2016 Sustainability Index and Dashboard Summary: Nicaragua

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

<table>
<thead>
<tr>
<th>Score Description</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dark Green (Sustainable)</td>
<td>8.50-10 points</td>
</tr>
<tr>
<td>Light Green (Approaching sustainability)</td>
<td>7.00-8.49 points</td>
</tr>
<tr>
<td>Yellow (Emerging sustainability)</td>
<td>3.50-6.99 points</td>
</tr>
<tr>
<td>Red (Unsustainable)</td>
<td>&lt;3.50 points</td>
</tr>
</tbody>
</table>

The workshop was held in Managua on January 28 2016 with the participation of 80 representatives from Government, Civil Society, Academic Institutions and NGOs. There was a preliminary review of over 120 documents that provided information about the four areas assessed by the SID tool.

Nicaragua is a country classified as low median income, and has a concentrated HIV epidemic.

The country has been showing important advances in the areas of governance, leadership and accountability, reaching the highest score (10.00) in planning and coordination, followed by public access to information (8.00), and policy and governance (7.50). Civil society participation (5.93) needs to be improved, especially to sustain the advances to date, which are highly dependent on external support. The area with the lowest score was private sector participation.

Regarding the National Health System and service provision, there have been important advances in the area of Human Resources for Health (8.08) followed by the improvement of the Logistics System capacity (7.23). Laboratory capacities (6.11) and Service Provision (5.74) need to be improved, especially to sustain the advances to date, which are also highly dependent on external support. The area with the lowest score is quality management (1.95).

Regarding the strategic investment, efficiency and sustainable financing area, the assessment recognized the advances in health sector technical efficiencies (8.45), and recognized the gap in the mobilization of national financial resources (5.83).

There have been important advances in strategic information especially related to performance evaluation (7.66) and epidemiological data (6.67). Financial and expenditure analysis needs to be improved, especially to sustain the advances to date, which are also highly dependent on external technical support. This is a very important area that requires more development of local capacity.
Sustainability Analysis for Epidemic Control: Nicaragua

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

### Governance, Leadership, and Accountability

<table>
<thead>
<tr>
<th>Element</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Planning and Coordination</td>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Policies and Governance</td>
<td>7.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Civil Society Engagement</td>
<td>5.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Private Sector Engagement</td>
<td>2.57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Public Access to Information</td>
<td>8.00</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### National Health System and Service Delivery

<table>
<thead>
<tr>
<th>Element</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Service Delivery</td>
<td>4.31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Human Resources for Health</td>
<td>8.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Commodity Security and Supply Chain</td>
<td>7.23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Quality Management</td>
<td>1.95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Laboratory</td>
<td>6.11</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Strategic Investments, Efficiency, and Sustainable Financing

<table>
<thead>
<tr>
<th>Element</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Domestic Resource Mobilization</td>
<td>5.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Technical and Allocative Efficiencies</td>
<td>8.45</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Strategic Information

<table>
<thead>
<tr>
<th>Element</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Epidemiological and Health Data</td>
<td>6.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Financial/Expenditure Data</td>
<td>5.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Performance Data</td>
<td>7.66</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Financing the HIV Response

- Partner Gov't
- PEPFAR
- Global Fund
- Other Donors
- Private Sector
- Out of Pocket

### GNI Per Capita (Atlas Method)

- **current U.S. dollars:**
  - **1990:** 0
  - **1994:** 1000
  - **1998:** 1500
  - **2002:** 2000
  - **2006:** 2500
  - **2010:** 3000
  - **2014:** 3500

- **Population Pyramids (2015):**
  - Female %
  - Male %

### National Clinical Cascade

- **Total Population**
- **PLHIV**
- **Diagnosed**
- **Linked to Care**
- **On ART**
- **Retained on Tx**
- **Virally Suppressed**

### Epidemiological Data

- **Adult Prevalence (%)**
- **Adult Incidence (%)**
- **PLHIV**
- **AIDS-related Deaths**

### Population and Fertility

- **Total Pop. (millions)**
- **Pop. Growth Rate (%)**
- **Fertility Rate (%)**

### Population Pyramid (2015)

- **Age Range:**
  - 0-4
  - 5-9
  - 10-14
  - 15-19
  - 20-24
  - 25-29
  - 30-34
  - 35-39
  - 40-44
  - 45-49
  - 50-54
  - 55-59
  - 60-64
  - 65-69
  - 70-74
  - 75-79
  - 80+

- **Gender Distribution**
  - Female %
  - Male %
## Domain A. Governance, Leadership, and Accountability

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

### 1. Planning and Coordination

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</td>
<td></td>
<td>1.1 Score: 2.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1 National Strategic Plan STI/HIV/AIDS Plan (NSP) November 5, 2011.</td>
<td>1.1.1 The cost of the NSP was approved by CONSIDA in 2014, but it has not been published. The data in the plan was used for the Concept Note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.2 NSP 2015-2019 has been finished but it is not yet published</td>
<td>1.1.2 SNP 2006-2010; 2011-2015 is posted in: <a href="http://www.pasca.org/content/planes-estrategicos-y-operativos">http://www.pasca.org/content/planes-estrategicos-y-operativos</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. There is a multiyear national strategy. Check all that apply:</td>
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<tr>
<td></td>
<td></td>
<td>It is costed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>It is updated at least every five years</td>
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<tr>
<td></td>
<td></td>
<td>Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care (including children and Adolescents), PEPFAR, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Strategy includes explicit plans and activities to address the needs of key populations.</td>
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<tr>
<td></td>
<td></td>
<td>Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children</td>
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<tr>
<td></td>
<td></td>
<td>1.2 Score: 2.50</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>A. There is no national strategy for HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. The national strategy is developed with participation from the following stakeholders (check all that apply):</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Its development was led by the host country government</td>
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<tr>
<td></td>
<td></td>
<td>Civil society actively participated in the development of the strategy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy</td>
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<tr>
<td></td>
<td></td>
<td>Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>External agencies (i.e. donors, other multilateral orgs., etc.) Supporting HIV services in-country participated in the development of the strategy</td>
<td></td>
</tr>
</tbody>
</table>
### 1.3 Coordination of National HIV Implementation

To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?


*Monitoring and Evaluation of the National Strategic Plan 2011-2015. Published on July 2012*

The National Nicaraguan Commission held a workshop to evaluate the Information System and the Monitoring and Evaluation Plan of the HIV National Response, with the participation of a total of 40 representatives of the different sectors involved in the national response to HIV. *Available at:* [http://www.pasca.org/noticias/docs/NI141_022615.pdf](http://www.pasca.org/noticias/docs/NI141_022615.pdf)

### 1.4 Sub-national Unit Accountability

Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)

#### 1.4.3 General Health Law No. 423, approved March 14, 2002, and published in La Gaceta No. 91 on May 17, 2002


The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes.

- Joint operational plans are developed that include key activities of implementing organizations.
- Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.

### Planning and Coordination Score:

<table>
<thead>
<tr>
<th>1.3</th>
<th>2.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4</td>
<td>2.50</td>
</tr>
</tbody>
</table>

**Total:** 10.00
### 2. Policies and Governance

Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

For each category below, check no more than one box that reflects current national policy for ART initiation:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CD4 &lt;500</td>
<td>A. The guidelines of the Ministry of Health establish ARV treatment with a CD4 below 500. In the Concept Note it is also established initiation of ARV treatment with CD4 counts below 500. This is the norm followed at health facilities. Concept Note, page 31: effective decentralization of ART at municipal level, ensuring ARV treatment in the co-formulation of fixed dosages in a single tablet with the preferred first-line regimen recommended by WHO/PAHO (TDF/FTC/EFV) to all new ART patients with a CD4 count of 350–500 cells per mm3</td>
</tr>
<tr>
<td>B. Pregnant and Breastfeeding Mothers</td>
<td>Test and START/Option B+ (current WHO Guideline)</td>
<td>B. Antiretroviral Therapy Guide for Adults with HIV, page 26</td>
</tr>
<tr>
<td></td>
<td>Option B</td>
<td>C. Guide for the Management of Mother to Child Transmission of HIV, page 31</td>
</tr>
<tr>
<td>C. Adolescents (10-19 years)</td>
<td>Test and START (current WHO Guideline)</td>
<td>D. Idem</td>
</tr>
<tr>
<td></td>
<td>CD4=500</td>
<td></td>
</tr>
<tr>
<td>D. Children (&lt;10 years)</td>
<td>Test and START (current WHO Guideline)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CD4=500 or clinical eligibility</td>
<td></td>
</tr>
</tbody>
</table>

### 2.1 WHO Guidelines for ART Initiation

Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?

