

**REPORT ON THE MIDTERM INTERNAL EVALUATION
NICARAGUA/ DECENTRALIZED HEALTH SERVICES PROJECT
JULY 7 - 25, 1997**

**Prepared by: Malcolm Bryant
James Eckroad
John Pollock
Wendy Santis**

Project number: 524-C-00- 94-000001800

TABLE OF CONTENTS

I. ACKNOWLEDGMENTS	1
II. EXECUTIVE SUMMARY / KEY RECOMMENDATIONS	2
III. SCOPE OF WORK FOR THE EVALUATION	6
IV. METHODOLOGY	7
V. ORGANIZATION OF THE REPORT	7
VI. BACKGROUND TO THE PROJECT	8
VII. OBJECTIVES AND ATTAINMENTS OF THE PROJECT	10
A. Institutional Strengthening Objectives	10
1. Training Objectives and Indicators	10
2. Management Objectives and Indicators	11
B. Progress Indicators	13
VIII. OVERARCHING POLICY ENVIRONMENT	13
A. Decentralization of Health Services	14
B. Other Donors	14
C. Management Capabilities and Improvement of Management Systems	14
D. Alternative Sources of Financing	14
IX. PROGRESS IN THE CREATION OF FULLY FUNCTIONAL SERVICE DELIVERY POINTS	15
A. Trained and Motivated Personnel	16
1. Strategy of Integration	16
2. Training Interventions	18
a. Community Health Workers	18
b. Clinic-based Services	19
c. Training of Trainers	19
B. Adequate Equipment, Materials and Pharmaceuticals	21
1. SICS (Spell out)	21
2. SIVIC (Spell out)	23
3. Model for Rational Use of Antibiotics in the Treatment of ARI	24
4. Materials and Supplies	25
C. Operational Infrastructure	25
D. Referral System	26
E. Sufficient Information for Operational and Strategic Decisions	27
1. Financial Management System (SAF)	27

2. Other Clinical Record Based Models	30
3. Community Censuses and Other Instruments	30
4. Epidemiological Surveillance System	30
5. Service Delivery Statistics Information System	31
6. Training Management Tool (TMT)	31
X. COMMUNICATIONS AND RELATIONSHIPS	32
A. Organizational Structure of the Project	32
B. Human Resource Management in the TA team	32
1. Delegation	32
2. Supervisory Structure	33
3. Prioritization, Resource Allocation and Decision Making	33
C. Structure for Communication	34
1. Intra-team	34
2. Home office relations	34
3. Subcontractor relations	35
4. MINSA counterparts and USAID	35
5. Cooperating Agencies	35
D. Final Points	36
XI. RECOMMENDATIONS OF THE MSH INTERNAL EVALUATION TEAM	37
XII. ANNEXES	
ANNEX I: SCOPE OF WORK	
ANNEX II: LIST OF MEETINGS	
ANNEX III: GLOSSARY	
ANNEX IV: DOCUMENTS REVIEWED	
ANNEX V: TECHNICAL ASSISTANCE TEAM ORGANIZATIONAL CHART	
ANNEX VI: MINSA ORGANIZATIONAL CHART	
ANNEX VII: FULLY FUNCTIONAL SERVICE DELIVERY POINT	
ANNEX VIII: MODEL FOR INTEGRATED HEALTH CARE FOR WOMEN AND CHILDREN	
ANNEX XIX: COMMUNICATIONS AND RELATIONSHIPS QUESTIONS	

I. ACKNOWLEDGMENTS

The Internal Evaluation Team from Management Sciences for Health (MSH) would like to express its thanks to MINSA (Nicaraguan Ministry of Health) staff at the central, SILAIS (Local System of Integrated Health Care), municipal and community levels, members of the Decentralized Health Services Project (DHSP), and USAID/Nicaragua (United States Agency for International Development). The team would also like to express its gratitude to representatives at Pan American Health Organization (PAHO), Profamilia, the World Bank, and Forsap. Thanks to all who took time for interviews as well as for providing important documents.

Special thanks are also due to Megan Waterfield, Jamileth Paley and Karen Buitrago for translation and editing assistance.

II. EXECUTIVE SUMMARY / KEY RECOMMENDATIONS

A team from MSH conducted an internal evaluation of the DHSP between July 7 and 25, 1997. The DHSP contract was initiated in March, 1994 and will be completed in September, 1998. The purpose of this evaluation which occurs prior to the final 18 months or final phase of the project, is to identify factors that facilitate or impede the Project's progress, to reformulate objectives to conform to the USAID Strategic Objective and associated Results Packages, and to determine what can be expected to be accomplished by the end of the project given current achievements.

The evaluation focused on five primary areas: development and implementation of strategic objectives, progress towards goals and objectives, communications and relationships, the organizational structure and systems of the Project, and capacity building. The four-person evaluation team consisted of Dr. Malcolm Bryant (Director, Strengthening Health Services), Mr. John Pollock (Director, Human Resources), Mr. Kip Eckroad (Principal, Strengthening Health Services), and Ms. Wendy Santis (Program Associate, Strengthening Health Services).

The Project team worked through a major restructuring that began 20 months ago. Some Project components and subcomponents were eliminated. Changes allowed additional provision of support to the SAF (Financial Administrative System) by Fredy Flores, but hindered progress in other areas, such as IEC (Information, Education and Communication), MIS (Management Information System), and alternative financing.

Objectives and Attainments of the Project

In the area of training, the institutional strengthening objectives have been accomplished and in some cases expanded upon, except for the IEC subcomponent. One challenge has been meeting the broader objective of providing sustainable impact on MINSA operations given the high turnover of health personnel.

There is still a real need for a strategy to address alternative sources of financing. While a few studies have been carried out on health financing there has been little by way of concrete changes. The current government now appears to have both the interest and political will to consider these issues.

Fully Functional Service Delivery Point

The Fully Functional Service Delivery Point (FFSDP) is a useful model for assessing the effectiveness of DHSP implementation. The five components of the model are: trained and motivated personnel; adequate equipment; materials and pharmaceuticals; an operational infrastructure; a referral system; sufficient information for operational and strategic decisions. Two pieces of the FFSDP are explicitly supported by the Project, the operational infrastructure and the referral system, however it was felt that all five areas of the framework should be examined.

Trained and Motivated Personnel

The integrated model for women and children is a major step forward for health services in Nicaragua. There are, however, limitations to the model. It lacks clear integrated clinical and preventive standards. Some of this will be addressed by IMCI (Integrated Management of Childhood Illnesses). IMCI implementation must be carried out in the way that does not detract from the breadth and depth of MAIMN.

Trainings have been well received among MINSA staff. ARI trainings with a focus on self evaluation have reached almost all SILAIS. SIVIC trainings have also reached almost national coverage. The TOT model has been institutionalized.

Adequate Equipment, Materials and Pharmaceuticals

Tools and instruments developed by the Project are quite impressive. The SICS program appears to be a well-conceived system with valuable functionality for monitoring procurement and logistics at all levels. In the event that the SICS cannot be implemented, there needs to be another automated system of logistics management in place. The SIVIC is a very successful example of a simple management tool that has had a major impact on policies and decisions at all levels of the MINSA. Finally, the Model for Rational Use of Antibiotics in the Treatment of ARI is an effective intervention which is producing improvements in a crucial area of the health care delivery system.

Operational Infrastructure

Buildings are often inadequate, poorly designed, or adapted from other sources. Consultation rooms are often overcrowded. Notwithstanding, all sites that the team visited were clean and well-maintained.

Referral System

The referral system appears to be strongest at the primary health care level. There seems to be a “disconnect”, however, once patients need to be referred from the primary to the secondary levels.

Sufficient information for operational and strategic decisions

The general purpose and functionality of the SAF appears to fulfill an important need for better financial control at the SILAIS and Health center level. There do appear to be some problems in getting all users to the point where their systems are functioning smoothly. The ongoing sustainability of the SAF beyond the life of the Project is at risk as long as there is no organizational unit within MINSa which will take ownership and responsibility for the computerized aspects of the SAF.

While the Project has developed tools for accessing clinical record information, the MINSa lags behind in the development of an effective information system for service delivery statistics.

Communications and Relationships

The Project team is well-managed, has a positive morale, and an atmosphere of mutual support and respect among individuals. The DHS Project staff are offering technical assistance to the MINSa which is both valued for its content and remarkably free of the misunderstandings that can arise when outside consultants are imposed on a system and create complications that might tend to hinder the testing of new ideas. The MSH staff in Nicaragua is in the position to serve as an effective conduit for channeling the efforts of other donors into the development needs of the MINSa because of the combination of their strong technical skills and high level of respect and credibility with the MINSa staff.

The DHS project is well on its way to achieving the goals focussed on 1) decentralization of financial management, 2) institutionalizing capacity for delivery of high quality, and 3) integrated services related to maternal and child health.

Key Recommendations

Below is a set of key recommendations. Additional recommendations are included in the body of this report. The full set of recommendations is in Section XI of this report.

Overarching policy recommendations:

- *Actively embrace and look for alternative sources of funding. Continue to focus on how to reach those areas that do not have professional health services, or little or no access to services.*

Objectives and Attainments of the Project

- *The DHSP needs to follow up with AID to reconcile the progress indicators. Identify the indicators that are unmeasurable or will require a special survey.*

Trained and Motivated Personnel:

- *Introduce IMCI carefully. The integrated standards of IMCI must be applied to MAIMN without detracting from breadth/depth of MAIMN.*
- *Supervision needs to be practiced, not preached, placing greater emphasis on quality of care*
- *Look for creative ways to fund future IEC programs. An IEC Program is needed in Nicaragua to continue the process of establishing an integrated MCH/FP/IMCI program. However, resources to provide training, supplies, and salaries for expanded demand must be secured before actively promoting IEC.*
- *Reinforce and continue training in administration of health services especially for new SILAIS directors. Examples of areas for follow up include: epidemiology (e.g. vector borne diseases), working with indicators, evaluation, and cost-effectiveness analysis of training-identifying local (national) health problems with cost-effective solutions.*
- *Adapt the ARI training program so that it can be used to conduct similar trainings on diarrheal disease.*
- *In order to insure project sustainability, increase the DHSP training line item for Project Year Five.*
- *There needs to be a standardized approach to training course development and course materials.*

Adequate Equipment, Materials and Pharmaceuticals:

- *CIPS and DNMS (Division of Norms for Medical Supplies) should take responsibility and ownership of the SICS; the programming modifications for the central level module should be finished; MINSA staff should be provided the skills and knowledge to train for and maintain the use of the SICS; and implementation in SILAIS and health centers should be supported.*
- *There is a need for improvements and support for procurement and logistics at the macro level.*
- *MSH should take further steps to insure that the SIVIC and ARI methodology are presented to a wider international audience, and that they be considered for implementation in other MSH field projects.*

Operational Infrastructure:

- *Continue to focus on how to reach those areas that do not have professional health services, or little or no access.*
- *Every health facility should have the capacity to communicate, and there should be working radios where telephones do not exist.*

Referral System:

- *A formal referral system with clear criteria needs to be established, with clear criteria, understanding what can be dealt with at primary and secondary levels, and with the appropriate equipment, materials, etc. being present at each level. This referral system needs to include a feedback mechanism both up and down the levels to make sure that referrals to any level are handled appropriately. In addition, the secondary level should have the same treatment protocols, etc., to assure that patients do not have care changed inappropriately, and therefore, lose faith in the peripheral staff.*

Sufficient Information for Operational and Strategic Decisions:

- *A consultant visit from Boston should be made to help adapt the TMT97 (MSH's Training Management Tool) to the Project's needs and train personnel in its use.*

- *A comprehensive assessment needs to be carried out of the procurement and logistics system to identify bottlenecks and solutions.*
- *Primary emphasis should be placed on developing a sustainable support mechanism for the SAF within MINSA through establishment of institutional links. Since this should be a major concern for the new World Bank project, it would make sense to join forces with them in working out an arrangement with MINSA.*
- *A long-range support capability which provides flexible ongoing training and systematic technical assistance and problem solving is needed for the SAF. The training component should develop a scheme for classifying and monitoring the skill levels of individuals, and should develop more customized responses to specialized needs. The MSH/MINSA technical staff responsible for supporting the SAF should keep a detailed log of complaints or problems raised by users along with the resolution of any issues.*

Communications and Relationships:

- *Exchange Home office and project staff meeting minutes and distribute to staff to improve communications with the home office.*
- *Complete the process of performance management for administrative staff.*
- *Have regular meetings between DHS staff and key PAHO staff to assure that program activities are complementary*
- *The MSH Contracts Officer should communicate directly with the USAID Contracting Officer to assure clear understanding.*
- *Actively seek linkages with other NGO's and donors in implementing final year of DHS Project activities to promote sustainability of project results and clarify possible next steps MINSA might take in pursuing its goals.*

III. SCOPE OF WORK FOR THE EVALUATION

Annex I contains the full scope of work used to conduct this evaluation. A number of key principles underlay the work of the evaluation team:

- The process was designed to help the Project team and MSH identify any unexpected or previously unanticipated problems with the execution of the Project.
- The evaluation team's primary goal was to validate the approaches taken by the Project and to give guidance on areas where successes can be built upon. Where areas of weakness or need for corrective action were identified the team offered possible actions to be taken.

- An important additional output of the evaluation was the systematic description of those things that have worked, and why they have worked, so that we can elaborate a clear framework for each critical area and/or system in the project. Documenting why something is working, while not a contractual requirement of the project, is an essential reference for future planning.
- The evaluation was designed to be comprehensive but not exhaustive.

