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USAID/NICARAGUA FAMILY PLANNING GRADUATION STRATEGY FINAL EVALUATION REPORT OCTOBER 2012



Family planning users, El Yara, Mozonte, Nueva Segovia/ V Gutiérrez

This publication was produced for the United States Agency for International Development. It was prepared by independent consultants Graciela Ávila and Vilma Gutiérrez (Contract AID-524-O-12-00006), Marianela Corriols (USAID Nicaragua) and Kimberly Cole (USAID/Washington).

USAID/NICARAGUA

FAMILY PLANNING GRADUATION STRATEGY

FINAL EVALUACION REPORT
OCTOBER 2012

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACRONYMS

| | |
|------------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| APEO | Post-obstetric event contraception |
| CS | Contraceptive Security |
| CSC | Contraceptive Security Committee |
| CMP | Social security medical clinics within the public sector |
| CYP | Couple Year of Protection |
| ECMAC | Community Distribution of Contraceptive Methods |
| EMNV | Leaving conditions survey (in Spanish) |
| DHS | Nicaraguan Demographic and Health Survey (ENDESA in Spanish) |
| FAMISALUD | Families United for Health project |
| FP | Family Planning |
| FPGS | Family Planning Graduation Strategy |
| GON | Government of Nicaragua |
| HCI | Health Care Improvement Project |
| HIV | Human Immunodeficiency Virus |
| INIDE | National Institute for Development Information |
| INSS | Nicaragua's Social Security Institute |
| IPSS | Nicaragua's private sector social security providers |
| IUD | Intrauterine device |
| JSI | John Snow Inc. |
| LOI | Letter of Implementation |
| MCPR | Modern Contraceptive Prevalence Rate |
| MOH | Ministry of Health |
| MSH | Management Science for Health |
| NICASALUD | Nicaraguan Federation of 28 NGOs working on health |
| NGO | Non-Governmental Organization |
| PASIGLIM | Automated Information System for Medical Supplies Logistics Management |
| PASMO | NGO working on HIV, FP and condom social marketing |
| PPF | FP Promotion, community-based education and referral strategy |
| PROFAMILIA | Local IPPF affiliate |
| RH | Reproductive Health |
| SCMS | Supply Chain Management System project |
| SIGLIM | Information System for Medical Supplies Logistics Management |
| SILAIS | Local Integrated Health Systems |
| SOAG | Strategic Objective Agreement |
| TFR | Total Fertility Rate |
| UNFPA | United Nations Population Fund |
| URC | University Research Corporation |
| USAID | United States Agency for International Development |

TABLE OF CONTENTS

| | |
|--|----|
| ACRONYMS..... | 2 |
| LIST OF TABLES | 4 |
| LIST OF FIGURES | 5 |
| GLOSSARY | 6 |
| ACKNOWLEDGMENTS | 8 |
| EXECUTIVE SUMMARY | 9 |
| I. INTRODUCTION | 14 |
| II. BACKGROUND | 16 |
| HEALTH AND FP ASSISTANCE IN NICARAGUA | 16 |
| USAID FAMILY PLANNING PHASE-OUT STRATEGY | 17 |
| FP GRADUATION STRATEGY IN NICARAGUA..... | 17 |
| III. METHODOLOGY | 22 |
| IV. RESULTS..... | 26 |
| GENERAL FINDINGS..... | 26 |
| CONCLUSIONS | 27 |
| MAIN GAPS..... | 28 |
| RECOMMENDATIONS..... | 29 |
| FINDINGS, CONCLUSIONS AND RECOMMENDATIONS BY STRATEGY COMPONENTS | 30 |
| CONTRACEPTIVE SECURITY | 30 |
| MARKET SEGMENTATION | 37 |
| STRENGTHENING OF HEALTH SYSTEMS | 40 |
| IMPROVED SERVICES AND QUALITY ASSURANCE | 45 |
| DATA FOR DECISION MAKING | 49 |
| V. GENDER ANALYSIS..... | 51 |
| REDUCTION OF GENDER DISPARITIES IN ACCESS TO, CONTROL OVER AND BENEFIT FROM RESOURCES, WEALTH, OPPORTUNITIES, AND SERVICES | 52 |
| INCREASED CAPABILITY OF WOMEN AND GIRLS TO REALIZE THEIR RIGHTS, DETERMINE THEIR LIFE OUTCOMES, AND INFLUENCE DECISION MAKING IN HOUSEHOLDS, COMMUNITIES, AND SOCIETIES..... | 55 |
| REDUCE GENDER-BASED VIOLENCE AND MITIGATE ITS HARMFUL EFFECTS | 55 |
| VI. LESSONS LEARNED | 58 |
| VII. BIBLIOGRAPHY..... | 59 |
| VIII. ANNEXES | 62 |

LIST OF TABLES

| | |
|----------|--|
| Table 1 | Components of the Family Planning Graduation Strategy |
| Table 2 | USAID Nicaragua funding levels for the strategy period |
| Table 3 | Methodology used based on the FPGS critical questions |
| Table 4 | People contacted per sector during the FPGS evaluation |
| Table 5 | Contraceptive funding sources and trends 2005-2012 in US\$ |
| Table 6 | Key gaps in family planning for the post-graduation phase |
| Table 7 | Performance indicators for contraceptive security |
| Table 8 | Performance indicators for market segmentation |
| Table 9 | Performance indicators for health system strengthening |
| Table 10 | Performance indicators for improved access and quality assurance |
| Table 11 | Family planning training provided from 2007-2012 |
| Table 12 | Performance indicators for data for decision making |

LIST OF FIGURES

- | | |
|-----------|---|
| Figure 1 | Geographic coverage of USAID Nicaragua's FPGS (2007-2012) |
| Figure 2 | Total Fertility Rate and Modern Contraceptive Prevalence Rate trend Nicaragua, 1985-2007 |
| Figure 3 | Contraceptive funding evolution from 2005-2011, Nicaragua |
| Figure 4 | Percentage of MOH facilities experiencing stock outs of at least one contraceptive method, Nicaragua, 2007-2012 |
| Figure 5 | Family planning market segmentation trends, Nicaragua, 2005-2012 |
| Figure 6 | FP counseling and method distribution after an obstetric event in health centers, Nicaragua, 2003-2012. |
| Figure 7 | Intrauterine device users trend, Nicaragua 2005-2012 |
| Figure 8 | Trend in maternal mortality ratio in Nicaragua, 1992-2011 |
| Figure 9 | Use of FP method. By sector in Nicaragua, 1993-2006 |
| Figure 10 | Registered birth and percentage of adolescent pregnancy, Nicaragua, 2000-2010 |

GLOSSARY

| | |
|-------------------------|--|
| APEO: | MOH's Post obstetric event contraception strategy aimed at improving the quality and increasing women's access to family planning services and methods after delivery. The APEO strategy allows post-partum women to leave the health facility with information and family planning methods voluntarily chosen. |
| Birth Plan: | MOH's Birth Plan for Safe Motherhood strategy helps reduce risks during pregnancy, childbirth, and the postpartum period through a proactive plan in which women, their partners, their families and the community get involved in the care of pregnant women and their newborn, knowing what to do in case of an emergency. |
| ECMAC: | MOH's Community health strategy that facilitates the delivery of family planning services for women and men in remote communities with limited access public health facilities. |
| MCPR: | Modern Contraceptive Prevalence Rate is the percent of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time, almost always reported for women married or in sexual union. For population-based statistics, the numerator and the denominator usually come from household surveys (with the numerator consisting of the number of women using a contraceptive in a community or country, including male-oriented methods, and the denominator usually consisting of women of reproductive age in the same community or country). |
| CYP: | Couple Years of Protection is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed to clients during that period. For each contraceptive method, the CYP is calculated by taking the number of units distributed to FP clients during a specified period and dividing this number by a constant representing the number of contraceptive units needed or estimated to protect one couple from pregnancy for one year. The values of these constants are method-specific and are derived from empirical evidence on the amount of each method used by a couple during a year. |
| Dual protection: | A strategy to prevent both HIV/STI transmission and unintended pregnancy through the use of condom alone, the use of condoms |

combined with other methods (dual method use) or the avoidance of risky sexual activity.

Fertility Rate: Measures the average number of births women would have by the time they reach age 50 if they were to give birth at the current age-specific fertility rates. The TFR is expressed as the average number of births per woman.

Integrated Logistic System: Is the merging of two or more logistics systems by integrating vertical system(s) into the logistics system for distributing essential medicines, or vice versa. The separate steps of the logistics cycle are carried out for all products within one system; procurement, storage, and transportation are coordinated through a single office.

Market Segmentation: Provides a comprehensive examination of the contraceptive market, identifies current roles of various sectors with respect to consumer groups (public sector, NGO, Social Security, commercial sector etc.), and helps determine how roles need to change to achieve contraceptive security.

ACKNOWLEDGMENTS

The evaluation team would like to thank all of the individuals in Nicaragua who gave generously of their time and whose contributions we hope are reflected in this report. Their names are included in Annex 4. A special recognition to Mr. Kirk Dahlgren, USAID Nicaragua Deputy Director, Alicia Dinerstein, Office of Human Investment Director and Clelia Valverde, Health Officer, and Marcela Villagra, Evaluation Officer, for participating in all aspects of the evaluation and the report development. We would also like to thank USAID/Washington's Lindsay Stewart, Mary Vandenbroucke, Veronica Valdivieso, Kelly Saldana, Maggie Farrell and Elaine Menotti for their feedback on findings and recommendations.

EXECUTIVE SUMMARY

PURPOSE

The purpose of the evaluation was to assess the success of United States Agency for International Development (USAID) Nicaragua's Family Planning (FP) phase-out strategy, including progress on recommendations from the mid-term assessment and for the post-graduation phase.

The report is intended to inform USAID and other United States Government personnel, health donors, representatives from the Government (GON), non-governmental and civil society organizations.

BACKGROUND

USAID Nicaragua's Family Planning Graduation Strategy (FPGS) was implemented from October 1st, 2007 through September 30th, 2012, with a budget of approximately US\$ 13.5 million. The implementing partners included John Snow Inc. (DELIVER Project), University Research Co., LL (Health Care Improvement Project), NicaSalud Federation (FamiSalud project) and MSH (PRONICASS Project).

METHODOLOGY

The evaluation focused its efforts on assessing the FPGP's *accountability* by measuring project effectiveness with a focus on outputs and outcomes that were under the control of the Agency. At the same time, the team explored the *learning* aspects of the FPGP by answering the following critical questions:

- **Has the USAID/Nicaragua FP program made the expected achievements on key objectives outlined in the phase-out plan?**
- **Which factors affected the lack of achievement?**
- **Which factors contributed to the achievement?**
- **Did the FPGS contribute to gender equity?**
- **What recommendations will contribute to the sustainability of the results during the post-graduation phase?**

The evaluation was conducted from August 9th, 2012, to September 27th, 2012. During the evaluation, the team reviewed pertinent documentation, interviewed USAID partners, government counterparts, donors and beneficiaries, conducted field visits to seven regions of the country and validated the main findings with key stakeholders. The evaluation process was focused on the five strategic components (contraceptive security, market segmentation, system strengthening, improved services and quality assurance y data for decision making) and 17 performance indicators of the FPGS.

The evaluation team used a wide range of methods to generate reliable information and a combination of quantitative and qualitative methods to analyze the data. For each of the five strategic components, this report provides information on the achievement of key objectives, the factors affecting the achievement, and recommendations for future actions. A section on gender equity describing how gender was incorporated into the FPGS is included.

RESULTS

Taking into account the USAID Technical Note on Graduation for Family Planning and based on the findings discussed in this section, the evaluation team concludes that **Nicaragua has achieved a successful graduation stage and that it is reasonable to expect that the provision of family planning (FP) services will be sustained in the future, that the Contraceptive Prevalence Rate (CPR) will be maintained at the level achieved prior to graduation and that inequities in access will not be increased.**

There is sufficient evidence that the three conditions for a successful graduation were met. These conditions are as follows:

- Although updated data on CPR will be available next year when the 2012 DHS is published, is important to highlight that the MOH has increased the CYP produced by 63%, from 304,900 in 2007 to 484,467 in 2012. This increase shows a high level of knowledge and use of family planning methods.
- The country has developed the technical, administrative and programmatic capability to sustain the provision of FP services and to adapt the services if necessary. Evidence of such capability consists of the CSC plans and the evaluation conducted throughout the past several years.
- There is continued funding for the provision of FP services within the public sector, including the procurement of contraceptives supplies.

Overall, the implementation of USAID/Nicaragua's FPGS has been successful. USAID has achieved the main goals included in the strategy, and 15 of the 17 indicators defined by the FPGS have been met. The two unmet indicators, which are related to market segmentation and the participation of the Ministry of Health (MOH) and the social security in the market share, are in the process of being achieved. Through the implementation of the FPGS, USAID contributed to establishing a foundation for a solid, efficient and sustainable provision of family planning services in Nicaragua.

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. At the same time, USAID Nicaragua designed and implemented with great success a monitoring system for compliance with USG policies and regulations for FP programs, including the promotion of voluntarism and free choice and the definition of specific indicators.

With regard to gender equity, there has been a positive impact of the plan, by increasing access to FP methods for women nationwide. According to the Contraceptive Security committee (CSC) plans (2005-2008 and 2009-2012), the increase in contraceptive prevalence has contributed to a remarkable reduction in maternal mortality (by a third) during the past five years.

Although the FPGS did not specifically include a gender perspective during implementation and evaluation, efforts were made to incorporate gender perspective as a cross-cutting theme. The different projects carried out specific strategies to increase women's and men's participation in FP. The FPGS benefited the MOH, INSS, NGOs, universities and training schools' institutional plans so as to sustain gender-related results once the assistance ends.

Public health policy in Nicaragua and the Nicaraguan government's endorsement of several international agreements related to reproductive health were key to the success of the strategy implementation.

Another important factor that contributed to the indicators has been the close coordination and integration of USAID, its partners and other key players, such as the MOH, the CCSC and other donors.

GAPS

Despite the advances and impressive results attained, the country still faces several gaps in family planning that need to be addressed:

CONTRACEPTIVE SECURITY

Financial: The MOH receives donations of contraceptives from the United Nations Population Fund (UNFPA) and the GON expect to increase their budget in order to procure 100% of the contraceptives needed once UNFPA ceases donations. UNFPA reported that there has been no definite decision on continuing the donation of contraceptives beyond 2013.

Human Resources: Limitations still exist with regard to the quantity and quality of trained personnel needed to operate the Automated Information System for Medical Supplies Logistics Management logistic system (PASIGLIM) at all levels. Eight national staff in charge of logistic quality assurance, who are currently funded by UNFPA and DELIVER, will need to be absorbed by the MOH in the near future, yet funding for these positions has not been secured.

Strategic information analysis: Capacity to analyze the data generated by PASIGLIM is still weak and needs to be improved.

MARKET SEGMENTATION

Social Security: Coverage of social security services providers (IPPS) with FP services is still limited.

HEALTH SYSTEM STRENGTHENING:

Norms: The continuous generation of knowledge, especially evidence-based medicine, requires a periodic update of norms.

QUALITY IMPROVEMENT:

Adolescent's unmet needs: High rate of adolescent pregnancy (one of the highest in the region) and unmet FP needs for this age group according to the last DHS are evidence of the inequity in access to FP services by adolescents.

DATA FOR DECISION MAKING:

Demographic Health Survey (DHS): The analysis, dissemination and use of the 2013 DHS are pending tasks. This will be particularly important for the

evaluation of the CSC plan and the design of a new plan as well as to complement the information contained in this report.

RECOMMENDATIONS

The general recommendations for the post-graduation phase for USAID Nicaragua are as follows:

- Address adolescent reproductive health with an integrated approach to youth in risk and gender-based violence prevention. This will imply considering structural and social determinants (poverty, education and exclusion) and social and cultural norms.
- Maintain its contribution to the CSC, promoting the integration of FP into HIV and maternal health and providing targeted assistance for the evaluation of the current plan and the design of a new plan for 2013-2015.
- Continue the promotion of integrated services, including FP, in projects currently underway (maternal health and HIV).
- Continue the transfer of the training package (*maleta pedagogica* in Spanish) to universities and nursing schools.
- Complete the technical support provided for the strengthening of the logistic system and rational use with the MOH and the IPSS.
- Develop publications summarizing the lessons learned and good practices identified during the graduation period.

The recommendations for the post-graduation phase for key national actors, local counterparts and other donors in Nicaragua are as follows:

- Maintain CSC advocacy efforts to increase the level of funding for contraceptive purchases.
- Incorporate successful strategies developed by the MOH with USAID support in the planning and programming of other donors, especially ECMAC and APEO.
- Increase efforts to provide FP services to adolescents, including peer-to-peer counseling, an appropriate referral system and an adolescent ECMAC.
- Incorporate the needs of men in the provision of FP services.
- Continue the integration of FP with other health areas such as HIV and chronic diseases.
- Incorporate the CYP indicator, incorporating the women of reproductive age population to monitor the impact of FP activities by all sectors.
- Ensure that the staff currently financed with donor funds is incorporated by the MOH budget.

- Train additional staff on PASIGLIM, ensuring that at least two people per health facility have the knowledge and the technical skills to use the system.
- Maintain an adequate level of support to the almost 3000 community promoters trained with USAID support.
- Incorporate the information produced by the SILAIS into the National Statistics Information System in order to consolidate data for decision-making purposes.

The recommendations for the post-graduation phase for USAID Global Health and LAC bureaus are as follows:

- Support the Nicaragua's CSC through regional initiatives.
- Collaborate with the analysis of the 2013 DHS when published.
- Share Nicaragua's successful experience in CSC regional meetings.



FP Users, Community El Yaral, Mozonte, Nueva Segovia/ V. Gutiérrez.

I. INTRODUCTION

The purpose of this evaluation was to assess the success of USAID/Nicaragua's FP phase-out strategy, including progress on recommendations from the mid-term assessment and for the post-graduation phase. The report is intended to inform USAID and USG personnel, other donors, representatives from the GON and NGOs and civil society organizations.

This report describes USAID/Nicaragua's implementation of the phase-out strategy, the successes achieved and the challenges that remain for the future. The report also explores the government's level of commitment to FP programs, especially the level of FP financial resources available. Taking into account unexpected events within the country that may have affected progress and contributed to the lessons learned, potential threats and risk mitigation are discussed. The report also includes a review of how the program promotes gender equity. Finally, the report provides recommendations for the post-graduation period to ensure the sustainability of results.

The phase-out strategy for USAID assistance to Nicaragua for family planning was implemented from October 1st, 2007 to September 30th, 2012, with an estimated funding of US\$ 13.5 million. The implementing partners were MSH through the PRONICASS project, John Snow Inc. through the DELIVER Project, University Research Co., LL (URC) through the Health Care Improvement (HCI) project and the local Federation of NGOs, NicaSalud, with the FamiSalud project. The strategy was implemented nationwide in 17 departments during the first two years; in the last three years, the project concentrated its work in the eight departments (RAAN, RAAS, Rio San Juan, Chontales, Matagalpa, Jinotega, Madriz and Nueva Segovia) that had the highest unmet need for family planning. Figure 1 shows the FPGS geographic coverage.

Figure 1
Geographic coverage of USAID Nicaragua's FPGS (2007-2012)



Source: USAID projects.

The evaluation was conducted to answer five critical questions:

- I. Has the USAID/Nicaragua FP program made the expected achievements regarding key objectives outlined in the phase-out plan?**
- II. For objectives for which progress has not been achieved as expected:**
 - a) What caused this lack of accomplishment?
 - b) What actions were taken to try to improve achievement of the program's objectives?
 - c) Was the strategy design (including project staffing, management and budget) adequate?
 - d) What lessons can we learn from the strategy design?
 - e) Did unexpected events within the country affect progress?
- III. For objectives that did make progress:**
 - a) Were the original assumptions sufficiently valid to ensure successful phase-out?
 - b) For the eight indicators that were achieved by the mid-term evaluation, has Nicaragua sustained this achievement?
 - c) What risks threaten continued progress during the post-graduation phase and what can be done to mitigate those risks?
- IV. Has the USAID/Nicaragua FP program contributed to improving gender equity?**
 - a) Was the FP graduation strategy gender-responsive?
 - b) Did projects integrate gender considerations into their activities and develop measures to enhance participation of both women and men in FP?
 - c) If so, how did strategy implementation increase the sustainability of these gender-specific achievements?
- V. What recommendations are made for the post-graduation period to improve the likelihood of sustaining the achievements made during the family planning graduation period?**
 - a) What are the recommendations for the post-graduation period for the Mission's Office of Health and Education?
 - b) What are the recommendations for the post-graduation period for key national and local counterparts and other donors in Nicaragua?
 - c) What lessons learned should be disseminated to other countries by USAID's Latin America and Global Health bureaus, and how can these bureaus support regional activities that will in turn help Nicaragua sustain progress?
 - d) How can USAID/Nicaragua share this successful experience within the country, with other countries, and with other Missions?
 - e) What threats exist that may hinder further FP progress in the country, and how can they be mitigated?

II. BACKGROUND

HEALTH AND FP ASSISTANCE IN NICARAGUA

With a multicultural and multiethnic population of 6,071,045 (INIDE 2012), 51% women and 49% men and a population growth rate of 1.217% (CEPAL, 2010), Nicaragua is the second-poorest country in the Western Hemisphere. More than 40% of its population live in poverty, and close to 15% live in extreme poverty (EMNV 2009). One-third of the population is under fifteen years of age. Nearly 15% is indigenous population or African descent. Population density is low (48 inhabitants/km²), with the majority of the population living in urban areas (55.9%). Thirteen percent of the population is affected by external migration.

