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**PROYECTO CAPACITY
CENTROAMÉRICA**



USAID|Central America Capacity Project

Strengthening the quality of care and improving the quality of life
of people living with HIV and other vulnerable populations

Cooperative Agreement No. AID-596-A-00-09-00106-00

Final Report
(October 2009 to September 2013)

Guatemala, December 18, 2013

TABLE OF CONTENTS

ACRONYMS/ABBREVIATIONS	iii
EXECUTIVE SUMMARY	v
I. REGIONAL RESULTS	1
1. Optimizing Performance for Quality –OPQ– and the Continuum of Care – CoC –	1
2. In-service Training.....	9
3. Pre-Service Training.....	13
4. Information Technology	19
5. Systematization and Institutionalization	24
II. ADMINISTRATIVE REPORT	29
III. FINANCIAL REPORT	30

ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
CENDEISS	Centro of Desarrollo Estratégico e Información en Salud and Seguridad Social
CoC	Continuum of Care
CODESIDA	Coordinadora Departamental de la Lucha contra el SIDA
COMUREVIH-D	Comisión Multisectorial of Respuesta al VIH en Desamparados
CONE	Consejo Nacional de Enfermería
CRSSI	Costa Rican Social Security Institute
CUM	Centro Universitario Metropolitano
ENEG	Escuela Nacional de Enfermería de Guatemala
EOP	End Of Project
FBO	Faith-based Organization
GD	General Director
GGP	Genesis Group of Panama
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources for Health Information System
IEPROES	Instituto Especializado de Educación Superior de Profesionales de Salud de El Salvador
iHRIS	Human Resources Information Software Platform
IT	Information Technology
JSI	John Snow Inc.
KP	Key Population
LFP	Learning for Performance
LOP	Laps Of Project
MARPS	Most at risk populations
MOE	Ministry of Education
MOH	Ministry of Health
MSH	Management Sciences for Health
NAC	National AIDS Commission (Belize)
NAP	National AIDS Program
NICRA	Negotiated Indirect Cost Rate Allocation
NC	North Carolina
NDACC	National Drug Abuse Control Council
NGO	Non-governmental Organizations
OPQ	Optimizing Performance for Quality
PAHO	Pan American Health Organization
PASCA	Programa para Fortalecer la Respuesta Centroamericana al VIH
PASMO	Pan American Social Marketing Organization
PEPFAR	President's Emergency Plan for AIDS Relief

PI	Performance Improvement
PLHIV	People Living with HIV
PSI	Population Services International
PwP	Prevention With Positives
REDCA+	Regional Network of PLH+
SCMS	Supply Chain Management System
SIGSA	Guatemala Health Management Information System
SIRC	Sistema de Registro e Impresión de Certificados
SSI	Social Security Institutes
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TOT	Training of Trainers
UCA	Universidad Autónoma Centroamericana
UJMD	Universidad de Costa Rica
UCR	Universidad José Matías Delgado
URC	University Research Corp., LLC
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling Test
WHO	World Health Organization

EXECUTIVE SUMMARY

During the past four years (October 2009 through September 2013) the USAID|Central America Capacity Project (CAMCAP) has strengthened the ministries of health (MOH), social security institutes (SSI), governmental and non-governmental organizations (NGO), civil society, and universities and training institutions to provide a coordinated response to HIV in Belize, Costa Rica, El Salvador, Guatemala and Panama. Through the provision of Technical Assistance (TA) the Project transferred to and empowered the counterpart with the capacities needed to ensure that health workers had the knowledge, skills and abilities to provide quality services to people living with HIV (PLHIV) and key populations (KP) at higher risk. The Project made strategic alliances with other organizations such as PAHO, UNAIDS, other USAID partners, ministries of health and the social security institutes in the five countries assuring a coordinated approach to avoid financial and technical duplication.

Activities under the five following results were as follows:

- Result 1: Optimize Performance and Quality (OPQ) in hospitals and multi-sector networks.
- Result 2: In-service training for human resources for health (HRH) and training for participants in the networks (governmental NGOs and Civil Society).
- Result 3: Strengthening of pre-service training for treatment providers, with updated information on HIV/AIDS and increase access to early diagnosis through voluntary counseling and testing.
- Result 4: Information technologies and human resources information system.
- Result 5: Systematization and institutionalization of OPQ.

In terms of Result 1, the OPQ methodology was applied in 57 hospitals, 49% of the total in the five countries and three more than the original target. The multidisciplinary hospital teams applied this tool to identify performance gaps through the measurement of approximately 300 standards for 18 hospital service areas. The multidisciplinary hospital quality committees then made intervention plans for closing these gaps to meet performance standards. The average overall performance scores for each country improved steadily with each measurement round.

Under this result, the Project has operationalized the Continuum of Care (CoC) model that has been the basis for the formation and development of departmental multi-sector networks consisting: of governmental and non-governmental organizations; faith-based organizations (FBO); and civil society including the affected populations. One network in each of the five countries developed: strategic and intervention plans; and conducted monthly meetings to monitor implementation of plan activities aimed to assure access to quality services. Support for adherence to antiretroviral therapy was done by strengthening the referral and response system to link community services with the health system.

The in-service training result reached 106% of the goal through competency-based trainings in: bio-safety; stigma and discrimination; counseling and testing; and OPQ. Moreover, the Project conducted trainings in team work, assertive communication; and conflict resolution to promote leadership and commitment of the participants in sustaining the interventions. These trainings helped close gaps in knowledge and skills, even though the high level of rotation of personnel was a constant challenge.

During the past four years the Project provided TA to 14 universities and training institutions for designing updated HIV curricula including incorporation of topics of regional relevance. Eight specific HIV curricular proposals were presented to the university authorities.

Trainings in peer pre and post-test HIV counseling and testing were provided to the university professors and students, in coordination with each country's MOH National AIDS Program (NAP). The universities then organized Testing Days to provide practice for their students and access to HIV testing for the wider student body.

In relation to the Information Systems Result, the Project supported Costa Rica, El Salvador and Guatemala in implementing and/or improving the information system with essential information on human resources. In the case of Costa Rica, the national training authority for the Social Security Institute (CENDEISS) has a structured system that reports on personnel trained by service, topic and profession and the Project supported the development of a module for cleaning the data and facilitating decision making. In El Salvador, in spite of an initial expression of interest in the iHRIS software platform, the MOH decided they wanted to use a different platform on which they had standardized their other information systems.

The Guatemalan MOH, together with PAHO agreed to implement the iHRIS software platform that would provide them with updated workforce information following which they would develop the in-service training module. After signing a Memorandum of Understanding, they updated more than 80% of the health worker records in 87 implementation units.

In terms of Result 5, Systematization and Institutionalization, the Project developed forums, workshops, national meetings and cross-site visits for the hospital multidisciplinary teams and central level personnel responsible for implementing OPQ to refine its application and determine best practices for improving performance. Panama, Belize, Costa Rica and Guatemala have made progress in institutionalizing the methodology. These four countries presented formal letters for OPQ expansion and will institutionalize the methodology national level.

Financial Report

The Project executed a total of \$5,909,531 (\$4,560,185 Direct Costs and \$1,349,346 Indirect Costs). This amount matches the budget approved in Modification No. 8 and reflects the NICRA change from 30.68 percent to 28.77 percent. Modification 8, dated July 7, 2013 reduced project funding by \$1,090,469 (from \$7,000,000 to \$5,909,531) and obligated \$78,003 to match the new total funding, and shortened the Project completion date by one year to September 29, 2013.

During the LOP the CAMCAP project collected 1,092,689 in cost-share, 23 percent above the EOP target of \$886,430 set in Modification 8. This achievement evidences the commitment and success that each Country Representative had in collecting cost-share. This amount comes from efforts to implement the OPQ strategy through the Ministry of Health, partner hospitals and the National AIDS Programs.

I. REGIONAL RESULTS

The Project contributed to the following five results (October 2009 – September 2013) in the Project countries of Belize, Costa Rica, El Salvador, Guatemala and Panama.

- Result 1: Optimize Performance and Quality (OPQ) in hospitals and multi-sector networks.
- Result 2: In-service training for human resources for health (HRH) and training for participants in the networks (governmental NGOs and Civil Society).
- Result 3: Strengthening of pre-service training for treatment providers, with updated information on HIV/AIDS and increase access to early diagnosis through voluntary counseling and testing.
- Result 4: Information technologies and human resources information system.
- Result 5: Systematization and institutionalization of OPQ.