The evaluation focused on five major areas:

1. Development and implementation of strategic objectives
2. Progress towards goals and objectives
3. Communications and relationships
4. The organizational structure and systems of the Project
5. Capacity building

In addition to the above, three underlying principles guided the team:

- Are targets being met?
- To what extent is this program laying the groundwork for the next phase?
- Are activities being carried out in the most efficient way?

IV. METHODOLOGY

The Internal Evaluation process included:

- review of key DHS project documents
- preparation of a scope of work by each of the four team members
- in-depth interviews with DHS project personnel, key MINSA staff, and key staff from other organizations
- visits to four project SILAIS as well as one non-project SILAIS (Chontales)
- initial meeting and final debriefing with DHSP staff as well as the AID COTR

V. ORGANIZATION OF THE REPORT

The body of the evaluation is covered in five major sections. Section VI on background outlines the four original Project components, the period of Project restructuring, and what has happened since that period. Section VII, which covers the objectives and attainments of the project, examines contract objectives and discusses whether or not the results have been accomplished. The overarching policy arena, with a focus on macro-level issues, is covered in Section VIII. The five elements of the fully functional service delivery point are introduced in Section IX as a framework to better examine the Project in the context of other work that MSH is performing. Section X on Communications and Relationships covers Project organization, management of the DHSP team, and the structure for communication. Recommendations are scattered throughout the body of the report and listed as a group in Section XI. Annexes are contained in Section XII.

VI. BACKGROUND TO THE PROJECT

Original Design and Restructuring of the Project

The DHSP originally had four components:

1. Accelerated Start Component (ASC) - Six assessments critical to the formulation of the first workplan:

a. human resource assessment, b. donor survey, c. assess and support implementation of cost containment, d. cost recovery inventory/assessment, e. pharmaceutical management assessment (part I: technical) and f. pharmaceutical management assessment (part II:management)

2. Alternative Sources of Financing Component (AFSC) - Studies of local initiatives, policy seminars on alternative financing, and review of progress made to date in the development of alternative income sources, and final report on lessons learned from both cost recovery and cost containment initiatives.

3. Maternal Health and Child Survival (MH/CS) Component - a. Control of Diarrheal Disease, Acute Respiratory Infection, Maternal Health, Birth Spacing, Nutrition Education, and Immunization b. MCH Training of clinical and community personnel

4. Management/Financial Decentralization Component (MFDC) -A. Financial Management: Decentralizing management of funds -a. budgeting, b. program budgeting, flow of funds, c. performance contracts, d.cost containment and cost recovery, and e. internal control. B. Management Training C. Strengthening MIS

Restructuring

The DHSP team worked through a major restructuring that began at the end of 1995. While the memory of that difficult period is still vivid, the DHS Project team has achieved a remarkable standard for high quality and mutual support.

At the beginning of the Project, the strategy of strengthening management capabilities and improving management systems at the SILAIS as well as the MINSA Central levels was supported by three long-term advisor positions, the Health Care Financing/Health Care Management Advisor, the Management and Finance Specialist, and the Senior Systems Analyst/Manager. In addition, approximately 50 person months were to be specifically allotted for financial management and information systems development.

At the end of the second Project year (1995) this situation had changed considerably. At the end of 1995, the Health Care Financing/Health Management Advisor position was concluded by reducing the time frame from 51 months to 20 months. At the same time the Senior Systems Analyst/Manager position was reduced from 51 months to 30 months, and the terms of reference were changed to that of exclusively supporting the development of the Financial Management System.

In addition, when the Project contract was revised, the IEC components (subcomponent of MH/CS) were eliminated. In addition, participant training was eliminated, a KAP study was added, and funds were transferred to the USPHS for medical supplies.

Current focus - Some highlights

The DHS Project continues its commitment to reducing infant mortality, maternal mortality and total fertility rates. Key strategies it supports include integrated care for women and children, decentralization, institutional development and technical training.

Supporting Integrated Model

The Project supports the MAIMN (integrated model for women and children) with instruments, case management and technical and administrative assistance. In the area of MCH, a large focus is on improving organization for service delivery, growth monitoring, promotion of breast feeding, reducing mortality from ARI and CCD, and attention in reproductive health. The DHSP would like to focus energies in the next year on supervision and monitoring that will support the MAIMN.

Supporting Decentralization

Decentralization is supported by strengthening local management capabilities. One of the Project's largest contributions to decentralization has been through the SAF. Fredy Flores has been able to provide additional help to the SAF. The SAF can now control expenditures against budget and has been expanded to function at municipal health centers. The SAF appears to fulfill an important need for better control of financial information at SILAIS and health center levels.

Developing Institutional Capacity

Technical capacity has been strengthened by assistance in case management in ARI, nutrition education, reproductive health as well as in other areas. The KAP study (Knowledge, Attitudes and Practices) done with health care workers in early 1996 included both clinical and community staff. It has been used as a tool to better focus the training work plans as well as the training content in each of the four SILAIS. Trainings have been directed to the strategic approach of supporting the MAIMN and decentralization of health services. DHSP trainings have been well-received among MINSAs clinical and community staff.

Some training activities have proven so effective that they have gone beyond the DHS Project level to the national level. The ARI-pneumonia case management training, the SIVIC, the TOT for Permanent Education Facilitators, the distribution of the Facilitator's Manual, team building and leadership promotion, and the utilization of instruments and training for the Growth Monitoring and Promotion Program as well as other programs are in that category.

Communications and Relationships

In the area of Communications and Relationships, the communication is quite good between Peter Boddy and field staff. In addition, working relationships have improved with PAHO, the World Bank, and Profamilia. MSH needs to actively seek linkages with other NGOs and donors in implementing final year DHSP activities to promote sustainability of project results and clarify possible next steps.

VII.OBJECTIVES AND ATTAINMENTS OF THE PROJECT

The contract objectives fall into two categories. First, there are institutional strengthening objectives measured by the achievement of specific objectively verifiable management performance indicators. Second, there are health objectives which are measured by changes in progress indicators. These indicators include infant, child and maternal mortality rates as well as service delivery uptake rates. These indicators were developed during the Accelerated Start Component (ASC) and are being monitored on a regular basis.

A. Institutional Strengthening Objectives

1. Training Objectives and Indicators

The Project contract outlines certain outputs and benchmarks related to training:
(*These activities are discussed in the management objectives and indicators section of the report.)

- *Human Resources Assessment conducted in Project SILAIS by 120 days after contract award date. (Year 1);*
- *Training of trainers for health intervention training and health promotion training conducted by 13th month after contract award date. (Year 2);*
- *IEC campaign designed and pre-test of materials conducted by 13th month after contract award date (subsequently removed from Project scope with mod. 14) (Year 2);*
- *General management skills training designed and initiated 18 months after award date of contract (Year 2);*
- *MC/CS training plan developed (year 2);*
- *Transport/logistics training conducted (Year 3)* ;*
- *Design and implement a focused KAP study (Knowledge, Attitudes and Practices) in the four project SILAIS. The study will provide information and indicators regarding the training needs of healthcare workers in the four priority child survival interventions and the integration of services. Submit to COTR by June 15, 1996 (Modification 14);*
- *Work with representatives from MINSA at the central and SILAIS level, PAHO and PVOs to develop a training content and training work plans based on results of KAP study.*

Submit to COTR by June 30, 1996 (Modification 14);

- *Develop an overall training strategy and curricula for the 4 SILAIS which focuses on the four major child survival interventions; control of diarrheal disease, ARI, maternal health including birth spacing, and nutrition education (June 30, 1996) (Modification 14); and*
- *General computer training conducted (year 4)**

Findings: With the exception of the IEC program, these results were accomplished, and some of them were expanded upon. Some training activities have proven so effective that they have gone beyond the DHS project SILAIS level to the national level. The ARI-Pneumonia case management training, the SIVIC, the TOT for Permanent Education Facilitators, the distribution of the Facilitator's Manual are in that category. In addition, team building and leadership promotion, and the utilization of instruments and training for the Growth Monitoring and Promotion Program have reached the national level. This process has been facilitated by the excellent working relationships that MSH has with MINSA. The DHS Project has exceeded the goals in the project scope of work to meet training needs of MINSA personnel.

Findings: Dr. Aldo Martinez, Director of Training for MINSA, noted his strong satisfaction with his collaboration with MSH/DHS staff. He specifically noted that the MSH participative methodology improved the interchange of ideas and experiences. He feels that this approach would have a very positive impact on the effectiveness of training in Nicaragua if it were to be applied nationwide.

The DHS Project workplan also contains its own training indicators to measure its progress toward stated goals which include Person days training of MINSA and community personnel as well as Person days training of Permanent Education Facilitators.

Findings: The DHS has completed its requirements in this area and in some cases far exceeded the goal of number of person days trained. However, due to the high turnover rate of health personnel in MINSA, it has been a challenge to meet the broader objective of providing sustainable impact on MINSA operations and on health indicators given the funds available. There need to be additional funds committed to training for Project Year 5 to insure that key individuals are trained and that training is reinforced with operational support to insure Project sustainability.

2. Management Objectives and Indicators

The original contract calls for the achievement of specific management related outputs and benchmarks. The following section examines the primary results called for in the management area for the accelerated start component (ASC) and each of the five years.

The following outputs/benchmarks are related to general systems for monitoring project progress:

- *Design methodology and collect baseline data for end of project status indicators (EOPS) and objectively verifiable indicators (OVIs) (ASC);*
- *Integrated planning and budgeting for MH/CS services (Year 4);*
- *System to track progress reaching projects objectives/indicators, and track receipt and monitor supply status of project funded commodities (USPHS purchased) (Year 1); and*
- *Transport/logistics training conducted (Year 3).*

Findings: The first two points, and the first part of the third point, have to do with planning and monitoring of Project activities. In this area the Project has been very successful, from the initial definition of EOPS and OVIs, to the submission of annual plans and annual reports.

Findings: The second part of the third point and the fourth point relate to aspects of procurement and tracking of Project purchases. There has been less success in this area, in part due to lack of good coordination and communication with the procurement agent (USPHS), and in part due to the removal of the integrated MIS component. Recently the Project produced a report on equipment needs and an inventory of Project related equipment, which provides the requisite information. Unfortunately this was an ad hoc effort and not part of a sustainable information system,

The following outputs/benchmarks are related to the health care financing component:

- *Implement cost containment and cost recovery policies including analyses of feasibility of cost containment and cost recovery initiatives and the introduction of appropriate cost containment/cost recovery measures (ASC)*
- *First study of alternative income sources by 17 month (Year 2);*
- *Second study of alternative income sources conducted (Year 3);*
- *Financial Management skills training completed (Year 3) ;*
- *Third and fourth studies of alternative income sources (Year 4);*
- *Policy seminars on alternative health financing (Year 4); and*
- *All policy seminars conducted on alternative financing sources (Year 5).*

Findings: The initial cost containment/cost recovery activities under the Accelerated Start Component were carried out, and the first study of alternative income sources was accomplished through a study of "Farmacia Popular" in Ocotal. The other results were not accomplished due to the elimination of the health care financing component toward the end of the second year.

The following outputs/benchmarks are related to the financial management component:

- *Management analysis and inventory diagnostic of SILAIS structures; general orientation of management and financial decentralization component (Year 1);*
- *Financial management system designed by 14th month (Year 2);*
- *Financial management skills training designed and implemented by 18th month (Year 2);*
- *Pilot analysis of information systems requirements for one SILAIS and one urban health center by 18th month (Year 2);*
- *FMS/MIS extended into at least ten of remaining SILAIS (Year 4); and*
- *FMS/MIS extended to all SILAIS (Year 5)*

Findings: All of the results called for in this area have been attained; most of them, including the

results for year five, were expanded upon and/or carried out ahead of schedule.

The following outputs/benchmarks are related to the integrated information system/MIS:

- First procurement specifications for MIS hardware, software and peripherals by 12th month (Year 2);
- Implementation for establishment and operation of MIS (Year 3);
- Financial management and MIS training in pilot SILAIS (Year 3);
- MIS in pilot SILAIS launched (Year 3); and
- General computer training conducted (Year 4).

Findings: All of these results were accomplished only with respect to a financial management information. The results with respect to an integrated system were dropped from the Project and generally to date have not been picked up by other donor agencies.

B. Progress Indicators

Indicators are designed to tell us if and when we have achieved our goals, and how to ensure our progress toward those goals. The DHSP progress indicators were created during the ASC phase of the Project. A majority of these indicators continue to be useful and reliable. An example of an indicator that is not very reliable is "Supplementation with Vitamin A". Vitamin A is only distributed during special campaigns and not on a regular basis. The DHSP team has been proactive in pressing for better Vitamin A distribution in the health centers--some now do it systematically. The team is going to continue using the Vitamin A indicator to take solid action.

Recommendations:

The DHSP needs to follow up with AID to reconcile some of the progress indicators. Identify the indicators that are unmeasurable or will require a special survey.

VIII. OVERALL STRATEGIC APPROACH /OVERARCHING POLICY ENVIRONMENT

This section highlights the central or overarching health policy environment issues in Nicaragua. Decentralization, the donor arena, management capabilities and improvement of management systems, and alternative sources of financing are the main areas of discussion. Section IX then introduces the Fully Functional Service Delivery Point (FFSDP) as a framework for a discussion of the more micro-level issues of the DHSP service delivery context.

