17). Consequently, these issues impeded evidence-based strategic planning, especially for key populations.

As stated by the TRP, the funding request had gaps in the proposed interventions to achieve ambitious goals in a context where there has been little progress in the national HIV response towards reversing the epidemic. A great concern expressed by the TRP, as well as technical partners, the MoH, and the CCM, has been the suboptimal achievement of results of the treatment cascade for second and third 90 goals, which was nevertheless not well addressed in the funding request.

Strength of Evidence: (Ranking =1)

The finding is consistently supported across key informants and complementary information on the consultants and observations and CCM minutes, as well as the TRP revision.

Finding 4: Country stakeholders perceived the funding request process to be open, inclusive and transparent; however, sustained participation was a challenge.
Stakeholders reported that an open invitation was sent to all sectors and organizations working in HIV. Early in the process, more than 100 stakeholders participated in three working groups in approximately thirty sessions between April and August of 2017. The three working groups were the following: 1) Incidence and Human Rights, 2) Prevention, and 3) Care & Treatment. The topics of M&E, budget and sustainability were crosscutting to all three working groups. The CCM had originally planned for only two groups, but representatives of the key populations requested an additional group to address human rights(18).

Observations and CCM minutes indicate that the working groups included representative experts from a diverse body of governmental and non-governmental sectors under the coordination of the CCM. Although there was broad representation across sectors, inconsistent participation by persons who could make technical and administrative decisions hindered progress. Rotation of persons sent to replace prior ones was not conducive to cohesive work within the groups. A review of the working group attendance records showed that only a handful of stakeholders participated in most of the working sessions and meetings; several respondents complained that it was difficult to give continuity to each work session when participants were not aware of the advances already in place. Stakeholders also perceived an urban bias, as stakeholders outside Guatemala City were scarcely represented (no stipends were available for travel and lodging).Respondents across the groups also expressed that they felt participants

were not as committed to the process as in previous years and were more concerned about securing funding for their own causes than reaching consensus on national priorities.

Participation from the public sector was limited to the MoH. Key government ministries such as the Ministry of Finance and Planning Secretariat were not present, although they were invited by the CCM. Human rights, gender, and indigenous experts were also absent in the work groups.

> *"The process was inclusive. The report was socialized to all sectors. There was an intentional effort to have all sectors represented, but key populations lack sufficient technical expertise and their attendance was erratic due to work related obligations…these factors affected the continuity of the funding request process."* ***KII, Technical Partner***

> *"The process was very centralized in Guatemala City because it was led by organizations with offices in the capital, which influenced an urban perspective of proposals. Key Populations from sites outside the capital are not present in the final stages when critical decisions are taken, so the urban-capital city vision prevails over rural areas."* ***KII, Civil Society Stakeholder***

Although the funding request process was seen as inclusive, the TRP questioned the gaps regarding human rights, gender and indigenous populations expertise. For many stakeholders, the first two sectors were well represented in the working groups. They mentioned that gender and ethnicity are crosscutting issues and were not directly addressed. The TRP raised issue with the lack of consideration for programming needs for indigenous women and girls and MSM. For example, issues of HIV and its relationship with violence against women were not included in the initial submission. In response, the HIV iteration includes components to address stigma against women mainly through advocacy and community mobilization. Interventions to reach women in a context of violence are proposed to be achieved by lobbying for better legislation and effective implementation, including scaling up of care and treatment for women and girls in general, indigenous women and girls, and women living with HIV.

Most stakeholders did not question the transparency of the funding request process. Stakeholders reported that they felt they were included and understood the steps taken throughout the funding request. The PR selection process was debated and several stakeholders found it controversial, but not lacking in transparency.

Strength of Evidence (Ranking = 1)

Strong triangulation was found across high-quality data sources (KIIs, document review, invitation letters, meeting observations, letters sent to the CT regarding the PR selection process, and CCM minutes). Bias of specific stakeholder groups were considered and taken into account during analysis related to PR selection. Among KIIs, there was strong convergence across multiple types of stakeholders. Data is considered high quality and from informed sources.

Finding 5: Stakeholders perceived low government engagement during the funding request development. At the time the funding request was being prepared for its submission (window 3), there were profound changes going on in the MoH: the NSP was still requiring a substantial revision, the MoH announced it would not continue as a PR, and most efforts were going into a primary health model. According to most stakeholders, lack of political will and engagement from higher authorities within the MoH were the main reasons for inadequate participation and country leadership. As expressed in a meeting in the CCM offices, "Since the Minister took possession almost a year ago, the heads of programs have not been asked to meet with the new authorities, nor have they visited the program´s offices to have an exchange of information…." as stated during the presentation of the MIS model to CCM(20). New authorities, in place since the end of August 2017, have expressed more support toward the national programs and place greater importance on the Global Fund, as evidenced by the fact that shortly after taking office the new Minister summoned the heads of national programs and instructed them to do what it takes to achieve approval of upcoming grants. Furthermore, the Minister supported the continuation of the MoH as the Principal Recipient for the malaria grant. According to most stakeholders, the main decision-makers were still not involved in the funding request and the absence of an approved NSP during the application process exacerbated the lack of a shared national vision.

In addition, stakeholders reported inadequate technical expertise and leadership within the CCM board. In this context, international technical partners stepped in, trying to fill the technical and management voids. Their support was seen as a mixed blessing, as many stakeholders felt technical partners exerted undue influence on the drafting of the 2017 funding request. These respondents did acknowledge that their influence is sanctioned by the CCM, which has granted external partners two votes out of 22 votes.[3]

Strength of Evidence (Ranking = 2)

Strong triangulation was found across high-quality data sources and multiple stakeholders. There is a good balance across sources, such as meeting observations, attendance records, as well as KIIs. Data is considered high quality and from informed sources.

Finding 6: The STC policy is new, but government and CCM stakeholders are in the early stages of addressing STC issues in Guatemala. Both the CT and the CCM informed and discussed the new STC policy with stakeholders, but the CCM did not revisit this discussion once the working groups were organized. For this reason, the policy was not fully considered during the funding request process as was pointed out in the TRP review. Furthermore, during the funding request process, the Minister of Health did not pledge to co-finance (new authorities came to office in late August 2017).

There is limited evidence in KIIs or observation notes about the country´s plans to establish a roadmap toward sustainability. The elements of the policy were not discussed thoroughly in the 2017 funding request, which addressed elements of sustainability, but did not draw up clear

[3]In previous years, international technical partners had voice but no voting rights in the CCM Assembly.

plans on how to achieve them. On the other hand, the iterated 2018 funding request contains some key actions, for example, the MoH has assumed the commitment to lobby and advocate for more resources to finance the response to HIV before the Congress of the Republic and the Ministry of Finance (21). The success depends heavily on the tax revenues and how the Congress prioritizes the annual budget, both situations beyond the control of the MoH. Another action towards sustainability mentioned in the iteration is drafting an Operative Annual Plan for the NSP, which can be used as a planning tool to lobby for increased financial resources in annual budgets, as well as to guide its implementation.

There was no mention in KIIs, CCM minutes, observation notes or other documents available to the PCE on specific planning tools recommended by the Global Fund, such as development by the CCM of Health Financing Strategies to provide a framework for developing and advancing priorities outlined in the NSP. An important aspect for preparing toward sustainability is to seek integration of health systems, including information systems (22). Currently, there exist parallel information systems, a pending challenge to be addressed by the CCM and the MoH (21).

In regards to co-financing, as the NFM sets forth, the MoH has implemented actions towards RSSH. Starting this year, the MoH will absorb salaries of all the staff from the central HIV program, and has progressively absorbed staff from the Integral Care Units (UAI) throughout the country, all previously paid by a Global Fund grant (21). Even more, some of the initial grant sub-recipients are now independent from Global Fund financing, including the HIV Clinics in national hospitals Roosevelt and San Juan de Dios, and the private association, ASI. Nevertheless, most civil society organizations continue to depend strongly on Global Fund financing, which poses a challenge for sustainability and transition. As reported in the 2015 MEGAS report, "…95% of prevention activities for [key populations] are currently financed by external cooperation, mostly by the Global Fund. "There has been discussion in the CCM in regards to future contracting of Global Fund sub-recipients by the government, congruent with recommendations from the STC policy, but feasibility is questioned given legislative barriers.

> *"It is perverse to ask for sustainability from civil society organizations that work in the street with key populations because their nature is to help not generate resources. Sustainability should be a work between the Ministry and civil society… Mechanisms should be sought, for example, for the MoH to pay for staff working in the NGOs´ clinics because otherwise many organizations will fade out when the Global Fund goes away."*
> ***KII, Civil Society Stakeholder***

An interesting proposal presented to the CCM and stakeholders by the Instituto de Estudios Fiscales (ICEFI) is to use tax money recovered by the Tax Administration Bureau from tax evaders (which amounts to millions) to finance health gaps including HIV. The disclosure of tax evaders has occurred recently in the framework of improving transparency(23).

As the country is still not transitioning out of the HIV component, no specific transition preparedness was assessed and was not mentioned or documented. It was noted in several meetings that the absence of both the Ministry of Finance and the Presidency Programming and Planning Secretariat (SEGEPLAN) has been detrimental to discussions on sustainability. Despite multiple invitations by the CCM, both government bodies did not attend meetings or

participate in proposed discussions, even though they participated in the NSP design. The quality of their participation cannot be assessed as the PCE did not cover the NSP process.

> *"Despite multiple invitations by the CCM, they [MoF and SEGEPLAN] have never attended meetings or participated in the discussions [of the FR]."* ***KII, CCM Stakeholder***

For several stakeholders from the key populations, the need to change the political and legal climate is the first step towards sustainability. Representatives of key populations advocate for the approval of the Gender Identity Law and changes in the HIV legislature to bring forth the LGTBI public policy, as well as the regulation of generic pharmaceutical drugs (currently banned). For these stakeholders, political legitimacy and recognition is paramount for reducing stigma and discrimination and achieving dignified lives.