Check all that apply:

- [ ] A. national public health service act that includes the control of HIV
- [ ] A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART
- A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits
- Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)
- Policies that permit patients stable on ART to have reduced ARV pick-ups (i.e. every 3-6 months)
- Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready
- Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS

#### 2.1 Score: 1.07

### 2.2 Enabling Policies and Legislation

Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?

Check all that apply:

- [ ] A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART
- A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits
- Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)
- Policies that permit patients stable on ART to have reduced ARV pick-ups (i.e. every 3-6 months)
- Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready
- Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS

#### 2.2 Score: 1.02
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections [not specific to HIV] for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)

<table>
<thead>
<tr>
<th>Population</th>
<th>Law/policy exists</th>
<th>Law/policy is fully implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults living with HIV (women):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults living with HIV (men):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children living with HIV:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay men and other men who have sex with men (MSM):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who inject drugs (PWID):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with disabilities:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3 Score: 0.87

This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. Regulations to Law 820: Law for the Promotion, Protection and Defense of the Human Rights for HIV/AIDS, and for its prevention and care. Published in La Gaceta, official newspaper, on June 29, 2015

General Health Law No. 423, approved March 14, 2002, and published in La Gaceta No. 91 on May 17, 2002

National Policy for the prevention and control of STI, HIV and AIDS. Nicaragua, November 2006

Ministerial Resolution 671-2014 issued by the Ministry of Health in Nicaragua

Law 655 for the Protection of Refugees; General Law 761 for Migration and Immigration

Law No 763. Law for the rights of persons with disability


Law 779, Integral Law against violence to women and Reforms to Law No 641, Penal Code

Law No. 287. Code of Childhood and Adolescence, Republic of Nicaragua

### Prisoners:
- [ ] Law/policy exists
- [ ] Law/policy is fully implemented

### Sex workers:
- [ ] Law/policy exists
- [ ] Law/policy is fully implemented

### Transgender people:
- [ ] Law/policy exists
- [ ] Law/policy is fully implemented

### Women and girls:
- [ ] Law/policy exists
- [ ] Law/policy is fully implemented

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

Check all that apply:

- Criminalization of sexual orientation and gender identity:
  - [ ] Law/policy exists
  - [ ] Law/policy is enforced

- Criminalization of cross-dressing:
  - [ ] Law/policy exists
  - [ ] Law/policy is enforced

- Criminalization of drug use:
  - [ ] Law/policy exists
  - [ ] Law/policy is enforced

- Criminalization of sex work:
  - [ ] Law/policy exists
  - [ ] Law/policy is enforced

- Ban or limits on needle and syringe programs for people who inject drugs (PWID):
  - [ ] Law/policy exists
  - [ ] Law/policy is enforced

#### 2.4 Score: 1.32

This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question. Decree No 74-99, Regulations to Law No. 285, Reform Law and additions to Law No. 177, Law for narcotics, psychotropics and controlled substances.

This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Law/policy exits</th>
<th>Law/policy is enforced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ban or limits on opioid substitution therapy for people who inject drugs (PWID):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ban or limits on needle and syringe programs in prison settings:</td>
<td></td>
<td></td>
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<tr>
<td>Ban or limits on opioid substitution therapy in prison settings:</td>
<td></td>
<td></td>
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<tr>
<td>Ban or limits on the distribution of condoms in prison settings:</td>
<td></td>
<td></td>
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<tr>
<td>Ban or limits on accessing HIV and SRH services for adolescents and young people:</td>
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<td></td>
</tr>
<tr>
<td>Criminalization of HIV non-disclosure, exposure or transmission:</td>
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<td></td>
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<tr>
<td>Travel and/or residence restrictions:</td>
<td></td>
<td></td>
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<tr>
<td>Restrictions on employment for people living with HIV:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights? | There are host country government efforts in place as follows (check all that apply):
- To educate PLHIV about their legal rights in terms of access to HIV services
- To educate key populations about their legal rights in terms of access to HIV services
- National law exists regarding health care privacy and confidentiality protections
- Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found | 2.5 Score: 1.07 |

| Regulations to Law 830: Law for the Promotion, Protection and Defense of the Human Rights for HIV/AIDS, and for its prevention and care. Published in La Gaceta, official newspaper, on June 29, 2015 |
| General Health Law No. 423, approved March 14, 2002, and published in La Gaceta No. 91 on May 17, 2002 |
| National Policy for the prevention and control of STI, HIV and AIDS. Nicaragua, November, 2006 |
| Ministerial Resolution 671-2014 issued by the Ministry of Health in Nicaragua |

| 2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)? | A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. |
| B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. |
| C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less. | 2.6 Score: 1.43 |

| A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. |
| B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. |
| C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less. |

| 2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS? | A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. |
| B. The host country government does respond to audit findings by implementing changes as a result of the audit. |
| C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable. | 2.7 Score: 0.71 |

| Policies and Governance Score: 7.50 |
### 3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.

#### 3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?

- A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response.
- B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen.
- C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.

**Check A, B, or C; if C checked, select appropriate disaggregates:**

- ☐ There are no formal channels or opportunities.
- ☐ There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback.
- ☐ There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:
  - During strategic and annual planning
  - In joint annual program reviews
  - For policy development
  - As members of technical working groups
  - Involvement on government HIV/AIDS program evaluation teams
  - Involvement in surveys/studies
  - Collecting and reporting on client feedback

**Score:**

<table>
<thead>
<tr>
<th>3.1 Score:</th>
<th>1.67</th>
</tr>
</thead>
</table>

**Data Source**

- Regulations to Law 820: Law for the Promotion, Protection and Defense of the Human Rights for HIV/AIDS, and for its prevention and care. Published in La Gaceta, official newspaper, on June 29, 2015. Article 26 of the Nicaraguan National AIDS Commission, CONISIDA

**Notes/Comments**

- CONISIDA and the Country Coordinating Mechanism (CCM) have representatives from the civil society and donors.

- The documents described in the source column were elaborated jointly with civil society and donor agencies.

- The report on the epidemiological situation of HIV/AIDS is presented annually to delegates from various CONSIDAS.

#### 3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?

- A. There are no formal channels or opportunities.
- B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback.
- C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:

  - During strategic and annual planning
  - In joint annual program reviews
  - For policy development
  - As members of technical working groups
  - Involvement on government HIV/AIDS program evaluation teams
  - Involvement in surveys/studies
  - Collecting and reporting on client feedback

**Score:**

<table>
<thead>
<tr>
<th>3.2 Score:</th>
<th>1.43</th>
</tr>
</thead>
</table>

**Data Source**

- Monitoring and Evaluation of the National Strategic Plan 2011-2015. Published on July 2012
- National Policy for the prevention and control of STI, HIV and AIDS. Nicaragua, November, 2006

**Notes/Comments**

- The documents described in the source column were elaborated jointly with civil society and donor agencies.

- The report on the epidemiological situation of HIV/AIDS is presented annually to delegates from various CONSIDAS.
### 3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?

- **3.3 Score:** 1.67


### 3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)?

- **3.4 Score:** 0.00


### 3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?

- **3.5 Score:** 1.17


**Civil Society Engagement Score:** 5.93
4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.

<table>
<thead>
<tr>
<th>4.1 Score: 0.56</th>
<th></th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Article 34 of Law 820 establishes that the representative of the private sector is the person who integrates the Projects Management Committee at the national and regional autonomous level, which is presided by the Minister of Health. The law contemplates the participation of the private sector, providing a space for its integration. It has been noted that there is poor attendance to ordinary and extraordinary sessions to which they are invited.</td>
<td></td>
</tr>
</tbody>
</table>
4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?

A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS.

B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply):

- In patient advocacy and human rights
- In programmatic decision making
- In technical decision making
- In service delivery for both public and private providers
- In HIV/AIDS basket or national health financing decisions
- In advancing innovative sustainable financing models
- In HRH development, placement, and retention strategies
- In building capacity of private training institutions
- In supply chain management of essential supplies and drugs

4.2 Score: 0.56

Law 820: Law for the Promotion, Protection and Defense of the Human Rights for HIV/AIDS, and for its prevention and care. Article 6. “Education for Prevention. The Ministry of Health, by conduct of its Committee for Information, Education and Prevention of CONISIDA, together with the Ministry of Education, the Office of the Ombudsmen for the Defense of Human Rights, organizations of the civil society, social and community movements and the private sector, must draft a plan for education and prevention of HIV, which will be used at different levels for formal and non formal education, and in public and private entities and institutions.”

USAID, with projects ASSIST and DELIVER, work in capacity building directed to health workers from the private sector focusing primarily on HIV.