A. Decentralization of health services

Decentralization of health services has become a major trend in Latin America, with development efforts often targeted to provinces or districts. Even major donors (IDB, World Bank, etc.) are focusing more and more on regional and local initiatives. Much of the responsibility for managing the regions has been delegated to regional leadership. In Nicaragua, efforts began in the early 1990's during the Chamorro government to democratize management. It was felt that decentralizing health services would integrate the vertical programs and address the health needs of the entire population. The "Local Systems for Integrated Health Care" or SILAIS, would create a less politicized health system.

B. Other donors

The strategic focus on managing decentralized health services in Nicaragua has proven to be very effective in improving the quality of services, and in overall management. In addition to DHSP, other donors such as the World Bank, PAHO, DANIDA, and GTZ have supported the decentralization of health services in management systems, infrastructure, and overall technical assistance.

More information on other donors is contained in the Communications and Relationships section.

C. Management Capabilities and Improvement of Management Systems

An important strategy for the decentralization of health services lies in the strengthening of management capabilities and the improvement of management systems, at the SILAIS as well as the MINSA Central level.

The SAF supports the decentralization of management of health service delivery. The SAF was originally designed to give SILAIS the ability to better control flow of funds to and from the SILAIS. Later, the ability to control expenditures against budget was added as well as an expansion to function at municipal health centers. The SAF is currently installed and functioning fairly well in all SILAIS and municipal health centers. It appears to fulfill an important need for better control of financial information at SILAIS and at health centers. *The status of the SAF is covered in more detail later in this document.*

D. Alternative sources of financing

A final overarching policy issue is the need for a real need for a strategy to address financing of health services in the Nicaraguan periphery.

The DHSP activities have stimulated an increased demand for services. To address the increase in demand, the MINSA needs to become more self-sufficient and generate alternative sources of income. In the near future, the MINSA can continue to rely on donor support, however this is not a likely source of income for the long term. This strategy should include both ways of further increasing efficiency of services, and ways in which revenue can be generated to finance health services.

Findings: In the area of health care financing reform it was considered that the World Bank would be providing adequate support. In the area of information technology and integration of information systems, some of the tasks, such as the establishment of a Central Information Unit, had been carried out by the time the Project started. It was also noted that the World Bank was carrying out a project in this area.

Findings: The modifications made to the Project at the end of the second year have led to a significant reduction in what MINSA has been able to accomplish in the area of health financing reform. While a few studies have been carried out on health financing there has been little by way of concrete changes. The current government now appears to have both the interest and political will to consider these issues.

IX. ARE WE CREATING FULLY FUNCTIONAL SERVICE DELIVERY POINTS?

In order to examine the Project in the context of other work that MSH is performing, we have found it most useful to use the model of the Fully Functional Service Delivery Point to assess both the appropriateness of the strategy being used, and the effectiveness of the implementation.

The Fully Functional Service Delivery Point is defined as the integration in the same place, and at the same time, of all the technical and management resources necessary to assure the delivery of a minimum package of quality services that meets the needs of the local population and insures effective interaction between client and provider. In order to have this, it is necessary to have

- trained and motivated personnel
- adequate equipment, materials, and pharmaceuticals
- an operational infrastructure
- a referral system
- sufficient information for operational and strategic decisions

The FFSDP doesn't apply equally across its five points. There are some points that are not explicitly supported by the Project, but are still worth mentioning in the report for future reference. In addition, there are some points that require more detailed examples than other points.

(See Annex VII for more information on the FFSDP).

A. FFSDP - Part One -Are there trained and motivated personnel?

This section on trained and motivated personnel has two components. The first part highlights the DHSP strategic approach to ensuring that there are trained and motivated personnel. The discussion focuses mainly on the introduction of the MAIMN, the integrated model for women

and children. The second part outlines the training interventions of the Project, and what additional changes may be useful to ensure effective implementation through the life of the project as well as after the project has ended.

1. Strategy of Integration

The Project was designed to specifically ensure that there are trained and motivated personnel, and it is fair to comment that the project is conducting its training in a very effective fashion. This element is key to the overall success of the Project.

A preliminary step in training and motivation is a need for clear standards and goals, and these exist through the MAIMN, the integrated model for women and children. MAIMN was initiated by MINSa in 1995. The model provides an important focus on the whole person rather than the disease that's presented. MAIMN grew out of a need to move away from the vertical MCH programs. Project SILAIS began implementation in 1995. Managerial tools were prepared to support the integrated services at the SILAIS level.

This integrated approach is a major step forward for the health services in Nicaragua, and ensures that Nicaragua is literally at the cutting edge of appropriate health care delivery. MAIMN strives to decrease missed opportunities for services. The strategic change that the Project took to focus on the *integrated services* was very appropriate and has turned out to be successful.

Findings: There are some limitations to the MAIMN model. Most specifically, it lacks clear integrated clinical standards, and clear integrated preventive standards. This will be addressed in part by the introduction of IMCI (Integrated Management of Childhood Illnesses), but there are real dangers associated with this introduction. The integrated standards of IMCI must be applied to MAIMN without detracting from the breadth and depth of MAIMN and use this application to influence the development of integrated standards of preventive and maternal care. The project objective of expanding the reach of MAIMN, and its collaboration with both BASICS and PAHO is very important in this area.

Findings: The separation of immunization as a specific MAIMN intervention has led to some failings in the coherence of service delivery. Strategically, it may be more appropriate to have a single agency responsible for technical assistance to the whole package of services, but it is acknowledged that this is not always possible.

In terms of having adequate numbers of personnel, there is a problem that is especially acute in Jinotega, and that is the shortage of physicians in the rural areas. While the policy of decentralization allows some degree of autonomy for individual SILAIS to allocate their staff, there seem to be many ways of "beating the system". Once a staff member moves elsewhere, their position goes with them, which leads to significant problems. In addition, when staff arrive from Medical School for their rural year of service, they usually have had no training or orientation towards primary health care or rural health care, and consequently they generally cannot respond to the needs of health centers and health posts and often contradict MINSa norms.

Finally, an essential part of any training and motivation program is the existing system of supervision. It is clear that most staff understand that supervision is a collaborative, strengthening exercise, and that it should not be regarded as a police-like control activity. It is equally clear that the project is modeling appropriate supervision. It was a little disappointing to see that supervisory instruments at two SILAIS appear to be checklists, with little or no guidance of how to interact or follow up on findings, however, it was encouraging to accompany a senior nursing officer on a supervisory visit and observe a good, collaborative supervisory session taking place. It is also clear that while extensive schedules for supervisory visits are planned, visits take place less often than planned due either to lack of availability of vehicles, or other problems.

Recommendations:

- *IMCI needs to be introduced carefully. The integrated standards of IMCI must be applied to MAIMN without detracting from breadth/depth of MAIMN*
- *At present there seems to be a real separation of secondary and primary care. The breadth of interventions in MAIMN are narrow, and left up to the individuals to decipher and work out for themselves. While the Project is already playing a very important role in this, it needs to be strengthened.*
- *In order to address the Human Resource Development issue, staff need to be allocated appropriately, more suitably trained in community medicine at medical school, and measures related to training reinforcement, performance incentives, and recognition of achievements need to be taken to improve retention of staff in the periphery.*
- *Supervision needs to be practiced, not preached, placing greater emphasis on quality of care.*

2. Training Interventions

DHSP training covers all levels of the health system including MINSAs Central, SILAIS, health center, health post, community health workers, programmers, computer operators, etc. For the purposes of this report, training interventions are divided into three general areas: community health workers, clinic-based services, and training of trainers.

Training plans support adoption of the MAIMN and facilitate decentralization at all levels of the health system. As part of the planning process, the goal of each training activity, the length of the activity, the methodology, as well as a monitoring and evaluation plan is clearly spelled out. The DHSP has been especially successful with its self-instructional modules, which allow health care workers to receive training at their work sites. Finally, the DHSP has used creative financing strategies, collaborating with other organizations to carry out a number of its trainings and should continue to do so. In addition, as an extension to this training, the project has provided ongoing technical assistance and monitoring of MINSAs staff.

a. Community health workers

Community health promoters and TBAs (Traditional Birth Attendants) play an important role in the integrated care model. They assist in the provision of preventive and primary health services. Most of their ongoing training takes place at the local (health post and health center) level; an appropriate strategy that fits their needs. The DHSP has done a wonderful job at working to improve knowledge and case management skills of front line community personnel. Notwithstanding, there is still a need for more materials, and additional training in certain areas. These community workers need to continue to feel empowered as an integral part of MINSA.

Closely monitoring TBAs is important, and can be especially difficult, given that many of them are illiterate, and not accustomed to filling out paperwork. Close supervision will encourage TBAs to comply with MINSA norms, some of which need to be updated, especially in the area of quality of care.

In addition, the ongoing communication between the community workers and the health centers can be strengthened further. Finally, the MAIMN needs an IEC campaign to reinforce the community health workers' actions:

Recommendations:

- *Create additional nonfinancial incentives and rewards for health promoters in order to support their service to the community. Assure that a supply of certificates and carnets is available. Facilitate special recognition days.*
- *Adapt training materials for illiterate TBAs. Look at the feasibility of training and forming a group of facilitators (directive group) in each barrio - one TBA and one promoter to represent each barrio (comarca).*
- *Continue updating the norms for TBAs; some of the current norms are obsolete. Improve systematization of midwife training to better include the MINSA norms, especially the importance of prenatal care. Include additional emphasis on prevention and continuous community-based health care activities, especially on sanitation/hygiene and nutrition as part of health promoter training. Finally, reinforce MINSA norms re: supervision of TBAs and promoters.*
- *Look for creative ways to fund future IEC programs (individuals who were interviewed consistently expressed the view that there is a need for follow up in this area). An IEC Program is needed in Nicaragua to continue the process of establishing integrated MCH/FP/IMCI program. Resources to provide training, supplies, and salaries for expanded demand must be secured before actively promoting IEC.*

b. Clinic based services

Trainings have been well-received among MINSA clinical staff. The accreditation of Centers "Amigos de la Mujer y la Ninez" in Managua and Boaco is due in part to the success of the

DHSP training programs. Second, the tools and instruments developed by the Project are quite impressive. ARI trainings with a focus on self-evaluation have almost reached all of the SILAIS. These management training programs for handling ARI cases are for medical personnel who prescribe antibiotics. This innovative program was designed to better handle correct diagnosis and treatment of ARI, through self-evaluation and discussion. The program, which has been extended to the national level, was piloted in Boaco in five primary health centers, and average antibiotic use decreased by 15%. Third, the SIVIC training, a program used to achieve control and rational use of essential drugs, another project innovation, was developed, piloted and approved in 1995. A manual was completed in 1996. The SIVIC training has almost reached national coverage, and needs to be reinforced in certain SILAIS. Finally, there needs to be more of a focus on training in the areas of quality of care and nutrition.

Recommendations:

- *Support continuous training in PHC and norms for doctors doing their rural year (e.g. diarrheal disease, anthropometry, correct filling out of forms, etc.) being sure to address quality of care issues. Reinforce the use of self-monitoring tools.*
- *Adapt the ARI training program so that it can be used to conduct similar trainings on diarrheal disease.*

c. Training of Trainers

MINSA is committed to the decentralization of health services through the SILAIS structure, and the impact of the TOT model on that structure has been outstanding. The DHSP training activities support that structure by contributing to institutional strengthening. This is a program that can be replicated and is sustainable. Trainers have received workshops covering technical as well as pedagogical skills. The "Manual del Facilitador" has reached all project SILAIS in Nicaragua. It has also reached Bolivia, Honduras and Guatemala.

In addition, the DHSP conceived and is currently collaborating with other NGOs in and MINSA to run a certificate program in Health Administration which includes: Epidemiology, Monitoring and Evaluation, and Leadership. This program not only accomplishes the goal of regular technical upgrading of staff skills, but provides a mechanism for reinforcement of training and a tangible motivation for staff. Dr. Aldo Martinez, Director of Training, has expressed appreciation toward the DHS team (with mention of the technical and "human" contributions of Claritza Morales, Mario Lacayo, and Peter Boddy) for their part in conceiving the 10 month in-service training program that selected MINSA staff may now be designated to participate in. Finally, leadership/mgmt training courses have also been well-received.

Recommendations:

- Reinforce and continue training in administration of health services especially for the new SILAIS directors. Examples of areas for follow up include: epidemiology (e.g. vector borne diseases), working with indicators, evaluation, and cost-effectiveness analysis training-identifying local (national) health problems with cost-effective solutions.
- Follow up with the Pan American Health Organization to jointly facilitate "Analysis del Desempeno del Equipo Local de Salud", a PAHO created training program that assists with strategic planning strengthening teamwork and improving quality of care. Dr. Armando Guembes, Health Services consultant with PAHO mentioned that PAHO would be willing to provide training materials. In addition, in our meeting with Dr. Aldo Martinez, he highlighted this program and noted a desire to have MSH collaborate with PAHO.
- Train facilitators in the methodology of doing CAP studies so that it becomes institutionalized.
- Follow up to see if AID/MINSA can authorize selling the Manual de Facilitadores to Nicaraguan bookstores, as well as to bookstores in other countries.

General Findings/Recommendations - Training Interventions:

Findings: The quality of the material presented by the DHSP team is extremely high. Across courses, however, DHSP staff have different ways of presenting material. There should be a standardized approach to course development.

- Insure a standardized approach to course development.

Other Recommendations:

- In order to insure project sustainability, increase the DHSP training budget for Project Year Five.
- Encourage the DHSP team in tandem with MINSA to publish case studies (e.g. in SILAIS Boaco) on monitoring training programs.