Strength of Evidence (Ranking = 1)

Strong data triangulation was found from multiple data sources and document review (KIIs, budgets, notes on observations and documents review (i.e. 2017 funding request documents, 2018 funding request documents - iteration and Global Fund policies)), as well as stakeholders' responses in KIIs, but only a handful of respondents were knowledgeable about the policy. Data is considered high quality and from informed sources.

Finding 7: There was strong participation from key and vulnerable populations in the application process; however, the differentiated strategies needed to address the specific prevention and treatment needs of key populations were not adequately addressed in the initial 2017 funding request. Within the initial HIV working groups proposed by the CCM, there was no specific group focused on key or vulnerable populations. Representatives of key populations demanded there be one and were granted a specific working group to address human rights and issues attaining to key and vulnerable populations(24).Each key population developed a different strategic approach for HIV prevention and treatment programming; however, these were not included in the final proposal document. Stakeholders mentioned that the consultant was given the responsibility of deciding what was included and excluded from the funding request submitted in window 3, and this process was not done in consultation with working group members. According to the hired consultant, their needs were not always reflected in the funding request submitted in window 3 due to insufficient strategic focus and technical expertise.

While some representatives of key populations actively participated, other groups were not included in the funding request submitted in window 3, such as representatives from indigenous persons, but are being considered and addressed in the iteration.

> *"When the CCM changed, the representation model also changed. Thus we, the key populations, stepped in and began to advocate through our own representatives within the CCM… because you cannot talk about a proposal to improve the key populations' environment if these populations are not present."* ***KII, Key Population Stakeholder***

Strength of Evidence (Ranking = 1)

Very strong data triangulation was found from multiple data sources and document review (KIIs, budgets, and documents (i.e. 2017 funding request narrative, 2018 funding request documents - iteration, studies on behavior)), as well as stakeholders' responses in KII. Data is considered high quality and from informed sources.

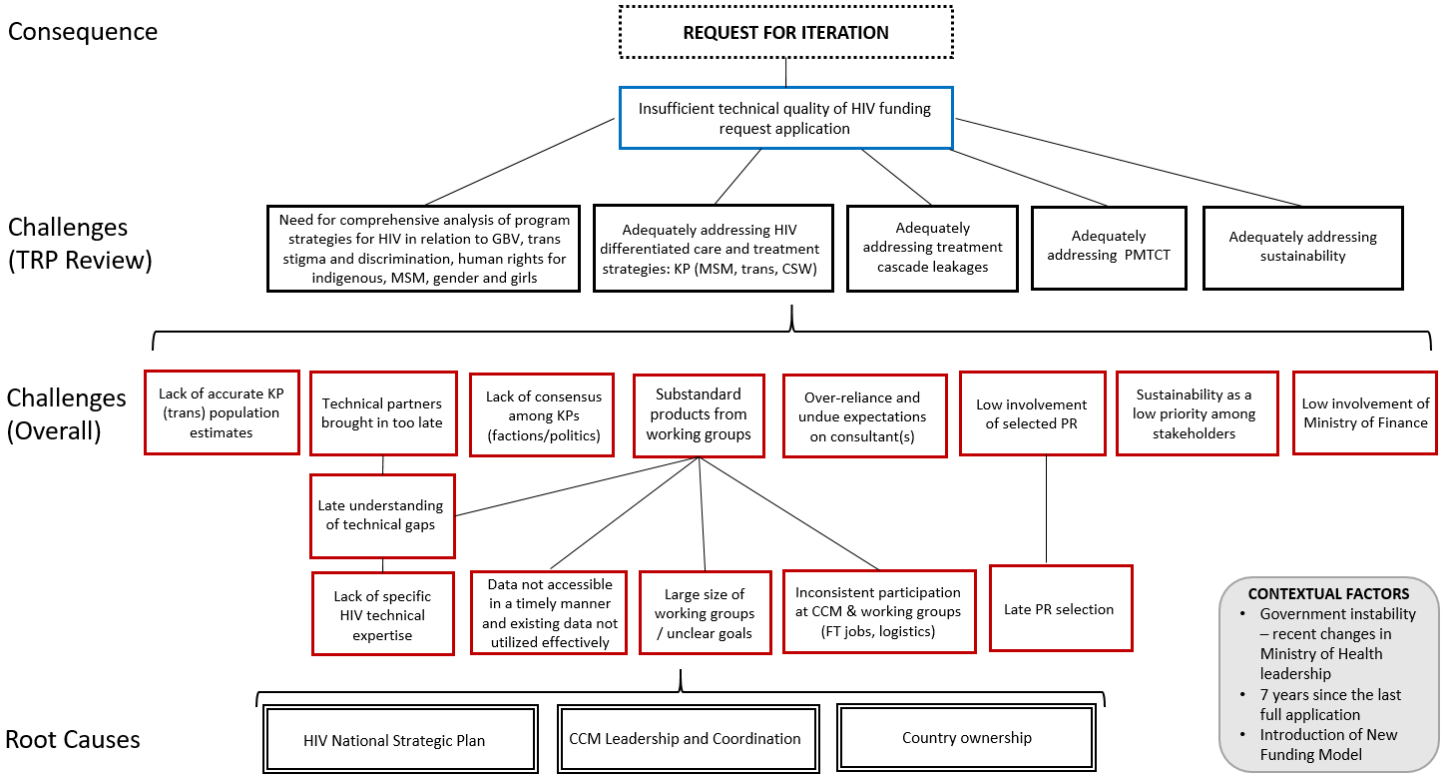
3.4 Other Global Fund processes linked to grant cycle: Global Fund policies, a source of expectations and frustration

The key informant interviews showed a pervasive opinion that more explicit and straightforward guidance was needed regarding Global Fund's policies. All twenty stakeholders interviewed for this evaluation said that the CCM needed to rethink its organization and many felt frustrated by what they saw as lack of response from the CT. Stakeholders are requesting the CT to provide solutions to the disorganization they feel has permeated the CCM, not acknowledging the non-prescriptive role of the CT. Several stakeholders felt trapped in a situation that everybody knew was dysfunctional, yet felt no one was working seriously towards changing it. Many analyzed the shortcomings of the CCM, but few, if any, could offer a solution beyond "strengthen its leadership." They perceived that the rules governing the CCM were ambiguous and expected the CT to delineate a solution, as they could not envision anybody else who could do it. It is apparent that the role and responsibilities of the CT are not well known.

Another source of frustration for some stakeholders was the bias against malaria and TB, as most of the CCM representatives are linked to HIV-related programs. Yet, these stakeholders said, CCM members are asked to review and approve funding requests for the two other epidemics for which they are not necessarily qualified or fully informed.

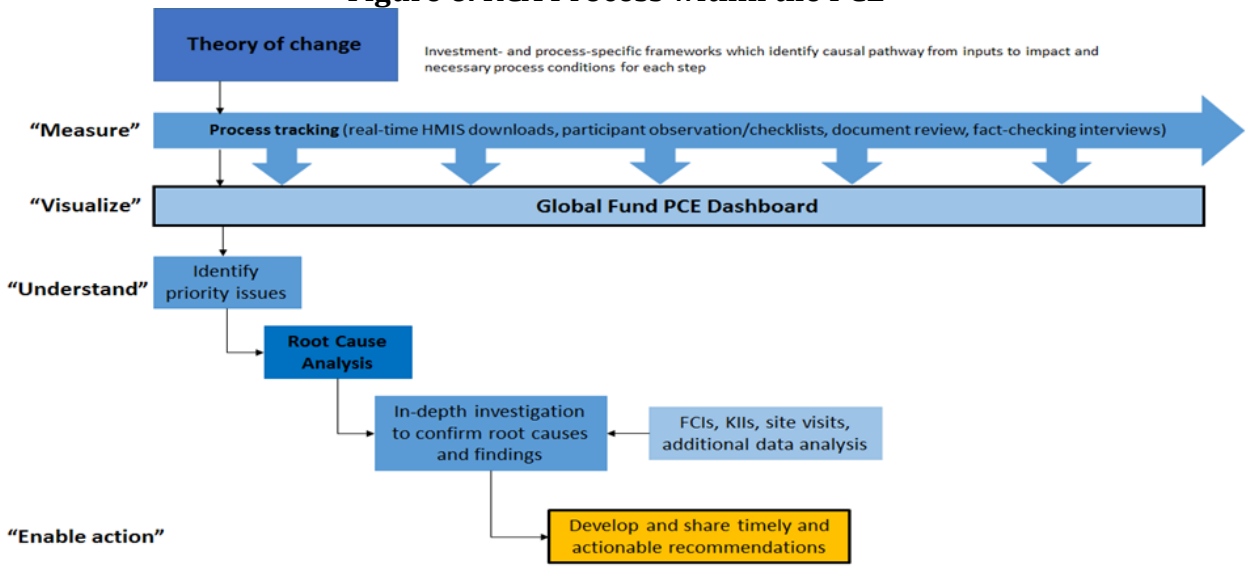
Finally, some stakeholders felt frustrated by the perceived leniency of the Global Fund. There was discontentment about processes that the Global Fund has allowed and failed, in their view, to correct. These ranged from the lack of functionality of the CCM to allowing unsustainable activities, such as the PR's use of expensive software that the MoH is unlikely to adopt due to cost, and sub recipients giving out incentives for receiving HIV testing. There was also a perception of reckless spending from the PR HIVOS, including costly rentals and very high salaries for staff officials.