During the period of execution (October 2009 – June 2013) the Project worked to comply with the goals in accordance with the Cooperative Agreement No. AID-596-A-00-09-00106-00. The work focused on supporting the ministries of health (MOH), social security institutes (SSI), governmental and non-governmental organizations (NGO), civil society, and universities and training institutions to provide a coordinated response to HIV in Belize, Costa Rica, El Salvador, Guatemala and Panama. The Project closed one year early due to the unification of activities with the CAMPLUS project (Cooperative Agreement No. AID-596-LA-11-00001) under a TEC increase.

1. Optimizing Performance for Quality –OPQ– and the Continuum of Care – CoC –

Improve HIV/AIDS provider performance and integrate treatment with community-based support ensuring complementarities and prevention promotion.

➤ 1.A OPTIMIZING PERFORMANCE FOR QUALITY –OPQ –

From 2009 to 2013 the Project strengthened the technical capacity of the MOH, SSI, and other governmental and non-governmental organizations (NGO), and civil society to implement OPQ in 57 hospitals at the tertiary and secondary levels. In order to implement OPQ the Project conducted negotiations at the policy and technical levels, and conducted capacity-building workshops for the management and multidisciplinary teams at the local and central levels. The workshops combined the background information to provide knowledge of the methodology with practice to acquire the necessary skills to: apply the measurement instruments; analyze the results; and develop intervention plans for closing performance gaps.

For implementing this methodology, it was essential that the central and local level of the MOH and NAP define and approve the standards to be used for the health facilities' performance assessments. Project TA in this area was directed to the MOH/SSI, other governmental and non-

governmental organizations, and civil society. Other key coordination was with national and international entities to align methodologies and action plans, coordinate agendas for going to the field, and, in some cases, develop joint activities principally for performance gap-closing.

Table 1.1 shows the total number of hospitals applying OPQ by country and the Project year they began their participation. During Project Year 1, 36 hospitals in the five countries initiated the application of OPQ with 20 more hospitals joining in during Year 2 and three more initiating in Year 3. Originally the Project was only going to work in 54 hospitals, but at the requests and needs of the MOH/SSI, the target was raised to 57 facilities: 7 in Belize (2 of which are clinics); 9 in Costa Rica, 12 in El Salvador; 15 in Guatemala and 14 in Panama.

Table 1.1 Health facilities implementing OPQ by country and project year of initiation as of September 2013

USAID Capacity Central America Project Year	Belize	Costa Rica	El Salvador	Guatemala	Panama
37 participating facilities in year I (Oct 2009- Sep 2010)	1. Karl Heussner Memorial 2. Orange Walk 3. Cleopatra White 4. Corozal 5. Policlínica Family Life Association	1. Hospital San Rafael of Alajuela 2. Hospital Nacional of las Mujeres 3. Hospital México 4. Dr. Max Peralta of Cartago	1. San Juan of Dios Santa Ana. 2. Dr. Jorge Mazzini. Villacorta Sonsonate. 3. Saldaña 4. San Rafael the Libertad. 5. Santa Gertrudis San Vicente. 6. San Juan of Dios San Miguel. 7. La Unión.	1. Coatepeque 2. Huehuetenango 3. Quetzaltenango 4. San Benito Petén 5. Amistad Japón 6. Infantil-Elisa Martínez 7. Cobán 8. Antigua Guatemala 9. Cuilapa 10. Escuintla 11. San Vicente 12. Zacapa	1. Metropolitano Dr. Arnulfo Arias Madrid 2. Del Niño 3. Manuel Amador Guerrero 4. Aquilino Tejeira 5. Nicolás A. Solano 6. Santo Tomás 7. José Domingo Obaldía 8. Regional Rafael Hernández
20 new participating facilities in year II (Oct 2010 -Sep 2011)	6. Dangriga 7. Punta Gorda	5. Hospital San Carlos 6. Hospital Nacional of Niños Dr. Carlos Sáenz Herrera 7. Dr. Tony Facio of Limón 8. Hospital Monseñor Sanabria of Puntarenas 9. Hospital Dr. Escalante Pradilla of Pérez Zeledón	8. Ahuachapán 9. Morazán 10. De Niños Benjamín Bloom 11. Rosales 12. Chalatenango	13. Suchitepéquez 14. Retalhuleu	9. Pediátrico del Seguro Social 10. Marvel Iglesias of Aligandí, Guna Yala 11. of the Santos 12. de Bocas del Toro 13. Veraguas 14. Herrera
1 additional participating facility year III (Oct 2011 - Sep 2012)				15. Malacatán	
57 Health Facilities Total	7	9	12	15	14

Source: M&E Unit, USAID| Central America Capacity Project

The Project includes 55 of the 145 (38%) public hospitals at the secondary and tertiary level in the five countries. (See Tables 1.1 and 1.2)

Table 1.2 Total number of hospitals in country vs. number of hospitals supported by CAMCAP, by level of care, from October 2009 - September 2013

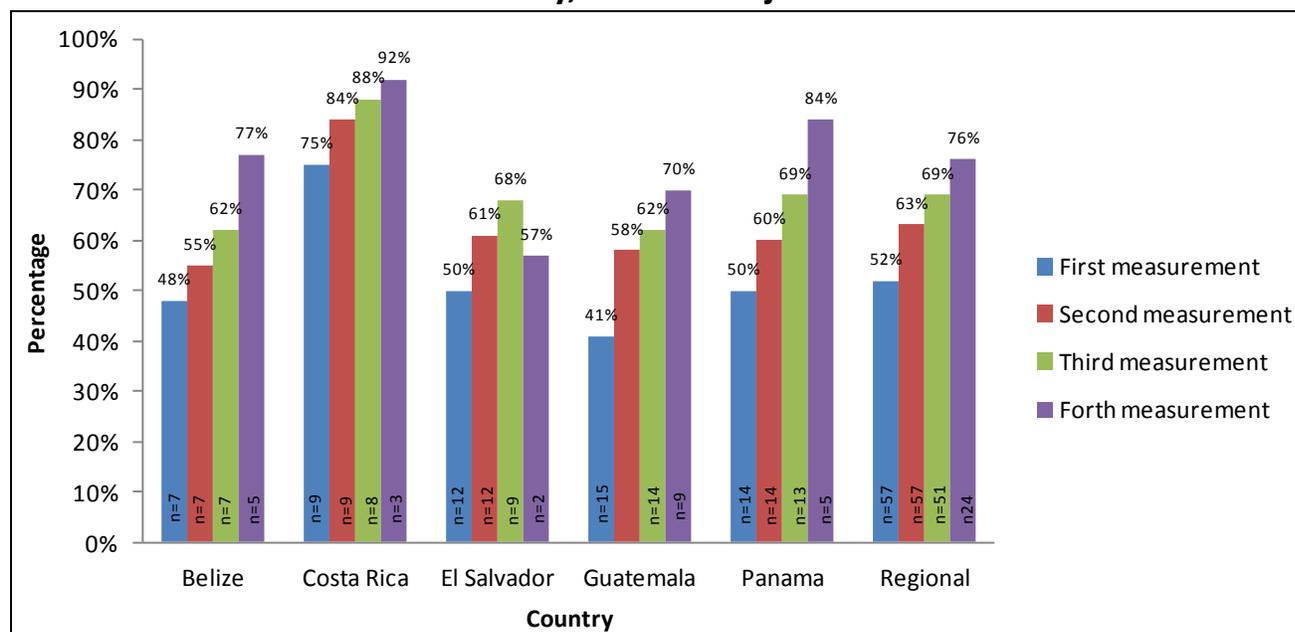
Country	Second level			Third level		
	Total facilities in the country	Supported by the project	%	Total facilities in the country	Supported by the project	%
Belize	6	4	67%	1	1	100%
Costa Rica	20	6	30%	9	3	33%
El Salvador	21	8	38%	5	4	80%
Guatemala	0	0	0	43	15	35%
Panama	31	9	29%	9	5	56%
Total	78	27	35%	67	28	42%

Source: M&E Unit, USAID| Central America Capacity Project

The technical teams and experts designated by the MOH/SSI prepared a set of approximately 300 performance standards for 18 service areas maintaining the vision that the central purpose of the exercise was to measure the performance of HIV-related services. MOH/SSI personnel conducted the performance measurements with support from project personnel. The teams varied in their composition by country. For example, in Guatemala the Vice Ministry of Hospitals together with the NAP provided the leadership. In Belize, the regional offices led the measurements of the facilities in the other regions. In Panama the Head of Health Facilities and Services and hospital personnel conducted the measurements through cross-site visits.