B. FFSDP - Part Two - Adequate equipment, materials, pharmaceuticals

In first part of this section, we'll cover centrally funded issues such as procurement, fulfilling requests, and what is done at the actual FFSDPs. This section will also discuss management at the service delivery point such as with the SIVIC, the Model for Rational Use of Antibiotics in the Treatment of ARI and materials and supplies at the health center and health post level.

1. SICS - Sistema de Informacion de Control de Suministros

The project has designed and developed a computerized system for programming and

monitoring the use of medicines and supplies at the SILAIS and Health center levels. While the primary focus is on the SICS system, it is important to consider it in the larger context of supplies logistics. During the evaluation some effort was made to understand the supply logistics system, in part to assess the Project's SICS system but also because of the crucial role that medical supplies play in the provision of health care services.

Supply Process

The supply process covers three types of products: pharmaceuticals, clinical supplies and laboratory reagents. The steps in the process include: 1) projection of requirements, 2) approvals of projection quantities based on budget considerations, 3) monthly requests for supplies, 4) special requests for supplies, and 5) dispatch and delivery of supplies. The process is complicated considerably by the fact that, while it functions on a calendar year, budgeted quantities are often not approved until the year is half over.

Projections of requirements are done on a bottom-up basis, with health centers making their estimates based on demographics and morbidity estimates, and amounts used the previous year. These projections are sent to the SILAIS where they are consolidated and sent on to the central level. The process of supply requests is also bottom-up, from health centers to SILAIS and then on to the central level. Monthly requests are generally based on average monthly projections minus stock-on-hand. It is not unusual for requested amounts to be short-shipped or not filled at all due to shortages at the higher level. This system for distributing medicines and supplies results in health centers under consuming in spite of very low budgets. Health centers are not supplied more than their average monthly projected requirements minus quantity on hand for any particular item. If their consumption is below average, what is left over is deducted from the following month's allotment. If, due to shortages or stock-outs at the central level, an allotment is reduced or canceled all together, this reduction cannot be made up later. This situation is ameliorated somewhat if the health center is successful in justifying a special request; justifications are often supported by data from the Project's SIVIC information system.

Findings: The current system for distributing medicines and supplies results in health centers under consuming in spite of very low budgets.

The fact that this system is based on projections that are not finalized by budget allocations until the year is half over further complicates the situation. Both the monthly limits on request, as well as the annual budget limits can change significantly requiring mid year adjustments. If the change is a reduction, which it may well be, then it may be necessary to reduce consumption even more during the second half of the year. This uncertainty is not conducive to a rational planning and utilization of medical supplies.

At the central level there are two MINSA offices involved in the supply process. The "Dirección de Normalización de Insumos Medicos" (DGNIM) is responsible for the norms and policies for supplies procurement and utilization, and the "Centro de Insumos para la Salud" (CIPS) is responsible for the physical logistics of the supplies. In spite of the obvious relationship between these two agencies, there exists no unified system for sharing information on requests from, and disbursements to the SILAIS and health centers. Requests first arrive for approval by DGNIM and are then passed on to CIPS for disbursement. However, the actual amounts disbursed may be less than requested without DGNIM being aware of the changes.

Findings: There exist a number of structural difficulties within the procurement and logistics system that can only be resolved by carrying out a comprehensive assessment of the system to identify bottlenecks and optimal solutions.

The SICS System

The SICS (Computerized Information System for the Control of Supplies) evolved from a series of Project supported activities beginning in SILAIS Matagalpa with the elaboration of modules for programming required quantities of medicines and supplies. The concept was developed further working with the SILAIS Occidental in the development of modules for requests and disbursements of medicines and supplies. A short time later, the SILAIS Central solicited technical support from the project to develop a computerized system that would encompass the complete process of annual programming, monthly requests, the receipt of monthly disbursements to the municipality health centers from the CIPS, as well as maintain information on stock levels and consumption.

Specifications were developed for the system and it was programmed in Clipper following the lead taken in the SAF development. A complete manual documenting the system has recently been produced, the program has been completed, and the software installed in the SILAIS Managua and the health centers of Pedro Altamirano, Tipitapa and Edgar Lang. However, during visits to SILAIS Managua and health center Pedro Altamirano it was found that the SICS system is not yet functioning. This is in part due to the fact that the technical person at SILAIS Managua most knowledgeable in the use of the SICS program has left.

A brief review of the SICS program reveals a system with good functionality, that seemed stable in its operation. The problem is that any computerized system can be expected to experience start-up problems during the first six months of operation, and Carlos Tobon, the Project consultant responsible for its development, lives in Honduras with limited options for returning to Nicaragua. Currently there does not appear to be a person within the MINSA capable of moving the SICS implementation forward.

During the last visit of Dr. Tobon in May a meeting was held to discuss the future of the SICS and the steps needed to move it forward. In this meeting, as well as a previous one, there was interest on the part of DGNIM to take responsibility for the implementation of the SICS; the computer programmer for SICS would take responsibility for the technical, computer related, aspects of the system. If these are firm commitments then the SICS has potential for successful implementation throughout the country; without these commitments the SICS may be still-born.

Findings: The SICS program appears to be a well-conceived system with valuable functionality for monitoring procurement and logistics at all levels. It appears to do a good job of integrating the processes of programming, requesting, dispatching and monitoring the movement of medicines and supplies. If it were implemented in all SILAIS and health centers it would provide more useful management information than that which is currently handled manually. However, without a strong commitment from MINSA it is unlikely that effective implementation will get off the ground.

Recommendations

- *A thorough review of the pharmaceutical supply system should be conducted. This review needs to look at the system of ordering from the periphery and the understanding of how well the periphery understands the system.*
- *Training of Bodega staff and at all levels in drug management is needed.*
- *CIPS and DGNIM should take responsibility and ownership of the SICS; the programming modifications for the central level module should be finished; MINSA staff should be provided the skills and knowledge to train for and maintain the use of the SICS; and implementation in SILAIS and health centers should be supported.*
- *In the event that the SICS cannot be implemented, there needs to be another automated system of logistics management in place*

2. SIVIC – Sistema de Vigilancia de Insumos Criticos

The “Sistema de Vigilancia de Insumos Criticos” (SIVIC) was developed by the Project in response to the realization of the severity of stock-outs of medicines and other medical supplies in health units throughout the MINSA system. The objective for which this management tool was developed was to provide the health facilities with a simple methodology for measuring the supply level status for a list of critical medicines and supplies, and to present the results in a visual form. A second objective, which was added during development and testing, was to provide a mechanism for attributing a reason for each of the stock-outs.

The SIVIC is a simple manual system that consists of several tables for recording, calculating and or consolidating information for about twenty of the most important pharmaceutical and medical supplies. Data is collected and processed weekly, using a scheme based on two variables: consumption and quantities on hand. The primary data, stock on hand at the beginning of the week and consumption the previous week, are taken from the stock control cards (tarjeta estiba) for each of the items. Each item is classified as having sufficient quantities, having quantities for only a short period of time, or being out of stock all-together. The results are posted on a type of horizontal bar chart where, for each week, a green, yellow or red square is added to represent the items’ respective status.

The SIVIC was initially installed in the health centers in the four Project SILAIS, but has been so well received by the MINSA that it has been extended country wide. In a relatively short period of time the SIVIC has become a major management tool which is used at all levels as an indicator of the status of the drug supply system. While much of the problem is due to scarcities at a higher level, the SIVIC has increased awareness of the situation and there is some indication that it has resulted in improvements through facilitating special orders. The DGNIM also uses the SIVIC’S consolidated results to evaluate the SILAIS’ monthly orders.

The SIVIC has a printed manual as well as other documentation. Effective training was developed and carried out in the implementation of the system.

Findings: The SIVIC is a very successful example of a simple management tool that has had a major impact on policies and decisions at all levels of the MINSA. In addition, the design is generic to the point that it can easily be adapted to health systems elsewhere.

Recommendations

- *MSH should take further steps to insure that the SIVIC methodology is presented to a wider international audience, and that it be considered for implementation in other MSH field projects.*

3. Model for Rational use of Antibiotics in the Treatment of ARI

This model was actually developed as a training module, but is classified here as a management tool because it includes specific forms and methodologies for collecting and analyzing information and drawing conclusions. The objective of the model or training is to improve the application of treatment norms for acute respiratory infections (ARI) and, in the process, to achieve a more rational utilization of antibiotics.

The analytic methodology is based on the review and classification of information in patient clinical records. Patient records are first analyzed for signs and symptoms and then classified by type and gravity of respiratory infection. The use or non-use of antibiotics is also analyzed and a matrix is developed of numbers and percentages for appropriate use, appropriate non-use, inappropriate use and inappropriate non-use. While this is a simplistic description of a more complex process, it helps to underline the simplicity of the concept.

This training was originally developed for and applied to the Project SILAIS, but has since been adopted by the whole MINSA and, with additional support from DANIDA, has been extended to all of the SILAIS. Application of this management tool has already achieved some impressive results in improved rationalization of antibiotic use. The project is currently considering a similar model for treatment of diarrheal disease.

Findings: Model for Rational use of Antibiotics in the Treatment of ARI is an effective intervention which is producing improvements in a crucial area of the health care delivery system.

Recommendations

- *MSH should take further steps to insure that the ARI methodology is presented to a wider international audience, and that it be considered for implementation in other MSH field projects.*

4. Materials and Supplies

It is not within the purview of the Project to delve into the concept of an integrated logistics system. It is, however, worth briefly covering this area since it is part of the FFSDP. There needs to be more support of a logistics system. The existing dual system for ordering medicines and supplies creates stockouts. An example of this is the need for a constant supply of material to the brigadistas and parteras. Family Planning commodities supply also seems to be a

particular problem that needs to be addressed.

Recommendations:

- *Attention should be given to providing materials and supplies to the parteras and brigadistas.*

C.FFSDP - Part Three- Operational infrastructure

This piece of the FFSDP is not explicitly supported by the Project, however it is worth mentioning in this document for future reference. The MSH Internal Evaluation Team observed and discussed operational infrastructure issues during their visit and felt it was useful to include this brief section in the report.

Buildings are often inadequate, poorly designed, or adapted from other sources. Consultation rooms are overcrowded, often with nurses and doctors seeing different clients in the same room, and there is no real opportunity for privacy. These rooms are often noisy and chaotic, not optimum spaces for delivery high quality health services. Notwithstanding, all sites that we visited were well maintained, clean, and clearly cared for.

Communications mechanisms are poor in remote health centers and health posts. Many radios that exist for communication are missing or broken and need to be either repaired or replaced.

Recommendations

- *Continue to focus on how to reach those areas that do not have professional health services, or little or no access to services.*
- *Every health facility should have the capacity to communicate, and there should be working radios where telephones do not exist.*

D. FFSDP - Part Four- Referral system

This piece of the FFSDP is not explicitly supported by the Project, however it is worth mentioning in this document for future reference. The MSH Internal Evaluation Team observed and discussed referral issues during their visit and felt it was useful to include this brief section in the report.

The referral system appears to be strongest at the primary health care level. Basic health service referrals are handled well. There seems to be a “disconnect”, however, once patients need to be referred from the primary to the secondary levels. There is a failure to communicate feedback and action that has been taken/needs to be taken between these providers. This results in serious consequences with respect to quality of care. Morale levels and confidence in the health system are adversely affected. Existing MINSA norms in this area are not being

widely followed, and additional norms need to be established.

Recommendations:

- *A formal reference system needs to be established, with clear criteria, understanding what can be dealt with at primary and secondary levels, with the appropriate equipment, materials, etc. being present at each level. This reference system needs to include a feedback mechanism both up and down the levels to make sure that referrals to any level are handled appropriately. In addition, the secondary level should have the same treatment protocols, etc., to assure that patients do not have care changed inappropriately, and therefore, lose faith in the peripheral staff.*
- *In addition to the monthly health center meetings, include case management discussions for promoters at the municipal level every three months. Also include a yearly evaluation. Pilot test separate monthly reporting forms for promoters and TBAs. Make them very simple, two-sided forms that include drawings. Look at the feasibility of using the same forms across SILAIS; currently different forms are being used. Adapt the form for TBAs created in Jinotega.*

E. FFSDP - Part Five- Sufficient information for operational and strategic decisions

The true test and assessment of the Project's accomplishments in the management area lies in the consideration and evaluation of the various systems and tools which have been developed and implemented by the Project. This section provides an in-depth analysis of some of these systems, including consideration of progress and accomplishments as well as problems and issues of sustainability.

Some information systems and tools such as the SICS, SIVIC, and Model for Rational Use of Antibiotics in the Treatment of ARI were mentioned in the section on Adequate equipment, materials and pharmaceuticals. Now, we'll discuss critical information that is needed to make operational and strategic decisions. Examples highlighted here are the SAF, Clinical Record Based Models, Community Censuses, Epidemiological Surveillance System, Service Delivery Statistics System, and MSH's Training Management Tool.

1. SAF - Sistema Administrativa Financiero

The SAF is the most significant of the management systems developed by the Project, both in terms of its complexity and its required level of effort. A significant portion of the specified project outputs/benchmarks are related to the development of the system, and most of the efforts of the Management and Finance Specialist and the Senior Systems Analyst were directed specifically toward this activity.

Development

The development process began in 1995 with a management analysis and inventory diagnostic of SILAIS structure and a general assessment of management and financial decentralization component. A report was produced during the first year that documents this process and outlines the design parameters. From this a more detailed set of specifications was developed and documented. The specification documentation has been maintained, with additions and modifications made as the system evolved. An assessment was made of existing capabilities within the SILAIS and a decision was made that the appropriate level of technology called for a DOS based system in a compiled menu driven program. This led to the selection of Clipper as the software development platform.