Figure 5. Root Cause Analysis Flow Chart - 2017 HIV funding request



A root cause analysis flow chart was developed to illustrate the underlying causes of key process challenges discussed throughout Chapter 3, which led to the iteration outcome for the 2017 HIV funding request. The root cause analysis is presented in figure 5, and the PCE approach used to build it is presented in figure6 below. The main goal of the analysis was to unpack the causal factors and root causes leading to the iteration, and better understand the technical challenges highlighted by the TRP review. Through this initial process, the root causes identified focused on issues of country ownership, lack of a technically sound, costed and approved HIV National Strategic Plan, as well as challenges with CCM leadership and coordination of the application. The issue of country ownership was found to be a foundational cause, as key ministerial bodies, Ministry of Health and Finance, were not actively engaged in the funding request process. More specifically, the Ministry of Finance was not present in budgetary discussions. In the case of the Ministry of Health, the clear gap was the absence in most of the meetings of the representative of the Minister to the CCM, failing to make high-level decisions related to the funding request and ensure alignment with government priorities. Connected to country ownership was the lack of a technically sound, costed, and approved NSP. As the funding request relies heavily on utilizing existing national strategies, it created technical consequences for the application. Lastly, the functioning of the CCM as the leader and coordinator of the process was highlighted as one of the main issues contributing to the iteration outcome. It is understood that the root causes are closely connected, but not linear, and all contribute to the causal factors, highlighted in red, and the end outcome of iteration. The root cause analysis process is being utilized to follow identified key challenges that emerge from the evaluation process tracking. The approach will continue to be iterative as new data are collected and analyzed.

Figure 6. RCA Process within the PCE



Chapter 4: Translation of the Global Fund Strategy in country

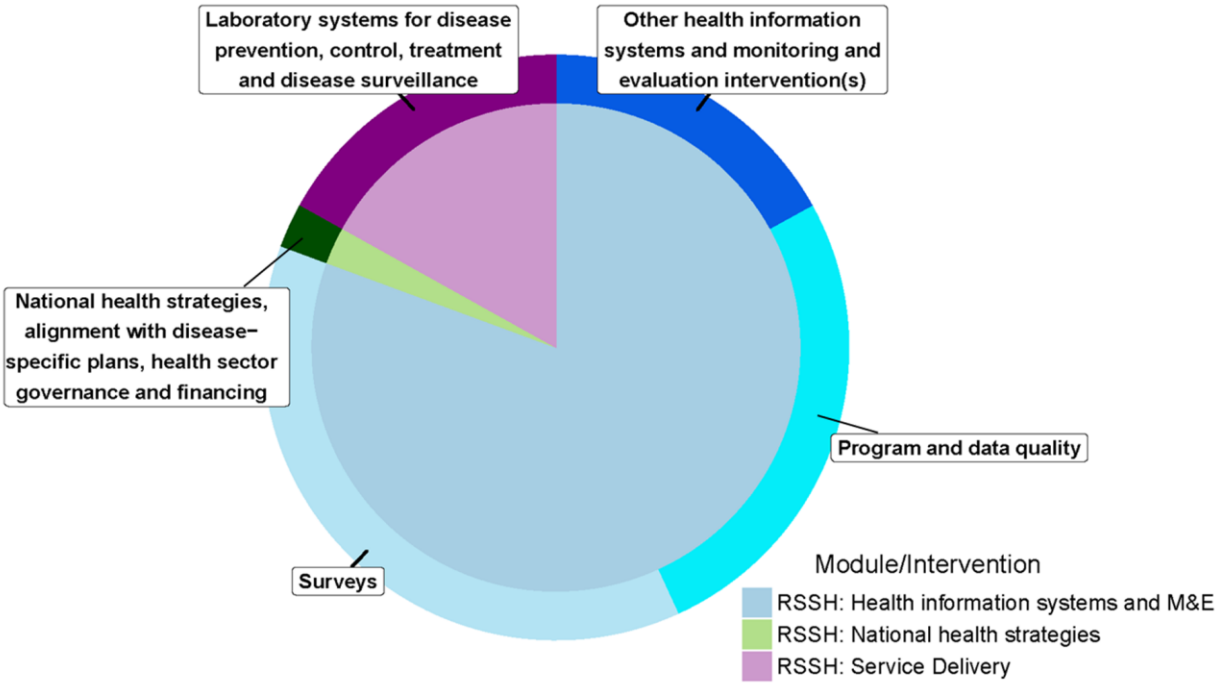
This chapter examines the evaluation approach, findings, and conclusions against the specific evaluation questions related to areas of the Global Fund Strategy that were agreed upon with country stakeholders and with the TERG. Findings in this section are preliminary and will be expanded as the PCE continues. The intention is to observe and evaluate how the Global Fund's policies and strategies are operationalized through implementation during 2018 and 2019, and thus we can expect more robust and in-depth findings in due course. The findings from the funding request and grant making will inform the review of grant implementation in 2018. The indicative Strategy Areas of RSSH, gender and human rights, key and vulnerable populations, and the STC policy are described as follows:

4.1. Resilient and Sustainable Systems for Health (RSSH)

Guatemala allocated US$608,000 in the 2018-20 HIV budget in the iterated funding request submitted for review. This accounted for 4% of the total budget, which was lower than the 13.3% in the initial funding request that was sent back for iteration.

Within the US$608,000 allocated to RSSH modules, the majority (US$490,000) was allocated to health management information systems and M&E, with integrated service delivery and quality improvement accounting for approximately US$103,000, RSSH as part of national health strategies accounting for US$15,000 and procurement and supply chain management systems no longer included in the budget. Figure 7 below displays the proportion of all RSSH funding allocated to each of these modules, including the intervention categories within each module.

Figure7. Proportion of All RSSH Funding Allocated to Each RSSH Module, including Intervention Categories within Modules.



Source: February 5, 2018 detailed HIV budget FR100-GTM-H-DB-INCAP

4.2. Gender and Human Rights

The Global Fund Gender Equality Strategy was presented to the Technical Review Committee in 2009. It explores how the Global Fund can encourage a positive bias in funding towards programs and activities that address gender inequalities and strengthen the response for women and girls. "*Gender inequalities are a strong driver of the HIV/AIDS, tuberculosis (TB) and malaria epidemics, and close attention needs to be paid to how such inequalities fuel the spread of disease and affect the ability of women and girls, men and boys to access health care and other services equitably"* (25).

Guatemala has in place strong legislative framework against gender violence, but enforcement is weak, especially in rural areas. However, as noted in Chapter 3, no experts in gender and human rights worked in the initial funding request, which did not include HIV activities for women and girls living in a context of violence or indigenous populations. The iteration does include interventions for women and girls aimed at reducing discrimination and HIV, harmful norms and violence against women and girls in "all their diversity", without distinguishing between indigenous or Afro descendants. It also includes activities to upscale the scope and impact of national women NGOs that advocate for positive women and interconnect with indigenous and afro-descendant women. The NSP, on the other hand, encompasses all women (and men)

between the ages of 15-49 (defined as fertile age) for prevention, testing and care, including attention for HIV.

The 2017-funding request considered gender in the context of trans women and gender-based violence focused on MSM and trans populations, but was not comprehensive for women outside the pregnant group or girls.

4.3. Key and vulnerable populations

In Guatemala, the populations with highest HIV seroprevalence are MSM, sex workers and transgender women (26)referred to as Key Populations or prioritized populations as they are also denominated in the recently approved National Strategic Plan. Additional to these key populations, the NSP prioritizes the following populations: a) pregnant women, b) children of HIV positive women, and c) persons with HIV/TB co-infection. Persons living with HIV/AIDS are also considered prioritized populations (27). The NSP identifies other vulnerable groups in the country such as prisoners, migrants and victims of gender violence. The burden of HIV (and STIs) is different for the vulnerable populations, with seroprevalence <1%, while key populations exhibit a higher burden with seroprevalence as high as 24% for transgender women, 10.5% for MSM and 1% for women sex workers as reported by the latest Bio-Behavioral Surveillance (IBBS).

The socio-cultural context of key populations is characterized by the following factors (28):

- High levels of stigma and discrimination against all key populations but especially against trans women and rural MSM and trans populations.
- Insufficient health service coverage providing differentiated care for key populations (trans and MSM) with – except for commercial sex workers and, as stated in the NSP, *"the MoH staff is not fully sensitized to provide care free of stigma and discrimination to positive persons and members of LGBTI group…"*This occurrence is more marked in rural areas.
- A deficient response of the judicial administrative system for the follow up, investigation and application of sanctions for violations of human rights of LGBTI, positive persons and other vulnerable populations, e.g. prisoners.
- Outdated legislative framework, ineffective for protecting legal and political rights of LGBTI, positive persons and other vulnerable populations. In recent years, protection measures and cares for abused women and children have improved by the creation of *Fiscalías para la Mujer*, but coverage reaches mostly urban towns.
- Discriminative religious practices.
- Traditional households, particularly in rural areas, where MSM and transgender persons are often expelled and disinherited. According to the ECVC (26),one third of transgender women surveyed reported having been rejected and expelled from their homes and/or workplaces.

Women and girls, including indigenous women and women living in a context of violence, are better represented in the iteration than in the prior , with interventions focusing in the protection of human rights of HIV positive persons and vulnerable populations (21). As

described above, the iteration defines interventions towards women and girls, primarily focused on legislative actions, community mobilization (improving the impact of local organized groups), and advocacy for the rights of women and girls. On the other hand, the NSP defines actions (and indicators) in the Strategic Guidelines, for women and young persons. Nevertheless, no distinction is made between indigenous and ladino women.