Under the Project there were 189 performance measurements in the 57 health facilities. 100% of the hospitals had a first and second measurement; 89% (51/57) had a third measurement; and 42% (24/57) a fourth measurement. For the first three measurement rounds, there was a consistent trend for improvement in the average overall performance scores across all countries. The regional overall performance average increased by eleven percentage points between the baseline and the second measurement with a six point increase in the regional average between the second and third measurements. This upward trend appears to be continuing for the fourth measurement in all countries with the possible exception of El Salvador that to date had only conducted the fourth measurement in two hospitals. (See Graph 1.1)

Average OPQ result in health services by number of measurement and country, oct 2009 to june 2013



Source: M&E Unit USAID I Central America Capacity Project

Whereas Costa Rica had the highest overall performance score on the third measurement at 88%, Guatemala had the largest percentage gain between the first and third measurements, 21 percentage points above the baseline followed by: Panama (19 points), El Salvador (18 points), Belize (14 points), and Costa Rica (13 points). Results for the fourth round are incomplete, but the positive trend appears to be continuing with the possible exception of in El Salvador.

All of the facilities prepared their gap-closing intervention plan after each measurement based on the analysis of the gaps encountered and their root causes. They then identified appropriate actions to resolve the performance gaps in the form of an action plan which should be completed within the year. The target was that 60% (34) of health facilities would achieve good compliance with their performance gap-closing plans, receiving at least an 80% compliance score at their third follow up visit. By the end of project, 17 facilities achieved a minimum of 80% compliance, 50% of the target. (See Table 1.3)

Table 1.3 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements in respect to final goals, September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
1.1.3.	% of health services that achieved good compliance the performance gap-closing plan Good compliance = minimum of 80% at the third follow up visit	60% (34 of 57)	50% (17 of 34)

Source: M&E Unit USAID I Central America Capacity Project

Based on the results of comparing the last performance measurement with the previous one in each health service, 63% (36/57) achieved an improvement in their “global” status, 90% of the target of global status improvement in 40 facilities. (See Table 1.4)

Table 1.4 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to final goals, September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
1.1.4	% of health services that improved their global rating with regards to their last performance improvement measurement <ul style="list-style-type: none"> - If the health service achieved between 85-100% in its last measurement, it is categorized as GREEN and it must maintain a rating above 85% in the following measurement. - If the health service achieved between 60-84% in its last measurement, it is categorized as YELLOW and it must increase its rating by at least 10% in the following measurement or move to the GREEN category. - If the health service achieved between 0-59% in its last measurement, it is categorized as RED and it must increase its rating by at least 20% in the following measurement or move to the YELLOW category. 	70% (40 of 57)	90% (36 of 40)

Source: M&E Unit USAID I Central America Capacity Project

The desired facility performance is based on the number of measurement rounds completed. Based on the last measurement 49% (28/57) improved their global rating, 70% (28/40) of the target number of facilities improving their global rating status (See Table 1.5).

Table 1.5 Optimizing Performance for Quality in Health Services that Provide Comprehensive Care for HIV (18 technical areas) Achievements regarding to final goals, September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
1.1.5.	% of health services with expected improvement to their last performance improvement measurement Expected Improvement: 55% in first measurement, 70% in second measurement, and 85% in third measurement.	70% (40 of 57)	70% (28 of 40)

Source: M&E Unit USAID I Central America Capacity Project

The expected performance improvement is the target facility score for the period based on its previous measurement. Twenty-eight facilities met this expectation, 70% of the Project target (28/40). (See Table 1.5)

➤ 1.B Continuum of Care (CoC)

At the community level, the five multi-sector networks (one per country) received project TA for the implementation of the phases of the Continuum of Care (CoC) for HIV strategy. The networks implement activities to sustain a continuum of care for HIV to provide quality comprehensive care and prevention for people living with HIV and key populations at higher risk. The networks are made up of governmental and non-governmental organizations, organized civil society groups, and, in some cases, the private sector. The goal of forming the network is to provide a united and coordinated front in responding to the HIV epidemic at the departmental level.

The implementation of the Continuum of Care for HIV multi-sector network strategy involved a large effort of negotiation and discussion due to the challenge of coordinating and bringing together different sectors, agencies, institutions and individuals into a shared vision and approach. This process has been complicated by the fact that each participating entity has its own agenda and objectives which often impedes its uninterrupted participation in the network. Nevertheless, the local organizations have displayed an interest in participating in the networks as a comprehensive solution to the HIV problem.

Project-supported networks are: Corozal in Belize, Desamparados in Costa Rica, La Unión in El Salvador, CODESIDA in Escuintla, Guatemala and Colón in Panama (See Table 1.6). The network development follows the phases represented in Table 1.6 culminating in the implementation of an intervention plan to close performance gaps to improve the quality of services and make them more accessible to the target populations with an emphasis on adherence to treatment and prevention with positives (PwP). The five networks consolidated and strengthened their organizations through incorporation of other community groups working together to achieve their common objectives in responding to the HIV situation in their community achieving 100% of the Project target (See Table 1.6).

To be considered as organized and functioning, a network must have passed through each of the following phases: Presentation and Negotiation; Situation Analysis; Presentation of Results; and Formal Formation of the network so as to enter into the baseline performance measurement. Compliance with these phases took longer than expected due to the complexity of bringing together all of these local organizations around a common work agenda. Another challenge was identifying the lead entity for convening and coordinating the group. Common findings from the situational analysis was that in spite of the fact that the organizations had a common objective, they were working in an uncoordinated manner with the only activity that they consistently joined together on being the commemoration of World AIDS Day.

The different ongoing responsibilities and actions each network member organization was involved in plus their changing agendas posed a constant challenge for complying with the networks' programmed activities.

Table 1.6 Progress in implementing the CoC for HIV strategy by country, October 2012 - September 2013

Area	Presentation Negotiation	Base line measurement	Intervention plan	Follow up visit	Second measurement	Intervention plan	Follow up visit
Belize							
Corozal	X	39%	X	x	60%	x	X
Costa Rica							
Desamparados	X	34%	X	x	31%	x	X
El Salvador							
La Unión	X	32%	X	x	71%	x	X
Guatemala							
CODESIDA	X	47%	x	x	65%	x	X
Panama							
Colón	X	35%	x	x	62%	x	X

Source: M&E Unit USAID I Central America Capacity Project

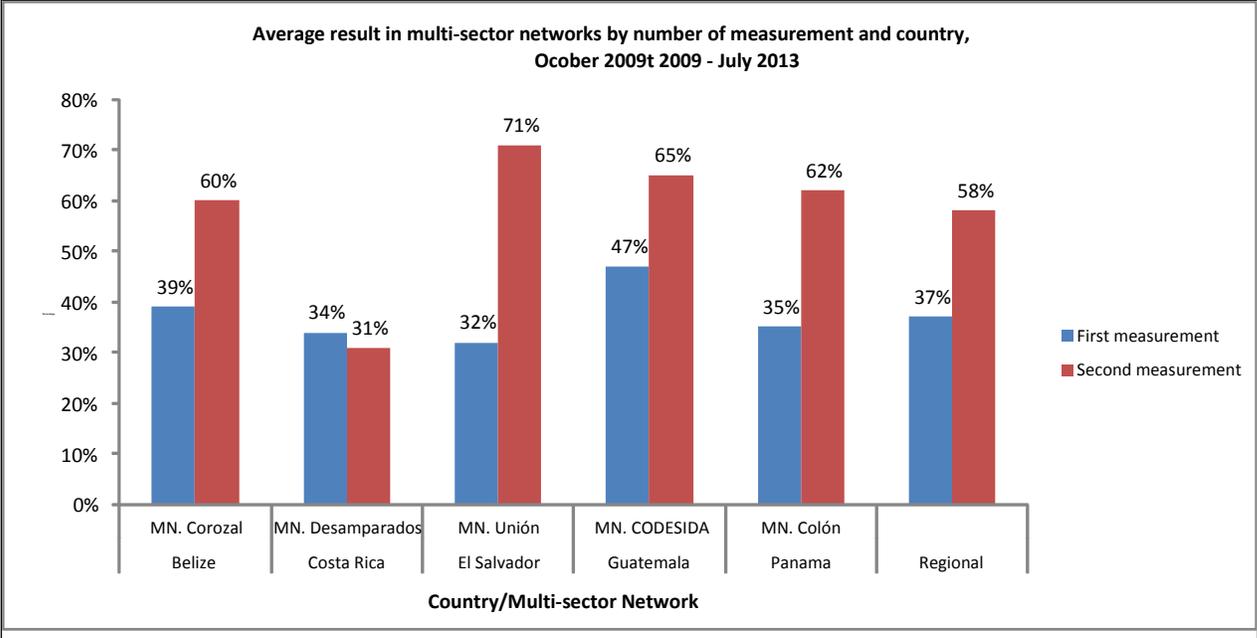
The five networks are now consolidated with organizational structures and defined functions permitting them to work together to achieve their common objectives in the context of the national response to HIV, thereby achieving 100% of the Project objectives of five multi-sector networks formed and supported in the implementation of the CoC strategy.