Findings: The SAF appears to be based on a sound conceptualization and is well documented in both its purpose and its structure.

The original objective of the SAF was to provide the SILAIS with an improved system for controlling the flow of funds coming into and leaving the SILAIS. Later, additional functionality was added to control expenditures against budget categories and to submit to a higher level an accounting for the expenditures. The system was also expanded to function at the Health center as well as the SILAIS level. The SAF has now been installed in all SILAIS and in all Health centers located in departmental capitals.

In interviewing users of the SAF in several SILAIS and Health centers, it became clear that there is close to unanimity in agreement on the SAF's utility. In spite of frustration by some over operational problems with SAF, all were united on its value and functionality. All of the users that were interviewed showed considerable excitement about its potential, feeling that its usefulness will certainly out-weigh any startup difficulties. The report of difficulties in the utilization of SAF varied considerably among users interviewed with some reporting trouble-free use while others were quite frustrated. Where problems were found there seemed to be inconsistencies between the users and the support team as to what the problems were. To the extent that problems were being encountered in its use, they seemed to occur primarily in the newer budget control and account balancing modules.

Findings: The general purpose and functionality of the SAF appears to fulfill an important need for better financial control at the SILAIS and Health center level. There do appear to be some problems in getting all users to the point where their systems are functioning smoothly.

While the SAF has been developed with specific objectives for meeting financial management needs at the SILAIS and municipality level, the Project has anticipated the need to integrate with other projects and government agencies' efforts in MIS. Recently two such efforts have

surfaced which require consideration. The Ministry of Finance (MINFIN), with financing from USAID, is undertaking the development of a new information system (SIGFA) which attempts the integration of budgeting and finance information across all Ministries. The Project is in the process of modifying its scope in order to respond to the need to integrate the SAF with the SIGFA. In addition, the World Bank is now ready to begin its project to develop an integrated information system for the MINSA. Initial meetings have been held between the Project and the World Bank team and there is a consensus to collaborate and minimize any potential duplication of efforts.

Training

Installation and training for the SAF appears to have been both systematic and thorough. The training consisted of several stages, beginning with the basic computer skills training for perspective SAF operators. This was followed by a workshop on the general design and use of the SAF, which, in turn, was followed by in-service training in the use of the SAF. In addition, quarterly regional seminars are held to evaluate progress and solve problems. More recently there have also been seminars for Directors to explain the functionality and usefulness of the SAF. Training and implementation was first carried out for the four Projects SILAIS and later expanded to the rest of the SILAIS and to the departmental capitals' Health centers.

In spite of a well designed and implemented training plan, it is suspected that some of the operational problems encountered in the field are due to some users not having the capability, understanding and confidence that others do. It can be expected that different users will begin with different aptitudes and skill levels, and as a result different approaches and concentrations of training may be required. To that end, the quarterly regional workshops represent a good strategy for providing customized response for different situations.

Findings: The training and preparation for the implementation of the SAF has been well conceived and effectively implemented. Nevertheless, due to differences in individuals' needs and the turnover of personnel, the training function should be viewed as a continuous activity requiring an internal MINSA capability.

Support

Any computerized information system requires a certain level of user support, relatively concentrated in the beginning and tapering off to a maintenance level once the system is stabilized. To date, the technical staff of the Project has been providing that support fairly effectively through telephone and personal contact with the field, and through remote modem connections directly with the field computers. The fact that during interviews inconsistencies were noted between field users and central support teams as to the nature of the problems and the responses provided indicates a need for more systematic logging of both problems and solutions.

A major concern for the sustainability of the SAF program is the ability of MINSA to provide the technical support after the Project ends. This concern is particularly acute due to the lack of MINSA counterparts during any of the computerized aspects of the system. During the design and implementation of the SAF, the "Dirección de Administración y Finanzas" (previously "Dirección Económica") has participated as counterpart for technical aspect of financial

management, but a counterpart for the computerization aspect has been non-existent. In the early design phase there was involvement of a technical person from SILAIS Occidental and there is currently working with the Project team a MINSA employee contracted with World Bank funds. Nevertheless, in neither of these cases has there been an institutional link or home within any organizational unit of the MINSA.

Findings: The ongoing sustainability of the SAF beyond the life of the Project is at risk as long as there is no organizational unit within MINSA which will take ownership and responsibility for the computerized aspects of the SAF.

Findings: Although the technical support for the SAF has been comprehensive and effective, it needs to become more systematic and better documented in order to provide on-going support for its users.

Recommendations

- *Primary emphasis should be placed on developing a sustainable support mechanism within MINSA through establishment of institutional links. Although this could be within the "Dirección de Administración y Finanzas," a better choice might be the computerized information unit within the "Dirección de Planificación." Since this should be a major concern for the new World Bank project, it would make sense to join forces with them in working out an arrangement with MINSA.*
- *A long-range support capability for the SAF is needed which provides flexible ongoing training and systematic technical assistance and problem solving. The training component should develop a scheme for classifying and monitoring the skill levels of individuals, and should develop more customized responses to specialized needs. The MSH/MINSA technical staff responsible for supporting the SAF should keep a detailed log of complaints or problems raised by users along with the resolution of any issues.*

2. Other Clinical Record based Models

The Project is in the process of developing other analytic models based on the review and classification of information in patient clinical records. One set of instruments is for monitoring integrated health care delivery for children and the other is for monitoring integrated health care delivery for women. The clinical records are analyzed for a number of different variables, the diagnoses and treatments and indicators are developed which measure the accuracy of information, and the effectiveness and efficiency of treatment. The forms and methodologies are linked to the specific clinical record forms used by MINSA.

The purpose of these instruments is to detect deficiencies in the data entry and interpretation that can help identify corrective measure that may be needed. The models are still in the design phase but will soon be tested in the primary care units of the Project SILAIS.

Findings: These additional models will be valuable management tools for improving some aspects of quality of care for integrated health service delivery.

3. Community censuses and other instruments

Community censuses and other instruments target and monitor community level care. It would help to have the community level workers more actively involved in MIS, but the decentralization to the individual health post, and care provider is exceptionally good. The work on tools and instruments is outstanding as locally appropriate management tools. Information is actively used on planning and in working with the community for decision making. Perhaps there is not enough understanding of some of it.

Recommendations:

- *Some measure should be taken to adjust official census data in relation to service delivery charts so that the charts can play a useful monitoring role.*

4. Epidemiological Surveillance System

There is an epidemiological surveillance system that is effective, but not coordinated country-wide. It is left to individual SILAIS to establish criteria. While there is a lot of attention paid to epidemiological detail, there is inconsistency in the interpretation of disease as well as in the way in which people respond to incidences and problems. This system needs more coordination and coherence across all of the SILAIS.

Recommendations:

- *Epidemiological surveillance needs to be strengthened and rationalized. There needs to be an increased focus on interpretation of statistics, emerging infectious diseases and response.*

5. Service Delivery Statistics Information System

This topic is included, not for what has been done, but for what has not been done. During the evaluation visit there was little mention of collection and use of service delivery statistics. The MINSA information system for service delivery statistics is a manual one and there does not appear to be much reliance on the information. Since the integrated information system component was dropped from the Project, it was not possible for the Project to work in this area. It is possible that the new World Bank project may address this issue but, since the design should be bottom-up, it may not fit in their plans.

It is interesting to note that it is more common for a ministry of health to have a computerized information system for service statistics, but not have effective access to information at the clinical record or case level. With the Project tools described above it appears that the reverse is true in Nicaragua.

Finding: While the Project has developed tools for accessing clinical record information, the MINSA lags behind in the development of an effective information system for service delivery statistics.

6. TMT – Training Management Tool

There have been several management tools developed by the project which are candidates for extension to other projects in other countries. MSH strongly supports the concept of cross-fertilization among its projects, and in developing tools which can be replicated repeatedly. There is an example where this philosophy can also benefit the DHS Project.

Based on experience from other projects, MSH has developed a generic Training Management Tool (TMT). TMT97 is a relational database system developed in Microsoft Access97, which records and processes data for planning and monitoring training activities. This system was introduced to the Project and the reaction has been that it would be very useful for tracking the Project training activities across the various parameters that are required by the contract or needed by MINSA.

Recommendations

- *A consultant visit from Boston should be made to help adapt MSH's Training Management Tool 97 to the Project's needs and train personnel in its use.*

X. Communications and Relationships

This section covers the organizational structure of the Project, human resource management in the TA team, and the structure for communication.

A. Organizational Structure of the Project *Also see Background section as well and Annex IV.*

The DHS Project technical assistance team is organized in four units (Administration, Training, Maternal & Child Health, and Financial Administration Systems) with a fifth unit on the organizational chart to represent the significant inputs to the technical work of the project from consultants. These units are managed by the Project Director, Dr. Peter Boddy.

The departure from Nicaragua of three of the original DHS project team members was followed by the addition of Mario Lacayo, Claritza Morales, and Peter Boddy. Each of these new team members has made key contributions to the development of DHS initiatives and provided leadership in the process of implementation that has been noted by those interviewed in the SILAIS, in the central Ministry of Health, at USAID, and by other members of the DHS team.

B. Human Resource Management in the TA team

Each member of the DHS technical assistance team has a clear job description and workplan. In discussion with each staff member, it became clear that each member of the staff feels that she or he has the essential authority and resources to carry out plans and meet responsibilities. The following questions were outlined for DHS Project team members in a group meeting and each individual was given a copy (See Annex IX). Subsequently, the evaluation team met with each individual for discussion.

1. Delegation

For the effective delegation of significant activities related to project goals, it is necessary to clearly define the role to be played by the designated individual and what goals are to be achieved. The level of authority must be in accord with the level of responsibility and accountability. The appropriate resources must be made available and necessary specialized training must be identified and provided. The supervisor must have an operational mechanism for monitoring, evaluation, and feedback. On going performance results should feed directly into the process of planning for future activities. Technical staff have indicated that they feel they are encouraged to play leadership roles in their areas.

The DHS staff have all indicated that they understand their roles and feel able to pursue their performance goals. In reviewing the individual work plans of the staff, it is clear that attention has been paid to staff training needs (the employees' action plans include specification of additional training in Windows NT, Internet use, use of Power Point, Quatro Pro, English, EPINFO, Project Design, Cost-Benefit Analysis, Quality of Care Promotion, and Training Facilitation). Equipment needs are also specified in these plans and have been acted on by the Project Director (e.g. laptop computers and a multimedia projector have recently been made available to improve staff capacities to accomplish project goals).

2. Supervisory Structure

The supervisory structure of the project is well understood by each staff member. Work plans are developed on schedule and regular interaction and feedback is provided along with periodic, formal performance reviews. The Management structure of the team has been flexible enough to be changed when changes in the work priorities or operational issues have indicated the need for a change. There had been a concern expressed by administrative staff that work plans had not been fully developed for them in the past, but, in conjunction a recent reorganization of the Administration Unit, Dr. Boddy has already initiated that component of the Project performance management system.

3. Prioritization, Resource Allocation, and Decision Making

Each of the team members noted that there is a collaborative process for decision making and resource allocation. There was, in fact, some difficulty in understanding the concept of resource conflict. There is, in fact, a conflict between the need to dedicate national resources to extension of the SAF into areas requiring solid capacity for financial management (hospitals) and the need to add depth to the training provided to the SILAIS units.

In the SILAIS areas, each of the Technical Advisors had to deal with a smaller budget allocation

than they had requested to carry out work plans. Each of them sought other avenues to leverage support for training and programming to allow plans to be carried out. In some cases, other donor support for training activities was negotiated, in other cases, the design of the training programs was altered to reduce the costs.

Findings: In Jinotega, the SILAIS Deputy Director made a point of observing the value of the contribution of Mario Valencia as an advisor (he serves with the SILAIS management committee), in the training of trainers and in the area of child growth and development. He noted the success in achieving the lowest ARI rate of the SILAIS in the context of an increased patient load and reduced use of antibiotics.

Findings: In Matagalpa, the SILAIS Deputy Director noted a strong concern about accessibility and communication. The health posts do not have working radios or telephones (there are generally radios in place, but they do not work). He noted that the SAF was very important and in full use. He also noted that DHS has been helpful in promoting cross fertilization among the SILAIS (with a particular expression of appreciation for the efforts of Eduardo de Trinidad and Mario Lacayo)

Findings: SILAIS Boaco has had a number of achievements including significant decreases in the use of antibiotic use thanks to the ARI training as well as the accreditation of centers “Amigos de la Mujer y la Ninez”. (See Training Interventions section). This is the only SILAIS where the World Bank and DHS overlap. Carlos Saenz has been highly effective in promoting the DHS program in all areas of this “most manageable” of the four project SILAIS.

Findings: In SILAIS Managua, Alba Luz Solorzano works in connection with service delivery staff rather than as an advisor to the SILAIS Director. The huge scale and significant urban component of this SILAIS makes this approach a more sensible way of providing technical assistance. Her efforts should also lauded in the accreditation of a health center as “Amigos de la Mujer y la Ninez” in Managua.

Dr. Peter Boddy, Dr. Mario Lacayo, and Lic. Claritza Morales were consistently recognized by MINSA colleagues as providing important inputs and guidance.

Findings: The team is well managed, has a positive morale, and an atmosphere of mutual support and respect among individuals. When problems arise they are faced and resolved constructively. Resources within the DHS Project are well managed. The sustainability of project initiatives will depend on the continued commitment of MINSA to provide the staff, training and resources to promote high quality, integrated service delivery and support the information systems that DHS developed for management of financial resources (SAF) and essential drugs (SIVIC). The GoN has a resource constraint in this area that must be resolved in the context of a strong policy for free essential services to target populations and very limited financial resources. One promising avenue that MINSA is exploring is securing intersectoral cooperation in program efforts. If this initiative for efficient use of national resources can succeed, the conservation of resources will be an effective addition to available for program support.

