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USAID/NICARAGUA HEALTH PROGRAM PERFORMANCE

CONTRIBUTING TO IMPROVED MATERNAL, REPRODUCTIVE AND CHILD HEALTH IN NICARAGUA

PERIOD DECEMBER 2008 - JANUARY 2013

This document was presented by Development and Training Services, Inc., CAMRIS International and Engility-IRG to the U.S. Agency for International Development under USAID Contract # AID-OAA-C-13-00032.

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Cover Photo: Vilma Gutiérrez, Title: Women at El Yaraje during a family planning counseling session. Mozonte, Nueva Segovia- August 2012.

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ACRONYMS

ADD	Acute Diarrhea Disease
AIDS	Acquired Immune Deficiency Syndrome
ALIANZAS	Strategic Alliances for Public/Private Social Investment
AMCHAM	American Chamber of Commerce
ANF	American Nicaraguan Foundation
APEO	Post-Obstetric Event Contraception (APEO in Spanish Atención Post Evento Obstétrico)
API	AIDS Program Effort Index
ARD	Acute Respiratory Disease
ART	Antiretroviral Treatment
BICU	Bluefield's Indian & Caribbean University
BMFH	Baby and Mother Friendly Hospitals
BTO	Bilateral Tubal Occlusion
CAM	USAID's Health Strategy for Central America and the Caribbean
CCM	Country Coordination Mechanism
CCP	Central Contraceptive Procurement
CDC	Center for Disease Control and Prevention
CELADE	Centro American and Caribbean Demographic Center
CEPRESI	AIDs Prevention and Education Center (NGO working with HIV/AIDS)
CHW	Community Health Worker
CM	Children Mortality
CMP	Social Security Medical Clinics within the Public Sector (CMP in Spanish: Clínicas Médicas Previsionales)
COMISCA	Central America and the Caribbean Ministry of Health Council (in Spanish: Consejo de Ministros de América Central y El Caribe)
CONISIDA	Nicaraguan HIV/AIDS Committee (Comision Nicaraguense de VIH/SIDA)
CQI	Continuous Quality Improvement
CS	Contraceptive Security
COSEP	Superior Council of Private Enterprise (in Spanish: Consejo Superior de la Empresa Privada)
CURIM	Committees for Rational Use of Medical Supplies
CYP	Couple Year of Protection

DAIA	Committee on Contraceptive Procurement (DAIA in Spanish Disponibilidad Asegurada de Anticonceptivos)
DAISSR	Committee on Contraceptive Procurement and Sexual Reproductive Health (DAISSR in Spanish: Disponibilidad Asegurada de Insumos de Salud Reproductiva)
DELIVER	Technical Assistant Project to ensure logistical Health Supply Chain Management
DGECA	Ministry of Health- Directorates-General of External Cooperation, Quality and Education of Health Services (DGECA in Spanish Dirección General de Cooperación Externa, Extensión, Calidad y Educación)
ECMAC	Community-based distribution of contraceptives (ECAMC in Spanish: Estrategia de Entrega Comunitaria de Métodos Anticonceptivos)
ENDESA	Nicaraguan Demographic and Health Survey (ENDESA in Spanish: Encuesta Nicaragüense de Demografía y Salud)
EOC	Essential Obstetric Care
EONC	Essential Obstetric and Neonatal Care
EONC-C	Essential Obstetric and Neonatal Care at Community Level
EP	Educational Packages and Kits
ESAFC	Family and Community Health Team (in Spanish: Equipos de Salud Familiar y Comunitario)
FAMISALUD	Families United for Health Project
FBO	Faith Based Organization
FP	Family Planning
FPGS	Family Planning Graduation Strategy
FSW	Female Sex Workers
FZT	Zamora Terán Foundation
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	The Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GFCV	Family, Community and Life Committee (GFCV in Spanish: Gabinetes de la Familia, Comunidad y Vida)
GHI	Global Health Initiative
GHTECH	Global Health Technical Assistance Project
GHS	Gestational Hypertensive Syndrome
GON	Government of Nicaragua

HACAP	Humanization Cultural Adaptation of Delivery Care (HACAP in Spanish: Humanización y Adecuación Cultural de la Atención del Parto)
HBB	Helping Babies Breathe
HBCR	Hospital Bertha Calderon Roque
HCI	Health Care Improvement Project
HHR	Human Health Resources
HIV	Human Immunodeficiency Virus
HNP	Health National Plan
HR	Human Rights
HS	Health Services
HSS	Health System Strengthening
IDB	Interamerican Development Bank
IDU	Intravenous Drug User
IMCI	Integrated Management of Childhood Illness
IMCI-C	Integrated Management of Childhood Illness at the Community Level
IMR	Infant Mortality Rate
INIDE	National Institute for Development Information (In Spanish Instituto Nacional de Información de Desarrollo
INSS	Nicaraguan´s Social Security Institute (INSS in Spanish: Instituto Nicaragüense de Seguridad Social)
IOM	International Organization for Migration
IPSS	Health Services Provider Institutes (IPSS in Spanish: Instituciones Prestadores de Servicios de Seguridad Social)
IUD	Intra Uterine Device
JSI	John Snow Inc.
LOI	Letter of Implementation
MATEP	Active Management of the Third Stage of Labor (MATEP in : Manejo Activo del Tercer Periodo del Parto)
MARP	Most-At-Risk Populations
MASIRAAN	North Atlantic Region Family and Community Intercultural Health Model (MASIRAAN in Spanish Modelo de Salud Intercultural de las Regiones del Atlántico Norte)
MASIRAAS	South Atlantic Region Family and Community Intercultural Health Model (MASIRAAS in Spanish: Modelo de Salud de las Regiones del Atlántico Sur)
MCH	Maternal and Child Health

MCHGS	Maternal and Child Health Graduation Strategy
MCM	Modern Contraceptive Methods
MCPR	Modern Contraceptive Prevalence Rate
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MEGAS	AIDS Expenses Measurement (MEGAS in Spanish: Informe de Medición del Gasto en SIDA)
MEP	Monitoring and Evaluation Plan
MM	Maternal Mortality
MMR	Maternal Mortality Rate
MINED	Ministry of Education
MINSA	Ministry of Health (in Spanish: Ministerio de Salud)
MINREX	Ministry of Foreign Affairs (in Spanish: Ministerio de Relaciones Exteriores)
MODES	AIDS Modes of Transmission Study (in Spanish: Estudio de modos de transmisión de SIDA)
MOSAFC	Family and Community Health Model (MOSAFC in Spanish: Modelo de Salud Familiar y Comunitario)
MSH	Management Sciences for Health
MSM	Men who have Sex with Men
MTE	Midterm Evaluation
NGO	Non Government Organization
NICASALUD	Nicaraguan Federation of 28 NGO´s working on health
NM	Neonatal Mortality
NMR	Neonatal Mortality Rate
NSRHS	National Sexual and Reproductive Health Strategy
PAHO	Pan American Health Organization
PASCA	Program for the Centro American Strengthening Response to HIV/AIDS
PASIGLIM	Automated Information System for Medical Supplies Logistics Management (PASIGLIM in Spanish: Programa Automatizado del Sistema de Información Gerencial Logístico de Insumos Médicos)
PASMO	Pan American Social Marketing Organization. NGO working on HIV prevention, contraceptives and condom social marketing
PEPFAR	President's Emergency Plan for AIDS Relief
PEN	National Strategic Plan for HIV/AIDS(in Spanish: Plan Estratégico Nacional)

PHC	Primary Health Care
PLHIV	People living with HIV/AIDS
PNC	Pre Natal Care
PNDHS	National Human Sustainable Development Plan (In Spanish: Plan Nacional De Desarrollo Humano Sostenible)
POLISAL	Polytechnic Institute of Health (In Spanish: Instituto Politécnico de la Salud)
PPH	Postpartum Hemorrhage
PROFAMILIA	NGO working on Family Planning
PROCOSAN	Health and Nutrition Community Program (in Spanish: Programa Comunitario de Salud y Nutrición)
PRONICASS	Nicaraguan Social Sector Support Program (in Spanish: Programa de Apoyo al Sector Social de Nicaragua)
RCM	Regional Coordination Mechanism
RHS	Reproductive Health Service
SCMS	Supply Chain Management System Project
SIGLIM	Information System for Medical Supplies Logistics Management (SIGLIM in Spanish: Sistema de Información en Gestion Logística de Insumos Médicos)
SILAIS	Local Integrated Health Systems (in Spanish: Sistema Local de Atención Integral a la Salud)
SOAG	Strategic Objective Agreement
SONIMEP	Nicaraguan Medical Perinatal Association (in Spanish: Asociación Médica Perinatal de Nicaragua)
SRH	Sexual Reproductive Health
SV	Sexual Violence
STI	Sexual Transmitted Infections
SWAP	Sector-Wide Approach
TFR	Total Fertility Rate
UNAIDS	United Nations Special Program for HIV/AIDS
USAID	United States Agency for International Development
UNAN	Nicaraguan Autonomous University (in Spanish: Universidad Autónoma de Nicaragua)
UNDP	United Nation Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

UNICEF	United Nations Children's Fund
URACCAN	Nicaraguan Autonomous Caribbean Region University
URC	University Research Corporation
VCT	Voluntary Counseling Testing
VSC	Voluntary Surgical Contraception
WB	World Bank
WHO	World Health Organization
WRA	Women in Reproductive Age

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GLOSSARY OF TERMS

IMCI-C: (AIEPI-C in Spanish: Atención Integral a las Enfermedades Prevalentes en la Infancia-Comunitario) "Integrated Management of Childhood Illness at the Community Level" - One of the three basic components of the Integrated Management of Childhood Illness strategy mobilizing all social networks from one location to improve knowledge and practices in the family and systematically promoting the application of home child care and upbringing practices in families and in the community.

IMCI-H: (AIEPI-H in Spanish: Atención Integral a las Enfermedades Prevalentes en la Infancia-Hospitalario) "Integrated Management of Childhood Illness at the Hospital Level" - A sequential process for treating sick children as soon as they arrive at the hospital. The first stage is rapid screening, rapid classification or rapid admission (triage) to identify those in need of emergency treatment and those who are at particular risk and should receive priority attention, such as very young infants and severely malnourished children.

APEO (Atención Post Evento Obstétrico): "Post Obstetric Event Contraception"- A strategy aimed at improving the quality of services and strengthening access to post-obstetric event contraception by reinforcing local capacities that help decrease the female reproductive risk. Postpartum women receive family planning counseling and leave the clinic with a family planning method of their own choice.

EONC-C (Essential Obstetric and Neonatal Community Care): A strategy for community-based essential obstetric and newborn care that includes the participation of several agents, including institutional suppliers, traditional birth attendants, NGOs and social organizations, to quickly identify risk factors and warning signs for the timely referral of pregnant, laboring and postpartum women and newborns, thus reducing maternal and perinatal morbidity and mortality.

Unmet FP Demand: The percentage of women with partners (married and free union) who do not want to have more children or would postpone the next birth of a child but are not using a family planning method.

Dispensarization: Integrated health care of high technical, scientific and human quality that is supplemented with health promotion, disease and other damage prevention and with restoration and rehabilitation actions. Such integrated health care takes a bio psychosocial approach that is organized, planned and proactive and coordinated with the person seeking care. It involves the continuous and dynamic observation of individuals, families and the community with the aim of controlling risks and damage to individual and collective health.

ECMAC (Estrategia Comunitaria de Entrega de Métodos Anticonceptivos): "Community-based distribution of contraceptives" is a mode of contraceptive delivery used by MINSA and designed to improve access to family planning services for women and men in remote communities. ECMAC is a way to bring contraception to women who have difficulty attending health facilities, either because the facilities are very distant, because the women's working schedules are an obstacle or because adolescents and young people feel more comfortable seeking information about family planning or contraception from other teens in their community.

Stigmatization and Discrimination: Stigmatization is the attribution of undesirable characteristics to an individual or group, reducing their status in the eyes of society. As part of collective and individually imagined constructs, stigmatization is not necessarily noticeable because even when a person feels stigma toward another, they may decide not to behave in a way that is unfair or discriminatory. Discrimination is the objective manifestation of stigma. It is any form of negative distinction, exclusion or restriction against individuals and groups by act or omission, based on one or more stigmatized attributes. It is expressed when a distinction against one person results

in unfair treatment on the basis of that person's belonging - or the belief that they belong - to a particular group.

HACAP: Humanization and Cultural Adaptation of Delivery Care is a MINSA policy aimed at ensuring the satisfaction and well being of the pregnant woman and her family. HCADC consists of the cultural adaptation of delivery care services that identify cultural gaps between health services and users and define and implement necessary changes to provide quality care that is sensitive to the needs of all women.

Evidence-based HIV Interventions: Interventions based on the national epidemic, the epidemic's drivers and the most current understanding of behavioral and/or social science. HIV behavioral interventions that have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. the elimination or reduction of risky sexual behavior or drug use) are implemented. These interventions are considered scientifically sound, provide sufficient evidence of their effectiveness in other contexts and/or target populations and meet communities' HIV prevention needs by targeting their specific populations.

Educational Package or Kit: A methodological tool for developing the skills of health personnel in institutions providing health services and in the students being trained for the health sector.

MATEP (Manejo Activo de la Tercera Etapa del Embarazo) - "Active management of the third stage of labor" is performed to prevent postpartum hemorrhage. AMTSL includes three stages: a) administering uterotonic drugs (oxytocin 10 IU injection, which is the drug of choice), b) delayed umbilical cord clamping, c) controlled cord tension and d) uterine massage immediately after placental expulsion and every 15 minutes during the first two hours postpartum.

MOSAFC (Modelo de Atención en Salud Familiar y Comunitario): The Family and Community Health Model is a health instrument that brings together the political and economic vision of the Nicaraguan State within the health field. It organizes intra- and intersectoral actions and allows them to be fairly and effectively implemented in a geographical- and population-specific space by allowing variations based on characteristic elements of a given environment.

PASIGLIM: The "Automated Integrated Logistics System for Essential Drugs and Contraceptives Program" is the automated version of Information System for Medical Supplies Logistics Management (SIGLIM). It provides access to real-time logistics information for decision-making and ensures the availability of supplies across the service network of MINSA.

Family Planning: The right of couples and individuals to freely and responsibly decide how many children they want, the right time to have them and time between pregnancies; to have access to the information and methods they need to achieve their desires; and the right to obtain a better quality of sexual and reproductive health.

Plan de Parto (Delivery Plan): A community strategy in which the woman, her partner and her family develop the conditions for pregnancy, childbirth, postpartum and newborn care with the support of health workers, civil society and an organized community.

Combined Prevention: Providing a variety of prevention services simultaneously, such as promoting the knowledge and skills needed to adopt safe behaviors. These services include the knowledge of one's HIV status along with knowledge about risks, reducing the number of sexual partners, consistent condom use, testing and preventing mother-to-child transmission.

PROCOSAN: The Community Health and Nutrition Program is an official strategy of the Ministry of Health of Nicaragua that develops health promotion from a holistic perspective, with a focus on disease prevention. It reinforces community action, facilitating the development of personal skills

and attitudes, and it promotes the adoption of health care and nutrition behaviors among pregnant women and children under 5 years of age, with an emphasis on children under 2 years of age.

Maternal Mortality Rate (MMR): The number of maternal deaths per 100,000 live births. Sometimes 1,000 or 10,000 live births are used to calculate this rate.

Reproductive Health: A state of complete physical, mental and social well being (not merely the absence of disease or ailment) in all matters related to the reproductive system and its functions and processes. Reproductive health therefore implies the ability to have a satisfying and safe sex life without the risk of childbearing and the freedom to decide whether, when and how often to have sex.

SIGLIM: The Information System for Medical Supplies Logistics Management (SIGLIM) is an integrated logistics system for medical supplies. Its goal is to manage the supply of all medical products, including contraceptives.

Total Fertility Rate (TFR): The total fertility rate (TFR) is the number of children that would be born per woman (or per 1000 women) if the woman or women were to have children throughout their reproductive years based on the specific fertility rates for age of the population at the time of study.

Infant Mortality Rate: The number of deaths of infants under one year of age per 1,000 live births in a given year.

Neonatal Mortality Rate: The number of infants who die before reaching 28 days of age per 1,000 live births in a given year.

Maternal Mortality Rate: The number of maternal deaths per 100,000 women of childbearing age (defined as 15-44, 10-44 or 15-49 years).

Child Mortality Rate: The number of children under 5 years of age who die in one year per 1,000 children in that age group.

Contraceptive Use Prevalence Rate: The proportion of women of reproductive age using (or whose partners are using) a contraceptive method at a given time. This rate often includes only married or cohabiting women.

HIV Prevalence Rate: The adult HIV prevalence rate is calculated by dividing the number of adults living with HIV/AIDS at year-end by the total adult population at the end of the year.

Gender-based violence: Physical or psychological violence against any person on the basis of sex or gender that negatively impacts their identity and social, physical and/or psychological well being. According to the United Nations, the term is used "to distinguish common violence from that which is directed toward individuals or groups on the basis of their gender".

EXECUTIVE SUMMARY

INTRODUCTION

The purpose of the evaluation was to determine the extent to which the objectives of the USAID/Nicaragua Health Program (2008-2013) were met and their contribution to the gender approach; to evaluate the implementation of the mid-term (2007) evaluation recommendations; and to identify the key factors that contributed to or prevented achieving the proposed results.

USAID has provided technical and financial assistance in Nicaragua since 1962. In 1990, it became a major health contributor. In 2003, it redefined its collaboration with the government of Nicaragua (GON) through the Health Strategy for Central America and the Caribbean (CAM 2003-2008, extended to 2013), with a focus on family planning (FP), maternal and child health (MCH) and Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS)[1]. In 2006, the graduation process of the various components of the health program started; to date, the following programs have graduated: the central donation of contraceptives (2006-2009), FP technical assistance (2008-2012) and MCH technical assistance (2011-2013). Since 2012, the HIV/AIDS cooperation program has been part of the Regional HIV/AIDS Program of USAID (PEPFAR Partnership Framework), which is based in Guatemala.

The present report is aimed at a broad audience, which includes the mission and its implementing partners, international cooperation agencies, GON, universities, health training schools and representatives of civil society and the private sector.

The USAID Health Program was implemented by Management Sciences for Health (MSH)-PRONICASS, JSI-DELIVER, URC-HCI and URC-PrevenSida, RTI-Alianzas 2, NicaSalud-FamiSalud Federation, although reference is also made to the contributions of regional projects (PSI-Prevention, Combined, Futures Group-PASCA, and SCMS-Logistics).

METHODOLOGY

The evaluation was conducted from May 29, 2013 to January 30, 2014. It used a mixed quantitative-qualitative, descriptive and comparative methodology, obtaining information from documentary and literature reviews, individual and group interviews and field visits to communities and health posts. The data sources included USAID, donors, implementing partners and counterparts: health services, universities, non-governmental organizations (NGOs). In 11 departments throughout the country, the following facilities were visited: 18 municipalities, 10 hospitals, 9 health centers 5 social security clinics (IPSS), 4 maternity houses, 8 communities, 18 NGOs, 4 universities and 6 donor agencies.

The evaluation focused on 4 of the health program's strategies (listed in Table 4), including 45 performance indicators: 18 FP, 15 MCH, and 12 HIV/AIDS. Overall, the evaluation team interviewed 251 people (see details in Annex 2).

GENERAL RESULTS

In general, during the period studied, Nicaragua has made significant progress in family planning and maternal and child health. The GON-led implementation of health policies, plans and strategies, coupled with the harmonization and coordination of international health cooperation (including USAID cooperation), has contributed to progress in the main demographic and maternal and child health indicators: Total Fertility Rate (TFR), Maternal Mortality Rate (MMR), Mortality Rate (MR) in children under 5 years of age, Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMR) and

[1] USAID/Nicaragua. Country Program 2003-2008. Available at: http://www.rmportal.net/framelib/ltpr/052709/usaid-nicaragua-coanco Country-plan-2003-2008.pdf

Chronic Malnutrion (CM) in children under 5 years of age (see Table 8). In the case of HIV/AIDS, as expected, increasing the coverage of counseling and voluntary testing in key populations has increased the disease's prevalence and incidence, but has reduced its lethality and mortality. As this report shows, implementing the Family and Community Health Model (MOSAFC) has been fundamental to the country's health achievements, especially the role of the Family, Community and Life Committee (GFCV), which is the cornerstone of Ministry of Heath (MINSA) health promotion and prevention work.

The report presents evidence of the contribution that the cooperation of USAID and other donors made to these health achievements and to the strengthening of MINSA and the overall health sector (e.g. expanding coverage to vulnerable populations, decentralization and the horizontality of MOSAFC). Similarly, the results of specific health program performance indicators based on the targets agreed upon by the projects implementers are presented. The report highlights the successful and effective association and coordination with donors through spaces such as the specific technical committees of Sexual Reproductive Health (SRH) and HIV/AIDS, the Global Alliance for Vaccines and Immunization (GAVI) Committee, the Country Coordination Mechanism (CCM) and especially the Committee on Contraceptive Procurement (DAIA)- Committee on Contraceptive Procurement on Sexual Reproductive Health (DAISSR).

Family planning: The strategy of the central donation of contraceptives and the graduation of FP technical assistance was evaluated by the performance analysis of five components (contraceptive security, market segmentation, strengthening of the health system, quality improvement and data for decision making) and 18 indicators (one for the central donation of Modern Contraceptive Method (MCM) and 17 for FP technical assistance). Complete fulfillment was found in 15 indicators and partial fulfillment was found in 3 indicators, for an overall fulfillment of 83% of the indicators.

GON's decision to increase funding for the purchase of MCM and its leadership in the DAIA Committee, now DAISSR, has enabled a MCM increase from 0.6% in 2006 to 75% in 2012, reducing the shortage from 36% in 2007 to 0.8% in 2012[2]. Other achievements include management of needed financing, which has enabled the government to assume an increasing fiscal budget for the purchase of MCM; Health System Strengthening (HSS) via in-service and preservice training; the implementation of key strategies, such as Post-Obstetric Event Contraception (APEO), which by 2012 allowed more than 90% of women to leave obstetric care with a MCM; MCM delivery (through Community-based distribution of contraceptives - ECMAC) benefiting approximately 80,000 people in 804 rural communities (30% of the communities in departments prioritized by USAID/Nicaragua); and the Continuous Quality Improvement (CQI) successful approach to services that allowed the incorporation and/or updating of national guidelines, technical standards, protocols, standards and procedures.

Maternal and child health: Three components were implemented: HSS, mobilization and community practices and evidence use and 14 indicators of the graduation strategy were evaluated. Thirteen components were completed and one was partially fulfilled, for an overall performance of 92.8%.

Among the main achievements, the following should be mentioned: HSS through the performance improvement training of over 7,200 staff members in Essential Obstetric and Neonatal Care (EONC), hospital pediatric care, the integration of HIV and FP counseling, APEO, and Voluntary Surgical Contraception (VSC); the transfer of educational packages and kits based on regulations, protocols and standards on more than 200 subjects (FP, HIV, MCH) and 25 subjects related to logistics management and the rational use of medicines and supplies to MINSA (central and 18

[2] Five FP methods that were available in the health centers monitored in 2012.

SILAIS), 8 universities and health training schools; innovative, evidence-based MCH strategies, such as Delivery Plans, Active Management of the Third Stage of Labor (MATEP), Humanization of Childbirth (HACAP), Helping Babies Breathe (HBB), Early Attachment, the Kangaroo Mother Strategy and Health and Nutrition Community Program (PROCOSAN); and the implementation of community strategies (ECMAC, PROCOSAN, Delivery Plan, EONC, IMCI-C) that helped improve rural, indigenous and poor areas' access to Reproductive Health Service (RHS) and MCH services in 1,568 inaccessible communities, 78 municipalities and 12 departments, benefiting more than 300,000 people annually.

HIV and AIDS: Between 2008 and 2011, the USAID HIV program was implemented with funding from USAID/Nicaragua; since 2012, the Regional USAID HIV Program based in Guatemala has funded the program. Since 2010, the HIV strategy has been part of the PEPFAR Partnership Framework for Central America coordinated with the region's governments under the Central America and the Caribbean Ministry of Health Council (COMISCA) and Regional Coordinating Mechanism (RCM) frameworks. The HIV program has four components (prevention, HSS, strategic information and policies). The success of the cooperation with PEPFAR is evident in the strengthening of MINSA for the effective decentralization of Antiretroviral Treatment (ART) (from 3 to 32 units), counseling and voluntary testing (up to the local level), the formation of multidisciplinary teams in hospitals, the reduction of stigma and discrimination, and intensive training via undergraduate studies and in-service human resources. The implementation of these successful strategies combined prevention with serving key populations through a network of 40 NGOs. In 2012, these services covered approximately half of men who have sex with men (MSM), more than 70% of transgender (TG) people and one-third of female sex workers (FSW). Research has generated strategic information (e.g. NGO baselines, stigma and discrimination, seroprevalence surveys and behavioral change, single records) and has strengthened key processes of HIV national policymaking, e.g. the Strategic Plan of M&E, HIV National Strategic Plan (PEN) development and assessment, related legislation, the AIDS Expenses Measurement (MEGAS), the AIDS Modes of Transmission Study MODES, etc.

Gender equality: The USAID/Nicaragua Health Program has contributed to the reduction of gender inequality, as shown by a reduction in gender disparities in access to health for women and adolescents, women's increased access to and control of decisions about their fertility (APEO, ECMAC, Delivery Plans) and the reduction in Gender Based Violence (GBV), which has given MSMs and transgender people greater access to combined HIV prevention services without discrimination, including specific training to address GBV at the provider, NGO and key population levels.

CONCLUSIONS

Effectiveness of the USAID/Nicaragua Health Program: USAID/Nicaragua obtained the results of the goals set forth in its health cooperation program to achieve a more educated and healthy population with a greater ability to contribute to and share the benefits of a growing economy and strengthen the health sector of Nicaragua (e.g. public and private sectors, NGOs, universities and communities). These goals were based on the program's effective arrangement and adaptation to the country's needs, resulting in an effective health program that is relevant to the country. The report presents evidence of USAID's contribution to these health achievements and to the strengthening of MINSA and the healthcare sector.

Along with other health donors, maternal-child and reproductive health care contributed to the reported achievements in reducing maternal and infant mortality, reporting specific contributions in hospitals receiving direct benefits (e.g. reduced frequency of postpartum hemorrhage (PPH), gestational hypertensive syndrome (GHS), asphyxia and neonatal sepsis, in the logistics system

(fewer MCM stock-outs) and increased coverage of preventive services in remote rural communities.

USAID has also helped to improve key populations' coverage and quality of access to combined HIV prevention services, showing a significant increase in the access coverage of previously underserved populations.

Contribution to MINSA's efforts and the Millennium Development Goals (MDGs) achievements: During the period studied, Nicaragua made significant progress in family planning and maternal and child health, highlighting a one-third reduction in maternal mortality and a one-half reduction in the mortality of infants, neonates and children under the age of 5 years. There has been a 20% reduction in chronic malnutrition in children under the age of 5 years. TFR continues to decrease, and the prevalence rate of MCM use continues to increase. All midterm health indicators have improved significantly, and the immunization rate has been maintained. In the case of HIV/AIDS, as expected, increasing the counseling and voluntary testing coverage among key populations has increased the disease's prevalence but has reduced lethality and mortality.

Coordination with other donors and United Sates (U.S.) government agencies: The USAID/Nicaragua program successfully coordinated with and complemented the health activities of U.S. agencies and other health partners. There was close coordination with the Technical Committee of Donors, thus increasing the likelihood that components of their programs would be institutionalized with the support of other donors.

What worked best: The country's demonstrated sustainability to purchase the previously donated MCM; Automated Information System for Medical Supplies Logistics Management (PASIGLIM) institutionalization; the strategic facilitator function of the DAIA committee; the strengthening of various areas of the health sector (finance, logistics, human resources, information systems, quality and coverage improvement); coordination and transfer of the products of cooperation to MINSA, universities and donors; the integration of the regional HIV program under the PEPFAR regional framework; the development of the combined prevention strategy; and the single record of services to key populations.

What can be improved: There is still the challenge of increasing adolescents' access to modern methods and especially delaying first pregnancies; strengthening the coverage of preventive services in the Caribbean region and difficult-to-access rural areas; increasing the coverage of social security services as the MCM provider for insured populations; and the consolidation and expansion of successful strategies; and, overall, methods of quality improvement.

Sustainability: The excellent framework of public health policies, short-, medium-, and long-term health plans, health strategies and the health care model are determinants of program sustainability and the institutionalization of progress. The FP program has financial assurance and institutional capacities (reproductive health, contraceptive security, DAISSR), and the evidence shows that the trend is toward expanding the coverage of FP, MCH and HIV services. The institutionalization of hospital- and community-based strategies - including funding from taxes, other donors and lending - continues the achievements. Transfers to universities and training schools ensure that educational packages of programs for the hospital management of the newborn; safe management of delivery, surgical sterilization and post-obstetric event; management; and logistics systems are the cornerstone of country ownership and sustainability.

Unexpected impacts: Beyond what was expected regarding logistics, it was possible to extend the logistics approach used for contraceptive methods to other supplies and medicines; similarly, the DAIA committee's focus was expanded to broader sexual and reproductive health subjects, including HIV/AIDS, when it evolved to the DAISSR Committee.

Another unexpected positive impact was the transfer of the products of cooperation to private and public universities and training schools, which transcends the recommendation made by the Midterm Evaluation (MTE)-2007 to incorporate quality in undergraduate education. Likewise, the development of the single HIV record has transcended the scope of the project and the cooperation of PEPFAR, reaching the private sector and subrecipients of the Global Fund (GF) and allowing the preparation of consolidated prevention coverage reports at the national level.

Gender equality: USAID/Nicaragua contributed to gender equality by addressing determinants of equality, such as access to comprehensive health services that reduce the burden of disease and death in women, adolescents and children; improved access and decision making for the control of fertility and humanized delivery care; reducing the stigma and discrimination associated with gender inequalities; and reducing GBV in sexually diverse populations, especially transgender and MSM populations.

RECOMMENDATIONS

To USAID: Continue to transfer and provide technical assistance for the current cooperation program to national and local health teams in the various subsectors. Document and widely share the health collaboration experience of USAID/Nicaragua in the country. Maintain effective coordination in the Sector Roundtable of Donors, strengthening the already initiated transfer processes and technical assistance to key committees, such as DAIA/DAISSR, GF, CCM and the Nicaraguan HIV/AIDS Committee (CONISIDA). Apply the lessons learned in FP process and MCH graduation to the current cooperation in HIV/AIDS, including the design and implementation of a sustainability strategy for HIV in the midterm and strengthening country's ownership, the health system and intersectoral coordination mechanisms. Document the experience of institutional strengthening for the universities.

To MINSA: Maintain and strengthen interagency coordination spaces, such as DAIA/DAISSR, CCM, sectoral dialogue spaces and technical committees. Continue the good assessment practices of the DAIA/DAISSR Plan and future strategic planning, with an emphasis on HIV and other reproductive health services. Continue the educational packages developed for family planning, maternal and child health, HIV/AIDS and quality improvement. Monitor the results of health research supported by USAID and assess, if applicable, the implementation of the recommendations. Continue integrating and strengthening the vast network of community workers trained by FamiSalud. Expand successful strategies for quality improvement, ECMAC, Delivery Plan, HBB and Kangaroo Mother. Continue to expand the coverage of FP social security services. Strengthen the incorporation of the social determinants of health analysis framework into the analysis of the country's health situation, promoting a multisectoral approach.

To CONISIDA: Continue to strengthen the integration of different information sources regarding the progress of the national response to HIV; incorporate sustainability issues into the strategic planning of the national response to address HIV according to the HIV sustainability strategy in Central America and the advances demonstrated by the midterm evaluation of HIV National Strategic Plan (PEN); develop actions that contribute to the sustainability of combined prevention activities for key population, strengthen the coordination between cooperating agencies on HIV. Increase the use and dissemination of HIV research findings.

To donors: Adopt USAID's successful working experiences for current and future cooperation, especially with regard to strengthening health systems, with emphasis on updating technical standards and university curricula and implementing community health strategies and working with the NGO sector. Use the tools developed in maternal and child health, such as educational packages, measuring standards, measurement and mapping of human resources skills, checklists and the updated document on evidence-based maternal and child health interventions. Continue assisting the country on gender equality and reproductive right, including the use of educational

materials on preventing gender-based violence, reducing stigma and discrimination, and integrating the Combined Prevention comprehensive interactive education package. Explore possible collaboration regarding strengthening civil society for the technical and methodological transfer of USAID-prepared tools and packages for the administrative and financial strengthening of NGOs. Develop joint HIV interventions using the health determinants approach, with emphasis on key populations and youth.

To NGOs, universities and the private sector: Continue consolidating and implementing strategies that were transferred by the USAID Health Program. Continue to strengthen activities related to continuous CQI and reducing stigma and discrimination, including sexual diversity subjects and the prevention of GBV. Continue strengthening active and informed participation in areas related to the national coordination of the response to HIV.

PHOTO: USAID/FAMISALUD.

PROCOSAN STRATEGY: BABY-WEIGHING SESSION

I. INTRODUCTION

The purpose of the evaluation was to determine the extent to which the objectives of the USAID/Nicaragua Health Program (2008-2013) and its contribution to the gender approach were reached. This evaluation examined the implementation of the MTE-2007 recommendations and identified key factors that contributed to or prevented the achievement of the proposed results.

The report is aimed at a broad audience, which includes the mission and its implementing partners, international cooperation agencies, the government, health universities and health training schools and representatives of civil society and the private sector.