Law 820: Law for the Promotion, Protection and Defense of the Human Rights for HIV/AIDS, and for its prevention and care. Chapter IV, Human Rights and Obligations to persons living with HIV and AIDS, article 12. Rights: “The Ministry of Health, through the Ethics and Human Rights Committee of CONISIDA, jointly with the institutions, organizations and private sector that work in HIV are responsible to guarantee that the human rights of persons living with HIV are respected, as established in article 13 of said Law. It is against the law to require any type of HIV testing as a condition for a job, education or health service, from employers or in behalf of them, in public or private, national or foreign institutions based in the country.”
The legislative and regulatory framework makes the following provisions (check all that apply):

4.3 Score: 0.63

- Systems are in place for service provision and/or research reporting by private sector facilities to the government.
- Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART.
- Tax deductions for private health providers.
- Tax deductions for private training institutions training health workers.
- Open competition for private health providers to compete for government services.
- General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national level (e.g., district levels).
- Freedom of private providers to advocate for policy, legal, and regulatory frameworks.
- Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.

General Health Law, Law No. 423, approved on March 14, 2002. Published in La Gaceta No. 91, date May 17, 2002. Article 3: Health Sector and Health Systems: “For the effect of this Law, it is understood that Health Sector means the ensemble of institutions, organizations, persons, public and private facilities, programs and activities, which have the common objective to provide health care to the individual, the family and the community with actions that comprise prevention, promotion, recovery and rehabilitation.”

Law No. 891, Law of Reforms and Additions to Law No. 822, Law of Tax Concertation, Article 77, Subjective Exonerations: “Only those activities destined to constitutive purposes are exempt from Income Tax, and from other income taxes derived from capital and loss of capital, including the following: I. the Universities and Superior Level Technical Education Centers, in conformity with article 125 of the Political Constitution of the Republic of Nicaragua.”

4.4 Score: 0.83

The legislative and regulatory framework makes the following provisions (check all that apply):

- Tax deductions for health-related private businesses (i.e., pharmacists, supply chain, etc.).
- Systematic and timely process for private company registration and/or testing of new health products, drugs, diagnostics kits, medical devices.
- Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business.
- Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response.
- Workplace policies support HIV-related services and/or benefits for employees.
- Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.

By means of USAID (PASCA LMG), in coordination with CONISIDA, have supported the elaboration of HIV policies for the work place in companies of the private sector. Said policies include the commitments to reduce practices and behaviour that favor discrimination and stigmatization of PLHIV and members of Key Populations.

Response of the private sector to HIV. Available at: http://www.pasca.org/content/respuesta-empresarial-al-vih

Meeting on the implementation of HIV/AIDS policies in the workplace. Available at: http://www.pasca.org/content/reun%C3%B3n-sobre-implementaci%C3%B3n-de-pol%C3%ADticas-de-vihsida-en-el-lugar-de-trabajo

Workshop for the elaboration of HIV policies in the Workplace. Available at: http://www.pasca.org/content/taller-para-la-elaboraci%C3%B3n-de-pol%C3%ADticas-de-vihsida-en-el-lugar-de-trabajo

Article 27 of Law 820 includes as members of National CONISIDA a representative of each of the sectors of the private enterprise. The Regulations of the same Law, in Article 34, establish that a representative of the private sector is a member of the Committee for Projects Management at the National and Autonomous Regional levels, which is presided by the Minister of Health.
### 4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?

- **A.** There are no enablers for private health service provision for lower and middle-income HIV patients.
- **B.** The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply):
  - Private-for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs.
  - The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.

<table>
<thead>
<tr>
<th>4.5 Score:</th>
<th>0.00</th>
</tr>
</thead>
</table>

### 4.6 Private Health Sector Demand:

Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?

- **A.** The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector.
- **B.** The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply):
  - HIV-related services/products are covered by national health insurance.
  - HIV-related services/products are covered by private or other health insurance.
  - Adequate risk pooling exists for HIV services.
  - Models currently exist for cost-recovery for ART.
  - HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.

<table>
<thead>
<tr>
<th>4.6 Score:</th>
<th>0.00</th>
</tr>
</thead>
</table>

**Private Sector Engagement Score:** 2.57
5. **Public Access to Information:** Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.

<table>
<thead>
<tr>
<th><strong>Score</strong></th>
<th><strong>Source of Data</strong></th>
<th><strong>Notes/Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1 Score:</strong> 1.00</td>
<td><strong>5.2 Score:</strong> 1.00</td>
<td><strong>5.3 Score:</strong> 2.00</td>
</tr>
<tr>
<td>The epidemiological situation of HIV. MOH. Statistics, component on STI and HIV/AIDS.</td>
<td>The epidemiological situation of HIV. MOH. Statistics, component on STI and HIV/AIDS.</td>
<td>The epidemiological situation of HIV. Component of Statistics component on STI and HIV/AIDS.</td>
</tr>
<tr>
<td>It is presented to the group of donors and members of CONSIDA integrated by government and civil society institutions.</td>
<td>It is presented to the group of donors and members of CONSIDA integrated by government and civil society institutions.</td>
<td>It is presented to the group of donors and members of CONSIDA integrated by government and civil society institutions.</td>
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</tbody>
</table>

### 5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?

- A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection.
- B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years.
- C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.

### 5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?

- A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures.
- B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures.
- C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.

### 5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?

- A. The host country government does not make HIV/AIDS performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming.
- B. The host country government makes HIV/AIDS performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming.
- C. The host country government makes HIV/AIDS performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming.
### 5.4 Procurement Transparency

**Does the host country government make government HIV/AIDS procurements public in a timely way?**

- A. Host country government does not make any HIV/AIDS procurements.
- B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.
- C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.
- D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.

<table>
<thead>
<tr>
<th>Description</th>
<th>5.4 Score</th>
<th>MOH Website: Contracts &amp; acquisition (<a href="https://www.minsa.gob.ni/">https://www.minsa.gob.ni/</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.</td>
<td>2.00</td>
<td>5.4 Score: 2.00</td>
</tr>
</tbody>
</table>

### 5.5 Institutionalized Education System

**Is there a government agency that is explicitly responsible for educating the public about HIV?**

- A. There is no government institution that is responsible for this function and no other groups provide education.
- B. There is no government institution that is responsible for this function but at least one of the following provides education:
  - Civil society
  - Media
  - Private sector
- C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.

<table>
<thead>
<tr>
<th>Description</th>
<th>5.5 Score</th>
<th>MOH. General Department of Teaching and Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>2.00</td>
<td>5.5 Score: 2.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public Access to Information Score: 8.00</th>
</tr>
</thead>
</table>

**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A**
## Domain B. National Health System and Service Delivery

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

### 6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.1 Responsiveness of facility-based services to demand for HIV services:</strong> Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)</td>
<td><strong>6.1 Score:</strong> 0.37</td>
</tr>
<tr>
<td><strong>6.1.1 Ministry of Health -MINSA. Family and Community Model</strong></td>
<td><strong>6.1.1</strong> The country has a Model of Health Care that permits the adaptation of health services in relation to demand and that is articulated with community health services. The universities, in coordination with the Ministry of Health (MINSA), place graduates in high demand sites. Decentralization of rapid tests and ARVT in 2006 by the MINSA, with support of USAID and CDC, is a clear evidence of this capacity to respond to needs. The universities and civil society movement are joining efforts in training new health resources.</td>
</tr>
<tr>
<td>**6.1.3 MINSA. General Division of Human Resources, October, 2015. USAID</td>
<td>HCI. Cost-effectiveness in the quality of care to persons with HIV in Nicaragua, March 2012.**</td>
</tr>
</tbody>
</table>
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation components of community-based HIV services through (check all that apply):

- Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services
- National guidelines detailing how to operationalize HIV services in communities
- Providing official recognition to skilled human resources (e.g., community health workers) working and delivering HIV services in communities
- Providing financial support for community-based services
- Providing supply chain support for community-based services
- Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)

6.2.1 MINSA. Family and Community Model
6.2.5 USAID|DELIVER. Diagnosis: storage conditions and internal control of medical supplies in non governmental organizations who care for population who have high risk for HIV/AIDS, October, 2013.

6.2 Score: 1.11

6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)?

(if exact or approximate percentage known, please note in Comments column)

- A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas
- B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas
- C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas
- D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas
- E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas

6.3 Score: 0.00

6.2.1 and 6.2.2 The authorities of the Ministry of Health expressed that they have a model that allows constant adjustment of strategies so that each month, 100 medical brigades are mobilized throughout the country to reach 100 municipalities. The brigades travel with medications, rapid tests and other resources. The medical teams have been trained to improve care to persons living with HIV. Currently 1000 nurses are being trained to join these health teams. Likewise, the work of CONISIDA at local and national scale have increased the participation of civil society.