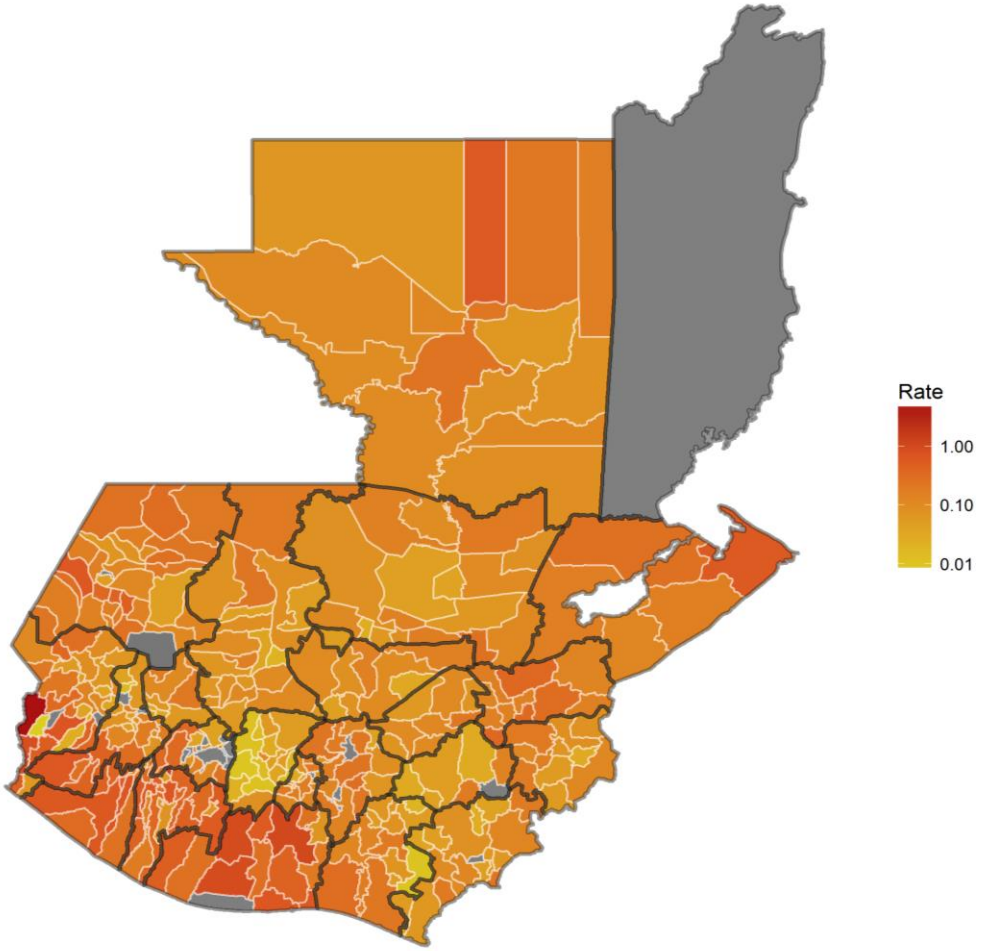
The burden of the disease appears to be higher among indigenous women and men, afflicted by poverty, limited access to healthcare and low educational levels, but there are few well-designed controlled studies to venture conclusive statements. Two studies on HIV risk behavior and ethnicity report a lower risk among indigenous populations due to lower risky behavior (14,15)but a study performed in Clínica Familiar Luis Angel Garcia, one of Guatemala's largest HIV-testing sites, reports a higher percentage of positive tests among persons identified as indigenous vs those identified as ladinos. A univariate analysis of the associations between the individual components and HIV infection showed that socio-demographic variables lower income, lower education and Maya ethnicity had a positive predictive value with testing positive for HIV (31). The erratic correlation between high-risk behavior and testing positive for HIV has been acknowledged by the WHO and CDC, attributed partly to the fact that people lie about their practices. That is the reason to recommend routine HIV testing, and moving away from targeting testing. Currently, neither the NSP nor the iteration define specific interventions directed to indigenous populations.

Prisoners are considered a vulnerable population in the iterated 2018 funding request, but not in the NSP. The iteration includes three main interventions in five prisons, which comprise the bulk of the prisoners in the country: prevention package, condom/lubricant provision, and advocacy to reduce stigma and discrimination.

4.4. Outcome Measurement and Impact Evaluation

Preliminary results for the impact evaluation are advancing. At this stage, the analytical focus has been on gathering secondary data sources and establishing baseline measures of key performance indicators. For example, the CIESAR team has identified subnational data for TB case notifications and is analyzing levels and trends on TB incidence reported at the municipality level. Figure 8 displays preliminary baseline measures, pooled from 2012 to 2015 to display a clearer spatial distribution.

Figure 8. Preliminary Baseline Measures of TB Incidence rate per 1,000 person-years for years 2012 to 2015



Source: TB National Program Database, map created by CIESAR

These findings support what is already understood about TB in Guatemala: areas in the Southern coast such as Escuintla, Retalhuleu and Suchitepéquez and Izabal in the Western region, experience much higher rates of incidence, in some cases by a 10-fold margin. The "Northern Transversal Strip" also shows high rates of TB. It is not clear yet if these data are biased towards those people that did seek health care resulting in underestimation of the incidence rate if people who do not consult health facilities are factored in. Analysis of death certificates and treatment-seeking behavior (based on surveys) is underway by IHME/PATH team, which will improve estimations of the burden of TB, HIV and Malaria in Guatemala. In addition to this, a baseline measurement of mortality rates/fractions is actively underway using subnational vital statistics and household surveys for a variety of indicators, including covariates to characterize risk factors, such as poverty and indigenous populations. Initial results have found low correlation between indigenous population percentage and TB incidence at the municipality level, although further exploration is necessary. Appendix 1.3 details secondary data accessed to date. Ongoing monitoring of these and other indicators will be used to evaluate the upcoming implementation phase of grants.

Chapter 5: Capacity Development

5.1 The development of capacities for the CEP occurred in four main ways:

1. Weekly Skype conference calls in which CIESAR, IHME and PATH HQ teams exchanged updates on the work in progress, discussed data collection, planned for workshops, meetings and deliverables, examined emerging findings, provided feedback on evaluation tools, celebrated milestones reached, and prepared for next steps. Methodological questions or uncertainty were reviewed and clarified.
2. Basecamp, an online work stream platform, is used to upload key documents including CEP observation notes, PCE evaluation instruments, information on quantitative research, official communications shared by the Global Fund, and PCE reports and slide presentations.
3. CEP-GEP in-person workshops (Table 5)

Table 5: PCE Workshops in Guatemala

July - August 2017	**October 2017**	**January 2018**
Pre PCE workshop	**End of Inception phase**	**Annual Report**
• Training CEP on PCE framework and Theory of Change • Drafting and discussions of preliminary general Evaluation Questions • Planning PCE dissemination Stakeholder Workshop • Post workshop briefing and agreements for final Evaluation Questions	• Analysis of findings and deliverables of Inception phase • Training on Qualitative methodologies shared by IHME/PATH and CIESAR experts to rest of the consortium team • Training CEP on Network Survey • Revision & discussion of KII guides designed by CEP experts with the IHME/PATH team • Validation of KII instruments and post validation discussion • Training in use of Analysis Matrix for organization of PCE data • Discussion on impact evaluation goals and guidance on early quantitative analysis • Knowledge transfer for resource tracking tools and practices	• Team work to review findings to January ´18 compiled in Analysis Matrix • Training CEP to rate evidence from Analysis Matrix based on three dimensions of evidence robustness (triangulation, other sources and perception and data quality) • Based on the former analysis, IHME/PATH and CIESAR prepared slide deck for February TERG presentation Guidance to CEP team on Annual Report Outline and drafting of Annual Report

5.2 Plans for future capacity development

CEP plans to continue engaging with GEP for further training based on country-specific needs. Trainings will aim to ensure that capacities required for the Evaluation Phase are aligned with the PCE data collection and analytic needs. CEP will continue to lead many analyses for outcome measurement, and CEP and GEP will continue to collaborate on code, tools, and data analysis for resource tracking and impact evaluation. Furthermore, CEP will depend on guidance from the GEP to harmonize PCEs across the other two GEPs to the extent to which harmonization is possible and desirable. A multi-partner meeting is planned for cross-CEP knowledge sharing and GEP-CEP working sessions in Seattle in June 2018.

Chapter 6: Conclusions

While the PCE aims to analyze the process of implementation and to assess the impact of the activities conducted with funds from the Global Fund grants, this report concentrates on the process of drawing the funding request for HIV in Guatemala, given the advance of the country in this process. The PCE will continue with further work in process and impact evaluation, as it will be detailed in Chapter 7 of this report. So far, the PCE proved to be useful in uncovering evidence and gaining a more nuanced understanding of the HIV funding request and has helped explain the request for iteration of the 2017-funding request. The underlying causes for the iteration outcome are complex and reflect the challenges found in Guatemala. Nevertheless, lessons learned from the HIV experience will inform the upcoming funding request for the tuberculosis national program.

Results suggest that the “all encompassing” methodology used by the CCM to elaborate the proposal, which was attractive for being inclusive, eventually posed some problems. Most participants were unable to meet the high demands of the process, which included many lengthy working sessions that did not produce good quality results. A minority of those who started attending the work groups continued until the end. It was soon apparent that working with large groups, where few were well informed on the NFM, was not leading to concrete results. Hiring external consultants and receiving technical assistance from partners was seen as a potential solution, but these support mechanisms were brought on too late into the process and were unable to take on all the tasks required of them. Underlying this issue was the fact that the national HIV strategy was not yet approved, costed or seen as technically sound. Due to the absence of this guiding national document, there was an additional level of difficulty in aligning the multiple strategies and activities in the funding request to national priorities. The national strategic plan is now approved and can be utilized moving forward.

The CCM also faced coordination challenges that had an impact on their leadership role. According to the information provided by some stakeholders, the CCM Board was disengaged from the process, particularly after the first draft was submitted.