USAID began its health cooperation with Nicaragua in 1962, focusing on support to health services in rural areas and humanitarian assistance during the earthquake (1972) and after Hurricane Mitch (1998). Since 1991, USAID has been a major donor of health cooperation in Nicaragua, working very closely with the GON, NGOs, universities and other donors. The cooperation focused on maternal and child health, reproductive and family health, HIV/AIDS and, where necessary, support during emergencies. Since 2000, the cooperation adopted a technical-assistance model based on strengthening the health system, which was reinforced with the design of USAID's strategy for Central America in 2003. Starting in 2006, the process of graduating the different components of the cooperation program began.[3]

As part of its compliance with USAID evaluation policy, the USAID/Nicaragua Mission periodically evaluates its cooperation program. In the case of health-related issues, several midterm evaluations were performed in the last decade, emphasizing the midterm health program evaluation in 2007[4], which provided valuable recommendations to adjust the health program and focus on the actions needed for successful graduation from the health cooperation program. Graduation was scheduled for 2009 for the contraceptive donation program, 2012 for the family planning program and 2013 for maternal and child health.

This report covers the 2008-2013 cooperation period. The implementation organizations were MSH-PRONICASS, John Snow, Inc., DELIVER, University Research Corporation Co. LLC (URC)-Health Care Improvement (HCI), PrevenSida, RTI-Alianzas 2 and the NicaSalud-FamiSalud Federation. Additionally, the following regional projects contributed: PSI-Combined Prevention, Futures Group-PASCA and SCMS-Logistics.

During this period, the health cooperation program was implemented at the national level in 15 departments and 3 special regions.

[3] USAID/Nicaragua. General Report of USAID Cooperation.

[4] USAID/Nicaragua Health Program Evaluation. April 2008.

TABLE 1: USAID/NICARAGUA PROJECTS AND THEIR COVERAGE IN THE COUNTRY

	LOCAL			GLOBAL (FIELD SUPPORT)			REGIONAL (CENTRAL AMERICA)			
Project	FamiSalud	PrevenSida	FSL	HCI	DELIVER	PRONICASS	Alianzas	PASMO	PASCA	SCMS
Period	2006-13	2010-16	2010	2006-14	2006-15	2009-2010	2010-13	2006-3	2010-13	2012
Coverage	National	National	Rio San Juan	National	National	Boaco. León, Nueva Segovia	National	Chinandega León Managua Rivas Rio San Juan Ocotal, Esteli Matagalpa	National mechanisms	Main storage
Counterparts	MINSA, NGOs NicaSalud MINED, universities volunteers, community	CIES CEPRESI 50 NGOs GF CONISIDA	MINSA	MINSA INSS Universities NGOs IPPS	MINSA INSS DAIA Universities NGOs	MINSA Universities	Fund. Zamora Teran ANF AMCHAM John XXIII Institute COSEP EDUQUEMOS	NGOs working on the national response to HIV	CONISIDA COSEP NGOs (MARP) Academy USAID partners	MINSA

The evaluation addressed two objectives and the following key questions:

Objective 1: To determine the effectiveness of the USAID health approach and the results achieved.

To what extent have the specific results (midterm and Sub-IRs) identified in the Strategic Objective Grant Agreement (SOAG) been achieved?

To what extent has USAID contributed to the achievement of objectives 4, 5 and 6 of the MDGs?

To what extent have program efforts strengthened MINSA's capacity to plan and manage investments in the health sector at all levels?

Did the USAID Health Program supplement actions carried out by USG agencies and other donors?

What worked well, and what did not work well?

To what extent did external factors, such as unexpected events in the country, help or hinder progress?

What were the positive or negative unexpected impacts?

Has the progress achieved through USAID Health Program assistance been institutionalized in the public sector?

What elements are more or less likely to be sustainable after the end of the program, and why?

Objective 2: How has the USAID/Nicaragua Health Program contributed to gender equality in health?

Could the projects effectively and appropriately integrate the gender approach into their activities?

What were the most important findings related to gender issues and are they sustainable?

Were there any unexpected results regarding gender?

II. BACKGROUND

2.1 SOCIODEMOGRAPHIC FACTORS

Nicaragua has a multiethnic and multicultural population of 6.1 million inhabitants[5] and a growth rate of 1.2%[6]. One-third of the population is under 15 years of age, and nearly 15% are of Native American and African descent. There is a low population density (49 inhabitants per km^2)[7], with most of the population living in urban areas (56%).[8]

In 2008, the Human Development Index (HDI) reached 0.597 points, improving to 0.599 in 2012. By 2013, the HDI placed Nicaragua in the group of countries with medium human development.[9]

Demographic trends indicate that by 2015, the total population, including the women in reproductive age (WRA) and its average age will increase; there will be a decrease in death rates (overall, maternal, child), fertility rates and the proportion of migrants[10].

2.2 ECONOMIC FACTORS[11]

Nicaragua remains the second poorest country in the hemisphere (above only Haiti): 40% of the population lives in near-poverty, and 15% lives in extreme poverty conditions[12], with resulting limitations in quality of life. Although poverty has declined steadily in recent years, it remains high. More than 80% of the poor live in rural areas, mostly in remote communities with little access to basic services. Because the poverty level is not an indicator that changes in the short term, it remains a challenge despite GON's significant efforts to reverse the high poverty rates.

With the structural adjustment and poverty alleviation programs and macroeconomic policies that promote exports and foreign direct investment, the country has achieved an average economic growth similar to that of Latin America in the past decade. The economic recovery that has taken place since 2010 is remarkable. The economy grew 5.1% in 2011, the highest rate within a decade. Inflation has also been reduced to single digits. The macroeconomic indicators are stable, with an estimated economic growth of 4.2% for 2013, and foreign direct investment and trade show favorable prospects. The gross domestic product (GDP) increased from US$1,632 to US$1,730.8 in 2008[13]. However, poverty and inequality persist in health financing (approximately 45% of health spending comes from households) [13].

[5] INIDE 2012. http://www.inide.gob.ni/estadisticas/Cifras%20municipales%20a%C3%B1o%202012%20INIDE.pdf

[6] Central American Bank for Economic Integration (CABEI) Listing Nicaragua. http://www.bcie.org/uploaded/content/article/1249943988.pdf

[7] World Bank Available at: http://datos.bancomundial.org/indicador/EN.POP.DNST

[8] CABEI Nicaragua file: Available at: http://www.bcie.org/uploaded/content/article/1249943988.pdf

[9] UNDP. Human Development Index 2013. Available at: http://www.undp.org.ni/files/doc/1363288237_IDH%20mundial%202013%20PNUD_140313.pdf

[10] CELADE, Population, Land and Sustainable Development. Special Committee of ECA on Population and Development. Ecuador, June 2012.

[11] World Bank Nicaragua overview. At: http://www.bancomundial.org/es/country/nicaragua/overview

[12] INIDE. Living Standards Measurement Study (LSMS), Nicaragua 2009.

[13] Central Bank of Nicaragua. http://www.bcn.gob.ni/estadisticas/cuentas_nacionales/index.php

2.3 HEALTH FACTORS

2.3.1 INSTITUTIONAL FRAMEWORK

The Constitution of Nicaragua (Art. 105) establishes free health care and the state's obligation to provide health services to the population. The Health Act (2002) and Regulations (2003) states that MINSA is responsible for providing resources to meet health needs and priorities and is the primary health care provider. MINSA has a service network of over 1,000 health care centers, including 32 hospitals, 175 health centers and 868 health posts, covering approximately 60% of the population. The Nicaraguan Institute of Social Security (INSS) provides health services to salaried people through a network of public and private care providers known as the Health Services Provider Institutes (IPSS), which covers 17% of the population. The private sector, NGOs and traditional medicine complete the population's health care coverage.

In 2007, GON guided the policy of free health services and the strengthening of interventions that improve access to and the quality of health services by implementing the Family and Community Health Model (MOSAFC). MOSAFC promotes free services, strengthens promotion and prevention actions, promotes community ownership and involvement in health activities, and presents a cross-sectoral approach to priority health problems, including differentiation in the provision of public, private and insured services.

The government's development priorities, including health, are defined in the National Human Development Plan (NHDP), which focuses attention on poor and vulnerable population groups and emphasizes the Nicaraguan state's responsibility to ensure their rights. Donors acknowledged this plan as a comprehensive and multisectoral tool for the country's development. It focuses on economic and social development, and special emphasis on the particularly disadvantaged Atlantic Coast for poverty reduction, as evidenced by the increase in social spending, is an NHDP priority.

The 2011-2015 Multi-Year Health Plan is an integral part of NHDP; it defines the achievement of the health-related MDGs as a greater goal. This plan aims to provide free universal access to basic health care; improve the quality of care through an integrated approach to health based on the population's needs and ongoing health personnel training; and provide interinstitutional coordination to improve the population's overall health status (e.g. food security, education, water and sanitation, prevention of violence, etc.).

2.3.2 HEALTH SITUATION

A) MATERNAL HEALTH

According to data from MINSA, the Maternal Mortality Rate (MMR) decreased by 32% from 2006 to 2011 (from 92.8 to 61.9 maternal deaths per 100,000 live births)[14].

[14] MINSA. Surveillance System.

FIGURE 1: MMR IN NICARAGUA 1992-2011

Fuente: Ministerio de Salud. Oficina Nacional de Estadísticas.

Source: Ministry of Health National Statistics Office.

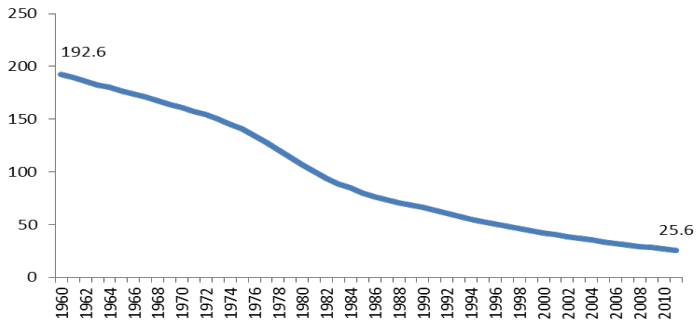
This remarkable improvement in the MMR is related to the progress of midterm indicators of MDG 5[15],[16] in 2006-2012, which is summarized as:

- An increased percentage of institutional deliveries, from 74% to 88.2%
- An increased rate of contraceptive use, from 72.4% to 80.4%
- A reduction in TFR from 2.7 children to 2.4 in 2012.

B) CHILDREN'S HEALTH

According to comparative data from Nicaraguan Demographic and Health Survey (ENDESA) 2006/7 and 2011/12, the mortality rates of children under 5 years of age were reduced from 35 to 21 (40%), the infant mortality rate (IMR) for children under one year reduced from 29 to 17 (59%), and the neonatal mortality rate (NMR) reduced from 16 to 8 per 1000 live births[17](50%). It is worth noting the significant reduction of NMR, which represented a major challenge for the country.

FIGURE 2: DECREASE IN THE MORTALITY RATE FOR CHILDREN UNDER 5 YEARS OF AGE IN NICARAGUA (1960-2010)



Title: Mortality rate in children under 5 years of age (per 1000 live births)

[15] INIDE. Nicaraguan Demographic and Health Survey, ENDESA. 2006/2007.

[16] INIDE. Nicaraguan Demographic and Health Survey, ENDESA. 2011/2012. Preliminary data.

[17] idem 16

This remarkable improvement in the MR of children under the age of 5 years, IMR and NMR is related to the progress of midterm indicators for MDG 4 from 2006-2012, which is summarized by the following:

- A reduction in chronic malnutrition rates from 21.7% to 17.3%, in 2006 to 2011-12.
- A drop in the percentage of overall malnutrition in children under 5 years of age from 5.5% in 2006 to 5% in 2011/ 2012.
- The maintenance of full vaccine coverage in children under 5 years of age from 85% in 2006 to 84.1% in 2011/2012.

However, there are still challenges for MM and NM, adolescent pregnancy and chronic malnutrition in children under 5 years of age.

C) HIV/AIDS

The HIV/AIDS epidemic began in Nicaragua in 1987 and remains concentrated in key populations (18.1% transgender, 7.7% gay, 4.7% bisexual, and 1.9% FSW)[18]. According to MINSA, until 2013, 8,450 People Living with HIV/AIDS (PLHIV) cases had been reported, of which 6,628 were HIV positive, 741 cases and 1,030 deaths. The current prevalence in the overall population in 2013 is estimated at 0.22% (0.3% according to the latest report from UNAIDS), and the incidence in 2012 was 32 cases per 100,000 population.

TABLE 2: HIV EPIDEMIOLOGICAL DATA (1987-2013)

Cumulative 1987-2013				
Description	1987-2012	Third quarter 2013	First nine months 2013	Up to 2013
Total persons with HIV	7,875	180	575	8,450
HIV	6,071	179	557	6,628
Cases	734	1	7	741
Deceased	1,019		11	1,030
Prevalence rate		0.22 x 100	0.22 x 100	
Incidence rate		5.5 x 100,000	17.5 x 100,000	
No information	51			

Source: Database of the HIV/AIDS component 2013.

2.4 USAID COOPERATION

Table 3 summarizes the background of USAID cooperation, identifies milestones related to the design and evaluation of interventions and provides the framework for presenting the results of this evaluation.

TABLE 3: MAIN HEALTH CARE STAGES AND ACTIVITIES IN THE COUNTRY

Period	Main health care stages and activities in the country
1958	Pre-stage for USAID: Malaria eradication project

[18] University of Valle, CDC. Central American sexual behavior surveillance survey and prevalence of HIV and STIs in vulnerable populations. ECVC. Managua, Nicaragua. University of Valle, CDC 2010.

Period	Main health care stages and activities in the country
1962-1982	Stage of rural service expansion Large-scale loans in key areas to increase the government's capacity to provide basic services in rural areas; the construction and operation of mobile health posts, health centers and hospitals; the extension of services to rural areas as part of an integrated rural development strategy (55 new health centers and 10 rural hospitals built, 65,000 sets of vaccines administered, 28 community health organizations established, among other achievements) 1968: USAID began supporting FP (providing 1,650 trained health workers to provide FP services; 105 health centers offer FP services, 63,000 women receive FP services) 1972: Post-earthquake assistance in Managua: repair of the Hospital Velez Paiz and construction of the Hospital Oriental and Hospital Occidental.
1990-2002	Stage of expansion of key preventive services Provided assistance to demobilized people, refugees and orphans and 1,326 tons of emergency medical supplies. Expanded childhood immunizations. Provided FP services and contraceptives (449 distribution points). Focused on expanding the coverage of HS in remote areas. ProFamilia expanded from 2 to 10 clinics. 1998: Hurricane Mitch. Emergency humanitarian aid was provided. 1999-2002: Cooperation became more focused. Emphasis was placed on health education, water and sanitation in rural communities. Coverage for FP and hospital births was expanded. The NicaSalud Network Federation began. HIV regional projects (PASMO and PASCA) were incorporated.
2003-2006	Stage of strengthening of health systems 2003: USAID strategy for Central America and the Caribbean began. The health goal was to invest in more educated and healthy people/families. Assistance was based on long-term strategic objectives and thematic milestones: FP, MCH and HIV/AIDS. 2010: USAID/DELIVER, in coordination with WHO/PAHO in Nicaragua, supported the MINSAs provision of the H1N1 vaccination with the acquisition, customs clearance, receipt and storage of 117,600 syringes and 1,375 safety boxes (incineration or destruction of syringes), which were distributed with the vaccine to health centers and hospitals across the country.
2006-2013	Stage of FP graduation and MCH cooperation 2006: Designed and implemented new portfolio of USAID/Nicaragua projects with the goal of sustainability. 2007: MTE of the health program (maternal-child and HIV) was performed; the design of the FPGS was developed. 2008: The health cooperation program was adjusted with MINSA according to the new health policy and ENDESA 2006/7 model of care and outcomes. 2010: MTE of the FPGS and strategy design for maternal and child health graduation was performed. 2012: The FP graduation strategy was evaluated 2013: Final evaluation of the 2008-2013 health program and regional evaluation of PEPFAR and the HIV program were performed.
2014-2016	Stage of HIV sustainability and postgraduation in FP and MCH

Source: USAID/Nicaragua. Systematization report of USAID health cooperation from 1962 to 2013. September 2013.

In 2003, USAID defined its collaboration with GON through the Health Strategy for Central America and the Caribbean (CAM), with the objective of forming "*more educated and healthier families*" with greater ability to contribute and share the benefits of a growing economy. The strategy established two intermediate objectives: a) to increase transparency and investment in the social sector and b) to improve the integrated management of reproductive and child health. The cooperation strategy of USAID/Nicaragua, which was approved on August 27, 2003, established the policy and strategic direction of the mission's cooperation with Nicaragua. The strategy noted the need to make a significant effort to improve the health of households and communities by extending FP and MCH services and improving nutrition and hygiene and dietary practices under the midterm result of Improved Integrated Care in Reproductive and Children Health[19]. The

[19] USAID/Nicaragua. Nicaragua Country Plan in support of the Central America and Mexico Regional Strategy 2003-2008. August 2003. Available at: http://www.rmportal.net/framelib/ltpr/052709/usaid-nicaragua-country-plan-2003-2008.pdf

strategy initially covered the 2003-2008 period but extended to the 2008-2013 period, redefining its objectives in maternal and child health: extending the coverage of FP services, promoting institutional deliveries and promoting HIV prevention.

As part of several USAID graduation processes in Latin American countries (because of advances in economic and health indicators in several developing countries and focusing cooperation in geographical regions with greater health gap), a quadruple graduation strategy began in 2006 with many components of cooperation: central MCM donation (2006-2009), FP technical assistance (2008-2012) and MCH technical assistance (2011-2013).

TABLE 4: GRADUATION STRATEGIES OF THE USAID/NICARAGUA HEALTH PROGRAM

Component	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Central donation of contraceptives											
Family planning											
Maternal and Child											
HIV-AIDS *											

Source: USAID/Nicaragua.

In 2006, USAID/Nicaragua and GON signed LOI No. 4 regarding the progressive reduction of contraceptive donations and the increase in purchased contraceptives by the country. This component successfully graduated in 2009, when the last MCM donation was made and the country came to fulfill the agreed indicator.

In the field of FP, USAID designed the graduation strategy of FP cooperation in 2007. The strategy was divided into two phases: strengthening systems (2008-2009) and sustainability (2010-2012). The phases focused on four components: contraceptive security, market segmentation, strengthening of health systems and improving the quality and coverage of services and data for decision-making. The Family Planning Graduation Strategy (FPGS) was launched in 2008 and implemented between 2008 and 2012. Its findings and results were validated and were widely and successfully disseminated in September 2012[20].

In addition to these recommendations, USAID and MINSA analyzed data from ENDESA 2006/7 and agreed to refocus cooperation, concentrating on the departments and regions with the greatest health divide. Thus, as of 2008, at the request of MINSA, cooperation with community programs focused on the 8 SILAIS with the weakest health indicators: Chinandega, Nueva Segovia, Matagalpa, Rio San Juan, Madriz, Chontales, Jinotega, RAAN and RAAS.

[20] USAID Evaluation of the USAID Graduation Strategy in Family Planning in Nicaragua. 2012.

2.5 RECOMMENDATIONS FROM PREVIOUS EVALUATIONS

In 2007, USAID conducted a MTE of the Health Program, the results of which confirmed that the program was in keeping with the strategic lines of MINSA. The MTE concluded with 11 recommendations for monitoring up to 2013, which served to reorient the cooperation program[21].

TABLE 5: USAID/NICARAGUA HEALTH PROGRAM MTE RECOMMENDATIONS (2007)

Maternal and child health	
1	Continue to support the HSS
2	Build links to support the critical path of care (primary, secondary and tertiary care), especially maternal health gaps.
3	Expand work in quality assurance towards preservice education.
4	Develop a training program for trainers to support interventions in quality assurance.
5	Strengthen public-private partnerships to strengthen technical innovation capabilities.
HIV	
6	Use the tools and procedures already developed (multidisciplinary teams, clinical rotations, treatment guidelines and protocols, diagnostic algorithms).
7	Take VCT training to the national level and reduce stigma and discrimination.
8	Adjust and use effective approaches for interpersonal communication for behavior change in HIV.
9	Increase information on HIV seroprevalence and behavioral surveys in key populations.
10	Emphasize HIV primary prevention among key populations by working with NGOs.
11	Prevent interventions that have limited effects on prevention.

Source: Nicaragua Health Program Evaluation, April 2008. Latest version.

In 2013, the regional PEPFAR program conducted an assessment of HIV cooperation in Central America, including Nicaragua, focusing on the aspects of country ownership and sustainability[22]. Among the findings, some remarkable experiences were recognized in the country, such as the transfer to universities and the strengthening of NGOs working with key populations; however, it is acknowledged that despite advances in political and technical sustainability in the region and the country, limited financial sustainability persists.

In addition, between November 2013 and January 2014, USAID/Nicaragua developed a specific evaluation of the HIV program that was scheduled to be completed before this evaluation, but could not be completed for reasons of consultant availability.

[21] USAID/Nicaragua Health Program Evaluation. April, 2008.

[22] PEPFAR. Evaluation Framework for Cooperation in Central America. October 2013. Available at: http://www.pasca.org/userfiles/PEPFAR-evaluacion%20del%20Marco%20de%20Cooperacion_Espanol_Oct_2013.pdf

III. METHODOLOGY

The evaluation was conducted in two stages: the first from May 29, 2013 to July 20, 2013 for the field phase and development of the draft, and the second, held December 2, 2013 to January 30, 2014, to update data collected from the preliminary results of ENDESA 2011/2012 and other recent reports, insert the results of Health Program graduation activities and validate the preliminary draft report with the mission, implementing partners, MINSA, donors and other counterparts (NGOs, universities and training schools). Table 6 summarizes the methodology used.

TABLE 6: EVALUATION METHODOLOGY USED TO ANSWER THE EVALUATION QUESTIONS

Questions	Type of question	Type of information	Collection method	Data source	Selection criteria
Objective 1: To determine the effectiveness of the USAID health approach and the results achieved					
To what extent has the USAID/Nicaragua Health Program reached the specific outcomes identified in SOAG?	Descriptive	Qualitative and quantitative	Individual and group interviews. Document, report and presentation reviews. Data analysis. Field and service network visits. Observation. Focus groups. Exit interviews. Service delivery reports. National accounts. Performance reports. Agreements Plans. POAS. Evaluations. MTP Indicators MINSA budget. Municipal and MINSA budgets. MINSA plans.	USAID/ Nicaragua and Washington Donors, Sector roundtable, MINSA, Universities, Community leaders	Field visits, interviews and discussions with100% partners: 18 NGOs, 4 universities and 6 donors. Selection of 7 communities and activities in 11 SILAIS and 18 municipalities, 10 hospitals, 9 primary health care units, 5 health services provider institutions (IPSS) belonging to the INSS, four maternity houses and 8 communities
To what extent did the USAID Health Program contribute to achieving the objectives of the MINSA-MDG 4, 5 and 6 and implementing MOSAFC? To what extent did the program's efforts strengthen the capacity of MINSA at all levels to plan and manage investments in the health sector?	Comparative and descriptive	Qualitative and quantitative			
Did the USAID Health Program supplement the actions of USG agencies and other donors?	Comparative	Qualitative			
What worked well and what did not work well within the USAID Health Program?	Comparative	Qualitative			
To what extent did external factors, such as unexpected events in the country, help or hinder progress?	Descriptive	Qualitative and Quantitative			
What were the unexpected positive or negative impacts of the USAID/Nicaragua Health Program?	Comparative	Qualitative and quantitative			
Has the progress achieved been institutionalized through USAID Health Program assistance in the public sector? Is such progress sustainable?	Descriptive	Qualitative and quantitative			
What elements of the health program are more likely to be sustainable after the end of the program and why? What elements are least likely to be maintained and why?	Comparative	Qualitative			

Questions	Type of question	Type of information	Collection method	Data source	Selection criteria
Objective 2: How has the USAID/Nicaragua Health Program contributed to gender equality in health?					
Did the projects effectively and appropriately integrate the gender approach into their activities? What were the most important findings related to gender, and are they sustainable? Were there any unexpected results in the Health Program's activities with respect to gender?	Descriptive Comparative Descriptive	Qualitative Qualitative and quantitative Qualitative and quantitative	Group interviews. Document, report and presentation reviews. Data analysis. Field and service network visits. Observation. Focus groups. Exit interviews. Service delivery reports. National accounts. Performance reports. Agreements Plans. POAS. Evaluations. MTP Indicators MINSA budget. Municipal and MINSA budgets. MINSA plans.	USAID/Nicaragua and Washington Donors, Sector roundtable, MINSA, Universities, Community leaders	Field visits, interviews and discussions with100% partners: 18 NGOs, 4 universities and 6 donors. Selection of 7 communities and activities in 11 SILAIS and 18 municipalities, 10 hospitals, 9 primary health care units, 5 health services provider institutions (IPSS) belonging to the INSS, four maternity houses and 8 communities

The evaluation focused on 4 Health Program strategies, listed in Table 4, and included 45 performance indicators (18 FP, 15 MCH, and 12 HIV/AIDS indicators). A mixture of qualitative and quantitative methods was used to generate the evidence supporting the analysis. For each of the 4 components, the report provides information on the fulfillment of the indicators, the factors that affected fulfillment, and the conclusions and recommendations. A specific section is included to assess gender issues. The methods used include the following:

Literature review: The existing literature and available data were reviewed, including information on country context, USAID strategic documents, reports from health and international cooperation partners and MINSA statistics and reports, including annual program reports and technical reports prepared by projects.

Individual and group interviews: Visits and interviews with the team at the mission's Health and Education Office, implementing partners and health workers at different levels of the health system were performed. Meetings were held with representatives of 18 NGOs, 4 universities and 6 donors. The team also visited the offices of the mission and the implementing partners. The informants were managerial and technical personnel in SILAIS, nurses and doctors in hospital units served by the projects, laboratory personnel, health center directors and staff and technicians at specific organizations at the national level (DGECA, Health Surveillance, Teaching and Foreign Cooperation). Representatives of maternity houses and local health NGOs were also interviewed. Thirty-three individual and group interviews were conducted, and 68 people participated in the group discussions. Overall, the evaluation team interviewed 251 people (see list in the annex).

From December 2 to 8, 2013, meetings were held with the mission and partners to perform the first validation of the results and complete the final evaluation report.

Field visits: During May and June 2013, field visits were conducted to find evidence of performance. Sites were selected in all regions of the country (North, Central, Caribbean and Pacific) based on the geographical coincidence of more than one USAID project and locations where activities at different levels of the health system (SILAIS, hospital/facility health/community) could be observed. Field visits allowed contrasting information to be obtained during the literature review and interviews. The visits included MINSA headquarters, 11 SILAIS and 18 municipalities, 10 hospitals, 9 primary health posts, 5 Health Services Provider Institutes (IPSS) belonging to the INSS, 4 maternity houses and 8 communities.

Validation sessions: Three validation events involving 66 people (implementing partners, counterparts and donors) were performed between January 15 and 17, 2014. Contributions were obtained through a validation instrument and were summarized and incorporated into this final report to the extent that they were relevant.

Data analysis: The data were reviewed, processed, consolidated and analyzed by arranging them according to the evaluation questions in synthetic tables based on the general processes at the contribution level down to their specific functions, which were evaluated by the degree of indicator fulfillment for both the projects' strategies and their consolidated monitoring plan.

Limitations encountered: Limitations included the late publication of ENDESA details, only having preliminary national data available at the time of publication and field visit limitations caused by the short time available to the evaluation team and the many activities of the health teams at the local and central levels. Internally, the change in USAID indicators in 2009 made it difficult to consolidate data prior to the 2010-2013 period.

IV. RESULTS

4.1 GENERAL RESULTS

In general, during the period studied, Nicaragua made significant progress in FP and MCH, highlighting a one-third reduction in maternal mortality (MM) and a one-half reduction in the mortality of children under 5 years of age and infants and a 20% reduction in malnutrition. The total fertility rate (TFR) continues to decrease, and the rate of use of MCM continues to increase. All midterm health indicators improved markedly except for the immunization rate, which remains similar. In the case of HIV/AIDS, as expected, increasing the coverage of counseling and voluntary testing among key populations has increased the disease's prevalence but has reduced lethality and mortality.

The report presents evidence of USAID's contribution to these health achievements and to the strengthening of MINSA and the health sector (extending coverage to vulnerable populations, decentralization and horizontality of MOSAFC through leadership and governance strategies, HHR training, CQI processes and the expansion of services and provision of logistics, technology and information systems). Similarly, the results of specific health program performance indicators, based on the targets that were agreed upon with the project implementers, are presented. The report highlights the effective and successful linkage and coordination with donors through spaces such as the specific SRH and HIV/AIDS technical committees, the GAVI Committee, CCM and especially the DAIA-DAISSR Committee.

During the evaluation period, the USAID/Nicaragua Health Program was implemented through the following national and international implementation partners.

TABLE 7: USAID/NICARAGUA HEALTH PROGRAM IMPLEMENTERS (FY 2007-2015)

Implements	Project Type	Period	Amount in US$	Coverage	Counterparts	Actions
CCP-Donation	Central	2007-2008	1,047,250	National	MINSA	MCM donation
DELIVER	Central	2007-2013	3,395,020	National	MINSA INSS Universities NGOs	Logistics system
PRONICASS	Central	2007-2010	6,669,054	León, Nueva Segovia, Boaco	MINSA Universities	Strengthening of the health system
HCI-ASSIST	Central	2007-2014	6,367,174	National	MINSA Universities NGOs INSS	Institutional strengthening, maternal health quality improvement, child FP, Improving health personnel capabilities and performance
FamiSalud	Local	2006-2013	16,129,000	12 departments	MINSA Universities NGOs MINED Volunteer network and community volunteers	Technical assistance, training, extension of coverage and quality improvement of community strategies
PrevenSida	Local	2010-2016	7,000.000	National	NGOs CONISIDA Global Fund CIES, CEPRESI	Institutional strengthening, Extension of coverage and quality of combined HIV prevention services
Alianzas 2	Regional	09/2010-10/2013	3,300,000	National	COSEP, Foundation Zamora Teran, American Nicaraguan Foundation, Juan XXIII Institute EDUQUEMOS	Creating public-private partnerships, teacher training, increasing access to essential medicines, health and nutrition improvement by the private sector

Implements	Project Type	Period	Amount in US$	Coverage	Counterparts	Actions
San Lucas Foundation	Local	2010-2011	100.000	Rio San Juan	MINSA Communities	Improving maternal health and reducing GBV
CRS	Central	2010-2012	1,600,000	Matagalpa	MINSA, FBOs Communities	Child survival
Regional Programs						
PSI/Combined Prevention	Regional	2010-2015	1,404,196	National	NGOs	Combined HIV prevention
FG/PASCA	Regional	2010-2014	1,277.037	National	CONISIDA COSEP NGOs	Strengthening the national response to HIV
SCMS	Regional	2011-2012	500.000	Managua	MINSA central storage facilities	Strengthening storage

Source: USAID/Nicaragua Health Program Systematization.

The evaluation results are grouped into three main categories:

- Contribution to the MDGs (on health and their midterm indicators).
- Strengthening the institutional capacity of MINSA and the health sector, including the institutionalization and sustainability of processes.
- Determining the scope of specific outcomes (midterm and sub-RIs) identified in SOAG, including the quality of strategy design and implementation (complementary actions performed by USG agencies and other donors), M&E, identification and control of risk factors.

4.1.1 CONTRIBUTION TO MDGS

The following section presents an overview of the main indicators of fertility, maternal and child health and HIV-AIDS to which the USAID cooperation program intended to contribute. To a lesser extent, USAID cooperation has also contributed to the fulfillment of MDG 1 with its wider cooperation program.

The implementation of health policies, plans and strategies, led by MINSA, operationalized through MOSAFC and coupled with the harmonization and coordination of international health cooperation (including USAID cooperation), made possible the progress seen in the main demographic and maternal and child health indicators: TFR, MMR, MR in children under 5 years, IMR, NMR and CM under 5 years (see Table 7).

Regarding HIV, which is an epidemic concentrated in high-risk populations (MSM, transgender and FSW), an increase is observed in the disease's incidence and prevalence in these populations because of efforts to provide counseling and voluntary testing have been intensified.

Regarding FP, the MINSA decision to increase funding for the purchase of MCM and its leadership in the DAIA Committee (now DAISSR) has allowed an increase in public funding for MCM from 0.6% in 2006 to 75% in 2012 and a reduction in MCM stock-outs in health posts from 36% in 2007 to 0.8% in 2012 (see Figure 4).

Table 7 shows the link between impact and midterm health indicators and the strategies and evidence-based interventions that are known to contribute positively to each indicator. Obviously, the USAID program has contributed to the country's efforts, led by the Ministry of Health and supported by other donors, NGOs and universities. It is worth mentioning the role of NGOs and local actors in the implementation of community strategies. Proper implementation of MOSAFC

has been the main factor in achieving success at the community level, although there greater ownership is still needed by families and communities to achieve greater health.

It is relevant to note that during this period, there were significant structural changes, such as the passing of such macro laws as the Food and Nutritional Security Act, and an Early Childhood Policy was enacted.

Also, it should be considered that the indicators presented here correspond to national averages and that there are areas, especially those that are rural and on the Caribbean coast, where there are still gaps in access and quality.