The analysis of demographic indicators trends and estimations for 2015 show that total population, women of reproductive age (WRA) and the population's average age will increase. On the other hand, the number of adolescent women, the annual growth rate and maternal and infantile mortality, as well as the total fertility rate and the proportion of migrants, will decrease. The TFR has, in fact, decreased, although geographic and ethnic disparities still exist and adolescent fertility is very high.

USAID has supported health and other development programs in Nicaragua continuously since 1991, with significant expansion following Hurricane Mitch in 1998. The health program has focused on maternal and child health, water and sanitation, FP/RH, and HIV/AIDS. Roughly one-third of the health funds have been designated for FP/RH programs.

For two decades, USAID has been a leading donor in population/FP/RH assistance to Nicaragua, working closely with the GON, the private sector, and multiple local NGOs. During this period, USAID, jointly with the UNPFA, was one of the largest donors of contraceptives to the MOH. USAID also provided technical assistance regarding management, logistics and financial systems and training for health care providers to ensure high-quality services.

Following Hurricane Mitch, USAID assisted in the creation of NicaSalud, a federation of 28 NGOs working in the health sector (including in FP) in Nicaragua. In 2001, the country, with USAID support, established the CSC (or DAIA, in Spanish) to guarantee the security and continued availability of contraceptives during the course of the health program and after USAID FP graduation. The CSC is now an official MOH committee and acts with participation from UNPFA, USAID projects (DELIVER, HCI, and FamiSalud), Profamilia, PASMO and the INSS.

According to the USAID Nicaragua Country Plan (USAID, 2003), USAID supports the MOH policies, plans and strategies, especially as they relate to Intermediate Result 3.3: Comprehensive child and reproductive health care. Shortly after this plan was developed, new information emerged from a demographic and health survey that initiated the FP graduation period.

The graduation period coincided with the GON's transition of the Comprehensive Health Care Model (MAIS) to a new health model. First implemented in the early 2000s, MAIS evolved in 2007 to become the Family and Community Health Care Model (MOSAFC) in 2007 (MINSa 2010). It is based on a systemic/holistic approach that focuses on individuals and families and on active community participation by strengthening community networks, promoting improved health care management and decentralizing health services. The MOH has divided the national territory into several geographic areas in order to address the health needs of individual families, visiting them in their homes and offering health services that are responsive to local needs as determined by community diagnosis. Currently, the MOH, with its network of 1,000 facilities (32 hospitals, 179 health centers and 869 health posts), provides health care coverage to approximately 76% of the population. MOSAFC is the largest provider of health services in Nicaragua.

USAID FAMILY PLANNING PHASE-OUT STRATEGY

In 2005, USAID began a process of gradually phasing out its FP assistance in countries with high contraceptive prevalence and low total fertility rates. The graduation process is intended to focus resources toward countries where the unmet need for FP is the greatest. To ensure that past investment and achievements in the graduating countries are sustained, USAID has worked with the correspondent Missions to elaborate a logical, gradual phase-out with the primary goal of successfully transferring responsibilities and ownership to local actors.

According to the USAID Technical Note¹, successful graduation is defined as follows: *Family planning service delivery continues to support the level of contraceptive prevalence achieved before graduation and inequities in access to services have not increased.*

The technical note also states that a successful graduation process requires:

- *A modern contraceptive prevalence rate that reflects high knowledge about and use of modern family planning methods;*
- *In-country technical, administrative and programmatic capacity to maintain family planning service delivery and adapt to changes as appropriate; and*
- *On-going financing of essential aspects of family planning service delivery and products, including contraceptives.*

FP GRADUATION STRATEGY IN NICARAGUA

The 2003-2008 SOAG (8/19/03) between the USG through USAID and the GON established that *although USAID will continue to support procurement of public sector contraceptives, the aim is to do so at diminishing levels through the strategy period.*

In 2006, a Letter of Implementation was signed between the Nicaraguan Government and USAID/Nicaragua to gradually reduce the donation of contraceptives from USAID to the MOH beginning in 2007 and ending in 2009. At the same time, the GON was to progressively increase the MOH's budget for the purchase of commodities.

¹ USAID, Technical note. Approach to Phase-out of USAID Family Planning Assistance, 2006

After sixteen years of USAID family planning assistance in Nicaragua (1991-2007), a USAID Washington/Nicaragua team² led a graduation strategy development process in 2007 that included high levels of participation from USAID/Washington, USAID/Nicaragua, and in-country stakeholders. The team consulted with a variety of host country partners, including representatives from the GON (including the MOH and the Nicaraguan Institute of Social Security (INSS)), the private sector, NGOs, advocacy groups, other donors, and implementing partners. The primary objective of the consultation was to identify the key constraints and opportunities posed by graduating USAID's FP assistance, with specific attention to those factors that 1) are critically important to the long-term reach, quality and sustainability of the country's family planning program; and 2) can be affected in very substantial measure by the limited USAID resources available over the life of the recommended five-year strategy period.

At that time, despite the obvious strength of Nicaragua's family planning program, challenges to the program's long-term success existed. These challenges included dependence on donations of family planning commodities, insufficient market segmentation, weaknesses in system governance, inequities in access to and quality of service and a lack of human, institutional and financial resources for reproductive health surveys. These challenges were addressed through the strategic plan for family planning graduation drafted in March 2008 and updated in October 2008 (USAID 2008).

In 2008, the DHS confirmed the advances made by the country in the last two decades. Nicaragua has achieved an impressive reduction in the total fertility rate from 5.8 children per woman in 1985 to 2.7 in 2007. At the same time, the modern contraceptive prevalence rate increased from 57.4% in 1998 to 69.8% in 2007 (INIDE, 2007). The country is currently conducting a new DHS, the results of which should be available in 2013.

USAID's goal was to leave Nicaragua with the capability of providing quality contraceptives and family planning services in all departments. The objective of the graduation strategy was *to ensure that mechanisms are in place post-graduation for advocacy, private sector enhancement, quality improvement and management strengthening* (USAID 2008).

Nicaragua's family planning graduation strategy was divided into two stages: a health system strengthening phase (2008-2009) and a phase of sustainability development (2010-2012). The strategy was organized by components. These components, in order of priority were:

- Contraceptive security
- Market segmentation
- System strengthening
- Improved services and quality assurance
- Data for decision making

The development hypothesis of the FPGS holds that if USAID implementing partners and the GON work to strengthen contraceptive security, segment the market, strengthen systems, improve quality and use data for decision making, the end result will be the

² USAID Washington team: Marguerite Farrell, (team leader), Kevin Pilz, and Kelly Saldana. USAID Nicaragua: Heather Smith, USAID/Nicaragua. In June 2008, Marianela Corriols was incorporated into the USAID Nicaragua team.

sustainable provision of quality contraceptives and FP services in all departments of the country.

Table 1 summarizes the main components of the strategy. It specifies the problems to be solved and addresses the objectives by component. It also includes key activities, lists indicators and specifies the implementing mechanisms to be used and each partner's responsibilities to ensure that each component is achieved.

Table 1 Components of the Family Planning Graduation Strategy

| Component | Problem addressed | Objectives | Key activities | Indicators | Implementing partners |
|--|--|---|--|---|-----------------------------|
| Contraceptive Security | Strong external dependence | To protect CSC achievements | CSC Committee support. Coordination among agencies Competitive procurement. Advocacy to increase financial resources. Expansion of logistics system. | Increased contraceptive use. Increased MOH participation in procurement. Budgetary line for contraceptives. CSC plan implemented and evaluated. | DELIVER HCI FamiSalud |
| Market segmentation | Unequal access; weak participation of other health subsectors | To ensure better market segmentation | Increase participation of social security, NGOs and private sector in contraceptive service provision. | FP included in MOSAFC. FP included in social security offer. Reduction of MINSA participation in the total market. Increased participation of social security, NGOs and private sector in the total market. | DELIVER HCI |
| Health System Strengthening | Insufficient financial resources and planning. Insufficient stewardship. insufficient compliance with FP norms | To ensure compliance with norms and approval of standards. To improve internal advocacy around FP/RH issues. | FP strategies and norms are included in the new health model Advocacy activities to incorporate other MOH General directions in the CSC | MOH financial commitment FP norms developed/updated. | DELIVER HCI |
| Improved services and quality assurance | Quality and access gaps Limited in-service and pre-service training. | To ensure that quality standards and procedures are maintained or improved | Dissemination of norms and standards. In-service and pre-service training. Improve access for vulnerable population (ECMAC) | Updated curricula for medical and nursing schools. Human resources trained. Rural women with improved access through ECMAC's service provision. | DELIVER HCI FamiSalud |
| Data for decision making | Strong dependence on external funding sources | To ensure DHS is implemented, disseminated and used. | To disseminate and use DHS results To advocate for the new DHS 2011/12 | Budgetary line from MOH and donors | DELIVER PRONICASS |

Source: USAID Nicaragua Family Planning Graduation Strategy, 2008.

Seventeen process indicators were identified to monitor the strategy's progress. Each implementing partner had specific responsibilities related to the achievement of these indicators, and their progress was measured both quarterly and annually.

When the FPGS was designed, the assumptions underlying the strategy were that Nicaragua would enjoy political and economic stability throughout the strategy period, that willing, competent partners (public sector, private and professional organizations) would work with USAID in the design and implementation of the strategy, that adequate USAID population funds and Mission staff would be available to implement the strategy and, finally, that USAID would continue to elicit counterpart cooperation and support during a period of declining population assistance.

With regard to the political context, family planning is a priority for the GON and is included in the Health Plan for the 2011–2015 period that was developed by the Ministry of Health in September 2010. The document expressly includes reproductive health as one of its strategic actions (# 1.1.1.5), with family planning promotion included as a key action. The plan also includes FP indicators such as Indicator 4: Adolescent fertility rates; Indicator 32: Postpartum family planning coverage; Indicator 35: Percentage of health facilities offering at least three family planning methods; Indicator 22: Percentage of adolescents receiving reproductive health education through family health teams.

The favorable political context is expressed through the MOH's strong commitment to increase its financial investment in the program and the efforts expended to harmonize and align other donors' cooperation around the goals of the national policy and plans.

With regard to the financial investment made by USAID, the total budget for the FPGS period was US\$13 million (9% more than the planned level) to implement the FPGS from 2006 to 2011. (See Table 2) This amount does not include the value of contraceptives donated during 2007-2009 (more than half a million dollars per year).

Table 2 USAID Nicaragua funding levels for the strategy period

| Population funds planned vs. received in US\$ | | |
|---|-------------------|-------------------|
| Fiscal year | Planned level (a) | Received (b) |
| 2007 | 2,661,000 | 2,600,000 |
| 2008 | 2,700,000 | 2,700,000 |
| 2009 | 2,600,000 | 2,700,000 |
| 2010 | 2,200,000 | 2,700,000 |
| 2011 | 2,200,000 | 2,900,000 |
| TOTAL US\$ | 12,361,000 | 13,600,000 |

Source: (a) USAID Nicaragua Family Planning Graduation Strategy, 2008 and (b) USAID Nicaragua Program Office

In October 2010, a midterm evaluation of the plan was conducted to evaluate the implementation successes. The goal was to assess whether successful graduation from USAID FP assistance in September 2012 remained feasible in accordance with the phase-out strategy. At the time, eight of 17 indicators had been accomplished, and the others were on target for timely completion. The report concluded that there was no need to modify the FPGP's vision, objectives, or strategic areas, each of which

remained relevant and important to the development of a sustainable, successful FP program in Nicaragua.

This report discusses the results, findings and recommendations of the FPGS final evaluation. The report emphasizes the challenges that still exist in the country, as well as the lessons learned and best practices that can be shared with other countries currently implementing a graduation process.



FP 'Mural'. Health Center El Almendro, Chontales. /V Gutiérrez.

III. METHODOLOGY

As defined in the USAID Evaluation Policy (USAID 2011), the evaluation team focused its efforts on assessing the FPGP's *accountability* by measuring project effectiveness with a focus on outputs and outcomes that were under the control of the Agency. At the same time, the team explored the *learning* aspects of the FPGP by answering critical questions to identify best practices and lessons learned. Table 3 summarizes the methodology in relation to each of the five critical questions of the evaluation.

Table 3 Methodology used based on the FPGS critical questions

| Evaluation questions | Type of question | Type of information needed | Method for collecting data | Data source | Selection or sample criteria |
|--|------------------|------------------------------|--|---|--|
| 1. Were the FPGS goals achieved? -contraceptive security -market segmentation -health system strengthening -quality improvement -data for decision making | Comparative | Qualitative and Quantitative | Documents review | USAID Nicaragua USAID Washington Implementing partners MOH Local health providers (public, private and NGOs) Universities Community promoters | Meetings and interviews: 100 % USAID staff involved, implementing partners, NGOs, CSC, donors, universities and MOH officially delegated staff. |
| 2. What factors affected the lack of achievement? - causes - corrective measures - design, resources -lessons learned -unexpected events | Comparative | Qualitative | Open meetings, open interviews and semi-structured interviews Site visits to health facilities and communities | FP users CSC Donors table | Field visits: 47% of the country departments (75% of the prioritized regions) 12% of all municipalities and 23% of target municipalities 3% of ECMAC promoters 2.2% of communities benefited by the assistance |
| 4. Which factors contributed to the achievement? -validity of assumptions -maintaining achievement post midterm evaluation -risk factors - mitigation measures | Comparative | | | | |
| Did the FPGS contribute to gender equity? - design -implementation -contribution | Descriptive | Qualitative and Quantitative | Revision of official gender related reports from MOH and the DHS Interviews with key stakeholders and FP users Validation sessions Context analysis | Donors table CSC MOH Community promoters and FP users | 100 % USAID staff involved, implementing partners, NGOs, CSC, donors, universities and MOH officially delegated staff |

| Evaluation questions | Type of question | Type of information needed | Method for collecting data | Data source | Selection or sample criteria |
|--|------------------|----------------------------|--|---|---|
| 5. What are the recommendations for sustainability? - USAID Nicaragua - USAID WDC - Key players - Dissemination - Threats - Mitigation | Descriptive | Qualitative | Meetings and interviews with key informants Validation sessions Context analysis | Findings and conclusions of the evaluation team. Conclusions and recommendations from the validation sessions. | 100 % USAID staff involved, implementing partners, NGOs, CSC, donors, universities and MOH officially delegated staff 57% of Universities |

The evaluation was conducted from August 9, 2012, to August 30th, 2012. The team reviewed pertinent documentation and conducted field visits to eight regions of the country. This final evaluation covers the assistance provided by USAID Nicaragua during the implementation of the FPGS from 2007 to 2012.

The evaluation was focused on the five strategic components and 17 performance indicators of the FPGS. The evaluation team used a wide range of methods to generate reliable information and used a combination of quantitative and qualitative data analysis. For each of the five components, this report provides information on the achievement of key objectives, the factors affecting the achievement, and recommendations for future actions. A section on gender equity is included, which describes how gender was incorporated into the FPGP and the implementing partners' activities and provides recommendations for improvement.

Literature review: Several central documents were reviewed, including the Technical Note on Graduation from Family Planning, the Family Planning Graduation Plan for USAID/Nicaragua, partners' agreements, work plans and reports. GON and other donors' documents were also analyzed.

Individual and group interviews: The team conducted several interviews (both individual and group interviews) with Nicaraguan government officials, other donors working in family planning, implementing partners, public health personnel, community members and FP users. The main purpose of the interviews was to collect information on the advances and challenges. (Annex 4 includes the list of interviewees, and Annex 2 includes the questionnaires used for the interviews, by audience.) The team was able to interview and interact with more than 170 people, including representatives from the MOH central, regional and local levels, donors, universities, community promoters and FP beneficiaries.

Field visits: USAID Nicaragua's office officially informed the MOH about the evaluation, requesting written authorization to visit SILAIS and health services. During the field visits, the team was accompanied by representatives from the partner organizations. The team traveled to eight regions of the country (Managua, Chontales, Rio San Juan, Estelí, Nueva Segovia, Madriz, Matagalpa and Jinotega), visiting 17 districts (Managua, Juigalpa, Muelle de los Bueyes, Nueva Guinea, San Carlos, El

Almendo, Boca de Sábalos, Solentiname, La Trinidad, Estelí, Mozonte, Telpaneca, Somoto, el Tuma-La Dalia, el Cua, Quilali and Matagalpa).

During the site visits, the evaluation team had the opportunity to contact 178 people, including USAID Nicaragua and Washington staff, MOH central and regional level personnel, hospital, health center and health post staff, INSS personnel, implementing partners' staff, NGOs personnel, representatives from universities, community promoters, donors and FP users.

Validation sessions: Four validation and dissemination events were conducted to share the findings, conclusions and recommendations of the evaluation. The preliminary report was validated with 94 people (implementing partners, counterparts, CSC members and donors) on September 25 and 26. Feedback was collected and incorporated when pertinent.

The disaggregated data show that during the site visits and the validation sessions the evaluation team had the opportunity to contact people at all levels. See table 4.

Table 4 People contacted per sector during the FPGS evaluation

| People reached by sector | Contacts | | | |
|--------------------------|-------------------------------|-----------------------|---------------------|-----------------------|
| | Meetings and field interviews | Number and % of women | Validation sessions | Number and % of women |
| MOH central level staff | 5 | 1 (20) | 4 | 2 (50) |
| MOH SILAIS staff | 6 | 2 (33) | | |
| Hospital personnel | 18 | 11 (61) | | |
| Local level personnel | 30 | 15 (50) | | |
| INSS (CMP/ISPP) | 6 | 5 (83) | | |
| Universities | 6 | 6 (100) | 5 | 4 (80) |
| ECMAC promoters | 32 | 23 (72) | | |
| Implementing NGOs | 25 | 7 (28) | 11 | 4 (36) |
| FP users | 14 | 14 (100) | | |
| CSC members* | 10 | 5 (50) | 9 | 5 (56) |
| USAID partners* | 13 | 7 (54) | 44 | 17 (39) |
| Donors* | 7 | 3 (43) | 9 | 7 (78) |
| USAID Nicaragua staff* | 6 | 3 (50) | 4 | 3 (75) |
| USAID Washington staff | | | 6 | 6 (100) |
| TOTAL | 178 | 102 (57) | 92 | 48 (52) |

Source: Based on participant lists from different events and/or formal consultation activities. *Eight people on the list of 178 participated in two events; therefore, the total number of participants is 170. At the validation sessions, for which the total number of participants was 86, 6 of the 92 participants attended two meetings.

The final report will be disseminated to a wider audience that includes USAID Nicaragua and USAID Washington staff and staff of other USG agencies, Government of Nicaragua representatives, MOH staff, USAID implementing partners and other NGOs, members of the Academia and scientific societies, and the media. This report is published in English and Spanish with a Policy Note that summarizes the essential content of this document.



Meeting with health personnel, Hospital La Trinidad, Estelí. /V. Gutierrez.



Meeting with health authorities, San Carlos, Rio San Juan. /V. Gutierrez.



Meeting with health personnel, Hospital Asuncion, Chontales. /V. Gutierrez.

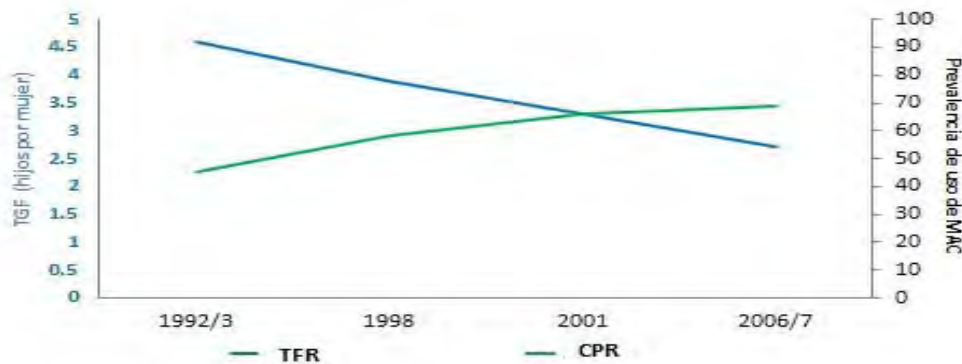
IV. RESULTS

GENERAL FINDINGS

According to the previously mentioned USAID Technical Note on FP graduation and based on the findings that are presented in this section, the country has achieved successful graduation, showing strong evidence that *family planning service delivery will continue to support the level of contraceptive prevalence achieved before graduation, and inequities in access to services will not increase*. Figure 2 shows the impressive advances made by the country in the last 27 years with regard to TFR and CPR.

Figure 2

Total Fertility Rate and Modern Contraceptive Prevalence Rate Trends



Source: USAID Nicaragua, using official INIDE data.

The following evidence shows that the three requirements for successful graduation have been met:

- Although the official MCPR for 2012 will not be known until after the publication of the 2013 , the MOH's Couple-Years of Protection (CYP) has increased by 63% from 304,900 in 2007 to 484,467 in 2012, reflecting a high level of knowledge about and use of modern family planning methods;
- The country has developed technical, administrative and programmatic capacity to maintain family planning service delivery and adapt to changes as appropriate. This is evident in the two CSC plans and evaluations already implemented;
- There is ongoing financing of essential family planning services delivery and products, including contraceptives. Table 5 shows the increase in contraceptive procurement funding by the MOH.

