



# **GAVI Health System Strengthening Support Evaluation**

RFP-0006-08

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## **Nicaragua Desk Study**

Final Version – August 2009  
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## Abbreviations and Acronyms

APR	Annual Progress Report (GAVI Secretariat)
DGPD	General Bureau of Planning and Development
EPI	Expanded Programme of Immunisation
GoN	Government of Nicaragua
HSS	Health System Strengthening
MCH	Maternal and Child Health
MCSS	Health Sector Coordination Roundtable ( <i>Mesa de Coordinación del Sector Salud</i> )
MHCP	Ministry of Treasury and Public Credit
MINSA	Ministry of Health (MINSA)
MOLHSA	Ministry of Labour, Health and Social Affairs
PRSP	Poverty Reduction Strategy Paper
SILAIS	Integral Health Care Local Systems
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
PAHO	Pan American Health Organisation (Regional Office of WHO)

## Summary of key findings, conclusions and recommendations

The main goal of GAVI HSS in Nicaragua is to reach and maintain immunisation coverage rates greater or equal to 95%, with all vaccines and at all levels in the country. Key areas of intervention include: A) **Improving Health Services Management** through: Improving information systems (e.g. quality of data and use thereof) and; Strengthening supervision and monitoring at operational levels (e.g. ensuring supervisory visits to selected communities are conducted in a comprehensive and systematic way), B) **Improving delivery of services** through: Improvement of quality and supply of health services through the delivery of a basic health care package in remote communities and the implementation of a quality management programme in the health units, C) **Increasing involvement of Civil Society** through: Promotion of community networks and different forms of citizen participation in health at the community, municipality and departmental levels.

GAVI HSS activities are planned for implementation over a period of four years (2008-2011) with a total amount of US\$1,387,334.50 funds provided by GAVI. The Bureau of Planning and Development within the Ministry of Health has overall responsibility and oversight of GAVI HSS in Nicaragua, with the Bureau of Health Services responsible for its implementation.

As there is currently no APR available to report on HSS activities during 2008, it has not been possible to assess the level of progress of GAVI HSS in Nicaragua, nor make any observations on implementation issues. However it has been possible to review the **proposal design and preparation** with the following key findings:

- **The proposal development process appears to have been country led, highly inclusive and collaborative;** involving a wide range of partners, including civil

society. Proposal writing was led by the technical inter-institutional committee<sup>1</sup> coordinated by the MoH (MINSa). PAHO/WHO Country Office and Regional advisors provided technical support.

- The **proposal formulation process also benefited from the use of GAVI proposal development funds**; MINSa contracted two national consultants to support the drafting process.
- Nicaragua conducted a **joint-design** process for all three GAVI proposals<sup>2</sup> – all starting from a common central problem: "Difficulty in maintaining coverage greater or equal to 95% with all vaccines and at all levels in the country". From that point, effects and immediate, root and structural causes, were identified separately for the health system and services, and for immunization services. **This may be an interesting approach for other countries wishing to apply for several GAVI funds at the same time; promoting complementarity and synergies in applying GAVI funds.**
- **Submission to approval time was impressive**: a total of approx. **five months** was required.

At a more strategic level and specifically linked to the key questions this evaluation is attempting to answer, the following observations have been made through this review:

- Without the 2008 APR **it has not been possible to make any assessment as to whether or not GAVI HSS is on track**, nor make any suggestions as to how it might be improved. However, interviews suggest that GAVI HSS-specific activities are yet to begin.
- As a percentage of all HSS funding, GAVI is providing approx. 3% in Nicaragua. This suggests that **had GAVI HSS funding not been available, the types of interventions GAVI is currently funding would still be supported** – albeit to a lesser extent – by the GoN and other funding agencies. It has not been possible to

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<sup>1</sup> The committee included: · Director, MINSa General Bureau of Planning and Development (Coordinator ); Chief, National Expanded Immunization Program (EPI); A technical official from the MINSa General Bureau of Health Services; The monitoring and evaluation officer from the General Bureau of Planning and Development; Three officials from PAHO/WHO Country Office in Nicaragua (Advisor on Health Policy, Systems and Services Strengthening & Epidemiologist Advisor of the EPI and the Programme Officer).