Another causal factor for a non-cohesive effort was the instability of the authorities of the MoH. The rotation at different levels of the MoH during the length of the funding request was detrimental to the continuity of actions and political decisions. It is perceived that the current

Minister of Health, who came after the resignation of the former one, has a different perspective and is supportive of national programs and Global Fund grants. It is expected that under this new leadership, the grant performance will improve.

The CCM is using a different approach for the iteration and is benefitting from lessons learned during the former experience. The PCE will provide more insight on the iteration as the team analyzes preliminary findings.

Conclusions

The funding request for window 3 faced specific root causes and funding request challenges that emerged from these issues: i) limited government engagement at a time when national government was undergoing changes in MoH leadership and rethinking the national model of care; ii) technical gaps, specifically at the moment of submission of the first funding request, the lack of an approved, robust and costed National Strategic Plan; and iii) coordination and leadership limitations in the functioning of the CCM.

Technical Gaps

1. There were main challenges encountered to address the financial aspects of the funding request related to lack of expertise in budgeting and financial planning, i.e. linking results (targets) to financial resources, which resulted in gaps for a feasible implementation and unclear prospects of sustainability. For example, there was an absence of a well-defined plan for gradual absorption of key interventions by national authorities (such as, but not limited to, drug procurement, prevention programs for key populations, programs to reduce human rights and gender related barriers to services).
2. It was perceived by some stakeholders that the composition of the CCM had an imbalance of technical and non-technical core staff. Decisions that had to be based on scientific evidence and strategic information were difficult to grasp by non-technical members of the CCM participating in the funding request. There was a tension between what different groups expected from the funding request and what was actually feasible and technically sound.

Government Engagement

3. The country underwent serious political events at the time of drafting the funding request, which hindered a more favorable process and a successful outcome.
4. The information system of the country is currently not integrated, with co-existence of parallel systems, which pose a challenge for sustainability.
5. Plans to advance to sustainability are incipient and mostly circumscribed to lobbying in the Congress and the MoF to increase budget for health and the three diseases.
6. It is important for the MoH to regain leadership of the national response to provide guidance and norms to the funding request process

Coordination and Management

7. Key lessons learned were useful to reorganize the process of elaboration of the iteration, for example, changing the methodology of work groups to a streamlined committee and bringing in a consulting team with thorough knowledge of Global Fund processes and expertise in HIV and finance.

Lessons Learned from the 2017 funding request process

As the PCE team followed the funding request process, it was possible to document the main factors that the CCM took into account to better organize themselves to achieve success in the iteration. Highlights on the overall approach are listed below:

- Change in methodology from large working groups to a smaller, 18-member group, the Iteration Committee. Rules to communicate and feedback within the Iteration Committee, as well as delegating authority to the Iteration Committee to make technical decisions were established since the beginning to prevent delays and misunderstandings within stakeholders who integrate the CCM.
- Hiring of a new, more experienced consultant and a financier to compile, review and organize contributions from the Iteration Committee to produce the final funding request.
- Stronger involvement from the new Minister of Health and high-level authorities with decision-making power has already proven helpful to advance the iteration.
- Inclusion of the newly selected PR has been mandatory as absence of the PR was detrimental to former process.
- Balanced participation of technical partners and "lay" stakeholder within the Iteration Committee.
- Use of lessons learned from prior experience to streamline and improve process and data management.

The iteration was submitted on February 7, 2018, currently awaiting approval, so the PCE will be following closely to continue to assess the process.

Chapter 7: Plans for 2018

The main PCE activities for the first half of 2018 are illustrated in a work plan in Annex 4. Overall, the Network survey for HIV, observation of CCM, national program meetings and CT country visits continued in January.

7.1 Process Evaluation

Over February, the PCE team continued with the Process Evaluation for the Malaria funding request (KIIs, observations, network survey, document review, and resource tracking) and submission of the annual report. The key activities in March were the National Advisory Panel

meeting, and CIESAR with IHME-PATH also set the scope and work plan for the upcoming six months of work. Finally, the National Dissemination workshop took place in April 2018.

7.3 Partnership Network Survey

The Network Survey was initiated in February 2018, after the KIIs were completed. The first rounds of respondents were the same interviewees. It was decided to launch it as an online survey, considering that the first "wave" of stakeholders were knowledgeable and cooperative towards the PCE. The second wave of respondents came from referrals from the first group, representing network contacts. The contacts had to have been involved in the funding request. A link to access the online survey was sent by email. If a week went by without a response, a reminder was sent also by email. If needed, a telephone call followed to encourage the stakeholders to respond to the survey. The time to answer the online survey was estimated in 15 minutes in pre-launch trials. It is comprised of 20 multiple-choice selection questions.

A response rate of 64% has been reached out of the 59 network surveys sent. Table 6 shows updated results:

Table 6: Summary of Network Survey Outcomes

Round No.	Surveys submitted No.	Online survey responses No.	Response rate
Round 1 HIV[1]	**21**	**18**	**86%**
Round 2: Contacts from Round 1[2]	**28**	**15**	**54%**
Round 3: Contacts from Round2	**6**	**20**	**33%**
Round 1 Malaria1	**10**	**85**	**63%**
Total	**59**	**38**	**64%**

[1]Two surveys sent in a month period

[2] One survey sent in a month period

7.4 Advisory Board Meeting

CIESAR held a meeting with the Advisory Panel in mid-March 2018 to present the PCE findings to date and obtain feedback from the AP, both for the annual report as for the meeting planned for dissemination of results to stakeholders. The methodology for the meeting was discussed and the panel's recommendations were taken into account in planning. Likewise, the panel´s observations were included in the annual report.

7.5 Stakeholder Dissemination Meeting

The second PCE workshop took place on April 11, 2018 in Guatemala City with the purpose of disseminating findings to date. The workshop attendance was substantial and included the participation of 82 stakeholders, which included members from all stakeholder groups. The workshop invitation was sent to all stakeholders in the CCM, the Global Fund Country Team, the PCE Advisory Panel, the LFA and other interested parties, such as the consultants involved in drafting the iterated HIV and the malaria funding requests. Members of the TERG were also present and provided background information on their role in the PCE and the results obtained to date in other PCE countries. Among the absentees were the members of the Advisory Panel (AP) and USAID representatives, this was due to a joint meeting part previously scheduled for the same day.

The aim of the dissemination workshop was to provide stakeholders with updates on the PCE process, initial PCE findings, and provide a platform to receive feedback and recommendations moving forward. The workshop began with presentations by the GEP and TERG members, providing more details on the evaluation methodology and global progress to date. Following these presentations, the CEP presented the key initial findings from the first phase of the evaluation. The workshop then transitioned into nine small working groups, which were structured to included representatives from various sectors, to discuss specific findings and provide input on the root causes and recommendations. Each group designated a facilitator and rapporteur to document the discussion and recommendations. At the conclusion of the workshop, each group presented their feedback regarding the key findings and provided recommendations moving forward with the PCE.

The nine groups confirmed the main findings and conclusions presented by the PCE. The working groups provided the following feedback and recommendations:

1) The HIV national program should have more authority to administrate their budget.
2) It is necessary to engage other government entities in the CCM: Ministry of Finance, representatives from the Congress of the Republic and the Presidential Secretary for Planning.
3) The CCM board needs to have a better balance of technical and non-technical participants and assume co-responsibilities between the board and the members of the assembly in terms of consistent participation and dissemination of information back to their sectors.
4) The budget of the 2017-2021 National Strategic Plan (NSP) needs to be finalized in the shortest term possible given that the lack of a robust and costed NSP was detrimental to the HIV FR process and for prospects of sustainability.
5) Sustainability must include, among other things, strategic alliances between the government and the civil society to finance HIV services currently provided by NGOs highly dependent on external financing, such as the Global Fund.

6) The Global Fund must prepare the CCM better when introducing changes in the grant application process and formats, since the CCM had incomplete knowledge on the new model and formats.
7) The government, not only international partners, should assume leadership in research and financing of investigations.
8) International cooperation should focus in the next years in improving competencies of civil society organizations to assume challenges of sustainability.
9) Legislation must be improved to provide protection to key populations against stigma and discrimination (some actions are presently ongoing but have not advanced in the Congress of the Republic).
10) More expertise on gender, indigenous people, and human rights is needed.