The expenditure in HIV for prevention actions is 58% of total budget for HIV/AIDS, and it is provided by national resources (Nicaraguan Institute for Social Security -INSS, MINSA). For 2014, the country committed to cover 10% of ARVT. 65 health facilities of the INSS provide HIV services. The General Secretary of Health expressed that by year 2016, the Ministry of Health will procure 50% of ARV.
6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?

- A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions.
- B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance.
- C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance.
- D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.

6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)?

(if exact or approximate percentage known, please note in Comments column)

- A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas.
- B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas.
- C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas.
- D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas.
- E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.

6.4 Score: 0.37

6.5 Score: 0.43


The expenditure on HIV prevention is covered to a large extent by the public sector (69%). Nevertheless, the expenditure for care and treatment (ARV and tests) are financed largely by cooperation agencies. Representatives of the Universidad del Valle expressed that the studies performed by the university (BSS 2013-2014 y 2006-2010) have also shown the above distribution of HIV expenditure distribution.

In the Conclusions of the study "Modes of Transmission Model" it states the following, "the evaluation of the HIV epidemic in Nicaragua by studying incidence cases has permitted the disaggregation of total incidence and prioritization of the most affected groups, beyond the prevalence analysis which is dependent on the denominator population size and does not reflect the current modes of transmission."

According to the data of NASA 2013, the proportion of expenditure on Key Populations is only 7.8% of total expenditures.
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?

- A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.
- B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.
- C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.
- D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.

6.6 Score: 0.37


The participants expressed that funds are required so that NGO can work closer to health facilities and also to be able to provide accompaniment to victims living with HIV who have suffered violations of their rights when they present their complaints to the national police.

6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?

The national MOH (check all that apply):
- Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.
- Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.
- Assesses current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.
- Develops sub-national level budgets that allocate resources to high burden service delivery locations.
- Effectively engages with civil society in program planning and evaluation of services.
- Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.

6.7 Score: 0.93


6.7.3 No official sources were found, but officials from MOH & NAC expressed that there is ongoing work on a Human Resource Needs Assessment.

7.4 The Concept Note of the GF describes the allocation of funds to populations based on epidemiological criteria.
### 6.8 Sub-national Service Delivery Capacity

Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?

<table>
<thead>
<tr>
<th>Sub-national health authorities (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.</td>
</tr>
<tr>
<td>☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.</td>
</tr>
<tr>
<td>☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.</td>
</tr>
<tr>
<td>☐ Develop sub-national level budgets that allocate resources to high burden service delivery locations.</td>
</tr>
<tr>
<td>☐ Effectively engage with civil society in program planning and evaluation of services.</td>
</tr>
<tr>
<td>Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.</td>
</tr>
</tbody>
</table>

**Notes/Comments**

- 6.8 Score: 0.74

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The policies have been implemented from the national level to subnational levels through local branches of CONISIDA in each territory. The organizations of the civil society are assuming the leadership of CONISIDA decentralized branches, for example ADESENI.

A participant from organizations of the sexual diversity groups expressed that even when civil society has assumed a more active role, its participation has to improve and become more significant.

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### 7. Human Resources for Health

HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.

#### 7.1 HRH Supply

To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?

<table>
<thead>
<tr>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ The country’s pre-service education institutions are producing an adequate supply and skills mix of health care providers</td>
</tr>
<tr>
<td>☐ The country’s health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden</td>
</tr>
<tr>
<td>☐ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas</td>
</tr>
<tr>
<td>☐ The country’s pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children</td>
</tr>
</tbody>
</table>

**Notes/Comments**

- 7.1 Score: 0.67

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#### 7.1.2 MOH. General Division of Human Resources. Distribution of physicians by specialty and subspecialty. October, 2015, (access January 14, 2016).


**Notes/Comments**

- The MOH projects ASIST and DELIVER have provided technical assistance to improve knowledge and skills to human resources in 10 universities in HIV service provision, with a coverage of 94% of future physicians and 100% of future nurses.

- There is a collaboration agreement between the Ministry of Health and the universities. Each year, students graduating from the universities are located in positions where the MOH has defined there is a need, but this process requires some refinement.

- A professor of POLISAL University expressed that there are advances in incorporating HIV into the academic curricula, following the experience of universities that have an HIV counseling clinic where students can rotate and learn. The universities of Leon, UNAN and UCAP expressed that the subject of HIV is fully integrated into their curricula. The universities work with the MINSA to design the contents of said courses.
### 7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>There is no inventory or plan for transition of donor-supported health workers</td>
</tr>
<tr>
<td>B.</td>
<td>There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support</td>
</tr>
<tr>
<td>C.</td>
<td>There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented</td>
</tr>
<tr>
<td>D.</td>
<td>There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</td>
</tr>
<tr>
<td>E.</td>
<td>No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</td>
</tr>
</tbody>
</table>


In the Concept Note, page 42, it is mentioned that the government will be assuming gradually the payment of human resource, stating since July 2014. The physicians of the VICTIS (KP-friendly) clinics have been transferred to the MINSA budget as well as several physicians who work at the Roberto Calderón facility. Authorities of the MINSA expressed that they have gradually assumed the salary of medical human resources, for example internists at the EMID.
### 7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Host country institutions provide no (0%) health worker salaries</td>
</tr>
<tr>
<td>B.</td>
<td>Host country institutions provide minimal (approx. 1-9%) health worker salaries</td>
</tr>
<tr>
<td>C.</td>
<td>Host country institutions provide some (approx. 10-49%) health worker salaries</td>
</tr>
<tr>
<td>D.</td>
<td>Host country institutions provide most (approx. 50-89%) health worker salaries</td>
</tr>
<tr>
<td>E.</td>
<td>Host country institutions provide all or almost all (approx. 90%+) health worker salaries</td>
</tr>
</tbody>
</table>

**Score:** 3.33

**7.4 Pre-service:** Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?

1. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)
2. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):
   - Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services
   - Institutions maintain process for continuously updating content, including updated content or revised content
   - Updated curricula contain training related to stigma & discrimination of PLWHA
   - Institutions track student employment after graduation to inform planning

**Score:** 1.17

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MOH Budget 2016. [access January 14, 2016].

**7.3 Score:** 3.33

**7.4 Score:** 1.17

In the budget of the MOH 2016, page 262, it is stated that 50% of the budget of the MOH will be dedicated to payment of staff salaries who are contracted for delivery of professional services. Nevertheless, in the NASA Report 2012, in page 42, it states that salaries were 37% of the total expenditure in HIV. Additionally, it mentions that 64% of services delivered are provided by staff from the public sector, mainly in health centers and hospitals with HIV/STI clinics.

In Nicaragua, birth attendants and midwives do not receive a salary.

A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)

B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):

- Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services
- Institutions maintain process for continuously updating content, including updated content or revised content
- Updated curricula contain training related to stigma & discrimination of PLWHA
- Institutions track student employment after graduation to inform planning
### 7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?

(if exact or approximate percentage known, please note in Comments column)

Check all that apply among A, B, C, D:

- A. The host country government provides the following support for in-service training in the country (check ONE):
  - Host country government implements no (0%) HIV/AIDS related in-service training
  - Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training
  - Host country government implements some (approx. 10-49%) HIV/AIDS in-service training
  - Host country government implements most (approx. 50-89%) HIV/AIDS in-service training
  - HIV/AIDS in-service training

- B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS

- C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians

- D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)

### 7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?

- A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management
- B. There is no HRIS in country, but some data is collected for planning and management
- C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:
  - The HRIS is primarily financed and managed by host country institutions
  - There is a national strategy or approach to interoperability for HRIS
  - The government produces HR data from the system at least annually
  - Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)

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**Human Resources for Health Score**: 8.08

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**7.5 Score: 0.58**


http://www.theglobalfund.org/en/portfolio/country/?loc=NIC

USAID | ASSIST. Pedagogical package to develop competencies among health care workers in Family Planning, Mother Child Care and HIV/AIDS, April 2015.

USAID | DELIVER. Pedagogical package to develop competencies in logistics management and rational use of medical supplies, February, 2013.

**7.6 Score: 1.33**

MDH: Labor Force by Department, Municipality and Profiles, October 2015, (access January 15, 2016).

file:///C:/Users/user/Downloads/FL_Por_Departamento_y_Municipio_y_Perfil.pdf


file:///C:/Users/user/Downloads/metas_desafio_nicaragua_final_junio2012.8291.pdf

A y B. 42 health facilities from the public and private sector provide HIV care to people living with HIV. There exists coordination between the institutions MFI FAMILIA of the MINSA and the Ministry of Education which train families with children with HIV, by means of the program AMOR (LOVE).