Table 5 Contraceptive funding sources and trends, 2005-2012 (in US\$)

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------------|-----------|-----------|---------|-----------|-----------|---------|-----------|-----------|
| MOH | | 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: Ministry of Health

CONCLUSIONS

The overall implementation of the USAID Nicaragua graduation plan was a success. The Mission and its partners achieved the key objectives outlined in the plan. Through the implementation of this FPGP, USAID helped establish the foundation for solid, efficient and sustainable FP services in Nicaragua.

The Mission was successful in achieving 15 out of 17 indicators outlined in the graduation plan, with the exception of market segmentation indicators related to the MOH and INSS.

All the recommendations from the 2010 mid-term review were discussed with and assigned to the USAID partners, and their implementation was carefully monitored by the health office. The Mission was also successful in developing and implementing a detailed monitoring system for compliance with USGFP policies and regulations that included widespread promotion of informed and voluntary decision making and the incorporation of specific indicators for monitoring.

With regard to gender, the plan played a significant role in increasing access to FP methods for women covered by the public sector nationwide, as measured through the increase of 63% in CYP production between 2006 and 2012. According to the CSC plans (2005-2008 and 2009-2012), the increase in the use of FP methods contributed to the impressive reduction in maternal mortality that has occurred during the past five years.

The main findings from the interviews and field visits are as follows:

- There is a general consensus that the USAID assistance that was provided through the different projects benefited and positively affected the improvement of FP services in the country.
- The assistance provided to the public sector increased access and improved the quality of services.
- Stock-outs of contraceptives are almost nonexistent and have not affected the end users.
- Materials that promote voluntarism and informed choice are available at health facilities.

- Management tools developed by the different projects have improved the management of services.
- Community work is a successful strategy for expanding access and promoting informational and educational activities within the population.
- The FPGS was successful at strengthening health systems, improving their quality and expanding access to FP methods nationwide.

The design, implementation and evaluation of the FPGS were effective in incorporating a gender perspective. The various projects within the program developed specific actions to increase both men's and women's participation in FP. Additionally, the FPGS strengthened the MOH, INSS, NGOs, and universities' institutional plans to increase the sustainability of the results.

The public health policy in Nicaragua and the Government endorsement of several international agreements related to reproductive health were key to the success of the strategy implementation.

Key to the success in achieving most of the FPGS indicators has been the coordination and integration between USAID, its partners and other key players such as the MOH, the CSC and other donors.

MAIN GAPS

Despite the advances and impressive results achieved by Nicaragua with regard to FP, several gaps remain that still need to be addressed. (See Table 6)

Table 6 Key gaps in family planning for the post-graduation phase

| Component | | Gaps |
|------------------------------------|---------------------------------------|---|
| Contraceptive security | Financial | The MOH continues to receive contraceptive donations from UNFPA and will not need to budget for 100% of the required financial resources until after 2013 or later. At the time of the evaluation, it was unclear whether UNFPA will continue donations after 2013. |
| | Human resources | There is a limited number and quality of trained staff with the technical skills to operate the PASIGLIM at all levels of the public system. |
| | Strategic information analysis | Capacity to analyze the data generated by PASIGLIM is still weak and needs to be improved. |
| Market segmentation | Social Security | Coverage of IPSS with FP services is still limited. |
| Health system strengthening | Norms | The continuous generation of knowledge, especially evidence-based medicine, requires a periodic update of norms. |
| Quality improvement | Adolescents' unmet needs | High rate of adolescent pregnancy (one of the highest in LAC) and data from the latest Demographic and Health Survey are evidence of the inequity in access to FP services by adolescents. |
| Data for decision making | DHS | The analysis, dissemination and use of the 2012/13 DHS are pending tasks. This will be particularly important for the evaluation of the CSC plan, the design of a new plan and to complement the information contained in this report. |

RECOMMENDATIONS

USAID Nicaragua:

- Maintain a presence on the CSC, promoting FP integration with other reproductive health areas such as HIV-AIDS and maternal health. If feasible, the mission should support the CSC in the evaluation of its current strategic plan and in designing a new plan for 2013-2015.
- Continue to promote integrated service delivery, which includes FP, throughout all remaining health programs, incorporating FP into the Maternal Health and HIV-AIDS ongoing programs.
- Continue transferring the FP training package to the MOH and universities, finalizing this transfer by September 2013.
- Support key activities currently underway, such as strengthening the logistics system, promoting rational use of the MOH, and strengthening FP services (including social security IPSS).
- Develop a series of publications summarizing the lessons learned and best practices identified during the graduation period so as to increase knowledge among other Missions and countries.

Donors:

- Maintain CSC advocacy efforts to increase the funding level for contraceptive purchases.
- Incorporate successful strategies developed by the MOH with USAID support in the planning and programming of other donors, especially ECMAC and APEO.

MOH:

- Increase efforts to provide FP services to adolescents, including peer-to-peer counseling, an appropriate referral system and an adolescent ECMAC.
- Incorporate the needs of men in the provision of FP services. Cultural norms should be addressed.
- Continue the integration of FP with other health areas such as HIV and chronic diseases.
- Incorporate the CYP indicator, incorporating the women of reproductive age population so as to monitor the impact of FP activities on all sectors.
- Strengthen the capacity to monitor social and economic determinants data and to identify at an early stage potential threats that could affect the FP results.
- Ensure that the staff currently financed with donor funds is incorporated into the MOH budget.
- Train additional staff on PASILIGM, ensuring that at least two people per health facility have the knowledge and the technical skills to use the system.
- Maintain an adequate level of support to the almost 3000 community promoters trained with USAID support.

USAID's Latin America and Global Health bureaus:

- Provide support to the CSC committee to ensure the continuity of its operations. This can be accomplished through fostering champions and maintaining communication with the LAC Regional Contraceptive Security Initiative.
 - Once the new DHS is released, analyze the data to obtain a new market segmentation analysis and to determine the unmet need among adolescents.
 - At future regional CSC meetings, Nicaragua's experience should be presented as a successful model.
 - After two years, evaluate the sustainability of the actions and the results achieved upon completion of the FPGS implementation.
-

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS BY STRATEGY COMPONENTS

CONTRACEPTIVE SECURITY

In 2007, the strategy for contraceptive security largely focused on reducing the public sector's reliance on commodity donations. Overcoming this threat required support and advocacy efforts by the CSC for increased financial resources for procurement within the MOH, as well as for policies that allow contraceptive procurement at competitive prices through both local and regional markets.

All of these efforts required analysis and close monitoring by the CSC. The Committee was able to plan for and respond to potential emergencies before stock-outs occurred. The strategy contributed to improved efficiency and coordination within the MOH divisions that had roles in contraceptive procurement and logistics (Planning, Medical Supplies and Health Services). Beyond procurement improvements, the expansion of the integrated logistics system (PASIGLIM) and the strengthening of the CSC are key factors to sustainability. UNPFA has been and will be an instrumental partner in this process, not just as a cooperating agency but with the purpose of continuing to monitor the interventions.

The main findings of the meetings with the central MOH, the CSC committee and other donors regarding contraceptive security are as follows:

- USAID support to the MOH has been instrumental in the development of FP services and the results achieved by the country. With the FPGS, the MOH has been able to finance the procurement of contraceptives, and funding for contraceptives is protected and considered a priority for the MOH.
- Interventions such as the ECMAC, post-obstetric event contraception (APEO), and PASIGLIM were incorporated by the MOH, who also lead the CSC.
- The assistance provided by USAID for the implementation of PASIGLIM allowed the MOH to strengthen its information system within the Medical

Supplies division of the MOH; it is now automated and generates consolidated data.

- USAID has also provided assistance on rational use of medicines. During 2010, plans for rational use were developed. The evaluation guidelines for rational use provided a quality approach for the use of medicines and supplies. Measurement of the impact of the strategy remains pending, and the design and implementation of plans for improvements should be developed.
- It is recommended that guidelines on rational use be disseminated within the universities and other training institutions and that research on rational use based on health unit experiences be promoted.
- Sustainability of the CSC is a priority of the MOH, who have demonstrated a strong political will. FP activities within the development arena contribute not only to reduction in maternal mortality but also to the right of women to choose the number of children they want, which is linked to the gender policy.
- The Mesoamerican Initiative is aimed at strengthening demand through the ECMAC and delivery plan strategies; it also includes the procurement of contraceptives and the strengthening of community networks in case a gap in UNFPA donations occurs. The urban ECMACs represent a challenge due to the need to guarantee access to contraceptives as demand increases.
- All donors interviewed have demonstrated their interest in supporting several of the strategies developed by USAID under the FPGS. UNFPA, the main donor, has expressed its commitment to support the MOH by donating contraceptives at least until 2013 and by collaborating in strategic areas of service provision.
- The CSC is active and motivated to continue with coordination and advocacy efforts. It has expanded its focus to include other sexual and reproductive health topics. It is led by the MOH, with high levels of participation from different actors. The committee needs to evaluate its current strategic plan and develop a new plan for the upcoming years.

Overall, the indicators of the contraceptive security strategic component were met. Table 7 shows indicators related to the CS strategy component, including evidence of achievement for each.

Table 7 Performance indicators for contraceptive security, Nicaragua 2012

| Contraceptive security | Achieved | Not achieved | Evidence of achievement |
|------------------------|----------|--------------|---|
| CSC functioning | | | <p>CSC functioning actively since 2005, led by GON with participation of MOH, INSS, NGOs, private sector and donors. The calendar of meetings is set by the Minister.</p> <p>2005-2008 CSC plan implemented and evaluated</p> <p>2009-2012 CSC plan implemented</p> <p>Scope was expanded to include other reproductive health supplies, including HIV.</p> |

| Contraceptive security | Achieved | Not achieved | Evidence of achievement |
|---|----------|--------------|---|
| Graduation Strategy included as sub-intermediate result (IR.2) in SOAG | | | It was included in the Mission plan. |
| Letter of implementation signed and implemented for gradual reduction of USAID contraceptive donation to the public sector. | | | LOI was signed and fully implemented. Accompanying USAID gradual reduction, MOH increased their purchasing from 0.6% in 2006 to 74% in 2011 of all contraceptives with their own resources. UNFPA is donating the difference. |
| Donor coordination improved in RH/FP issues | | | Since 2006, USAID has coordinated with other donors to avoid duplication and improve the country's support. There was coordination with UNFPA, UNICEF and PAHO to develop and disseminate national norms. UNFPA will remain the main donor for RH/FP. USAID has continued coordination, focusing on transfer of successful strategies to other donors and banks (UNICEF, PAHO, UNICEF, Luxembourg, IDB, WB, among others). |
| Integrated logistic system implemented | | | The integrated logistic system (PASIGLIM) is functioning at the central level, SILAIS, and health centers. SIGLIM, the manual version, is functioning in health posts. |
| Decrease in the number of health centers and health posts that experience stock-outs of contraceptives. | | | Stock-outs decreased from 36% in 2007 to 0.8% in 2012. |

Source: Ministry of Health, Deliver and USAID Nicaragua documents.

CSC FUNCTIONING

The CSC has been active in Nicaragua since a 2003 meeting at which representatives from nine countries developed the conceptual framework of the CS at a regional meeting conducted in Managua. At this meeting, the gradual reduction of donations and the need to incorporate FP as a fundamental pillar to improve maternal and child health were discussed. As a result of this meeting, CSCs were established in all the participating countries. The main role of the CSCs was to promote coordination in topics such as contraceptive financing, procurement and distribution of contraceptives with support from international donors. Later, USAID (through the DELIVER Project and the Policy II project) evaluated the CS situation in five countries (Bolivia, Honduras, Nicaragua, Paraguay and Peru) and recommended that efforts be focused in four key areas: political commitment and leadership, procurement and financing, market segmentation and logistics. In 2003, the first CSC was established in Nicaragua with participation from the MOH, INSS, PROFAMILIA and agencies that cooperate with its respective projects.

During 2005, the CSC developed its first strategic plan for the 2005-2008 period. This plan was officially approved by MOH resolution 384-2006 in December 2006, and a manual establishing roles and responsibilities was provided. During that period, the CSC conducted meetings with a variety of stakeholders.

Currently, the CSC is coordinated by the MOH; the USAID DELIVER Project assumes the executive secretariat until August 2012. The CSC has four working committees:

logistics, advocacy and policy, market segmentation and financing, all of which are active based on needs. The current members of the CSC are as follows: the MOH (Quality Division, Planning and Development Direction, Medical Supplies Division and CMPS Direction), INSS (through its Preventive Services Division), NGOs (NICASALUD, PASMO, PATH, PROFAMILIA), the Academia and cooperating agencies (UNFPA and USAID).

The MOH leads the call for meetings and the approval of new members; however, its technical leadership needs to be strengthened. The committee is implementing its second strategic plan for 2010-2012 with regular meetings.

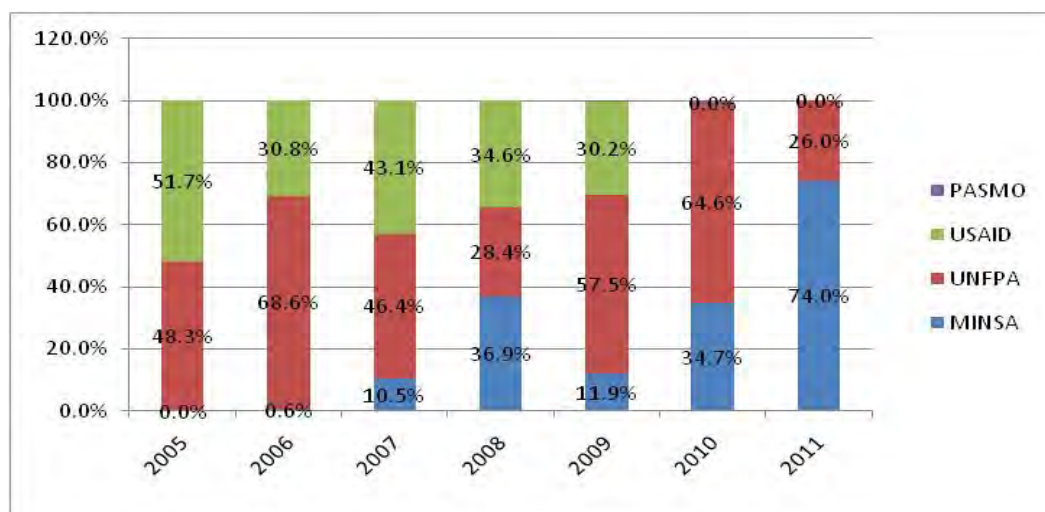
As in other countries within the region, the CSC has expanded its focus to include all areas related to SRH, including HIV, and has changed its name to reflect the expansion. The CSC is now called DAIRSS – RSS (RSS signifies sexual and reproductive health, which includes HIV).

GRADUAL REDUCTION OF USAID CONTRACEPTIVE DONATIONS

The MOH is procuring locally and regionally at very competitive prices and is forecasting its FP requirements without external assistance from DELIVER. The Letter of Implementation signed in 2006 established that by the end of the USAID contraceptive donation, the GON should provide 20% of the USAID donation. As shown in Figure 3, in 2010, the GON provided 34.7% of all contraceptive funds; this value increased from 0.6% in 2006 to 74% in 2011, except in 2009, when UNFPA increased their donation, which resulted in the MOH reducing its budget.

Figure 3

Contraceptive funding evolution, Nicaragua 2005-2011



Source: Ministry of Health

DONOR COORDINATION IMPROVED

Coordination efforts began in 2003 and were systematized by the successful implementation of the CSC Committee, which has functioned without interruption since 2005.

The key donors have been UNFPA and PAHO. With both agencies, USAID coordinated the revision, production and dissemination of norms and protocols. In previous years, the collaboration of ASDI was fundamental for the printing of materials. On the other hand, the current DAIA strategic plan includes a budget per activity and the donor responsible for providing financial and/or technical support.

The MOH Medical Supplies General Direction has a multiannual operational plan (2011-2016) that integrates all donor support on FP commodities contributing to the financial gap. Under this plan, the USAID DELIVER Project, in coordination with UNFPA, has worked on the implementation of the PASIGLIM to avoid duplication of effort (donation of equipment, materials, training, supervision, etc.)

A similar process was used in previous years to determine the type and quantity of contraceptives to be donated by each cooperating agency based on the forecasting exercises developed by the MOH with USAID support with PIPELINE. The MOH is currently using the same tool to forecast needs for all medicines.

Complementing the process to improve the data generated by PASIGLIM, support to increase rational use was provided through the design and implementation of norms and guides in coordination with PAHO, UNFPA, AIS and FarmaMundi. In Matagalpa and Jinotega, efforts were conducted in coordination with the Integrated Health Network project financed by IDB.

More recently, USAID has also coordinated efforts to strengthen the Logistic System and improve warehousing conditions together with the Global Fund, USAID/Supply Chain Management System (SCMS, with PEPFAR funds for HIV), UNFPA/Prisma and the IDB/Integrated Health Network project. It is important to emphasize the need for additional investment in improving warehousing conditions nationwide.

In June 2012, USAID led a meeting with donors to inform them about advances in the graduation strategy and to discuss the gaps still pending in the country. As a result, several donors expressed their interest in continuing to support USAID-initiated activities with the MOH. Coordination efforts continue, and it is expected that cooperation agreements will be established during the remaining period of USAID assistance to the sector.

INTEGRATED LOGISTIC SYSTEM IMPLEMENTED

Nicaragua has been successful in establishing an integrated logistic system. Until 2007, the MOH had nine parallel systems in place. Based on the strength of the information system designed for contraceptives (SIAL) and supported by USAID, the MOH decided to expand and improve the system so as to integrate all medicines and, during 2008, all medical supplies. In 2011, antiretroviral and the HIV rapid test were also incorporated into the system, which is known as PASIGLIM.

The PASIGLIM consolidates consumption data and stocks of medicines and supplies in all municipalities, hospitals and SILAIS, ensuring information flow up to the central level. The system includes a control panel that provides a fundamental tool for managing stock at all levels and providing information for decision making. The PASIGLIM has been officially approved by the MOH. The system is implemented

nationwide, with the information updated on a monthly basis. It can generate reports on “non-delivered prescriptions” (*recetas no atendidas*), information that is reported daily to prevent and resolve stock-outs. Although PASIGLIM was designed in 2008, it has been subject to periodic reviews and improvements and currently is a friendly program that has been incorporated into the pharmaceutical schools’ curricula. PASIGLIM has allowed the MOH to substantially improve the availability of medicines and supplies, avoiding stock-outs previously generated by management problems and allowing annual forecasting based on real demand.

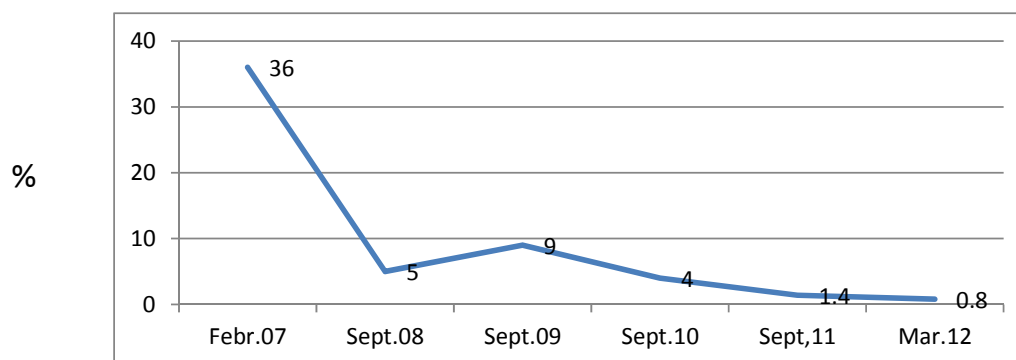
The USAID DELIVER Project, in coordination with UNFPA, has provided support to the MOH for the implementation of PASIGLIM nationwide, providing training to health personnel, donating computers and financing internet access for data transmission. The system is currently functioning in all hospitals and health centers and in the central MOH. Training in the use of PASIGLIM has been robust. However, in general, only one person per health center is trained in its use. This represents a weakness because that person cannot be absent for vacation or sick leave without putting the continuity of the supply chain at risk. Eight of 13 staff at the MOH in charge of quality assurance are funded by UNFPA (7) and DELIVER (1); at the time of the evaluation, the MOH had not formally committed to incorporating the staff into the MOH budget.

DECREASED STOCK-OUTS

An impressive result achieved with USAID support is a dramatic reduction of stock-outs. Figure 4 shows how stock-outs were reduced from 36% in 2007 to 0.8% in 2012. UNFPA and the USAID DELIVER Project were instrumental in achieving this result through their contributions to the strengthening of the MOH’s capacity to properly monitor and efficiently distribute and use medicines, including contraceptives. Proper implementation of PASIGLIM was an important factor in the impressive reduction in contraceptive stock-outs.

Figure 4

Percentage of MOH facilities experiencing stock outs of at least one contraceptive method, Nicaragua 2007-2012



Source: PASIGLIM and MOH reports

The USAID DELIVER Project supported the MOH regarding the definition of tracer drugs, a list of 30 critical medicines including contraceptives and medicines for

obstetric care, HIV and laboratory tests. All health facilities, from health posts to hospitals, are responsible for monitoring tracer drugs so as to guarantee their availability. When vulnerability is identified, the management staff at the local and regional levels is responsible for taking immediate action to correct the situation.

Based on the above-mentioned findings, the evaluation team concludes that the FPGS original assumptions related to this component were valid and that they ensured a successful graduation in Nicaragua. All six specific indicators were achieved, and this achievement has been sustained since the mid-term evaluation.