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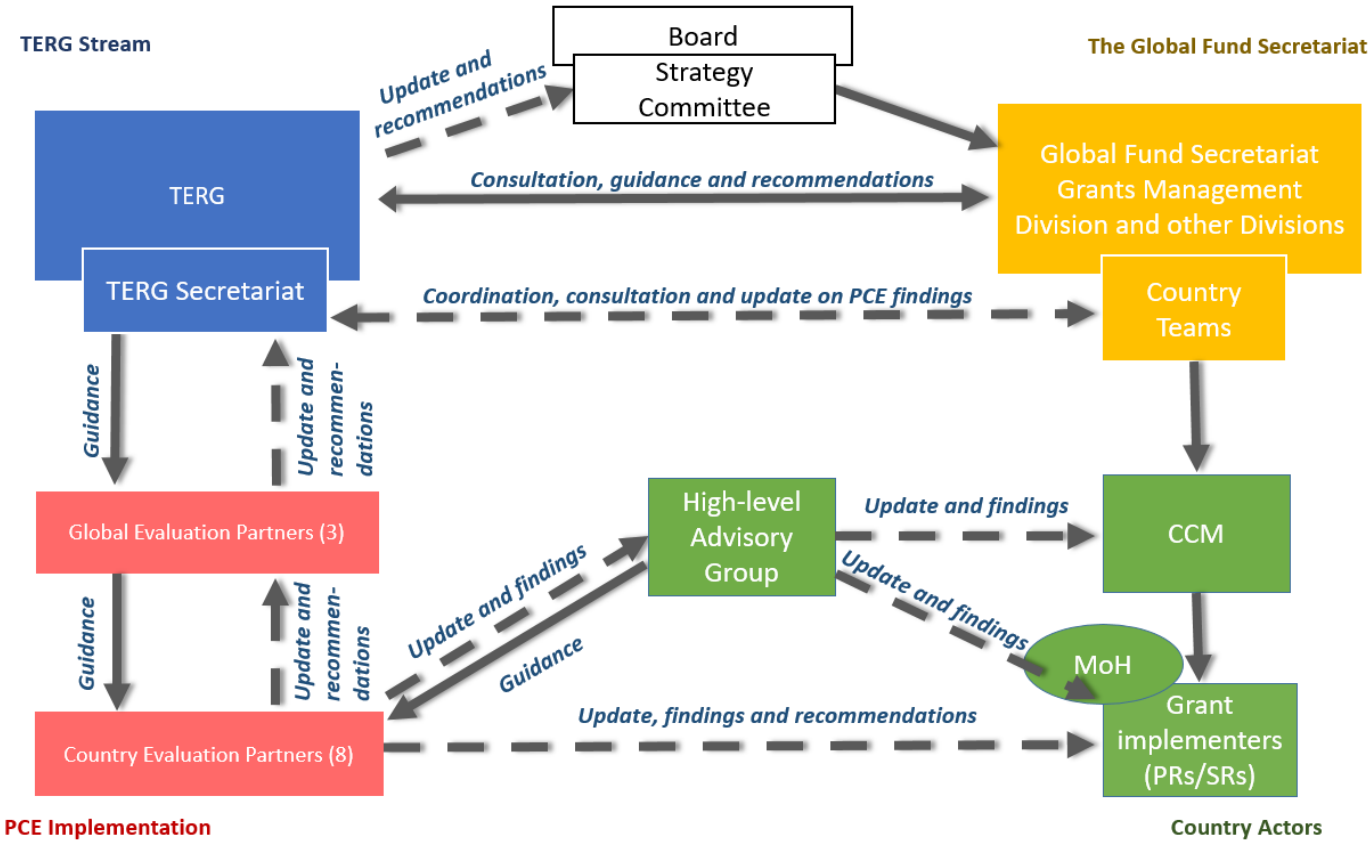
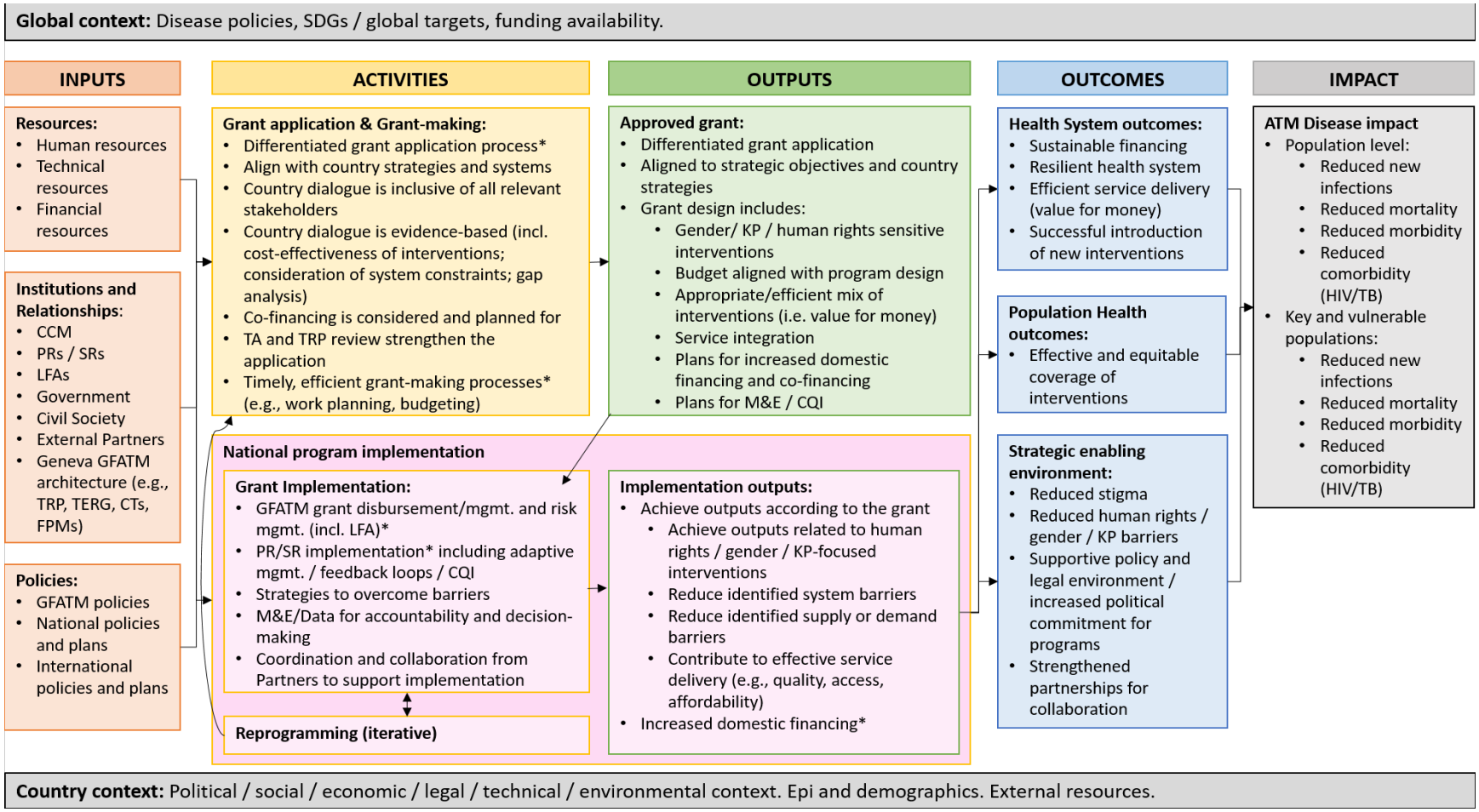
Annex I: PCE Governance structure



Annex II: Global Theory of Change



Annex III: Evaluation framework including specific evaluation questions, methods and prioritization

EVALUATION QUESTIONS		SUB-THEMES	ToC Areas	Theme	Global	GTM
Funding Requests, Grant Application & Making	1. What is the nature and role of partnerships between Global Fund and in-country stakeholders participating in the grant application and making processes?	•Partnership structure and strength of ties	Strategic enabling environment			X
	2. What are the barriers and facilitators for a successful grant application / making process, including responsiveness to country priorities, perceived needs, and resource allocation decisions?	•Time gap: preparing funding requisition without knowing about new PR selection •Co-financing uncertainty •Role of partnerships & influence in application cycle •Programmatic gaps and information systems •Inclusive, transparent country dialogue, including funding request approach •Incorporate lessons from previous application cycles •Flexibility to decide resource allocation to key populations vs. other populations (prisoners, pregnant women) •Flexibility to define and decide interventions •Country ownership: Extent process steered toward GF priorities, rather than country priorities •Linking NSPs to GF activities •Challenges related to change in PR •MOH leadership transition during FG/GM phase; ongoing challenges with government engagement	Grant application & making; Strategic enabling environment; Inputs (Resources); Inputs (Institutions & Relationships)			X
	3. What barriers and facilitators have been experienced in negotiating co-	• How effective is the STC policy in stimulating co-financing? •Use and application of STC policy for co-financing	Inputs (Policies, (Resources, Institutions			X

Funding Requests, Grant Application & Making	financing commitments, as compared to previously?	•Level of co-financing commitments versus actuals	&Relationships); Grant application & making			
	4. To what extent are expected implementation bottlenecks anticipated and planned for in the grant application and making phase?	•Procurement challenges •Contractual delays	Grant application & making			**X**
	5. How effectively does the CCM coordinate stakeholders and partners for grant application/making and program implementation (across program areas)?	•Influence of CCM on MOH/Government priorities	Grant application & making; Strategic enabling environment			**X**
	6. How has the CCM ensured program continuation during the transition from the current to new principal recipient?	•PR selection process •Why MOH passed off PR role for HIV •Program continuation during PR transition	Strategic enabling environment			**X**
	7. How effectively are key and vulnerable populations considered, defined, and addressed in the grant application and making process?	•Definition of key and vulnerable populations and strategies for reaching •How much money is devoted to key and vulnerable populations •Level of involvement of key and vulnerable constituencies in application	Grant application & making; Inputs (Policies)			**X**
SO1 | Impact, Transition, Challenging Operating Environment	8. What are the trends and distribution (geographic, demographic and socio-economic) of HIV, TB and malaria-related health outputs and outcomes?	•Geographic distribution of key health outputs & health outcomes	Outputs; Outcomes			**X**
	9. To what extent do Global Fund resources contribute to improvement in health outputs and outcomes for HIV, TB and	•Intensity of GF resources coincide with changes in key health outputs	Outputs; Population Health Outcomes;			**X**