In 2012, USAID, with projects HCI and DELIVER, supported the development of a pedagogical package to be used for continuous in-service education of health care workers. The program was adopted by the MINSA.

The representatives from Universidad del Valle and CDC expressed that they have a Training Plan under the modality of a certification course directed to all the physicians of the VICITS clinics. The course is coordinated by the MINSA.
### 8. Commodity Security and Supply Chain

The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.

#### 8.1 ARV Domestic Financing

What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)

(if exact or approximate percentage known, please note in Comments column)

<table>
<thead>
<tr>
<th>Option</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. This information is not known.</td>
<td>8.1 Score: 0.22</td>
</tr>
<tr>
<td>C. Minimal (approx. 1-9%) funding from domestic sources</td>
<td>Until 2013, all antiretroviral drugs were funded by the Global Fund, but in 2014 the country gradually started funding the procurement of ARVs using state resources (from the Treasury), covering an estimated 10 percent of first-line ARV medications, which is 6% of the total. The plan is to use the Strategic Fund provided by PAHO as the procurement mechanism.</td>
</tr>
<tr>
<td>D. Some (approx. 10-49%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>E. Most (approx. 50 – 89%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>F. All or almost all (approx. 90%+) funded from domestic sources</td>
<td></td>
</tr>
</tbody>
</table>

#### 8.2 Test Kit Domestic Financing

What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)

(if exact or approximate percentage known, please note in Comments column)

<table>
<thead>
<tr>
<th>Option</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. This information is not known</td>
<td>8.2 Score: 0.42</td>
</tr>
<tr>
<td>C. Minimal (approx. 1-9%) funding from domestic sources</td>
<td>The country provides HIV tests to all pregnant women for early diagnosis and prevention of MTCT. According to the General Secretary of the MOH, Dr. Beteta, 300,000 rapid tests are performed each year and all related costs are covered by the MOH.</td>
</tr>
<tr>
<td>D. Some (approx. 10-49%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>E. Most (approx. 50 – 89%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>F. All or almost all (approx. 90%+) funded from domestic sources</td>
<td></td>
</tr>
</tbody>
</table>

#### 8.3 Condom Domestic Financing

What is the estimated percentage of condom procurement funded by domestic (not donor) sources?  
**Note:** The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.

(if exact or approximate percentage known, please note in Comments column)

<table>
<thead>
<tr>
<th>Option</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. This information is not known</td>
<td>8.3 Score: 0.83</td>
</tr>
<tr>
<td>C. Minimal (approx. 1-9%) funding from domestic sources</td>
<td>The Concept Note reports that 7 to 9 out of every 10 persons living with HIV are receiving condoms in health centers and hospitals of the Ministry of Health.</td>
</tr>
<tr>
<td>D. Some (approx. 10-49%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>E. Most (approx. 50 – 89%) funded from domestic sources</td>
<td></td>
</tr>
<tr>
<td>F. All or almost all (approx. 90%+) funded from domestic sources</td>
<td></td>
</tr>
</tbody>
</table>
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?

8.4 Score: 2.02

- A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).
- B. There is a plan/SOP that includes the following components (check all that apply):
  - [ ] Human resources
  - [ ] Training
  - [ ] Warehousing
  - [ ] Distribution
  - [ ] Reverse Logistics
  - [ ] Waste management
  - [ ] Information system
  - [ ] Procurement
  - [ ] Forecasting
  - [ ] Supply planning and supervision
  - [ ] Site supervision

CIPS is undergoing rehabilitation so Laboratorio RAMOS is acting as Logistics Operator. It offers adequate capacity and security conditions for storage.

Improvement of storage facilities is co-financed by the government and the Global Fund in 8 storage facilities throughout the country in hospitals and SILAIS.

Additionally, the information systems are being integrated from SIGLIM to Galeno.

The General Secretary of the Ministry of Health expressed that currently there are no problems with the supply chain because of the existence of a central warehouse (ALMACENTRO), and because staff at the departmental level has been trained in supply management and are supervised periodically by the Central MOH. When stock outs of ARV do occur, it is usually attributable to local management errors at the health facility.

The delegate from CDC suggests that instead of supplying PLHIV with medications every month, they should switch to three-month supplies to favor adherence to therapy.

In June, 2013 USAID, with its projects DELIVER and SCMS, helped MINSA to draft a plan to improve the storage conditions in the storage rooms of CIPS.

8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)?

(if exact or approximate percentage known, please note in Comments column)

8.5 Score: 0.42

- A. This information is not available.
- B. No (0%) funding from domestic sources.
- C. Minimal (approx. 1-9%) funding from domestic sources.
- D. Some (approx. 10-49%) funding from domestic sources.
- E. Most (approx. 50-89%) funding from domestic sources.
- F. All or almost all (approx. 90%+) funding from domestic sources.
8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?

- The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities.
- Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time.
- MOH or other host government personnel make re-supply decisions with minimal external assistance.
- Decision makers are not seconded or implementing partner staff.
- Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects.
- Team that conducts analysis of facility data is at least 50% host government.

Score: 2.22

8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years?

- A comprehensive assessment has not been done.
- B. A comprehensive assessment has been done but the score was lower than 80% or in the bottom three quartiles for the global average of other assessments.
- C. A comprehensive assessment has been done and the score was higher than 80% or in the top quartile for the assessment.

Score: 1.11

Commodity Security and Supply Chain Score: 7.23

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services.

- The host country government does not have structures or resources to support site-level continuous quality improvement.
- The host country government:
  - Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement.
  - Has a budget line item for the QM program.
  - Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions.

Score: 0.67


Notes/Comments: The Concept Note provides insights on the integration of the information systems from Siglim to Galeno.

The MOH General Secretary expressed that the quality of services provided to the populations needs to improve. He believes quality assessment to be the main problem of MOH health facilities, which was corroborated by the representatives of organizations from civil society and key populations.

Dr. René Gutiérrez from Universidad del Valle expressed that VICITS (KP-friendly) clinics have a quality assurance plan, which started to be implemented in February 2016.
| 9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.) | 9.2 Score: 0.00 | USAID | HCI. A successful path to improving maternal-child, family planning and HIV/AIDS healthcare. September 2013, [access January, 2016]. Posted in: https://dec.usaid.gov/dec/content/Detail.aspx?ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjktZTcxMjM2NDBmY2Uy&rID=MzY1NTEx&inr=VHJ1ZQ==&dc=YWRk&bckToL | There are norms, protocols and algorithms for the prevention, diagnosis and treatment of HIV/AIDS, as well as standards and indicators for quality monitoring. |
|---|---|---|---|
| A. There is no HIV/AIDS-related QM/QI strategy | | | |
| B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) | | | |
| C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements | | | |
| D. There is a current HIV/AIDS program specific QM/QI strategy | | | |
| 9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting? | 9.3 Score: 0.00 | USAID | HCI. A successful path to improving Family Planning, HIV/AIDS and Mother-Child care. September 2013, [access January, 2016]. Posted in: https://dec.usaid.gov/dec/content/Detail.aspx?ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjktZTcxMjM2NDBmY2Uy&rID=MzY1NTEx&inr=VHJ1ZQ==&dc=YWRk&bckToL | The Ministry of Health has a unit which has the responsibility to collect HIV information in regard to testing, positive cases, follow-up on data and epidemiological surveillance so all cases are registered. It operates nationwide. |
| | | | |
| A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. | | | |
| B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): | | | |
| - The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement. | | | |
| - There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities. | | | |
| - There is documentation of results of QI activities and demonstration of national HIV program improvement. | | | |
| 9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services? | 9.4 Score: 1.00 | USAID | ASSIST. Pedagogical package to develop competencies among health care workers in Family Planning, Mother Child Care and HIV/AIDS, April 2015. | There are norms, protocols and algorithms for the prevention, diagnosis and treatment of HIV/AIDS, as well as standards and indicators for quality monitoring. |
| | | | |
| A. There is no training or recognition offered to build health workforce competency in QI. | | | |
| B. There is health workforce competency-building in QI, including: | | | |
| - Pre-service institutions incorporate modern quality improvement methods in curricula. | | | |
| - National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services. | | | |
### 9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?