<sup>2</sup> ISS, NVS and HSS

assess any added value of GAVI HSS in this context with the data available for this review.

- One has to assume that **GAVI HSS is addressing the ‘right’ bottlenecks** as it is directly supporting the priority areas of action already identified in the National Health Policy and Plan, in support of the implementing the Comprehensive Healthcare Model (MAIS)
- The **design processes appear to be well aligned with GAVI principles<sup>3</sup>** overall. In particular, GAVI HSS is designed to be both well aligned and harmonized with national health priorities and SWAp administration and financial systems. It is not possible to assess the extent of alignment with these principles in implementation.
- **The results framework for GAVI HSS is largely consistent with the existing country monitoring framework** (as interventions support the delivery of the Comprehensive Healthcare Model - MAIS) and includes indicators that are measurable with existing systems. Output indicators and targets appear to be realistic and measurable; suggesting that the country’s capacity to deliver on these has been considered.
- It is not possible to make an informed assessment of outputs and outcomes, with the information available. However, given its modest proportion of total HSS funds available in Nicaragua **GAVI HSS is unlikely to have a significant impact alone.**
- **PAHO/WHO (at both regional and country levels) contributed considerable technical support to the proposal preparation process.** In addition, the different technical units at the MINSA, community based organizations, NGOs and bilateral and multilateral cooperation entities (including USAID, UNICEF and PAHO/WHO Regional Office) provided oversight via several consultations; for example during the Health Sector Coordinating Roundtable meetings. **It has not been possible to assess the value of regional and global support mechanisms to GAVI HSS in Nicaragua during implementation,** nor, therefore, to allow any consideration of how these might be improved.

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<sup>3</sup> **Country driven; Aligned, Harmonised; Predicatble; Accountable, inclusive and collaborative; Catalytic; Results oriented; Sustainable; Helping to improve health equity**

- With the absence of the 2008 APR it is not possible to make any suggestion as to what might be the focus of the 2012 evaluation.
- Due to the nature of its design and close alignment with National Health Plans, **GAVI HSS support promises to contribute to sustainability efforts<sup>4</sup>**. The sustainability of these interventions partially supported by GAVI is also promoted through their incorporation in the 5 Year Health Plan, the Immunization 5 year Plan and Medium Term Expenditure Framework.
- **Finally, the design of interventions and selection of locations to focus GAVI HSS efforts in Nicaragua lends itself well to contributing to health equity improvements.**

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<sup>4</sup> The majority of GAVI HSS funds (as shown in Table 1) are being used to strengthen supervisory and monitoring functions at local levels, improving data quality management through training; and promoting a quality culture in health institutions through modular training courses; all contributing to long-term institutional capacity of the health system.

# 1 Scope, Approach and Methodology

## 1.1 Background

This report contains the findings of the case study conducted in Nicaragua in July 2009 as part of the GAVI HSS Evaluation Study. The evaluation conducted 11 In-depth case studies in the following GAVI HSS recipient countries, Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. This current study is one of an additional 10 countries that were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested from HLSP. To keep this report short these broader methodological issues will not be discussed here.