SO1 | Impact, Transition, COE	malaria? How does that contribution vary geographically and demographically, and what are the barriers and facilitators to achieving outputs and outcomes?	•Geographic distribution of key health outputs coincide with geographic distribution of health outcomes •Intensity of GF resources coincide with changes in health outcomes	National program implementation			
	10. To what extent is the Global Fund STC policy applied and contributing to preparing for sustainability and transition?	•Country initiatives planned or in place for STC •Domestic resource mobilization for ATM	Inputs (policies); Implementation outputs; Health systems outcomes	💰		**X**
	11. How effective and efficient are Global Fund risk management and oversight mechanisms at enabling program results?	•Indifference to monitoring •No consequences or actions tied to results of strategic monitoring (by LFA)	*Not explicit – consider adding to ToC*			**X**
	12. How do the current strategies of the MOH (e.g. new model for healthcare, "MIS") affect implementation of national disease programs and Global Fund grants?	•Role of GF in influencing government priorities and investments •Extent of power/influence of GF over country priority setting •MOH leadership transition during FG/GM phase; ongoing challenges with government engagement	Inputs (Policies); Implementation outputs; Health systems outcomes			**X**
SO2 | Build RSSH	13. How do Global Fund investments improve the efficiency and effectiveness of health information systems (HIS) in the country?	•Info system as barrier to grant application and implementation •Connections to RSSH •Quality of the information systems • Age/sex disaggregation	Inputs (Resources); Implementation outputs			**X**
	14. Are Global Fund investments in programs to reduce human rights and gender-related barriers to HIV, TB and malaria services of sufficient amount, quality, and effectiveness?	• How are Global Fund supported programs addressing barriers to services for the most vulnerable, including key populations? • What have been the challenges and successes of implementing gender responsive programs?	Inputs (Resources); Implementation outputs	💰		**X**

SO3 | Human Rights & Gender	15. To what extent have plans, policies and programs (related to three diseases in 2017-2019 allocation period) been designed and implemented in accordance with gender responsive programming, within country contexts receiving GF support?	• To what extent has gender been addressed in the design of the grant application?	Grant application & making; Inputs (Policies)			**X**
SO4 | Mobilize Resources	16. What are the trends and distribution of Global Fund resources (inputs), and how do they compare with need?	•Distribution of GF and non-GF resources by health function, geographic area, & financing agent	Inputs (Resources); Population Health Outcomes			**X**
	17. What are the drivers of consistently low rates of absorption (financial execution) of Global Fund investments?	•Drivers of variation in absorption by PRs, SRs, disease (lower for TB & malaria) •Financial paralysis •Legal issues, procurement law •GF rules and regulations •Aspects of Guatemala's regulatory framework that facilitate or hinder absorption •Response times of MOH/management relative to the speed of GF requests	*Not explicit – Consider adding to ToC*			**X**
	18. What factors influence sustainability considerations (or lack thereof) related to Global Fund investments?	•Links to prioritization and agenda setting within country •Ongoing challenges with government engagement	Inputs (Institutions & Relationships); Strategic enabling environment			**X**

Strategic Enablers	19. What are the facilitators and barriers to the CCM functioning effectively within the standards/scope as defined by the Global Fund business model?	•Leadership issues •Partnerships (strength, functionality) •CCM composition •Conflict of interests •Communication channels •Strained relationships	Strategic enabling environment			**X**

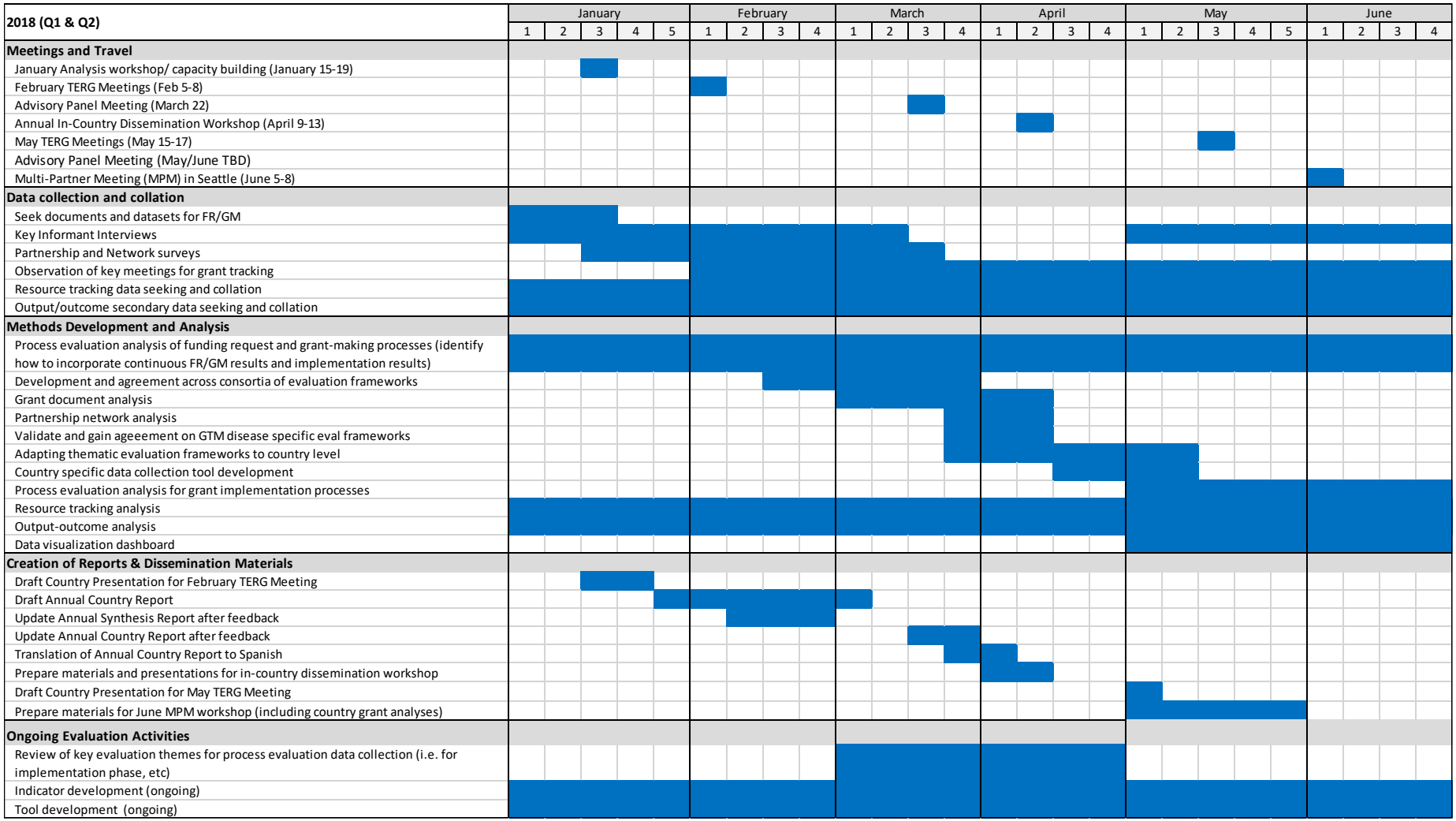
Questions considered across countries to address a strategic objective – proposed by IHME/PATH or drawn from the Global Fund Request for Proposal

Prioritization of Evaluation Questions: **High** **Med** **Low**

Thematic Area Symbols Key:

Partnership Country ownership Sustainability, co-financing, transition Value for money

Annex IV: Indicative country-level work plan for January – June 2018



Annex V: Key Informant Interview Guide

Muchas gracias por acceder a nuestra entrevista.Quiero asegurarle que la información que provea será tratada de manera estrictamente confidencial y que su nombre no se utilizará en ningún informe, por lo que me diga quedará registrado de forma anónima.

Quisiera que conversáramos sobre la elaboración de la propuesta.Quisiéramos conocer cómo ha funcionado el proceso, qué aspectos han sido más fáciles de seguir y cuáles han sido más complicados. Pero antes de empezar quisiera que me contara algo sobre Ud.

¿Cuál ha sido su participación en los proyectos del Fondo Mundial?

- **¿Por cuánto tiempo ha trabajo Ud. con el tema de VIH?**

¿Cuál fue su participación en la preparación de la propuesta actual?

- **¿Participó en alguna mesa de trabajo?**
- **¿Ha participado anteriormente en los procesos de solicitud de financiamiento del Fondo Mundial?** *Nota: Si la respuesta es "no", adapte las preguntas como sea necesario.*

Tema 3: ¿Fue un proceso transparente, inclusivo y dirigido por el país para confirmar la división del programa, el enfoque de solicitud de financiamiento y la selección del PR?	
Preguntas clave	**Preguntas exploratorias**
1.1 Quisiera que me comentara sobre sus impresiones sobre el proceso que llevó a la formulación de la propuesta 2017-2019.	
1.2 Ahora quisiera que me contara sobre las mesas de trabajo	a) ¿Cómo fue la coordinación de las mesas de trabajo en que Ud. participó? b) ¿Cree que los acuerdos a los que se llegaron en las mesas de trabajo quedaron adecuadamente reflejados en la última propuesta?
1.3 El FM está tratando de impulsar procesos transportes e inclusivos.Quisiera que me contara si …	a) ¿Cree que fue un proceso transparente? EXPLICAR b) ¿Cree que incluyó a todos los sectores? c) ¿Quedaron excluidos del proceso grupos que deberían haberse incluido? d) ¿Cree que se logró que el contenido de la propuesta reflejara realmente las prioridades del país? e) ¿Quiénes o qué grupos de interés tuvieron la mayor influencia sobre el proceso y toma de decisión?
1.4 ¿Conoce Ud cómo quedó la asignación de recursos?	a) SI: ¿Cree que estas asignaciones respondan a las necesidades de la epidemia de VIH en el país?