The national-level QM structure:
- ☐ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services
- ☐ Regularly convenes meetings that includes health service consumers
- ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement

Sub-national QM structures:
- ☐ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services
- ☐ Regularly convene meetings that includes health service consumers
- ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement

Site-level QM structures:
- ☐ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement

<table>
<thead>
<tr>
<th>Quality Management Score</th>
<th>9.5 Score: 0.29</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The Ministry of Health has a unit which has the responsibility to collect HIV information in regard to testing, positive cases, follow-up on data and coverage, but there are no evidences that this information is used to improve quality of care at clinical level.</td>
</tr>
</tbody>
</table>

### 10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.

10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?

- A. There is no national laboratory strategic plan
- B. National laboratory strategic plan is under development
- C. National laboratory strategic plan has been developed, but not approved
- D. National laboratory strategic plan has been developed and approved
- E. National laboratory plan has been developed, approved, and costed

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Officials from CNDR and NAC were consulted and they stated that currently there is work to formulate the Laboratory Strategic Plan, with the support of the Global Fund.</td>
</tr>
</tbody>
</table>

10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites?

(if exact or approximate percentage known, please note in Comments column)

- A. Regulations do not exist to monitor minimum quality of laboratories in the country.
- B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated).
- C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated).
- D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated).
- E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated).
- F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The laboratory networks in the country comprise 238 laboratory facilities; 192 belong to the MINSA, 38 to IPSS, 4 to the Military Hospital and 11 to the Ministry of the Interior. They all use a standardized algorithm for rapid tests. The regional and departmental hospitals are responsible for confirmatory tests; quality control is performed by CNDR.</td>
</tr>
</tbody>
</table>
### 10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.11</td>
<td>O. There are not adequate qualified laboratory personnel to achieve sustained epidemic control</td>
</tr>
<tr>
<td>3.33</td>
<td>O. There are qualified laboratory personnel to perform the following key functions:</td>
</tr>
<tr>
<td></td>
<td>- HIV diagnosis in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- TB diagnosis in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- CD4 testing in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- Viral load testing in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- Early Infant Diagnosis in laboratories</td>
</tr>
<tr>
<td></td>
<td>- Malaria infections in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- Microbiology in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- Blood banking in laboratories and point-of-care settings</td>
</tr>
<tr>
<td></td>
<td>- Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings</td>
</tr>
</tbody>
</table>

### 10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>O. There is not sufficient infrastructure to test for viral load.</td>
</tr>
<tr>
<td>8.4</td>
<td>O. There is sufficient infrastructure to test for viral load, including:</td>
</tr>
<tr>
<td></td>
<td>- Sufficient viral load instruments and reagents</td>
</tr>
<tr>
<td></td>
<td>- Appropriate maintenance agreements for instruments</td>
</tr>
<tr>
<td></td>
<td>- Adequate specimen transport system and timely return of results</td>
</tr>
</tbody>
</table>

### 10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.33</td>
<td>O. No (0%) laboratory services are financed by domestic resources.</td>
</tr>
<tr>
<td>1.11</td>
<td>O. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.</td>
</tr>
<tr>
<td>1.11</td>
<td>O. Some (approx. 10-49%) laboratory services are financed by domestic resources.</td>
</tr>
<tr>
<td>1.11</td>
<td>O. Most (approx. 50-89%) laboratory services are financed by domestic resources.</td>
</tr>
<tr>
<td>1.11</td>
<td>E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.</td>
</tr>
</tbody>
</table>

**Laboratory Score: 6.11**

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**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B**
### Domain C. Strategic Investments, Efficiency, and Sustainable Financing

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


<table>
<thead>
<tr>
<th>11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is no explicit funding for HIV/AIDS in the national budget.</td>
<td>Nicaragua. Concept Note for the request of funding for HIV from the Global Fund, 2015-2017 period.</td>
<td>11.1b HIV is a priority for the government, so it is explicit in the national budget, which has been presented to the donor community and cooperation agencies. The approach to the epidemic is cross-cutting, in which financing of prevention, treatment and social support is executed within the projects and programs with population focus (family and community), from the platform of the corresponding ministries (health, education, youth and others).</td>
</tr>
<tr>
<td>B. There is explicit HIV/AIDS funding within the national budget.</td>
<td>NAC. Measurement of Expenditure in AIDS, MEGAS 2013, Nicaragua. Published in 2015. NAC. National Strategic Plan - NSP, 2015-2019. [Concluded but not yet published].</td>
<td></td>
</tr>
<tr>
<td>The HIV/AIDS budget is program-based across ministries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The budget includes or references indicators of progress toward national HIV/AIDS strategy goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The budget includes specific HIV/AIDS service delivery targets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National budget reflects all sources of funding for HIV, including from external donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1 Score: 1.67</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (If exact or approximate percentage known, please note in Comments column)

<table>
<thead>
<tr>
<th>11.2 Score: 1.67</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There are no HIV/AIDS goals/targets articulated in the national budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.2.6 The Principal Recipient-Nicaraguan Institute of Social Security of the Global Fund reports 89% performance of indicators related to budget execution based on the targets and objectives of the grant. As such, the score will be E.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 11.3 Budget Execution

*For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e., excluding any donor funds) at both the national and subnational level?*

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Information is not available</td>
<td>0.00</td>
<td>MDH. Nicaragua. DAIA Plan 2009-2012</td>
</tr>
<tr>
<td>B. There is no national HIV/AIDS budget, or the execution rate was 0%</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>C. 1-9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. 10-49%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. 50-89%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. 90% or greater</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.3.a Although there is no information on the execution of national resources in HIV, the country has experience in the estimation of public expenditures and procurement of contraceptive supplies (DAIA).

### 11.4 Domestic Resource Mobilization

*PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)*

### 11.5 Domestic Spending

*What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)?*

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. None (0%) is financed with domestic funding.</td>
<td>2.50</td>
<td>NAC. Measurement of Expenditure in AIDS, MEGAS 2012, Nicaragua. Published in 2014.</td>
</tr>
<tr>
<td>B. Very little (approx. 1-9%) is financed with domestic funding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Some (approx. 10-49%) is financed with domestic funding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Most (approx. 50-89%) is financed with domestic funding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. All or almost all (approx. 90%+) is financed with domestic funding.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.5.d As reported in the NASA expenditure measurement, 2012, the government is assuming 58% of the national expenditures (public and private).

**Domestic Resource Mobilization Score:** 5.83
12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicaragua. Concept Note for the request of funding for HIV from the Global Fund, 2015-2017 period.</td>
<td>12.1.2 The 2015 Concept Note, lists the tools used to assign resources, for example, Spectrum.</td>
</tr>
<tr>
<td>NAC. Measurement of Expenditure in AIDS, NASA, Nicaragua. Published in 2014.</td>
<td>12.1.4 The study, Modes of Transmission, has also been used to focus strategic actions in correlation with financial resources.</td>
</tr>
<tr>
<td></td>
<td>12.1.b.5 Use of the Unique Code Model</td>
</tr>
</tbody>
</table>

### 12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources?

(note: full score achieved by selecting one checkbox)

- [ ] Optima
- [ ] Spectrum (including EPP and Goals)
- [ ] AIDS Epidemic Model (AEM)
- [ ] Modes of Transmission (MOT) Model
- [ ] Other recognized process or model (specify in notes column)

<table>
<thead>
<tr>
<th>12.1 Score:</th>
<th>1.43</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1.a.1 The 2015 Concept Note, lists the tools used to assign resources, for example, Spectrum.</td>
<td>12.1.2 The 2015 Concept Note, lists the tools used to assign resources, for example, Spectrum.</td>
</tr>
<tr>
<td>12.1.a.4 The study, Modes of Transmission, has also been used to focus strategic actions in correlation with financial resources.</td>
<td>12.1.b.5 Use of the Unique Code Model</td>
</tr>
</tbody>
</table>

### 12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations?

(if exact or approximate percentage known, please note in Comments column)

- [ ] A. Information not available
- [ ] B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.
- [ ] C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.
- [ ] D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.
- [ ] E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.
- [ ] F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.

<table>
<thead>
<tr>
<th>12.2 Score:</th>
<th>0.71</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2.a.1 The 2015 Concept Note, lists the tools used to assign resources, for example, Spectrum.</td>
<td>12.1.2 The 2015 Concept Note, lists the tools used to assign resources, for example, Spectrum.</td>
</tr>
<tr>
<td>12.2.a.4 The study, Modes of Transmission, has also been used to focus strategic actions in correlation with financial resources.</td>
<td>12.1.b.5 Use of the Unique Code Model</td>
</tr>
<tr>
<td>12.2.a.5 Use of the Unique Code Model</td>
<td>12.1.b.5 Use of the Unique Code Model</td>
</tr>
</tbody>
</table>
12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)?