TABLE 8: CONTRIBUTION TO IMPACT AND MIDTERM HEALTH INDICATORS

Health impact indicators	**Source 2006/7**	**Source 2011/12**	**Strategies and evidence-based interventions that contributed to the reduction**
Fertility impact indicators	**ENDESA 2006/7**	**ENDESA 2011/12**	
Total fertility rate (TFR)	**2.7**	**2.4**	APEO: USAID/HCI and UNFPA Donation of contraceptives ECMAC: USAID FamiSalud, Development of standards and dissemination of FP regulations: PAHO Strengthening of logistics systems: USAID, UNFPA Long-term and permanent methods: USAID DELIVER and HCI, UNFPA, PASMO and Profamilia. Service organization, management tools and personnel skills development: USAID-HCI Delivery Plan: USAID FamiSalud FP in prenatal and postpartum care. Curricula of community medical practice: universities
MCM prevalence rate (%)	**72.4**	**80.4**	

Maternal health impact indicators	**MINSA 2006**	**MINSA 2012**	**Strategies and evidence-based interventions that contributed to the reduction**
Maternal mortality ratio (maternal deaths per 100,000 live births)	**92.83**	**50.9**	Maternity houses: National Network of Maternity Houses, BID, UNFPA, UNICEF, municipalities, private sector (local producers and traders) and FamiSalud COE: IDB, UNICEF, EONC-Community (USAID FamiSalud) Skills development for Prenatal Care (PNC) and surveillance through health indicators: USAID/HCI Collaborative improvement strategy for the prevention, diagnosis and treatment of obstetric complications: PPH and GHS (USAID-HCI) FP strategies: ECMAC, APEO, long-term (USAID/HCI, USAID/PASMO, USAID/DELIVER, UNFPA) Humanizing delivery: HACAP-HACC (USAID HCI and UNICEF) MATEP: USAID HCI Delivery Plan for Safe Motherhood: USAID FamiSalud
Prenatal care by a professional	90.2	94.7	
Institutional delivery	74.0	88.2	

Child health impact indicators	**ENDESA 2006/7**	**ENDESA 2011/12**	
Mortality rate in children under 5 years of age (deaths in children under 5 years of age per 1,000 live births)	35	21	Safe water: USAID/FamiSalud IMCI-C: USAID FamiSalud IMCI-H: implementation of rules, standards and quality indicators (USAID HCI) Early attachment Helping Babies Breathe (HBB): USAID HCI Management of severe asphyxia: EONC-C (USAID FamiSalud) Development of standards and quality indicators Development and reproduction of quality standards and health personnel training: UNICEF Collaborative improvement strategy for the prevention, diagnosis and treatment of neonatal complications: HBB, Neonatal resuscitation, diagnosis and treatment of sepsis: USAID-HCI Collaborative improvement strategy for the diagnosis
Infant mortality rate (deaths in children under 1 year of age per 1,000 live births)	29	17	
Neonatal mortality rate (neonatal deaths per 1,000 live births)	16	8	
Chronic malnutrition prevalence in children under 5 years of age (%)	21.7	17.3	
Children from 12 to 29 months who are fully immunized	85	84.1	
Children under 5 years of age with EDA treated with ORT	58.6	65.4	
Children under 5 years of age being treated for ARI or fever	64.1	78.6	

Child health impact indicators	ENDESA 2006/7	ENDESA 2011/12	
Children from 0-5 months who are exclusively breastfed	30.6	31.7	and treatment of ADS in children: USAID-HCI "Saving Lives" Strategy: CARE Training of community health professionals and male facilitators of MCH: USAID-CRS HACAP: USAID HCI, UNICEF Hospitals friends of childhood Kangaroo Mother: USAID HCI Community case management: Save the Children Management of newborn sepsis: USAID HCI Promotion of exclusive breastfeeding Design and implementation of the Plan to reduce neonatal mortality: Nicaraguan Medical Pediatric Association (SONIMEP) PROCOSAN – Newborn Care Checklist: FamiSalud[23] PROCOSAN: USAID FamiSalud, Nicaraguan Red Cross Family, School and Community Hygiene Program
Health impact indicators			

HIV AIDS	MINSA 2006	MINSA 2012	
HIV mortality rate (per 100,000)		1.3	Updated standards for ARV treatment and of HIV OI: USAID HCI Access and quality of counseling and voluntary testing: (VCT), GF, USAID HCI and PrevenSida, PAHO TB-HIV co-infection: CDC VCITS clinics: CDC Donation of ARVs: Global Fund, South Cooperation, South Strengthening of the laboratory network: CDC, USAID HCI and PrevenSida Prevention Services and Combined Prevention of Most-at-risk populations (MARP) and positive people: GF, USAID PrevenSida and Regional Combined Prevention, CDC, Peace Corps, Global Fund Organization of services and improved access to ART: USAID/HCI Other donors that have supported several HIV strategies: Netherlands, Norway, UNFPA, UNICEF, UNDP, IOM, UNAIDS, EU, GF, Grand Duchy of Luxembourg), HIVOS, GIZ Horizon 3000, IDB
Incidence rate (per 100,000)	7.6[24]	32	
Prevalence rate (%)	0.1	0.3	
Coverage of combined prevention in MSM (%)	0	33.3	
Coverage of combined prevention services for transgender people (%)	0	88.46	
Coverage of combined prevention services for TSF (%)	0	49.64	

Source: MINSA, ENDESA.

4.1.2 STRENGTHENING OF THE INSTITUTIONAL CAPACITY OF MINSA AND THE HEALTH SECTOR

Until 2007, in the context of health reform undertaken by most countries in Latin America, Nicaragua was heading towards outsourcing health services. However, with the change in government in late 2007, social policy was restated to grant all people the right to free health care. A process of adjusting the government's social policies was initiated, which in the case of health was expressed in an extension of coverage to vulnerable populations, free health, decentralization and horizontalization of the health model.

The following summarizes USAID/Nicaragua's interventions to strengthen the health system through the joint work of the implementing partners.

[23] Community Health and Nutrition Program (PROCOSAN). Strategy Paper.

[24] Health in the Americas: Nicaragua chapter. Available at: http://www.paho.org/saludenlasamericas/index.php?id=48&option=com_content

TABLE 9: INTERVENTIONS BY PROJECT TO STRENGTHEN THE HEALTH SYSTEM

Component	Leadership and governance	Health human resources	Quality	Coverage of services	Logistics and technology	Information systems
CCP-Donation						
DELIVER						
PRONICASS						
HCI						
FamiSalud						
PrevenSida						
Alianzas 2						
San Lucas Foundation						

The USAID Health Program has established effective cooperation through various local, regional and global implementation mechanisms in the various components of the FP, MCH and HIV and AIDS strategies. Additionally, projects have been implemented during emergencies for leptospirosis, dengue and H1N1, and the contributions of the PRONICASS, FamiSalud and DELIVER projects have been important.

Example of collaboration during emergencies: In March 2010, the USAID/DELIVER PROJECT, in coordination with WHO/PAHO in Nicaragua, supported the MINSA in H1N1 vaccination through the acquisition, customs clearance, receipt and storage of 117,600 syringes and 1,375 safety boxes (for the incineration or destruction of syringes), which were distributed with the vaccine to health centers and hospitals across the country.

TABLE 10: JOINT HEALTH COOPERATION PROGRAM

PROJECTS	Family planning					Maternal and child health			HIV/AIDS			
Component	CS	MS	SHS	MC	DD	SHS	EU	CPM	CP	SHS	SI	LP
Central projects												
CCP-Donation												
DELIVER												
PRONICASS												
HCI												
Local projects												
FamiSalud												
PrevenSida												
Alianzas 2												
San Lucas Foundation												
Regional contribution												
CRS: Child Survival												
SCMS: Storage												
Capacity: SS performance												
Combined Prevention: CCM												
PASCA: policies												
ABT: mapping condoms												
AIDSTAR1: trans diagnosis												

Codes: Contraceptive Security (CS), Market Segmentation (MS), Strengthening of Health Systems (SHS), Data Dissemination (DD), (Community Practices and Mobilization (CPM), Combined Prevention (CP), Strategic Information (SI) Law and Politics (LP).

4.1.3 RELEVANCY OF THE MIDTERM USAID RESULTS

A) COOPERATION HARMONIZATION AND ADJUSTMENT

Based on the MTE Health Program recommendations (2008), the mission continued its strategic focus on health system strengthening (HSS) and the beginning of a process of adjusting their cooperation based on the following facts:

Positive changes in public health policy[25] and in the National Health Plan[26] focusing on free services, strategies to expand coverage and quality, transformation of the Integral Health Care Model (IHCM), which was valid until 2007, to the MOSAFC, including the horizontality and decentralization of services, dispensarization and the operation of community family health teams to serve the population at the community level[27].

ENDESA 2006/7[28] findings that identify demographic and health progress and clearly define geographical areas with greater health gaps that should receive focused cooperation.

- The emergence of new actors for health cooperation, especially the projects in Round 8 of the GF, provided the country with vast resources in the areas of HIV/AIDS, malaria and tuberculosis. More recently, these agencies have demanded a focus on sustainability for new project proposals[29].
- The initiation of the PEPFAR Partnership Framework for Central America (2010) based on principles of country ownership and sustainability[30].
- The gradual decrease of the cooperation of traditional bilateral donors, including the gradual reduction of USAID health cooperation in Latin America.
- The increase in loans (IDB and World Bank) to meet part of the financial health gap, representing an opportunity to provide continuity for successful strategies by including them in the design of new loans.
- The launch of the GHI from the USG[31].

These factors, internal and external, led to an adjustment of the annual work plans of health projects (PRONICASS, FamiSalud, DELIVER and HCI) in response to the new environment of public policy, and in turn, demanded that the formulation of new projects be adjusted to the new context and gaps, as in the case of the PrevenSida project, which arose in response to critical gaps in HIV cooperation that remained after the HIV project in Round 8 of the GF.

The MSH/PRONICASS project played an important role as a pioneer of the transfer processes to the UNAN Managua and León, in 2008-2010, providing technical assistance in the development of curricula for the rotating teaching internship in hospitals, development of the management and leadership program by skills of a medical degree-UNAN Managua.

Similarly, regional programs also adjusted their annual programming, for example, given the importance of the public policy environment, the Mission requested the resumption of activities of two regional projects: PASCA in 2010, and the storage strengthening project, SCMS, in 2012, to fill cooperation gaps in these areas.

The Mission incorporated all the recommendations made in the 2007-MTE of the health program and from the evaluations (MTE and FE) of the FP graduation strategy.

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[25] MINSA. National Health Policy. 2008. Available at: http://apps.who.int/medicinedocs/documents/s18995es/s18995es.pdf

[26] MINSA. National Health Plan. Ministerial Resolution 589. 2007.

[27] MINSA. Model of Family and Community Health: Managua, Nicaragua, June 2008.

[28] INIDE. ENDESA 2006/2007. Available at: http://www.inide.gob.ni/bibliovirtual/Endesa/Endesa_2006/InformeFinal06_07.pdf

[29] The Global Fund. Nicaragua Portfolio . Available at: http://portfolio.theglobalfund.org/en/Country/Index/NIC

[30] USAID Cooperation Framework to support the implementation of the regional response to HIV in Central America. 2010. http://www.pepfar.gov/documents/organization/139196.pdf

[31] The Global Health Initiative. Available at: http://www.ghi.gov/

TABLE 11: STATE OF IMPLEMENTATION OF USAID/NICARAGUA HEALTH PROGRAM GRADUATION STRATEGIES

Component	Scheduled	State
Central donation of contraceptives	September 2009	Fulfilled and evaluated. The country buys with its own funds, about 80% of the contraceptive methods required for the public sector.
Family planning	September 2012	Fulfilled and evaluated. Evidence shows that the delivery of FP services is maintained or even increased compared to the prevalence level of the use of contraceptive methods, achieved prior to graduation and that inequalities continue to decline.
Maternal and Child	September 2013	Fulfilled and evaluated the public component graduation in September 2012. In the process of finalizing, the component of transfer to universities ended in September 2013.
HIV-AIDS		Design of HIV Sustainability Strategy for Central America. PEPFAR second period (2010-2014) in the implementation process. Regional and national mid-term evaluation process. Country-led Alliances including PEPFAR, Global Fund and UNAIDS.

B) COORDINATION WITH DONORS

Nicaragua has a rich tradition of international health cooperation, including work with bilateral and multilateral agencies, UN agencies and global funds (GAVI, GF). In the early 2000s, the country implemented the Sector-Wide Approach (SWAP); through cooperation, effective efforts to harmonize and align health cooperation with health policy and short-, medium- and long-term national strategic plans were implemented. The role of bilateral agencies, such as the health cooperation liaisons initiated by Sweden and led by the Netherlands during this evaluation period, was extremely important for maintaining excellent coordination between donors and MINSA.

The country's external cooperation is bilaterally coordinated with the Ministry of Foreign Affairs (MINREX) and a group of health donors through the Donor Roundtable. In the case of health issues, twice a year the MINSA calls for formal dialogue meetings with donors, and specific actions are coordinated through technical working groups in areas of mutual interest. USAID has participated in these sectoral dialogue sessions, which are characterized by technical exchange, the monitoring and evaluation of joint plans and the generation of reports based on agreed-upon progress indicators, including local joint visits.

Table 12 shows the variety of coordination efforts with international health donors.

During the evaluation period, several donors ended their health-related technical assistance to Nicaragua: Denmark, Sweden, Austria (1983-2013)[32], The Netherlands, Finland and GTZ. The following donors are currently active: Luxembourg, European Union, Spain, Japan, United Nations, IDB and the World Bank.

[32] Austrian Development Cooperation 2011-2013. Available at: http://www.entwicklung.at/uploads/media/LS_Nicaragua_span.pdf

TABLE 12: COORDINATION WITH DONORS ON HEALTH COOPERATION ISSUES

	Donor roundtable	MCM donation	FP and MCH, family and reproductive health	Maternal and child health	HIV/ AIDS	Emergencies	Gender
Netherlands							
Sweden							
Finland							
Norway							
Austria							
Luxembourg							
Spain							
Japan							
Norway							
UNFPA							
PAHO							
UNICEF							
UNDP							
UN Women							
IOM							
CABEI							
World Bank							
Global Fund	CCM						

Source: USAID/Nicaragua systematization report of 2013.

Examples of successful cooperation:

For the FP program, the mission conducted close coordination with other donors, managing successful programs with UNFPA to provide contraceptives and logistics systems and with PAHO to strengthen systems. PAHO, UNFPA, AIS and Farmamundi have supported the improvement in PASIGLIM's reported data on the rational use of drugs through legislation. Additionally, other actions to improve the storage of health supplies have been performed with the World Fund, SCMS with PEPAFR, UBFPA/Prisma and IDB/RIS funds.

The transfer of experiences from USAID Programs was also performed with donors, with whom the results of the Graduation Strategies were presented. One purpose of graduation interventions was to allow donors to assume, as part of their cooperation, the USAID/Nicaragua programs' experience and, in some cases, their implementation. The evaluation team met with representatives of the Grand Duchy of Luxembourg, the Netherlands, the United Nations System (PAHO, UNFPA, and UNICEF) and IDB. Donors expressed interest in incorporating some of USAID/Nicaragua's strategies and activities.

Other areas of important coordination have been:

- Specific technical committees for SRH and HIV/AIDS
- The CCM of the Global Fund

- The GAVI Committee
- The DAIA-DAISSR Committee

Committee on Contraceptive Procurement (DAIA): Coordination efforts initiated in 2003 found a space in the DAIA committee to strengthen MINSA's FP efforts and implement the Strategy for SRH, which is now part of the DAISSR Committee.

Coordination with international and national NGOs: During the development of the USAID Health Program, an important factor in the achievement of its objectives was the interproject, interagency and interinstitutional relationship, which allowed the programs to work in synergy with other donors, combining technical and financial resources to support the MINSA's priorities in maternal-child health, HIV/AIDS and family planning.

The following areas of coordination with other donors have been identified for 2014-2016:

TABLE 13: AREAS IDENTIFIED FOR COORDINATION WITH DONORS, 2014-2016

Cooperator	Coordination areas
PAHO	Family and Community Health Model: HIV: strategic information, reducing stigma and discrimination, monitoring and controlling STIs[33]
UNFPA	Population dynamics: training in the use of ENDESA data; gender equality: reducing GBV in key populations; Youth Sexual Education: HR and SRH of MSM and transgender youth; SRH: improving youth access to HIV prevention for key populations[34]. Logistics: coordination with the DAISSR Committee.
UNICEF	Children and HIV/AIDS: preventing infection among adolescents and young people; policy advocacy and partnerships: monitoring and statistics[35]
Luxembourg	Support Jinotega and Matagalpa SILAIS: transfer of work experiences within the health sector[36], Working with NGOs
European Union	Transfer of tools and technical content
AECID	Transfer of tools and technical content
Japan	Transfer of tools and technical content
IOM	HIV prevention with female sex workers
UN WOMAN	GBV prevention with NGOs
IDB	Transfer of experience in logistics, quality and human resources.
World Bank	Transfer of experience in logistics, quality and human resources.
Global Fund	Technical assistance in logistics through the DAISSR committee

C) SUSTAINABILITY OF THE MAIN STRATEGIES

During the validation exercises, the participants were asked to assess the extent to which the main strategies had been transferred across sectors and which aspects of sustainability were considered achieved. A complete transfer to the MINSA was observed; the transfer to universities, NGOs and donors was less pronounced. In terms of sustainability, the participants believed that there was technical and political sustainability and, to a lesser extent, financial sustainability.

[33] PAHO. Website: Prevention of HIV and STIs. Available at: http://www.paho.org/nic/index.php?option=com_content&view=article&id=349

[34] UNFPA. Website. http://www.unfpa.org.ni/componentes/

[35] UNICEF. Website. http://www.unicef.org/spanish/infobycountry/nicaragua_22340.html

[36] Luxembourg Website Support to Nicaragua's Health Sector. Available at: http://www.lux-development.lu/en/activities/project/NIC/025

TABLE 14: SUSTAINABILITY OF THE MAIN HEALTH STRATEGIES PROMOTED BY USAID/NICARAGUA

	Technical transfer to				Sustainability			
	MINSA	Donors	NGOs	Universities	Policy	Financial	Technical	Community
Family planning								
DAIA committee								
ECMAC								
APEO								
MCM donation								
Maternal and Child								
Delivery Plan								
PROCOSAN								
IMCI C								
Kangaroo Mother Method								
HBB								
EONC								
Prevention of intrahospital infections								
HACAP								
HIV								
Combined prevention								
Stigma and discrimination								
GBV								
Single registration								
Quality improvement								
Collaborative improvement								
Rapid cycles (transversal)								

Source: Validation exercise with implementers and partners, January 15 and 16, 2014.

Fulfillment of agreed-upon indicators for Health Program strategies and indicators in the contracts of the implementing partners

In the next section, the fulfillment of agreed-upon indicators for each of the cooperation strategies is presented. Additionally, the fulfillment of the quantitative indicators in each implementing partner's contracts is presented for the first period, from October 2009 to September 30, 2013. No first-year data are presented for changes in indicators that hinder the consolidation of these data in a manageable format because the mission has conducted several evaluations and adjustments of its M&E system, which was standardized in 2010.

PHOTO: VILMA GUTIÉRREZ

Mozonte Health Center. Mozonte-Indian couple waiting for family planning care (2012).

"Family planning has a high priority for MINSA. There is political will to make the program sustainable, and financial resources are also intended for the purchase of contraceptives. FP under the development framework is a contribution not only to the prevention of maternal mortality, but also to women's right to decide how many children they have. FP is linked to gender policy."

Dr. Carlos Cruz, Planning Director, MINSA (interviewed during the final evaluation of FPGS, Nicaragua 2012)

4.2 RESULTS FOR FAMILY PLANNING

During the evaluated period, two large interventions were performed: continuation of central contraceptives donation and graduation of FP technical assistance. These interventions were evaluated across 18 performance indicators (one for the central donation of MCM and 17 for FP technical assistance); 15 of these indicators were fulfilled, and 3 were partially met, for an overall fulfillment of 83% of the performance indicators. See Table 15.

TABLE 15: FULFILLMENT OF FP STRATEGY INDICATORS, 2008-2012

Component indicators	Fulfillment Level	Evidence of fulfillment
I. Central purchase of contraceptives		
In 2009, MINSA would invest 20% of the USAID donation in that year	Fulfilled	In 2009, MINSA invested 39% of the USAID MCM donation.[37]
2. Graduation strategy for FP technical assistance		
2.1 Contraceptive security		
DAIA committee operation	Fulfilled	The DAIA committee has operated since 2005; in 2012, it was converted to DAISSR.
FPGS included as a result in the SOAG	Fulfilled	FPGS was included as result in the USAID SOAG.
LOI signed to implement the gradual reduction of MCM	Fulfilled	The LOI was achieved.
Improved coordination with donors	Fulfilled	Effective coordination with UNFPA was achieved for MCM donation and FP technical assistance.
Implemented integrated logistics system	Fulfilled	PASIGLIM institutionalized and sustainable, operating at the national level
Reduced number of health centers and units experiencing stock-outs	Fulfilled	Shortage reduced at the local level, from 36% (2007) to 0.8% (2012).
2.2 Market segmentation		
MINSA participation reduced to 60%	In process	Preliminary data from ENDESA 2011/12 confirmed the trend toward reduction from 74% in 2008 to 68.6% in 2012.
INSS participation increased to 18%	In process	Preliminary data from ENDESA 2011/12 confirmed the trend toward an increase from 1% in 2007 to 7.8% in 2012.
Lucrative private sector participation between 14 and 16%	In process	Preliminary data from ENDESA 2011/12 confirmed the trend toward a reduction in the lucrative private sector participation (clinic, hospital clinic, pharmacy and supermarket) from 18.5% in 2007 to 17.9% in 2012. Nonprofit sector (NGO) participation was reduced from 7.7% to 4.1%.
Projections of market segmentation used for budget allocation and long-term planning	Fulfilled	MINSA uses DAIA projections to plan the procurement of public sector and UNFPA donations.
2.3 Strengthening of the health system		
Reproductive Health Strategy- National Sexual and Reproductive Health Strategy (NSRHS) SRHS) implemented	Fulfilled	DAIA supports NSRHS objectives
ECMAC implemented	Fulfilled	ECMAC updated and deployed within the context of MOSAFC.
Post-obstetric event contraception (APEO) strategy implemented	Fulfilled	APEO was developed, and its institutionalization in health services increased from 12% (2003) to 91.2% (2012).
2.4 Improving the quality of services and coverage		
FP national standards updated and implemented	Fulfilled	National standards were updated and more than 13,000 HHR were trained, including transfer to seven universities and 17 schools, inserting content into the curriculum.
Increased availability of long-term methods	Fulfilled	Mini-lap and IUD insertion training techniques were provided and equipment was donated. IUD use increased from 7,000 to 20,000 users during this period.
2.5 Data for decision making		
Increased use of ENDESA 2006/7 for decision making	Fulfilled	ENDESA 2006/7 was disseminated widely; secondary

[37] MINSA. Directorate of Health Products, 2013.

Component indicators	Fulfillment Level	Evidence of fulfillment
		analyses were conducted, and DAIA used their data for strategic planning.
Development plan for the new ENDESA 2011/12	Fulfilled	Government performed ENDESA 2011/12, and preliminary data are available.

Source: FPGS evaluation report 2012, adjusted

Table 16 shows the fulfillment of the FP performance indicators that the implementer projects agreed to in their contracts. MCM delivery points are not included because their reach is related to the increased access to MCM in MINSA health posts, as demonstrated by preliminary data from ENDESA 2011/12.

TABLE 16: FULFILLMENT OF FP PROJECT INDICATORS IN 2010-2013

Indicators	Goal 2010-2013	Fulfilled 2010-2013	% Fulfilled
Couple protection years – CPY- (DELIVER)	1,030,000	1,149,482	111.60
Number of FP/RH counseling visits (HCI FamiSalud, FSL)	534,254	464,211	86.89
Number of people who received messages from FP/RH (HCI FamiSalud, DELIVER, FSL)	1,330,781	1,499,933	112.71
Number of people trained in FP/RH (HCI FamiSalud, DELIVER)	4,618	8,920	193.16
• Men	1,901	2,918	153.50
• Women	2,837	5,993	211.24
Number of policies or guidelines developed to improve access to FP/RH services (DELIVER)	5	5	100.00
Number of delivery points providing FP counseling or services (HCI FamiSalud)	2,067	1,451	70.20
Value in US$ of MCM purchased by MINSA (DELIVER)	3,310,546	4,395,989	132.79
Number of institutions with improved management information systems	5	5	100.00
Number of evaluations conducted	3	7	233.33

The following section describes each of the interventions and their respective components in greater detail.

4.2.1 CENTRAL DONATION OF CONTRACEPTIVES

Historically, USAID and UNFPA have been the main MCM donors for the country.

The Central Contraceptive Procurement (CCP) project of USAID (January 1990-December 2020) implements the USAID policy of centralized contraceptive and condom procurement by providing a simplified mechanism for the transfer, responsibility and disbursement of funding for these supplies and for the social marketing program[38]. Nicaragua has received MCM donations from this program since 1991.

Considering the progress made on FP in 2006, USAID/Nicaragua and GON signed Letter of Implementation (LOI) No. 4, which expressly stated that USAID/Nicaragua would gradually reduce MCM donations to MINSA (between 2006 and 2009); at the same time, the GON would gradually increase its procurement in 2009 to reach 20% of the USAID donation that year[39].

In 2009, MINSA contributed US$227.500 to buy MCM, and USAID donated US$577.833; thus, MINSA's purchase reached 39% of USAID's contribution, doubling the amount agreed upon in the LOI of 2006.

[38] USAID Central Contraceptive Procurement. Available at: http://www.usaid.gov/node/50611

[39] LOI #4. USAID/Nicaragua and Ministry of Foreign Affairs of the Government of Nicaragua.

TABLE 17: SOURCES OF AND TRENDS IN CONTRACEPTIVE FINANCING IN US$ NICARAGUA 2005-2012

	2005	2006	2007	2008	2009	2010	2011	2012
MINSA		9,000	103,830	591,665	227,500	321,935	2,025,891	1,658,065
UNFPA	1,017,945	1,030,672	461,213	455,676	1,098,935	600,002	715,000	932,662
USAID	1,089,894	461,726	428,450	554,645	577,833	0	0	0
PASMO					6,240	6,759	0	0
Total	2,107,839	1,501,398	993,493	1,601,986	1,910,508	928,696	2,740,891	2,590,727

Source: MINSA.

4.2.2 FAMILY PLANNING TECHNICAL ASSISTANCE

FP technical assistance is closely linked to the central donation of contraceptives and was a key component in contraceptive security.

As a result of improvement in the indicators of increased MCM use and decreased TFR, among others, USAID Nicaragua designed FPGS, which was implemented over a five-year period (2008-2012). The FPGS had five components: contraceptive security, market segmentation, strengthening of the health system and improving the quality of data for decision-making. The following sections describe each of the components.

A) CONTRACEPTIVE SECURITY

The aim of this component was to reduce dependence on the external donation of MCM and avoid stock-outs. The DAIA, whose leadership was assumed by MINSA as directed by the FPGS, was decisive in achieving this goal.

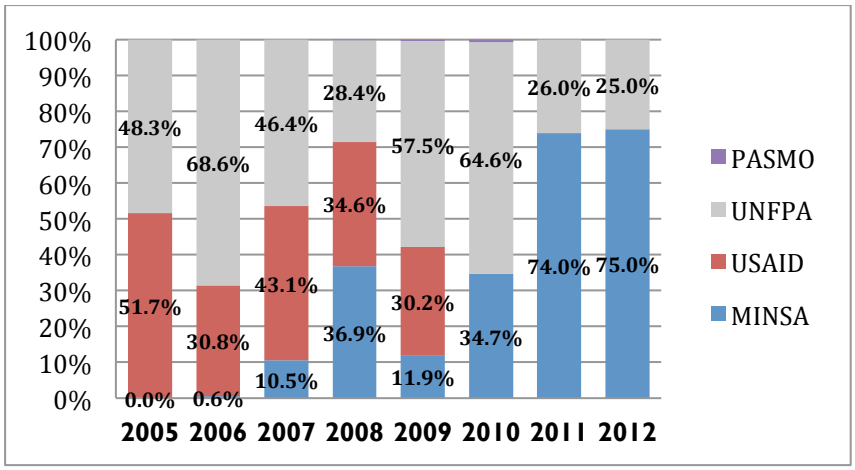
The performance indicators for this component were the establishment of an operative DAIA committee; FPGS included in the SOAG; LOI signed to ensure the gradual reduction of donated MCM; improved coordination with donors; the implementation of an integrated logistics system; and a reduction in the number of health centers and units experiencing stock-outs.

DAIA Operative Committee: The DAIA committee has operated since 2005, and was converted to the DAISSR in 2012.

FPGS included in the SOAG: FPGS was included in the USAID Health Program cooperation strategy in Nicaragua.

LOI signed to ensure the gradual reduction of donated MCM: In the previous section, the fulfillment of the performance indicator of the LOI was demonstrated in 2009, which was the last year of MCM donation to the country. Since the DAIA committee was established, an increase in the allocation of MINSA financial resources to purchase MCM has been advocated, and competitive and agile MCM procurement procedures have been introduced to avoid stock-outs. As a result, MINSA increased its financing for MCM purchase from 0.6% in 2006 to 75% in 2012, which reduced the reliance on foreign donations and enabled MINSA to become the leading provider of modern contraceptive methods, covering 70% of the population (see Figure 3). GON public policy and its support for several international agreements on reproductive health are key factors in the continued use of public funds to provide MCM. The country has reported that once this donation ceases, it will assume 100% of the total purchase.

FIGURE 3: PROGRESS OF THE MCM PURCHASE FUNDING PUBLIC SECTOR, 2005-2012



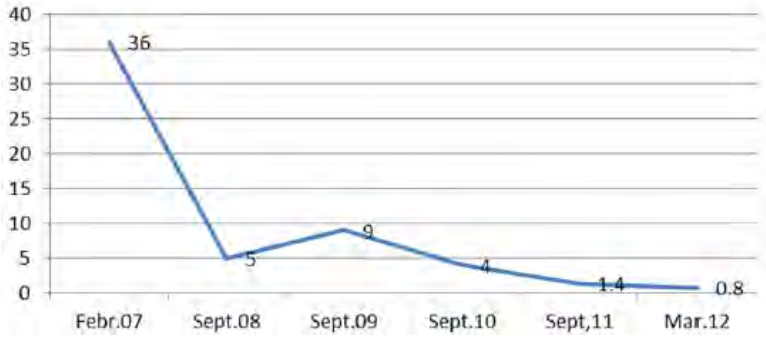
Source: Ministry of Health.

Improved donor coordination: Coordination efforts initiated in 2003 found a space in the DAIA committee to strengthen the GON's FP efforts. UNFPA, UNICEF and PAHO have been key allies of USAID. The improvement of data reported by PASIGLIM for rational drug use through regulations has been supported in conjunction with PAHO, UNFPA, AIS and Farmamundi. Additionally, other actions to improve the storage of health supplies have been taken in conjunction with the World Fund, SCMS using PEPAFR, UBFPA/Prisma and IDB/RIS funds.

Implementation of an integrated logistics system[40]: The support of PEPFAR and UNFPA was instrumental in implementing the information system that would ensure the logistics of medical supplies (SIGLIM), which is the basis for managing all SILAIS supplies. With UNFPA, the PASIGLIM was developed to ensure the control of MCM supply. PASIGLIM makes real-time logistics information available to prevent stock-outs of medical supplies. The training conducted by in-service health personnel (which allowed the achievement of optimal contraceptive security indicators) is detailed later in the text.

Reduction of the number of health centers experiencing stock-outs: Ensuring the supply of MCM and the implementation of PASIGLIM was fundamental for reducing the MCM shortage from 36% in 2007 to 0.8% in 2012.

FIGURE 4: TREND IN THE PROPORTION OF MINSA HEALTH POSTS WITH STOCK-OUTS OF AT LEAST ONE CONTRACEPTIVE METHOD, 2007-2012



Source: PASIGLIM 2012.

[40] MINSA. PASIGLIM manual.

B) MARKET SEGMENTATION

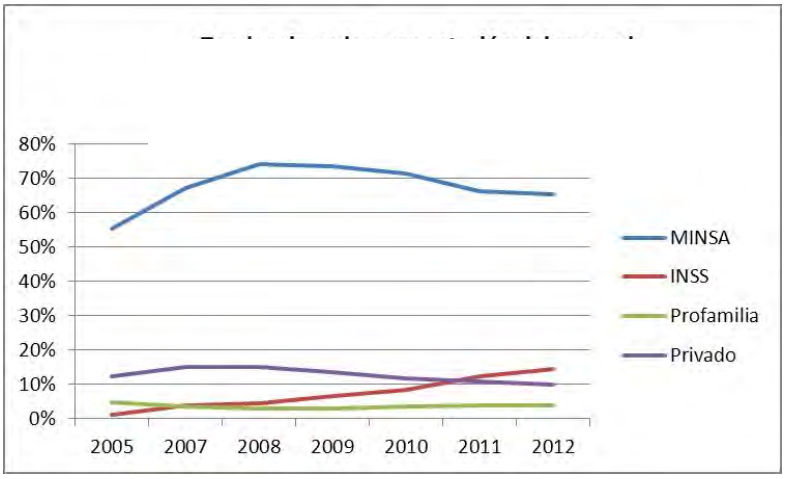
The aim of this indicator was to promote better distribution of health care providers to support MINSA in caring for people with fewer resources, to incorporate social security and to maintain the private sector's cooperation with NGOs to provide FP services. An important aspect is DAIA's role in developing market segmentation projections for MINSA's budget allocation and long-term planning. This component had three indicators: MINSA participation was reduced to 60%, INSS participation increased to 18%, and private sector participation increased or was maintained between 14-16% of market share. Figure 5 shows the trends of these three indicators in 2012 based on estimates made by the DAIA Committee.

MINSA share reduced to 60%: Although MINSA's participation increased to 74% in 2009 because of interventions to cover underserved areas; its share then fell to 68.6%[41] because of increased INSS participation. Although progress in this indicator is evident, it has not yet reached the expected target.

INSS share increased to 18%: FPGS findings increased INSS participation from 17 Social Security Medical Clinics within the Public Sector (CMP) and IPSSs that provided FP in 2007 to 28 in 2011. Recent data from the INSS indicate that by 2012, all CMPs and IPSSs (36 in total) offered FP services[42]. Despite this, the INSS's MCM delivery share showed an increase of 7.8% by 2011, which was lower than expected[43].

Private sector participation increased or maintained between 14-16% of market share: Excluding the INSS data, which was reported earlier, preliminary data from ENDESA 2011/2012 reflect a 5 percentage point decrease in the market share of MCM from 27% in 2006/2007 to 22% in 2011/2012. This is attributable to MINSA's effective implementation of the free health policy[44].