The main risks to continued progress during the post-graduation phase for the MOH are the need to:

- Ensure sufficient funding to cover 100% of the MOH once UNFPA donation ends;
- Receive technical assistance to improve the quality and analysis of data;
- Improve its technological platform, including sustained access to the internet for all public health facilities with government financial resources;
- Guarantee the financial resources to maintain key staff currently financed by international donors.

With regard to recommendations, although the MOH has expressed its commitment to fulfill the gap once UNFPA stops donating, this topic should be closely monitored and strengthened. One of the financial mechanisms already in place that should help the GON to ensure FP commodity security is the inclusion of an FP component in the new IDB/Mesoamerican Initiative agreement. Another promising activity is the continued effort to increase the participation of the social security sector in providing contraceptive services.

A specific recommendation mentioned by UNFPA is the need to deepen its analysis of the contraceptive market so as to improve and promote more efficient procurement mechanisms and potentiate local purchases based on available offers.

USAID and other donors should maintain and strengthen their presence in the CSC committee and, if possible, should provide targeted assistance. This is particularly important due to the CSC's role in monitoring and advocating for the timely execution of MOH funding for the procurement of contraceptive and other RH supplies for maternal health and HIV. The CSC needs to evaluate its current plan and develop a new strategic vision and plan for 2013-2016, both of which should be in line with the national Health Plan.

The MOH should consider including universities and professional associations in the CSC so as to better coordinate and integrate all actors involved in providing FP services of any kind.

The eight MMOH staff in charge of logistic quality assurance, who have key roles in ensuring the functioning of PASIGLIM, are currently funded by UNFPA and DELIVER, will need to be absorbed by the MOH in the near future. This was not pre-planned and will be a budgeting challenge; however, these positions are essential for the continuity of PASIGLIM functioning. In addition, new staff must be trained on PASAGLIM to ensure continuity of information at all levels of the public system.

To fill the gap related to data analysis, the MOH should evaluate its real capacity and implement actions aimed at strengthening the monitoring and evaluation of the quality and use of the data.

MARKET SEGMENTATION

The market segmentation component is aimed at ensuring that there is a well-segmented market, with the commercial sector and NGOs providing methods to those who can afford to pay (including for lower-cost commercial products), INSS covering its beneficiaries, and the MOH thus able to focus public sector efforts on targeting the poor, uneducated and inaccessible populations.

The activities implemented to promote better market segmentation included the following: working with the MOH to explore the best way to target underserved populations; ensuring that social security service providers provide family planning services to the insured and their spouses in accordance with INSS policies; reaching underserved populations in the poorest municipalities with integrated MCH-FP services and community-based distribution while strengthening local health posts and centers; and encouraging the private sector to supply socially marketed family planning methods to the private sector, the IPSS and the INSS and to introduce mid-priced products. At the same time, the private sector was encouraged to offer FP methods through PASMO and PATH.

The main findings and conclusions obtained from the visits to the CMPs and IPSS are as follows:

- Both CMPs and IPSS expressed that the USAID support was beneficial in permitting them to improve their organizational capacities and to establish record-keeping systems based on the national norms.
- FP is a priority for the CMPs and no stock-outs were identified. The methods offered are different from the MOH list but its availability is guaranteed.
- FP counseling is offered to 100% of the clients and around 90% of them choose a method.
- The number of IPSS offering FP services is still limited and needs to be increased to cover 100% of the facilities.

Table 8 shows indicators related to this strategy component and the evidence of achievement for each indicator.

Table 8 Performance indicators for market segmentation

| Market segmentation | achieved | Not achieved | Evidence of achievement |
|---|----------|--------------|--|
| MOH participation decreasing to 60% | | | Data from next DHS is not available; however, CSC projects a decrease from 74% in 2008 to 65% in 2012. |
| Social security participation increasing to 18% | | | Data from next DHS not available; current projection shows an increase from 1% in 2005 to 15% in 2012. |

| Market segmentation | achieved | Not achieved | Evidence of achievement |
|---|----------|--------------|---|
| Private sector and NGOs increased and maintained between 14 -16% of participation in market | | | Data from next DHS is not available; according to projections, private sector participation has decreased from 17% in 2005 to 14% in 2012. |
| Projection of market segmentation used for budgetary assignments and long-term planning | | | The MOH used data from the previous DHS and from other subsector sources (MOH, INSS, NGOs and private sector pharmacies) for budgetary assignments for annual and long-term planning. |

Source: CSC Committee estimations.

MOH PARTICIPATION

The MOH is the largest health care provider in Nicaragua, providing free services to more than 70% of the population. During recent years, the country has made important advances in the development of reproductive health services, with positive results in the provision of quality maternal and family planning services. This is reflected in the reduction in maternal and neonatal mortality that official data show has occurred and in the increase in the use of modern methods of contraception.

The market segmentation trend in Nicaragua during the 2005-2012 period is shown in Figure 6. According to the 2007 DHS, the MOH represented 67.6% of the total market (38.1% in health centers, 27.6% in hospitals, 2% in health posts and 0.1% in clinics). In addition, 0.7% of community coverage was reported (0.4% for “*casas base*” and 0.3 for community promoters). The MOH share of the market increased between 2007 and 2009 due to the need to cover underserved areas. As expected, MOH has been decreasing its participation over the last three years due to increased participation of the INSS sector, which, as desired, was the sector with the highest increase.

The CSC expects that in the future, the share of the market held by MOH will be reduced by increasing the participation of the INSS, thus reducing the cross-subsidies that currently exist.

SOCIAL SECURITY PARTICIPATION

According to the Social Security Law, it is mandatory for employers to register their employees with the Social Security System within the first 72 hours of employment. The number of insured workers has increased to 38% over a five-year period, from 420,316 in 2006 to 578,340 in 2011. Of these workers, 4% are women, more than 50% are between 20 and 34 years of age, and the average age is 35 years. These numbers clearly reflect the potential of the sector (INSS, 2012).

FP services were first included as part of the basic health package in 2005; according to the 2007 DHS, they reached 3.6% of the total market in 2007, and they covered 15% in 2011. It is important to mention that long-term methods of contraception were the most popular within this segment and that the method mix is now more diversified.

Access to FP through the INSS has dramatically expanded: 17 of 28 CMPs and 4 of 17 IPSS are now providing FP to those with insurance. The IPSS still requires assistance to increase their FP services.

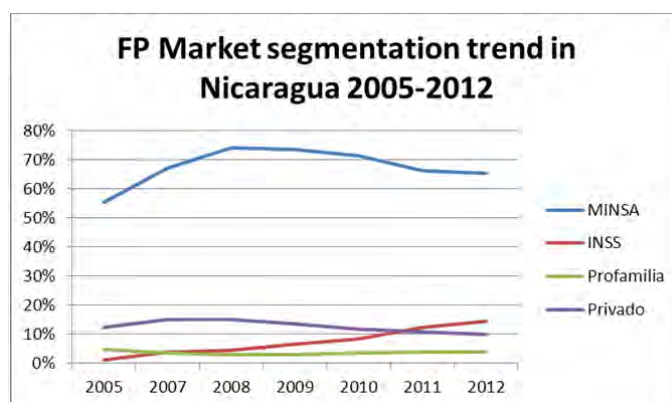
PRIVATE SECTOR PARTICIPATION

According to the 2007 DHS, the private sector share of the contraceptive market was 29.6% (excluding the social security previously mentioned), with pharmacies having the highest portion (14.4%), followed by the PROFAMILIA clinics (4.9%), private clinics and hospitals (3.6%), IXCHEN clinics (1.8%) and others 2.2% (clinics, supermarkets and promoters).

Due to the implementation of the free services policy and the efforts to increase coverage and improve the quality of FP services implemented by the MOH, the participation of this sector was reduced, although it remains important.

CSC estimations show a reduction in the participation of pharmacies from 14% in 2005 to 10% in 2011 as well as a reduction in the participation of the NGO sector from 5% to 4%. Together, these changes represent a reduction in the private sector share of the market from 19% to 14%. These data provide evidence of a better financial equity of the health system and indicate that the poorest quintile of the population was able to reduce its out-of-pocket expenditures. At the same time, the data reflect increased access of formal workers to FP methods through the INSS clinics. This is consistent with the information provided by the latest Living Conditions Survey (EMNV, 2009), which shows a reduction in total out-of-pocket expenditures. It is important to emphasize that conclusive data on market segmentation will be available once the 2013 is published. Figure 5 shows the market segmentation trend from 2005 to 2012.

Figure 5



Source: USAID Nicaragua, using CSC Committee estimations

For the two indicators for which progress was not achieved as expected, an important factor affecting the accomplishment was the limited number of INSS clinics offering FP services. USAID Nicaragua and other donors should continue to advocate for ensuring coverage for all eligible individuals and should attempt to make sure that those who are covered utilize the INSS system of clinics. To achieve this, all INSS public clinics need to train their personnel so that they are prepared to offer FP services. When the DHS 2013 is released, USAID should work with the CSC to analyze the data and propose appropriate actions toward better FP market segmentation.

The original assumptions of the FPGS for this component were valid and ensured a successful phase-out. Two specific indicators were achieved, and this achievement has been sustained since the mid-term evaluation. Two indicators are in the process of being achieved; the trends for both of these demonstrate that they are on track for achievement.

The challenge to continued progress during the post-graduation phase is maintaining and increasing the participation of the social security subsector as an FP service provider.

The main recommendations are as follows:

- Provide support to the IPSS to increase its capacity and expand its range of FP services. This can be accomplished with the remaining MCH and HIV program activities and with other donors' support or MOH resources.
- The INSS should improve its services and monitor the provision of contraceptives, including long-term methods.
- Once DHS data are available, support to the CSC should be provided to update the market segmentation analysis.
- The commercial private sector should be incorporated into the CSC, and this sector should be serving Q4 and Q5 (the two highest) of the income quintiles.
- The MOH has expressed its interest in the reverse-auction model discussed at the last CSC regional meeting in Lima³. This model is recommended as a cost-effective procurement approach, and the MOH should consider using this model.

STRENGTHENING OF HEALTH SYSTEMS

The objective of the health system-strengthening component was to ensure compliance with and approval and dissemination of standards related to family planning and reproductive health services provision in Nicaragua, as well as to improve advocacy around those issues.

USAID Nicaragua provided support for the MOH in strengthening its stewardship with respect to family planning, including training for better oversight of the family planning and reproductive health services provided by INSS through IPSSs, NGOs and the private sector. The assistance provided also included support for the implementation of the FP component of the National Sexual and Reproductive Health Strategy, which was mainly manifested in the effective multi-agency planning conducted by the CSC.

The main findings and conclusions from the visits to public health services are as follows:

- All health services visited acknowledge the value of the USAID assistance. With support from the USAID projects, stock-outs of contraceptives were eliminated, the quality and management of services (with the introduction of management and information tools) increased, and voluntarism and free choice are being promoted among users.
- The community work is recognized as valuable, and there is a consensus that it should be expanded to new municipalities and communities. The MOSAF has enabled MOH to reach more women and has reinforced the APEO

³Reverse auction is a bidding process whereby the supplier of a good is chosen based on the best price offered and not on the technical characteristics of the good. All other characteristics, including quality, are predefined and applied as a minimum standard for participating in the auction.

strategy. Overall, between 95% and 98% of women are leaving health facilities with a contraceptive method after an obstetric event.

- Adolescent pregnancy is a problem mentioned in all health facilities visited. Although percentages vary, all health services reported that adolescent pregnancy represents a high percentage of institutional deliveries, with percentages ranging from 20% to 40%.

Table 9 shows the indicators related to the system-strengthening strategy component and the evidence of achievement for each indicator.

Table 9 Performance indicators for health system strengthening

| System strengthening | Achieved | Not achieved | Evidence of achievement |
|---|----------|--------------|--|
| Reproductive Health National Strategy Implemented | | | FP Strategy contributed to the achievement of one key objective of the national RHS. |
| Contraceptive Community Distribution Strategy developed | | | ECMAC and community promotion of FP implemented in 84 municipalities and 804 districts. MOH has expressed its commitment to continue ECMAC because it fits within the MOSAFC strategy. |
| Post-obstetric event contraception strategy (APEO) | | | APEO designed and implemented nationwide. Data from HCI shows an increase from 12% in 2003 to 91.2% in 2012. MOH has included two indicators to measure performance. |

REPRODUCTIVE HEALTH NATIONAL STRATEGY:

In 2008, the MOH launched the National Reproductive Health Strategy (NRHS), which is a part of the National Development Plan. This strategy is organized based on nine key objectives related to universal access to Reproductive Health Services and includes access to FP methods. Through the CSC plans, which were aligned with the national policies and plans, USAID directly contributed to the strategic objective of the NRHS of “promoting informed and responsible choices and use of secure and effective family planning methods that are accessible to all...”

According to the DHS 2007, 72% of WRA in Nicaragua were using a family planning method. After female sterilization (24.36%), injectables were the most popular method (23.4%), followed by pills (13.5%), condoms (3.8%), IUDs (3.4%) and, finally, other methods, such as natural FP and withdrawal (4.1%). The country has the second highest CPR after Costa Rica; however, 20.3% of women expressed an intention to use a different method in the future, 78% would keep the same method, 0.7% would use none, and 0.7% did not know. Female sterilization was the most-wanted method for 39.6% of women, followed by injectables (27.6%), oral pills (14.6%) and IUDs (11.3%). According to CSC estimations, in 2012, a higher proportion of women had had access to female sterilization and more injectables, condoms and IUDs are being distributed, thus improving the method mix.

Another important improvement in the use of FP methods was reduction of the rural gap. This gap was only 3% in 2007 (71% urban vs. 68% rural), and it has decreased drastically since 1993. Moreover, according to the 2007 DHS, geographic gaps still exist, mainly in RAAN, Jinotega, Madriz and Matagalpa, all of which are priority regions for the FPGS.

Using DHS data, the CSC has oriented its strategic plan toward the reduction of equity gaps. Geographic regions, age groups and population segments with the highest in-need populations were prioritized. An intercultural approach, especially for indigenous groups on the Atlantic and Pacific coasts, is still a challenge.

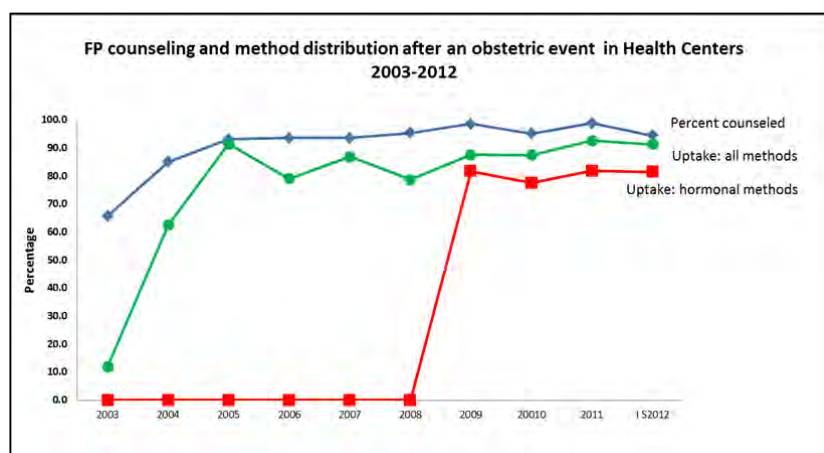
To contribute to the FP strategic goal of the National Reproductive Strategy, the CSC developed two multiannual operational plans implemented by all sectors. The first DAIA plan (2005-2008) was evaluated, demonstrating important results, and the second plan is still under implementation. The second plan was funded with an estimated budget of US\$ 11,373,544 for all sectors involved (PROFAMILIA, PASMOS, PATH, USAID and UNFPA) for a four-year period. The CSC expects to evaluate this plan during the next year, following the release of the new DHS results.

POST-OBSTETRIC EVENT CONTRACEPTION STRATEGY

The post-obstetric event contraception strategy (APEO in Spanish) is a strategy promoted by UNFPA in Nicaragua since the late 1990s; it has received support from the CSC since 2003. Through the USAID DELIVER Project and QAP, USAID supported the MOH in its promotion, resulting in an impressive increase in counseling levels from 65% in 2003 to almost 100% in 2012. This increase in counseling levels directly affected the voluntary use of contraceptive methods, which increased from 12% in 2003 to 91.2% in 2012. The postpartum use of IUDs has increased from 1.8% in 2009 to 5.2% in 2012.

The MOH has incorporated post-obstetric FP into the FP norms and uses monitoring tools with specific indicators to monitor performance at all levels of the system. Data collected on post-obstetric family planning counseling demonstrates strong informed and voluntary decision making. After their initial supply, women can obtain resupply from either their community ECMAC promoter, if they live in a rural area, or their local facility. Figure 6 shows the impressive results achieved with this strategy.

Figure 6



Source: USAID HCI project using MOH data

CONTRACEPTIVE COMMUNITY DISTRIBUTION STRATEGY

The community promotion strategy was initially designed with support of USAID MSH Project in 2003 and was further developed by USAID FamiSalud Project (including distribution of methods, ECMAC and promotion of FP services, among other topics), has been developed by the MOH as the national strategy. Although it currently covers eight regions of the country, it is expected to be scaled up by the MOH with support from other donors. The project designed and implemented a graduation model for communities based on a set of criteria that can be used to categorize communities into three levels (A, B & C) of readiness before terminating assistance.

According to the FamiSalud project intermediate evaluation, which specifically evaluated the ECMAC strategy, “the community volunteers have accumulated good experiences and knowledge in sexual and reproductive health, the population visits the health centers which has an impact on the reduction of unwanted pregnancies, mainly among adolescents and women at high risk, who benefit from improved access to family planning methods, thus contributing to the reduction of maternal, perinatal and infant mortality.

We take notice of the political will which enables the leaders at the SILAIS and municipalities level to negotiate and work in coordination with the agencies, and that people are increasingly demanding access to family planning; the MINSA has improved counseling services and users from remote areas are able to get access to family planning methods. This is a very sustainable strategy because it is taking place directly in the communities, through the intersectional efforts of FamiSalud, the community, and primarily through the monitoring services provided by the MINSA” (GSC, 2012).

Comparing the 2006 baseline with the ECMAC implementation evaluated at the end of 2011, the community network was expanded with new trained social workers. The social workers facilitate access to family planning methods in the rural communities attended by FamiSalud; they have been provided with educational materials, and the community users have expressed their satisfaction. In absolute numbers, the FamiSalud mid-term evaluation reported the implementation of ECMAC and PPF-C in 804 communities, benefiting 79,855 people including men, women and adolescents, and the training of 413 health officials and 1775 community counselors.

During the past years, with Famisalud support, an evaluation of ECMAC implementation was conducted, and a proposal for updating the strategy was presented. The proposal is currently awaiting formal MOH approval.



FP Counselor, Community La Patriota, Muelle de los Bueyes, Chontales./Vilma Gutiérrez.



FP Counselors, Community El Yaral, Mozonte, Nueva Segovia. /Vilma Gutiérrez

The FamiSalud project developed and implemented a set of tools to support the implementation of MOSAF. One example, very important for the sustainability of the project, is a “community graduation model” based on criteria that classify the sites according to three levels of maturity. When a community reaches the highest level, it is considered that the basic conditions for ending the assistance have been met.

The main findings and conclusions from the site visits to the communities are as follows:

- The community work has been strengthened with a network of very well-trained promoters and with the appropriate leadership to conduct promotional activities.
- A strong link among promoters and health providers was perceived, and reference and counter-reference seem to be working properly.
- Promoters have the tools, materials and supervision required to implement program activities and maintain the necessary motivation levels.
- No stock-outs of contraceptives were found, and there is a general consensus that the work being done to increase access to FP methods is important.
- All women interviewed expressed their satisfaction with the promoters’ activities and shared their positive experience in using modern FP methods.
- The fact that the majority of promoters are men does not seem to have affected the female users, who manifested their confidence and trust in talking about FP with them.
- The number of young promoters encountered was interesting because it facilitates communication with and access to FP methods by a target population that is usually reluctant to go to health facilities.

Related to this strategic component, the original assumptions made by the FPGS were valid and ensured a successful phase-out. The specific indicators were achieved, and this achievement has improved or been sustained since the mid-term evaluation.

The main risk to continued progress during the post-graduation phase is the need for sufficient resources to maintain and increase the implementation of the ECMAC using other sources of funding (other donors, loans, etc.).

The core recommendation for the MOH will be to sustain and expand the ECMAC strategy because it has been a successful strategy for increasing access to FP methods. This includes increasing the monitoring and supervision of ECMAC promoters to ensure the continuity of the strategy. The strategy should incorporate an adolescent and a working-women module (urban ECMAC) to better respond to the needs of these target groups.

IMPROVED SERVICES AND QUALITY ASSURANCE

The improved services and quality assurance component was intended to ensure that FP quality standards and procedures, including access to the safest long-term and permanent contraceptive methods, are maintained in the MOH and social security systems in all departments, including those serving the most poor and least accessible.

The activities implemented to achieve this objective included the following: development, testing, approval and dissemination of family planning standards and

guidelines; support for pre- and in-service training on family planning; support training for management; the dissemination of norms and guidelines; monitoring of the implementation of all activities, especially in the facilities in the poorest and most underserved areas; and working with service delivery points located in the poorest municipalities to ensure that providers were trained on IUD insertion and mini-laparoscopic procedures for voluntary sterilization, as well as providing technical assistance and training in other family planning methods.

The HCI project implemented a tool called “quick improvement cycle” that has proved to be an efficient intervention for solving specific problems at the service level and has been positively received by health providers.

The main findings and conclusions regarding the improved access and quality assurance component are as follows:

- USAID assistance was recognized as valuable and positive by all health services.
- There has been an increase in the use of permanent methods (IUDs and female sterilization).
- The major universities and training facilities in the country are incorporating the national norms, protocols and tools into their curricula.