The networks are organized into specific commissions for greater efficiency including: a Coordination Commission charged with functioning and compliance with programs, work plans and convening meetings; and various Technical Commissions e.g. Prevention; Treatment, and Support Services. Each network has a strategic plan, by-laws and an annual action plan.

Each network conducted baseline and follow up performance measurements, 100% of the Project target. The annual performance measurements are based on compliance with the standards for five components: Prevention and Promotion; Adherence to ARV Treatment; Management; Care and Treatment; and support services. The following graph shows the average overall performance score for each network's first and second performance measurement as well as the regional average. With the exception of Costa Rica, the networks made notable improvements between the first and second measurements with the regional average overall performance score increasing by 21 points. The highest improvement was in El

Salvador (39 points) followed by Panama (27 points), Belize (21 points), and Guatemala (18 points) while the network in Costa Rica declined by 3 points largely due to a modification of the measurement instrument. (See Graph 1.2)

Graph 1.2 Average results for multi-sector networks by measurement round and country, Oct 2009 – July 2013



Source: M&E Unit USAID I Central America Capacity Project

All five networks developed their action plans after the measurements for closing the identified performance gaps and prioritizing activities for closing those gaps for a more coordinated and comprehensive response to HIV.

Furthermore, 80% (4/5) networks achieved their target global performance rating score according to the measurement round, 133% (4/3) of the target for the reporting period (See Table 1.7). The multi-sector networks in El Salvador, Panama, and Belize increased 20 points over their previous measurement and Guatemala advanced from the "red" category to "yellow". These four networks all exceeded 55% in their follow up measurement.

Table 1.7 CoC networks achieving the desired global performance rating score, October 2012 - September 2013

#	INDICATOR	Project Year Target		% of Target Achieved
		Target	Actual	
1.2.6.	<p>% of networks that improved their global rating with regards to their last performance improvement measurement.</p> <ul style="list-style-type: none"> - If the health service achieved between 85-100% in its last measurement, it is categorized as GREEN and it must maintain a rating above 85% in the following measurement. - If the health service achieved between 60-84% in its last measurement, it is categorized as YELLOW and it must increase its rating by at least 10% in the following measurement or move to the GREEN category. <p>If the health service achieved between 0-59% in its last measurement, it is categorized as RED and it must increase its rating by at least 20% in the following measurement or move to the YELLOW category.</p>	60% (3 of 5)	80% (4 of 5)	133% (4 of 3)
1.2.7.	<p>% of networks with expected improvement</p> <p>Expected Improvement: 55% in second measurement</p>	60%	80%	133% (4 of 3)

Source: M&E Unit, USAID| Central America Capacity Project

Activities contributing to improvement in performance scores included standardization of guidelines and care and treatment manuals; strategic and operational plans; and design and use of educational materials. Network members were trained in: stigma and discrimination and human rights; counseling and testing; teamwork and assertive communication; and conflict resolution. The networks are also working on the guidelines for a referral and response system.

2 IN-SERVICE TRAINING

Provide in-service training and updates to HIV/AIDS care providers from the public, private, and NGO sectors. For example: diploma and other short courses on specific themes related to comprehensive care and treatment of HIV/AIDS. Support the updating, development and reproduction of materials and/or scholarships for participation in courses at private institutions. At a minimum, topics to be covered include: ART; HIV-TB co-infection; bio-safety; performance improvement; and stigma and discrimination.

In consideration that health workers are the most valuable resource in the health system, the Project supported the development of competent training teams capable of updating the health worker knowledge and skills thereby improving their ability to respond to changing conditions. The Learning for Performance (LFP) methodology developed by IntraHealth with support from USAID, provides a step by step methodology for achieving this goal through the combination of: performance improvement and instructional design for effective learning interventions that can be taken to scale. LFP is linked to OPQ through an analysis that identifies essential knowledge and skills to perform certain tasks in the workplace. These skills and knowledge are incorporated into the resulting curricular design with focus on the students' specific needs, the work context, and the skills necessary to perform specific tasks. All LFP participants are required to develop study plans and train others as part of their work responsibilities. The Project also applies LFP for in-service trainings to close performance gaps identified through OPQ. Topics of these trainings include: stigma and discrimination; HIV counseling and testing; and bio-safety.

The Project trained country personnel through a combination of remote and face to face methods to strengthen health worker capabilities to provide quality comprehensive care free of stigma and discrimination to PLHIV and key populations through the reduction of stigma and discrimination and the reduction of other barriers to access treatment.

LFP in-service training focuses on core competencies essential to improved health worker job performance and on effective learning methods. The training addresses factors in the learning and work environments in order to guarantee the application of new skills on the job. Table 2.1 presents achievements during the past project year.

At the regional level 238 health providers were given Training of Trainer (TOT) in LFP skills, 101% of the target (238/235). Guatemala had a lower performance due to constant changes in personnel in the hospitals and at the central level that interfered with the training schedule.

Table 2.1 In-service training in LFP, Achievements made against Year 4 cumulative target

#	INDICATOR	End of Project (EOP)	
		Target	% of Target Achieved
2.1.			
2.1.1.	# health service providers trained as trainers in Learning for Performance	235	101% (238 of 235)
	Belize	32	131% (42 of 32)
	Costa Rica	36	128% (46 of 36)
	El Salvador	37	116% (43 of 37)
	Guatemala	90	78% (70 of 90)
	Panama	40	93% (37 of 40)

Source: M&E Unit USAID I Central America Capacity Project

These TOT training recipients in turn trained regional hospital personnel in topics e.g.: bio-safety; stigma and discrimination; HIV counseling and testing; nutrition; leadership and teamwork. The hospital quality teams also received training in OPQ to better implement the methodology in their workplace. 4,084 persons were trained in these topical areas, 106% of the Project target of 3,844 with the excess being due to the demand by local institutions for trainings to close performance gaps.

Almost 3 times the number of females as males (2,983:1,101) received training with the difference being most notable in the nursing category (1,433:163). In terms of medical personnel, the ratio was closer to 1 (336:317).

**Table 2.2 Personnel trained in competencies disaggregated by country, profession and gender
(LFP Methodology) October 2012 - September 2013**

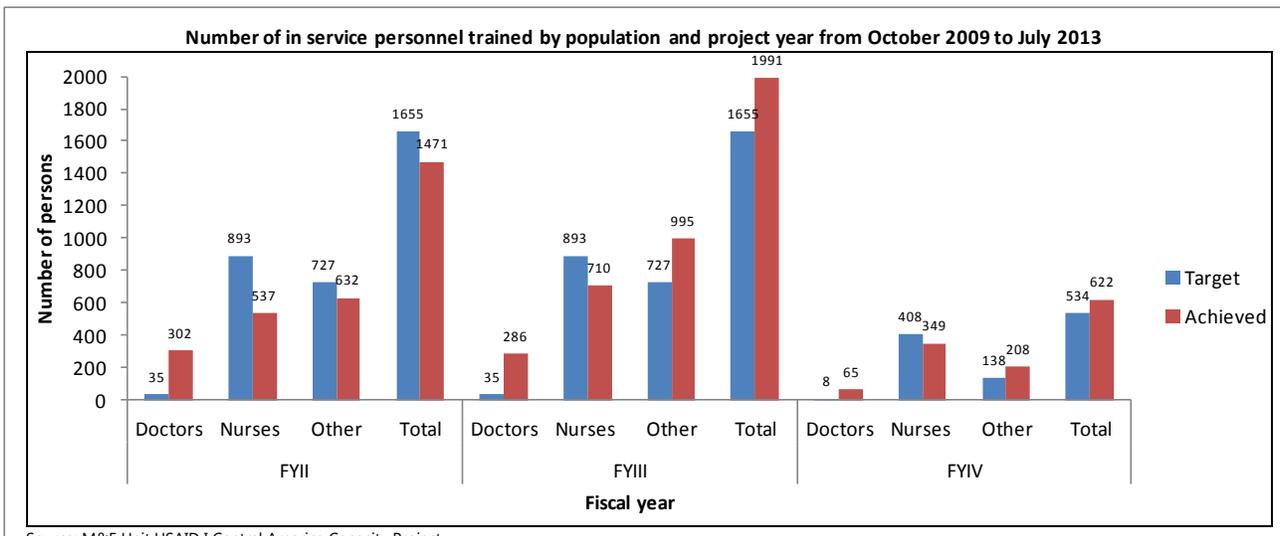
#	INDICATOR	End of Project (EOP)	
		Target	% of Target Achieved
2.1.2.	# health service providers who successfully completed the training program. Topics include OPQ and themes in HIV including, gender, stigma and discrimination	3864	106% (4084 of 3844)
TOTALS (for the region)	Male	1749	63% (1101 of 1749)
	Female	2115	141% (2983 of 2115)
	Doctors	78	837% (653 of 78)
	Male	41	820% (336 of 41)
	Female	37	857% (317 of 37)
	Nurses	2194	73% (1596 of 2194)
	Male	926	18% (163 of 926)
	Female	1268	113% (1433 of 1268)
	Others	1592	115% (1835 of 1592)
	Male	782	77% (603 of 782)
	Female	810	152% (1232 of 810)