FIGURE 5: MCM MARKET SEGMENTATION TREND IN NICARAGUA FROM 2005 TO 2012



Source: USAID/Nicaragua, with data from the DAIA Committee.

[41] INIDE. ENDESA 2011/2012, p. 45.

[42] INSS. Yearbook 2012, p. 76.

[43] ENDESA 2011/2012, p. 45.

[44] MINSA. National Health Policy.

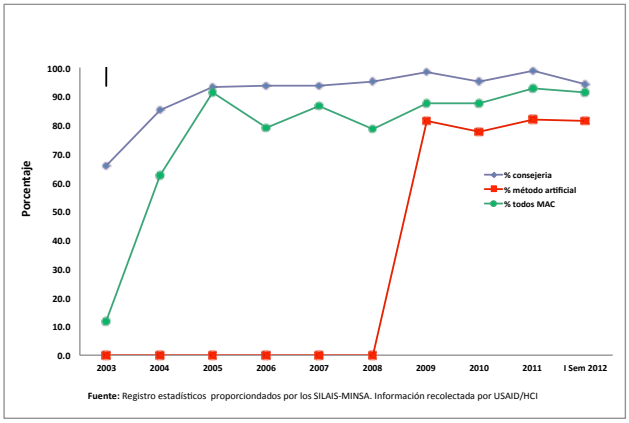
C) STRENGTHENING OF THE HEALTH SYSTEM

The aim of this component was to ensure the adoption, dissemination and fulfillment of standards related to the provision of FP and reproductive health services in Nicaragua and to improve advocacy[45]. The main indicators of this component were implementing SRH, APEO and ECMAC strategies.

National Sexual and Reproductive Health Strategy (NSRHS) implemented: The strengthening plans prepared by the DAIA Committee contributed directly to the development and launch in 2008 of the NSRHS[46] and supported its operationalization through the CQI process in the FP program's management and care processes[47]. Two operational multiannual plans were implemented. The first plan was evaluated in 2009[48]; the second plan is being implemented and will be evaluated after the full disclosure of ENDESA 2011/2012.

APEO implemented: MINSA and INSS were supported in making reliable data sources available, defining the flow of information and strengthening their health human resources capacity through the development of skills that meant that by 2012, more than 90% of women had MCM when they left obstetric care. APEO was adapted to record data for postpartum adolescents through monitoring and analyzing the MCM supply by age. This information allows the monitoring of puerperal adolescents at the local level[49]. New tools, databases and one FP clinical note facilitated the proper application of medical eligibility criteria when prescribing to ensure informed consent and voluntary MCM selection in puerperal women. Approximately 95% of users receive MCM according to medical eligibility criteria.

FIGURE 6: APEO IN HEALTH POSTS, SEPTEMBER 2003-FIRST HALF OF 2012



Source: HCI project report with MINSA data.

Strategy for Community-Based Distribution of Contraceptives (ECMAC)[50]: ECMC became a successful FP strategy. It was designed by MINSA with support from USAID and UNFPA

[45] USAID/Nicaragua. FPGS 2012, p. 42.

[46] MINSA. National Sexual and Reproductive Health Strategy (NSRHS) implemented: August 2008. Available at: http://www.iadb.org/WMSfiles/products/SM2015/Documents/website/MINSA_Nicaragua-Estrategia_nacional_salud_sexual_reproductiva.pdf

[47] USAID/Nicaragua. FPGS 2012, p. 43.

[48] DAIA Committee DAIA Evaluation Plan 2005-2008.

[49] USAID/HCI. Report systematization. Sept. 2012, p. 58.

[50] NicaSalud. FamiSalud. FamiSalud/USAID summary, April 2008-September 2013.

in 2003. Since 2006, it has been driven by USAID/FamiSalud, training 413 health care providers and 1,775 community counselors. It has provided direct benefits to approximately 80,000 people in 804 rural communities, which represent 30% of all communities in the 8 departments prioritized by USAID/Nicaragua: Madriz, Jinotega, Matagalpa, Nueva Segovia, Chontales, Rio San Juan, RAAN and RAAS. In 2013, ECMAC was adapted to reach the adolescents in response to the high fertility rate in this group, one of the highest in the region.

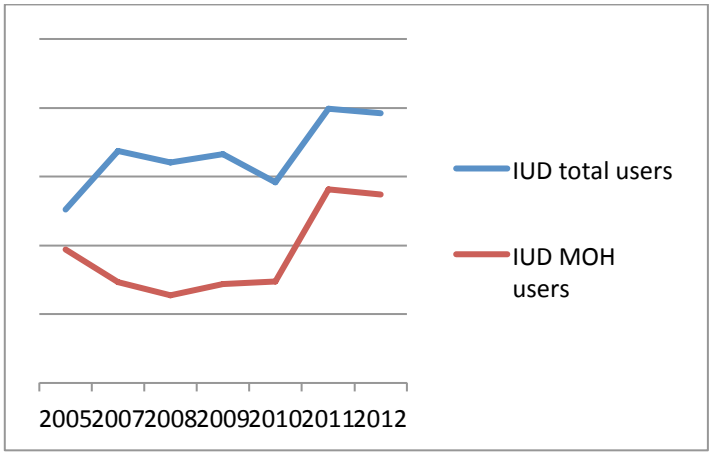
D) IMPROVING THE QUALITY AND COVERAGE OF SERVICES

The aim was to support MINSA and INSS in incorporating standards and procedures, including access to long-term permanent methods in all departments of the country, with emphasis on the poorest and most inaccessible places. The indicators of this component were updating and implementing national guidelines for FP and increasing the availability of long-term methods.

Updating and implementing national guidelines for FP: USAID/Nicaragua supported updating a series of technical rules, guidelines, standards and protocols for the different areas of service provision and training providers. This intervention was a cornerstone of CQI services. Processes such as "rapid improvement cycles" and "collaboration" were performed to share experiences and solve specific problems at the service level. In total, benefits were extended to 18 SILAIS, 20 hospitals, 66 health centers, 4 IPSS, 17 CMPs and 3 NGOs. Through the development of educational packages, standards, protocols and other FP tools were transferred to universities and health training schools to provide skill development opportunities for students and staff members from institutions providing health services[51]. Through an "educational package", a full-semester course was inserted in the curriculum of universities. Approximately 13,000 individuals studying for the pharmacy degree were trained and involved in providing FP services in various areas: rules, protocols, management, rapid cycles of improvement, counseling, logistics system, inventory control and supervision[52].

Increase the availability of long-term methods: Methods such as the IUD, which reached no more than 2% of postpartum women in 27 health posts, increased its use in APEO by three percentage points between 2009 and 2012[53].

FIGURE 7: TRENDS IN IUD USE AT THE NATIONAL LEVEL, MINSA NICARAGUA, 2005-2012



Source: USAID/Nicaragua with data from the DAIA Committee

[51] USAID/DELIVER Nicaragua. Annual Report 2013, p.8-12.

[52] USAID/HCI. Systematization final report. Nicaragua 2012. See Annexes: standards, protocols, guidelines and other tools, developed and implemented with the technical support of USAID.

[53] USAID/HCI. Systematization final report. Nicaragua 2012 p. 56.

In the public and private health services visited during this assessment, providers expressed their appreciation for the technical assistance they received and indicated that the technical support of USAID Nicaragua had been close and very effective.

E) INFORMATION FOR DECISION MAKING

The aim was to ensure that the implementation of ENDESA is a priority and that resources and capabilities are available for its implementation at the national level. The indicators were greater use of ENDESA 2006/7 for decision-making and the development of a plan for the new ENDESA 2011/12.

Greater use of ENDESA 2006/7 for decision-making: PRONICASS implemented specific actions to disseminate and use information from ENDESA 2006/7 at the national level. Additionally, funding was provided to UNDP to work with INIDE, PAHO and MINSA on decentralized dissemination procedures and the analysis and use of data for local analyses of the health situation. The DELIVER project developed two secondary studies on market segmentation and equality gaps from the ENDESA 2006/7 database; those studies served as inputs for the DAIA Committee. As already noted in the MTE report, ENDESA 2006/7 was widely disseminated to different audiences and its data were used for decision-making at different levels (central, SILAIS), allowing programs to focus on the most vulnerable populations. Examples of this usage are evident in both DAIA plans[54], in the evaluation of the first DAIA plan[55], in the design and adjustment of USAID/Nicaragua health projects and in the design of this same graduation strategy[56].

Development plan of the new ENDESA 2011/12: With its capacity installed and strengthened by previous support from the donor community, INIDE conducted the fieldwork for the ENDESA 2011/12 survey. This survey was financed with funds from a World Bank loan and received technical assistance from the UN system agencies. Preliminary results were published in 2013. USAID/Nicaragua held several meetings with INIDE and the Donors Roundtable, providing support for the preparation and/or dissemination of the new ENDESA, which was not detailed because of delays in the survey's start date.

[54] DAIA 2005-2008, 2009-2011 and 2012-2014 Plans.

[55] DAIA Committee Evaluation of the DAIA 2005-2008 Plan.

[56] USAID/Nicaragua. Graduation Strategy for Family Planning 2012, p. 53.

PHOTO: USAID NICARAGUA

Kangaroo Mothers at Bertha Calderon Hospital in Managua..

PHOTO: USAID/FAMISALUD.

Promotion of educational materials PROCOSAN. Photo: USAID/FamiSalud.

4.3 MATERNAL AND CHILD HEALTH RESULTS

The Strategy of MCH was part of strategic objective # 3 in the CAM Strategy, which was related to the investment in a better-educated and healthier population. That objective was also designed to improve child and reproductive health care management. The activities supported public and private efforts to achieve a healthier population with greater capacity to contribute to and share the benefits of a growing economy. Since 2008, USAID has incorporated the MTE recommendations into its maternal and child health program.

The global reduction of USAID cooperation resources, coupled with the significant improvement in health indicators, entailed the start of MCH's graduation process; therefore, in 2010, the Graduation Strategy for Maternal and Child Health (MCHGS) was designed with support from USAID Washington and coordinated with MINSA and donors for future implementation.

Between January 2011 and September 2013, MCHGS formally began with direct coordination with the DGECA at MINSA.

MCHGS was based on an integrated programs approach to assist women and children during prepregnancy, pregnancy, delivery and early childhood cycle. Technical areas include preparation for childbirth, safe delivery, prevention of postpartum hemorrhage, treatment of complications, postpartum and newborn care, family planning and maternal health among adolescents.

MCHGS had three components: the strengthening of health systems (health human resources, logistics and quality improvement); mobilization and community practices; and research and the use of evidence in health management. In total, MCHGS had 14 indicators, of which 13 were fulfilled and 1 was met only partially, for 92.8% overall performance. Table 18 shows the indicators for each component and the summarized fulfillment evidence.

TABLE 18: FULFILLMENT OF MCHGS

Objectives	Fulfillment level	Evidence
I. Strengthening the health system		
Inclusion of MCH content, and logistics in continuing education by MINSA and undergraduate education	Fulfilled	MCH content and logistics were included in continuing education from MINSA and in undergraduate education[57].
EP designed, validated, implemented and in use	Fulfilled	The CQI educational package/kit and logistics were instituted at 18 SILAIS, 8 universities and CMPs.
DAIA plan implemented and Evaluated	Fulfilled	DAIA with work plans was approved by MINSA and was evaluated; it has since been subsumed by DAISSR[58].
PASIGLIM installed and functional across the country	Fulfilled	PASIGLIM has been institutionalized and operates in all SILAIS[59].
Institutionalized tracer supplies monitoring	Fulfilled	Technical manual and procedures manual for Committees for Rational Use of Medical Supplies (CURIM) were developed and placed in public and private hospitals.
Improvement of quality established	Fulfilled	CQI in MCH, established in hospital obstetric and neonatal services[60].
Recommendations of operations research in implementation	Fulfilled	CQI: 11 studies were conducted in MCH.
Transfer of successfully completed Experiences	Fulfilled	The CQI package was developed and health management was strengthened, as were the activities of DAIA and PASIGLIM. 127 FamiSalud communities graduated.
2. Mobilization and community practices		

[57] USAID/DELIVER Educational package.

[58] DAIA PLAN 2012-2014.

[59] Ministry of Health. PASIGLIM annual reports.

[60] USAID/HCI. Systematization report of CQI in MCH established in hospital obstetric and neonatal services.

Objectives	Fulfillment level	Evidence
Adapting the ECMAC Manual, developed and in use	Fulfilled	Manual of community health volunteers developed, validated and adopted[61].
Update of the three community strategies: ECMAC, Delivery Plan and PROCOSAN	Fulfilled	Three updated strategies[62].
Increased coverage of community strategies in intervention areas of FamiSalud and Alianzas.	Fulfilled	FamiSalud and Alianzas increased coverage of community strategies benefiting more than 300,000 rural population per year[63].
Systematization and transfer to MINSA of the experiences of the community health program	Fulfilled	Manual of key interventions transferred to MINSA. 127 graduate communities were created. FamiSalud support was achieved[63].
3. Research and use of evidence in management (ENDESA)		
Use of evidence in management (ENDESA)	Not Fulfilled	Activity rescheduled for 2013-14 due to a delay in publication of preliminary data from ENDESA. Final data have not yet been published.

Table 19 shows the fulfillment of MCH indicators that the implementers agreed to in their contracts, with the exception of postpartum visits, which are related to the increased use of maternity houses by postpartum women in the communities that benefited from FamiSalud.

TABLE 19: FULFILLMENT OF AGREED-UPON INDICATORS FOR PROJECTS IN THE AREA OF MCH

Indicators	Target 2010-2013	Fulfilled 2010-2013	% Fulfillment
Number of disinfected liters of water (FamiSalud)	107,903,856	137,049,238	127.01
Prevalence (%) of exclusive breastfeeding in beneficiary communities (FamiSalud)	35	56	160.00
Number of CPNs by supported providers (HCI, Alianzas, San Lucas Foundation)	178,687	177,401	99.28
Number of children treated for Acute Diarrhea Disease (ADD) (HCI, FamiSalud, Alianzas)	26,842	22,286	83.03
Number of children with pneumonia treated with antibiotics by CHW (HCI and Alianzas)	16,997	21,938	129.07
Number of births attended by skilled personnel (HCI)	107,070	100,747	94.09
Number of medical and paramedical staff trained in evidence-based clinical guidelines (HCI FamiSalud Alianzas)	1,677	4,456	265.71
Number of NB infections treated with AB (HCI, Alianzas)	3,665	3,048	83.17
Number of NB receiving EONC (HCI)	110,471	99,098	89.70
Number of people trained in maternal and newborn health (HCI FamiSalud, DELIVER, Alianzas)	6,316	9,357	148.15
Number of postpartum visits (FamiSalud, Alianzas, San Lucas Foundation)	21,480	13,700	63.78
Number of people trained in child health and nutrition (FamiSalud, DELIVER, Alianzas)	6,266	11,287	180.13
Number of children benefiting from nutrition programs (FamiSalud and Alianzas)	31,530	29,012	92.01

Note: Information in parentheses indicates the projects that contributed to the fulfillment of each indicator. For projects that provided technical assistance to improve the quality of health services but were not direct service providers the numerical target indicates the services provided by the health posts that received direct technical assistance.

The following describes in detail the implementation of each of the 3 components of the strategy.

[61] USAID/FamiSalud. Community health volunteer manual developed, validated and adopted.

[62] NicaSalud/FamiSalud. FamiSalud/USAID summary. April 2006 - September 2013.

4.3.1 STRENGTHENING THE HEALTH SYSTEM

This component aimed at providing training to strengthen service delivery by MINSA, NGOs and INSS (IPSSs, CMPs) and undergraduate training in schools of medicine, pharmacy and nursing. To this end, work focused on strategies to improve human resources, logistics and quality, areas that contribute to the strategic lines of MINSA No. 3 and No. 6, which relate to the accelerated training of professionals, technicians and assistants and the systematic development of managerial capabilities and leadership in MINSA.

A) INCLUSION OF MCH CONTENT AND CONTINUING EDUCATION LOGISTICS BY MINSA AND IN UNDERGRADUATE EDUCATION[63]

This component was implemented by the PRONICASS, HCI, DELIVER, FamiSalud and Alianzas projects. Training to improve performance in health human resources was one of the most significant efforts in this component. Between 2008 and 2012, training was provided to more than 7,200 health professionals on such topics as EOC, hospital pediatric care, integration of FP and HIV counseling, APEO, VSC and EONC using novel instructional methodologies based on Problem-Based Learning and the development of "collaboratives" as a forum for sharing experiences.

TABLE 20: EVIDENCE OF THE STRENGTHENING OF HHR: HEALTH PERSONNEL TRAINING, 2003-2013

Collaborative and workshops	People trained
EOC	3,511
Pediatric care hospital	2,340
EONC	1,274
Workshops in MCH	6,338
EP on MCH-HCI	8 universities
EP on logistics-DELIVER	7 universities, 48 teachers, 498 pharmacy students
EP on community health-FamiSalud	In progress

B) EDUCATIONAL PACKAGES (EP) DESIGNED, VALIDATED AND IMPLEMENTED

These indicators were met through transfer to universities and health training schools. Undergraduate training was conducted in hospitals and training schools via the delivery of methodologies that integrated teaching, educational packages and kits with a selection of over 200 subjects (FP, HIV and MCH) and approximately 25 subjects on logistics management and the rational use of medicines and supplies. The EP and kit based on MINSA's regulations, protocols and standards reached 18 SILAIS and 8 universities: UNAN/Managua and Polytechnic Institute of Health (POLISAL), UNAN/León, BICU, URACCAN, UPOLI, UAM and the UCAN.

College and continuing education teachers were trained on and are using the EP and kit to strengthen the teaching-learning process so that students who are graduating from universities have a greater mastery of MINSA's regulations. Additionally, checklists were provided for to assess undergraduate and graduate student learning.

The curricula of several universities was also updated to include MCH subjects and the concept FP and HIV as transversal. Additionally, it was possible to refocus the content of the Intercultural Medicine degree curriculum according to the skills proposed in the educational package.

[63] USAID/HCI. Systematization Report 2013, Table 20.

The transfer to hospitals and continuing education in MINSA allowed the inclusion of MCH content and logistics in MINSA and undergraduate education. That transfer has provided health staff with national care protocols[64] for obstetric complications, standards and indicators.

Additionally, the methodological tools of MINSA community strategies were transferred through FamiSalud, allowing this knowledge to be used by future health professionals.

During the evaluation period, 4,456 health human resources, medical, paramedical and community personnel were trained through various projects.

C) DAIA PLAN IMPLEMENTED AND EVALUATED

The DAIA Plans for 2005-2008, 2009-2011 and 2012-2014 ensured the availability of FP methods, further improving indicators for fertility and MCM coverage and use and reducing maternal and perinatal mortality[65].

One of the biggest successes of supporting the DAIA Committee has been its evolution over the past two years into the DAISSR Committee[66], which expanded its approach from MCM availability towards the availability of supplies necessary for overall health, especially including supplies needed for MCH.

In 2013, through the DELIVER Project, USAID supported the fulfillment of 51% of the DAISSR Plan. Fifty of the 55 tasks assigned to the Plan were addressed, representing 90% of the agreed-upon tasks[67].

D) PASIGLIM INSTALLED AND FUNCTIONAL ACROSS THE COUNTRY

The accomplishment of this indicator has been a key aspect for strengthening MINSA's management capacity. PASIGLIM has become an efficient and sustainable logistics system for which the technical cooperation of USAID, along with help from other key donors, has been an essential factor. Currently, PASIGLIM is institutionalized and functional in 18 SILAIS in the country[68].

E) MECHANISM FOR MONITORING TRACER SUPPLIES

Through the creation of the Committees for Rational Use of Medical Supplies (CURIM) and monitoring tracer supplies, the rational use of medicines was improved. To achieve this goal, the technical standard of rational use and procedure manual and the design and application of a working guide were implemented, and teams were trained at SILAIS, municipalities, hospitals and health centers when CURIM was formed. It was possible to extend this experience to 8 private clinics affiliated with the INSS. The manual was also included in the EP. Logistics management processes were also strengthened for the rational use of medicines in 18 SILAIS and 8 medical companies belonging to the INSS.

F) QUALITY IMPROVEMENT (CQI)[69]

USAID/HCI focused on CQI use via collaborative approaches and assistance using evidence-based interventions that contributed to the strategic line of Health National Plan (HNP) No. 4. Capabilities were developed for human resources and in the CQI processes of MCH, including the

[64] USAID/HCI. Systematization final report.

[65] INIDE. ENDESA 2012. Preliminary data.

[66] DAIA PLAN 2012-2014.

[67] USAID/DELIVER Annual Report 2013, p.15.

[68] USAID/Nicaragua. FPGS 2012, p.35 and 36.

[69] USAID/HCI. Systematization final report. 2013.

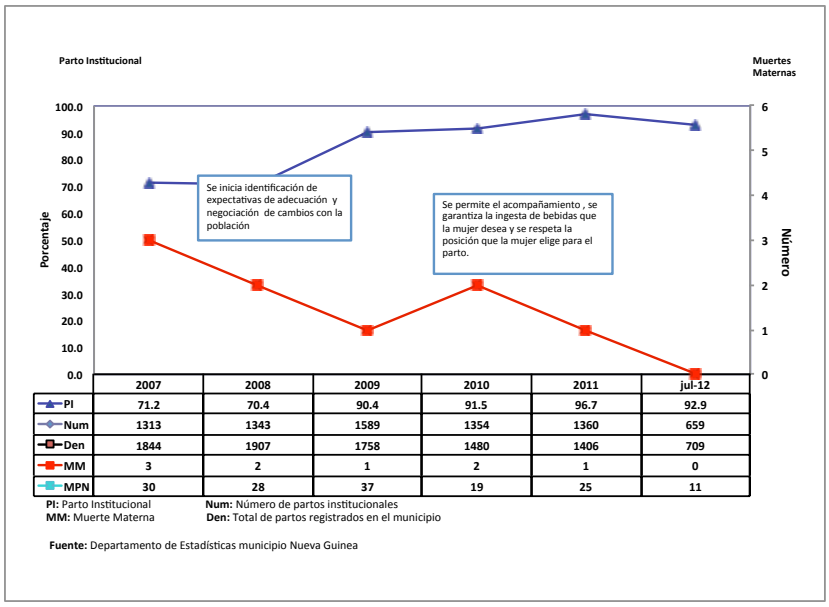
design and dissemination of regulations; national guidelines and care protocols; standards and indicators for monitoring compliance with protocols and quality of care; the design of educational tools such as tapes, flowcharts, algorithms and information materials for the population.

During this period, 12 regulations and protocols, 8 clinical guidelines, 11 educational materials and 8 technical tools were developed and printed. These materials were issued by MINSA with assistance from the HCI project. USAID/HCI also collaborated to issue innovative MCH strategies based on scientific evidence. Those strategies included the following:

Active Management of the Third Stage of Labor (MATEP): Since 2003, HCI has supported MINSA in the implementation of standards and quality indicators in delivery care to prevent Postpartum Hemorrhage (PPH). In 2008, it supported staff updating and training in the specific MINSA standard, including the four steps of MATEP. The two processes (MATEP and immediate postpartum surveillance) reached a fulfillment of 90%-95%. Between 2009 and 2011, the increase in MATEP fulfillment in 12 hospitals was clear, reducing PPH by 30%.

Humanization and Cultural Adaptation of Delivery Care (HACAP): HACAP is a successful intervention that began in 2006 with 22 health posts in 9 SILAIS and was institutionalized at the national level in 2010. USAID and UNICEF supported its national adoption.

FIGURE 8: HACAP IN NUEVA GUINEA 2007-2012



	2007	2008	2009	2010	2011	jul-12
PI	71.2	70.4	90.4	91.5	96.7	92.9
Num	1313	1343	1589	1354	1360	659
Den	1844	1907	1758	1480	1406	709
MM	3	2	1	2	1	0
MPN	30	28	37	19	25	11

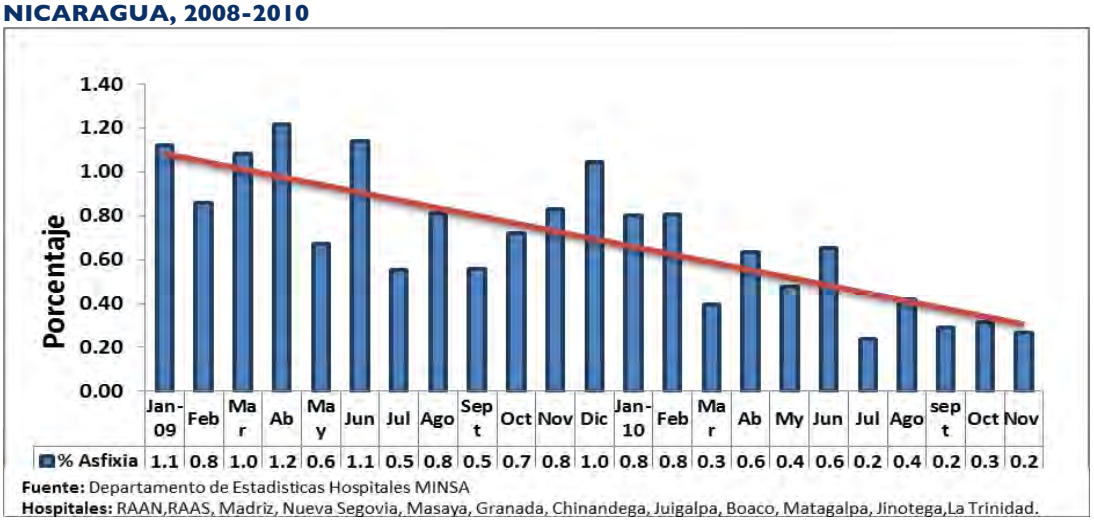
PI: Parto Institucional **Num:** Número de partos institucionales
MM: Muerte Materna **Den:** Total de partos registrados en el municipio

Fuente: Departamento de Estadísticas municipio Nueva Guinea

Helping Babies Breathe (HBB) strategy: Since 2009, HCI emphasized technical assistance to MINSA with integrated neonatal health interventions, including training in rapid assessment, neonatal resuscitation and the identification of risk factors for sepsis and asphyxia and use of diagnostic algorithms to implement clinical and laboratory criteria for monitoring sepsis. The achievements are reducing the percentage of asphyxia at birth by 44% in 2009-2011 (0.68 to 0.38) and decreasing the incidence of neonatal sepsis by 88%, using diagnostic algorithms to apply clinical and laboratory criteria for monitoring sepsis in emergency, and labor and delivery rooms[70].

[70] USAID/HCI Nicaragua. Systematization final report. Sept. 2013, p. 36.

FIGURE 9: REDUCTION OF SEVERE BIRTH ASPHYXIA IN 12 HOSPITALS IN NICARAGUA, 2008-2010



Source: Department of Hospital Statistics MINSA:

Institutionalization of Kangaroo Mother Care: Since 2010, HCI has supported MINSA in implementing CQI at Bertha Calderon Hospital, training health personnel in the organization of the neonatology department and in the design, dissemination and implementation of the treatment protocol, follow-up cards, weight gain curves, growth curves, head circumference, parent education manual, materials and equipment. The results are evident: hospital stay in preterm babies was reduced (4.6 days), the use of exclusive breastfeeding increased (0 to 71%), adequate weight gains were made (18 and 20 g per kg of weight), integrated approach (psychology, ophthalmology and audiology) and follow-up until one year of life were implemented and hospital costs decreased (by not using the incubator, decreasing antibiotic use and reducing the need to buy infant formula).

Other new programs that were successfully supported by USAID Nicaragua with regard to CQI processes are the use of antiseptic and disinfectant solutions, EONC Collaboratives, the initiative of breastfeeding through the Baby and Mother Friendly Hospitals (BMFH), and correct partogram use by the medical and nursing staff, which increased indicator fulfillment from 5% to 80%, strengthening teamwork and constant monitoring.

G) OPERATIONAL RESEARCH IN IMPLEMENTATION[71]

Between 2008 and 2012, HCI supported the development of 11 studies in MCH, a study on HIV/AIDS, a study in the area of FP and 9 studies on general CQI subjects.

HCI/USAID conducted a series of systematic studies and systematization documents on specific topics that have served in providing CQI for MCH care, HIV/AIDS and FP.

H) COMPLETED TRANSFER OF SUCCESSFUL STRATEGIES[72]

The purpose of this process was to contribute to the sustainability of USAID cooperation activities through its HCI, DELIVER and FamiSalud projects, providing continuing education via MINSA and medical and nursing degrees in colleges and health training schools with the content and experiences gained through USAID cooperation. This information was mainly through two channels: training and the inclusion of content and methodologies in EP and Kits and in the curriculum of related subjects.

[71] USAID/HCI. Systematization final report. Sept. 2013, Table 20, p. 74.

[72] USAID/HCI. Systematization final report. Sept. 2013, p. 14.

For universities, students in the related degree programs were prepared to enter the health care system and provide the health care that the Nicaraguan population requires. The USAID/HCI project was transferred successfully to the 8 planned universities, and EP was included in curriculum documents, which also guaranteed that an appropriate training approach would be used.

It was evident that at the end of their health program's training, graduating students had learned about the subjects and methodologies raised in the EP.

Specific achievements of this indicator are:

- Efforts refocused the curriculum content of the Intercultural Medicine degree according to skills proposed in the educational package.
- The EP was used to unify the approach to the subjects and skill development during teaching.
- The POLISAL Department of Nursing extended the use of EP in MINSA subsites and nursing schools that use their curriculum.
- Learning assessment methodology was strengthened with the use of checklists and anatomical models and by assigning an additional a day to address life-saving practices in the newborn.
- The management and presentation of maternal health subjects for undergraduates was strengthen and standardized.
- Checklists for undergraduate and graduate student learning assessment were implemented.
- Pharmacy degree students at the School of Science and Engineering of the pharmacy degree students were offered access to a new hospital pharmacy program that addressed rational drug use, among other subjects.

A systematization document was developed for the transfer of the community pharmacy educational aspect of the pharmacy degree program at UNAN Managua.

4.3.2 MOBILIZATION AND COMMUNITY PRACTICES[73]

The USAID Health Program worked on strengthening community strategies to improve coverage of SRH and MCH services to rural, indigenous and very poor areas. It supplemented MINSA in the development of an evidence-based strategy to reduce neonatal mortality at the national level, and it promoted the launch of community health services for 1,568 remote communities, in 78 municipalities and 12 departments, benefiting more than 300,000 people annually. The main project implementer was FamiSalud (2006-2013). The program also contributed to the Alianzas 2 project, encouraging public-private partnerships, and to the Juan XXIII Institute to promote the Healthy Communities (COMSALUD) project, through which it trained doctors on the use of evidence-based clinical guidelines on such subjects as pneumonia, cough, labored breathing, diarrhea, weight monitoring, growth and development and the feeding of children with diarrhea and dysentery, all of which contribute to improving the health care provided by project beneficiaries.

Specific indicators of this component are: comprehensive manual developed and in use, updating of the 3 community strategies (Delivery Plan, ECMAC and PROCOSAN), increased coverage of community strategies in intervention areas of FamiSalud, systematization and transfer to MINSA of experiences of the community program.

[73] NicaSalud Network Federation. Annual Reports of the FamiSalud Project.

A) COMPREHENSIVE MANUAL DEVELOPED AND IN USE

This component was performed by USAID/FamiSalud in conjunction with MINSA and PAHO to develop manuals and educational materials of the strategy of IMCI-C, with reference to the IMCI strategy given by WHO and UNICEF in 1992, in which FP, maternal health and nutrition (pregnancy, childbirth and postpartum), child and newborn health, water and sanitation and personal hygiene were integrated, among others. The purpose of this manual is that health personnel, technical field teams and the community network would have available training and educational materials that would enable a comprehensive approach at the community level. This manual was approved by MINSA and used in communities where PROCOSAN was not implemented; therefore, it was not necessary to develop a new comprehensive manual. Flipcharts are available as supporting material that the community network uses to provide information and to counsel families in each community.

B) UPDATE OF THE DELIVERY PLAN, ECMAC AND PROCOSAN COMMUNITY STRATEGIES[74]

Through the FamiSalud project, the implementation of the following community strategies was supported: ECMAC, Delivery Plan and Obstetric and Neonatal Care, PROCOSAN and IMCI-C for child health.

Delivery Plan: This strategy focused on guiding the organization, early care and monitoring of delivery to improve the health of pregnant women and reduce household MM. Conceptually, it is based on the MOSAFC and Safe Motherhood, Three Delays and Community Organization and Participation strategies. It is a community strategy in which the woman, her partner and her family prepare for pregnancy, childbirth, and postpartum and newborn care with the support of health workers, civil society and organized community.

Between 2011 and 2013, the community network, in coordination with MINSA helped 29,126 pregnant women manage their delivery plans and receive referrals to the health center for prenatal care. The Delivery Plan strategy was active in 1,099 communities, where 1,548 MINSA resources and 6,393 community volunteers had been trained.

PROCOSAN: This strategy aims to promote growth and good nutrition for children under 2 years of age, prevent and manage diseases that are prevalent in children under 5 years of age and improve the nutritional status of pregnant women. USAID/FamiSalud contributed to the strategy's implementation in 1,312 rural communities of 38 municipalities in 15 departments, serving approximately 100,000 children under 2 years of age and their mothers.

A training evaluation of the PROCOSAN strategy and a discussion of its results led to an operational, methodological and normative proposed adjustment in July 2012 to enhance its effectiveness at all levels and in all sectors involved, such as MINSA, NGOs, the community and international cooperation.

ECMAC: Started in 2003 and institutionalized in 2007, ECMAC was designed to improve access to FP services for women and men in remote and inaccessible communities. With its implementation, access to MCM was improved; the number of WRAs using a MCM was increased; coverage was provided to all inaccessible communities within the area of certain health centers and units; MM was decreased; pregnancies were spaced; access to information about proper MCM use by women and men improved; and community participation was achieved by male and female volunteers and birth attendants.