	b) Explique c) PARA LOS FINANCIEROS. ¿Podría explicarme cómo fue el proceso de trasladar las actividades o componentes de la propuesta a montos financieros? ● ¿Sabe quién estuvo a cargo de esta asignación?
1.5 ¿Cuál fue el rol del equipo técnico del FM en el desarrollo de la propuesta?	a) ¿Cree que fue adecuada? b) ¿Qué hizo el equipo técnico para asegurar que se incluyera financiamiento para la sostenibilidad? c) ¿Cómo hubiera ayudado el equipo técnico de manera más efectiva para resolver las brechas y debilidades identificadas en los borradores?
1.6 ¿Qué tipo de apoyo técnico [NACIONAL O INTERNACIONAL] recibieron durante el desarrollo de la propuesta?	a) ¿Cuál ha sido su mayor contribución?DEFINIR INSTITUCIÓN Y TIPO DE APOYO b) ¿Cree que hubo un verdadero compromiso de su parte? c) ¿Cómo se podría aprovechar mejor el apoyo técnico a modo de obtener resultados más sólidos?
1.7 Ahora quisiera que habláramos de las discusiones que se dan al seno del MCP.	a) ¿Qué tanto se comprometieron los diferentes actores en estas discusiones para elaborar la propuesta? b) ¿Cambió el nivel de compromiso de algunos sectores a lo largo del desarrollo de la propuesta? ● SI: Explique
1.9 Hablemos ahora sobre la revisión que hizo el TRP del FM de la propuesta que enviara Guatemala.	a) ¿Le causó sorpresa que no la hubiesen aprobado? EXPLICAR b) ¿Cree que se hubiera podido evitar la no aprobación? EXPLICAR c) En su opinión, ¿por qué no fue aprobada?
1.10 La recomendación que dio el RTP fue la iteración, es decir, volver a presentar la propuesta.	a) ¿Cuáles son los desafíos principales que tienen ahora para mejorar la propuesta? b) ¿Qué impresión tiene sobre la participación del Programa Nacional de Sida en el desarrollo de esta nuevapropuesta? ● Impresiones sobre conocimientos técnicos ● Impresiones sobre el poder de decisión de los participantes

Área temática 1 y 2:

Ahora vamos a cambiar de tema. El FM ha introducido cambios en la forma de aplicación de la propuesta así como en nuevos objetivos estratégicos.

Preguntas clave	Preguntas exploratorias
2.1 ¿Cómo se comunicó esta información dentro del MCP?	a) ¿Cómo se tomaron los objetivos estratégicos en cuenta al momento de desarrollar la propuesta?
SOLO A RESPONSABLE DE LA PROPUESTA 2.2 ¿Qué cambios ha observado en este ciclo 2017-2019 con relación al nuevo modelo que ha propuesto el FM?	a) ¿Cree que estos cambios hayan facilitado el proceso? EXPLICAR b) ¿Cree que el costo en tiempo y recursos que conllevó el proceso de la elaboración de la propuesta fue eficiente?

Área Temática 4:¿Se ha enfocado este proceso más en sostenibilidad, transición y cofinanciamiento que los anteriores?	
Preguntas principales	**Preguntas exploratorias**
3.1 El FM introdujo una nueva política de sostenibilidad para el ciclo 2017-2019.¿Han discutido Uds este cambio de política?	a) ¿Han recibido una guía adecuada de parte del equipo técnico del FM? b) ¿Qué tanto se ha considerado esta política en la propuesta? ● ¿Qué logros han tenido para la aplicación de esta política? ● ¿Y qué dificultades?
3.2 ¿Cuál ha sido la participación del Ministerio de Finanzas con relación al desarrollo de la propuesta? ● ¿Cómo ha sido la discusión sobre la sostenibilidad que deberá asumir el MSPAS?	
3.3PARA FINANCIEROS ¿Conoce Ud la respuesta que dio el TRP del FM relacionado al uso de recursos financieros?	a) El TRP comenta que hay poca planificación para lograr un financiamiento sostenido de los programas de prevención y tratamiento. ¿Cómo podría resolverse? b) Otro comentario del TRP es que se necesita revisar los costos estimados de prevención. ¿Por qué se habrá hecho una estimación errónea? c) Y por último, el TRP pide también que se revise los altos costos administrativos (42%), que además no están alineados con las prioridades y metas de la propuesta.¿A qué se debe este costo tan alto? d) ¿Qué implicaciones tendría bajar los rubros de recursos humanos, viajes y costos administrativos?

3.3 PARA FINANCIEROS En su opinión, ¿quién debe verificar el cumplimiento de los compromisos de financiamiento del Estado?	● ¿Cómo se realizaría esta verificación? ● El TRP plantea el riesgo de no cumplimiento de los compromisos de financiamiento de parte del Estado. ¿Qué piensa Ud. de esto? ● ¿Incluye la propuesta actividades para movilización y monitoreo de los fondos locales?

Área Temática 5: ¿Seles ha puesto ahora más atención a las poblaciones claves y vulnerables, los derechos humanos y el género en comparación a propuestas anteriores?	
Preguntas clave	**Preguntas exploratorias**
4.1 ¿Hubo una participación adecuada de las poblaciones clave y vulnerables?	a) ¿Cómo fue la convocatoria a las poblaciones clave? b) ¿Qué tan influyente fue la participación de estos grupos en la preparación de la propuesta? ● Por favor dé un ejemplo c) ¿Hubo en este ciclo alguna diferencia en la convocatoria y participación de estos grupos en comparación al ciclo anterior?
5.2 La mitad de las recomendaciones del TRP se refieren a mejorar el abordaje poco apropiado de la violencia por género, de las poblaciones indígenas, de la discriminación de mujeres trans y de otras poblaciones clave.	● ¿Le sorprende esta recomendación? ● ¿Por qué cree que no fueron abordadas de manera más satisfactoria?

Annex VI. Communication and Dissemination Strategy for In-Country

The main actions for the communication and dissemination strategy are the following:

1. Focus on a personalized communication by e-mail, informing stakeholders [and other interested parties] about PCE activities, progress reports, newsletters and main results, all conveyed in concise and short messages. Invitations to relevant events will also be posted by e-mail.
2. A Newsletter will be published monthly with updates and links to the official BLOG for the PCE-GT website.
3. PCE website, periodically updated, and further on, use of Facebook as dissemination tool.
4. E-mailing will be a main means of communication as it was mentioned as the most effective way to pass on information (recent survey among participants to the PCE Dissemination Workshop, April 9, 2018).
5. Selected printed material, i.e. brochures, will be produced for specific purposes. The survey results showed that stakeholders rendered some written materials as useful.
6. The use of media for interviews with key stakeholders (i.e. CT and TERG authorities) for specific topics related to the PCE will be explored. If and when used, any media broadcasts will abide by the Standard Operating Procedures (SOP) guidelines.

Our dissemination and communication strategy is prospective, meaning that it will be tailored along the way to address the needs and activities that arise during the evaluation.

Annex VII. Secondary Data Accessed to Date

Table 7. Secondary Data Summary

Program Area	Data	Data Source	Level of Detail	Time Period
Malaria	Development Assistance for Health (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2004-2016
TB	Development Assistance for Health (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2011-2016
HIV	Global Fund Investments (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2011-2016
Malaria	Global Fund Investments (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2011-2016
HIV	Government Health Investments (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2004-2016
TB	Government Health Investments (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2011-2016
Malaria	Government Health Investments (Tracked at Country Level)	Sistema de Contabilidad Integrada (SICOIN)	Month, Municipality	2011-2016
HIV	Approved/Submitted Global Fund Grant Budgets	Fund Portfolio Manager	Quarter, Service Delivery Area	2010-2020

TB	Approved/Submitted Global Fund Grant Budgets	Fund Portfolio Manager	Quarter, Service Delivery Area	2011-2018
Malaria	Approved/Submitted Global Fund Grant Budgets	Fund Portfolio Manager	Quarter, Service Delivery Area	2010-2019
HIV	Progress Update/Disbursement Requests	Local Fund Agent	Quarter, Service Delivery Area	2010-2017
TB	Progress Update/Disbursement Requests	Local Fund Agent	Quarter, Service Delivery Area	2016-2019
Malaria	Progress Update/Disbursement Requests	Local Fund Agent	Quarter, Service Delivery Area	2011-2018
HIV	Development Assistance for Health (Tracked at Global Level)	Financing Global Health Report 2017	Financing Source, Service Delivery Area	1990-2016
TB	Development Assistance for Health (Tracked at Global Level)	Financing Global Health Report 2017	Financing Source, Service Delivery Area	1990-2016
Malaria	Development Assistance for Health (Tracked at Global Level)	Financing Global Health Report 2017	Financing Source, Service Delivery Area	1990-2016
TB	Vigilancia Epidemiológica de TB	Programa Nacional de Prevención y Control de TB	Month, Municipality	2014-2015
. Appendix 1.3 details secondary data accessed to date. HIV	ARV Supply Chain/Distribution Data	Unidad de Logística, Medicamentos e Insumos, Programa Nacional de Prevención y Control de ITS, VIH y Sida	Month, Municipality	2011-2017

TB	TB Essential Medicines Supply Chain/Distribution Data	Unidad de Logística, Medicamentos e Insumos, Programa Nacional de Prevención y Control de TB	Month, Municipality	2011-2017
HIV	Vital Statistics	Instituto Nacional de Estadística	Month, Municipality	2009-2016
TB	Vital Statistics	Instituto Nacional de Estadística	Month, Municipality	2009-2016
Malaria	Vital Statistics	Instituto Nacional de Estadística	Month, Municipality	2009-2016
Cross-Cutting	Encuesta Nacional de Salud Materno Infantil	Instituto Nacional de Estadística	Complete Micro data	2008-2009, 2014-2015
Cross-Cutting	Encuesta Nacional de Condiciones de Vida	Instituto Nacional de Estadística	Complete Micro data	2000, 2006, 2011, 2014
Cross-Cutting	Encuesta Nacional de Empleo e Ingresos	Instituto Nacional de Estadística	Complete Micro data	2002-2017
HIV	WorldPop population density estimations for Guatemala.	University of Southampton, Geodata Institute.	Raster image with population density at a resolution of 100x100m	2010, 2012, 2015
TB	WorldPop population density estimations for Guatemala.	University of Southampton, Geodata Institute.	Raster image with population density at a resolution of 100x100m	2010, 2012, 2015
Malaria	WorldPop population density estimations for Guatemala.	University of Southampton, Geodata Institute.	Raster image with population density at a resolution of 100x100m	2010, 2012, 2015