## 1.2 Brief conceptual framework of the Evaluation

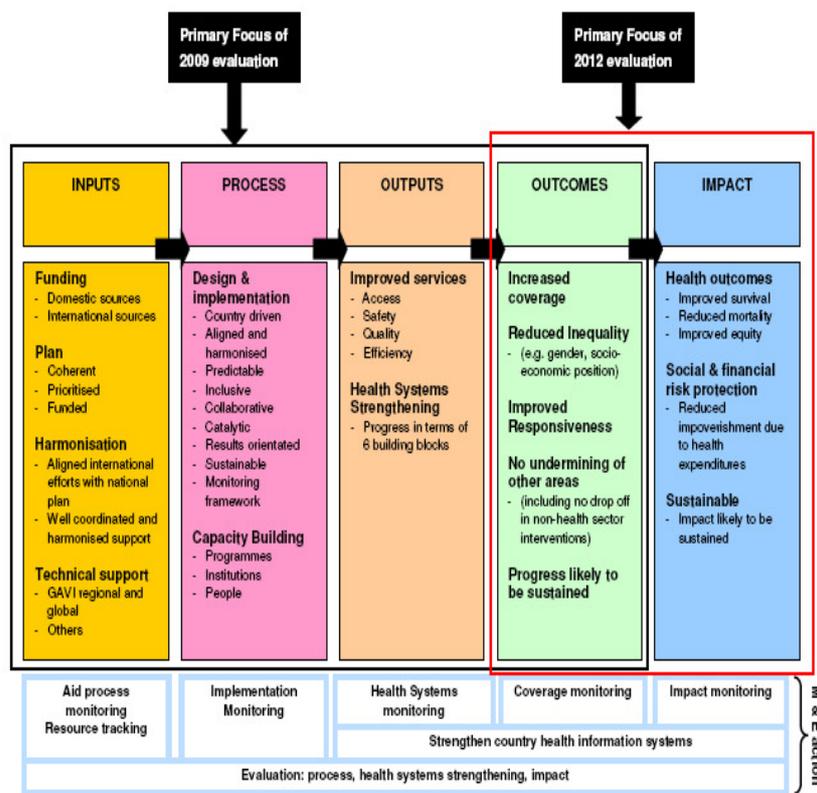
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation – the first one ever conducted on the GAVI HSS component- will focus primarily on issues linked to: proposal design; approval and review

processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

**Figure 1: The conceptual framework - logical progression from inputs to impact**



Our priority questions have been summarised in Box 1 below.

### **Box 1: Examples of Questions for the HSS Evaluation Study**

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the “right” bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

### **1.3 Approach to the Nicaragua Deeper Desk Study**

The Nicaragua Deeper Desk Study used a combination of document review, email and telephone interviews in order to gain insight into how GAVI HSS funding has support health system strengthening more generally in the country. Both the document review and interviews took place in early July 2009. Annex 1 provides a list of resources for the Nicaragua desk study. Annex 2 lists those stakeholders approached for telephone interview. Despite having contacted a number of stakeholders in Nicaragua, it was only possible to speak to two stakeholders in PAHO-WHO.

## 2 The GAVI HSS proposal – inputs, outputs and progress to date

### 2.1 HSS proposal design

The GAVI HSS proposal was formulated jointly in 2007, alongside the preparation of GAVI proposals for ISS and NVS. At the beginning of the process, a strategic diagnostic and planning exercise was held with the participation of SILAIS (Integral Health Care Local Systems<sup>5</sup>) technicians and MINSA Central Level officials from different technical areas in order to analyse the main difficulties and situation of immunization coverage at different levels: country, SILAIS, and municipalities.

The design of the proposal was inspired by recent health system evaluations carried out in Nicaragua, which highlighted a number of current bottlenecks in the health system. The proposal also presents a table showing which of these ‘bottleneck’ areas were / are already being covered by other development partners implicated in health systems strengthening efforts.

It is worth noting that Nicaragua conducted a joint-design process for all three GAVI proposals – all starting from a common central problem: "Difficulty in maintaining coverage greater or equal to 95% with all vaccines and at all levels in the country".