Table 10 shows the indicators related to this strategy component and the evidence of achievement for each indicator.

Table 10 Performance indicators for improved access and quality assurance

| Improve access and quality assurance | Achieved | Not Achieved | Evidence of achievement |
|---|----------|--------------|---|
| Family planning national guidelines updated and implemented | | | In-service training: More than 10,000 health workers trained on norms and national guidelines. Pre-services: A training package for universities was designed to ensure transfer of the FP norms and protocols in 7 Universities and 17 faculties (medical schools, nursing schools and pharmacy schools); MOH officially approved ECMAC |
| Increase availability of long-term methods | | | In-service training on mini-lap provided to MOH, CMPs. Assistance was provided to the SILAIS to reorganize the services. Donation of equipment for IUD insertion. |

FP NATIONAL GUIDELINES UPDATED AND IMPLEMENTED

All USAID projects worked intensively in coordination with other actors in updating a series of technical norms, guides, protocols and standards related to the provision of FP services. After validation and official MOH approval, the documents were printed and disseminated through the continuing education plan of the MOH.

In-service training on a wide range of FP national guidelines was one of the pillars used to improve the quality of FP services offered by the national health network, including service offered at the community level. Although included in the national norms, knowledge and information about emergency contraception is still limited. Table 11 shows the number of people trained by topic and entity.

Table 11 Family Planning Training, Nicaragua 2007-2012

| Implementing partner | Type of personnel trained | Type of training | Number of people trained |
|--|--|--|--------------------------|
| Health Care Improvement Project | MOH CMP and IPSS NGOs Universities Nursing schools | PF counseling, clinical norms and protocols PF management PF/HIV integration BTO with local anesthesia Quality improvement | 2,768 |
| Deliver Project | MOH CMP IPSS NGOs Universities Nursing schools | Logistic system Inventory control Rational use of drugs and committees Monitoring and Programming FP Logistic supervision Basic drugs lists | 6,291 |
| FamiSalud project | MOH NGOs | ECMAC Community FP counseling | 1,038 |
| | Community counselors | | 2,867 |
| Total | | 10,097 health personnel 2,867 community counselors | 12,964 |

Source: Implementing partners' reports and USAID Nicaragua database.

A training package (known as “*maletas pedagógicas*” in Spanish) for universities and nursing schools has been developed. It is based on the national norms and focuses on logistics, FP counseling, and quality improvement, all of which are topics supported by USAID and now officially adopted by the MOH. The first phase has been completed with four universities; the next phase will be implemented in seven universities with 17 degree programs. USAID coordinated efforts with its partners, HCI, DELIVER and the FamiSalud project in the design, production, and distribution of this training package.

In addition, the USAID Deliver Project, in coordination with other donors, provided support on the rational use of medicines in conjunction with their work strengthening the logistics system. Guidance for rational use was developed and is in the early stages of implementation.

The HIV Project PrevenSida has incorporated FP into their materials and approach, and they promote dual protection. The Mission is also ensuring that FP topics are included in its maternal health activities as a pillar for safe motherhood.

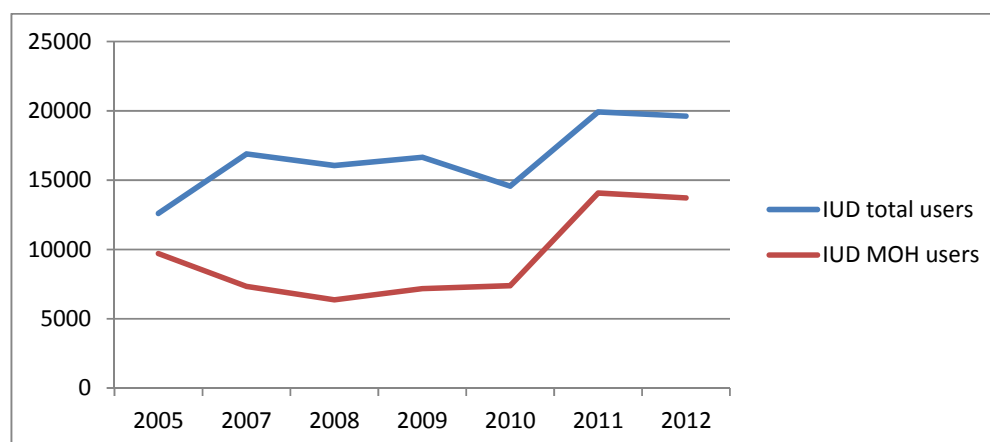
INCREASED AVAILABILITY OF LONG-TERM CONTRACEPTIVE METHODS

The 2007 DHS shows that the main provider of long-term methods is the public sector (69.5%), primarily hospitals. Within the private sector (29.5%), PROFAMILIA and

IXCHEN are the main suppliers. IUD provision is similar (69.2% and 30.8% for the public and private sectors, respectively).

Through the FPGS, the USAID-funded projects implemented targeted actions to improve the technical skills of providers and the availability to public facilities of materials and equipment for IUD insertion. In-service training in IUD insertion technique was provided to the MOH and the CMPs; this resulted in an increase in IUD uptake that was also influenced by the donation of devices by PSI/PASMO. Figure 7 shows the IUD users trend from 2005 to 2012.

Figure 7
Intrauterine device users trend, Nicaragua 2005-2012



Source: USAID Nicaragua, using CSC Committee figures

The evaluation team concludes that the original assumptions of the FPGS were valid and ensured a successful phase-out. The specific indicators were achieved, and this achievement has either improved or been sustained since the mid-term evaluation.

The main risk to continued progress during the post-graduation phase is to maintain and update the national guidelines for family planning, to effectively carry out transference and training (pre- and in-service) and to increase the availability of long-term methods.

The main recommendations are as follows:

- USAID should continue the transfer of the training package to universities and other training institutions, promoting the incorporation of its contents into all public and private universities.
- The MOH should maintain the use of the training package for in-service training of health personnel, especially new staff.
- FP norms from 2008 should be updated, with the MOH taking the lead.
- The MOH should conduct a gender analysis and must incorporate male needs aspects of FP into its efforts to improve FP services.
- Integration of FP with maternal health and HIV must continue because it is considered a best practice.
- The “quick improvement cycle” model designed by the HCI project should be promoted within the MOH and with other donors because it has been very

effective in improving the quality of services as perceived by both providers and users.

- Health providers nationwide should receive refreshment training on emergency contraception. At the same time, information about emergency contraception should be broadly disseminated.
- Emergency contraception should be promoted as an option for women victims of violence or those who have had unprotected sex; currently, it is only promoted for victims of rape.

DATA FOR DECISION MAKING

The objective of the data for decision-making component was to ensure that implementation of a national health survey remains a priority and that local capacity to implement the survey exists. Activities to promote this objective include the following: involvement of relevant local agencies in south-south exchanges for capacity building and development of manuals or guides for survey implementation; advocacy with the Government of Nicaragua to include line items for funding the DHS as part of the monitoring/evaluation activities written into new health sector loans; advocacy with multilateral and bilateral donors who utilize the data to provide significant funding for future surveys so as to ensure that the 2012 DHS is fully funded and that it is undertaken and the results are disseminated. Table 12 shows indicators related to this strategy component and the evidence of achievement for each indicator.

Table 12 Performance indicators for data for decision making

| Data for decision- making | Achieved | Not Achieved | Evidence of achievement |
|--|----------|--------------|---|
| DHS survey increased use for decision making | | | The 2007 DHS was widely disseminated, and the data were used for planning, focusing on the most vulnerable populations. Multiple organizations have conducted secondary analyses and used them for decision making. |
| Next DHS preparation plan | | | Field work for the next DHS is in progress; it is expected that the results will be available in 2013. It is funded with a World Bank loan; no USAID funding or TA has been provided. |

DHS SURVEY INCREASED USE FOR DECISION MAKING

The USAID MSH PRONICASS project implemented specific actions to disseminate and use the DHS information at the national level. In addition, USAID provided funds to UNDP to conduct decentralized activities to disseminate analyze and use the data as part of local-level health assessments in coordination with INIDE, PAHO and MOH.

Based on the results of the DHS survey, the USAID DELIVER project conducted two secondary analyses of market segmentation and equity gaps; these secondary analyses were used by the CSC. As stated in the Mid-Term Review, the 2007 DHS was widely disseminated, and the data were used for decision making at all levels (central, SILAIS, health center and community levels), allowing programs to focus on the most vulnerable populations. Examples of the use of the data can be found in the two CSC plans, the

evaluation of the first plan, and the design of the FPGS and the revision of USAID Nicaragua health projects.

NEXT DHS PREPARATION PLAN

The 2006/7 DHS was conducted with support from various donors under the leadership of the INIDE. Technical assistance was provided by the CDC, and financial support was provided by UFNPA, UNICEF, UNDP, the World Bank, USAID, IDB, the Canadian Program and CDC.

Using the technical capacity built with support from international donors, INIDE is currently in the field data-gathering stage of a new DHS 2012/13, funded by a World Bank loan and with technical assistance from the United Nations. The results are expected to be released in 2013.

USAID Nicaragua conducted several meetings with INIDE and the donor group, offering support if needed in the preparation and/or dissemination of the new DHS. Provision of this support was finally not possible due to delays in the start of the survey work. It is expected that the results will be beneficial for the evaluation of not only the FPGS but also other areas, such as maternal and child health and nutrition.

Although not included as a strategic component of the FPGP, it is important to highlight the efforts of USAID projects, with leadership from the Mission, to provide assistance to the MOH with tools for data collection and information gathering that are being used for monitoring and decision making.

The evaluation team concludes that the original assumptions of the FPGS were valid and ensured a successful phase-out. The specific indicators were achieved, and this achievement has been improved or sustained since the mid-term evaluation. The team did not note any significant risks to continued and sustained use of data for decision making.

Once the DHS is completed, it is recommended that the dissemination, analysis and use of data be strengthened; this also applies to secondary analysis, with emphasis on market segmentation and gaps. It is also recommended that a module on data analysis and use of information be included within the training packages (*maletas pedagogicas*) that are being transferred to the universities.



FP Counselors, Community El Yaral, Mozonte, Nueva Segovia.

V. GENDER ANALYSIS

Central to USAID's work, including the FP graduation approach, is the understanding that gender equality and female empowerment are core development objectives fundamental to the realization of human rights and key to effective and sustainable development outcomes. This evaluation of the Nicaragua strategy included a gender analysis, an acknowledgement of the historical context of gender inequalities in Nicaragua and a review of the current situation as it relates to the FP program.

USAID implements a Gender Policy aimed at empowering women; the main goal of this policy is to improve citizens' lives by promoting equity among men and women, thus empowering women and girls to participate in and benefit from development. USAID integrates these principles into its entire cooperation process. The Gender Policy includes seven principles related to the effective integration of gender perspective: pursuing an inclusive approach for foster equality; building partnerships across a wide range of stakeholders; harnessing science, technology, and innovation to reduce gender gaps and empower women and girls; addressing the unique challenges in crisis- and conflict-affected environments; serving as a thought leader and a learning community; and finally holding accountable of the results.

According to internal USAID requirements, gender analysis must be conducted at the strategic and project levels. At the strategic level, gender inequity and barriers should be analyzed, and they should be addressed at the project level. USAID Nicaragua began to conduct a gender analysis in 2012; however, previously developed documents that guide the design of the FPGS were not gender-responsive. During the implementation of the strategy, gender has become an important priority within USAID. In response, the Mission and its implementing partners acknowledged that gender must be incorporated into the strategy. Within the constraints of the national FP program, which is not especially gender-responsive because the current MOH FP program is women-centered and designed for women, the Mission and its partners did their best to implement their activities in a gender-responsive manner. The FPGS did not include specific gender-related indicators to measure impact on gender, although disaggregated data on training and services provision were collected.

USAID's Gender Policy is designed to produce the following results through the implementation of its programs: reduce gender disparities in access to, control over and benefit from resources, wealth, opportunities, and services; reduce gender-based violence and mitigate its harmful effects on individuals and communities so that all people can live healthy and productive lives; finally, increase the capability of women and girls to realize their rights, determine their life outcomes, and influence decision making in households, communities, and societies. This section analyzes and describes the contribution of the FPGS related to these three results. To permit evaluation of the contribution of FP to these results, some indicators are presented. In some cases, for example, in reducing maternal mortality and out-of-pocket expenditure levels, FP's contribution was positive; in other cases, although there has been improvement, it was limited and not sufficient, especially with regard to adolescent pregnancies and male participation in FP.

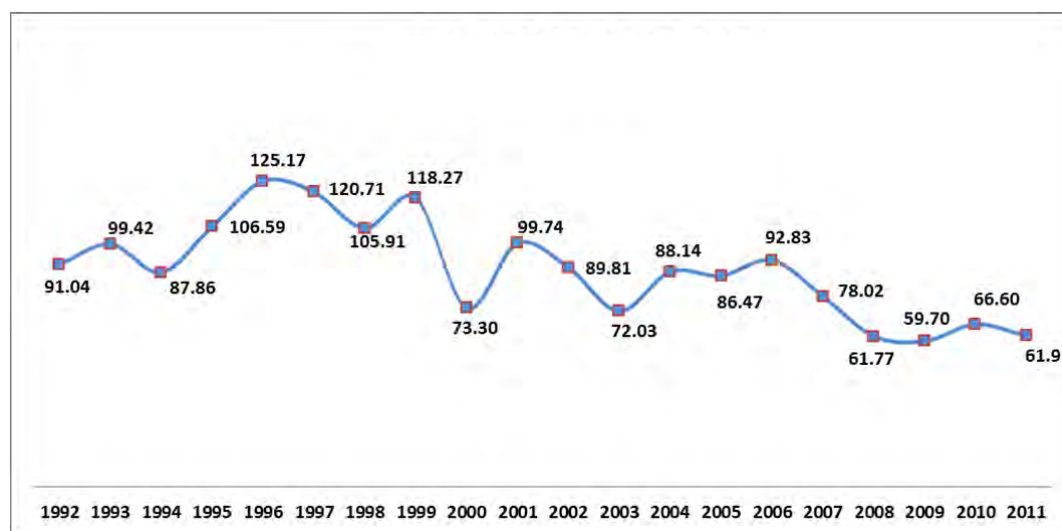
REDUCTION OF GENDER DISPARITIES IN ACCESS TO, CONTROL OVER AND BENEFIT FROM RESOURCES, WEALTH, OPPORTUNITIES, AND SERVICES

EXPANDED ACCESS TO FP METHODS FOR HIGH-RISK WOMEN:

The unmet need of vulnerable populations negatively affects women's health. According to the MOH, in 2007, 72 out of 115 (63%) maternal mortality cases involved women who were not using a FP method. This percentage was even higher in 2008, with 79 out of 95 cases (83%) and in 2009 (80%). In both the 2005-2008 and 2009-2012 CSC plans, there is recognition of the irreplaceable contribution of increased access to FP, especially among women living in the most vulnerable situations, in successfully reducing maternal mortality. Avoiding unwanted pregnancy can help reduce maternal mortality by up to 20% in developing countries. Figure 9 reflects the impressive advances made in Nicaragua during the past six years, during which maternal mortality was reduced by a third. The MOH officially recognized the contribution of FP in this critical achievement. However, Chontales, Jinotega, RAAN and RAAS are still experiencing high maternal mortality rates, and two of these areas, Jinotega and RAAN, had the lowest contraceptive prevalence in 2006.

Figure 8

Trend in maternal mortality ratio in Nicaragua, 1992-2011



Source: Ministry of Health, 2012.

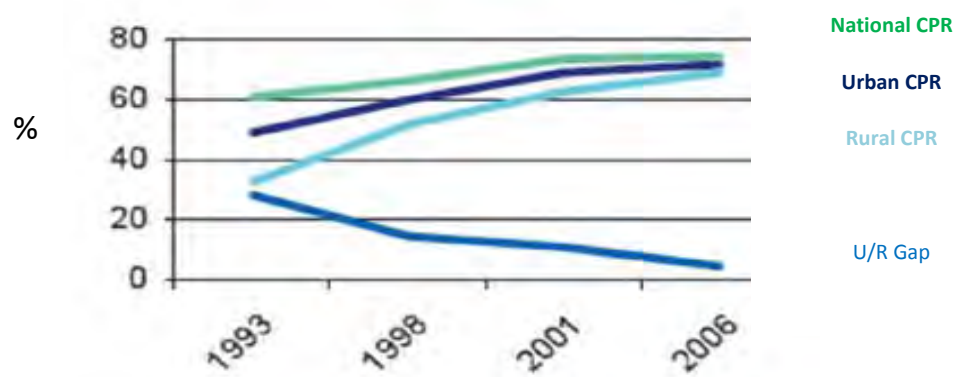
The cultural adaptation of birthing services initially promoted by the HCI project and currently adopted as an official strategy has been very successful in increasing the number of institutional deliveries. Women at public health facilities are now entitled to decide who will accompany them during delivery, what they will have to eat, and what position they wish to assume during birth, among other things. According to the MOH, this strategy has also been instrumental in reducing maternal mortality. At the same time, it has increased the number of institutional deliveries; as a result, more women have received post-partum counseling on FP methods, and all are offered contraceptive methods, as described in the previous sections.

REDUCTION OF THE DISPARITY IN ACCESS TO FP FOR RURAL WOMEN IN GENERAL:

The national average for the use of FP methods in Nicaragua increased by 23% between 1993 and 2006. The increase was even higher in rural areas (36%). This increase benefited the reduction in the rural-urban gap (3% in 2006) that is shown in graphic 9. The 2012 DHS will provide updated data on the current situation.

Figure 9

Use of FP method by sector in Nicaragua, 1993–2006



Source: UNFPA using Family Health Survey 1993 and DHS 1998, 2001, 2006

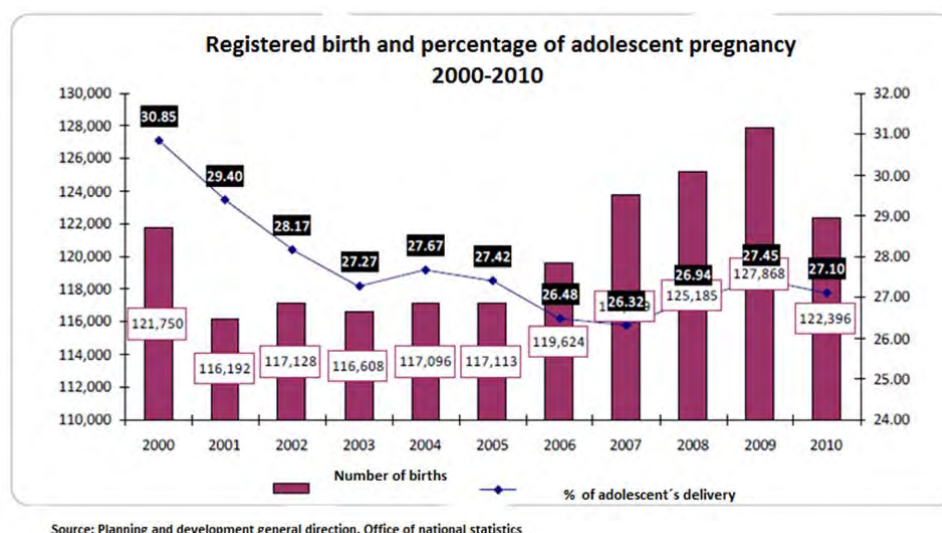
REDUCTION IN OUT-OF-POCKET EXPENDITURES AMONG POOR WOMEN:

Because FP services and methods are free within the public system, inequalities in access are mitigated because women do not need resources (other than transportation) to take advantage of FP. The reduction in out-of-pocket expenditures in Nicaragua for the 2005-2009 period was documented in the Living Conditions Survey. The percentage of out-of-pocket expenditures for health, considering the total expenditures of a household, decreased from 6.5% in 2005 to 5.3% in 2009.

INSUFFICIENT REDUCTION OF ADOLESCENTS' ACCESS GAP:

The most important gap in the implementation of the National Reproductive Health Strategy was the low prevalence of contraceptive use among sexually active adolescents (ages 15-19 years), which was 59.7 % in 2007. This group had the highest unmet need, 33% more than the national average (10.7% nationally vs. 14.3% in adolescents). Twenty-five percent of the adolescents using a FP method for the first time already had a child. This situation requires a holistic approach to modify the cultural norms that prevail. Graphic 10 shows the adolescent pregnancy trend in Nicaragua; although the rate has decreased over the past ten years, it is still one of the highest in Latin America.

Figure 10



INSUFFICIENT PARTICIPATION OF MEN IN FP

Currently in Nicaragua, almost all of the responsibility for family planning falls on women. Even the information gathered through surveys comes, for the most part, from interviews with women. Therefore, there is little knowledge of men's views of FP. According to the 2007 survey, almost 100% of women in relationships knew about FP methods such as female sterilization and injectables; however, only two-thirds of them knew about male sterilization. Men's participation in FP continues to be very limited and represents an important gap. In addition, services for men are limited, and vasectomy is almost nonexistent as a FP option, although it is included in the national norms. Since 2012, approximately 13% of women have been receiving condoms for FP (a 2.7% increase from 2006), while men receive condoms mainly through the HIV and STDs programs via health facilities or community-level activities. However, research conducted on HIV prevention demonstrates that condom use is not consistent in the majority of men, thus maintaining the risk of an unwanted pregnancy or HIV/STD transmission.