Source: M&E Unit USAID I Central America Capacity Project

In relation to targets by category of health provider, the Project trained: 837% (653/78) of physicians; 73% (1,596/2,194) of nurses; and 115% (1,835/1,592) of administrative and support personnel. The reason for the overage in medical personnel was due to the recognition that training them in such areas as bio-safety and stigma and discrimination towards PLHIV and key populations would contribute to closing important performance gaps. In spite of best efforts, the Project had difficulty in getting authorization for nurses' participation in trainings due to their multiple responsibilities. (See Table 2.2)

Graph 2.1 presents an overview of goals and results by type of personnel and project year. The percent of overall achievement rose from 89% in Year 2 to 120% in Year 3 and 116% in Year 4 for an LOP result of 106%. (See Graph 2.1 and Table 2.2)

Graph 2.1 Number of in-service personnel trained, by cadre and Project year, Oct 2009 – July 2013



89% (4,084 /4,587) of the trainees over the course of the Project acquired the minimum required competency requirements of a: pre-test; and post-test score and skills verification of at least 80%, reaching 127% (4,084/3,211) of the total project goal. (See Table 2.3). In accordance with the terms of the cooperative agreement, the Project only reports as trained those individuals who met those requirements.

Table 2.3. Percentage of health personnel with minimum competencies acquired during in-service training, October 2009 - September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
2.1.3.	% of trainees who achieved the minimum required competencies	70% (3211 of 4587)	127% (4084 of 3211)

Source: M&E Unit USAID I Central America Capacity Project

Also, during the Project, members of the five CoC networks were trained in LFP and then supported trainings in areas such as: stigma and discrimination; counseling and testing; adherence; and human rights and the legal framework related to HIV. From June to September 2011 the Project provided a diploma level course in HIV and human rights for network members. The purpose was to strengthen the HIV activists working in the networks in all five countries. The diploma was recognized by the San Carlos University, Guatemala

In spite of the considerable achievements in all five countries, there were also challenges the most significant of which were:

- Commitment of LFP TOT trainees to comply with their intervention plans without the Project having to intervene.
- Lack of supervision, supplies, equipment and resources to close gaps, which complicated the transfer of learning to the workplace.
- The central level did not have information on trained personnel.

- Need for agreement upon a better and greater participation of nurses due to their multiple responsibilities and demands.
- Natural disasters and epidemics complicating convening and following up on the trainees.
- High level of rotation of trained personnel.

3. PRE-SERVICE TRAINING

Strengthen pre-service training of care providers with updated HIV/AIDS content and increase access to early diagnosis with a VCT strategy. The Project will support updating and incorporating appropriate modules and materials related to comprehensive HIV/AIDS care into the training programs of the medical and other health/social service providers. Topics to be covered at a minimum include: antiretroviral therapy, TB-HIV co-infection, bio-safety, performance improvement, and stigma and discrimination.

During the past year the Project continued strengthening updated training programs in HIV for higher learning institutions. These activities focused on:

- Training university faculty in LFP
- Updating HIV curricula

➤ UPDATING CURRICULA IN INSTITUTIONS OF HIGHER LEARNING

The universities with health training programs tended to provide a fragmented academic training on HIV. Moreover, these institutions do not always join in to the national response. Given the importance of involving the universities that train medical and social service providers to respond more effectively to the HIV epidemic in the region, as well as to respond to the call to strengthen the health workforce in the region to achieve the goal of universal access, the Project supported strengthening the inclusion of HIV into the existing study plans.

Even though the objective was to incorporate updated information into the curricula, it was doubtful from the outset that there would be sufficient time to assure changes in the universities' *pensum* of studies. Changing university curricular content is a long and highly bureaucratic process. With a timeline of four years, the Project focused on promoting the introduction of competencies in HIV into the current curricula including: gender; stigma and discrimination; counseling and testing, and bio-safety. Through the revision of the medical and nursing study plans, utilizing LFP as the basis for determining the contents, the Project supported the development of teaching manuals and student content in HIV. The pre-service strategy included coordination with the Deans, directors of the schools, and in some cases, the professional associations.

The Project provided accompaniment and TA for the development of proposals for updated HIV curricula including themes of regional relevance. The working group presented eight new proposals with HIV-related themes to institutions of higher learning in the region. (See Table 3.1)

Table 3.1 Technical proposals for updating HIV curricula and higher learning institutions applied to October 2009 - September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
3.1			
3.1.1.	# of technical proposals for curriculum update to include themes related to HIV	8	100% (8 of 8)
	Belize	1	100% (1 of 1)
	Costa Rica	2	100% (2 of 2)
	El Salvador	2	100% (2 of 2)
	Guatemala	1	100% (1 of 1)
	Panama	2	100% (2 of 2)
3.1.3.	# of higher education institutions that implemented the updated curriculum with themes in HIV for their teaching program.	5	220% (11 of 5)
	Belize	1	100% (1 of 1)
	Costa Rica	1	700% (7 of 1)
	El Salvador	1	100% (1 of 1)
	Guatemala	1	100% (1 of 1)
	Panama	1	100% (1 of 1)

Source: M&E Unit USAID I Central America Capacity Project

Belize has a specific course on HIV, *Health Education: HIV and other STIs* that initiated in January 2002. It is included in the School of Nursing, Allied Health, and Social Work and is offered to all students with a three credit value.

The contents were developed using LFP with the objective of offering the acquisition of practical skills as well as knowledge. The faculty trained in LFP worked on developing the contents as well as participated in the pilot course including the modifications to the educational materials.

Beginning in 2013 they initiated the three credit course for 20 students. With collaboration of the National AIDS Commission (NAC) the students empowered in the material have been transmitting their acquired knowledge to the rest of the student body through demonstrations and posters. (See Success Stories Annex)

In **Costa Rica** the startup was slower due to the Costa Rica University (UCR) faculty's lack of interest in LFP for curriculum development. Nevertheless, the faculty came to understand the benefits of the methodology for structuring and including curricular contents. Currently, the post-graduate students utilize LFP to develop materials and activities for their community training practicums. The HIV curriculum contents for the UCR are implemented in the third level of the University pre-graduate program in the module "Nursing Interventions for Adolescence" and in the fifth year of the Nursing Management program.

Through the National Nursing Counsel (CONE), and with the collaboration of UCR, they initiated the process of standardizing the HIV contents for the seven nursing schools in the country. The curriculum includes: counseling and testing; and stigma and discrimination. This process will harmonize the HIV training for all nursing graduates in the country. The seven nursing schools now have printed materials and teachers' and students' guides and CONE will oversee implementation during the second semester. The Central American Autonomous University (UCA) will incorporate the HIV contents into their curricula with accompaniment from CONE as part of the national standardization process.

The Matías Delgado (UJMD) University of **El Salvador** is implementing the curriculum in the second and fourth years of the medical training and as in-service post-graduate updating, particularly for residents at the San Rafael Hospital. The UJMD was selected to guarantee the application of the curriculum since it is responsible for accrediting specialists. Two hundred twenty-five undergraduate students are currently benefitting from the curriculum along with 46 postgraduate medical specialists. IEPROES (the El Salvador Higher Learning Specialized Education Institute) developed with the nursing school a proposal to update the HIV curriculum. The faculty trained in LFP participated in the situational analysis with the resultant guides covering such areas as: general information about HIV; prevention; treatment; stigma and discrimination; and counseling and testing. The next steps will be a pilot to validate the contents.

In **Guatemala** the MOH Coordinator of Department of Human Resources Training presided over the delivery of the faculty and student guides for the National Nursing School (ENEG). The Coordinator requested project assistance for the schools in Alta Verapaz and Quetzaltenango. The guides, developed through application of LFP cover both knowledge and the acquisition of skills. Through the MOH Department of Human Resources the Project is working to expand the curriculum to other nursing schools to standardize contents with the one developed with ENEG.