From that point, effects and immediate, root and structural causes, were identified separately for the health system and services and for immunization services. For each identified problem, strategies and activities were defined looking for linkages to the National Health Plan and Five-Year National Immunization Plan. The activities to be supported by each GAVI type of support were subsequently selected; taking into

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<sup>5</sup> SILAIS<sup>5</sup> is the administrative and operational unit of the Health System in a geographic territory. As a health authority in such territory, it controls or regulates so that the defined rules and decision-making in this respect are fulfilled. In Nicaragua, the health sector reform has gone through several stages. The most recent one (1991) started to form the facilities named ‘Local Comprehensive Health Systems’ (SILAIS), to consolidate the democratic process of civil society participation in service management or delivery, improving efficiency both in management of State-owned resources and quality and an opportunity of the public services for the Nicaraguan population. MAIS Conceptual Framework, pages 1 & 29, 2004, MINSA

account that in strengthening health services, the Expanded Program on Immunizations would also be strengthened.

This may be an interesting approach for other countries wishing to apply for several GAVI funds at the same time; promoting complementarity and synergies in applying GAVI funds.

**Table 1** below outlines the areas the proposal aims to address include:

Objectives	Activities	Funding allocation / activity 2008-2011
<b>Objective 1:</b> Effective and comprehensive delivery of basic services for children and women described within the MAIS for remote communities	Activity 1.1: Visits to selected communities conducted in a comprehensive and systematic way.	\$587,992
<b>Objective 2:</b> Manager's training at first care level units, to strengthen the statistics system and to improve data quality management.	Activity 2.1: Human resource's training on collection, analysis, and use of statistics.	\$52,300
<b>Objective 3:</b> Strengthening of quality management processes, with emphasis on the managerial capabilities and leadership of local teams, through the development of a monitoring and supervision program.	Activity 3.1: Development of a municipal quality assurance program; using self training modules from the Course "Promoting a quality culture in health institutions."	\$50,000
	Activity 3.2: Improved supervision and monitoring to operational units. Support for mobilization of 10 SILAIS teams to local levels four times a year.	\$122,347
<b>Objective 4:</b> Implementation of some components of the MAIS aimed to the escalation of community networks and the promotion of different forms of citizen participation in health at the community, municipality and departmental levels.	Activity 4.1: Complete the process of "sectorization" and assignment of basic health teams responsible for each territory (sector)	\$50,000
	Activity 4.2: Civil society stakeholder's training on social participation	\$189,995

	mechanisms in health management.	
	Activity 4.3: Health community worker's comprehensive education	\$176,200
M&E costs		\$76,000
Technical Support		\$82,500
<b>TOTAL</b>		<b>\$1,387,384</b>

## 2.2. HSS application and approval processes

The proposal writing was led by the technical inter institutional committee<sup>6</sup> under the coordination of the MINSA. PAHO/WHO Country Office and Regional advisors provided technical support. The proposal formulation process also benefited from the use of GAVI proposal development funds; with which the MINSA contracted two national consultants to support the drafting process.

As shown in Table 2 overleaf, the proposal development and approval process appears to have been highly collaborative, inclusive and iterative. On reviewing the Nicaragua HSS proposal the IRC made the following observation, noting this to have been a particular strength:

'This proposal has been developed through an inclusive process – involving all stakeholders – except those in the private sector. The process took place over a period of 7 months (March-Sept 2007) and involved consultations with technical experts in various groups within and outside of the Ministry of Health, with NGOs, bilateral and multilateral agencies in Nicaragua, and with persons and organisations at the local community levels. National workshops were held and there is some evidence that the feedback from these consultations was incorporated into the final proposal. Of special

<sup>6</sup> The committee included: · Director, MINSA General Bureau of Planning and Development (Coordinator); · Chief, National Expanded Immunization Program (EPI). · A technical official from the MINSA General Bureau of Health Services. · The monitoring and evaluation officer from the General Bureau of Planning and Development. · Three officials from PAHO/WHO Country Office in Nicaragua (Advisor on Health Policy, Systems and Services Strengthening, Epidemiologist Advisor of the EPI and the Programme Officer).

note is the incorporation of external peer review as well as the consultation with the National Public Investment Committee. The development of the proposal has also been tied in with the process for developing the GAVI ISS and the NVS proposals’.