Nicaragua's FP program is a model of success in increasing access for women. However, women and girls continue to face disadvantages. Nicaragua has the opportunity to engage men and boys in FP and reproductive health, which will lead to improvements in the health of both men and women and will help sustain the gains achieved to date.

The participation of men as providers of FP is important. Within the network of services, 26% of the persons trained by the HCI project, 30% of those trained by the USAID DELIVER Project and 34% of those trained by the FamiSalud project were men. Through the FamiSalud project at the community level, 2867 voluntary promoters were trained in FP topics, 25% of whom were men. Currently, of the 1056 promoters working at the community level, 32.3% are men.

INCREASED CAPABILITY OF WOMEN AND GIRLS TO REALIZE THEIR RIGHTS, DETERMINE THEIR LIFE OUTCOMES, AND INFLUENCE DECISION MAKING IN HOUSEHOLDS, COMMUNITIES, AND SOCIETIES

Gender-sensitive norms/protocols and IEC materials were developed, validated, and distributed, and staff were trained in their use in coordination with UNFPA and PAHO. Tools to monitor the quality of FP services (counseling, medical eligibility criteria, etc.) were also developed and incorporated by the MOH.

Important activities were implemented by the different projects to enable the capacity of women and adolescents to better understand their rights related to FP service provision, promoting counseling within the entire health system and at the community level. Although the 2007 DHS demonstrated a high level of knowledge of at least one FP method, this knowledge varied from 5.4% for implants to 98.8% for pills. Throughout the lifetime of the FPGS, efforts were intensified to inform women about the availability of all methods, natural and modern, temporary and long term. The increase in the level of information has affected demand and use, especially for long-term methods. In total, the USAID project reported the dissemination of FP messages to almost 1.4 million women, adolescents and men during the past three years. The impact of this communication campaign will be measured by the next; moreover, the 64% increase in CYP reported by the MOH indicates growing demand within the public sector.

During the site visits to the communities, all women interviewed expressed that they had made a free choice based on the information provided during counseling. This voluntary and informed choice was systematically monitored by the USAID-funded projects during the implementation of the FPGS. It is important to emphasize that the right of women to voluntarily choose a contraceptive method was guaranteed.

Men's and women's roles within the community need to be taken into account; failure to do so can lead to inequalities in access to medical and other types of healthcare, health education and information. Expectations of men's and women's behaviors affect their vulnerabilities to unintended pregnancy and sexually transmitted infections. Multiple respondents at the community level, especially adolescents, reported that men often ask for a 'test of love' (*prueba del amor*) from women. The 'test' that is sought is intercourse, often unprotected. The *prueba del amor* is just one of many manifestations of the machismo male gender norm that promotes this type of risky behavior and puts both individuals at risk for STIs and unintended pregnancy. Another cultural norm is the belief held by some (but not all) people that men desire many children. Finally, providers are often biased against offering FP services and supplies to men. These norms can limit men's knowledge of the benefits of FP and healthy timing and spacing of pregnancies and men's positive involvement in family planning/reproductive health services.

REDUCE GENDER-BASED VIOLENCE AND MITIGATE ITS HARMFUL EFFECTS

Women's access to FP methods that are under their own control (such as injectables) have allowed them, especially those in rural areas and those under risk of violence (which, according to national statistics, affects two-thirds of the female population) to make their own decisions about family planning. Women are taking advantage of their

visits to health facilities to obtain contraceptive methods. According to MOH reports, the use of DEPO-PROVERA has increased from 1% in 1993 to 23% in 2007. Its use has been linked with the reduction of the urban-rural gap previously discussed.

A woman's expanded knowledge of and access to reproductive health and FP methods has been linked to domestic violence in some cases. The new GBV law is an important step toward reducing risk because it provides legal consequences for violent offenses. Involving CBOs, NGOs and men's groups in FP advocacy and women's reproductive health will further mitigate this risk.

USAID Nicaragua has developed other gender-related experiences that have positively affected the reproductive health of both men and women. The methodology for working with men designed by CRS, NicaSalud, the GBV prevention project implemented by the San Lucas Foundation, and the approach against stigma and discrimination among groups of sexual diversity promoted by the PrevenSida project are examples of good practices.

To promote the integration of the gender approach, it is necessary to work toward building new cultural patterns and eliminating those that constitute obstacles for FP.

The main recommendations are as follows:

- USAID Nicaragua must respond to adolescent reproductive health issues with an integrated approach of youth in risk and gender-based violence prevention. This will necessitate considering structural and social determinants (poverty, education and exclusion) as well as social and cultural norms.
- The impact of GBV should be considered when responding to adolescent pregnancy, with all its legal, psychological and biomedical implications.
- All actors should work more strongly to incorporate the gender approach into FP. Men's participation in FP should be evaluated and included in DHS.
- Promoting men's participation in the MOH FP program would support women's empowerment and autonomy and improve men's access to FP.
- When updating the 2008 FP national norms, gender should be integrated so as to improve reproductive health services and address barriers related to gender norms and inequalities.
- The ECMAC program should continue promoting men's participation including couples or partners working together in remote communities.
- The MOH should collect disaggregated data, and these data must be interpreted in terms of men's and women's needs, priorities, statuses, opportunities and constraints over both the short and the long term.
- Investment in providers' training regarding vasectomy and in the creation of demand for the use of this method should be made. It will be also beneficial to intensify the demand for condoms by men as part of the dual protection strategy.



Adolescent girls, Community El Yaral, Mozonte, Nueva Segovia

VI. LESSONS LEARNED

The implementation of Nicaragua's FPGS has generated important 'lessons learned' that can be applied by other Missions that are implementing graduation strategies and by USAID's Washington colleagues. The primary 'lessons learned' can be described as follows:

FOR USAID WASHINGTON:

- It is critical to have a well-thought-out strategy plan for gradually terminating assistance. Benchmarks and indicators should be clearly defined and monitored.
- Funding for the strategy period should be maintained as planned.
- An appropriate number of staff should be devoted to closely monitoring the strategy's implementation.
- Mid-term review is a good practice to ensure that assumptions and key interventions remain valid throughout the strategy period.

FOR USAID MISSIONS:

- Open communication with the host country government, other donors and partners about the graduation process is critical to its success.
- Alignment of the strategy with the host country's policies and plans, when appropriate, will facilitate the sustainability of the results.
- A common view and integrated effort among all USAID partners promotes a more holistic approach that benefits the achievement of results.
- Written agreements with the host country government specifying indicators and targets to be met are essential to proper monitoring of success.
- Countries should have flexibility to adjust the strategy if the situation changes.

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1. Deliver/JSI
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3. Famisalud/Federacion Red Nicasalud
4. PRONICASS/MSH
5. Comité DAIA

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VIII. ANNEXES

ANNEX 1

SCOPE OF WORK

I – STRATEGY DESCRIPTION

Identification data:

Phase-out strategy for USAID assistance to Nicaragua for family planning

Strategy implementation dates: October 1, 2007 – September 30, 2012

Strategy planned funding: \$12,161,000

Implementing partners and project names: JSI (DELIVER),
URC (Health Care Improvement -HCI)
Red Nicasalud (FamiSalud)
MSH (PRONICASS, closed)

USAID/Nicaragua, Office of Health and Education (OHE) Chief: Alicia Dinerstein

USAID/Nicaragua Activity Manager: Marianela Corriols

After sixteen years of USAID family planning assistance (FP) in Nicaragua (1991-2007), a USAID Washington/Nicaragua team led a strategy development process beginning in 2007 that included high levels of participation from USAID/Washington, USAID/Nicaragua, and in-country stakeholders. The team consulted with a variety of host country partners, including representatives from the Government of Nicaragua (GON) (e.g. the Ministry of Health/MOH and the Nicaraguan Institute of Social Security/INSS), the private sector, non-governmental organizations (NGOs), advocacy groups, other donors, and implementing partners). The primary objective of those consultations was to identify the key constraints and opportunities posed by graduation of USAID's FP assistance, with specific attention to those factors that: 1) are critically important to the long-term reach, quality and sustainability of the country's family planning program; and 2) can be impacted in very substantial measure by the limited USAID resources available over the life of the recommended five year strategy period.

At that time, despite the obvious strength in Nicaragua's family planning program, challenges to the program's long-term success existed. These included dependence on donors for donation of family planning commodities; insufficient market segmentation; weaknesses in system governance; inequities in access to and quality of service; and a lack of human, institutional and financial resources for reproductive health (RH) surveys. These challenges were addressed through the strategic plan for family planning graduation drafted on March 2008 and updated in October 2008.

USAID's post-graduation purpose is to leave Nicaragua with the capability to provide quality contraceptives and family planning services in all departments. The objective of the graduation strategy is to ensure that mechanisms are in place post-graduation for advocacy, private sector enhancement, quality improvement and management strengthening.

The graduation team agreed that USAID financial support for the Nicaragua family planning program would end by 9/31/2011. Because of USAID's funding cycle, activities funded in FY2011 will carry over into FY2012. The family planning graduation strategy is divided into two stages: immediate phase out and phased graduation. Immediate phase-out, occurring in 2008-2009, was to consolidate the more general health systems strengthening work that has been funded with population assistance. A longer-term, more phased graduation, from 2010-2012, was to include priority activities that require continued support over the medium term to develop the sustainability of Nicaragua's family planning program. These activities, organized by component, in order of priority, are: contraceptive security, market segmentation, system strengthening, improved services and quality assurance, and data for decision-making. As seen in Table 1, demographic indicators in Nicaragua have been improving over the past twenty five year time periods and the official estimations for 2015 show a positive trend.

II -- BACKGROUND

USAID is graduating selected countries that have achieved high contraceptive prevalence and low total fertility rates. The graduation process is intended to make more funds available for countries where the unmet need for FP is greatest.

USAID's graduation planning process was intended to make the phase-out of FP assistance a calculated, logical sequence of activities that would ensure a successful transfer of responsibilities and ownership to local actors. Successful graduation is defined as:

Family planning service delivery continues to support the level of contraceptive prevalence achieved before graduation and inequities in access to services have not increased.

Successful graduation normally requires:

- *A contraceptive prevalence rate that reflects high knowledge about and use of modern family planning methods;*
- *In-country technical, administrative and programmatic capacity to maintain family planning service delivery and adapt to changes as appropriate; and*
- *On-going financing of essential aspects of family planning service delivery and products, including contraceptives.*

For countries facing phase-out of USAID FP assistance, country-level strategic graduation plans were developed to reinforce local commitment to provide FP products and services, including for underserved populations, and to strengthen the financing, capacities and leadership required for a successful and sustained transition to country ownership and sustainability. In Nicaragua, Fig 1 clearly shows the impressive reduction of total fertility rates from 5.8 children per woman in 1985 to 2.7 in 2007.

USAID family planning support to Nicaragua

Nicaragua, with a population of around 6 million, has a net population growth rate of 1.3 percent (2010) and is the second-poorest nation in the Western Hemisphere. USAID has supported health and other development programs in Nicaragua continuously since 1991, with significant expansion following Hurricane Mitch in 1998. The health program has focused on maternal and child health, water and sanitation, FP/RH, and HIV/AIDS. Roughly one-third of the health funds have been designated for FP/RH programs.

Since 1991, USAID has been a leading donor in population/FP/RH assistance to Nicaragua, working closely with the GON, the private sector and multiple local NGOs. During this period, USAID has been the major donor of contraceptives to the MOH, followed by the United Nations Population Fund (UNPFA); providing technical assistance on management, logistics and financial systems; and training health care providers to ensure high quality services.

USAID has also had a significant presence in private sector FP/RH services, by expanding and improving the quality of FP/RH services provided by PROFAMILIA, a local NGO. USAID also helped PROFAMILIA introduce a network of community-based services and social marketing of FP commodities. Following Hurricane Mitch, USAID assisted in the creation of NicaSalud, a successful federation of 28 NGOs working in the health sector in Nicaragua, including in FP. In 2001, the country, with USAID support, initiated a Contraceptive Security Committee (CSC or *DAIA* committee for its Spanish name) to guarantee the security and continued availability of contraceptives, including after USAID FP graduation.

The *DAIA* is now an official MOH committee, with participation of UNPFA, USAID projects (DELIVER, Health Care Improvement/HCI, FamiSalud), Profamilia, PASMO and INSS.

The 2003-2008 SOAG (8/19/03) between the governments of the USA, acting through USAID, and Nicaragua, established that "although USAID will continue to support procurement of public sector contraceptives, the aim is to do so at diminishing levels through the strategy period." Under this SOAG and based on the analysis of demographic (, 2001) and institutional indicators, in 2005 Nicaragua was targeted by USAID Washington for FP graduation. In 2006 a Letter of Implementation (LOI) was signed between the Nicaraguan Government and USAID/Nicaragua to gradually reduce the donation of contraceptives from USAID to the MOH - beginning in 2007 and ending in 2009 - which included the progressive increase of the MOH's purchase of contraceptives.

Nicaragua's FP graduation strategy was divided into two stages: 1) a health system strengthening phase (2008-2009), and 2) a phase of sustainable development (2010-2012). The strategy was organized by components. These components, in order of priority, were:

a) Contraceptive security: The public sector's FP program relies on donated commodities. This is perceived as a major threat; thus, the contraceptive security (CS) strategy largely focuses on increasing local ownership of the entire FP supply chain. Beyond procurement, this includes expanding the

integrated logistics system and strengthening the *DAIA* to ensure that these critical systems will be sustained beyond USAID phase-out.

b) Market segmentation: The market segmentation component aims at ensuring a well-segmented market. For the purposes of the strategy, this was defined as the commercial sector and NGOs providing methods to those who can afford to pay, including lower-cost commercial products, and the INSS covering its beneficiaries. These changes will allow the MOH to focus public sector efforts on targeting the poor, poorly educated and hard-to-access populations.

c) Health system strengthening: The objective of system strengthening is to ensure compliance with and approval and dissemination of standards related to providing FP and RH services in Nicaragua, as well as to improve advocacy around FP/RH issues.

d) Improved services and quality assurance: The improved services and quality assurance component aims at ensuring that FP/RH quality standards and procedures (including access to the safest, long-acting and permanent methods) are maintained in the MOH and INSS systems in all districts – including the poorest and most inaccessible.

e) Data for decision making: The objective of the data for decision-making component is to ensure that implementing a national health survey remains a priority and that local capacity to fund and implement the survey exists.

USAID/Nicaragua carried out a mid-term assessment of progress in implementing the FP Graduation (FPG) plan to assess whether successful graduation of USAID FP assistance in September 2012 remained feasible in accordance with the phase-out strategy and progress to date. The goals of the mid-term assessment were to determine if implementation of the FPG plan was on target, evaluate progress of the government and partners in promoting a sustainable FP program after USAID/Nicaragua FP assistance ends, and finally, make recommendations for any needed adjustments to the plan. The methodology included a review of relevant documents, interviews with key stake holders and informants, and visits to relevant project sites in-country. The mid-term assessment was conducted from October 18th to October 27th 2010 by an assessment team from USAID/Nicaragua and USAID/Paraguay, with oversight and input from USAID/Washington. The team interviewed key government contacts from the MOH central office of logistics, regional health authorities (known as *SILAIS* in Spanish) and health centers, NGOs, USAID implementing partners and UNFPA. The assessment team conducted a field visit to Matagalpa and Jinotega to learn about achievements and challenges to date from local counterparts (*SILAIS*, a regional hospital and municipal health centers). Staff from USAID/Washington provided support in reviewing assessment instruments and drafts of the report. Major findings and recommendations of the mid-term assessment team included the following: *Overall mid-term progress on implementing the FPG was very good, based on the team's examining progress within each of the five strategic areas included in the FPG plan in relation to illustrative benchmarks/indicators identified in the plan. Eight out of seventeen indicators had already been met or were right on target for timely completion. USAID Nicaragua had been very successful in integrating all of its current projects with a common vision and a shared goal towards graduation of USAID FP assistance. An impressive level of teamwork had been accomplished, with all USAID partners working together and complementing each other's efforts in supporting the MOH.* The mid-term assessment team concluded that there was no need to modify the FPG plan's vision, objectives, or strategic areas, each of which remained relevant and important to the development of a sustainable, successful FP program in Nicaragua.

An important benchmark within the FPG plan was achieved, with regard to financial sustainability of the FP program: over the previous three years, the MOH had increased the percentage of funding allocated for contraceptive commodities procurement, from 10.5% in 2007 to 50% in 2010). UNFPA procured some contraceptives, which has benefited the country with lower, more competitive prices. At the same time, data from the USAID/DELIVER project show that the INSS increased the number of insured women receiving FP services at its clinics, from 3.9% in 2008 to 31.3% in 2010. During this period, stock-outs were reduced and were limited to the central warehouse and did not affect end-users. The assessment emphasized the importance of ensuring financial sustainability during the remainder of the strategy, in light of the budgetary gap faced by the MOH, the dependency on UNFPA for half of its contraceptive commodities and the difficulties experienced in using the funding available. During the assessment, the team confirmed that the 2010 contraceptive commodity procurement had not been completed yet, which presented a key short-term challenge to avoiding stock-outs.

The CSC, led by MOH, developed a new strategic plan for 2009-2012. The committee holds regular meetings (with active participation from the MOH, UNFPA, John Snow, Inc. (DELIVER implementing partner), University Research Co. (Health Care Improvement implementing partner), NICASALUD

(Famisalud implementing partner), PROFAMILIA, PATH and IXCHEN) to monitor execution of the plan. There is a common perception among all individuals interviewed that the USAID/DELIVER project is taking the leadership role, convening the meetings, monitoring the strategic plan's implementation and providing overall assistance. The new strategic plan, however, recognizes this and actions are being taken to transfer the leadership role to the MOH during the remainder of the FPG plan. In order to guarantee that the objectives of the FPG plan are attained, a set of key recommendations were included by strategic area and are detailed in Attachment 2.

III -- PURPOSE AND AUDIENCE

The purpose of this Final Performance Evaluation is to carry out an evaluation of the Mission's FP phase out strategy and disseminate best practices and lessons learned with both internal and external audiences. Moreover, the evaluator is expected to comply with the approved USAID Evaluation Policy. The purpose of this final performance evaluation is to assess the level of accomplishment of USAID/Nicaragua's FP phase out strategy, including progress on recommendations from the mid-term assessment, and establish recommendations for the post-graduation phase. The dissemination process will include development of appropriate materials and organizing events which will serve to inform key stakeholders and partners about the results of the evaluation, sharing challenges and lessons learned. The expected audiences are both internal (USAID and Embassy) and external (GON, donors and civil society, including NGOs, universities and private sector).

IV – EVALUATION QUESTIONS

Q1: Has the USAID Nicaragua family planning program made the expected achievements on key objectives outlined in the phase out plan?

- a) Contraceptive security
- b) Market segmentation
- c) System strengthening
- d) Improved services and quality assurance
- e) Data for decision making

Q2: For those objectives where progress has not been achieved as expected:

- a) What caused this lack of accomplishment?
- b) What actions were taken to try to improve achievement of the programs' objectives?
- c) Was the strategy design (including project staffing, management and budget) adequate?
- d) What lessons can we learn from the strategy design?
- e) Have unexpected events within the country helped progress?

Q3: For objectives that have made the expected progress:

- a) Were the original assumptions valid to ensure successful phase out?
- b) For the 8 indicators that were achieved at the mid-term evaluation, have they sustained this achievement?
- c) What are the risks to continued progress during the post-graduation phase and what can be done to mitigate those risks?

Q4: Has the USAID/Nicaragua family planning program contributed to health gender equity?

- a) Was the FP graduation strategy gender-responsive?
- b) Did projects integrate gender considerations into their activities and develop measures to enhance participation of women and men in FP?
- c) If so, how did strategy implementation increase the sustainability of these gender-specific achievements?

Q5: What are the recommendations for the post-graduation phase to improve the likelihood of sustainability of family planning graduation achievements?

- a) What are the recommendations for the post-graduation phase for the Mission's Office of Health and Education?
- b) What are the recommendations for the post-graduation phase for key national and local counterparts and other donors in Nicaragua?
- c) What are the recommendations for the post-graduation phase for USAID's Latin America and Global Health bureaus, and how can these bureaus support regional activities that will in turn help Nicaragua sustain progress?
- d) How can USAID Nicaragua share this successful experience within the country, with other countries, and with other Missions?
- e) What threats exist that may hinder further FP progress in the country and how can they be mitigated?

V – METHODOLOGY

As mentioned before, the purpose of this final performance evaluation is to assess the level of accomplishment of USAID/Nicaragua's FP phase-out strategy, including progress on recommendations from the mid-term assessment and make recommendations for the post-graduation phase. Considering this purpose, the contractor should use various methods to assess the different components of the strategy to answer all the questions outlined above. Though the contractor will propose the methods they feel are appropriate at different stages of the assessment, these methods must be approved by USAID. All the process should be conducted in consultation with USAID/Nicaragua and Washington to ensure that the evaluation team has the fullest possible background and contact information. Per the Evaluation Policy, the Evaluation Design will be shared with key country-level stakeholders. Even though the evaluation will be conducted by an external evaluation team, some activities will require USAID Nicaragua and USAID Washington participation.

The methodological instruments to be used should focus on obtaining information, opinions, experiences and quantitative data from counterparts, implementers, partners, beneficiaries, GON entities, NGOs, private sector, and other donors. The following methods are highly recommended for the assessment:

- Literature review
- Observation and field visits to a sample of implementers, counterparts, and beneficiaries
- Focus group discussions
- Individual and group interviews using checklists or questionnaires
- Review of project documents

The contractor should consider starting the assessment with a review of the electronic sources and documents cited below. They should also make site visits and conduct interviews with key actors. The Mission expects the contractor to present strong quantitative and qualitative analysis that addresses key FP graduation strategy indicators.