C. Structure for communication

1. Intra-team

Communication within the team is good. The monthly staff meeting is highly valued as a mechanism for communication and exchange. It was cited by many staff members as a key element of the collaborative approach that Dr. Boddy has established for prioritization, resource allocation, and decision making. The distances to some of the rural areas the technical staff regularly work in combination with the frequent lack of telephone or even radio links make day-to-day communication somewhat sporadic. There is concern about the potential danger of armed groups in remote areas. The team has dealt with this circumstance by being clear with each other in exchanging information on travel plans.

2. Home Office relations

Relationships with the MSH home office are generally positive. The members of the team expressed some frustration with the difficulty of knowing much about other field projects and an eagerness to exchange information and ideas.

The MSH Controller, Carol Haupt, reports a very pleasant and constructive relationship with Mr. Dean Walter, Budget and Accounting Officer for USAID/Nicaragua. She feels that the project is on a positive tack with good communication and responsiveness, both in relation to dealings with USAID and with the Chief of Party. She noted the difficulty caused by the recent obligation delay, but recognized that everyone seemed to be doing what they could.

3. Subcontractor relations

The working relationship with DGI is positive. The DGI team member, Dr. Manuel Olave, remarked that the project operated as a unified team and that he appreciated that all project documents and notices reference MINSА/USAID/MSH-DGI.

4. MINSА Counterparts and USAID

Interactions with MINSА are cordial and constructive at all levels. The SILAIS Technical Assistants have all been accepted as key advisory resources to the decentralization and promotion of primary health care. In Jinotega, Matagalpa, and Boaco, The DHS SILAIS Technical Assistants are included as ex-officio members of the SILAIS Management Teams. In Managua, due to its size, the SILAIS Technical Assistant plays a role more directly linked to the service delivery level. In each of the four SILAIS, MINSА staff expressed a high level of confidence and appreciation for the efforts of the DHS staff in general and for the Technical Assistant in particular. At the central level of the project it is clear that the DHS Project team members share a common vision for the work of the project. The relationships with USAID are also positive. Comments were made in many quarters that DHS Project staff seemed well integrated with MINSА staff and were often also presumed to represent USAID. In fact, DHS staff have succeeded in promoting a constructive approach to program development and implementation that has a focus on meeting the goals of the parties involved. USAID in the July, 1997 Interim Contractor Performance Report gave the DHSP excellent ratings (a mean score of

3.8 out of 5.0) for quality, cost control, timeliness of reports, and USAID as well as end user customer satisfaction. Finally, Marion Aldrich of USAID expressed a desire to have more direct communication between the MSH Contracts Officer and the USAID Contracting Officer.

5. Cooperating Agencies

Profamilia - A meeting was held with Carlos Jarquin, Regional Representative at the Profamilia headquarters in Managua, and a subsequent visit was made to a Profamilia clinic in Chontales. The clinic facility was impressive; well-maintained and well-laid out. In addition, close attention was paid to quality of care issues. Relationships should be developed between Profamilia and FPMD to look at potential collaboration in Nicaragua.

World Bank - Two meetings were held with Elizabeth Cajina, Project Coordinator, MINSA/World Bank and Jorge Orochena, Coordinator, Primary Care. The World Bank is now ready to begin its project to develop an integrated information system for the MINSA. There is a consensus to collaborate with MSH and minimize any potential duplication of efforts.

PAHO - During a meeting with Dr. Lamy and Dr. Codina, we learned that there had been confusion at PAHO, at least on the part of Dr. Lamy, regarding who the DHS staff were and who the MINSA staff were. Dr. Lamy was surprised to learn of the small size of the DHS team and that most individuals he had assumed to be on the Project payroll are, in fact, MINSA staff with whom DHS staff work in collaboration. Through discussion regarding the complementary roles played by DHS and by PAHO in working toward MINSA goals, agreement was reached for Dr. Codina and Dr. Lacayo to coordinate PAHO and DHS activities through a series of regular meetings between PAHO and DHS staff. Dr. Lamy's emphasis on the dual role of PAHO (as provider of TA and as a policy arm of an international organization with a regional scope and mission) is an important reminder. His misunderstanding of who the DHS staff are is an indicator that MSH must do more to assure constructive communication with PAHO and also to work in a way that makes our roles clear in relation those of MINSA staff. A positive working relationship with PAHO can become a useful tool for sustainability of DHS efforts beyond the end date of the project itself. (See Training Interventions section for information on meeting with Dr. Guembes at PAHO.)

D. Final points:

Findings: Beyond confirming the success of the DHS team in implementing project programs, there is a conclusion to be drawn from this information coming from MINSA sources and from PAHO. The DHS Project staff are in a unique position to offer technical assistance to MINSA which is both valued for its content and remarkably free of the misunderstandings that can arise when outside consultants are imposed on a system and create complications and that might tend to hinder the testing of new ideas. The MSH staff in Nicaragua can serve as an effective conduit for channeling the efforts of other donors into the development needs of MINSA because of the combination of their strong technical skills and high level of respect and credibility with MINSA staff.

Findings: It was noted by Dr. Manuel Rodriguez that the DHS team "has carried through with

project goals and gained prestige in the SILAIS that is related to respect for the professional capacities and appreciation for personal contributions of each of the SILAIS Technical Assistants” He noted that he felt a strong concern for the DHS project during the time of the change of design and staffing because of both its importance to Nicaragua and, because of his own role, its potential impact on his professional career and authority. He feels that the valued relationship with USAID has been reinforced and that Peter Boddy’s strong capacity as a manager of complex issues has been a primary reason for the great advances of the project. He expressed his satisfaction with the contributions of each member of the team and noted the broad range of experience that they represent as a group.

Recommendations:

- *Exchange Home office and project staff meeting minutes and distribute to staff to improve communications with the home office.*
- *Complete the process of performance management for administrative staff.*
- *Have regular meetings between DHS staff and key PAHO staff to assure that program activities are complementary*
- *The MSH Contract Officer, Yen Lim, should communicate directly with the USAID Contracting Officer, Martin Napper, to assure clear understanding.*
- *Actively seek linkages with other NGO’s and donors in implementing final year of DHS Project activities to promote sustainability of project results and clarify possible next steps MINSA might take in pursuing its goals.*

XI. FULL SET OF RECOMMENDATIONS FROM THE MSH INTERNAL EVALUATION TEAM

Overarching policy recommendations:

- *Actively embrace and look for alternative sources of funding. Continue to focus on how to reach those areas that do not have professional health services, or little or no access to services.*

Trained and Motivated Personnel:

- *Introduce IMCI carefully. The integrated standards of IMCI must be applied to MAIMN without detracting from breadth/depth of MAIMN.*
- *Supervision needs to be practiced, not preached, placing greater emphasis on quality of care.*
- *At present there seems to be a real separation of secondary and primary care. The breadth of interventions in MAIMN are narrow, and left up to the individuals to decipher and work out for themselves. While the Project is already playing a very important role in this, it needs to be strengthened.*
- *In order to address the Human Resource Development issue, staff need to be allocated appropriately, more suitably trained in community medicine at medical school, and measures need to be taken to improve retention of staff in the periphery.*
- *Create additional nonfinancial incentives and rewards for health promoters in order to support their service to the community.*
- *Continue updating the norms for TBAs; some of the current norms are obsolete. Improve systematization of midwife training to better include the MINSA norms, especially the importance of prenatal care. Include additional emphasis on prevention and continuous community-based health care activities, especially on sanitation/hygiene and nutrition as part of health promoter training. Finally, reinforce MINSA norms re:supervision of TBAs and promoters.*
- *Adapt training materials for illiterate TBAs. Look at the feasibility of training and forming a group of facilitators (directive group) in each barrio - one TBA and one promoter to represent each barrio.*
- *Look for creative ways to fund future IEC programs. An IEC Program is needed in Nicaragua to continue the process of establishing an integrated MCH/FP/IMCI program. Resources to provide training, supplies, and salaries for expanded demand must be secured before actively promoting IE and C.*
- *Reinforce and continue training in administration of health services especially for the new SILAIS directors. Examples of areas for follow up include: epidemiology (e.g. vector borne diseases), working with indicators, evaluation, and cost-effectiveness analysis training-identifying local (national) health problems with cost-effective solutions.*
- *Follow up with the Pan American Health Organization to jointly facilitate "Analysis del Desempeno del Equipo Local de Salud", a PAHO created training program that assists with strategic planning strengthening teamwork and improving quality of care.*
- *Train facilitators in the methodology of doing CAP studies so that it becomes*

institutionalized.

- *Follow up to see if AID/MINSA can authorize selling the Manual de Facilitadores to Nicaraguan bookstores, as well as to bookstores in other countries.*
- *Adapt the ARI training program so that it can be used to conduct similar trainings on diarrheal disease.*
- *There needs to be a standardized approach to training course development and course materials.*
- *In order to insure project sustainability, Increase the DHSP training budget for Project Year Five.*
- *Encourage the DHSP team in tandem with MINSA to publish case studies (e.g. Boaco) on monitoring training programs.*

Adequate Equipment, Materials and Pharmaceuticals:

- *There is a need for improvements and support for procurement and logistics at the macro level.*
- *CIPS and DGNIM should take responsibility and ownership of the SICS; the programming modifications for the central level module should be finished; MINSA staff should be provided the skills and knowledge to train for and maintain the use of the SICS; and implementation in SILAIS and health centers should be supported.*
- *In the event that the SICS cannot be implemented, there needs to be another automated system of logistics management in place.*
- *MSH should take further steps to insure that the SIVIC and ARI methodology are presented to a wider international audience, and that they be considered for implementation in other MSH field projects.*

Operational Infrastructure:

- *Continue to focus on how to reach those areas that do not have professional health services, or little or no access.*
- *Every health facility should have the capacity to communicate, and there should be working radios where telephones do not exist.*

Referral System:

- *A formal referral system with clear criteria, needs to be established understanding what can be dealt with at primary and secondary levels, with the appropriate equipment, materials, etc. being present at each level. This referral system needs to include a feedback mechanism both up and down the levels to make sure that referrals to any level are handled appropriately. In addition, the secondary level should have the same treatment protocols, etc., to assure that patients do not have care changed inappropriately, and therefore, lose faith in the peripheral staff.*
- *In addition to the monthly health center meetings, include case management discussions for promoters at the municipal level every three months. Also include a yearly evaluation. Pilot test separate monthly reporting forms for promoters and TBAs. Make them very simple, two-sided forms that include drawings. Look at the feasibility of using the same forms across SILAIS; currently different forms are being used. Adapt the form for TBAs created in Jinotega.*

Sufficient Information for Operational and Strategic Decisions:

- *A consultant visit from Boston should be made to help adapt the TMT97 to the Project's needs and train personnel in its use.*
- *A thorough review of the pharmaceutical supply system should be conducted. This review needs to look at the system of ordering from the periphery and the understanding of how well the periphery understands the system.*
- *Training of Bodega staff and at all levels in drug management is needed.*
- *Primary emphasis should be placed on developing a sustainable support mechanism for the SAF within MINSA through establishment of institutional links. Since this should be a major concern for the new World Bank project, it would make sense to join forces with them in working out an arrangement with MINSA.*
- *A long-range support capability which provides flexible ongoing training and systematic technical assistance and problem solving is needed for the SAF. The training component should develop a scheme for classifying and monitoring the skill levels of individuals, and should develop more customized responses to specialized needs. The MSH/MINSA technical staff responsible for supporting the SAF should keep a detailed log of complaints or problems raised by users along with the resolution of any issues.*

- *Epidemiological surveillance needs to be strengthened and rationalized. There needs to be an increased focus on interpretation of statistics, emerging infectious diseases and response.*
- *Some measure should be taken to adjust official census data in relation to service delivery charts so that the charts can play a useful monitoring role.*

Communications and Relationships:

- *Exchange Home office and project staff meeting minutes and distribute to staff to improve communications with the home office.*
- *Complete the process of performance management for administrative staff.*
- *Have regular meetings between DHS staff and key PAHO staff to assure that program activities are complementary*
- *The MSH Contracts Officer should communicate directly with the USAID Contracting Officer to assure clear understanding.*
- *Actively seek linkages with other NGO's and donors in implementing final year of DHS Project activities to promote sustainability of project results and clarify possible next steps MINSA might take in pursuing its goals.*

Other:

- *The DHSP needs to follow up with AID to reconcile some of the progress indicators. Identify the indicators that are unmeasurable or will require a special survey.*

ANNEX I: SCOPE OF WORK

SCOPE OF WORK DHS PROJECT MIDTERM INTERNAL EVALUATION

Principles underlying the process:

- This is a process that is designed to assist the Project team and MSH in identifying any unexpected or previously unanticipated problems with the execution of the Project.
- The evaluation team's primary goal is to be able to validate the approaches taken by the Project and to give guidance on areas where successes can be built upon. Where areas of weakness or need for corrective action may be identified the team will recommend how these can be corrected constructively.
- An important additional output of the evaluation will be the ability to describe in a systematic fashion those things that have worked, and why they have worked, with the result that we can elaborate a clear framework for how each critical area and/or system in the project works. This is especially important, because documenting why something is working is not a contractual requirement of the project, but is an essential reference for future planning.