In terms of *internal*<sup>7</sup> approval, the final proposal was reviewed and approved by the MINSA Executive Management, which includes the Minister of Health; it also received the endorsement from the Minister of Finance and Public Credit and the HSCC (MCSS) designated members of the Sectoral Roundtable Technical Committee.

*External* review and approval from the IRC was completed within one month of proposal submission, approving it ‘with clarifications’. Approval with clarifications essentially means that the proposal was formally approved but further minor clarifications were needed. There is no documentation available detailing the extent of clarification submitted by MINSA, however the decision letter of the GAVI board states that clarifications were considered satisfactory and the proposal was formally approved by the GAVI board in February 2008. So from the time of submitting the proposal to its approval a total of approx. five months was required.

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<sup>7</sup> What we refer here to *internal* approval of the HSS proposal is actually referred to as *external* in the proposal itself – i.e. review from those outside the immediate proposal writing team but within the country / regional support remit.

**Table 2 Key milestones in the application development and approval process<sup>1</sup>**

Key milestone	Who involved / Activity	Date
<b>Expression of interest</b> and proposal development support requested to GAVI Secretariat.	MINSA	November 17, 2006
<b>Nicaragua Participation in the PAHO/WHO Regional Workshop:</b> "Formulation of proposals for Strengthening Health Systems and Health Services Networks in the framework of the GAVI Alliance initiative" carried out in Tegucigalpa, Honduras.	As a result of the workshop a national plan for the preparation of the proposals was elaborated	March 13-15, 2007
<b>Health Sector Coordinating Roundtable Meeting</b>	The MINSA requested the participation of MCSS members in the preparation of the proposals, and the political support from Alliance members represented at the table for the country proposals.	March 27, 2007
<b>Selection and contracting of two national consultants</b> (one to support the formulation of HSS proposal and another one for the ISS and NVS proposals).		April, 2007
<b>First National Workshop</b> "Strategic Analysis for the formulation of Nicaragua's proposals to the GAVI Alliance".	Participants to this workshop included: <b>Epidemiologists, EPI managers, and Organization of Health Services Officials from 10 SILAIS, the Technical Team for proposal formulation, USAID health specialist and a PAHO/WHO regional consultant.</b> A first draft of the HSS proposal containing : problem definition, strategies, interventions and areas of action was obtained from this workshop	May 31, 2007
<b>Working session</b>	Between technical personnel of the <b>Ministry of Health</b> (Planning, Health Services and	June 14, 2007

	Immunization), and staff members of <b>PAHO/WHO</b> for the review and improvement of the draft proposal.	
<b>Second National Workshop</b> for community insight.	The proposal was presented and discussed with <b>grassroots organizations, civil society, cooperation agencies and partners for development</b> in order to validate it and improve it	July 7, 2007
<b>Presentation of proposal to HSCC</b>		August 8, 2007
Presentation of the proposal to the MINSA Executive Management	Minister of Health and General Directors	September 17, 2007
External Peer review of the proposal	The external peer review group was composed by: <b>PAHO Regional EPI GAVI focal point, a Public Health Professor from the Catholic University of Ecuador, the Adviser on Health Policies, Systems and Services at PAHO/WHO Country Office in Bolivia, and a health consultant at UNICEF Nicaragua Representation.</b>	September 17-18, 2007
Presentation of the proposal to the National Technical Committee for Public Investment		September 20, 2007
Endorsement of final proposal from all parties		September 19 -24, 2007
Proposal submitted:	MINSA	5 October 2007
Approval with clarifications from GAVI board obtained	GAVI Board	November 07
Submission of clarifications		Not clear from info. Available
Formal final GAVI Board approval		18 February 2008
Funds received		Funds submitted from GAVI on 30 April 2008: \$343,500 <sup>8</sup> . Funds

<sup>8</sup> GAVI Secretariat Spreadsheet: Country TA Planning Guide 9FEB09

		were received (confirmed by PAHO/WHO)
Official start date		Not clear

### 2.3 HSS start up measures

As there is no written information about what has happened to date in Nicaragua it is not possible to comment on start-up measures in any depth. According to interviews conducted, however, funds were received from GAVI Secretariat in 2008. It is not clear if there were any delays experienced/ issues in receiving these funds from GAVI. It appears that no activities have taken place due to funding issues (see 2.5 below). The 2008 HSS section of the APR has not yet been submitted.