[74] FamiSalud. Evaluation of the Delivery Plan Community Strategy. Preliminary Results, November 2011.

C) INCREASED COVERAGE OF COMMUNITY STRATEGIES IN INTERVENTION AREAS OF FAMISALUD[75,76]

Community strategies were performed in the first period (2006-2009) with PROCOSAN, Delivery Plan, ECMAC, STI-HIV counseling, implemented in 12 departments (León, Chinandega, Estelí, Boaco, Madriz, Nueva Segovia, Matagalpa, Jinotega, Chontales, Rio San Juan, RAAN, RAAS) covering 69 municipalities and 1,372 communities. For the second and third period (2009-2013), 8 departments, 38 municipalities and 804 communities, with health indicators further away from the national average were prioritized. IMCI-C and Community Case Management were added.

Other community strategies that contributed to the maternal and child health program are:

EONC-C: Overall, 17,680 postpartum women were referred to the health care unit after delivery (postpartum) and 1,149 infants received essential care from the birth attendant during home deliveries. The EONC-C strategy is implemented in 622 communities, 226 MINSA resources and 786 trained birth attendants. The implementation of this intervention corresponding to the last 6 years has resulted in community volunteers performing postpartum home visits to 15,762 infants in the first 3 days of life.

IMCI-C: It trained 1556 health workers and 7,162 community volunteers. Its main achievements were the management of 16,202 ADDs in children under 5 years of age with diarrhea receiving oral rehydration solution, like the management of Acute Respiratory Disease (ARDs) in 7,307 children under 5 years of age with acute respiratory infections (ARI) who were referred to the health post for treatment and 22,522 children under 2 years of age who were seen in weighing sessions.

TABLE 21: COVERAGE OF COMMUNITY STRATEGIES IN INTERVENTION AREAS OF FAMISALUD AND HEALTH PERSONNEL TRAINING

STRATEGY	Communities served	Trained health personnel	Trained volunteers
By topic			
ECMAC/FP	804	1,054	2,925
Delivery Plan	1,099	1,548	6,393
PROCOSAN	1,312	1,127	5,160
EONC-C (birth attendants)	622	226	786
Safe Water		581	5,258
IMCI-C	223	429	1,552
MCM		4	34
Health coloring			896
By type of personnel			
Community network: volunteers, counselors and promoters			6,393
Health personnel			1,548
School teachers			896
Staff of maternity homes			147
Technical staff of NGOs			147
Total			9,131

Source: FamiSalud, Final Reports 2013.

Public Private Partnerships: Through USAID/PASCA, a commitment was achieved with the business elite of the Superior Council of Private Enterprise (COSEP). The indicators from Alianzas 2 show that the program contributed at a ratio of 4:1 for every dollar provided by the USG,

[75] NicaSalud Nicaragua Network Federation. NicaSalud summary. 2006-2013 December 2013.

[76] NicaSalud Network Federation FamiSalud Annual Reports.

generating US$4.2 million from USAID Nicaragua's contribution of US $1,273,000 (health and HIV/AIDS funding) and engaging a large group of Nicaraguan businessmen and foundations to support maternal and child health and HIV/AIDS activities.

Until September 2013, maternal and child health services were provided through Alianzas2 to 9,879 women of reproductive age and children under 5 years of age; 4,549 people were trained in health and nutrition practices; nutrition programs were implemented that benefitted 7,751 children under 5 years of age; and access to affordable medicines for 423,197 beneficiaries was facilitated.

Furthermore, to increase health coverage, USAID Nicaragua (through the RTI/Alianzas project) promoted public and private strategic partnerships that involved major private sector institutions (NGOs and corporate) and social sector domains (health and education) in a new 37-month agreement to improve access to services, MCH counseling and HIV/AIDS prevention.

D) SYSTEMATIZATION AND TRANSFER TO MINSA OF THE COMMUNITY PROGRAM'S EXPERIENCES

An EP was designed for university teachers from various health careers to teach the technical and methodological content of community strategies, including PROCOSAN, IMCI, ECMAC, Delivery Plan and MOSAFC-C, MASIRAAN and MASIRAAS. This content meshed with MINSA's regulations and protocols and was closely coordinated with the MINSA teaching area.

The team was able to confirm that the transfer was not fully achieved because of time constraints; however, universities providing the largest amount of health human resources were prioritized. A total of 138 university graduates participated in this process, thus reaching 90% of the target established in the implementation plan of Phase 3 of the project.

4.3.3 RESEARCH AND THE USE OF THE EVIDENCE IN MCH MANAGEMENT

The objective of this area was to increase the use of available evidence in the planning and in the evaluation of maternal and child programs. The indicator corresponds to the dissemination and use of ENDESA data, and PRONICASS and DELIVER are the main implementers. The main indicator for this area is the dissemination and use of data from ENDESA at the national level.

A) DISSEMINATION AND USE OF DATA FROM ENDESA AT THE NATIONAL LEVEL

USAID/DELIVER was responsible for implementing the dissemination and promoting the use of data from ENDESA 2011/12 at the national level and for performing a secondary analysis of data from MCH; however, this benchmark could not be achieved because the ENDESA database and the final data were not available. At the time of this evaluation, only preliminary data from ENDESA were ready, so these activities were rescheduled.

PHOTO: USAID|PREVENSIDA AÑO 2013.
MANAGUA, NICARAGUA

ABOVE: Marlene Rivas, director of ADESENI, and educators of the organization in a PrevenSida training workshop in grant management for institutional strengthening and HIV prevention in key populations.

PHOTO:: REDTRANS AÑO 2011.
MANAGUA, NICARAGUA

Silvia Martinez, director of REDTRANS, and leaders from REDTRANS and REDTRASEX receive recognition for their participation in the Central American Survey of Monitoring of the Sexual Behavior.

"With the PREVENSIDA grants, we acquired an accounting system that we worked without for over 19 years. This improved administrative and financial capacities of the staff, which helped allow reports to be scanned in a timely manner."
Campaña Costeña Contra el SIDA. Final report for 2013 grants

4.4 RESULTS ON HIV AND AIDS

USAID Nicaragua has been a leading donor in technical assistance for HIV since 1998 and has worked closely with the government, the private sector and local NGOs, especially in areas related to strengthening the health sector. Between 1998 and 2012, US$16,500,000 was spent on HIV prevention, accounting for 14.7% of the total health cooperation budget with Nicaragua.

The 2008 HIV/AIDS strategy of USAID Nicaragua included specific recommendations from the MTE for HIV; in 2010, recommendations from the Partnership Framework Strategy for HIV (2010-2014), funded by the President's Emergency Plan for AIDS Relief (PEPFAR) were added. The purpose of PEPFAR is to reduce HIV/AIDS's incidence and its prevalence in MARPs, joining resources and efforts for a strong and effective response to the epidemic in the region.

Under PEPFAR, the HIV cooperation program in Nicaragua is carried out through a bilateral PrevenSida project (2010-2016), 3 central HCI projects (2006-2013), DELIVER (2010-2015), ASSIST (2014-2016) and 1 regional project, Alianzas 2 (2011-2013). Additionally, the programs receive specific technical assistance from the regional projects of Capacity (2009), PASMO (2010-2015), PASCA (2010-2014), SCMS (2012) and AIDSTAR (2013).

Since 2012, USAID/PrevenSida has focused on the technical and methodological strengthening of local NGOs and on sexual diversity, through the transfer of skills to provide prevention services for MARPs and through interactive interpersonal methodologies that require a physical presence and aim at changing behavior. PrevenSida supports the strengthening of such programs' management and self-management capacities.

Since 2013, USAID has incorporated a virtual approach to MSM and PLHIV support groups through partnerships with two local NGOs in León and Managua, allowing them to have national coverage and linking them with other countries in the region.

Since October 2012, the HIV component of USAID/Nicaragua has been part of the USAID HIV Regional Program based in Guatemala, which has financial sustainability as part of USAID's Central America HIV policy[77].

PEPFAR cooperation for Central America focuses on four areas: prevention, strengthening of health systems, strategic information and policy environment[78].

TABLE 22: FULFILLMENT OF THE STRATEGY INDICATORS FOR HIV/AIDS IN NICARAGUA INCLUDED IN THE PEPFAR PARTNERSHIP FRAMEWORK IN CENTRAL AMERICA

Indicators	Fulfillment level	Evidence
1. Prevention		
Increase the number of MARPs reached with individual evidence-based interventions	Fulfilled	A combined prevention strategy was developed and implemented at the national level with NGOs. PrevenSida and Alianzas reached 144,309 MARPs between 2010 and 2013 (121% of the target).

[77] COMISCA. Sustainability Strategy of the advances in CA and Dominican Republic towards universal access to HIV-related prevention, care, treatment or support. Available at:

http://www.mcr-comisca.org/sites/default/files/files/MCR%202013%20Estrategia%20de%20Sostenibilidad%20en%20VIH%20Abril%2022.pdf

[78] Map of cooperation to support the implementation of the Regional Response to HIV/AIDS between the US Government and the governments of Belize, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama. March 2010. Accessed February 19, 2014 at: http://www.pepfar.gov/documents/organization/139196.pdf

Indicators	Fulfillment level	Evidence
Increase the number of MARPs with STIs who were diagnosed, treated and counseled in the past 12 months	Fulfilled	Counseling, referral and/or treatment to people with STIs was included in the combined prevention strategy. PrevenSida advised and referred 75,784 MARPs with STIs between 2011 and 2012.
Increase the number of MARPs who received an HIV test in the last 12 months and know their results	Fulfilled	Counseling and voluntary testing are offered as part of the combined prevention strategy. In 2010-2013, PrevenSida and HCI reached 189,267 people with tests (121% of the target).
2. Strengthening of Health Systems		
Increase the number of health facilities with the capability to perform HIV tests according to WHO guidelines	Fulfilled	HCI collaborated with 196 public health facilities to decentralize and improve the quality of test performance. PrevenSida collaborated with 15 NGOs that provide prevention services to MARPs to perform rapid HIV tests (115% of the target for the period)[79].
Increase the number of health workers and community workers who successfully complete a preservice and in-service training program	Fulfilled	HCI: 1,448 HR received in-service training (187% of the target); 2,118 received preservice training (105% of the target). DELIVER: 257 people received in-service training (68% of target); 156 received preservice training (156% of the target). PrevenSida: 1,955 HR staff received in-service training (155% of the target).
Reduce baseline ARV stock-outs	Fulfilled	DELIVER contributed to the inclusion of ART in PASIGLIM, thus strengthening storage capacities, including improving the cold chain and monitoring the data quality of PASIGLIM[80].
3. Strategic Information		
Create a national M&E Plan	Fulfilled	Indicator supported by PASCA[81]. PrevenSida Contribution[82]: Single record of MARPs shared with the Global Fund, Private Sector and PASMO HCI, DELIVER, PrevenSida contribute to the national M&E plan[83].
Increase the number of UNGASS indicators coming from the national information system	Fulfilled	Indicator supported by PASCA HCI[84], DELIVER, PrevenSida contribute to national reporting.
Collect national HIV prevalence data for MARPs in the last four years	Fulfilled	Indicator supported by MINSA and multiple agencies, CDC/UVG, GF, CEPRESI[85] PASMO Track Studies.
4. Political Environment		
Improve API policies	Fulfilled	Indicator supported by PASCA, demonstrating sustained index improvement of national policies[86].
Increase the number of GFATM projects evaluated as A1 and B1.	Fulfilled	All projects contributed to this indicator: PrevenSida to the single register system and institutional strengthening of sub-recipient NGOs; DELIVER to the strengthening of the national logistics plan (2012-2016) and improved logistics of subrecipient NGOs; PASMO to training subrecipient NGOs in CQI methodologies; and PASCA to strengthening

[79] USAID/Nicaragua. Performance Indicators 2010-2013.

[80] Notification of the GF project, M&E assessment of PEN, UNGASS reports.

[81] Nicaraguan AIDS Commission (CONISIDA). Monitoring and Evaluation Plan for STIs, HIV and AIDS 2011-2015. July 2012.

[82] PrevenSida website accessible at: http://www.prevensida.org.ni/

[83] PASCA website. Available at: http://www.pasca.org/node/71.

[84] HCI Nicaragua website. Available at: http://www.urc-chs.com/project?ProjectID=39

[85] Studies at: http://www.prevensida.org.ni/index.php?option=com_k2&view=itemlist&layout=category&Itemid=4&limitstart=25

[86] PASCA website at:

http://www.pasca.org/sites/default/files/HI7_%20API_NICARAGUA_2010.pdf

Indicators	Fulfillment level	Evidence
		CONISIDA, CCM and SR. This indicator reached the A2 level[87].
Increase the number of organizations receiving technical assistance for the development and implementation of HIV-related policies	Fulfilled	Training in this topic was provided. PrevenSida: 40 NGOs in 10 departments Partnerships: 7 companies: 70 trained counselors PASCA: COSEP and 33 trained companies, 13 of which developed HIV labor policies[88].

Source: see footnote for each entry.

The following table shows the excellent performance of the HIV/AIDS indicators to which the project implementers and their respective contracts agreed.

TABLE 23: FULFILLMENT OF AGREED-UPON HIV/AIDS INDICATORS FOR THE 2010-2013 PERIOD

Leading indicators	Target 2010-2013	Fulfilled 2010-2013	% Fulfillment
Number of individuals receiving VCT and receiving their results (HCI PrevenSida)	156,515	189,267	120.93
Men	49,899	47,982	96.16
Women	106,616	141,285	132.52
Number of people with HIV receiving a minimum package of preventive services (PrevenSida)	900	1,494	166.00
Number of MARPs reached with combined prevention (PrevenSida, Alianzas)	117,000	144,309	123.34
SW	9,500	12,500	131.58
IDU	0	71	
MSMs	34,000	33,076	97.28
Other vulnerable populations	73,500	97,903	133.20
Number of laboratories capable of performing perform clinical trials (HCI PrevenSida)	186	196	105.38
Number of new health workers who graduated from a preservice institution (HCI, DELIVER)	2,100	2,274	108.29
Number of community workers who completed a pre-service training program (PrevenSida)	200	189	94.50
Number of health workers who received in-service training (HCI, DELIVER, PrevenSida, Alianzas)	2,513	3,787	150.70
Number of NGOs strengthened with technical assistance (PrevenSida)	20	44	220.00

Source: M&E database, USAID/Nicaragua.

4.4.1 PREVENTION

This component addresses the insufficient coverage of primary and secondary prevention in key populations, with the goal of increasing healthy behaviors to reduce transmission. The main project implementers of this component are PrevenSida and PRPC-PASMO.

The main indicators of this component are increasing the number of MARPs reached with individual evidence-based interventions, increasing the number of MARPs with STIs who were diagnosed, treated and counseled in the past 12 months and increasing the number of MARPs who received an HIV test in the last 12 months and know the results.

The main technical approach is a combined prevention strategy, which integrates a package of basic preventive services such as counseling for behavior change; the provision of condoms and lubricants; counseling and voluntary HIV testing; counseling and/or referral to other complementary services, such as STI treatment, FP and other health services; addiction control; and structural activities, such as addressing GBV, stigma and discrimination, education and income generation.

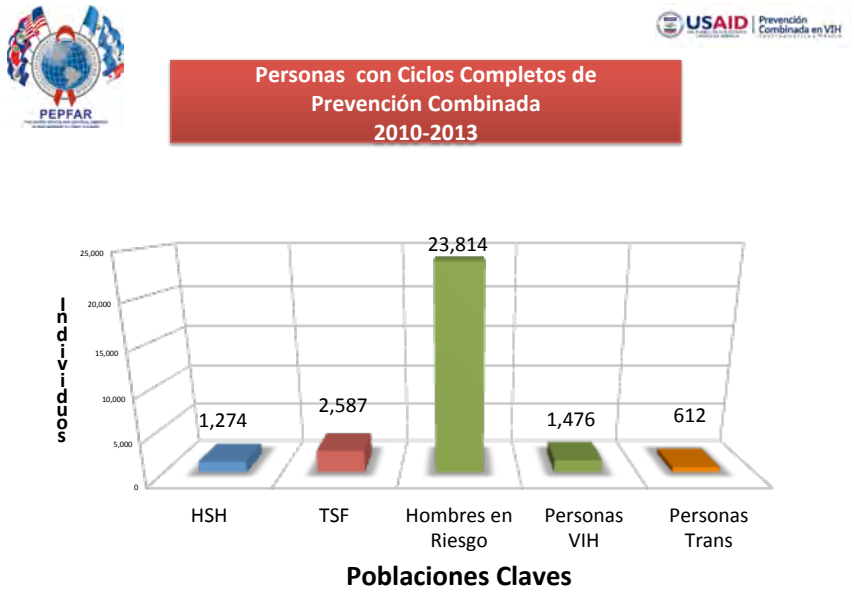
[87] GF website: http://portfolio.theglobalfund.org/en/Country/Index/NIC

[88] PASCA website M&E report. http://www.pasca.org/node/13

A) INCREASE OF THE NUMBER OF MARPS REACHED WITH INDIVIDUAL EVIDENCE-BASED INTERVENTIONS[89,90]

Between 2008 and 2010, HIV prevention activities were carried out by the PCR Project and implemented by PASMO, continuing the activities initiated in 2002. Figure 10 shows the contribution of this prevention coverage project to MSM and other populations. Since 2000, the regional HIV program implemented by PASMO has conducted supplemental activities focused on MARPs. Since October 2012, the PCR actions have focused on strengthening the capacities of NGOs involved in the national response to implement tools and methodologies for successful behavior change, in close coordination with PrevenSida and the Global Fund.

Figure 10: People with completed cycle of combined prevention 2010-2013



Source: PSI/PASMO data.

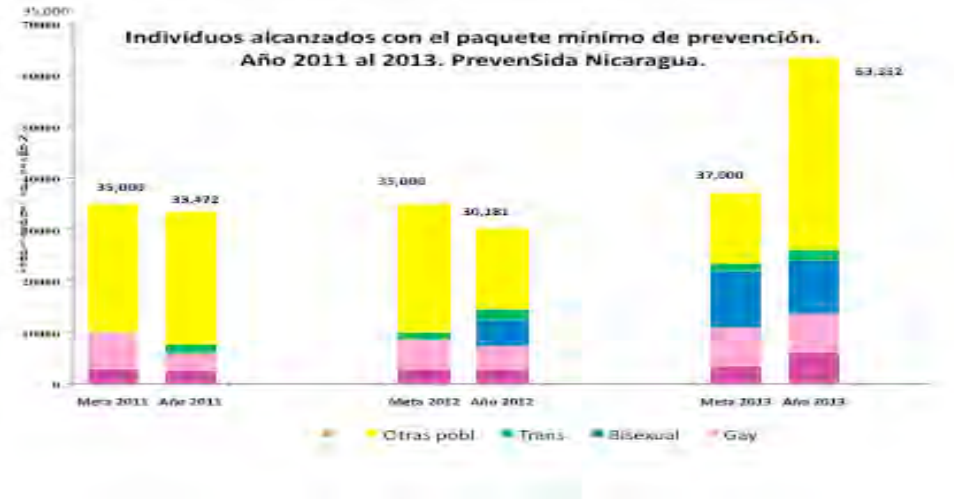
Since 2010, preventive actions have been driven through the new PrevenSida project, which developed an innovative and cost-effective approach to increase the coverage of prevention services for key populations, thus strengthening the institutional capacities of a network of NGOs. This has allowed access to quality services for combined prevention, information to reduce stigmas toward and discrimination against HIV and sexual diversity, and the development of managerial skills. During the 2010-2013 period, a total of 144,309 MARPs (target: 117,000 people for 123.34% fulfillment) benefited directly through this project with a package of combined prevention, including 27,382 rapid tests. A package of secondary prevention services was also provided to 1,494 people with HIV (target: 900 people for 166% fulfillment.)

Figure 11 shows the individuals reached during this period by type of population, highlighting the increased coverage in key populations, such as transgender, gay and bisexual people.

[89] USAID/Nicaragua Performance Indicators 2010-2013.

[90] USAID/PrevenSida. Annual Report 2012.

FIGURE 11: INDIVIDUALS REACHED WITH A MINIMUM PREVENTION PACKAGE VS. TARGETS FOR 2011-2013



Source: PrevenSida.

B) INCREASE OF THE NUMBER OF MARPS WITH STI´S WHO WERE DIAGNOSED, TREATED AND COUNSELED IN THE PAST 12 MONTHS

As of 2011, the single-register system of PrevenSida has allowed this indicator to be recorded, disaggregated and analyzed. Table 24 shows the high prevalence of people with STIs in populations receiving prevention services (83% in 2012 and 80.3% in 2013) and the duplication of services provided to these populations from year to year, including the greater percentage receiving treatment.

TABLE 24: COMBINED PREVENTION SERVICES IN POPULATIONS WITH STIS

Indicator	**FY12 (Oct 11 to September 12) N=30,181**		**FY13 (October 12 to September 13) N = 63,352**	
	Counseling	Counseling and treatment	Counseling	Counseling and treatment
% of individuals who received counseling on STIs out of the total attended	82.9	0.06	80.11	0.26
Number of (individual) MARPs who received counseling on STIs in the past 12 months	25,032	18	50,752	164
Gay	4,508	3	5,861	42
Bisexual	3,796	11	9,027	55
Transgender	1,749	1	1,514	7
Sexual Worker (SW)	2,457	1	4,073	19
Intravenous Drug User (IDU)	36	0	27	0
MARPs subtotal	12,546	16	20,502	123
Other vulnerable populations	12,486	2	30,250	41

Source: automated single register of MARP and HIVP.

C) INCREASE OF THE NUMBER OF MARPS WHO RECEIVED AN HIV TEST IN THE LAST 12 MONTHS AND KNOW THEIR RESULTS

Between 2008 and 2012, the HCI project supported the Ministry of Health to improve the quality and VCT coverage for the general population attending public health services, including people with STIs.

Between 2008 and 2010, PPR-PASMO provided VCT services to key populations.

Since 2011, the PrevenSida project has had an annual target of 10,000 MARPs and performing 28,236 tests, thus reaching 94% of the period target. Of the patients who were tested, 100% know the results. Through this activity, 99 reactors have been identified, especially in key populations; these have been referred to the MINSA for confirmation, and approximately 95% of cases have been confirmed.

TABLE 25: MARPS WHO RECEIVED HIV COUNSELING AND VOLUNTARY TESTING THROUGH PREVENSIDA IN 2011-2013

Indicator	FY11 (October 10 to September 11)		FY12 (Oct 11 to September 12)		FY13 (October 12 to September 13)	
	Target	Fulfilled	Target	Fulfilled	Target	Fulfilled
Number of MARPs who received an HIV test in the last 12 months and know their results	10,000	9,255 (92.55%)	10,000	6,472 (64.72%)	10,000	12,509 (125%)
Number of reactors (% reactors)	30 (0.3)	17 (0.2)	30 (0.3)	28 (0.4)	30 (0.3)	54 (0.4)
Population type						
Gay	1,780	1,497	1,780	481	1,780	1,554
Bisexual	-	-	-	329	2,170	2,377
Transgender	1,220	140	1,220	218	1,220	281
SW	500	172	500	759	500	1,654
IDU	0	-	0	4	0	5
Subtotal MARPs	3,500	1,809	3,500	1,791	5,670	5,871
Other MARPs	6,500	7,446	6,500	4,681	4,330	6,638

Source: Single register system of MARPs and PVVIH

4.4.2 STRENGTHENING OF THE HEALTH SYSTEM

This component addresses the problem of foreign aid dependency, institutional weaknesses and stock-outs of antiretroviral drugs and rapid tests, aiming to strengthen in-service delivery capacities; improve health human resources training and provide essential medical products in the public, private and NGO sectors.

The main implementer projects are HCI, DELIVER and PrevenSida. HCI and DELIVER mainly strengthened the capacities of the MINSA and universities, and PrevenSida strengthened over 40 NGOs working with MARPs in 10 departments, training more than 200 individuals in management and administration and granting 41 subsidies of approximately US$1 million in the 2011-2013 period.

The performance indicators of this component are increasing the number of health facilities able to perform HIV testing according to WHO guidelines; increasing the number of health workers and community workers who successfully complete an in-service and pre-service training program; and reducing baseline ARV stock-outs.

A) INCREASE THE NUMBER OF HEALTH FACILITIES ABLE TO PERFORM HIV TESTS ACCORDING TO WHO GUIDELINES[91,92]

HCI contributed to the supply and implementation of rapid HIV testing in 17 SILAIS (between hospitals and health centers in the country), supporting the decentralization of the rapid test, which went from being offered at 3 local health facilities to being available at 196. This increase exceeded the PEPFAR target of 186 for an over fulfillment of 105.4%. This increase was achieved by strengthening the laboratory network and the organization and provision of services; measuring and reorganizing the HIV counseling and testing flow; and creating multidisciplinary teams to provide

[91] USAID/HCI. Systematization report, 2013 p. 61.

[92] USAID/Nicaragua. Performance Indicators 2010-2013.

comprehensive and quality care for HIV-positive people. Regarding laboratories and diagnosis, the program depended on the design and implementation of the first diagnosis algorithm for HIV testing in the general population and HIV testing in pregnant women. It also depended on the provision of laboratory supplies to increase testing in vulnerable people. As a reminder of the fulfillment of the counseling and testing process, PrevenSida designed the algorithm "interventions to be performed using the combined HIV prevention approach" for training and as a quick reminder to promoters to meet the steps established in the intervention.

CQI was emphasized through the introduction of indicators to measure HIV counseling and testing and through systematic monitoring, application of the CQI methodology through rapid cycles of improvement and reorganizing the HIV counseling and testing flow in vulnerable contexts. These interventions resulted in a 26% increase in HIV testing and increased detection of cases.

Through the PrevenSida project during the 2010-2013 period, 15 NGOs working with MARPs were trained to provide counseling and rapid HIV testing (target: 13; 115.38% fulfillment).

B) INCREASE THE NUMBER OF HEALTH WORKERS AND COMMUNITY WORKERS WHO SUCCESSFULLY COMPLETE AN IN-SERVICE AND PRE-SERVICE PROGRAM

MINSA: During the 2008-2012 period, HCI and DELIVER supported the training of human resources at the national level. In 2010, PrevenSida began training human resources in the NGO sector. In September 2012, when cooperation with MINSA ended, the efforts of USAID/Nicaragua concentrated on strengthening NGOs and the private sector and transferring responsibility to universities and nursing schools.

Private sector: In 2013, together with the business sector, the Alianzas program of USAID/Nicaragua trained 70 counselors of 7 private companies grouped in COSEP in combined prevention of HIV/AIDS, gender-based violence and stigma and discrimination management. It is hoped that these counselors reach 10,350 workers.

Universities and nursing schools: By using an effective design and implementation of the transfer strategy to universities and training schools (2011-2013), HCI and DELIVER have strengthened the skills of the human resources involved in training other health human resources and in the organization and delivery of comprehensive HIV services at the national level. As of 2013, the HCI project covered 8 universities in their respective medical and nursing schools, with 328 teachers and 829 students (632 medical and197 nursing students) trained in MINSA protocols and regulations and in caring for people with HIV without stigmatization or discriminatory practices. The DELIVER project focused on the development of human resources in pharmacy, medicine and nursing at 7 universities (6 public and 1 private), training 48 university teachers and 498 undergraduate students; 76 pharmacists graduated from these programs.

NGO Sector[93]: PrevenSida concluded its scheduled courses on managerial aspects, training 189 people from NGOs working with MARPs (94.5% of its 200 target) at the end of its second year. The NGOs were strengthened with master manuals for administrative and financial management, monitoring guides and management training. During the 2010-2013 period, 25 NGOs completed their financial administrative manuals, and 10 NGOs acquired automated accounting systems. It is worth mentioning the success of the design and implementation of an interactive EP for combined prevention, which has allowed a cascading training methodology for NGOs.

C) REDUCTION OF BASELINE ART STOCK-OUTS

The main activities have been to strengthen the capacity of institutional and human resources to respond effectively to the HIV/AIDS epidemic in key populations and strengthen the logistics

[93] USAID/PrevenSida, 2012 and 2013 Annual Reports.

system of health supplies. The main implementers of this indicator have been DELIVER and Regional SCMS.

Between 2008 and 2009, the DELIVER project strengthened the integrated logistics system at the national level; in 2010, it supported the logistics component of HIV, facilitating the diagnosis of storage conditions and logistics and human resources training. DELIVER also continues to support the DAISSR Committee in advocating to ensure that ART logistics, treatment for opportunistic infections and rapid tests are sustainable and the capacity for the gradual purchase of these supplies is developed.

In 2012, the SCMS project supported capabilities for the storage of health supplies, including antiretroviral drugs, and prepared the technical proposals needed to implement further actions to strengthen the storage facilities, to be financed by the GF.

FIGURE 12: PROGRESSION OF COOPERATION EFFORTS FOR STRENGTHENING INTEGRATED LOGISTICS SYSTEMS

Decentralization and expansion of ART access[94]: The USAID/HCI project had the general aims "to support the organization of quality services for the decentralization of ART through multidisciplinary teams of MINSA health posts, including the reduction of stigma and discrimination." Those aims covered 17 SILAIS, 11 health centers and 20 hospitals. HCI supported the updating of technical regulations, standards, protocols and processes to improve overall quality and reduce stock-outs.

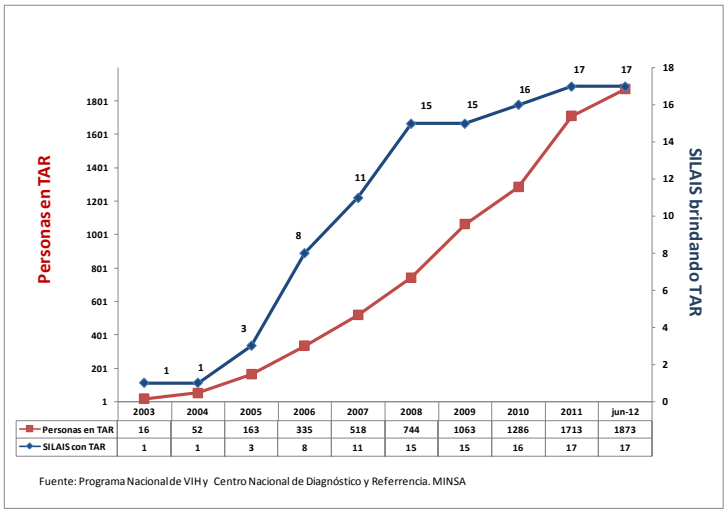
By the time the HCI assistance ended, it had contributed to the decentralization of ART, increasing access from three to 32 health posts. HCI contributed to the decentralization of ART in 7 SILAIS (CONISIDA).

USAID/HCI also contributed to improved coordination between hospitals and health centers for the monitoring, adherence, attendance and retention of people on ART; developing multidisciplinary teams' technical competence to care for people with HIV; and monitoring quality through standards and quality indicators. These developments allowed a 4% increase in retention of people on ART in hospitals, from 87% (January 2009) to 91% (September 2012), and a 10% improvement in the number of people on ART with good clinical status in hospitals. From 2003 to

[94] USAID/HCI. Final systematization report 2013, p. 61.

2012, the number of people on ART increased from 16 to 1,873, and the number of SILAIS who offered ART went from 1 to 17 SILAIS (see Figure13).

FIGURE 13: INCREASE IN PEOPLE WITH HIV ON ART AND SILAIS DECENTRALIZATION OF ART



Source: National HIV Program and National Center for Diagnosis and Reference. MINSA

4.4.3 STRATEGIC INFORMATION:

This component addresses the problem of the generation and insufficient use of strategic information, knowledge about the epidemic in key populations and the creation of an effective registration system, with the aim of building the capacity to manage and use information to improve understanding of the epidemic and allow appropriate actions that strengthen M&E and promote the use of data for decision making.

The main activities have been supporting the development of harmonized and sustainable information systems that offer new approaches to concentrated epidemics, including strengthening the collection, analysis, interpretation and dissemination of data to characterize the epidemic in high-risk and vulnerable populations. The main implementers are PASCA, Combined Prevention, PrevenSida, DELIVER and HCI.

USAID projects contributed to the following indicators of the national response: the existence of a monitoring and evaluation plan; increasing the number of UNGASS indicators from the national reporting system; and making HIV prevalence data for MARPs in the last four years available. It should be noted that these indicators are of a higher-level than those of the PEPFAR project.

The USAID/PASCA project has contributed key studies for understanding the epidemic and national response, such as transmission modes, measuring AIDS expenditures and measuring the political environment and stigma and discrimination. The project has also examined how these factors affect the implementation of PEN, GBV and HIV-related sexual violence (SV) and regulatory frameworks related to sexual diversity.

A) EXISTENCE OF A MONITORING AND EVALUATION PLAN[95]

In accordance with the HIV law, CONISIDA leads and coordinates the national response to HIV, including the development and implementation of Monitoring and Evaluation Plan (MEP). MEP was developed in 2011 and updated in 2012, and it aligned its indicators with the PEN 2011-2015,

[95] CONISIDA Monitoring and Evaluation Plan 2011-2015. July 2012. p. 1.