In **Panama** the Nursing School at Panama University has the curriculum guides developed with project assistance and the university authorities believe that they filled a gap in the HIV training. The curriculum is implemented in the first and fourth year of the professional nursing training in the fundamentals of nursing and psychiatric nursing courses. During the final Project year the Latin University concluded their curriculum proposal and had it accepted. It includes such topics as: HIV counseling and testing; stigma and discrimination; and bio-safety.

The Project achieved 220% (11/5) of the target of university curricula updated due to all six professional nursing schools in Costa Rica will apply the curriculum. (See Table 3.1) The Project trained faculty in LFP to enable their active participation in the revision and validation of the proposed HIV curricula. The methodology emphasizes: work areas; responsibilities; and tasks to be performed in the workplace. Curricular contents focus exclusively on those skills and essential knowledge to perform the tasks.

Table 3.2 Higher education faculty trained in LFP in the region, October 2009 - September 2013

#	INDICATOR	End of Project (EOP)	% of Target
		Target	Achieved
3.1	Updating curriculum at selected higher education institutions		
3.1.2.	# university teachers who successfully completed the training program in LFP	84	110% (92 de 84)
3.1.4	# university teachers who successfully completed the training program in the use of the new curriculum	70	60% (42 of 70)
	Belize	NA	NA
	Costa Rica	25	68% (17 of 25)
	El Salvador	20	125% (25 of 20)
	Guatemala	25	0% (0 of 25)
	Panama	NA	NA

Source: M&E Unit USAID I Central America Capacity Project

The Project trained 110% (92/84) of the target for faculty trained in LFP. The original target of faculty was 60; however, the number was increased at the request of the donor. (See Table 3.2) In terms of number of faculty trained in use of the new curriculum, the Project reached 60% of the target (42/70). The major delay was in Guatemala where the new faculty training program still had not been completed.

➤ VOLUNTARY COUNSELING AND TESTING PROGRAM

Due to the fact that the universities are not always included in the prevention strategies and campaigns, the Project worked to provide them with access to early diagnosis by supporting the university-based Testing Day in the five countries. Moreover than contributing to the training of the faculty and students, in VCT, it also brought peer education and promoted early detection; and gave the future health professionals the opportunity to get valuable practice in VCT and prevention.

From October 2009 to September 2012 the Project conducted trainings for university professors and students to perform peer education as part of the university Testing Days. The activity itself was held on the university campus with the participation of the MOH/NAP in each country. The Project achieved 95% of the target (1,199/1,262) for persons successfully trained in VCT of which 222 were professors (122% of the target) and 977 were pre-service students (90% of the target). In terms of gender at the regional aggregate level there was a 5:1 (185:37) female: male ratio for faculty, whereas the ratio for students was 4:1 (785:192). (See Table 3.4)

Table 3.4 Number of successful pre-service trainings in VCT in the region, October 2009 - September 2012

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
3.2	Pre-service trainings in VCT		
3.2.1.	# of pre-service personnel that have successfully completed training in VCT	1262	95% (1199 of 1262)
	# of university teachers trained as trainers on VCT	182	122% (222 of 182)
	Male	90	41% (37 of 90)
	Female	92	201% (185 of 92)
	# of students trained on VTC	1080	90% (977 of 1080)
	Male	530	36% (192 of 530)
	Female	550	143% (785 of 550)

Source: M&E Unit USAID I Central America Capacity Project

➤ THE UNIVERSITY TESTING DAY

The University Testing Days were developed from October 2009 to September 2012 in coordination with the MOH/NAP and the university authorities in each country achieving 100% of the target for number of participating universities (18/18).

In terms of the number of HIV tests with counseling provided the Project achieved 203% (8,718/4,304) of the target exceeding the goal in all countries except Belize and Costa Rica (95% and 78% respectively), largely due to lack of a local budget for providing the reagents.

Table 3.4. HIV tests with counseling in the universities, October 2009 - September 2012 by country

#	INDICATOR	End of Project (EOP)	
		Target	% of Target
3.3.2.	# of people with counseling prior and after testing for HIV in accordance to national and international regulations at universities.	4,304	203% (8718 of 4304)
	Belize	566	95% (537 of 566)
	Costa Rica	941	78% (735 of 941)
	El Salvador	941	264% (2483 of 941)
	Guatemala	1115	328% (3653 of 1115)
	Panamá	741	177% (1310 of 741)

Source: M&E Unit USAID I Central America Capacity Project

All of the countries except for Costa Rica had some test positives during Testing Day. However, the HIV prevalences are lower than those reported by UNAIDS for the general population. (See Table 3.5) Taking into account the low seroprevalence it was decided in consultation with the USAID Mission to focus instead on developing the university HIV curricula.

Table 3.5 HIV tests with counseling in the universities, October 2009 - September 2012 by country

Country	Number of tests	Number of positive tests	Number of negative tests	Number of indeterminate results	HIV prevalence
Belize	537	1	536	0	0.2
Costa Rica	1031	0	1031	0	0
El Salvador	2483	17	2464	2	0.7
Guatemala	3629	16	3613	0	0.4
Panamá	1310	1	1309	0	0.1
Total	8990	35	8953	2	0.4

Source: M&E Unit USAID I Central America Capacity Project

4. INFORMATION TECHNOLOGY

Development/use of information technology for distance training, care and treatment conferences, information dissemination, and a training information system.

➤ TECHNOLOGY THROUGH MOBILE PHONES

Beginning in Year 2 the Project implemented technology through mobile phones (mLearning) with graduates from the HIV course. In Year 3 the Project implemented mLearning at the pre-service level. University students, trained in Counseling and Voluntary HIV Testing (VCT), were the specific targets as described below.

The methodology was to send text messages using the Front Line SMS, 1.7.0-Beta- 17 software that records and tracks sent educational messages. During the fourth quarter of Year 3 the Project held four VCT trainings for students, two in Guatemala and two in El Salvador, recording post test results for each participant. The Project invited students to participate, voluntarily in the mLearning training methodology. Forty-nine students in Guatemala and 66 in El Salvador opted to participate.

Random groups were formed in each country. One group received informational messages on the topic. In Guatemala only, one group received questions and resent answers related to the topic. In addition, a control group received messages not related to the topic.

Table 4.1 Preliminary results using the mLearning strategy to train university students in VCT in El Salvador and Guatemala. October 2009 - December 2012

Group	Number	First Test Average	Second Test Average	Difference
El Salvador				
Control Group	27	88	90	+2
Messages Group	27	89	95	+6
Guatemala				
Control Group	16	94	82	-12
Messages Group	14	88	81	-7
Questions Group	16	92	83	-9

Source: M&E Unit. USAID I Central America Capacity Project

Table 4.1 shows the results favor the group receiving messages compared with the control group and the questions group. Those who received messages had a greater retention of knowledge over the control group. On a country by country basis the message groups in El Salvador and Guatemala had higher scores than the controls by four and five points respectively.

For the group receiving questions, which only took place in Guatemala, the difference compared to the control group was 3 points and was 2 points less than the group that received the contents messages. These differences are not statistically significant. Overall knowledge retention for the three groups was greater than 80 points three months after training, which is the minimum expected score to pass any type of training provided by the Project.

Ninety two percent (100 out of 109) of people voluntarily agreed to participate in the mLearning exercise, 46 out of 52 students in Guatemala, and 54 out of 57 in El Salvador. (See Table 4.1)

Table 4.1 Results on implementing mobile phone learning strategy (mLearning) integrated into the updating and strengthening of HIV related issues knowledge process. Achievement compared with the project final goal in September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
4.1	Implementing the mobile learning (m-Learning) strategy and integrated processes to upgrade and reinforce knowledge on HIV / AIDS		
4.1.1.	% of participants in updating and strengthening of knowledge on HIV issues through the m-Learning strategy	50% (55 of 109)	92% (100 of 109)
4.1.1.1.	% of m-Learning strategy participants acknowledging receipt of messages	75% (55 of 73)	100% (73 de 73)
4.1.2.	% of health providers participating in the m-learning strategy stay at the minimum desired knowledge at the end of the intervention	65% (47 of 73)	100% (73 de 73)

Source: M&E Unit. USAID I Central America Capacity Project

This objective's result is to strengthen the decision-making capability and the follow up and management of trained human resources in Central America. A situation analysis of the HIV trained staff information systems was conducted during the Project Year 2 in the five project countries with varying results. Belize and Panama did not have an information system. In Costa Rica, El Salvador and Guatemala the systems were at different developmental and implementation levels.