### 2.4 Annual Progress Reporting (APR) on HSS

As above: To date no APR has been completed to report on HSS activities. Interviews confirmed that the APR process for all other GAVI funding works smoothly and follows an agreed review and approval process however it is not clear how the HSS reporting fits alongside this. The observation was made that this same issue arises in other GAVI HSS countries also.

### 2.5 HSS progress to date

The following objectives are identified in the HSS proposal:

1. Effective and comprehensive delivery of basic services for children and women described within the Integrated Health Care Model (MAIS), through comprehensive visits to remote communities.
2. Manager's training at first care level units, to strengthen the statistics system and to improve data quality management.
3. Strengthening of quality management processes, with emphasis on the managerial capabilities and leadership of local teams, through the development of a monitoring and supervision program.

4. Implementation of some components of the MAIS aimed to the escalation of community networks and the promotion of different forms of citizen participation in health at the community, municipality and departmental levels.

It appears that no activities have taken place due to funding issues. Funds were received in country in April 2008. However, it is not currently clear where the funds for GAVI HSS are sitting. The Bureau for Planning and Development maintain that funds have been distributed to District level health teams, however, the Bureau for Health Services maintain that these funds have not been received. There is currently a financial audit taking place and it is hoped that the results of the audit will clarify this issue.

## **2.6 End of HSS Assessment**

Without the HSS APR and therefore any perspective on progress to date it is not possible to speculate on what may be possible to investigate at the end of the HSS grant.

## **2.7 Support systems for GAVI HSS**

### **2.7.1 Technical support for proposal design and approval**

The team tasked with designing and writing the proposal included three representatives from PAHO/WHO's Country Office (in addition to MINSA); therefore technical support was provided during its design. In addition different technical units at the MINSA, community based organizations, NGOs and bilateral and multilateral cooperation entities (including USAID, UNICEF and PAHO/WHO Regional Office) provided oversight via several consultations; for example during the Health Sector Coordinating Roundtable meetings. As outlined in the table above, two national workshops were also conducted during the proposal preparation phase to gather technical inputs and support from grassroots organizations, civil society, cooperation agencies and development partners in order to validate and improve the proposal. The internal peer review process also relied on technical support from PAHO Regional EPI GAVI focal point, a Public Health Professor from the Catholic University of Ecuador, the Adviser on Health Policies, Systems and Services at PAHO/WHO Country Office in Bolivia, and a health consultant at UNICEF Nicaragua.

### 2.7.2 Technical support to the APR

It is not possible to assess the level of support provided to the APR from information available.

### 2.7.3 Technical support for HSS implementation

The Ministry of Health (MINSa) Bureau of Planning and Development maintains overall oversight for GAVI HSS in Nicaragua and the MINSa Bureau for Health Services is responsible for managing its implementation. Wearing a second hat of technical secretariat of the SWAP, the Bureau of Planning and Development is also responsible for consolidating local plans and coordinating with all technical areas within the Ministry of Health. GAVI HSS Support is considered another partner in the SWAP process supporting the implementation of the 5 year Health Plan.

The Health Sector Coordinating Roundtable (*Mesa de Coordinación del Sector Salud*, MCSS) is the mechanism for coordinating GAVI HSS with other system activities and programmes. The MCSS has been operational since February 28, 2003, created by Presidential Decree in 2003. MCSS is led by the MINSa, presided by the Minister of Health herself and comprises three layers: a) The sectoral roundtable in full<sup>9</sup>; b) The Technical Committee; c) Three Thematic Working Groups<sup>10</sup>. The issue of GAVI HSS funds (explained in 2.5) was raised and discussed during an HSCR meeting in the weeks following the 15 May APR deadline, however the minutes of this meeting were not available for this review.