- The evaluation is comprehensive, but not exhaustive.

There are five major areas of focus of the evaluation:

1. Development and implementation of Strategic objectives.
2. Progress towards goals and objectives.
3. Communications and relationships.
4. The Organizational Structure and Systems of the Project.
5. Capacity Building.

In addition to the above, three underlying principles guide the team:

- Targets - are they being met
- To what extent is this program laying the ground work for the next phase
- Is this the most efficient way of doing it.

In addition, we will want to look at the basic design of the project, and assess whether, with the value of hind-sight, the project could have been designed in a different way, which would have been more efficient, or effective, with a more efficient use of resources.

SCOPE OF WORK - DHSP INTERNAL EVALUATION

I. Assessment of Training and Capacity Building

This assessment covers training, particularly in maternal health and child survival, the potential for long-term transfer of technology, and what additional changes may be useful to ensure effective implementation through the life of the project as well as after the project has ended.

Areas include:

A. MAIMN

- Community Based Services

- Clinic Based Services

B. Decentralization of Health Services

The evaluation will address the following types of questions:

1. Review goals and objectives and identify those which have been achieved or which

can reasonably be expected to be achieved based on the current status. (Are the targets being met?)

2. To what extent is this program laying the groundwork for the next phase? Is this the most efficient way of doing it?

3. After personnel have been trained, is sufficient attention being paid to refresher trainings and supervisory visits? (Quality of care focus)

4. With the value of hindsight, could the project have been designed in a different way (with respect to capacity building)?

5. What is the long term effect of the project going to be? Are we paying sufficient attention to issues of capacity building and sustainability?

6. What is the potential for long term transfer of technology, and are we following an appropriate path to implement a system that is appropriate to local needs?

7. Who still needs to be trained before Sept. 1998? Is there enough time/are there enough resources to train all of these people in that time?

8. What is the future of the trained staff employed by the Project?

II. Assessment of Decentralization, Integration of Primary Health Care, and the Broader MCH Context

The assessment will take place at three levels:

- a. Function of decentralization - central level
- b. Function of SILAIS units
- c. Function of staff members - doctor, nurse, brigadista, etc.

The evaluation will address the following types of questions:

1. How is the Project working now as compared with the initial vision documents?
2. How is the Project doing with respect to short term health status indicators such as those represented by the Expanded Program on Immunization?
3. How is the Project doing with respect to changing health seeking behaviors?
4. What is the model for Quality of Care being used? How is the Project doing with respect to impact, client access, rights, etc.?
5. What has the Project accomplished to date? (Based on its specific objectives)
 - * Degree of accomplishment
 - * Timeliness of accomplishment
 - * Quality of work done
 - * Appropriateness of work done
6. Are there new objectives that need to be defined?
7. How can we document this process for future benefit to both Nicaragua and MSH?

8. How have the changes in the Project affected implementation?

9. Is there enough time, are there enough resources to finish what needs to be done by Sept.1998?

III. Public Health Implications of Health Care Financing

What is the impact of having taken this component out of the Project?

What has been accomplished to date by other donors?

IV. Assessment of Project Design and Evolution

This assessment covers the organizational structure developed by the project, changes that have been made in the project to date, and what additional changes may be useful to ensure effective implementation through the life of the project, and assist long-term sustainability following the end of the project

Review of evolution of staffing, structure and roles

A) Past and Current Organization Charts

B) Time line of staff hires and roles (against work plan)

I) Job Descriptions against actual roles

ii) Activities

a) Prioritization

b) Staff size and Complexity (working groups and units?)

c) Individual links to Project goals and outputs

C) Structure for supervision

D) Structure for communication (internal)

I) Staff Relations

II) Home Office relations

III) Subcontractor Relations

E) Framework for decision-making

F) Structure for resource flow

Financial Systems

Allocation process

G) Integration and Coordination of activities between Project Units (Complement or Compete)

I) Staff management systems (Recruitment ,Hiring, Training, Performance Management, Compensation)

J) Leadership

K) Planning

Questions to explore

Do we need any expertise added to the project or have current staff allocations covered the necessary points.

How can the local staff of DHS be “institutionalized” in some way to carry on after the

end of the project? (Sustainability)

Is this staff and project structure a good foundation for any “ next phase”? (Are current long-term expatriate positions adequate for needs as understood?

Are Management & Financial systems effective and efficient and adaptable to changing needs? Is the exercise of satisfying the USAID requirements a useful training for the transfer of capacity for financial planning and control?

How are conflicts handled?

Observation of operations-in context (Units, interactions with counterparts, etc)

What are major strengths in project?

What are issues that might indicate a need for change?

Meetings with project staff, USAID, Inputs from Home Office Staff and Subcontractors

V. Assessment of Relations with Nicaraguan counterparts, USAID and other donors or CA's

This assessment covers the approaches currently being used for collaboration with counterparts, the appropriateness of the outcomes being achieved, and specific concerns that may be raised related to work with Grantees, USAID or other donors.

Relations with Counterparts

Relations with BASICS (and other projects)

Relations with USAID

Relations with other Donors

Relations with Grantees

Relations with GoN officials

Questions to explore

Is staff size appropriate to effective communication and linkage with many and various Nicaraguan contacts (Government, NGOs, etc)?

How do resources flow?

What are communications and feedback mechanisms?

Integration of efforts with BASICS or other projects?

Meetings with USAID, Ministry (and SILAIS) counterparts, other Donors, CA's

VI. Management Systems -- Management Tools

This area of the internal evaluation will focus on the projects efforts to increase decentralization and sustainability through the development and introduction of improved management procedures and methodologies. Consideration will include the following specific systems developments and implementations and other management related activities:

- # The computerized SAF system for programming and monitoring the SILAIS budget requirements.
- # The SIVIC system for tracking minimal stock levels in the clinics of essential drugs and supplies.
- # The SICS system for estimating requirements, ordering, and monitoring existence of pharmaceuticals.
- # The equipment survey and system for tracking existence and condition of essential equipment in clinics.
- # The logistics system for tracking food supplements.
- # Assessment of activities and requirements in the area of health financing.

The evaluation will address the following types of questions:

- # Has the Project developed other management tools not covered above?
- # Are there requirements for other tools and methodologies which have not been addressed?
- # What were the original assumptions and specifications that led to the development of the tools and procedures?
- # Have any of the original assumptions changed since the tools were developed, and do the current tools lend themselves to adaptation to changing requirements?
- # Have appropriate persons been trained and are the tools, in fact, being used?
- # What lessons can be learned from the development and implementation of the management tools?
- # What generic recommendations can be made with respect to requirements for

future activities in support of the MOH's management needs?

ANNEX II: LIST OF MEETINGS

Aldrich, Marion - COTR, USAID, Nicaragua

Alvarado, Enrique - National SILAIS Coordinator

Atha, Stanley - Director of Norms for Medical Supplies, Central Level, MINSA

Boddy, Peter - Chief of Party, DHSP

Buitrago, Karen - Executive Secretary/Administrative Assistant, DHSP

Cajina, Elizabeth - Project Coordinator/MINSA, World Bank

Castillo, Carlos - EPI Consultant, PAHO

Codina, Luis - MSH Advisor, PAHO

Darce, Roda María - Training Methodology Coordinator, Permanent Education, MINSA

de Trinidad, Eduardo - Technical Assistant, SILAIS Matagalpa

Duarte, Ma. Auxiliadora - Coordinator, Child Health Program, SILAIS Jinotega

Dussan, Mary Luz - Consultant, DHSP

Espinoza, Franc - SAF Operator, Juigalpa Health Center, Chontales, MINSA

Espinoza, Zorida - Supervision and Monitoring, SILAIS Managua

Flores, Freddy - Senior Systems Analyst/Manager, DHSP

García, Noé - Director of Permanent Education, Matagalpa, MINSA

Gonzalez, Floricelda - Director, SILAIS Matagalpa, MINSA

Güemes, Armando - Health Services Consultant, PAHO

Guivarra, Angelo - Programs Operator (SICS), Central Level, MINSA

Gutierrez, Carmen - Pharmacist, Pedro Altamirano Health Center, SILAIS Managua

Gutierrez, Sandra - Director of Medical Supplies., SILAIS Matagalpa

Hernandez, Irene - Director of Profamilia, Chontales

Icaza, Mario - Director of Epidemiology, SILAIS Boaco, MINSA

Incer, Armando - Director, SILAIS Boaco, MINSA
Jarquin, Carlos - Regional Representative, PROFAMILIA
Jarquin, Ivan -Municipal Director, SILAIS Jinotega, MINSA
Juarez, Eligia - Coordinator, Reproductive Health Division, MINSA
Kamp, Netty - Co-director, Proyecto Forsap, SILAIS Chontales
Lacayo, Mario - MCH Coordinator, DHSP
Lamy, Phillippe - Representative, PAHO
Linarte, Ma. Auxiliadora - Permanent Ed.,Central Level, MINSA
Luna, Javier - Municipal Director, Juigalpa, Chontales, MINSA
Malespin, Omar - Director of EPI, MINSA
Martinez, Aldo - Director of Training, MINSA
Martinez, Lombardo - Minister of Health, MINSA
McCoy, Martha - Vice Minister of Health (Admin), MINSA
Medrano, Julio - Director of Permanent Education, MINSA
Montalvan, Olga - Logistical Mgr./Coordinator, DHSP
Morales, Claritza - Health Trainer, DHSP
Napper, Martin - Contract Officer, USAID
Olave, Manuel - Mgmt/Financial Specialist, DHSP
Orochena, Jorge - Coordinator, Primary Health Care, World Bank
Ortega, Rene - Director of Information, Center for Medical Supplies, MINSA
Paley, Jamileth - Exec. Secretary/Admin Assistant., DHSP
Perez, Byron - Director of Health Center, Matiguas, Matagalpa, MINSA
Picharo, Mira - Responsable de Finanzas(SAF), SILAIS Chontales
Prado, Federico - Vice-Minister of Health (Medical), MINSA
Quiñonez, Ivette - Office Manager, DHSP

Quiroz, Fatima - Director General of MAIMN, MINSA
Ramirez, Humberto - Deputy Director, SILAIS Matagalpa, MINSA
Ramirez, Pedro - Municipal Director, SILAIS Boaco, MINSA
Robles, Haidee - Director of Nursing, SILAIS Boaco, MINSA
Rodriguez, Manuel - Project Coordinator, MINSA
Ruiz Gazo, Xiomara - Director, SILAIS Managua, MINSA
Saballos, Marisol - Secretary, DHSP
Saenz, Carlos - Technical Assistant, DHSP
Saenz, Pedro - Director, SILAIS Boaco, MINSA
Solorzano, Alba Luz - Technical Assistant, DHSP
Sujo, Franklin - Director, Center for Medical Supplies, Central Level, MINSA
Urbina, Elman - Director, SILAIS Chontales, MINSA
Valencia, Mario - Technical Assistant, Jinotega, DHSP
Vazquez, Gioconda - Director, MAIMN, SILAIS Managua, MINSA
Villareal, Esperanza - Director, Paraiso Health Post, SILAIS Boaco, MINSA

ANNEX III: GLOSSARY OF TERMS

LISTA DE SIGLAS

Siglas	Significado en Español	Significado en Inglés
AC	Agencias Cooperativas (AC)	Cooperating Agencies (CA)
AID	Agencia para el Desarrollo Internacional (AID)	Agency for International Development (AID)
AP	Atencion Primaria (AP)	Primary Health Care (PHC)
ARI	Infección Respiratoria Aguda (IRA)	Acute Respiratory Infection (ARI)
ASC	Componente de Comienzo Acelerado (CCA)	Accelerated Start Component (ASC)
AT	Asistencia Tecnica (AT)	Technical Assistance (TA)
ATCP	Asistencia Técnica de Corto Plazo (ATCP)	Short-Term Technical Assistance (STTA)
ATLP	Asistencia Técnica de Largo Plazo (ATLP)	Long-Term Technical Assistance (LTTA)
CA	Agencias Cooperativas (AC)	Cooperating Agencies (CA)
CAP	Estudios de Conocimientos , Actitudes y Practicas (CAP)	Knowledge Attitudes and Practices Study (KAP)
CCA	Componente de Comienzo Acelerado(CCA)	Accelerated Start Component (ASC)
CCMS	Centro de Insumos Para la Salud (CIPS)	Center for Dritical Medical Supplies (CCMS)
CDD	Enfermedad Diarreica Aguda (EDA)	Control of Diarrheal Disease (CDD)
CIPS	Centro de Insumos Para la Salud (CIPS)	Center for Dritical Medical Supplies (CCMS)
CIU	Unidad Central de Proceso (UCP)	Central Information Unit(CIU)
COP	Jefe del Equipo (JDE)	Chief of Party (COP)
COTR	Representante Técnico del Oficial de Contratos (RTOC)	Contracting Officer Technical Representative (COTR)
CSRH	Supervivencia Infantil y Salud Reproductiva (SISR)	Child Survival and Reproductive Health (CSRH)
DANIDA	Agencia de Operacion Para el Desarrollo (DANIDA)	Danish Development Operations Group
DGI	Grupo para el Desarrollo, S.A.	The Development Group, Inc. (DGI)
DGNIM	Direccion de Normalizacion de Insumos Medicos (DGNIM)	Division of Norms for Medical Supplies (DNMS)
DHS	Servicios de Salud Descentralizados (SSD)	Decentralized Health Services (DHS)
DHSP	Proyecto Servicios de Salud Descentralizados (PSSD)	Decentralized Health Services Project (DHSP)
DNMS	Direccion de Normalizacion de Insumos Medicos (DGNIM)	Division of Norms for Medical Supplies (DNMS)
DOS	Sistema Operativo de Disco (SOD)	Digital Operating System(DOS)
EDA	Enfermedad Diarreica Aguda (EDA)	Control of Diarrheal Disease (CDD)