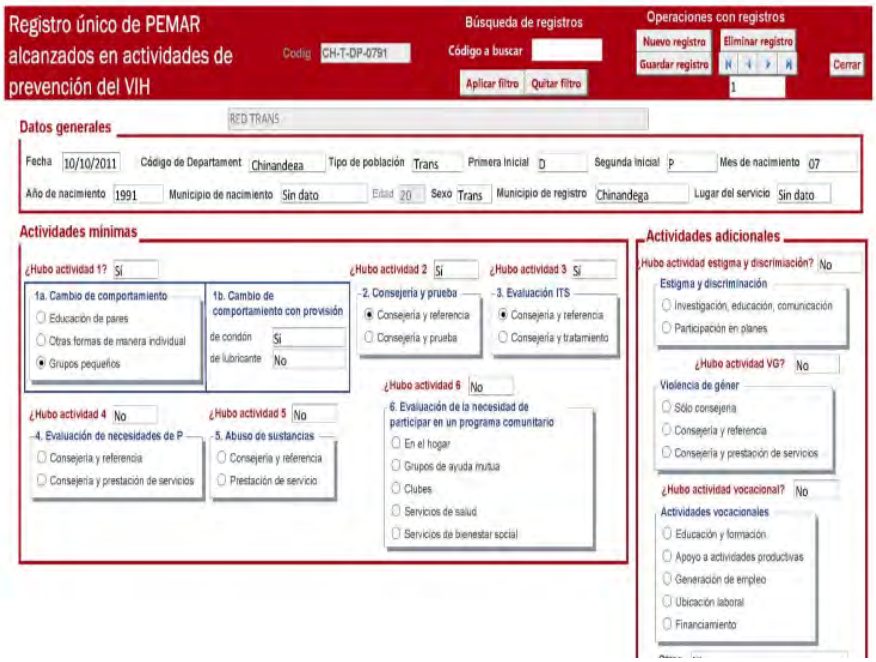
which was developed with broad multisectoral and multiagency participation and received technical and financial support from USAID/PASCA. PASCA supported prioritizing indicators by using an interactive array called the Basic Indicators Package to analyze and weigh the feasibility of measuring indicators through the USAID/PASCA project.

Through the PASCA project, USAID/Nicaragua has contributed to the national MEP, supporting actions for monitoring and evaluating the epidemic through technical assistance to CONISIDA. The organization has also strengthened capacities for monitoring and evaluating more than 50 public and private organizations implementing M&E via two editions of Central American Graduates and 60 members of public and private organizations implementing M&E. Likewise, with technical assistance from USAID|PASCA, the PASCA project met 56 of 83 PEN indicators by September 2013. This achievement represented a major advance in monitoring the National Response, given that the 2012 report met only total of 49 indicators and the 2010 report met only 16 indicators.

A contribution to the information system on MARPs is the design and implementation of the System of Single Registration of MARPs developed by PrevenSida that records the number of times an individual receives prevention information and counseling, even when located in different geographical areas, through the assignment of a unique identity code. This system allows disaggregating by type of population and municipality, the HIV testing, which allows NGOs to identify the coverage of their actions and the trend of reactors by recording rapid tests of the reactors. Although not confirmatory tests, preliminary project estimates indicate that 98% of identified cases are confirmed.

Currently, this system is being used by NGOs that benefit from PrevenSida, subrecipients of the Global Fund and the private sector. The Global Fund is using the same information system[96]. This system is part of the national monitoring of prevention activities of the national response to HIV.

FIGURE 14: UNITED REGISTER SYSTEM OF MARPS CAPTURE MASK



[96] USAID/PrevenSida. Report on the MARPs and PLWHA achieved with combined prevention 2013. http://www.prevensida.org.ni/index.php?option=com_k2&view=item&id=139:reporte-fy13&Itemid=4

B) INCREASE OF THE NUMBER OF UNGASS INDICATORS COMING FROM THE NATIONAL INFORMATION SYSTEM[97]

The completion of the analysis of performance measurement of 40 indicators (2011), which are monitored through CONISIDA, had the support of the regional USAID/PASCA project. The UNGASS report in 2012 was prepared based on these indicators.

With the support of PASCA and PrevenSida, NGOs working with MARPs have improved input data for national reports developed by CONISIDA. Next to the main recipient of the GF and in coordination with the CCM, PrevenSida provides information related to MARPs and key populations such as MSM (Gay, Transgender, Bisexual), FSW, to UNAIDS to develop country reports.

C) THE COUNTRY HAS HIV PREVALENCE DATA FOR MARPS IN THE LAST FOUR YEARS

With technical and financial support from CDC, the Global Fund and other organizations, including USAID, the country has developed research on seroprevalence and behavior that has been very useful for resource mobilization, planning and evaluation of the national response to the epidemic. Table 26 shows major studies available on HIV prevalence in MARPs.

TABLE 26: HIV PREVALENCE IN MANAGUA, MASAYA, LEÓN AND CHINANDEGA

Departments	MSM	Transgender	Female sex workers	Source	Year
Managua % HIV rate	7.5	18.8	1.8	ECVC, CDC	2010
Masaya % HIV rate	9.8	4.3		MINSA, UVG, CEPPRESI, GF	2011
León % HIV Rate	8.1			ECVC, CDC	2010
Chinandega % HIV rate	2.8	14.6	2.4	ECVC, CDC	2010

Source: PrevenSida.

PrevenSida has supported the dissemination and use of data generated by these studies among NGOs to facilitate the mobilization of resources and the development of technical grant proposals focused on key populations[98]. In coordination with PASCA and PASMO, model studies of transmission modes and tracking results continuously (TRaC) have been reported.

PrevenSida has promoted that the epidemiological surveillance data generated by MINSA are used by NGOs to focus their prevention efforts in areas of greatest prevalence and incidence. The single registration system together with epidemiological surveillance data and estimates of key populations, allows NGOs to know their coverage and perform improvement activities to reduce coverage gaps of their target populations.

4.4.4 POLICY ENVIRONMENT

This component addresses the problems of limited public funding, stigma and discrimination and gender inequalities and insufficient involvement of other sectors in the response. It aims to improve the policy environment for universal access to comprehensive HIV/AIDS services.

The main activities include supporting the development and implementation of policies with multisectoral participation to reduce stigma and discrimination (regarding sexual orientation and gender identity, HIV, occupation); gender inequalities; and the prevention of GBV.

Other actions include strengthening the design, management and implementation of GF grants for HIV, promoting multisectoral participation and NGOs' ability to participate effectively in strategic planning, policy design, implementation and monitoring. The main implementers are PASCA, Alianzas2 and PrevenSida.

[97] PEPFAR/PrevenSida. Nicaragua Second Year FY12 Annual Project Report.

[98] USAID/PrevenSida, University of Valle. Technical Workshop Report of the Second Generation Epidemiological Surveillance, emphasizing data management. January 2011.

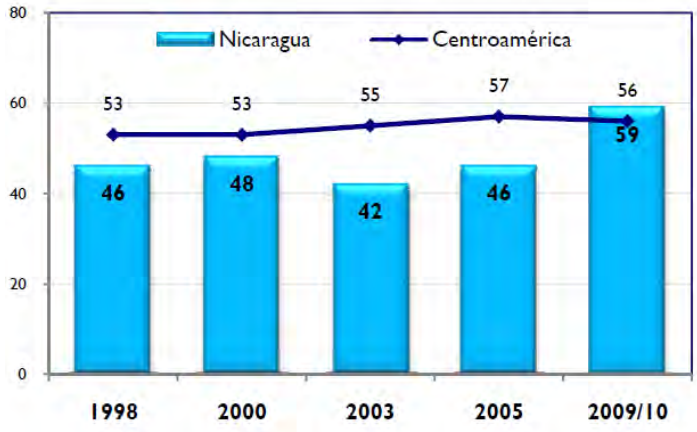
The indicators are an improved AIDS Program Effort Index (API) in policies, increasing the number of The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) projects evaluated as A1 and B1 and increasing the number of organizations receiving TA to develop and implement HIV-related policies.

A) IMPROVING THE API INDEX OF POLICIES

During the evaluation period, the program trained various groups for advocacy and policy dialogue to strengthen the national response to HIV through USAID/PASCA.

The following figure shows the countries in terms of this indicator and its relationship to the average index behavior in Central America.

FIGURE 15: PERFORMANCE OF THE API INDEX 1998-2010 IN NICARAGUA



Source: http://www.pasca.org/sites/default/files/HI7_%20API_NICARAGUA_2010_1.pdf

B) INCREASE OF THE NUMBER OF GFATM PROJECTS EVALUATED AS A1 AND B1.

All USAID projects contribute to the implementation of Global Fund HIV projects and participate in coordination meetings and information exchange.

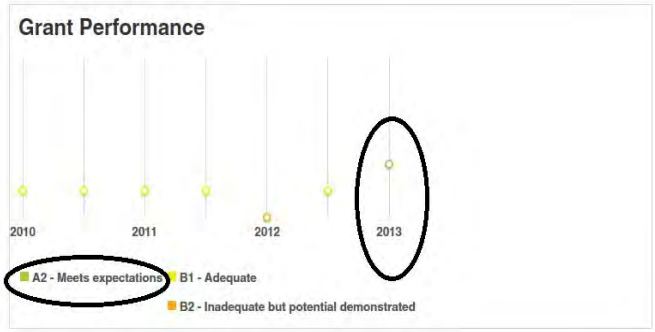
TABLE 27: CONTRIBUTION OF USAID/NICARAGUA PROJECTS TO THE IMPLEMENTATION OF THE GLOBAL FUND FOR HIV

Projects	Type of contribution
DELIVER	Strengthening integrated logistics systems (ARVs, rapid tests, medications for OI) Strengthening logistics capabilities of NGO fund subrecipients
HCI	Improving the quality of care in HIV Strategic planning with transgender populations
PrevenSida	Institutional strengthening of NGO fund subrecipients Single registration system
SCMS	Technical support to design the draft for storage improvement
PASMO	Training in methodologies for behavior change for NGO fund subrecipients
PASCA	Technical and financial support to CONISIDA for strategic information and policy environment. Technical and financial support to CONISIDA and CCM
USAID/Nicaragua	Participation as Representative of Donors or Substitute in the Coordinating Mechanism of the country. Technical Assistance specialized in HIV to the Donors Roundtable and to the Global Fund for the formulation, implementation and M&E of the projects.

Source: USAID/Nicaragua.

The following figure shows the evolution of HIV project's Global Fund performance rating, which reached the maximum expected level.

FIGURE 16: DEVELOPMENT OF THE OF THE HIV PROJECT'S GLOBAL FUND PERFORMANCE RATING



Source: http://portfolio.theglobalfund.org/en/Grant/Index/NIC-809-G06-H

C) INCREASE IN THE NUMBER OF ORGANIZATIONS RECEIVING TA TO DEVELOP AND IMPLEMENT HIV-RELATED POLICIES

Through the USAID/PASCA Project, an institutional commitment from COSEP was achieved, which has led a large group of entrepreneurs who have joined the national HIV response. With technical assistance from PASCA, COSEP created, by decree of its board in December 2010, an HIV commission to coordinate entrepreneurial efforts in the National Response. PASCA supported COSEP in advocating that the private sector should have a representative in the Nicaraguan AIDS Commission, which was set forth in Act 820; the Coordinator of the Commission on HIV from COSEP represents the private sector in CONISIDA. With technical assistance from USAID/PASCA, 33 companies were trained to design HIV policies in the workplace, 13 of which have HIV policies already designed and approved by senior management covering more than 26,500 direct collaboratives. COSEP has also designed an HIV policy for the entire union organization.

PASCA and the Alianzas2 project work with COSEP to promote and implement HIV policies in the workplace and awareness and capacity building of workers regarding HIV/AIDS. Whereas HIV/AIDS has a devastating impact on the economy and markets, the business union sector has become aware of their responsibility to act swiftly and to play a crucial role in the global fight against the epidemic and in particular within the workplace environment. Through Alianzas, COSEP undertook the commitment to train private sector resources in order that, through processes of replication, it could inform and educate more than 11,000 workers of the agro-industrial, textile and tourism sectors, on combined prevention during 2013.

4.5 GENDER ANALYSIS

Gender equality and women's empowerment are central goals of USAID work; therefore, USAID has always maintained gender equality principles in its cooperation process and, for years, it has had internal requirements that call for gender analysis at the vision, implementation and evaluation levels[99].

This evaluation recognizes the historical context of gender inequalities and reviews the USAID/Nicaragua health cooperation program's contribution to reducing those inequalities during the 2008-2013 period. The evaluation determined the USAID Nicaragua health program's contribution to gender equality in health and its projects' abilities to integrate gender considerations in their activities. The evaluation also considered the most important results related to gender and whether they are sustainable.

USAID implements gender policy with seven basic principles: an inclusive approach to promote equality; building alliances among decision makers; science, technology and innovation to reduce gaps; addressing challenges in crisis and conflict environments; providing a leadership and learning community; and being accountable for results. The following table shows the application of these principles when planning USAID health cooperation.

TABLE 28: ACHIEVEMENT OF THE GENDER EQUALITY POLICY PRINCIPLES, USAID NICARAGUA HEALTH PROGRAM

Principles for integrating gender equality	Achieved	Evidence
Inclusive approach that generates equality	Yes	Reduced the disparity in access to health services that focus on women and men according to their needs.
Partnerships with a broad group of partners	Yes	Coordinated effectively with the public sector, donors, NGOs, academia and the private sector to improve health.
The use of science, technology and innovation to reduce gender gaps and empower women and girls	Yes	Supported technologies that improve hospital services (ABBR, NVM, MATEP, reduction of PPH, PMTCT, bilateral tubal occlusion BTO, VSC, APEO) and community services (Delivery Plan, ECMAC, PROCOSAN) and are examples of applied technology and innovation.
A focus on the challenges of crisis and conflict situations	Yes	Focus on adolescents with MCM, APEO, and ECMAC. Programs for sexual diversity, VBG.
Exercising leadership and promoting learning	Yes	USAID Nicaragua has been the main donor in the health sector and has promoted the institutionalization of their activities and the transfer of skills and abilities to the academic sector.
Being accountable for its responsibilities	Yes	USAID Nicaragua has continuously invited other agencies to evaluate its activities, including its performance on gender issues.

In March 2012, USAID published its Policy on Gender Equality, which confirms that gender equality and the empowerment of women are fundamental requirements for achieving sustainable development results. USAID Nicaragua order 201-1 of April 27, 2012 assigns mission officials responsibility for implementing the gender policy in technical cooperation in Nicaragua.

According to USAID requirements, gender analysis is performed at the strategic level and must be addressed at the project level. USAID/Nicaragua started conducting gender analysis in 2012; however, the strategies and the projects designed before that date incorporated an emphasis on the health of women, girls and adolescents, implementing strategies that reduce the health gap and increase women's and girls' decision-making capacity. With the HIV component, the gender concept is extended to address gender inequalities arising from sexual orientation, with an emphasis on bringing the benefits of interventions to key sexual diversity populations (MSM and transgender populations).

The following table shows the link between the desired outcomes for gender policy and the presence of specific activities that contribute to that outcome in each of the strategies.

[99] USAID/Automated Directives System (ADS), Chapter 201, Integrating Gender into Health Programs. March 23, 2011.

TABLE 29: RESULTS FOR GENDER POLICY HEALTH STRATEGIES

Expected results from the USAID Gender Policy	MCM donation	FP	MCH	HIV
Reducing gender disparities in access, control and benefits				
Increase the decision-making capacity of women and girls				
Reducing violence and mitigate its adverse effects				

A brief overview of the specific contributions to each result:

A) REDUCTION OF GENDER DISPARITIES IN ACCESS, CONTROL AND BENEFITS:

Maternal mortality is "the most obvious indicator of gender inequalities that women face". The health program contributed significantly to the reduction of MMR from 78.02 deaths per 100,000 live births to 50.9 in 2007-2012, according to MINSA sources.

MCM donation directly benefited WRA, extending this benefit to couples.

The APEO and ECMAC strategies focused on the most vulnerable women – women who were from rural areas, were indigenous and had low income - reducing the urban-rural gap and keeping it at just 3%.

MNV studies show a reduction in families' out-of-pocket expenditures. In this case, the reduction was supported by access to free MCM and increased the access of women, adolescents and children to preventive maternal and child health services.

Transgender people and MSM gained increased access to combined HIV prevention services.

The specific fertility rate in adolescents declined as an objective of NSRHS (see Figure 17). Since 2008, FP cooperation has emphasized promoting MCM access for women under the age of 25, a goal that was incorporated into the DAIA plan.

USAID/PASCA promoted the need for HIV employment policies that include zero tolerance of sexual harassment and discrimination based on sexual identity.

FIGURE 17: REDUCTION IN SFR AMONG PEOPLE ≤ 25 YEARS. NICARAGUA, 2011-2012

Source: Preliminary data ENDESA 2011/12.

A gap that persists in the country is the insufficient participation of women in FP and MCH community strategies, although there have been some positive experiences with FamiSalud and CRS's child survival project.

B) INCREASE WOMEN AND GIRLS' DECISION-MAKING CAPACITY

In the FP field, gender-sensitive regulations and attention protocols were developed in coordination with UNFPA and PAHO to ensure that women could make voluntary and informed decisions based on eligibility criteria about the use of modern contraceptive methods, including IUDs and

VSC; the goal was to increase the instances of women taking control of their fertility and exercising their reproductive rights by eight percentage points. Increased dissemination of messages about FP, which reached 1.4 million women in only three years, was a key factor in the increased demand.

In the case of HIV/AIDS, regulations and protocols for HIV counseling and testing emphasized the voluntary aspect of such services and the need for previous informed consent and posttest counseling. This recommendation not only benefited women who demanded the test (especially those who were pregnant), but also the rest of the population, including people from sexually diverse populations.

C) REDUCTION OF GENDER VIOLENCE AND MITIGATION OF ITS ADVERSE EFFECTS

GBV that affects women, especially adolescents, and people of sexual diversity was specially addressed by the PrevenSida project and the project implemented by San Lucas Foundation to reduce infant mortality.

Through regional and national conversations on GBV and SV, PASCA promoted a group of sexual diversity organizations in Nicaragua that constituted a working group on sexual diversity. This group identified the absence of occupational and non-occupational Post Exposition Prophylaxis (PEP) clinical guidelines as a barrier to comprehensive care for sexual violence. Such guidelines would serve as a tool for the effective implementation of post-HIV exposure prophylaxis for victims of sexual violence. As a result of this working group's advocacy to CONISIDA, MINSA approved the Occupational and Non-Occupational Prophylaxis Guide for HIV[100].

D) INCORPORATION OF THE GENDER APPROACH IN PROGRAM PROCESSES

All of the mission-monitored relevant indicators of service provision and training include a breakdown by sex.

PrevenSida incorporated the gender perspective into its Annual Work Plan (AWP) 2012 and 2013[101]. In section 1.8.3 of the agreement with USAID, a robust proposal on gender equality is described to address the needs not only of men and women, but also of transgender people, female sex workers and other groups with specific needs; this agreement proposed indicators to measure its theory of change. The terms of reference for the subsidies that the NGOs received contain a gender focus. Technical applications for the grant include a section that integrates the gender perspective into the activities each NGO describes in its grant application.

The midterm and final evaluation of the FPGS incorporated gender analysis and provided conclusions and specific recommendations. The midterm evaluation of FamiSalud (2012) placed a strong emphasis on the issue[102]. The Alianzas project includes a section on gender and reports on the subject in general.

[100] Ministry of Health in Nicaragua. Website accessed on 19/02/14: http://www.minsa.gob.ni/index.php/repository/Descargas-MINSA/Dirección-General-de-Regulación-Sanitaria/Normas-Protocolos-y-Manuales/Normas-2013/

[101] USAID/ PrevenSida. FPGS 2012, p. 16. FPGS 2013, p. 27.

[102] Peter Body Social Consultants Group. Performance Evaluation of the FamiSalud Project, April 2012.

V. CONCLUSIONS

Effectiveness of the USAID Nicaragua Health Program

USAID Nicaragua, by contributing along with other health donors to the national effort led by MINSA, has achieved its health cooperation program's goals of achieving a more educated and healthy population with a greater ability to contribute to and share the benefits of a growing economy.

Contribution to the MINSA's efforts and the achievement of MDGs

Overall, during the studied period, Nicaragua made significant progress in FP and MCH, achieving a one-third reduction in MM and a one-half reduction in the mortality of children under the age of 5, infants and neonates. Chronic malnutrition in children under the age of 5 has been reduced by 20%. The TFR continues to decrease, and the rate of MCM use is increasing. All midterm health indicators have improved markedly. The immunization rate has been maintained. In the case of HIV/AIDS, as expected, increasing the coverage of counseling and voluntary testing among key populations has increased prevalence, but has reduced lethality and mortality.

The present report shows evidence of USAID cooperation's contributions to these health achievements and to the strengthening of MINSA and the health sector (extending coverage to vulnerable populations; decentralizing and horizontalizing MOSAFC through leadership and governance, HHR training, CQI processes, and the expansion of services; and providing logistics, technology and information systems). Similarly, the results of specific performance indicators of the health program based on the targets that the project implementers agreed to are presented. The report highlights the successful and effective linkage and coordination with donors through spaces such as the specific technical committees for SRH and HIV/AIDS, the GAVI Committee, CCM and especially the DAIA-DAISSR Committee.

The effectiveness of the USAID Nicaragua Health Program:

The USAID Nicaragua Health Program was effective in strengthening Nicaragua's health sector (public and private enterprises, NGOs, universities and communities) based on the effective alignment and adaptation of its program to the country's needs, resulting in an effective health program that is relevant to the country. Along with other health donors, maternal-child and reproductive health care contributed to the reported achievements in reducing maternal and infant mortality; made specific contributions to reducing HPV, PHS, asphyxia and neonatal sepsis in hospitals that received direct benefits; and reduced MCM stock-outs and increased coverage of preventive services in rural remote communities via the logistics system.

USAID has also helped to improve the coverage and quality of access of key populations to combined HIV prevention services, showing a significant increase in the access coverage of previously underserved populations.

Coordination with other donors and agencies of the United States Government:

The USAID Nicaragua program successfully coordinated and complemented health activities implemented with US agencies and other health cooperatives. There was close coordination with the Technical Committee of Donors, thus increasing the likelihood that components of their programs are institutionalized with the support of other donors.

What worked best:

The country's sustainable ability to purchase previously donated MCM; the institutionalization of an integrated logistics system; the strategic facilitator function of the DAIA committee; the strengthening focus of various blocks of the health sector (finance, logistics, human resources, information systems, increased coverage and quality); the coordination and transfer of cooperation

products to MINSA, universities and donors; the integration of the regional HIV program into the regional PEPFAR framework; the development of the Combined Prevention strategy; and the single registration of services to key populations.

What can be improved:

Challenges remain in the following areas: increasing adolescents access to modern methods and especially delaying the first pregnancy; strengthening the coverage of preventive services in the Caribbean and in difficult-to-access rural areas; increasing the participation of social security as MCM provider for insured populations; and consolidating and expanding successful strategies, such as Kangaroo Mother, HBB; and general quality improvement methods.

Sustainability:

The excellent framework of public health policies, short-, medium-, and long-term health plans, health strategies and health care models are determinants of program sustainability and the institutionalization of progress. The FP program has financial assurance and institutional capacities (reproductive health, contraceptive security and DAISSR), and the evidence shows that the trend is toward expanding the coverage of FP, MCH and HIV services. The institutionalization of hospital- and community-based strategies, including funding from taxes, other donors and lending, continues the achievements. The transfer to universities and training schools ensures that educational packages of programs for hospital management of the newborn, safe delivery management, surgical sterilization and post-obstetric events, management and logistics systems are the cornerstone of country ownership and sustainability.

Unexpected impacts:

Beyond what was expected in terms of logistics, it was possible to extend the logistics approach to contraceptive methods to other supplies and medicines; similarly, the focus of the DAIA committee was expanded to broader sexual and reproductive health issues, including the issue of HIV/AIDS, via the change to the DAISSR Committee.

Another unexpected positive impact was the transfer of the products of cooperation to universities and training schools, public and private, which transcends the MTE-2007 recommendation to include the issue of quality in undergraduate education. Likewise, the development of the single HIV record has transcended the project's scope and PEPFAR cooperation, reaching the private sector and the subrecipients of the GF, and it has allowed the preparation of consolidated prevention coverage reports at the national level.

Gender equality:

USAID/Nicaragua contributed to gender equality by addressing determinants of equality, such as access to comprehensive health services that reduce the burden of disease and mortality in women, adolescents and children. It improved access to and decision-making about fertility control and humanized delivery care, and it helped to reduce the stigma and discrimination associated with gender inequalities and to reduce GBV in sexually diverse populations, especially transgender and MSM populations.

VI. RECOMMENDATIONS

To USAID

- Continue to transfer and provide technical assistance regarding the current cooperation program's issue to national and local health teams, in the various subsectors.
- Document and widely share the successful experience of USAID/Nicaragua's health cooperation in the country.
- Maintain effective coordination of the Sector Roundtable of Donors, strengthening the already initiated transfer processes and technical assistance to key committees such as DAIA/DAISSR, CCM and CONISIDA.
- Expand coordination on the issue of HIV with an HIV team from the UN system and bilateral cooperation with the GF in the area of HIV/AIDS.
- Broaden the focused approach to HIV in terms of structural and human rights issues.
- Apply lessons learned from the FP and MCH graduation process to the current cooperation in HIV/AIDS.
- Design and implement a medium-term sustainability strategy for cooperation on HIV to be integrated into the national response.
- Continue supporting the institutional strengthening of the academic sector.
- Document the experience of the technical transfer to universities.

To MINSA

- Maintain and strengthen opportunities for interagency and intersectoral coordination, such as DAIA/DAISSR, CCM, CONISIDA, sectoral dialogue spaces and technical committees.
- Continue the good evaluation practices of the DAIA/DAISSR plan and future strategic planning, with an emphasis on HIV and other reproductive health services.
- Continue the EP developed for FP, MCH, HIV/AIDS and quality improvement.
- Monitor the results of health research supported by USAID and evaluate, if applicable, the implementation of the recommendations.
- Continue adding and strengthening the vast network of community workers trained by FamiSalud.
- Expand the successful CQI, ECMAC, APEO, Delivery Plan for Safe Motherhood, HBB and Kangaroo Mother strategies.
- Continue expanding the coverage of FP services in social security.
- Strengthen the integration of the framework for analyzing the social determinants of health into the analysis of the country's health situation to promote a multisectoral approach.

To CONISIDA

- Continue strengthening the integration of different information sources reporting on the progress of the national response to HIV.

- Incorporate sustainability issues in the strategic planning of the national response to HIV according to the HIV sustainability strategy for Central America and the advances demonstrated by PEN midterm evaluation.
- Develop actions that contribute to the sustainability of combined prevention activity with key populations.
- Strengthen the coordination between agencies on the issue of HIV.
- Increase the use and dissemination of HIV research findings.

To Donors

- Repeat successful working experiences for USAID's current and future cooperation, especially in work focused on strengthening health systems, with emphasis on updating technical standards and university curricula, implementing community health strategies and working with the NGO sector.
- Use the tools developed in MCH, such as EPs, standards measurement, human resource skills measurements and mapping, checklists and the updated document on evidence-based maternal and child health interventions.
- Continue collaborating with the country on issues of gender equality and reproductive rights, including the use of educational materials on preventing GBV, reducing stigma and discrimination and integrating the interactive, comprehensive Combined Prevention education package.
- Explore opportunities to collaborate on the issue of strengthening civil society to encourage the technical and methodological transfer of tools and packages prepared by USAID for the administrative and financial strengthening of NGOs.
- Develop joint HIV interventions using the health determinants approach, with emphasis on key populations and youth.

To NGOs, universities and the private sector:

- Continue strengthening and implementing strategies transferred by the USAID Health Program.
- Continue actions that strengthen continuous quality improvement and reduce stigma and discrimination, including sexual diversity issues and gender-based violence prevention.
- Continue strengthening active and informed participation in the national coordination of the response to HIV.

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VIII. ANNEXES

ANNEX 1: SCOPE OF WORK

Global Health Technical Assistance Bridge 3 Project GH Tech
Contract No. AID-OAA-C-13-00032
SCOPE OF WORK: April 17, 2013
Title: USAID/Nicaragua: Health Program Final Performance Evaluation
Contract: Global Health Technical Assistance Bridge 3 Project (GH Tech)
Performance Period: On/around April 24 – August 16, 2013
Funding Source: Mission-funded

Purpose of Assignment

USAID/Nicaragua has been continuously implementing its health program since 1991, with significant expansion following Hurricane Mitch in 1998, investing approximately $75 million during the last 10 year period. The health program has focused on maternal and child health, family planning and reproductive health, HIV/AIDS, and water and sanitation. Since 1991, USAID has been a leading donor in maternal and child health assistance to Nicaragua, working closely with the government of Nicaragua, private sector and multiple local Non-Governmental Organizations (NGOs). USAID has been the major supporter of the Ministry of Health (MOH) in assistance for management, logistics and financial systems, in training health care providers to ensure high quality services and implementing MOH's community strategies.

In 2007, the Mission evaluated the Health Program, and the evaluation team provided ten strategic recommendations to the Mission in order to provide the basis for future maternal and child health and HIV program priorities. The Mission is now interested in conducting a final evaluation to establish what results, both positive and negative, have been achieved through USAID/Nicaragua's health program to assess the sustainability of USAID's health sector investments; to identify priority activities at risk of not being continued after the phase-out of USAID support and recommend options to USAID for ensuring sustainability; and to provide recommendations to the MOH and other stakeholders for future actions to sustain gains to date and increase the impact of USAID's MCH, FP and HIV interventions.

The purpose of this Statement of Work is to provide a framework for and communicate the research questions to be studied to assess the level of accomplishment of USAID/Nicaragua's Health program for the years 2007-2013, determine to what extent recommendations from the 2007 health program evaluation were implemented, and identify key factors contributed to or impeded achievement of program results. Specifically, this evaluation will serve the purposes of both accountability and learning. The principal beneficiaries of the evaluation will be the Mission, the Government of Nicaragua (GON), donors, and civil society, including NGOs, universities, and the private sector.

Background

Nicaragua Health Situation

The Government of Nicaragua (GON) has recorded significant progress over the past two decades in maternal and child health, family planning and HIV. According to DHS 2006/07 childhood immunization coverage is high; nearly 85% of children have received all their recommended vaccines. In addition, 70% of women of reproductive age are using modern methods of contraception (DHS 2006/07), a rate which is approaching that of the United States (73%). Significant efforts to institutionalize labor and delivery have been successful: 74% of deliveries now occur in health facilities and are assisted by a skilled health worker (DHS 2006/07). Nicaragua has made progress in reducing maternal and child mortality, but rates are still quite high in isolated geographic regions and among the poorest segments of the population. Although the last published Demographic and Health Survey (DHS), conducted in 2006/2007, indicated that the

nutritional status of children under five years of age has improved, with the prevalence of global malnutrition decreasing from 11.2% in 1998 to 5.5% in 2006/07, malnutrition rates remain a major concern. DHS 2006/2007 data also indicate that at the time of that survey, almost 22% of children less than five years of age in rural areas were stunted and 28% of the children from families in the lowest wealth quintile were stunted, compared to only 4.5% of the children from the highest wealth quintile.

While the fall in fertility rates is having a positive effect on maternal and child health, maternal mortality remains still high. According to Ministry of Health (MOH) data, the maternal mortality ratio in Nicaragua declined from 2006 to 2011 by 32% -- from 92.8 maternal deaths per 100,000 live births to 62.7. DHS 2006/2007 data indicate that there was a significant improvement in the under-five mortality ratio from 1998 to 2006/2007, with a decline from 39 deaths per 1,000 live births to 29 and that infant mortality was reduced by half since 1992/93, falling from 58/1000 live births to 29/1000 in 2006/2007. However the same DHS 2006/2007 data also indicated that neonatal mortality had barely changed over the last ten year period, only dropping from 17 deaths per 1,000 live births in 1998 to 16 in 2006/2007, representing 55% of all deaths of children less than one year old.

While the data indicate that the country is making significant progress on high-level indicators and is on track to meet Millennium Development Goals (MDG), Nicaragua is not without remaining challenges in health. Morbidity and mortality related to pregnancy and delivery and neonatal mortality and chronic malnutrition among children under 5 years all continue to be potential obstacles to achieving MDGs 4 (Reduce child mortality) and 5 (Improve maternal health), especially in rural areas and among the lowest socioeconomic quintiles.

The 2002 National Health Law and its 2003 Regulation establish the MOH's responsibilities to direct health resources to meet the needs and priorities of Nicaraguans. The MOH is the primary provider of health care in Nicaragua. The MOH has a network of over 1,000 facilities, including 32 hospitals, 175 health centers and 868 health posts. At present, the MOH has an estimated coverage of 60% of the population. In addition to the MOH, the Nicaraguan Institute of Social Security (INSS) provides health services for salaried workers through a network of public and private hospitals known as Empresas Médicas Provisionales (EMPs). Coverage through EMPs is estimated at 17% of the population.

Since 2007, the national health policy establishes free medical care, improvements in coverage and quality of services through the implementation of a new model of service delivery named MOSAFC (Family and Community Health Model) coupled with the improved availability of drugs and supplies that has enabled an expansion of the health services network.

USAID Support

Since 1991, USAID has been supporting and implementing a health program, which was significantly expanded after Hurricane Mitch in 1998, that addresses maternal and child health, water and sanitation, family planning and reproductive health, and HIV/AIDS.

USAID has consistently been one of the leading donors in health assistance in Nicaragua, working closely with the government of Nicaragua, other donors, the private sector and multiple local NGOs. USAID assistance used to be provided through Strategic Objective Agreements (SOAG), covering the periods of 1993-1998, 1999-2003 and 2003-2008 that set forth USAID/Nicaragua's program priorities and results to be achieved. The health sector SOAG for the period 2003-2008 has been extended through 2013 for administrative purposes. Under the current strategy, USAID/Nicaragua is working to impact maternal and child health and the principal results anticipated by the end of the ten year strategy period will be to improve government capacities to plan and manage health investments and improve health status at the household and community levels.

USAID/Nicaragua has a Country Strategy that for the years 2003-2008 that has also been extended through 2013. Under the extended Country Strategy, the Office of Health and Education's (OHE) Strategic Objective (SO) is to achieve "Healthier, Better Educated People." During the strategy period, USAID focused its development assistance on efforts to: (a) improve government capacities to plan and manage health and education investments, (b) increase access to quality education at the primary level, and (c) improve health status at the household and community level. The SO framework includes three intermediate results (IR), of which two are related to health: IR 3.1: "Increased and Improved Social Sector Investment and Transparency" with two sub IRs:

- More efficient expenditures (including procurement processes) by Ministries of Health and Education.
- Increased and more decentralized investments in health and education and IR 3.3 "Improved Integrated Management of Child and Reproductive Health" with two sub IRs:
- Improved and expanded family planning and maternal and child health services and information/education
- Better nutrition and dietary and hygienic practices.