The contractor will be expected to develop a more detailed explanation of the proposed methodology for carrying out the assessment, and share it with USAID/Nicaragua for approval. The methodology should include a mix of tools appropriate to the assessment objectives.

VI – EXISTING DATA

Sources of information

The evaluation team will be expected to meet with members of the USAID Nicaragua and Washington FP team, USAID Nicaragua senior management and the staffs of the three implementing mechanisms (DELIVER, HCI, Famisalud), other key technical players and counterparts at national and local levels. The Mission will provide all existing documentation (hard or electronic copies) related to the graduation strategy and coordinate the inputs from the active and close implementing mechanisms contributing to the FP strategy implementation. (DELIVER, HCI, Famisalud and Pronicass)

USAID Nicaragua and its implementing partners will provide the assessment team with a package of briefing materials, including:

- Evaluation Policy and checklist for USAID evaluation reports
- Technical note. Approach to Phase-out of USAID Family Planning Assistance
- FP Phase-Out Strategy
- FP mid-term evaluation report
- Project contracts and amendments
- Project annual plans and reports
- Health strategy evaluation
- Phase-out FP strategy
- M&E reports
- and other studies including FP information, some of which is noted below

The contractor may find it useful to consult a broad range of background documents apart from project documents provided by USAID Nicaragua. These may include documents that relate to Family Planning and Reproductive Health in Nicaragua.

Type of documents

Electronic access:

USAID documents

USAID, 2006. TECHNICAL NOTE: Approach to Phase-out of USAID Family Planning Assistance.

Demographic estimations

Population estimates 1950-2100. In http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm

Interacciones entre transición demográfica y epidemiológica en Nicaragua: implicancias para las políticas públicas en salud

<http://www.eclac.cl/publicaciones/xml/7/32067/lcl2822-P.pdf>
 Demography and health surveys In http://www.inide.gob.ni/DHS/DHS_2006/InformeFinal06_07.pdf
 Living conditions surveys. In <http://www.inide.gob.ni/Emnv/Informe%20EMNV%202009.pdf>
 Census In <http://www.inide.gob.ni/censos2005/CifrasCompleto.pdf> 2005
 Demographic sector statistics In http://www.inide.gob.ni/Anuario2008/ModuloIISocial/ModuloII_SeccionII.1.pdf
Health sector
Ministry of Health
 Health situation analysis 2000-2011. In http://www.minsa.gob.ni/index.php?option=com_content&view=article&id=24&Itemid=130&Itemid=160
 Norms, protocols and guidelines: In http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=select&id=1459
 FP national norms. In <http://www.nicaragua.unfpa.org.ni/publidoc/Políticas%20Públicas%20y%20Legislación/NORMA%20Y%20PROTOCOLO%20PF.pdf>
 Logistic system (PASIGLIM). In http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=fileinfo&id=6863
 Health model (MOSAFC). In http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=fileinfo&id=5234
 Reproductive Health Strategy. In <http://www.nicaragua.unfpa.org.ni/publidoc/Políticas%20Públicas%20y%20Legislación/ENSSR2daVersion.pdf>
 Social Security Institute. In http://www.inss.gob.ni/index.php?option=com_content&view=section&layout=blog&id=8&Itemid=37
Other Key Players
 UNFPA: <http://www.nicaragua.unfpa.org.ni/publicaciones.php>
 PAHO: <http://new.paho.org/nic/>
 Implementing partners and DAIA members
 NICASALUD: <http://www.nicasalud.org.ni/>
 HCI/URC: <http://www.urc-chs.com/country?countryID=36>
 DELIVER/JSI: <http://www.jsi.com/JSIInternet/Projects/ListProjects.cfm?Select=Country&ID=276>
 PROFAMILIA: <http://www.profamilia.org.ni/>
 PATH: http://www.path.org/projects/rxgen_pharmacy_project.php
 PASMO: <http://www.psi.org/nicaragua>

2006-2012 DAIA documents

-Comité DAIA Nicaragua. (2009). Evaluación del Plan para la Disponibilidad Asegurada de Insumos Anticonceptivos en Nicaragua 2005-2008.
 -USAID | DELIVER PROJECT, Task Order 1. (2010). *Measuring Contraceptive Security Indicators in 36 Countries*. Arlington, VA: USAID | DELIVER PROJECT, Task Order 1.
 -USAID | DELIVER PROJECT, Task Order 1. (2009). *Contraceptive Security Index 2009: A Tool for Priority Setting and Planning*. Arlington, VA: USAID | DELIVERPROJECT, Task Order 1.

VII – TEAM COMPOSITION

As explained in Section 5- even though the evaluation will be conducted by an external evaluation team, some activities will require USAID Nicaragua and USAID Washington participation. Both USAID Nicaragua and Washington will define its participation in the whole process. Virtual participation and electronic feedback from both USAID Nicaragua and Washington is expected during the two months period.

VIII - SCHEDULING AND LOGISTICS

The contractor shall be responsible for arranging air travel and local ground transportation and accommodation and providing computers, printers, and other administrative services. USAID Nicaragua will provide overall direction to the contractor, identify key documents, and approve the work plan. USAID Nicaragua will assist in arranging meetings with key stakeholders, implementers, GON, donors and beneficiaries. USAID Nicaragua will make available all relevant documents. Dissemination activities

costs should be included as part of the proposal (organizing meetings, printing documents, etc).USAID Nicaragua's activity manager will be available to the team for consultations on logistic and technical issues during the evaluation process. Any other logistics issues will be handled by USAID/Nicaragua in consultation with the team.

IX - REPORT REQUIREMENTS

The evaluation report (Times New Roman 12, 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 25-30 page report, not including executive summary or attachments, among other criteria). In addition, the evaluation final report with corresponding annexes should be provided to USAID Nicaragua, in an organized, electronic format.

The evaluation report should answer the evaluation questions and conclude whether or not and to what extent the FP strategy objectives were accomplished as well as what needs to be done post-graduation to ensure continued forward progress in FP/RH and contraceptive security.

The report should follow the following format:

1. Table of contents

2. List of acronyms and abbreviations

3. 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.

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

5. Background: History and current situation with respect to the FP phase out plan. These sections should give a factual picture of the current situation with respect to the objectives of the phase out process; the implementers and participants, different phases; external factors that affected the achievement of objectives; and notable achievements and problems, if any, with respect to progress.

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

7. Findings/Conclusions/Recommendations – for each objective area; and also include data quality and reporting system that should present verification of indicators, issues and outcomes.

a. **Findings:** present key findings, including FP graduation strategy indicators evaluation (both quantitative and qualitative)

b. **Conclusions** about the key 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.

c. **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 FP experience, our achievements and problems faced as well as the long-term sustainability of the FP programs in Nicaragua.

8. References: bibliographical documentation.

9. Annexes: SOW, evaluation methods, data/records schedules, interview lists and tables, meetings, interviews and focus group. Should be succinct, pertinent and readable.

(END OF SCOPE OR WORK)

ANNEX 2: QUESTIONNAIRES FOR INTERVIEW WITH KEY ACTORS (IN SPANISH)

Guía de entrevista No. 1 para Socios de USAID: Deliver, HCI, Famisalud

SOCIOS DE USAID

Organización:.....

Nombre del Proyecto:.....

Fecha de Inicio:..... Fecha de finalización:.....

Persona que brinda la información:.....

Beneficiarios del proyecto:

- ☐ MINSA ()
- ☐ Seguridad Social ()
- ☐ Universidad/entidad formadora ()
- ☐ Otro ().....

Preguntas:

1. ¿Cuáles son las líneas de acción de su proyecto?
2. ¿Cuáles han sido los principales resultados alcanzados? –
3. ¿Tienen historias de éxito?, Cuáles son?
4. ¿Cómo es el cumplimiento de indicadores del acuerdo (solicitar copia de reportes que justifican el cumplimiento de los indicadores)
5. ¿Manejan datos desagregados por sexo?
6. ¿Cómo ve la sostenibilidad de los resultados obtenidos luego del retiro de USAID? ¿Cuáles son las amenazas? cuáles son las oportunidades?
7. ¿Cómo se ha dado la transición de liderazgo de la DAIA al Ministerio de Salud?
8. ¿Cuáles son las principales desafíos que deberá enfrentar el Programa de PF luego de la graduación?
9. ¿Cuáles serían las sugerencias para el apoyo posterior a la graduación?

Guía de entrevista No. 2 para el Nivel Gerencial del Ministerio de Salud

MINISTERIO DE SALUD – nivel gerencial

Fecha de la entrevista:.....

Nombre del entrevistado:.....

Cargo que ocupa:.....

Dependencia:.....

1. ¿Cuál ha sido el principal aporte de la USAID al servicio de PF del Ministerio en estos últimos años?
2. ¿Cuáles han sido los logros más importantes del Ministerio en el servicio de PF?
3. ¿Cuenta el Ministerio con financiamiento propio para la adquisición de insumos anticonceptivos, la cadena logística, la capacitación a funcionarios, la supervisión y otros aspectos propios de la implementación del servicio?
4. ¿Están los recursos financieros protegidos de alguna manera para garantizar que son utilizados en PF?
5. La PF es una prioridad para el Ministerio de Salud. ¿Cómo se refleja esta prioridad?
6. ¿Cuáles son a su criterio, los principales desafíos que debe enfrentar el servicio de PF del Ministerio a corto, mediano y largo plazo?
7. ¿Cómo se prepara el Ministerio para enfrentar estos desafíos?
8. ¿Cuenta el MINSA con apoyo de otros donantes para la implementación del servicio de PF y de que tipo?
9. Cual será el efecto de la graduación de la USAID en el servicio de PF?
10. ¿Si tuviera que priorizar acciones claves a ser apoyadas por la USAID en el futuro, cuáles serían?

Guía de entrevista No. 3 para Proveedores de Servicios del Ministerio de Salud (Hospital, Centros y Puestos de Salud)

MINISTERIO DE SALUD – Proveedores de salud

Fecha de la entrevista:.....

Nombre del entrevistado:.....

Cargo que ocupa:.....

Perfil:.....

Dependencia:.....

1. ¿Desde cuando funciona el servicio de PF en esta unidad?
2. ¿Que métodos de PF se ofrecen en este servicio?
3. ¿Existen otros servicios o dependencias de esta unidad de salud que brindan PF?
4. ¿Cuántos recursos ofrecen servicios de PF en este centro/hospital/puesto?
5. ¿Cuentan con todos los métodos de PF de la canasta básica del MINSA?
6. ¿Realizan consejería?, ¿En cuáles áreas o salas de esta unidad?
7. ¿Tiene disponible material impreso sobre PF para las usuarias? Estos materiales están elaborados en varios idiomas?.
8. ¿Si se ofrecen métodos permanentes, cuales son los criterios para proveer el servicio?
9. ¿Utilizan el formulario de consentimiento informado? Solicitar copia.
10. ¿Cuál es el método más popular entre sus usuarias? ¿Porqué?
11. ¿Se realizan consejerías en pareja?
12. ¿Cómo se vincula este servicio con el nivel comunitario?
13. ¿Reciben referencias de usuarias del nivel comunitario?
14. ¿Ha recibido Usted capacitación para ofrecer servicios de PF en el último año? Qué institución/organización las ha impartido?
15. ¿Tiene disponible las normas de PF?
16. ¿Recibe Usted supervisión? De quien y con qué frecuencia?
17. ¿Cuáles son las principales dificultades con las que Usted se enfrenta para implementar el servicio de PF?
18. ¿Qué otras necesidades usted tiene para implementar el programa?
19. Como le ha apoyado el proyecto HCI/DELIVER/ FAMISALUD en su tarea cotidiana?

Guía de entrevista No. 4 para el INSS (CMP)

CMP – nivel gerencial

Fecha de la entrevista:.....

Nombre del entrevistado:.....

Cargo que ocupa:.....

Dependencia:.....

1. ¿Cuál ha sido el principal aporte de la USAID al Programa de PF de la Institución en estos últimos años?
2. ¿Cuáles han sido los logros más importantes en materia de PF dentro de la Institución?
3. ¿Quiénes reciben servicios de PF?
4. ¿Cómo promueven la oferta de PF entre asegurados y sus beneficiarios?
5. ¿Cuenta la Seguridad Social con financiamiento propio para la adquisición de insumos anticonceptivos, la cadena logística, la capacitación a funcionarios, la supervisión y otros aspectos propios de la implementación del servicio?
6. ¿Están los recursos financieros protegidos para el servicio de PF?
7. ¿Es la PF una prioridad para la institución y cómo se institucionaliza como tal?
8. ¿Cuáles son a su criterio, los principales desafíos que debe enfrentar el servicio de PF a corto, mediano y largo plazo?
9. ¿Cuenta la seguridad con apoyo de otros donantes para la implementación del servicio y de qué tipo?
10. ¿Cuál será el efecto de la finalización del apoyo de USAID?
11. ¿Si tuviera que priorizar acciones claves a ser apoyadas por la USAID en el futuro, cuáles serían?

Guía de entrevista No. 5 para el INSS (CMP Proveedor de salud)

CMP – Proveedores de salud

Fecha de la entrevista:.....

Nombre del entrevistado:.....

Cargo que ocupa:.....

Dependencia:.....

1. ¿Desde cuando funciona el servicio de PF?
2. ¿Cuántas personas están capacitadas para ofrecer servicios de PF en este servicio?
3. ¿Qué métodos se ofrecen en este servicio?
4. ¿Realizan consejería?
5. ¿Tiene disponible material impreso sobre PF para las usuarias?
6. ¿Si se ofrecen métodos permanentes, cuáles son los criterios del servicio para proveer el servicio?
7. ¿Utilizan el formulario de consentimiento informado? Solicitar copia.
8. ¿Han tenido desabastecimiento en los últimos 6 meses?
9. ¿Ha tenido sobreabastecimiento de algún insumo?
10. ¿Si la respuesta al 7 y 8 es SI, explique de que método y por qué?
11. ¿En caso de desabastecimiento, que solución ofrece a las/os usuarias/os
12. ¿Cuál es el método más popular entre sus usuarias?
13. ¿Ha recibido Usted capacitación para ofrecer servicios de PF en el último año?
14. ¿Conoce las normas de PF?
15. Recibe Usted supervisión? De quien y con qué frecuencia?
16. ¿Cuáles son las principales dificultades con las que Usted se enfrenta para implementar el servicio?
17. ¿Como le ha apoyado el proyecto HCI/DELIVER (según corresponda) en su tarea cotidiana?

Guía de entrevista No. 6 para Usuarías de PF

USUARIAS DE PLANIFICACION FAMILIAR

Introducción a la entrevista: *Buenos días, estamos haciendo un seguimiento al programa de PF de este puesto/centro/hospital y quisiera conversar con Usted, no necesito su nombre ni ningún dato de identificación. La información que me brinde será absolutamente anónima y confidencial. No tomara más de 10 minutos. Esta dispuesta para conversar conmigo?*

Edad de usuaria/o: _____ Sexo: F ☐ M ☐ Número de hijos vivos: _____

| Pregunta | Respuesta | Comentario/Seguimiento |
|--|---|--|
| 1. ¿Utiliza actualmente algún método de planificación familiar? | Sí <input type="checkbox"/> No <input type="checkbox"/> | Si la respuesta es NO termine la entrevista |
| 2. ¿Qué método está utilizando? | | |
| 3. ¿Dónde Obtiene el método que utiliza? | | |
| • Centro o Puesto de Salud u Hospital | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Farmacia Privada | Sí <input type="checkbox"/> No <input type="checkbox"/> | Si la respuesta es SI termine la entrevista. |
| • Otro lugar | Sí <input type="checkbox"/> No <input type="checkbox"/> | Cual?: Si la respuesta es SI termine la entrevista |
| 4. ¿Cuándo fue la última vez que visitó la unidad de salud para obtener su método de planificación familiar? | | |
| • Tres meses o menos? | Sí <input type="checkbox"/> No <input type="checkbox"/> | Si la respuesta es NO termine la entrevista |
| 5. ¿Sobre que métodos fue informada cuando usted decidió planificar?: LEA las opciones: | | |
| • Orales (Píldoras) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Depoprovera (Inyectable trimestral) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Norigynon (Inyectable mensual) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • DIU | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Condón | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Esterilización masculina | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Esterilización femenina | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Métodos naturales (MELA, Collar) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Otro | Sí <input type="checkbox"/> No <input type="checkbox"/> | Cual?: |
| 6. ¿Cuál método eligió Usted? | | |
| • Orales (Píldoras) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Depoprovera (Inyectable trimestral) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Norigynon (Inyectables mensual) | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • DIU | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Condón | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Esterilización masculina | Sí <input type="checkbox"/> No <input type="checkbox"/> | |
| • Esterilización femenina | Sí <input type="checkbox"/> No <input type="checkbox"/> | |

| | | |
|---|---------------|---|
| • Métodos naturales | Sí [] No [] | |
| • Otro | Sí [] No [] | ¿Cuál? |
| 7. ¿Qué tipo de información recibió sobre el método que eligió? LEA las opciones: | | |
| • Como funciona | Sí [] No [] | |
| • Forma de Uso | Sí [] No [] | |
| • Reacciones adversas | Sí [] No [] | |
| • Ventajas | Sí [] No [] | |
| • Desventajas | Sí [] No [] | |
| • Cuando regresar a la unidad de salud | Sí [] No [] | |
| • Otro | Sí [] No [] | Cual? |
| 8. Decidió de manera voluntaria e informada la elección de un método de Planificación Familiar? | Sí [] No [] | Por qué? |
| 9. ¿Se ha sentido presionada/o por la persona que la atendió para que acepte un método de Planificación Familiar? | Sí [] No [] | Por qué? |
| 10. ¿Ha recibido algún tipo de estímulo económico o material para que acepte un método de Planificación Familiar? | Sí [] No [] | Cual: |
| 11. ¿Ha pagado Ud. por recibir métodos de planificación familiar? | Sí [] No [] | Cuanto: Donde: |
| 12. ¿Ha tenido problemas para que le den atención debido a que no aceptó algún método de planificación familiar? | Sí [] No [] | Si la respuesta es SI , explique: |
| 13. ¿Ha recibido información o consejería de parte del consejero comunitario de planificación familiar? | Sí [] No [] | Si la respuesta es NO , termine la entrevista. |
| 14. ¿Qué tipo de información recibió del consejero en la comunidad? | | |
| • ¿Qué es la Planificación Familiar? | Sí [] No [] | |
| • Los beneficios de la Planificación Familiar | Sí [] No [] | |
| • Sobre los métodos anticonceptivos | Sí [] No [] | |
| • Otra información | Sí [] No [] | Describa: |

| SOLO PARA MÉTODOS PERMANENTES: Si ud. se decidió por esterilización quirúrgica | | |
|--|--------------------------------|--|
| 15. Recibió Ud. alguna información sobre | | |
| • La existencia de otros métodos de PF disponibles | Sí [] No [] | |
| • Que el método es definitivo o irreversible | Sí [] No [] | |
| • Que el método necesita cirugía | Sí [] No [] | |
| • Que el método puede tener alguna falla, ya que ningún método es 100% seguro | Sí [] No [] | |
| • Que el procedimiento tiene riesgos | Sí [] No [] | |
| • Que el método no la protege contra una infección de transmisión sexual ni contra el VIH-SIDA | Sí [] No [] | |
| 16. Firmó Ud. algún documento para dar su permiso o consentimiento informado | Sí [] No [] No aplica [] | |

Guía de entrevista No. 7 para Cooperantes

COOPERANTES

Organización:.....

Fecha de la entrevista:.....

Persona que brinda la información:.....

1. ¿Qué tipo de apoyo brinda su organización a los servicios de Planificación Familiar?
2. ¿Este apoyo va dirigido al MINSA exclusivamente o a otras instituciones proveedoras?
3. ¿Cuáles son los principales avances conseguidos por Nicaragua en materia de PF en los últimos años?
4. ¿Cuáles son los desafíos y/o las amenazas de los servicios de PF?
5. ¿Cuáles son los planes de su organización de apoyo futuro ?
6. ¿Ha su criterio, cuáles han sido los mayores aportes de USAID a la PF en Nicaragua?
7. ¿Estaría su agencia interesada en continuar algunos de los esfuerzos iniciados por la USAID.
8. ¿Que actividades/estrategias específicas pueden coordinarse con USAID durante los próximos 12 meses?

Guía de entrevista No. 8 para el Comité DAIA

COMITÉ DAIA

Fecha de la entrevista:.....

Miembros presentes:

MINSA ()

INSS ()

Universidad/entidad formadora ()

ONGs ()

Donantes()

Proyectos de cooperación: ()

1. ¿Qué instituciones forman parte del comité?
2. ¿Cuenta el comité con un reconocimiento formal de las autoridades? Tiene un reglamento de funcionamiento? Si no, lo consideran necesario?
3. ¿Tiene el comité un plan de acción? A cuantos años? Cuáles son sus principales estrategias? están todas enfocadas a PF o han expandido el espectro temático?
4. ¿Cómo se gestiona el funcionamiento del comité? Periodicidad de reuniones, agendas, monitoreo de actividades?
5. ¿Cuáles han sido los principales logros del comité?
6. ¿Quién lidera el comité? El liderazgo tiene un carácter rotativo? Cada cuanto tiempo se rota la coordinación o el liderazgo?
7. ¿Cuáles son los principales desafíos del comité como tal?
8. ¿Cuenta el comité con financiamiento? De donde proviene este? Es necesario?
9. ¿Cuenta el comité con un plan estratégico?
10. ¿Han evaluado sus acciones?
11. ¿Si el actual plan finaliza este año, están en proceso de diseñar un nuevo plan?
12. ¿Cuáles han sido las contribuciones de sus instituciones al comité?
13. ¿Cómo ve el comité, la graduación de USAID?
- 14. ¿Cuáles han sido los principales aportes de USAID a la PF en el país y al comité?**

Guía de entrevista No. 7 para el Promotor ECMAC

Nivel comunitario

Departamento:.....