The management of human resources in health is a priority in Costa Rica, El Salvador and Guatemala. These countries started with a needs assessment to develop an information system to track trained human resources in the Ministries of Health/Social Security Institute.

Costa Rica

The CENDEISSS (Spanish acronym for Center of Strategic Development and Information in Health and Social Security) has an HRH information system. This system has a specific training information component. However, it did not have a tool to screen and migrate information from the legacy system into the new system to prevent duplicating records. The component for screening cases, attached to the CENDEISSS Certificate Recording and Printing System (SIRC), was developed and validated from 2012 to July 2013 in collaboration with the officers in charge of screening cases. Seven staff members were trained in using and managing this component. As a result, the CENDEISSS' SIRC now has reliable information to make decisions related to the human resources in health training, including HIV training. (See Table 4.2)

El Salvador

From October 2010 to July 2013, activities relating to management of human resources for health started with an exploratory and coordination meeting with the technical staff of the MOH's Directorate of Human Resources Development and Management Information Systems to identify needs to implement a comprehensive HR information system. The Project presented the iHRIS software platform and the MOH expressed interest in implementing iHRIS.

A MOU was signed in May 2011, with the MOH's Human Resources Directorate to build the MOH's Human Resources information component based on the Human Resources Information System developed by IntraHealth-iHRIS. The MOH Directorate of Human Resources, the DTIC (Spanish acronym for Technical Directorate of Information & Communication Technologies) and the Project, working together, conducted a needs analysis to implement and install iHRIS on the MOH server. The methodology transfer workshop occurred in September 2011 and a DTIC developers' leadership group was formed to install iHRIS on the MOH servers, perform those changes required by the Directorate of Human Resources and continue implementing the system. Nevertheless, in November 2012 the MOH determined that a unique standard information system platform based on a different ministry standard will be developed and that this new information system is not compatible with the current iHRIS database. Thus, iHRIS implementation is not feasible in El Salvador.

Guatemala

Coordination with the Training Department of the MOH's Directorate of Human Resources was established in 2010. The MOH Training Directorate presented their needs focused on a comprehensive HR Information System.

The Project presented the iHRIS software platform. A strategic alliance with PAHO, who is the MOH technical support on HR issues, started. WHO/PAHO selected three countries to perform a diagnostic of the iHRIS (Human Resources Information System). Selected countries were South Africa, considered as highly complexity, Guatemala as medium complexity, and Rwanda as low complexity.

Project participation in the situational analysis was through structured interviews addressed to Health Area, National and Regional Hospitals, Health Centers, and Health Posts authorities in the provinces of Guatemala, Zacapa and Escuintla, and other health workers training related organizations. The diagnosis found that the HRH information was fragmented and that there was no uniform data processing following MOH standards. Additionally there were no HRH Planning, Management, Training and Monitoring processes within the country. Information systems as developed by individual institutions do not incorporate the minimum information requirements needed to develop a comprehensive HRH information system.

In September 2011, as a follow up to diagnosis findings, MOH staff (Administrative Vice Ministry and SIGSA staff) attended the iHRIS implementation workshop in El Salvador. The conclusion reached during this workshop was that implementing iHRIS in Guatemala was both feasible and desirable. A joint report, with the USAID Central America Capacity Project, was submitted to the Vice Minister, who approved iHRIS implementation in the MOH.

Coordination and joint work meetings among the MOH, PAHO Guatemala Office and the Project to develop the human resources in health information system commenced to provide updated information on the existing human resources in health. iHRIS start up consisted of configuring the system and uploading data and supporting the available information through a situation analysis of the current human resources in health management system at the MOH General Directorate of Human Resources. The Project donated a server with the iHRIS system to the MOH Data Center that was integrated into the MOH institutional domain.

Table 4.3 Number of Human Resources for Health Information Systems developed and with staff trained to use and manage the system. October 2009 - September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
4.2.	Systematizing and updating the human resources training databases in MOH and Social security		
4.2.1	# of information systems for trained HR that are developed or contextualized	2	100% (2 of 2 CR and GUA)
4.2.2.	# of information systems for trained HR that are in use	2	100% (2 of 2 CR and GUA)
4.2.3.	# countries with at least two central level personnel using the info System for training HR	1	200% (2 of 1 CR and GUA)

Source: M&E Unit. USAID I Central America Capacity Project

To date there are 44,000 health workers' records uploaded into iHRIS. The MOH is running a census of all workers to update the database. In terms of skills transfers for MOH staff to use the iHRIS system: four people from Central Level have been strengthened to handle and screen all data entered at central level; and to prepare consolidated reports supporting the decision-making processes. At the implementing units in the 22 provinces, 597 persons have been trained to use and manage the iHRIS system and update the information. (See Table 4.3)

Table 4.3 Number and percentage of health workers trained in use and management of iHRIS System by department, Guatemala September 2013

Department	# of health workers trained	% of total # of health workers trained
Guatemala	97	16
Quetzaltenango	47	8
Jutiapa	46	8
Totonicapán	44	7
Izabal	31	5
San Marcos	29	5
Alta Verapaz	28	5
Quiché	28	5
Escuintla	27	5
Baja Verapaz	25	4
Chiquimula	23	4
Chimaltenango	22	4
Petén Sur Oriente	20	3
Jalapa	18	3
Suchipéquez	17	3
Petén Norte	16	3
Petén Sur Occidente	15	3
Sololá	14	2
El Progreso	14	2

Sacatepéquez	13	2
Santa Rosa	8	1
Zacapa	8	1
Retalhuleu	7	1
Total	597	100

Source: M&E Unit USAID I Central America Capacity Project

5. SYSTEMATIZATION AND INSTITUTIONALIZATION

Systemizing and institutionalizing the OPQ methodology in the region's health services is critical to achieve sustainability. To meet this objective and achieve appropriation of this methodology by the health workers and the policy level, the Project developed the OPQ operations manual and validated and tailored it to the national context in Belize, Guatemala and Panama.

Workshops and discussion forums took place in each country and the final product was the presentation of the country manual. Additionally some meetings were held to exchange: lessons learned; successful experiences; and challenges in applying the methodology and its use for decision-making. The Project also sponsored cross-site visits among hospitals to share "good practices" and successful experiences in closing gaps and applying the OPQ methodology in Guatemala, Belize and Panama.

The ultimate objective was optimizing the health services and strengthening the health workers skills to provide a high quality, free from stigma and discrimination attitudes, especially to PLHIV and KP. To date the OPQ experience was systemized in 10 health services in Guatemala by documenting the process through a written report that includes:

1. Initial situation: Before OPQ implementation.
2. Where are we? The current situation.
3. Lessons learned: Successes achieved in the country with the strategy.
4. What's next? Actions that need to be strengthened.

The current plan is to use this systemization document as the basis to systemize the OPQ methodology experiences in health services in Belize, Costa Rica, El Salvador and Panama. (See Table 5.1)

Table 5.1 Systemization and institutionalization of Optimizing Performance and Quality Health Services Providing VIH Comprehensive Care and Treatment. Achievements from October 2009 - September 2013

#	INDICATOR	End of Project (EOP)	% of Target Achieved
		Target	
5.1.	Institutionalization of the OPQ methodology		
5.1.1.	# of health service who have systematized OPQ strategy	10	100% (10 of 10)
5.1.1.1.	# of OPQ Champion workshops to share experiences and lessons learned by the multidisciplinary teams in implementing OPQ with governmental and non governmental institutions	10	80% (8 of 10)
5.1.1.2.	# of health centers with cross visits for experience exchanges	10	110% (11 of 10)

Source: M&E Unit. USAID I Central America Capacity Project

Strengthening the OPQ methodology systemization and institutionalization is done through holding forums and champions meetings to promote the quality teams sharing and documentation of successful experiences. Eight champions meetings occurred from October 2009 to July 2013; two in El Salvador, Guatemala and Panama each and one each in Belize and Costa Rica. The MOH provided leadership for all of these champions meetings. Participants include health staff from hospitals implementing OPQ in the country as well as officers from the regional and central level who shared accomplishments and challenges, and defined lessons learned in implementing OPQ. Quality teams updated their methodology knowledge base to implement a comprehensive approach facilitating analysis of information and clear identification of priority actions and activities to implement intervention plans.