The *Health Sector Roundtable Thematic Working Group on Public Health and organized response* is responsible for the monitoring and evaluation of GAVI HSS implementation, in its capacity as the specialized group within the HSCC following SWAP implementation. This thematic working group includes donors and cooperation agencies

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<sup>9</sup> The MCSS includes membership from the Ministry of Health Bureau of Planning and Development, MINSa General Bureau of Administration and Finance, MINSa General Bureau of Health Service, MINSa General Bureau of External Cooperation, Ministry of Foreign Affairs, Technical Secretariat Presidency of the Republic of Nicaragua, WHO/PAHO, WB, Embassy of Sweden and the Ministry of Finance and Public Credit.

<sup>10</sup> These include: *Working Group on Economics and Health; Public Health and organized response; Sectoral Leadership, Decentralisation, Social Participation and Institutional Management*

e.g. PAHO/WHO, UNICEF and the World Bank. It has not been possible to assess the extent of functionality of this working group in relation to its M&E role with regard to GAVI HSS.

### **3 Alignment with GAVI HSS principles**

This section will attempt to analyse the extent to which the Nicaragua HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equity issues – does GAVI HSS attempt to support an equitable distribution of health?

#### **3.1 Country Driven**

The proposal preparation appears to have been very much country driven and led by the Ministry of Health – with both the EPI and Planning divisions playing major roles. The National Health Coordination Roundtable (MCSS), presided (at the time of submitting the proposal) by the then Minister for Health and with broad participation from MINSA Director Generals of Departments seem to have been instrumental in initiating, preparing and reviewing the GAVI HSS proposal in Nicaragua.

#### **3.2. Is GAVI HSS aligned?**

Nicaragua's HSS proposal appears to be very much aligned with broader development and health policies and to a large extent with budgeting and reporting cycles also.

### **3.2.1 Alignment with broader development and health policies**

To cite from the IRC report (dated November 2007) on Nicaragua's proposal:

'The proposals are in line with the current thinking and trends in the country's health policy. The two National Health plans that cover the 2004-11 period stress the importance of the re-organisation of the MINSA. They have quite specifically identified the importance of developing a better primary health care system utilising a Comprehensive Health Care Model, greater community participation and involvement in health care, better patient-oriented quality health care, greater access by the ethnic groups and those in the remote areas, intersectoral co-ordination for health, and improving the health information systems. Earlier health assessments provide the conceptual and empirical underpinning for these policy directions...The priority problems that impede the achievement of immunisation and other health outcomes related to women and children have been identified and are in line with the cMYP. Some of the barriers relate to procedural and operational issues, but those related to the insufficiency of the available human resources, poor transportation and the poor data bases used for programming and planning are also identified.'

The HSS proposal clearly shows how the proposal development team identified specific bottlenecks, conducted an analysis of which development partners were working on which problems and opted to focus on seven out of the 14 major barriers identified through health sector assessments to improving immunisation coverage identified in recent assessments.

### **3.2.2 Alignment with budget and reporting cycles**

According to the proposal, GAVI HSS interventions in Nicaragua are fully aligned with Health SWAp. In the context of SWAP implementation, every year the Ministry of Health (through the General Division of Planning) prepares an Annual Report on progress against the Operational Annual Plan. This report is to demonstrate:

Proof of accountability for use of GAVI HSS funds;

provide proof of financial audit and proper procurement (in line with national regulations for FONSALUD);

efficient and effective disbursement of funds (e.g. from national to sub-national levels in the context of the SWAp mechanism);

progress against expected annual output targets and longer term outcome targets. It has not been possible to verify whether or not the above process actually happens.