Major implementing partners and projects for the strategy period have included Research Triangle Institute (RTI) (Alliances for Health and Education project), the NicaSalud Federation (FamiSalud project), Management Sciences for Health (MSH) (PRONICASS project), University Research Corp. (URC) (Quality Assurance Project and Health Care Improvement Project); John Snow, Inc. (JSI) (Deliver project), Population Services International (PSI) (PASMO Behavior Change Communications project). In addition, USAID regional- and Washington-funded projects were implemented by Abt. Associates (PASMO Condom Availability project), and by Futures group (PASCA project: Programa para fortalecer la respuesta centroamericana al VIH), Partnership for Supply Chain Management (SCMS project: Supply Chain Management System, the Adventist Development and Relief Agency (ADRA), Catholic Relief Services (CRS), Project Concern International (PCI), Save the Children Federation (SCF), but as those projects are not included in our SOAG and they do not contribute to our strategy, they will not be part of this evaluation. If those projects are present in the municipalities or communities been evaluated, their participation should be mentioned as external factors.

Previous Evaluations

In 2007, USAID Nicaragua performed a Health Program Evaluation (GH Tech, 2008)[103] which reviewed MCH and HIV activities, as well as overall program performance from 2003 to 2007. This evaluation noted that USAID/Nicaragua's MCH program is clearly in accordance with MOH's priorities, the projects have succeeded in meeting their indicator targets, and that projects were achieving unanticipated results that were not quantitatively measured. The evaluation recognized that one of the strategy's main strengths was that, by design, the projects were working at scale.

The evaluation included several strategic recommendations for the Mission:

The linkages between the community and hospitals should be strengthened. Maternal nutrition and immediate postpartum care are not being adequately addressed. Giving more attention to filling these gaps and more support to maternity homes will help fortify linkages between the community and the formal health system. Lastly, although it is important to use private/public partnerships as a springboard for innovations, the door is too wide open: A lack of technical health capacity has compromised the selection of alliances that would have the best strategic fit with USAID/Nicaragua's overarching MCH strategy.

USAID-supported HIV interventions prior to 2008 concentrated on prevention of the spread of the disease. The 2008 evaluation found that the two most cost-effective interventions, free

[103] Reynolds, J. Bongiovanni, A, GH Tech Consultants. USAID Nicaragua Health Program Evaluation. April 2008.

distribution of condoms and social marketing of condoms, were implemented by the MOH and by another PASMO project (not USAID funded), respectively. The evaluation also identified some gaps in HIV activities, including a need for HIV prevalence data for planning and evaluation and more focus on prevention among high-risk populations. The report included five strategic recommendations: 1) Conduct sero-prevalence and behavioral surveys of high-risk populations; 2) Discontinue funding of MOH activities for preventing mother to child transmission (PMTCT); 3) Emphasize primary prevention as the main intervention; 4) Expand primary prevention among high-risk groups through consortia of NGOs; and 5) Unless significant additional funding is available, avoid several popular interventions that only had limited effects on prevention.

USAID/Nicaragua's Family Planning Graduation Strategy (FPGS) was implemented from October 1st, 2007 through September 30th, 2012. Broadly, the Nicaragua FPGS identifies five critical areas for continued support prior to the phase-out of USAID FP assistance to ensure that the objective of the FPGS was met. In October 2010 USAID/Nicaragua conducted a mid-term formative assessment of progress in implementing the FPGS to assess whether successful graduation of USAID FP assistance in September 2012 was feasible. This assessment found that overall implementation of the PFGS was very good and that USAID/Nicaragua had achieved important benchmarks during its implementation and an important number of the plan's indicators were met or are right on track for timely completion. The assessment team found no need to make modifications to the plan and determined that general assumptions remained valid.

A final evaluation of the FPGS was conducted from August to September 2012. The purpose of the evaluation was to assess the success of the Strategy, including progress on recommendations from the mid-term assessment, and to make for the post-graduation phase. The evaluators found that all recommendations presented in the mid-term evaluation of 2010 were implemented and monitored by the USAID health office, allowing adjustments to be made during implementation. The evaluation found that the conditions for a successful graduation were met, the implementation of USAID/Nicaragua´s FPGS had been successful, and that USAID had achieved the main goals included in the strategy. The evaluation also included recommendations for addressing gaps under each of the five strategic components in the FPGS.

An HIV program evaluation will also be carried out during 2013, however final report will not be ready by the time this evaluation finish. Results from the FPGS evaluation should be considered into this program evaluation, looking at the overall effect of FP on the USAID/Nicaragua health program.

Scope of Work

The evaluation team should answer the following key evaluation questions:

Objective 1: Determine the effectiveness of the USAID health approach used and outcomes achieved.

Specific Questions to be answered:

To what extent has USAID/Nicaragua's Health program achieved the specific results (Intermediate Results and Sub-IRs) identified in the SOAG's Amplified Program Description?

To what extent has USAID's Health program contributed to achievement of the MOH's objectives related achieving Millennium Development Goals 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases), as well as to the implementation of MOSAFC. It is expected that this evaluation can show how the FP, MCH and HIV components were integrated to support child and maternal mortality reduction (describing both successes and challenges). How successful were the program's efforts to strengthen the capacity of the MOH at all levels to plan and manage health sector investments?

Did USAID's health program complement activities implemented by other USG agencies and other donors? Provide examples of successful complementarity that led to achievement of greater than expected results and of missed opportunities.

What worked well and what did not work well within the USAID Health Program?

To what extent have external factors, such as unexpected events within the country, helped or hindered progress?

What were the unexpected impacts (positive or negative) of the USAID/Nicaragua Health Program?

Are advances achieved through USAID's Health Program assistance in the public sector institutionalized and sustainable?

Which elements of the health program are most likely to be sustained after the program closes, and why? Which elements are least likely to be sustained, and why?

Objective 2: How has the USAID/Nicaragua Health program contributed to gender equity in health?

Did projects effectively and adequately integrate gender considerations into activities?

What were the most important results achieved related to addressing gender issues and will they be sustainable?

Have there been any unintended results of the Health program activities with respect to gender?

Methodology

As mentioned above, the purpose of this evaluation is to assess to what extent USAID/Nicaragua's Health program has achieved the specific results identified in program and project documentation and to assess how/to what extent USAID's Health program has contributed to the achievement of the MOH's objectives related to maternal and child health, FP, and HIV.

In preparation for the evaluation, the team should plan to hold a two-day team planning meeting (TPM), planned and facilitated by the Team Leader. The team will meet with USAID/Nicaragua during the TPM to discuss the scope of work in detail and obtain any necessary clarifications. The purpose of this meeting will be as follows:

Clarify team members' roles and responsibilities;

Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;

Develop and finalize a work plan for the evaluation;

Review and request clarifications on evaluation questions;

Review and finalize the assignment timeline and share with USAID;

Finalize data collection plans and tools;

Review and clarify any logistical and administrative procedures for the assignment;

Develop a preliminary draft outline of the team's report; and

Assign drafting responsibilities for the final report.

The Evaluation Team will be expected to submit suggested evaluation methods and work plan for USAID review, describing how the team will answer each of the above evaluation questions (matrix), including data source, data collection tools and which sample selection method will be used. The work plan should outline how information will be obtained from a wide variety of sources and include:

A full review of background materials, including annual and sector reports;

Document review, including instruments, methodology, data results, assessments, reports, projects documents and analyses conducted by the USAID/Nicaragua health projects, the MOH and stakeholders;

Structured individual and group interviews, using checklists or questionnaires, with implementing partners and key stakeholders at both the local and national level, i.e. (staff from USAID, MOH,

USAID projects, selected health units, select municipalities, and donor agencies supporting health), including the key information to be sought from each stakeholder group;

Observation and field visits to a sample of implementers, counterparts, and beneficiaries; and

Focus group discussions.

USAID requires that evaluations and assessments explore issues of gender; thus, the Evaluation Team should examine gender issues within the context of the evaluation of the Health Program activities and include their observations in the findings, conclusions and recommendations section of the report.

All activities should be carried out in consultation with USAID/Nicaragua to ensure that the evaluation team has the fullest possible background and contact information. USAID/Nicaragua will provide overall technical leadership and direction for the evaluation team throughout the assignment.

USAID/Nicaragua's Health Specialists -- Marianela Corriols and Clelia Valverde -- along with the Mission Monitoring and Evaluation Specialist, Marcela Villagra, will monitor progress through meetings, electronic messaging, and selected site visits with the Evaluation Team in order to assess the progress and quality of the implementation of this assessment.

Sources of information: The evaluation team will be expected to meet with members of the USAID/Nicaragua Health Office Team, USAID Nicaragua senior management, the staff of the on-going projects that work/have worked on Health (HCI, FamiSalud, Alliances 2, PrevenSida, DELIVER, PASMO, PASCA and SCMS), as well as with other key technical players and counterparts at national and local levels.

The Mission's Health specialists will provide all existing documentation (hard or electronic copies) related to the bilateral Health Program and will coordinate the inputs from active projects (HCI, FamiSalud, Alliances 2, Deliver, and PrevenSida) and one closed project (Pronicass), that have contributed to the Health Program implementation.

USAID/Nicaragua and its active implementing partners will provide the evaluation team with a package of briefing materials (on a CD or link), including:

- USAID Evaluation Policy and checklist for evaluation reports
- USAID Gender Policy
- Project descriptions
- Project annual plans and reports and baselines reports
- M&E plans and reports
- USAID Health Program Evaluation, 2007
- USAID MCH Graduation Strategy 2012
- USAID HIV Strategy
- USAID FPGS Evaluation, 2012
- Educational materials developed
- MOH National Health Plans
- Modelo de Salud Familiar y Comunitario (MOSAFC)
- MOH's Institutional management evaluation National HIV/AIDS Strategic Plans
- National HIV reports
- Matrix that lists implementing partners and their activities
- Team Composition, Skills, and Level of Effort (LOE)
- The evaluation team will require three local team members with the following minimal qualifications:

- Team Leader
- Ten years of experience in the design, implementation, monitoring and evaluation of national and/or international health programs;
- PhD or Master's level degree in public health, epidemiology, behavioral science or related field;
- Demonstrated skills in one or more of the following technical areas: monitoring and evaluation of health programs, prevention and behavior change methodologies, health system strengthening (treatment and care, development of standards and protocols, logistic system, health personnel, in-service training, pre-service training), strategic information and policy environment;
- At least one documented experience working in health program planning, implementation and evaluation;
- Deep knowledge of the Health situation in Nicaragua;
- Strong verbal and written communication skills in English and Spanish, including a demonstrated ability to write technical documents and give presentations;
- Ability to travel to departments in Nicaragua to conduct evaluation activities; and
- Strong interpersonal skills working as well as the ability to communicate with several stakeholders.
- Technical Team Members
- The team members should consist of one Health System Strengthening Specialist and one MCH and Nutrition Specialist. Each person should have a minimum of the following qualifications:
- Experience working on at least 5 health program evaluations;
- Five years of expertise on issues related to Health programs in Nicaragua and/or other Central American countries;
- Deep knowledge of the Health situation in Nicaragua;
- Strong verbal and written communication skills, including a demonstrated ability to write technical documents and give presentations; and

In addition, both, the Health System Strengthening Specialist and one MCH and Nutrition Specialist, should have demonstrated specific experience in one of these technical areas.

Level of Effort (LOE)

An illustrative table of the LOE is found below. Dates may be modified based on the availability of consultants and key stakeholders and the amount time needed for field work.

Activity	Team Leader	Technical Team Members
Mission sends background documents to GH Tech and Team Members	--	--
Review of background documents (remotely)	3	3
Travel to Nicaragua	1	1
In-briefing with USAID and team planning meeting, including development and submission of work plan and methodology	3	3
Field work, including data collection; interviews with implementing partners & key stakeholders; site visits to selected communities	21	21
Analysis & synthesis of key findings in preparation for mid-evaluation meeting	4.5	4.5
Mid-evaluation meeting with USAID/Nicaragua to discuss advances, structure, key findings, etc. to date	0.5	0.5
Preparation and submission of first complete draft evaluation report (in Spanish); prepare Power Point debriefing presentations	6	6
Debriefing presentation using Power Point to USAID/Nicaragua	0.5	0.5
Debriefing presentation using Power Point to USAID partners	0.5	0.5
Depart from Nicaragua	1	1

USAID reviews first draft evaluation report	--	--
Preparation and submission of second draft evaluation report (remotely)	5	5
USAID reviews second draft evaluation report	--	--
Return to Nicaragua	1	1
Finalize second draft report; prepare materials for validation activities	6	6
Validation activities	2	2
Departure from Nicaragua	1	1
Final draft report prepared by Team Leader and team and submitted to USAID/Nicaragua	3	1
Mission reviews final draft report and provides final sign-off to GH Tech	--	--
Translation of report from Spanish into English and editing and formatting of Spanish version of report	--	--
GH Tech provides final Spanish and English version of final report to USAID/Nicaragua	--	--
Total LOE	59	57

A six-day work week is approved while in-country.

LOGISTICS

GH Tech will be responsible for all travel and consultant logistics. Any other logistical issues will be handled by USAID/Nicaragua in consultation with the Team Leader.

DELIVERABLES AND PRODUCTS

The evaluation team will complete the following deliverables:

Work plan: During the team planning meeting, the team will prepare a detailed work plan, including the methodology (evaluation design/operational work plan) to be used in the evaluation. The work plan should be submitted to USAID/Nicaragua for approval immediately following the TPM.

Analysis and synthesis of key findings: After carrying out interviews and site visits, the Evaluation Team will prepare and present key findings to USAID/Nicaragua, approximately four weeks after submitting the work plan.

Mid-evaluation meeting: The team will schedule a meeting with USAID/Nicaragua to discuss the findings to-date, troubleshoot possible obstacles towards completing the evaluation as planned, and review a proposed detailed outline of the evaluation report's format.

First draft evaluation report (Spanish): After receiving feedback from USAID on the key findings, the team will incorporate this feedback as appropriate and prepare and submit to USAID/Nicaragua a first draft report in Spanish upon completion of the field work. The report should clearly describe findings, conclusions, and recommendations. USAID will provide comments and suggestions on the draft report as soon as possible.

Debriefing meeting with USAID and PowerPoint presentation: The team will present the major findings of the evaluation to USAID/Nicaragua and Washington, through a PowerPoint presentation in English following submission of the preliminary draft evaluation report. The debriefing will include a discussion of findings, issues, and recommendations. The Evaluation Team will compile USAID comments from the debriefing and incorporate them into the draft report as appropriate.

Debriefing meeting with partners: The team will present the major findings of the evaluation to USAID partners (as appropriate and defined by USAID) through a Power Point presentation in Spanish before the conclusion of the in-country evaluation work and following the USAID debrief. The debriefings will include a discussion of findings only, with no recommendations for possible modifications to program approaches, results, or activities.

Second draft evaluation report (Spanish): The team will prepare and submit to USAID/Nicaragua a second draft report in Spanish upon receipt of USAID's comments both on the first complete draft report and from the debriefing meetings.

Materials for Validation Events: The team will prepare an agenda and a 2-page fact sheet in Spanish to be distributed during the events. The fact sheet will include evaluation results, highlights,

and recommendations for decision makers and will require approval by USAID/Nicaragua. In addition, 100 copies of the second draft report in Spanish will be printed for distribution at the events.

Three validation events to review the second draft evaluation report with stakeholders: This report will be validated in three events to share evaluation results with stakeholders for review and comment: a) donor meeting, b) other partners meeting (MOH, NGOs and universities), and c) USAID implementing partners.

Report of the validation: The consultant team will submit a final report in English summarizing the validation process.

Final evaluation report (Spanish): The consultant team will submit a final report in Spanish that incorporates responses to USAID's comments and validation suggestions no later than five days after USAID/ Nicaragua provides written comments on the second draft. Thirty hard copies and an electronic version of the Spanish evaluation report will be submitted to USAID.

Upon receiving USAID's final approval of the Spanish version of the report, GH Tech will have the document professionally edited and formatted. The final report will be submitted electronically to USAID/Nicaragua and 30 copies will be printed locally by USAID. GH Tech will also have the Spanish report translated into English and will send the electronic version of this report to USAID/Nicaragua to be printed locally. Because there is not likely to be adequate time prior to GH Tech's contract end date, it is not likely that GH Tech will have time to edit and format the English version of the report; however, if USAID/Nicaragua so desires, GH Tech will work with USAID/Nicaragua to identify a separate mechanism that would have the time and capacity to edit and format the English version of the report.

Reporting Requirements

The evaluation report (single spaced, double spaced between paragraphs) is expected to comply with USAID's new Evaluation Policy and checklist for USAID evaluation reports (this requires a 30-40 page report, not including executive summary or attachments, among other criteria).

The evaluation report should answer the evaluation questions and conclude whether or not and to what extent the Health program results and impacts were accomplished as well as what needs to be done to ensure sustainability of achievements.

The report should follow the following format:

Table of contents

List of acronyms and abbreviations

Executive summary: Should include a simple statement of the purpose of the evaluation, a very short description of the program, methodology, key results, conclusions and recommendations. This section selectively highlights only the most important things found in the evaluation report and is aimed at a wider audience than will read the full report. Concisely state the most salient findings and recommendations.

Introduction: Purpose of the evaluation, audience, synopsis of task and statement of the key questions to be answered.

Background: History and current situation with respect to the USAID Nicaragua Health program. This section should give a factual picture of the current situation with respect to the objectives of the program, the implementers and participants, different phases and projects, external factors that affected the achievement of objectives, and notable achievements and problems, if any, with respect to progress.

Methodology: This section will describe evaluation methods, including constraints and gaps.

Findings/Conclusions/Recommendations: This section should be organized by each Health program component and also present data on indicators, issues and outcomes.

Findings: Present key findings, including Health program indicators evaluation (both quantitative and qualitative)

Conclusions: Present conclusions for the key evaluation questions or other key issues identified during the evaluation. These conclusions should be numbered, followed by a short discussion of each conclusion. Each conclusion represents the evaluators' positive/negative judgments about the facts discussed.

Recommendations: Each recommendation should also be numbered and concisely stated, usually corresponding to a major conclusion, possibly followed by a short discussion of each recommendation. The recommendations refer to future actions that should be undertaken by USAID, other donors, or country stakeholders and should consider future development activities that could benefit from taking into consideration the lessons learned from the Health program experience, its achievements and problems faced, as well as the long-term sustainability of the program in Nicaragua.

References: Bibliographical documentation.

Annexes: Evaluation methods, schedules, interview lists and tables, meetings, interviews and focus group, etc. Should be succinct, pertinent and readable.

RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

Recruit and hire the evaluation team.

Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID/Nicaragua will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before In-Country Work

SOW. Respond to queries about the SOW and/or the assignment at large.

Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.

Local Consultants. Assist with identification of potential local consultants, including contact information.

Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa letters of invitation etc.).

During In-Country Work

Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).

Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.

Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-Country Work

Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

Mission Contact Person(s)

Alicia Dinerstein, Chief
USAID/Nicaragua/Office of Health and Education (OHE)
Email: adinerstein@usaid.gov
Tel: (505)2252-7146 ext. 7550

Clelia Valverde, MCH Specialist
USAID/Nicaragua/OHE
Email: cvalverde@usaid.gov
Tel: (505)2252-7146 ext. 7517

Marianela Corriols, FP and HIV Specialist
USAID/Nicaragua/OHE
Email: mcorriols@usaid.gov
Tel: (505)2252-7146 ext. 7306

Marcela Villagra, M&E Specialist
USAID/Nicaragua/OHE
Email: mvillagra@usaid.gov
Tel: (505)22527148 ext. 7504

XIII. Cost Estimate: GH Tech will provide a cost estimate for this activity.

ANEXO 2: GUIAS DE ENTREVISTAS A GERENTES A NIVEL NACIONAL

Nombre:

_____

Cargo: _____Lugar trabajo: _____

Fecha: _____/_____/_____

EXPLIQUE A LA ENTREVISTADA/O: Esta es una evaluación realizada por USAID a través de GH Tech, que persigue conocer su opinión acerca del nivel de ejecución y efectividad del Programa de Salud de USAID/Nicaragua en el periodo 2007-2013, teniendo como eje la salud de la mujer y la niñez, principalmente aquellas relacionadas con PF, VIH, Nutrición, Agua y saneamiento y gestión en los servicios de salud.

PREGUNTAS OBJETIVO 1: Eficacia

¿En qué medida los objetivos del programa de salud USAID/Nicaragua son relevantes para el contexto de la salud en el país?

Explique:

Mucho	Regular	Algo	Poco	Nada	N/S
□	□	□	□	□	□

¿En qué medida las intervenciones implementadas por el programa de salud son relevantes para alcanzar los retos específicos de país en:

ODM 4 (Salud materna)
ODM 5 (Salud niñez)
ODM 6 (VIH):
ODM 7 (Saneamiento)
Plan Nacional de Desarrollo Humano (PNDH)
Política Nacional de Salud (PNS)
Modelo de Salud Familiar y Comunitario (MOSAFC)

¿Cuáles considera que han sido los elementos preponderantes que forman parte del programa de salud USAID/Nicaragua?

¿En qué medida estos elementos están vinculados con los objetivos del país en el tema de salud?

Explique:

Mucho	Regular	Algo	Poco	Nada	N/S
□	□	□	□	□	□

¿En qué medida la asistencia técnica de USAID ha contribuido al diseño de estrategias y programas en salud relacionadas a:

Mucho	Regular	Algo	Poco	Nada	N/S

Salud materna Explique:	□	□	□	□	□	□

Salud infantil Explique:	Mucho	Regular	Algo	Poc	Nada	N/S
	□	□	□	□	□	□

VIH Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

Planificación familiar Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

Agua y saneamiento Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

Capacidad gerencial (servicios atención y Logístico) Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

¿Se han fijado objetivos comunes en el diseño de las intervenciones del programa de salud de USAID y el país, así como para planificar la implementación?

Si ☐ No ☐ Explique

¿En qué medida y cómo las metas, objetivos e indicadores de monitoreo y seguimiento del programa de salud de USAID ha estado alineados con la política de salud del país?

Si están alineados ☐ Explique
No están alineados ☐ Explique

¿En qué medida y cómo los objetivos fijados para el programa de salud han apoyado al país en la lucha por reducir las desigualdades entre la población y lograr el propósito planteado?

Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

¿En qué medida considera que el programa de USAID contribuyó a la implementación eficaz de los procesos de la institución?

Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

¿Permitió esto el logro eficaz de los resultados?

Si ☐ No ☐
Explique

Enumere de mayor a menor los cinco resultados más eficaces del programa de salud de USAID

Resultados eficaces (Nivel de importancia Mayor a menor)

¿En qué medida el programa de salud de USAID en el país ha sido implementado y monitoreado conjuntamente?

Explique:	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

¿El modelo de gestión de USAID (uso de recursos, estructuras organizativas, flujos de información) y los métodos de implementación permitieron que se comprometieran activamente a las contrapartes nacionales?

Si ☐ No ☐
Explique:

¿Qué tipo de buenas prácticas y lecciones aprendidas se pueden extraer de la implementación del programa de salud en sus resultados e impactos a nivel nacional?

Buenas prácticas	Lecciones aprendidas

¿En qué medida el programa de salud ha logrado los resultados e impactos y aporta a la mejora de las condiciones de vida de la población meta relacionadas con?

Salud materna	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
Salud de la niñez	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
Nutrición	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
VIH	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
Planificación familiar	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
Agua y saneamiento	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□
Capacidad gerencial	Mucho	Regular	Algo	Poco	Nada	N/S
	□	□	□	□	□	□

¿Cuáles son los efectos deseados y no deseados que ha generado el programa de salud de USAID/Nicaragua?

Efectos deseados	Efectos no deseados

¿Por qué razones el programa ha generado los efectos deseados y no deseados descritos?

Razones Efectos deseados	Razones Efectos no deseados

¿En qué ha contribuido el programa de salud al logro de los ODM 4, 5 y 6 a nivel nacional, SILAIS y local?

	Nacional	SILAIS	Local
ODM 4			
ODM 5			
ODM 6			

¿A qué contribuyeron más y cómo? Lea las opciones y enumere por orden de importancia?

	No.	¿Cómo?
Diseño de las políticas nacionales		
Capacidad de gestión		
Salud materna		
Salud de la niñez		
Nutrición		
VIH		
PF		
Agua y saneamiento		
Participación comunitaria		
Enfoque de género		

¿En qué medida se han establecido vínculos claros entre los resultados del programa de salud USAID/Nicaragua y la implementación del MOSAFC para el logro de los ODM?

Explique:

Mucho	Regular	Algo	Poco	Nada	N/S
□	□	□	□	□	□

¿En qué medida las comunidades beneficiarias han jugado un papel activo en el logro de los resultados del programa de salud?

Explique:

Mucho	Regular	Algo	Poco	Nada	N/S
□	□	□	□	□	□

¿Qué modos de organización comunitaria y liderazgo han dirigido este proceso?

¿Hay un efecto visible de participación comunitaria en los resultados del programa de salud?

Si ☐ No ☐

Explique

¿En qué medida han tenido éxito el programa de salud USAID/Nicaragua para lograr el mayor impacto entre los grupos vulnerables (mujeres – niñez, pobres, rurales, etnias)?

Mucho	Regular	Algo	Poco	Nada	N/S

Explique:	□	□	□	□	□	□	

¿En qué medida las instituciones nacionales y/o locales han incorporado las experiencias y aportes del programa de salud a su estructura programática, operativas y de gestión?

Explique:	Mucho	Regular	Algo	Poco	Nada	N/S	
	□	□	□	□	□	□	

¿Han ayudado las intervenciones del programa de salud de USAID/Nicaragua a reforzar su capacidad gerencial?

Si ☐ No ☐
Explique

¿Están comprometidos con la continuación de determinadas actividades del programa de salud? ¿Cuáles? ¿De qué manera?

Si ☐ No ☐
¿Cuáles?
¿De qué manera?

¿Hay ejemplos o indicios de replicaciones o extensiones planificadas de las intervenciones del programa de salud? Mencione

¿Cómo va a contribuir esto al progreso en el logro de los ODM y al desarrollo del MOSAFC?

ODM	MOSAFCs

Objetivo 2. Género

¿De qué manera han operacionalizado la política de género en la implementación del programa y los proyectos?

¿El programa de salud ha tenido en cuenta las necesidades y derechos de las mujeres y hombres durante la planificación de las intervenciones?

Si ☐ No ☐ Explique

¿La aplicación del enfoque de género del programa de salud de USAID es consecuente con la política de género del país?

Si ☐ No ☐

¿De qué manera?

Explique

¿Ha tenido éxito el programa de salud en asegurar que los beneficios de las intervenciones se hayan repartido equitativamente entre mujeres y hombres?

Si ☐ No ☐ Explique

¿La asistencia de USAID contribuyó a que la institución conozca y aplique un enfoque de género coherente con la política nacional de género?

Si ☐ No ☐ Explique

ANEXO 3: PERSONAS ENTREVISTADAS POR EL EQUIPO EVALUADOR

SECTOR ENTREVISTADO	NÚMERO DE PERSONAS
Consejo Regional Autónomo	1
Equipos técnicos de hospitales	32
Personal SILAIS	18
Personal Centros de Salud	16
Beneficiarias /os Casas Maternas	31
Promotores Comunidades	45
Socios Sector Privado	1
Donantes	11
Socios Implementadores	31
Socios Alianzas	43
Universidades	5
USAID	8
Total	251

MINISTERIO DE SALUD NIVEL CENTRAL		
Dr. Alejandro Solís	Director General	Dirección Nacional de Planificación y Desarrollo MINSA
Dra. Wendy Idiáquez	Director General	Dirección General Calidad y Atención
Dr. Carlos Sáenz	Director General	Dirección General de Vigilancia y Salud Pública – MINSA
Dr. Emilse Herrera González	Director	Dirección Cooperación Externa- MINSA
Dr. Carlos Cuadra	Director	Servicios Especializados – MINSA
Lic. Inti López	Tecnico	Dirección General Cooperación Externa- MINSA
Dr. Jesús Marín	Director	Salud Ambiental- MINSA
Ing. Maritza Obando	Directora	Salud Ambiental – MINSA
Lic. Erenia Zamora	Técnico	Dpto. de Docencia- MINSA

CONSEJO REGIONAL AUTÓNOMO		
Cynthia Miguel	2da. Vocal de Junta Directiva	Consejo Regional de la RAAN

EQUIPOS TECNICOS DE HOSPITALES		
Dra. Norbell Taylor	Director	Hospital Regional RAAN
Dra. Maribel Hernández	Directora	HBCR -
Dr. Víctor Mantilla	Sub Director Atención Médica	HBCR -
Dra. Nieves Sánchez	Jefa Servicio de Neonatología	HBCR -
Dr. Pedro Castillo	Coordinador Comité de Calidad	HBCR
Lic. Concepción Vindel	Jefa de Enfermería	HBCR -
Dr. Manuel Villanueva	Coordinador Equipo Multidisciplinario VIH	Hospital España –Chinandega
Dra. Norma Angelina Castro	Sub-Directora	Hospital España –Chinandega
Lic. Beatriz Laínez	Enfermera Componente VIH/SIDA	Hospital España –Chinandega
Dr. Francisco Castillo	Sub Director Atención Médica	Hospital Departamental – Somoto

EQUIPOS TECNICOS DE HOSPITALES		
Dra. Flor de Ma. Cruz	Jefa de Ginecología	Hospital Departamental – Somoto
Lic. Karla Sánchez	Sub – Jefa de Enfermería	Hospital Departamental – Somoto
Dra. Hellen Munguía	Responsable Componente VIH	Hospital Departamental – Somoto
Dra. Martha Sánchez	Director	Hospital Victoria Motta – Jinotega
Dr. Víctor Gómez	Director	Hospital Victoria Motta – Jinotega
Dr. Peralta Alarcón	Ginecólogo	Hospital Victoria Motta – Jinotega
Dra. Mariela Guido	Sub Directora Hospital	Hospital Victoria Motta – Jinotega
Ing. José Ramón Amador	Responsable Estadística	Hospital Victoria Motta – Jinotega
Lic. Verónica Ramírez	Planificación Familiar	Hospital Victoria Motta – Jinotega
Dr. Víctor Gómez	Director	Hospital Victoria Motta – Jinotega
Dr. Peralta Alarcón	Ginecólogo	Hospital Victoria Motta – Jinotega
Dra. Mariela Guido	Sub Directora Hospital	Hospital Victoria Motta – Jinotega
Ing. José Ramón Amador	Responsable Estadística	Hospital Victoria Motta – Jinotega
Lic. Verónica Ramírez	Planificación Familiar	Hospital Victoria Motta – Jinotega
Lic. Ivania Zeledón	Enfermera Neonatología	Hospital Victoria Motta – Jinotega
Dra. Doris Joyas	Médico General	Hospital Victoria Motta – Jinotega
Dra. Gioconda Ramírez	Epidemióloga	Hospital Victoria Motta – Jinotega
Lic. Marisol Quintana	Responsable Insumos Médicos	Hospital Victoria Motta – Jinotega
Lic. Melina Navas	Jefa de Unidad	Hospital Victoria Motta – Jinotega
Lic. José Sobalvarro	Responsable Laboratorio	Hospital Victoria Motta – Jinotega
María Ángeles Quintanilla	Enfermera	Hospital Victoria Motta – Jinotega
Lic. Nelson Pérez	Coordinador VIH/SIDA	Hospital Victoria Motta – Jinotega
Dr. Oscar Vásquez	Director Hospital	Hospital Asunción – Juigalpa
Dr. Víctor Gómez	Director Hospital	Hospital San Carlos- Río San Juan
Dra. Norbell Taylor	Director Hospital Regional	Hospital Regional –RAAN
Lic. Mary Lacayo	Enfermera	Hospital Regional –RAAN
Dra. Alma Rosa Castro	Sun Directora Docente	Hospital Regiona RAAS

SILAIS		
Dra. Ivania López	Directora del SILAIS	Silais –Bilwi - RAAN
Dr. Alberto Javier Amador	Sub-Director del SILAIS	Silais –Bilwi - RAAN
Lic. Isabel Cunningham	Enfermera del SILAIS	Silais –Bilwi - RAAN
Dr. Ricardo Taylor	Director SILAIS	Silais- Bluefields -RAAS
Dra. Katia Sujo	Atención a la Mujer	Silais- Bluefields -RAAS
Dra. Susy Mayorga	Sub Directora Docente	Silais- Bluefields -RAAS
Dr. Harold Rugama	Director	Silais-Nueva Segovia
Lic. Rosangeles Ortez	Responsable Insumos Médicos	Silais - Madriz
Lic. Nohemí Vílchez	Responsable Enfermería	Silais - Madriz
Dr. Erasmo Jarquín	Director	Silais Matagalpa
Lic. María Á Quintanilla	AIMNA	Silais- Jinotega
Dr. Nelson Pérez R.	Coordinador Componente VIH	Silais- Jinotega
Dr. Eduardo Canales	Director	Silais - Chontales
Dra. Bernarda Oporta	Sub Dirección Atención Médica	Silais - Chontales
Dr. Fernando Canales	Director	Silais -Río San Juan
Dr. Aristeo Jirón	Responsable Epidemiología	Silais -Río San Juan
Lic. Karla Hernández	Responsable AIM	Silais -Río San Juan
Lic. María Teresa Centeno	Responsable componente VIH/SIDA	Silais -Río San Juan

CENTROS DE SALUD		
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Lic. Ellin Morales	Jefa de Enfermería Municipal	Centro de Salud - Laguna de Perlas
Sheymon Castillo	Enfermero Servicio Social	Centro de Salud - Laguna de Perlas
Marielby Joseph	Enfermera Servicio Social	Centro de Salud - Laguna de Perlas
Dra. Jaqueline Delgado Sánchez	Coordinadora Clínica VIH	Centro de Salud - Chinandega
Lic. Osmín Jirón	Equipo Multidisciplinario VIH/SIDA Municipal	Centro de Salud - Chinandega
Lic. Maribel Machado S.	Responsable Enfermería Municipal	Centro de Salud- Jinotega
Lic. Erika Siles B.	Responsable Estadística Municipal	Centro de Salud- Jinotega
Lic. Ligia Zelaya	Directora interina. Municipal	Centro de Salud -Jinotega
Dra. Marbel Zúniga	Directora Municipal	Centro de Salud- San Lucas, Somoto
Lic. Nidia Vásquez	Responsable de Insumos Médicos	Centro de Salud- San Lucas, Somoto
Dr. Diego Calvo	Director Municipal	Centro de Salud Nueva Guinea, Chontales.
Lic. Nicolasa Jarquín	Responsable Epidemiología	Centro de Salud Nueva Guinea, Chontales.
Lic. Bania Membreño	Responsable Insumos Médicos Municipio	Centro de Salud Nueva Guinea, Chontales.
Lic. Guillermina Cruz	Responsable de Enfermería Municipal	Centro de Salud Nueva Guinea,
Lic. Claudia Padilla	Responsable Enfermería Hospital Primario	Centro de Salud Nueva Guinea, Chontales

CASAS MATERNAS		
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Isolda Traña	Responsable	Casa Materna, Jalapa, Nueva Segovia
Paula Vanegas	Responsable	Casa Materna, San Ramón, Jalapa, Nueva Segovia

CASAS MATERNAS		
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Martha Elena Blandón	Beneficiaria	Casa Materna, San Ramón, Jalapa, Nueva Segovia
Maryoris Flores	Beneficiaria	Casa Materna, San Ramón, Jalapa, Nueva Segovia
Xiomara Flores	Beneficiaria	Casa Materna, San Ramón, Jalapa, Nueva Segovia
María Auxiliadora Dian González	Beneficiaria	Casa Materna, San Ramón, Jalapa, Nueva Segovia
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Yessica Zeledón Castro	Beneficiaria	Casa Materna Municipio Jinotega
Lic. Francisca Espinoza	Coordinadora Casa Materna	Casa Materna Municipio Jinotega
Masiel Rodríguez	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Marling Cruz Muñoz	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Ada Luz Chavarría	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Marlene Gadea P.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
María Paredes S.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Ana Gutiérrez R.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Iselda Blandón	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Erika Carvajal	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Petronila González	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Santos Pichardo	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Kenia Urbina	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Esmeralda López	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Mayra Pineda	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Justina B.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Lucía Tinoco L.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Aurora Ferrera G.	Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Martín Blandón	Acompañante Beneficiaria Casa Materna	Casa Materna Municipio Jinotega
Luizhangella Tenorio	Responsable Casa Materna	Casa Materna San Carlos, Río San Juan.
María Chavarría	Beneficiaria Casa Materna	Casa Materna San Carlos, Río San Juan.