Municipio:.....

Fecha:.....

1. ¿Cuántos voluntarios hay trabajando en esta comunidad?
2. ¿Qué actividades de PF/ECMAC realizan?
3. ¿Qué tipo de capacitación han recibido para realizar estas actividades?
4. Si entregan insumos anticonceptivos, de donde los reciben y donde los guardan?
5. ¿Han tenido faltantes de anticonceptivos en los últimos meses?
6. ¿Cuentan con materiales de apoyo para sus actividades?
7. ¿Cómo organizan sus actividades?
8. ¿Cómo registran sus actividades?
9. ¿Qué vínculos tienen con los servicios del MINSA?
10. ¿Cuentan con documentos específicos para la referencia y/o contra-referencia?
11. ¿Cómo realizan la evaluación de sus actividades?
12. ¿Realizan consejerías?
13. ¿Cómo es su relación con la Unidad de Salud?
14. Realizan consejerías para promover PF también en hombres?
15. Distribuyen MAC (condones) a hombres?, Con que periodicidad?, Cuántos condones entregan?

Guía de entrevista No. 10 para Farmacias (Insumos Médicos)

Hospital/centro/:.....

Fecha:.....

Región/municipio:.....

1. ¿Qué sistema (SIGLIM O PASIGLIM) utiliza usted para gestionar sus insumos de planificación familiar?
2. ¿Cuántas personas en esta unidad están capacitadas en SIGLIM o PASIGLIM?
3. ¿Qué tipo de información contiene el sistema?
 - a. Existencias
 - b. Cantidades consumidas
 - c. Ajustes
4. ¿Qué reportes se generan a través del sistema?
5. ¿A quién envía los reportes y con que frecuencia?
6. ¿De donde recibe Usted sus insumos?
7. ¿Durante los últimos 6 meses ha recibido Usted todos los insumos solicitados?
8. ¿Si la respuesta al #7 es NO, preguntar que insumos han faltado y por que.
9. ¿Ha tenido insumos vencidos en los últimos seis meses?
10. ¿Ha hecho pedidos de emergencia en los últimos 6 meses?
11. ¿Si la respuesta al 10 es SI, averiguar porque se han hecho pedidos de emergencia?
12. ¿De que nivel reciben los insumos?
13. ¿Cómo se transportan los insumos?
14. ¿Donde se almacenan?
15. ¿Cuenta el almacén con todas las condiciones optimas de almacenamiento?
 - a. Control de temperatura
 - b. Humedad
 - c. Pallets
 - d. PEPE
16. ¿Cómo se realiza la entrega de insumos a las/os usuarias/os?
17. ¿Deben las/os usuarias/os firmar alguna planilla por recibir sus insumos?
18. ¿Qué tipo de apoyo recibe usted del proyecto DELIVER?
19. ¿Cuáles han sido sus principales desafíos en la utilización del sistema?
20. ¿Si tuviera que mejorar algo del sistema logístico, que seria?

ANNEX 3: SITE VISITS LIST

| Department | Municipality Community | Institution/Project/ Division | Date |
|---------------|--|--|--------------|
| Managua | Managua | Deliver, HCI, Famisalud | August 20-22 |
| Managua | Managua | MOH nivel central – Dirección de Cooperación Externa | August 22 |
| Chontales | Juigalpa | Hospital | August 23 |
| Chontales | Muelle de los Bueyes/ Community La Patriota | Health Center Community | August 23 |
| Chontales | Nueva Guinea | Health Center | August 23 |
| Río San Juan | San Carlos | SILAIS | August 24 |
| Río San Juan | San Carlos | INSS (CMP) | August 24 |
| Río San Juan | El Almendro | Health Center Community | August 24 |
| Río San Juan | Boca de Sábalos | Health post Community | August 24 |
| Río San Juan | San Carlos | ONG implementadoras | August 24 |
| Río San Juan | Solentiname | Feria de Salud | August 25 |
| Managua | Managua | Comité DAIA | August 27 |
| Managua | Managua | Universidades de Managua y león | August 27 |
| Managua | Managua | Donors (Netherlands, UNFPA, UNICEF, European Union) | August 27 |
| Estelí | La Trinidad | Hospital | August 28 |
| Estelí | Estelí | SILAIS | August 28 |
| Nueva Segovia | Mozonte | Health Center Health post Community | August 28 |
| Madriz | Telpaneca | Health Center Community | August 28 |
| Madriz | Somoto | Implementing NGOs | August 28 |
| Matagalpa | La Dalia/El Tuma | Hospital Health post Community | August 29 |
| Matagalpa | Matagalpa | INSS (ISPP) | August 29 |
| Jinotega | Quilalí/ El Cuá | Health Center Community | August 29 |
| Matagalpa | Matagalpa | Implementing NGOs | August 30 |
| Managua | Managua | OPS | September 5 |
| Managua | Managua | MOH Nivel central | September 11 |

ANNEX 4: KEY INFORMANT INTERVIEWED DURING SITE VISITS.

| Sector interviewed | Number of people |
|----------------------------------|------------------|
| USAID Partners | 13 |
| Contraceptive Security Committee | 9 |
| Universities | 6 |
| Donors | 7 |
| MOH central authorities | 5 |
| SILAIS staff | 7 |
| Hospital level staff | 18 |
| Local level health personnel | 30 |
| INSS (CMP/ISPP) | 7 |
| ECMAC promoters | 32 |
| FP users | 14 |
| NGOs | 26 |
| TOTAL | 174 |

| USAID partners | | |
|-----------------------------|---|---------------------------------------|
| 1. Alfredo Ortega | Sexual and Reproductive health specialist. | Nica Salud/Famisalud |
| 2. Josefina Bonilla | Executive Director | Nica Salud |
| 3. Ivonne Gómez | Project coordinator | HCI |
| 4. Carolina Aráuz | Chief of Party | DELIVER |
| 5. Oscar Nuñez | Chief of Party | URC, PREVENSIDA |
| 6. Maritza arvaez | Logistics advisor | DELIVER |
| 7. Lester Narvaz | Logistics advisor | DELIVER |
| 8. Lesbia Duarte | Administrator | DELIVER |
| 9. Ever Davila | Rational use advisor | HCI |
| 10. César Rodriguez | Medical advisor | HCI |
| 11. René Villalobos | Technical advisor | HCI |
| 12. Carla Martinez | Technical advisor | HCI |
| 13. Adelina Barrera | Project coordinator | <u>Nicasalud/Famisalud</u> |
| MOH central level | | |
| 1. Lillian Rivera, | External cooperation director | MOH |
| 2. Oscar Aráuz Páramo | Rational Use Director | MOH |
| 3. Inti López Salvatierra | External cooperation analyst. | MOH |
| 4. Carlos Cruz Lesage | Evaluation office | MOH |
| 5. Wilmer Beteta López | Adolescent and maternal health director. DEGECA | MOH |
| Technical teams - hospitals | | |
| 1. Marisol Mejía Ruiz | Coordinator of women's care division | Hospital Asunción Juigalpa-Chontales |
| 2. Miguel Martínez | Community work coordinator. | Hospital Asunción Juigalpa-Chontales |
| 3. Josefa Sequeira Morales | Nurse | Hospital Asunción Juigalpa-Chontales |
| 4. Zenayda Aurora Suarez | Chief Nurse | Hospital Asunción Juigalpa-Chontales |
| 5. Carmen Hernández | Nurse | Hospital Asunción Juigalpa, Chontales |
| 6. Juan Carlos Gutiérrez, | Deputy Director | Hospital Asunción Juigalpa-Chontales |

| | | |
|--|-----------------------------|--|
| 7. Mauricio Suarez, | Medical supplies manager | Hospital Asunción Juigalpa-Chontales |
| 8. Lesbia Duarte Castella | Family planning assistant | Hospital Asunción Juigalpa-Chontales |
| 9. Eliazar Gurdíán | Hospital Director | Hospital La Trinidad- Estelí |
| 10. Rafaela Pineda | Chief Nurse | Hospital La Trinidad- Estelí |
| 11. Conny González | Obstetric care coordinator | Hospital La Trinidad- Estelí |
| 12. Reyna Isabel Navarrete | UEXT | Hospital La Trinidad- Estelí |
| 13. Juana Francisca Díaz Traña | Medical supplies manager | Hospital La Trinidad- Estelí |
| 14. Yamileth Sánchez | Obstetric services chief. | Hospital La Trinidad- Estelí |
| 15. Paúl Rodríguez | Director | Hospital La Dalia - Matagalpa |
| 16. César Tinoco Velásquez | Medical supplies manager | Hospital La Dalia - Matagalpa |
| 17. Arnoldo Cardonza | Chief nurse | Hospital La Dalia - Matagalpa |
| 18. Anielka Martínez | Nurse | Hospital La Dalia - Matagalpa |
| Health center and health post staff | | |
| 1. Diego Calvo | Director | Health Center de Nueva Guinea- Chontales |
| 2. Juan Carlos Hernández | Medical care director | Health Center de Nueva Guinea- Chontales |
| 3. Dania Membreño | Medical supplies manager | Health Center de Nueva Guinea- Chontales |
| 4. Francis Danelly Martínez | Statistics manager | Health Center de Nueva Guinea- Chontales |
| 5. Marvin Taleno | Nurse | Health Center Muelle de los Bueyes- Chontales |
| 6. Marvin González | Community work coordinator | Health Center Muelle de los Bueyes- Chontales |
| 7. Corina Brenes | Nurse | Health Center, Boca de Sábalos, Río San Juan |
| 8. Esmeralda Jaime Bustos | Medical supplies manager | Health Center, Boca de Sábalos, Río San Juan |
| 9. Oscar Norori | Health center director | Health Center Mozonte- Nueva Segovia |
| 10. Carmen Blandino Herrera | AINMA coordinator | Health Center Mozonte- Nueva Segovia |
| 11. Anayansin Sarantes López | Health post chief | Puesto de Salud El Yara-je- Mozonte- Nueva Segovia |
| 12. Marielis Jirón | Medical doctor | Puesto de Salud El Yara-je- Mozonte- Nueva Segovia |
| 13. Damaris González | FP coordinator | Health Center El Alemendro |
| 14. Azucena Mena | Medical supplies manager | Health Center El Alemendro |
| 15. Gloria Aráuz | Responsable CURI | Health Center El Alemendro |
| 16. Rosamelia Alemán | Director | Health Center Quilali |
| 17. James Martínez | Gynecologist | Health Center Quilali |
| 18. Yarlín Ríos López | Nurse | Health Center Quilali |
| 19. María Auxiliadora Rodríguez | Medical supplies manager | Health Center Quilali |
| 20. Carlos López Castellón | Epidemiologist | Health Center Quilali |
| 21. Mary López López | AINMA coordinator | Health Center Quilali |
| 22. Rosa Elena Zamora | Chief nurse | MINSA Telpaneca Madrí |
| 23. Oscar García | FP nurse | Community Monte de Piedad – Río San Juan |
| 24. Abel Ruiz | Municipal director | MINSA Telpaneca Madrí |
| 25. Wilber Paíz | Director | Health Center - El Cuá Jinotega |
| 26. Henry Meklin | Deputy Director | Health Center - El Cuá Jinotega |
| 27. Teresa Montoya | Nurse chief | Health Center - El Cuá Jinotega |
| 28. José Augusto Castilblanco | Logistic coordinator | Health Center - El Cuá Jinotega |
| 29. Eduardo Beteta | Medical Doctor | Puesto de Salud Santa Amalia - Jinotega |
| 30. Miguel Angel Membreño | Nurse | Puesto de Salud Santa Amalia - Jinotega |
| ECMAC FP promoters | | |
| 1. Trinidad Martínez | ECMAC promoter | Community La Patriota Muelle de los Buelles- Chontales |
| 2. Aurora Herrera Ramos | Brigadista de Plan de Parto | COMMUNITY DE MONTE PIEDAD |
| 3. Isidro Betancourt | Consejero comunitario | COMMUNITY DE MONTE PIEDAD |
| 4. Elba Montiel Zamora | ECMAC coordinator | Las Vegas El Almendro |
| 5. Ninfa Martínez | Traditional midwife | Las Vegas El Almendro |

| | | |
|----------------------------------|---------------------------------------|---|
| 6. Ofir Mejía Pastraña | ECMAC promoter | El Zapote- Nueva Segovia |
| 7. Elisandra Jiménez Amaya | ECMAC promoter | El Quebracho Nueva Segovia |
| 8. Yaquelin Janeth Aburto López | ECMAC promoter | El Yaraje Nueva Segovia |
| 9. Yadir Díaz | ECMAC promoter | El Yaraje Nueva Segovia |
| 10. Guillermina Mejía Sánchez | ECMAC promoter | El Yaraje Nueva Segovia |
| 11. Rafaela Ruiz Gómez | ECMAC promoter | El Zapote Nueva Segovia |
| 12. Leonisa Ruiz Gómez | ECMAC promoter | Community El Zapote Nueva Segovia |
| 13. Lexania Vásquez | ECMAC counselor | El Zapote- Madriz |
| 14. Urania Guerrero | ECMAC counselor | Community Amucayán Madriz |
| 15. Flor de María Bacilio | ECMAC counselor | Community Amucayán Madriz |
| 16. Hilda Gutiérrez | ECMAC counselor | Community Amucayán Madriz |
| 17. Rafael Antonio Castillo | ECMAC counselor | Community El Zapote Madriz |
| 18. Santos Tomás Muñoz | ECMAC counselor | Community El Limón Madriz |
| 19. Jerónimo Bucardo | ECMAC counselor | Community El Castillo- Jinotega |
| 20. Isabel Mairéna Sequeira | ECMAC counselor | Community Nueva Delhi- Jinotega |
| 21. Carla Cristina Aguirre | ECMAC counselor | Community Sta. Amalia Jinotega |
| 22. Federico Leonel Cruz | ECMAC counselor | Community Sta. Amalia Jinotega |
| 23. Erick Tórrez | ECMAC counselor | Community Sta. Amalia Jinotega |
| 24. José Castro | ECMAC counselor | Community El Destino Jinotega |
| 25. Félix José Gómez | ECMAC counselor | Community Sardina 1 Jinotega |
| 26. Martha Rodríguez | ECMAC counselor | Community Sta. Amalia Jinotega |
| 27. Ana Castellón | ECMAC counselor | Community El Coyolar - Matagalpa |
| 28. Adela Mairéna | ECMAC counselor | Community Los Cardones, Sébaco - Boaco |
| 29. Selena González | ECMAC counselor | Community El Ocote Matagalpa |
| 30. Mercedes Zelaya | ECMAC counselor | Community El Coyolar Matagalpa |
| 31. Maryuri Arellano | ECMAC counselor | Community El Zapote San Ramón - Matagalpa |
| 32. Eladia Hernández | ECMAC counselor | Community San Mulali, San Ramón - Matagalpa |
| Technical teams - SILAIS | | |
| 1. Fernando Canales | Director | SILAIS San Carlos- Río San Juan |
| 2. Hilda Mairéna | CMP MOH | |
| 3. Mauricio Romero Sevilla | Medical supplies director | SILAIS San Carlos- Río San Juan |
| 4. Víctor Hugo Gómez | Hospital Director | SILAIS San Carlos- Río San Juan |
| 5. Jackelin Membreño Rivas | Medical supplies director | SILAIS San Carlos- Río San Juan |
| 6. Karla Hernández | AIMNA coordinator | SILAIS San Carlos- Río San Juan |
| 7. Víctor Treminio | Director | SILAIS Estelí |
| INSS (CMP/ISPP) | | |
| 1. Hilda Mairéna | Director | CMP San Carlos- Río San Juan |
| 2. Yerglin Fletes | FP coordinator | CMP San Carlos- Río San Juan |
| 3. Douglas Pravia Méndez | Medical Director | Santa Fé Matagalpa (IPPS) |
| 4. Luisa Emilia Galeano Martínez | Nurse | Santa Fé Matagalpa (IPPS) |
| 5. Petrona del Carmen Lira | Chief Nurse | Clínica Santa Fé Matagalpa (IPPS) |
| 6. Juniese Daniela Paz Osorio | Nurse | Fé Matagalpa (IPPS) |
| 7. Emilia Mendoza Mairéna | FP chief | Santa Fé Matagalpa (IPPS) |
| Implementing NGOs | | |
| 1. Salvador Reyes | FamiSalud coordinator | CEPRESI Río San Juan |
| 2. Esperanza Camacho | FamiSalud coordinator | CEPS Río San Juan |
| 3. Josep David Vividea | Monitoring and Evaluation coordinator | CEPRESI Río San Juan Nueva Segovia-Madriz |
| 4. Darling Torres | Technical coordinator | CEPRESI Río San Juan |
| 5. Darling Josué Torres | Technical coordinator | CEPRESI Río San Juan |
| 6. Marvin Acosta | Technical coordinator | CEPS Río San Juan |
| 7. Kenia Rosales | Monitoring and evaluation coordinator | CEPS Río San Juan |
| 8. Melvin Sandoval | Technical coordinator | CEPS Río San Juan |

| | | | |
|--|-----------------------------|---|--------------------------------------|
| 9. | Guillermo Rodríguez | FamiSalud Coordinator | CEPS Río San Juan |
| 10. | John Merlo | FamiSalud Coordinator | CEPS |
| 11. | Kenia Iveth Blandón Vanegas | Monitoring and Evaluation coordinator | CEPS Nueva Segovia-Madriz |
| 12. | Alvaro Martínez Umanzor | Technical advisor | CEPS Nueva Segovia-Madriz |
| 13. | José Miguel Aguirre | Técnico advisor | CEPS Nueva Segovia-Madriz |
| 14. | Aliex Borjas | Técnico advisor | CEPS Nueva Segovia-Madriz |
| 15. | Rafael Jarquín G., | FamiSalud coordinator | INPRHU Nueva Segovia-Madriz |
| 16. | Francisco Huete | Technical advisor | INPRHU Nueva Segovia-Madriz |
| 17. | Armando J Aguilar | Technical advisor | INPRHU Nueva Segovia-Madriz |
| 18. | Ascensión Urbina | Technical advisor | INPRHU Nueva Segovia-Madriz |
| 19. | Oswaldo Acuña | Monitoring and evaluation coordinator | INPRHU Nueva Segovia-Madriz |
| 20. | Rigoberto Berríos | Project coordinator | CARE Matagalpa y Jinotega |
| 21. | Sara Rizo Rivera | Monitoring and evaluation coordinator | CARE Matagalpa y Jinotega |
| 22. | Juan Cerda | Project coordinator | PCI Matagalpa y Jinotega |
| 23. | Eugenio Arbízú | Technical advisor | CARE Matagalpa y Jinotega |
| 24. | Luis Manuel Rivera | Technical advisor | PCI Matagalpa y Jinotega |
| 25. | Xiomara Herrera | Technical advisor | PCI Matagalpa y Jinotega |
| 26. | Dalia Pérez Alaniz | Technical advisor | CARE Matagalpa y Jinotega |
| Universities and training schools | | | |
| 1. | Azucena Montenegro Reyes | Dean | UNAN León |
| 2. | Blanca López Monge | Public Health Department Chief | Facultad Ciencias Médicas, UNAN León |
| 3. | Zeneyda Quiroz Flores | Teacher | UNAN Managua Polisal |
| 4. | María Elena Suárez | Coordinator | UNAN Managua Polisal |
| 5. | Yaroff Mora Vargas | Obstetric nurse | UNAN Managua |
| 6. | Rosa María González | Teacher | UNAN Managua |
| Donors | | | |
| 1. | Han Kok | Technical coordinator | Luxembourg Development Agency |
| 2. | Irma Bolske | Technician | Luxembourg Development Agency |
| 3. | Andi Voets | Health expert | Netherlands Embassy |
| 4. | Edgard Narváez | RH Advisor | UNFPA |
| 5. | Isabel Tercero | Advisor | Unión Europea |
| 6. | Rafael Amador | Health, Nutrition and HIV specialist | UNICEF |
| 7. | Reynaldo Aguilar | Family and community health coordinator | OPS |
| FP users | | | |
| 1. | Darvin Jesenia López | FP users | El Zapote <u>Madriz</u> |
| 2. | Gladis Umansor | FP users | El Zapote <u>Madriz</u> |
| 3. | Darling Isabel López | FP users | El Zapote <u>Madriz</u> |
| 4. | Esperanza Hernández | FP users | Amucayán <u>Madriz</u> |
| 5. | Ligia Pérez Muñoz | FP users | El Zapote <u>Madriz</u> |
| 6. | Ana Carolina Pérez | FP users | El Zapote <u>Madriz</u> |
| 7. | Diana Evel Córdoba | FP users | El Zapote <u>Madriz</u> |
| 8. | Jaritzza Tórrez | FP users | Sta Amalia |
| 9. | Jessica Hernández | FP users | Sta. Amalia |
| 10. | Imelda Pérez | FP users | El Destino |
| 11. | Esmeralda Mairena | FP users | El Destino |
| 12. | Johana Rocha | FP users | El Destino |
| 13. | Noreida Rocha | FP users | Sta. Amalia |
| 14. | Damaris Castro | FP users | Sta. Amalia |