(If exact or approximate percentage known, please note in Comments column)

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Information not available.</td>
<td></td>
</tr>
<tr>
<td>B. No resources (0%) are targeting the highest burden geographic areas.</td>
<td></td>
</tr>
<tr>
<td>C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.</td>
<td></td>
</tr>
<tr>
<td>D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.</td>
<td></td>
</tr>
<tr>
<td>E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.</td>
<td></td>
</tr>
<tr>
<td>F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.</td>
<td></td>
</tr>
</tbody>
</table>

12.3 Score: 1.07


12.3 A Managua is the city where the epidemic is concentrated. Although, the NASA study is not disaggregated at subnational level, 1,403 out of 2,935 persons were receiving the ARVT in public health facilities in Managua. During that same year, out of the total of new infections detected in the country, 50% were people who resided in Managua (1,019).

In the near future, the plan is to increase the scope of the Global Fund coverage beyond Managua to other departments reporting high number of HIV cases.

12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprogramming domestic investments based on new or updated program data during the government funding cycle?

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is no system for funding cycle reprogramming</td>
<td></td>
</tr>
<tr>
<td>B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used.</td>
<td></td>
</tr>
<tr>
<td>C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</td>
<td></td>
</tr>
<tr>
<td>D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data</td>
<td></td>
</tr>
</tbody>
</table>

Q3 Score: 1.43


Reforms to the national annual budget are implemented by means of a law. This is the way to make adjustments in the budget within the current year (before the annual term has concluded).

12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes?

(Note: full score can be achieved without checking all disaggregate boxes).

<table>
<thead>
<tr>
<th>Option</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs</td>
<td></td>
</tr>
<tr>
<td>B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):</td>
<td></td>
</tr>
<tr>
<td>HIV Testing</td>
<td></td>
</tr>
<tr>
<td>Care and Support</td>
<td></td>
</tr>
<tr>
<td>ART</td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
</tr>
<tr>
<td>VMMC</td>
<td></td>
</tr>
<tr>
<td>OVC Service Package</td>
<td></td>
</tr>
<tr>
<td>Key population Interventions</td>
<td></td>
</tr>
</tbody>
</table>

12.5 Score: 1.43


Concept Notes are adjusted annually. It includes resources from the GF and government funds. There is no masculine circumcision performed in the country as a prevention strategy.
12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?

- Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies
- Reduced overhead costs by streamlining management
- Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc.
- Improved procurement competition
- Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years)
- Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)
- Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)
- Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years)
- Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)

12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year?

(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)

- A. Partner government did not pay for any ARVs using domestic resources in the previous year.
- B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen.
- C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen.
- D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen.
- E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.

Technical and Allocative Efficiencies Score: 8.45

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C
### Domain D: Strategic Information

#### 13.1 Who Leads General Population Surveys & Surveillance:

To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?

<table>
<thead>
<tr>
<th>Score</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</td>
<td>13.1.1 ENDESA, page 11, the support of the Global Fund through the project, “Nicaragua joined to respond toward a contained HIV/AIDS epidemic”, Round 8, and the World Bank project, “Improvement of Family and Community Services” implemented by the MINSAP, United Nations Population Fund (UNFPA), and the United Nations Fund for Children (UNICEF).</td>
</tr>
<tr>
<td>0.71</td>
<td>B. Surveys &amp; surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</td>
<td>13.1.2 The country has an agenda for evaluation and research on HIV: Inventory of performed studies and the research agenda.</td>
</tr>
<tr>
<td></td>
<td>C. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</td>
<td>13.1.3 INIDE, as a governmental entity is responsible for vital statistics of the population of Nicaragua and leads and coordinates activities related to information on HIV among the general population. Likewise, INIDE recognizes the important role played by the World Bank as a partner in different stages of research studies: a) design of the questionnaire; b) field data collection; c) training of survey teams; and d) analysis of data.</td>
</tr>
<tr>
<td></td>
<td>D. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies</td>
<td></td>
</tr>
</tbody>
</table>

#### 13.2 Who Leads Key Population Surveys & Surveillance:

To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?

<table>
<thead>
<tr>
<th>Score</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.2</td>
<td>A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</td>
<td>13.2.1 The studies realized in the country on behavior of key population are led by NAC and the donor agencies, have contributed to have a national research agenda based on analysis of knowledge gaps, which take into account cultural aspects of the rural indigenous and Afro-descendant populations, and have included topics of heterosexual men and MSM. Available in the SNP, page 35, Result 1.5.</td>
</tr>
<tr>
<td>0.71</td>
<td>B. Surveys &amp; surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</td>
<td>13.2.1a TRAC: NICARAGUA (2012): TRaC HIV/AIDS Study, Men that have Sex with Men in Managua and Chinandega. 3rd National Round, posted in: <a href="http://www.pasca.org/sites/default/files/2012_TRIAC_HSH_NICARAGUA.pdf">http://www.pasca.org/sites/default/files/2012_TRIAC_HSH_NICARAGUA.pdf</a></td>
</tr>
<tr>
<td></td>
<td>D. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies</td>
<td></td>
</tr>
</tbody>
</table>

#### 13.3 Who Finances General Population Surveys & Surveillance:

To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?

<table>
<thead>
<tr>
<th>Score</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.3</td>
<td>A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</td>
<td>13.3.1 ENDESA was financed by the Government of Nicaragua, the World Bank, UNFPA, UNICEF and the Global Fund, page 11.</td>
</tr>
<tr>
<td>1.67</td>
<td>B. No financing (0%) is provided by the host country government</td>
<td>13.3.2 Nicaragua, together with donors, has implemented six surveys to measure conditions of life (1993, 1998, 2001, 2005, 2009 y 2013).</td>
</tr>
<tr>
<td></td>
<td>C. Minimal financing (approx. 1-9%) is provided by the host country government</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Some financing (approx. 10-49%) is provided by the host country government</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Most financing (approx. 50-89%) is provided by the host country government</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F. All or almost all financing (90% +) is provided by the host country government</td>
<td></td>
</tr>
</tbody>
</table>
### 13.4 Who Finances Key Populations Surveys & Surveillance

To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?

<table>
<thead>
<tr>
<th>13.4 Score</th>
<th>0.83</th>
</tr>
</thead>
</table>

**13.4.1 Measurement of Expenditure in AIDS, Nicaragua 2012.**

In the study on expenditures on AIDS of year 2012, the expenditures corresponding to research was $202,758, which represented 1% of total expenditures.

**13.4.1 NAC. Measurement of Expenditure in AIDS, NASA 2012, Nicaragua.**

February 2014. Posted in: [http://www.pasca.org/userfiles/INFORME%20MEGAS%202012%20NI%20FINAL.pdf](http://www.pasca.org/userfiles/INFORME%20MEGAS%202012%20NI%20FINAL.pdf)

**13.5 Comprehensiveness of Prevalence and Incidence Data:** To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)

<table>
<thead>
<tr>
<th>13.5 Score</th>
<th>0.95</th>
</tr>
</thead>
</table>

**13.5.1 Modes of Transmission (MoT), AIDS Commission of Nicaragua, April, 2012.**


**13.5.2 Epidemiological Surveillance Report on HIV in Nicaragua.**

MINSA. October, 2015.

**13.5.2 In a periodic way (quarterly), the country, via the MOH AIDS program, generates information on incidence by age group, geographic distribution of affected population and PLHIV, and incorporates the data into the Epidemiological Surveillance Information System (SIVE).**

---

**Check ALL boxes that apply below:**

- [ ] The host country government collects at least every 5 years HIV prevalence data disaggregated by:
  - Age
  - Sex
  - Key populations (FSW, PWID, MSM/transgender)
  - Priority populations (e.g., military, prisoners, young women & girls, etc.)
  - Sub-national units

- [ ] The host country government collects at least every 5 years sub-national HIV incidence disaggregated by:
  - Age
  - Sex
  - Key populations (FSW, PWID, MSM/transgender)
  - Priority populations (e.g., military, prisoners, young women & girls, etc.)
  - Sub-national units

---

**Choosing...**

- No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years
- No financing (0%) is provided by the host country government
- Minimal financing (approx. 1-9%) is provided by the host country government
- Some financing (approx. 10-49%) is provided by the host country government
- Most financing (approx. 50-89%) is provided by the host country government
- All or almost all financing (approx. 90% +) is provided by the host country government

---

*Note: Full score possible without selecting all disaggregates.*
### 13.6 Comprehensiveness of Viral Load Data

**Data**

To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (If exact or approximate percentage known, please note in Comments column)