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Gloria Ortiz	Embarazada	Comunidad La Lucha, La Dalia – Matagalpa
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Llerenia Soza Blandón	Brigadista	Comunidad La Lucha, La Dalia – Matagalpa
Marveliz Ortega	Brigadista	Comunidad La Lucha, La Dalia – Matagalpa
Elida Mendoza	Brigadista	Comunidad La Lucha, La Dalia – Matagalpa
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Donald Rivera	Brigadista de Salud Adolescente	Los Canales. Mcpio. San Lucas – Somoto
Dora Guillén	Brigadista de Salud	Los Canales. Mcpio. San Lucas – Somoto
María Hernández	Brigadista de Salud – Partera	Los Canales. Mcpio. San Lucas – Somoto
Auxiliadora Hernández	Brigadista de Salud	Los Canales. Mcpio. San Lucas – Somoto
Porfirio Rivera	Brigadista de Salud	Los Canales. Mcpio. San Lucas – Somoto
Rosario González	Responsable ETV	Los Canales. Mcpio. San Lucas – Somoto
María Mendoza	Enfermera ESAFC 1. Los Canales	Los Canales. Mcpio. San Lucas – Somoto
Vicente Carazo	Brigadista de Salud	Los Canales. Mcpio. San Lucas – Somoto
Jarling Rivera M	Brigadista	Comunidad San Antonio Sisle, Jinotega
Juan J. Rivera Herrera	Brigadista	Comunidad San Antonio Sisle, Jinotega
Flora Granados	Brigadista	Comunidad San Antonio Sisle, Jinotega
Silvia Elena Rivera	Brigadista	Comunidad San Antonio Sisle, Jinotega
Ada Gloria Chavarría	Brigadista	Comunidad San Antonio Sisle, Jinotega
Máxima Ester Granados	Brigadista	Comunidad San Antonio Sisle, Jinotega
María Concepción Mejía	Beneficiaria Famisalud	Comunidad San Antonio Sisle, Jinotega
Alba Luz Herrera	Beneficiaria Famisalud	Comunidad San Antonio Sisle, Jinotega
Fátima Hernández	Beneficiaria Famisalud	Comunidad San Antonio Sisle, Jinotega
María B. Granados	Beneficiaria Famisalud	Comunidad San Antonio Sisle, Jinotega
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Martha Orozco	Brigadista Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
Vilma Bravo	Brigadista Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
Estelvina Amador	Brigadista Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
Salvadora Espinoza	Brigadista Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
María Acevedo	Beneficiaria Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
Cenelia López	Beneficiaria Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
Idania Sevilla	Beneficiaria Famisalud	Comunidad Never Oporta, San Miguelito, Río San Juan
María González	Beneficiaria Famisalud	Comunidad Never Oporta, San Miguelito
Fanny Duarte	Beneficiaria	Comunidad Never Oporta, San Miguelito, Río San Juan

COMUNIDADES		
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Ayling R. T.	Beneficiaria	Comunidad Never Oporta, San Miguelito, Río San Juan
Keylin A. B.	Beneficiaria	Comunidad Never Oporta, San Miguelito, Río San Juan

SOCIOS DEL SECTOR PRIVADO		
Mariela Terán		COSEP

DONANTES		
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María Jesús Largaespada	Experta para el Desarrollo Sector Salud	Embajada de los Países Bajos
Edgard Narváez	Asesor Salud Reproductiva	El Fondo de Población de las Naciones Unidas
Rafael Amador	Asesor en Salud /Nutrición /VIH	El Fondo de las Naciones Unidas para la Infancia
Enmanuelle Sánchez	Especialista en desarrollo Social	Banco Interamericano de Desarrollo
José Gómez	Representante Interino	OPS/OMS
Reynaldo Aguilar	Salud de la Familia y la Comunidad OPS/OMS	OPS/OMS
Wilmer Marquiño	Vigilancia de la Salud, Prevención y Control de Enfermedades	OPS/OMS
Gerardo Galvis	Desarrollo Sostenible y Salud Ambiental	OPS/OMS
Ivy Lorena Talavera	Salud Materna, Salud Reproductiva	OPS/OMS
Maritza Romero	Coordinador Salud Familiar y Comunitaria	OPS/OMS

SOCIOS IMPLEMENTADORES		
Melissa McSweggin	Coordinadora	ALIANZAS/RTI
Ivonne Gómez	Directora	HCI
Yvoly Carla Wong Blandón	Asesora USAID-HCI	HCI
Judith Wong		HCI
Luis Manuel Urbina T.	Asesor Mejoramiento de la calidad Salud Materna	HCI
Dr. Norman Bladimir Fornos	Gerente General	HCI – Alianzas
Josefina Bonilla	Directora Ejecutiva	NICASALUD
Fernando Campos	Sub Director Ejecutivo	NICASALUD
Adelina Barrera	Coordinadora de. Proyecto	NICASALUD
Ovidio Blanco	Responsable M&E	FAMISALUD
Dr. Guillermo Rodríguez	Responsable	FAMISALUD – CARE Matagalpa
Lesbia Duarte	Administradora	FAMISALUD – San Carlos, RSJ
Dr. Guillermo Rodríguez		FAMISALUD RIO SAN JUAN
Maritza Narváez		NIPRONICASS
Carolina Aráuz	Director	DELIVER
Dr. Rigoberto Berrios	Coordinador	DELIVER
Lic. Sara Rizo	Coordinadora de Campo	DELIVER

SOCIOS IMPLEMENTADORES		
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Jairo Nuñez	Asesor	DELIVER
Danilo Nuñez	Asesor	DELIVER
Rafael Arana	Asesor	PREVENSIDA
Carlos Jarquín	Asesor	PREVENSIDA
Roberto González	Asesor	PREVENSIDA
Edilberto Mendoza	Asesor	PREVENSIDA
Félix Garrido		PREVENSIDA RAAS
Sheyla López		PREVENSIDA RAAS
Oscar Núñez	Director de País URC	URC
Nelson González M.	Director Ejecutivo	URC
Manuel Calderón	Gerente Financiero	URC
Zoyla Segura	Coordinadora de Proyectos	URC
William José Peréz López	Responsable de Monitoreo y Evaluación	URC

ALIANZAS		
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Hna. Juana Ángela García	CARE Juan XXIII	Dispensario Divino Niño y Comedor Sta. Clara de Asís
Keitha Cooper	Coordinadora ACCCSIDA	ACCCSIDA
Jelissa Pineda	Coordinadora Proyecto ACCCSIDA	ACCCSIDA
Aurora Jarquín	Coordinadora Proyecto FADCANIC	FADCANIC
Ana Julia Obando	Coordinadora Programa Género FADCANIC	FADCANIC
Garry Gisby J.	Técnico Consejero en Salud	MDS RAAS
Tyron Aburto	Coordinador Proyecto	MDS RAAS
Yelky Ordóñez	Promotora de Laboratorio	Campaña Costeña - RAAS
Donald Downs	Promotor de Laboratorio	Campaña Costeña - RAAS
Joel Exequiel Natty González	Director Ejecutivo	MODISEC-Bilwi
Elmer Peter Johnson Sinclair	Programático	MODISEC-Bilwi
Jayson Kennedy Bermúdez	Promotor	MODISEC-Bilwi
Jessica Natty Gonzalez	Promotora	MODISEC-Bilwi
Justin Coban Bons	Promotor	MODISEC-Bilwi
Charly Igle Alberto	Promotor	MODISEC-Bilwi
Delvin Adonys Simons	Administrador	Asociación Vida Futura -Bilwi
Hilario Supper García	Secretario, Asociación Vida	Asociación Vida Futura -Bilwi
Marvin Sequeira Marshall	Promotor	Asociación Vida Futura -Bilwi
Roberto Jeréz	Asesor	ANF
Heriberto Cruz	Asesor	ANF
Rafael Lucio	Asesor	IDEUCA

ALIANZAS		
Marlene Vivas	Directora	ADESENI
Silvia Martínez	Directora	Red Trans
William José Pérez López	Responsable Monitoreo y Evaluación	Centro de Acción Juvenil-PELG
María Lourdes Rodríguez Bolaños	Director Ejecutiva	IXCHEN
Lucia Grilli Peral	Coordinadora	Gaviota
Norman Gutiérrez	Director Ejecutivo	CEPRESI
Patricia Gutiérrez	Directora Administrativa	CEPRESI
Javier Montiel	Coordinador Regional	CEPRESI
Antonia Sánchez	Coordinadora CEPRESI Occidente	CEPRESI - Chinandega
Eduardo Espinoza	Facilitador CEPRESI Occidente	CEPRESI Occidente
Jeyson Díaz	Médico CEPRESI Occidente	CEPRESI Occidente
Rod Montero	Psicólogo CEPRESI Occidente	CEPRESI Occidente
César Monge	Beneficiario Diversidad Sexual	
Calixto Chavarría	Beneficiario Diversidad Sexual	
Félix Orozco	Beneficiario Diversidad Sexual	
Víctor Sáenz	Beneficiario Diversidad Sexual	
Carlos Solís	Beneficiario Diversidad Sexual	
Luís Ríos	Beneficiario Diversidad Sexual	
Julio Mena	Director Ejecutivo	ANICP+Vida
Arelys Cano	Directora	ASONVIHSIDA

UNIVERSIDADES		
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Alicia Elena Kelly	Sub Directora Escuela de Enfermería	BICU – RAAS
Lic Jeannette Cash	Docente de la Carrera de Medicina	BICU – RAAS
Noel Soza	Docente	BICU – RAAS
Dr. Manuel Salvador Salas	Coordinador Carrera de Medicina Intercultural	URACCAN – RAAN

MISION USAID NICARAGUA		
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Alicia Dinerstein	Directora Oficina de Educación y Salud	USAID
Angela Cárdenas	Directora Oficina de Desarrollo General	USAID
Clelia Valverde	Especialista MCH	USAID
Marianela Corriols	Especialista VIH y PF	USAID
Marcela Villagra	Oficial de Evaluación	USAID

ANEXO 4
DESCRIPCION DE LOS PROYECTOS IMPLEMENTADORES DE USAID/NICARAGUA

Proyecto Mejoramiento de la Atención en Salud (HCI)

HCI brindó cooperación técnica centrada en el mejoramiento continuo de la calidad (MCC) en procesos clínicos, en las áreas de atención materna-infantil, VIH-Sida y planificación familiar (PF), a fin de contribuir con el logro de objetivos nacionales y compromisos internacionales propuestos entre las prioridades de salud; inicialmente fue a través del proyecto Garantía de Calidad (QAP/USAID) en el periodo de noviembre 1999 – septiembre 2006 y, posteriormente, con el de Mejoramiento de la Atención en Salud (USAID/HCI) de octubre 2006 – septiembre 2013.

El mayor tiempo de la asistencia técnica de los dos proyectos, hasta septiembre 2012, fue destinado al Ministerio de Salud (MINSA), específicamente en centros de salud y hospitales en los 17 SILAIS que funcionan en el país. También se apoyó a otras instituciones públicas y privadas del sector salud y a universidades.

Objetivos de la asistencia técnica

Asistir a los programas nacionales y locales para ampliar las intervenciones basadas en la evidencia y mejorar los resultados en salud materna, neonatal, infantil, VIH/SIDA, y la salud reproductiva.

Ayudar a mejorar la eficiencia y reducir los costos de la mala calidad, utilizando enfoques de mejora continua de la calidad.

Mejorar las capacidades y desempeño del personal de salud.

Transferir el paquete pedagógico de planificación familiar, salud materna, salud infantil y VIH a las universidades.

Número de contrato: GHN-I-03-07-00003-00

Fecha Inicio/Terminación: 10/2007 – 09/2013

% de tiempo implementado: 83%

Costo total estimado: $ 6,129,594

% Total del presupuesto desembolsado: 90%

Areas geográficas de Intervención:

(Nivel nacional- MINSA y Universidades (facultades de Medicina y Escuelas de Enfermería).

Actividades: Fortalecimiento institucional, Mejoramiento Continuo de la Calidad de Atención en Salud materna, infantil, planificación familiar y VIH, Mejoramiento de las capacidades y desempeño del personal de salud.

Proyecto DELIVER

La Agencia de Cooperación para el Desarrollo de los Estados Unidos, a través de su proyecto DELIVER, con oficina local en el país desde el año 2003, brinda asistencia técnica y financiera tanto al sector público (MINSA e INSS) como privado. Sus principales actividades han sido:

Fortalecimiento de datos oportunos y confiables de medicamentos a través del PASIGLIM

Fortalecimiento de la disponibilidad de anticonceptivos e insumos para las complicaciones obstétricas en puestos de entrega de servicios.

Fortalecimiento de la logística de Antirretrovirales (ARV) a unidades de salud que brindan Terapia Antirretroviral (TARV)

Fortalecimiento de la gestión del uso racional de medicamentos a través de los CURIM

Ferias de salud para promoción de Métodos Anticonceptivos (MAC), con énfasis en los de larga duración en el marco del plan Disponibilidad Asegurada de Insumos Anticonceptivos – DAIA.

Transferencia de habilidades a la Clínica Médica Previsional del MINSA para mejorar la gestión de la cadena de suministros.

Fortalecimiento de todas las actividades ejecutadas por el SILAIS mediante la entrega y distribución de material informativo, educativo y de comunicación.

Transferencia de habilidades en logística y uso racional a escuelas formadoras públicas y privadas en las carreras de farmacia, medicina y enfermería.

PEPFAR

USAID | PROYECTO DELIVER

Número de contrato:	GPO-1-00-06-00007-00
Fecha de Inicio/Terminación:	10/2006 – 09/2014
% de Tiempo Implementado:	**89** %
Costo Total Estimado:	$ 3,773,000
% Total del Presupuesto Desembolsado:	**94** %
Areas Geograficas de Intervención:	Nacional

Contrapartes:
MINSA (18 SILAIS, Clínicas Médicas - Seguridad Social, Comité DAIA (finalizando Sept. 12)
6 Universidades, 7 empresas médicas privadas- S. Social, 22 ONGs (Oct.12-14)

Proyecto PrevenSida

PrevenSida es el proyecto de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID) para la prevención de la transmisión del VIH/Sida en poblaciones de alto riesgo. Es un proyecto de cinco años (20 septiembre 2010 a 20 septiembre 2015) y con una inversión de $5 millones de dólares. Se implementa en los departamentos de Chinandega, León, Managua, Masaya, Granada, Rivas, Chontales, RAAN y RAAS. El programa es administrado por University Research Co., LLC (URC) bajo el acuerdo cooperativo número AID-524-A-10-00003.

Los indicadores son: Incrementar conductas saludables en personas en mayor riesgo, para disminuir la transmisión de VIH/sida a través del uso de condón, reduciendo el número de parejas sexuales, e incrementado el acceso a la consejería y promoción de la prueba de VIH.

Sus contrapartes son el Fondo Mundial, CONISIDA, Proyectos de USAID, Centro de Investigación y Estudios de la Salud (CIES), Centro para el Control y Prevención de las Enfermedades (CDC), Cuerpo de Paz y Organizaciones de la Sociedad Civil.

Los resultados esperados son: fortalecida la capacidad institucional de al menos 20 ONG, mejorado el acceso a servicios preventivos de calidad. Reducido el estigma y discriminación hacia las poblaciones clave y mejorada la participación de ONG en la respuesta nacional ante el VIH y Sida.

PEPFAR

USAID | PrevenSida

Número de contrato:	AID-524-A-10-00003
Fecha de inicio/terminación:	20/09/2010 - 20/09/2015
% de tiempo implementado:	50%
Costo total estimado:	$5,000.000
% Total del presupuesto obligado:	70.5%
Áreas de intervención:	Managua, Rio San Juan, Masaya, Rivas, Chontales, León, Chinandega, Granada, RAAN y

Actividades: **Fortalecimiento institucional, prevención con MARPS y PVS, reducción de estigma y discriminacion, fortalecer participacion informada de la sociedad civil en la respuesta nacional.**

Contrapartes: Fondo Mundial, CONISIDA, Proyectos de USAID, Centro de Investigación y Estudios de la Salud , Centro para el Control y Prevención de las Enfermedades , Cuerpo de Paz y Organizaciones de la Sociedad Civil.

Proyecto FamiSalud

La Federación Red NicaSalud implementó, en alianza con 18 ONG miembros, el proyecto comunitario Familias Unidas por su Salud (FamiSalud/USAID), en el contexto del objetivo estratégico N°3–OE3: Inversión Social "Población más saludable y más educada", del Plan Quinquenal Regional 2003-2008 de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID). En su modalidad de ejecución se implementó en tres fases en el periodo de abril 2006 a septiembre 2013. El objetivo de esta intervención estuvo dirigido a "mejorar el estado de salud de la población nicaragüense a través de cambios positivos en la salud y nutrición de hogares y comunidades".

En términos de cobertura el proyecto se implementó en 1,568 comunidades y benefició de forma directa a 607,528 personas en 78 municipios de 10 departamentos y 2 regiones autónomas del Atlántico. Contó con la participación de aproximadamente 5,000 voluntarios y voluntarias de comunidades que implementaron en conjunto con MINSA las estrategias: Plan de Parto, Planificación familiar (ECMAC o PPFC), PROCOSAN/AIEPI, Agua Segura y Coloreando en Salud con la participación del MINED, entre otras.

La principal contribución se ubica en términos de "Mejora de la cobertura y acceso de los servicios de salud materno e infantil; conocimientos y mejores prácticas comunitarias en el cuido de la salud de niños menores de 5 años, mujeres en edad fértil y embarazadas, planificación familiar; así como en mejorar las prácticas de higiene y consumo de agua segura en las familias.

USAID | PROYECTO FAMISALUD

Número de contrato:	524-A-00-06-00005-00
Fecha de Inicio/Terminación:	04/2006 – 09/2013
% de Tiempo Implementado:	99%
Costo Total Estimado:	$ 16,129,000
Areas Geográficas de Intervención:	Nacional: 12 SILAIS
Beneficiarios estimados:	607,528

Actividades: Asistencia técnica, capacitación, fortalecimiento de capacidades de ONG, instituciones contrapartes y de la red comunitaria; implementación de estrategias comunitarias para el mejoramiento de la salud materno infantil, planificación familiar, y la salud ambiental; investigaciones, monitoreo y evaluación; apoyo a casas maternas, trabajo en red y alianza con empresa privada y universidades.

Contrapartes:
ONG miembros de NicaSalud, MINSA, MINED, Universidades, Red de voluntarias y voluntarios comunitarios.

Programa Regional de Prevención Combinada para el VIH en Centroamérica y México (PASMO)

Presente en toda la región centroamericana a excepción de Honduras, tiene como objetivo la reducción de la transmisión del VIH en poblaciones en mayor riesgo. Se enfoca en cuatro resultados: reducir la prevalencia de comportamientos de alto riesgo, reducir el estigma y discriminación por orientación sexual, incrementar el acceso a un paquete mínimo de servicios de prevención y generar información estratégica para diseñar o ajustar las actividades de prevención y se implementa a través de alianzas estratégicas con ONGs locales, líderes comunitarios y desde las redes sociales.

Durante 2010-2012, en Nicaragua ha beneficiado a 10,816 personas, entre ellas 625 personas con VIH con el paquete mínimo de prevención, que integra la realización de 3,324 pruebas de VIH.

Desde octubre 2012, estableció sinergia con el Programa PrevenSida, para enfocarse en el fortalecimiento técnico – metodológico de ONGs locales a través de la transferencia de capacidades de ejecución de actividades de prevención a través de metodologías interpersonales, interactivas, presenciales dirigidas al cambio de comportamiento. A partir de 2013 ha incorporado el abordaje virtual con HSH y Grupos de Apoyo a PV a través de alianzas con dos ONG locales en León y Managua, que les permite tener una cobertura nacional y su enlace con el resto de países de la región.

Número de contrato:	CA-AID-596-A-10-00001
Fecha de Inicio/Terminación:	30/09/2010 a 30/09/2015
% de Tiempo Implementado:	70%
Costo Total Estimado:	$ 30,000,000 ($16,000,000 CA, $4,766,228 México) $ 1,404,196 (Nicaragua)
% Total del Presupuesto Desembolsado:	**75%**
Areas de Intervention:	Chinandega, León, Managua, Rivas, Rio San Juan, Ocotal, Esteli, Matagalpa

Actividades:

Intervenciones para promover Cambio de Comportamiento con PEMAR

Accesibilidad a productos y servicios para VCT, Diagnóstico temprando de ITS , Información Estratégica para toma de decisiones y generación de acciones para la disminución del Estigma y Discriminación por orientación sexual, status o actividad laboral.

Programa para Fortalecer la Respuesta Centroamericana al VIH (PASCA)

El Programa de USAID para fortalecer la respuesta centroamericana al VIH (USAID/PASCA) tiene como propósito brindar asistencia técnica para fortalecer y ampliar la respuesta centroamericana al VIH/SIDA en la región centroamericana, implementando actividades específicas por país en Belice, Costa Rica, El Salvador, Guatemala, Nicaragua y Panamá, así como otras de alcance regional que abarcan toda Centroamérica.

USAID/PASCA apoya la respuesta nacional y regional al VIH en las siguientes áreas estratégicas de la respuesta nacional:

Planificación, implementación, monitoreo y evaluación de planes estratégicos nacionales en VIH-Sida.

Alianzas estratégicas, abogacía y diálogo político para fortalecer la respuesta al VIH-Sida.

Involucramiento de la iniciativa privada en la respuesta al VIH

Actividades: Asistencia técnica y capacitación para la articulación multisectorial en monitoreo y evaluación, abordaje PEMAR, violencia basada en género e involucramiento del sector privado en la respuesta al VIH. El ámbito de intervención de PASCA es nacional.

PASCA trabaja con la Comisión Nicaragüense del Sida, Organizaciones de Poblaciones en Más Alto Riego, el Consejo Superior de la Empresa Privada, sector privado en general y la Academia.

USAID | PASCA

Número de contrato:	GPO-I-04-05-00040-00
Fecha de inicio/terminación:	1/10/2008-30/09/2013. Nicaragua inició el 1/12/2009 Extensión 01/10/13-31/03/14
% de Tiempo Implementado:	**98%**
Costo Total Estimado para Nicaragua:	$1,277,037
% Total del Presupuesto Desembolsado:	**98%**
Áreas de Intervención:	Nacional

Actividades: Asistencia técnica y capacitación para la articulación multisectorial en monitoreo y evaluación, abordaje PEMAR, violencia basada en género e involucramiento del sector privado en la respuesta al VIH.

Contrapartes: Comisión Nicaragüense del Sida (CONISIDA), Consejo Superior de la Empresa Privada (COSEP), Empresas, Organizaciones PEMAR, Academia, Programas Socios USAID

Proyecto RTI/Alianzas 2

El programa de Alianzas Multisectoriales, conocido como *Alianzas2,* es un acuerdo de cooperación entre USAID y RTI International, para fomentar alianzas público-privadas con el objetivo de combinar la experiencia en temas de desarrollo, conocimiento empresarial y el compromiso local. El objetivo fundamental es aumentar la inversión social en salud, educación y gobernabilidad e impulsar en Nicaragua, mayor estabilidad social, política y económica y mejorar la contención y mitigación del VIH/Sida. El proyecto contempla la recaudación de fondos de contrapartida en una proporción de 2:1 sobre la contribución de USAID de $3.3 milliones para ser invertidos durante el periodo de septiembre de 2010 a octubre 2013. RTI tiene la responsabilidad de construir alianzas vinculando socios del sector privado con las organizaciones implementadoras, trabajando al nivel nacional en las áreas técnicas de educación, salud, VIH y gobernabilidad. Para el tema de salud los resultados intermedios son:

Las alianzas con el sector privado aumentarán la cobertura, calidad y sostenibilidad de los servicios e información de la salud materna en zonas rurales y poblaciones de mayor riesgo, con el objetivo de disminuir la mortalidad materna infantil. Alliances2 mejorará el acceso a medicamentos en las zonas de mayor necesidad. Adicionalmente, ayudará a los proveedores del sector privado, de estos servicios, a mejorar sus conocimientos y prácticas al igual que alinearlas con las normas del sector público, con el objetivo de mejorar el cuidado de la salud materno infantil haciendo uso de la tecnología; incrementando el porcentaje de partos atendidos por personal capacitado; mejorando la intervención y apoyo comunitario; entrenando enfermeras y personal médico; promoviendo la lactancia materna; mejorando el cuidado del neonato; aumentando la cobertura de inmunización y brindando consejería y pruebas voluntarias de VIH/SIDA.

USAID | NICARAGUA
FROM THE AMERICAN PEOPLE

RTI INTERNATIONAL

Nombre del Proyecto:	**Strategic Alliance for Social**
Número de contrato:	520-A-00-10-00031-00
Fecha de Inicio/Terminación:	09/2010 – 10/2013
% de Tiempo Implementado:	93 %
Costo Total Estimado:	$ 3,300,000
Áreas Geográficas de Intervención:	Nacional
Beneficiarios estimados:	500,000

Actividades: creación de alianzas publicas-privadas, reducción de la mortalidad materno-infantil, capacitación de personal de salud, aumentar acceso de medicamentos básicos, capacitación de docentes y padres en nutrición,

Contrapartes: Fundación Zamora Teran (FZT), American Nicaraguan Foundation (ANF), American Chamber of Commerce (AMCHAM) Nicaragua, Instituto de Acción Social Juan XXIII, Consejo Superior de la Empresa Privada (COSEP), Foro Educativo Nicaragüense EDUQUEMOS

ANEXO 5

LISTA DE PARTICIPANTES A EVENTOS DE VALIDACION DEL INFORME DE EVALUACION DEL DESEMPEÑO DE LA COOPERACIÓN DE USAID EN NICARAGUA

Actividad 1: Reunión de validación con socios implementadores.

Hotel Princess, miércoles 15 de enero 2014

	Nombre	Institución	Cargo
1	René A. Villalobos M.	USAID PrevenSida	Asesor Monitoreo y Evaluación
2	Ivonne Gómez P.	USAID HCI	Directora
3	Carlos Jarquín G	USAID PrevenSida	Asesor
4	Anne Christian Largaespada	USAID PASCA	Representante de País
5	Oscar Núnez	USAID PrevenSida	Coordinador PrevenSida
6	Gertrudis Medrano	NicaSalud/FamiSalud	Coordinadora Gestión del Conocimiento
7	Yudy Carla Wong Blandón	USAID PrevenSida	Asesora
8	Josefina Bonilla	NicaSalud/FamiSalud	Directora Ejecutiva
9	Fernando Campos	NicaSalud/FamiSalud	Sub Director
10	Iván Tercero Talavera	USAID Nicaragua	Ex especialista en salud
11	Adelina Barrera	FamiSalud/NicaSalud	Coordinadora tecnica
12	Maritza Narváez	USAID DELIVER	Asesora Logística
13	Carolina Aráuz	USAID DELIVER	Coordinadora de País
14	Claudia Evans	USAID HCI	Ex - Asesora en PF
15	María Laura Aragón	USAID PASMO	Capacitadora
16	Martha Karolina Ramírez	USAID DELIVER	Gerente de Programa CCC
17	Rafael Arana	USAID PrevenSida	Asesor Monitoreo y Evaluación
18	Mario Lacayo	USAID PRONICAS	Coordinador de proyecto
19	Clelia Valverde	USAID Nicaragua	Especialista en Salud
20	Marianela Corriols	USAID Nicaragua	Especialista en Salud
21	Carolina Valle	GH Tech	Consultora

Actividad 2: Reunión de validación con contrapartes proyectos USAID (ONGs, Universidades, MINSA) Hotel Princess, jueves 16 de enero 2014

	Nombre	Institución	Cargo
1	Elisa María Estrada	Compañeros de las Américas	Directora Ejecutiva
2	Hugo René Pérez Díaz	Facultad de CC. Médicas UNAN Managua	Vice Decano AA Clínicas
3	Ramiro López Rivas	Facultad de CC. Médicas UCAN	Vice Decano General
4	Oscar Jerónimo Aburto	NicaSalud	Especialista Salud Ambiental
5	Ramiro Blanco Cuadra	Fundación ALISTAR Nicaragua	Responsable de Proyectos
6	David Tijerino	Plan Nicaragua	Coordinador M&E
7	Ellen Arnstein	Catholic Relief Services	Fellow
8	Patricia Pérez	NicaSalud	Nutricionista
9	Nelson Caballero	ADP	Médico
10	Ivonne Gómez	USAID/ASSISP	Directora
11	Roberto Jeréz	ANF	Gerente Programa Educativo, Alimentario y Especial
12	Byron Acevedo	Deliver	Comunicador
13	Alma Lila Pastora	UNICIT	Decano Facultad Ciencias de la Salud
14	Breddy Zeledón	NicaSalud	Especialista en Nutrición
15	Asención Urbina	INPHRU Somoto	Director de Programa
16	Jhon Merlo López	CEPS	Coordinador de Proyecto
17	Carolina Aráuz	USAID Deliver	Coordinadora
18	Félix López	UNAN Managua	Docente Facultad CC. Médicas
19	Rosa María González	UNAN Managua	Directora Departamento Docente de Química
20	Marcela Villagra	USAID Nicaragua	Monitoreo y Evaluación
21	Marianela Corriols	USAID Nicaragua	Especialista en Desarrollo de Proyectos
22	María Lourdes Rodríguez	IXCHEN	Directora Ejecutiva
23	Salvador Reyes	CEPRESI	Coordinador Técnico
24	Fidel Moreira	CEGODEM	Director Ejecutivo
25	Nancy Rodríguez	Procuraduría de Derechos	Secretaria Procuraduría Especial de la

		Humanos	Diversidad Sexual
26	Oscar Núnez	Prevensida	Coordinador
27	Janny Pérez	ADMUTRANS	Presidenta
28	Francisco José Pérez	ADMUTRANS	Promotor
29	Jhonson Hernández	ADMUTRANS	Secretario
30	Marlene Vivas	ADESENI	Presidenta y Representante Legal
31	Devon Rado	ADMUTRANS	Promotor
32	Julio Mena	ANICPTVIDA	Director Ejecutivo
33	Sharon Hernández	ADMUTRANS	Vice President
34	Carolina Valle	GH Tech	Consultora

Actividad 3: Reunión de validación con donantes

Hotel Princess, viernes 16 de enero 2014

	Nombre	Institución	Cargo
1	Han M. Kok	Lux Dev	Coordinador Técnico Proyecto
2	Jakub Dolezel	Embajada de Luxemburgo	Primer Secretario
3	Gerardo Galvis	OPS/OMS	Asesor
	Elizabeth Hernández	JICA	Oficial de Programa
5	Angela Cárdenas	USAID	Directora de Oficina
6	Marianela Corriols	USAID	Especialista en Desarrollo de Proyectos
7	Lesbia Duarte	Deliver	Facilitadora
8	Alexandra Bonnie	OIM	Coordinadora de Programas
9	Rafael Amador	UNICEF	Especialista de Salud, Nutrición y VIH
10	Ivy Talavera	OPS/OMS	Asesora en SSR/Adolescencia
11	Carolina Valle	GH Tech	Consultora