EID	Enfermedades Emergentes Infecciosos	Emerging Infectious Diseases (EID)
EOPS	Indicadores de Fin de Proyecto	End of Project Status Indicators (EOPS)
EPI	Programa Ampliado de Inmunizaciones (PAI)	Expanded Program on Immunizations (EPI)
FFSDP		Fully Functional Service Delivery Point (FFSDP)
FMS	Sistema de Gerencia Financiera	Financial Management System (FMS)
FORSAP	Fortalecimiento de Salud en Atención Primaria (FORSAP)	Strengthening Primary Health Care
FP	Planificación Familiar (PF)	Family Planning (FP)
GDMP	Vigilancia y Promoción del Crecimiento y Desarrollo (VPCD)	Growth and Development Monitoring and Promotion (GDMP)
GON	Gobierno de Nicaragua (GON)	Government of Nicaragua (GON)
IEC	Información Educación y Comunicación (IEC)	Information Education and Communication (IEC)
IFP	Indicadores de Fin de Proyecto (IFP)	End of Project Status Indicators (EOPS)
IMCI	AIEPE (Atención Integrada)	Integrated Management of Childhood Illnesses (IMCI)
IRA	Infección Respiratoria Aguda (IRA)	Acute Respiratory Infection (ARI)
IVO	Indicadores Verificables Objetivamente (IVO)	Objectively Verifiable Indicators (OVI)
JDE	Jefe del Equipo (JDE)	Chief of Party (COP)
KAP	Estudios de Conocimientos, Actitudes y Prácticas (CAP)	Knowledge Attitudes and Practices Study (KAP)
LTTA	Asistencia Técnica de Largo Plazo (ATLP)	Long-Term Technical Assistance (LTTA)
MAIMN	Modelo de Atención Integral a la Mujer y la Niñez (MAIMN)	Model for Integrated Health Care for Women and Children
MCH	Salud Materno Infantil (SMI)	Maternal and Child Health (MCH)
MFD	Descentralización Financiera/Gerencial	Management/Financial Decentralization (MFD)
MH/CS	Salud Materno y Supervivencia Infantil (SMSI)	Maternal Health and Child Survival (MH/CS)
MINSA	Ministerio de Salud (MINSA)	Ministry of Health (MOH)
MINFIN	Ministerio de Finanzas (MINFIN)	Ministry of Finance (MOF)
MIS	Sistema de Información Gerencial (SIG)	Management Information System (MIS)
MOF	Ministerio de Finanzas (MINFIN)	Ministry of Finance (MOF)
MOH	Ministerio de Salud (MINSA)	Ministry of Health (MOH)
MSH	Ciencias Gerenciales para la Salud	Management Sciences for Health (MSH)
NGO	Organización No Gubernamental (ONG)	NonGovernmental Organization (NGO)
NV	Nacido vivo (n.v.)	Live birth
ONG	Organización No Gubernamental (ONG)	NonGovernmental Organization (NGO)
OPD	Organización Privada para el Desarrollo (OPD)	Private Development Organization (PDO)

OPS	Organización Panamericana de la Salud (OPS)	PanAmerican Health Organization (PAHO)
OPV	Organización Privada Voluntaria (OPV)	Private Voluntary Organization (PVO)
OVI	Indicadores Verificables Objetivamente (IVO)	Objectively Verifiable Indicators(OVI)
PAHO	Organización Panamericana de la Salud (OPS)	Pan American Health Organization (PAHO)
PAI	Programa Ampliado de Inmunizaciones (PAI)	Expanded Program on Immunization (EPI)
PDO	Organización Privada para el Desarrollo (OPD)	Private Development Organization (PDO)
PF	Planificación Familiar (PF)	Family Planning (FP)
PHC	Atención Primaria (AP)	Primary Health Care (PHC)
PSSD	Proyecto Servicios de Salud Descentralizados (PSSD)	Decentralized Health Services Project (DHSP)
PVO	Organización Privada Voluntaria (OPV)	Private Voluntary Organization (PVO)
RTOC	Representante Técnico del Oficial de Contratos (RTOC)	Contracting Officer Technical Representative (COTR)
SAF	Sistema Administrativo Financiero (SAF)	Financial Administrative System
SICS	Sistemas de Información y Control de los Suministros (Medical) (SICS)	Supplies Information and Monitoring System (SIMS)
SIGFA	Sistema Integrado de Gestión Financiera (Administrativa y Contable) (SIGFA)	Integrated Administrative and Accounting System
SILAIS	Sistema Local de Atención Integral de la Salud (SILAIS)	Local System of Integrated Health Care
SIMS	Sistemas de Información y Control de los Suministros (Medical) (SICS)	Supplies Information and Monitoring System (SIMS)
SISR	Supervivencia Infantil y Salud Reproductiva (SISR)	Child Survival and Reproductive Health (CSRH)
SIVIC	Sistema de Información de Vigilancia de Insumos Críticos (SIVIC)	Critical Supplies Monitoring System
SMI	Salud Materno Infantil (SMI)	Maternal and Child Health (MCH)
SMSI	Salud Materno y Supervivencia Infantil (SMSI)	Maternal Health and Child Survival (MH/CS)
SOD	Sistema Operativo de Disco (SOD)	Digital Operating System(DOS)
SOW	Plan de Trabajo	Scope of Work(SOW)
SSD	Servicios de Salud Descentralizados (SSD)	Decentralized Health Services (DHS)
STTA	Asistencia Técnica de Corto Plazo (ATCP)	Short-Term Technical Assistance (STTA)
TA	Asistencia Técnica (AT)	Technical Assistance (TA)
TBA	Patrera	Traditional Birth Attendant (TBA)
TMT	Herramientas para Manejo de Capacitación	Training Management Tools(TMT)
TOT	Red de Facilitadores	Training of Trainers(TOT)
USAID	Agencia de los Estados Unidos para el Desarrollo Internacional (USAID)	United States Agency for International Development (USAID)

USPHS	Servicio de Salud Pública de los Estados Unidos	United States Public Health Service (USPHS)
VPCD	Vigilancia y Promoción del Crecimiento y Desarrollo (VPCD)	Growth and Development Monitoring and Promotion (GDMP)

ANNEX IV: DOCUMENTS REVIEWED

DHS Project Contract & Amendments

July 10, 1997 Performance Evaluation (USAID)

DHS midterm evaluation by MSI of November, 1995

MSH comments on MSI evaluation (January, 1996)

Performance Planning & Review Documents for DHS Project staff

Manual de Procedimientos, Sistema de Administracion Financiera(GoN)

SIVIC materials

Informe de Avance Area de Capacitation, Enero a Mayo 1997, DHS

Control Gerencial, un Enfoque Para Organismos Publicos de Salud (MINSa/USAID/DHS)

Informe Anual 1996, Proyecto Servicios de Salud Descentralizados, January, 1997

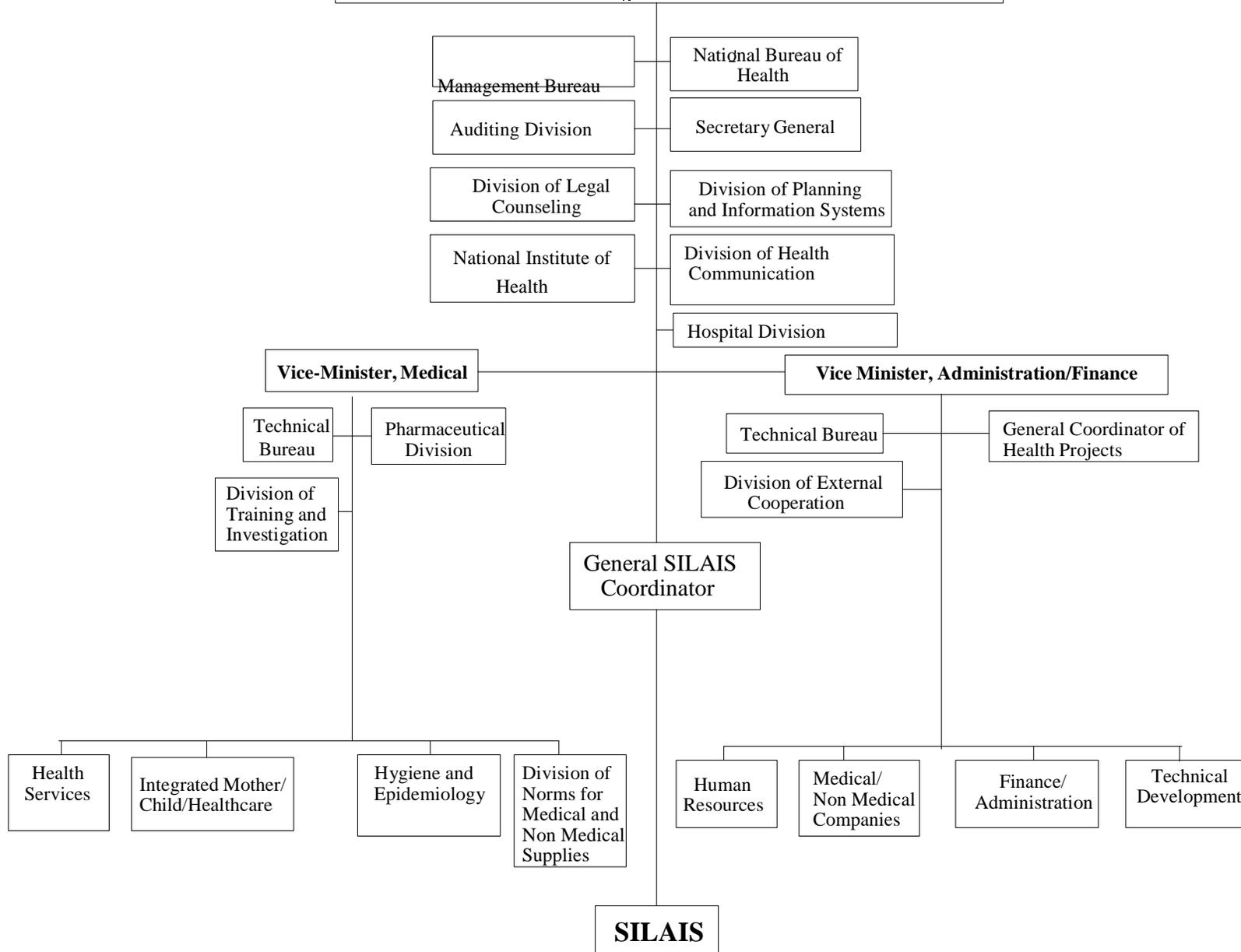
1995 Annual Report, Progress Toward the Goals of the DHS Project, January, 1996

Resumen Ejecutivo, proyecto Servicios de Salud descentralizados, Enero-Mayo, 1997, June 1997

ANNEX V: TECHNICAL ASSISTANCE TEAM ORGANIZATIONAL CHART

ANNEX VI: MINSA ORGANIZATIONAL CHART

Ministry of Health



ANNEX VII: FULLY FUNCTIONAL SERVICE DELIVERY POINT

The Fully Functional Service Delivery Point (FFSDP) is defined as the integration in the same place, and at the same time, of all of the technical and management resources necessary to assure the delivery of a minimum package of quality services that meets the needs of the local population and insures effective interaction between client and provider.

The components of a FFSDP include:

- Trained, committed, competent staff
- Contraceptives, drugs, supplies and equipment
- An operational facility
- A referral network
- Information about clients and resources

Why is the concept of the FFSDP important?

- To address quality
- To focus on customer/client needs
- To define integration and decentralization
- To coordinate multiple delivery systems (private, public and NGO)

ANNEX VIII: INTEGRATED MODEL FOR SERVICE DELIVERY

The integrated model for women and children was initiated by MINSA in 1995 and included a manual of norms. Project SILAIS began implementation in that same year. Managerial tools were prepared to support the integrated services.

The goal of the program is to operationalize the care given to women and children, allowing greater coverage, decreasing the number of missed opportunities. Another goal is to have more “coherent” health services, optimizing both human and material resources.

MAIMN focuses on strategies and activities that will increase coverage as well as quality of care, decreasing maternal as well as infant morbidity and mortality. In addition, it's focused on contributing to strengthening the interaction between hospitals and primary health centers

ANNEX XIX: COMMUNICATIONS AND RELATIONSHIPS QUESTIONS

1. Can you describe how your activities fit within the structure of the Project?
2. What are your key activities (and why)?
3. What has been the evolution of the project that has lead to your current set of priority activities?
4. Can you discuss your workplan for the coming year?
5. Can you discuss the process for setting priorities for individuals and for the Project in general?
6. How are conflicts handled?
7. How would you describe the process for allocation of project resources? Does the project have effective manage systems?
8. How would you describe the quality of relations among members of the DPH Project team? With the staff in the Boston Office? With Project subcontractors?
9. How does leadership function within the Project?
10. Who are your key counterparts and how do you organize communication with MINSA staff? With USAID? With other donor agencies and NGO's?
11. How are decisions made?
12. How is authority delegated?
13. How does the planning process work (for individuals and for the project)?
14. How does supervision and feedback work within the Project?
15. How do you feel about progress toward Project goals?
16. What issues and opportunities do you foresee in the coming year (with particular reference

to sustainability of project impacts and other needs that may go beyond the scope and time frame of the project)?