Exchange visits to share experiences started during the final year. There were eleven follow up visits: four health services in Belize and Guatemala, one health service in Costa Rica and Panama. The overall Project objective was achieved in 110 percent (11 out of 10). (See Table 5.1)

In June and July 2013, the OPQ Manual was tailored to the national context and validated in the five countries. This was done through working together with: MOH/SSI central level staff; members of the hospitals OPQ methodology quality committees; and other key stakeholders

Table 5.2 OPQ Systemization and institutionalization on Health Services Providing VIH Comprehensive Care and Treatment. Achievements from October 2009 - September 2013

		Target	Actual	% of Target Achieved
5.1.1.3.	# of countries that have contextualized the OPQ manual	4	5	125% (5 of 4)
5.1.1.4.	# of countries that have validated the OPQ manual	4	3	75% (3 of 4)
5.1.1.5.	# of countries that have disseminated the OPQ manual	3	3	75% (3 of 4)

Source: M&E Unit. USAID I Central America Capacity Project

➤ Progress in the integration of a gender perspective and human rights within the Project

IntraHealth has developed a guide to integrate a gender and human rights focus into the USAID|Capacity Project in Central America. The guide is intended as a reference for Capacity Central America's technical team and partner hospitals, health centers, universities, and networks within the region on how to integrate and uphold a gender and human rights focus and standards within their institutions, curricula and projects. The guide was developed based on Capacity's Continuum of Care (CoC) strategy, and integrates this focus within the strategy's components: Promotion & Prevention; Counseling and Testing; Treatment; Clinical Care; and Support Services. This process has developed into a larger effort to close the gaps regarding knowledge, practice and accessibility of user services, health workers, and the CoC networks we work with in regards to gender, human rights, stigma and discrimination, privilege and oppression, and the core groups of key populations at higher risk of HIV.

ACHIEVEMENTS

1. One hundred percent of hospitals improved performance, comparing the baseline measurement to the last measurement. One survey conducted by REDCA+ evidenced higher user satisfaction in those hospitals implementing OPQ in Belize, Costa Rica and El Salvador.
2. 22 departmental multi-sector Continuum of Care networks organized to provide a local, coordinated response to the HIV issue focused on: secondary prevention; stigma and discrimination reduction; and strengthening PLHIV adherence to treatment.
3. All eight districts in Belize implemented network actions under the direction of the National AIDS Commission and institutionalized the district committees.
4. Seven out of eight universities in Costa Rica implementing the updated HIV curriculum at the Nursing Schools. This achievement reinforces standardization of knowledge and pre-service skills.
5. University of Belize expanded LFP implementation in other schools in addition to the School of Nursing, Allied Health and Social Work
6. Skills based in-service training contributed to closing quality related performance gaps.
7. Guatemala institutionalized iHRIS as the HRH information platform, fundamental tool to manage human resources included training information.

8. In all five countries, the Project empowered local personnel in the OPQ methodology both at central and local levels. Four countries (Belize, Costa Rica, Guatemala and Panama) are currently advancing towards institutionalizing the methodology that has improved service quality in the HIV clinics and expanded to the whole hospital as a service unit.
9. Strategic alliances formed with other organizations pursuing similar objectives: PAHO/Guatemala, the five MOHs, UNAIDS and USAID partner organizations (Futures Group/PASCA, PSI/PASMO, MSH/SCMS, JSI/Deliver, and URC).
10. The Project is recognized at the Central American level as a quality leader organization promoting leadership, empowerment and sustainability. Project results reflect this leadership.
11. Technical tools developed to support the systemization work of the OPQ, LFP, CoC, and Gender and Human Rights methodologies.

CHALLENGES

- Turnover of decision-making authorities at the central level and staff at the local level. Additionally, there are no training plans on site to follow up on interventions improving quality.
- Countries in this region do not have a quality policy at the central level to provide technical and financial sustainability to implement OPQ.
- Modifying the students' curricula at universities and post-graduate schools is a burdensome, bureaucratic process.
- There are countless training manuals not focused on health worker job-related skills development. This is an obstacle to appropriate follow up to introduce new knowledge and skills at the health service center.
- The region is prone to natural disasters (floods, landslides, volcanoes, earthquakes and epidemics) that disrupt programming.

LESSONS LEARNED

- Health services quality improvement relied on local teams that implemented specific actions resulting in performance improvement with limited resources.
- Health services staff turnover, mainly in Guatemala and El Salvador, influenced the follow up to interventions. Thus, a strategy to ensure a continuous follow up to quality improvement should be considered.

- Despite being a highly bureaucratic process, the effort on updating the HIV curricula should continue at the university level to ensure more health workers are skilled in this area to provide quality health services free from stigma and discrimination.
- The process of organizing and consolidating the multi-sector Continuum of Care network is time-consuming and needs continuous effort and follow up to achieve consolidation.

RECOMMENDATIONS

1. Support the MOH/SSI to develop a quality policy.
2. Institutionalize the OPQ methodology at the local level strengthening the quality committees to promote sustainability of their health services quality coordination role.
3. Strengthen the supportive supervision process to ensure continuous quality.
4. Incorporate the nosocomial infections committees into the comprehensive quality focus to promote multi-causal approaches to reduce nosocomial infections.
5. Continue with in-service staff training focused on knowledge and skills transfer.
6. Strengthen the Continuum of Care (now referred to as the Coordinated Community Response) networks to support meeting the local and national objectives in confronting and controlling the HIV epidemic and achieving impact.

II. ADMINISTRATIVE REPORT

➤ REGISTRATION

IntraHealth International, Inc. is registered as an international NGO in Belize, Costa Rica and Guatemala. Registration in El Salvador is still in process. A delay in the planned timeline occurred due to the change in Country Representative who was the proposed legal representative. A new legal representative was proposed and the procedure is re-initiating. Registration in Panama will not be pursued.

➤ EMPLOYEE AND CONSULTANT CONTRACTS

Continuous effort during the LOP was paid to strengthen the technical and administrative staff to achieve better results in project implementation. This effort resulted in highly committed staff and a seamless transition to the new project.

There was no need to amend or terminate employees' contracts because they are not project-hired, but IntraHealth employees. Consultants' contracts were completed and closed out as of the Project closing date.

➤ ASSET DISPOSITION PLAN

The current plan is to dispose of assets purchased during the LOP, which have a market value below USD5,000 according to the plan included as an appendix to this final administrative report. To ensure compliance with administrative procedures transmittal letters will be prepared to transfer property to either the new USAID funded Project (Capacity Plus) or to third parties. The attached list also identifies those assets not recommended for donation.

III. FINANCIAL REPORT

The Project executed a total of \$5,909,531 (\$4,560,185 Direct Costs and \$1,349,346 Indirect Costs). This amount matches the budget approved in Modification No. 8 and reflects the NICRA change from 30.68 percent to 28.77 percent. Modification 8, dated July 7, 2013 reduced project funding by \$1,090,469 (from \$7,000,000 to \$5,909,531) and obligated \$78,003 to match the new total funding, and shortened the Project completion date by one year to September 29, 2013.

Budget Line Item	Executed
Salaries	\$ 1,643,112
Fringe Benefits	\$ 343,811
Consultant Fees	\$ 613,530
Travel and Transportation	\$ 385,246
Other Direct Costs	\$ 1,574,486
Total Direct Costs	\$ 4,560,185
Indirect Costs	\$ 1,349,346
Total Costs	\$ 5,909,531

Modification 8, dated July 7, 2013 reduced funding to this project by \$1,090,469 (from \$7,000,000 to \$5,909,531) and obligated \$78,003 to match the new total funding, and shortened the Project completion date to September 29, 2013.

The chart below shows the approved realigned budget as per Modification No. 8. This approved budget is the basis to report budget execution.

COST ELEMENT	APPROVED BUDGET US\$	CHANGES IN THIS MOD US\$	NEW TOTAL BUDGET US\$
Comprehensive care in Central America	4,771,809	(841,651)	3,930,158
Procurement	20,021	172,145	192,166
Training	560,670	(146,379)	414,291
Indirect Costs	1,647,500	(274,584)	1,372,916
TOTAL FEDERAL FUNDS	7,000,000	(1,090,469)	5,909,531
COST-SHARE AMOUNT	1,050,000	(163,570)	886,430
TOTAL USAID + COST-SHARE	8,050,000	(1,254,039)	6,795,961

* Cost-Share amount has been exceeded by US\$206,259 to a total amount of US\$1,092,689

➤ COST – SHARE

During the LOP the CAMCAP project collected \$1,092,689 in cost-share, 23 percent above the EOP target of \$886,430 set in Modification 8. This achievement evidences the commitment and success that each Country Representative had in collecting cost-share. This amount comes from efforts to implement the OPQ strategy through the Ministry of Health, partner hospitals and the National AIDS Programs.