**Possible scores**

- A. The host country government does not collect/report viral load data or does not conduct viral load monitoring
- B. The host country government collects/reports viral load data (answer both subsections below)
  - For what proportion of PLHIV (select ONE of the following):  
    - Less than 25%
    - 25-50%
    - 50-75%
    - More than 75%
  - A. Age
  - B. Sex
  - C. Key populations (FSW, PWID, MSM/transgender)
  - D. Priority populations (e.g., military, prisoners, young women & girls, etc.)


http://www.theglobalfund.org/en/portfolio/country/?loc=NIC

### 13.7 Comprehensiveness of Key and Priority Populations Data

**Data**

To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)

**Possible scores**

- A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (military, etc.).
- B. The host country government conducts (answer both subsections below):  
  - IBBS for (check ALL that apply):
    - Female sex workers (FSW)
    - Men who have sex with men (MSM)/transgender
    - People who inject drugs (PWID)
    - Priority populations (e.g., military, prisoners, young women & girls, etc.)
  - Size estimation studies for (check ALL that apply):
    - Female sex workers (FSW)
    - Men who have sex with men (MSM)/transgender
    - People who inject drugs (PWID)
    - Priority populations (e.g., military, prisoners, young women & girls, etc.)


http://www.theglobalfund.org/en/portfolio/country/?loc=NIC

### 13.8 Timeliness of Epi and Surveillance Data

**Data**

To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?

**Possible scores**

- A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys
- B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups
- C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups


**13.8.2** The National Program keeps records of the levels of viral load. Nevertheless, no systematic reports are available.

http://www.theglobalfund.org/en/portfolio/country/?loc=NIC
13. Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?

- No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.
- The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):
  - A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data
  - A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance
  - Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection
  - An in-country internal review board (IRB) exists and reviews reviews all protocols.

13.9 Score: 0.48

Epidemiological and Health Data Score: 6.67

14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.

- A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years
- B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions.
- C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with substantial external technical assistance.
- D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with some external technical assistance.
- E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance.

14.1 Score: 1.25


14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)?

- A. No HIV/AIDS expenditure tracking has occurred within the past 5 years
- B. No financing (0%) is provided by the host country government
- C. Minimal financing (approx. 1-9%) is provided by the host country government
- D. Some financing (approx. 10-49%) is provided by the host country government
- E. Most financing (approx. 50-89%) is provided by the host country government
- F. All or almost all financing (90% +) is provided by the host country government

14.2 Score: 1.67


"The results of data audits has been recorded and feedback has been given to those entities which have been audited."

There are guidelines for supervision of routine collection of data at the facilities that provide HIV services, both at urban and community levels. Nevertheless, it is necessary to standardize supervision guidelines, and it is imperative to train staff to guarantee the quality of data.

In regard to research on HIV, Law 820 stipulates that all NAC must approve all research.
### 14.3 Comprehensiveness of Expenditure Data
To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?

- ☐ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years
- ☐ B. HIV/AIDS expenditure data are collected (check all that apply):
  - By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others
  - By expenditures per program area, such as prevention, care, treatment, health systems strengthening
  - By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel
  - Sub-nationally

**Score:** 1.25


### 14.4 Timeliness of Expenditure Data
To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?

- ☐ A. No HIV/AIDS expenditure data are collected
- ☐ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago
- ☐ C. HIV/AIDS expenditure data were collected at least once in the past 3 years
- ☐ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures
- ☐ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures

**Score:** 0.83


**14.4.2** During the latest MEGAS study, the information flowed in a routine fashion from the actors participating in the national response by means of submission of data to the national authority. This was a different modality than before as the collection of information was mainly financed with national resources.

### 14.5 Economic Studies
Does the host country government conduct health economic studies or analyses for HIV/AIDS?

- ☐ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS
- ☐ B. The host country government conducts (check all that apply):
  - Costing
  - Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis)
  - Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation)
  - Market demand analysis

**Score:** 0.83


14.5.1 A recent health economic analysis on HIV, using 2010 data, showed that 65.5% of expenditures correspond to hospital care, with a total of 459 hospital days in 44 events, for an average of 1.79 hospital admissions per person and an average stay of 10.4 days, page 8. This data showed a reduction in costs as the number of hospitalizations events decrease and savings of $561 for each case that didn’t require hospital care. In summary, the intervention saved money and improved outcomes, so it is considered cost effective.

**Financial/Expenditure Data Score:** 5.83
### 15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
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<tbody>
<tr>
<td>15.1.1 CONISIDA. National Strategic Plan for HIV 2011-2015. Nicaragua, November 2011. Posted in: <a href="http://www.pasca.org/sites/default/files/Ni_PEN_2011_2015.pdf">http://www.pasca.org/sites/default/files/Ni_PEN_2011_2015.pdf</a></td>
<td>15.1.1 The country has an epidemiological surveillance system of second and third generation as well as an information, monitoring and evaluation system, and has established mechanisms for submission of information coming from the actors who participate in the HIV response: national institutions, cooperation agencies and non governmental organizations. A harmonized database has been compiled with multisectoral, indigenous and afro descendant population indicators, which respond to national and international commitments. The information is discussed and analyzed in forums where follow up is assessed, as well as the current situation of the epidemic and the national response, and compliance with prevention, diagnosis and treatment activities. Annually, lessons learned are used to improve the National Response to advance national and international commitments. 15.1.2 It was not possible to obtain information on all the variables of the Epidemiological Record. There is no standardization for submission of monthly reports, and often times submissions are untimely. Page 48.</td>
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</tbody>
</table>

### 15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?

<table>
<thead>
<tr>
<th>15.1 Score:</th>
<th>1.33</th>
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- A. No system exists for routine collection of HIV/AIDS service delivery data
- B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions
- C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution
- D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution
- E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government

### 15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)?

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<th>15.2 Score:</th>
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- A. No routine collection of HIV/AIDS service delivery data exists
- B. No financing (0%) is provided by the host country government
- C. Minimal financing (approx. 1-9%) is provided by the host country government
- D. Some financing (approx. 10-49%) is provided by the host country government
- E. Most financing (approx. 50-89%) is provided by the host country government
- F. All or almost all financing (90% +) is provided by the host country government
### 15.3 Comprehensiveness of Service Delivery Data

**A.** The host country government routinely collects & reports service delivery data for:

- [ ] HIV Testing
- [ ] PMTCT
- [ ] Adult Care and Support
- [ ] Adult Treatment
- [ ] Pediatric Care and Support
- [ ] Orphans and Vulnerable Children
- [ ] Voluntary Medical Male Circumcision
- [ ] HIV Prevention
- [ ] AIDS-related mortality

**B.** Service delivery data are being collected:

- [ ] By key population (FSW, PWID, MSM/transgender)
- [ ] By priority population (e.g., military, prisoners, young women & girls, etc.)
- [ ] By age & sex
- [ ] From all facility sites (public, private, faith-based, etc.)
- [ ] From all community sites (public, private, faith-based, etc.)

### 15.4 Timeliness of Service Delivery Data

**A.** The host country government does not routinely collect/report HIV/AIDS service delivery data

**B.** The host country government collects & reports service delivery data annually

**C.** The host country government collects & reports service delivery data semi-annually

**D.** The host country government collects & reports service delivery data at least quarterly

### 15.3.1 Epidemiological Surveillance Report on HIV in Nicaragua. MINSA. October, 2015.

15.3.1 A report on the behavior of the epidemic in the country is produced quarterly, highlighting new cases, PLHIV on ART/T, broken down by age, sex, geographical location and accumulated mortality data. Additionally, a progress report is published annually, with evaluation on the performance of a set of indicators which measure HIV care. The MINSA registers data on orphans, and provides care for this group with the participation of the program MI FAMILIA.

15.3.2 It was not possible to obtain information on all the variables of the Epidemiological Record. There is no standardization for submission of monthly reports, and often times submissions are untimely, page 48. There is not a unique database which includes all the variables necessary for the national response, page 49.
15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?

- A. The host country government does not routinely analyze service delivery data to measure program performance.
- B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):
  - Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention
  - Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.)
  - Site-specific yield for HIV testing (HTC and PMTCT)
  - AIDS-related mortality rates
  - Variations in performance by sub-national unit
  - Creation of maps to facilitate geographic analysis

15.5 Score: 1.00

15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?

- A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.
- B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):
  - A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance
  - A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of HIV program indicators, which are led and implemented by the host country government
  - Standard national procedures & protocols exist for routine data quality checks at the point of data entry
  - Data quality reports are published and shared with relevant ministries/government entities & partner organizations
  - The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans

15.6 Score: 0.27

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**Performance Data Score:** 7.66

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**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D**