As per the proposal the Ministry of Health is to send a copy of this report to all the Partners for Development, including GAVI, in April of every year. It is not clear from information available how this information is to feed into the GAVI APR however it would seem logical that the timing of this report would sit well with the GAVI APR deadline of 15 May. For 2008 the APR was not submitted on 15th May and remains to be submitted at the time of writing this review. GAVI APRS reporting on e.g. ISS funds have, however, been completed in recent years and follow an agreed process.

In terms of budgetary alignment<sup>11</sup> – GAVI HSS funds are to adhere to national procedures for accounting, reporting and procurement. Funds are channeled from GAVI Secretariat to the FONSALUD account<sup>12</sup>. FONSALUD is the financial mechanism in place to support the Health Five-Year Plan of the Ministry of Health. By MINSA request the Central Bank transfers funds to the General Treasury of the Republic (Ministry of Finance and Public Credit) in order to be channeled on to the Ministry of Health at the respective levels (Central, SILAIS, municipal or below). It has not been possible to verify whether or not this is happening in practice.

### **3.3. Is GAVI HSS Harmonised?**

GAVI HSS in Nicaragua appears to be particularly harmonized since it is focusing on priority areas of action already identified in the National Health Policy and Plan, in support of the implementing the Comprehensive Healthcare Model (MAIS)<sup>13</sup>. Although the proposal itself and processes outlined therein appear to be harmonized, however, it has not been possible to verify whether or not GAVI HSS is harmonized in its implementation.

As detailed in 3.2, reporting (to a certain degree) and budgeting procedures appear to be aligned with the health SWAp processes and procedures in Nicaragua.

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<sup>11</sup> According to minutes of the technical committee of the Sector Roundtable, dated Tues 7 August 2007 and the HSS proposal,

<sup>12</sup> United States Dollars Account at the Central Bank of Nicaragua

<sup>13</sup> The Comprehensive Health Care Model is the set of rules, procedures, instruments, manuals, and provisions that present the action lines implementation of a sector-wide transformation of health care. MAIS Conceptual Framework, MINSA, 2004

GAVI HSS funds are contributing approx. 3% of all HSS funds in Nicaragua, the majority share (94%) financed from government funds. The HSS proposal identifies other HSS players and levels of funding provided. However, it is not clear what these funds cover exactly and how any overlap with other development partners may have been considered more broadly. Complementarity with GAVI additional immunization efforts has been ensured through the joint-proposal design process followed since Nicaragua was applying for three GAVI streams of funding at once.

Nicaragua is not an IHP+ country but apparently has a functioning health SWAp and an active and apparently effective Health Sector Coordination Committee (MCSS) directly implicated in GAVI HSS.

### **3.4. Is GAVI HSS funding predictable?**

While it has been confirmed via interviews that the first tranche of funds were received it is not possible to say whether or not they were received on time as per the GoN financial cycle. On the other hand GAVI funds are predictable and budgeted over a 4 year period. As mentioned in 3.2.1 GAVI HSS funds are pooled in the common fund for health; using the FONSALUD mechanism.

### **3.5. Is GAVI HSS accountable, inclusive and collaborative?**

As outlined in Table 1 and reported in section 2.2 it is safe to say that at least for the proposal development process GAVI HSS in Nicaragua appears to have been highly accountable, inclusive and collaborative. Clear information regarding individual duties of implicated stakeholders as well as reporting and endorsement lines is included in the HSS proposal.

In line with GAVI guidance (and worth noting as not all countries have successfully done this) civil society organizations appear to have been an important part of the consultation process in drafting proposal through consultation workshops. NGOs and grassroots organizations were invited to provide inputs for the proposal. And in addition to providing advice from their community-based experience, civil society organizations have also committed to participating in and supporting activities in the implementation of GAVI

HSS support. It is noted in the proposal that there has been very limited participation of the private sector,<sup>14</sup> however, it is not made clear why this is the case.

It is not possible to make an observation about the implementation phase as there is insufficient information available to do so.

### 3.6. Does GAVI HSS have a catalytic effect?

It is not clear what kind of catalytic effect GAVI HSS may have in Nicaragua. The fact that it has aligned itself with the health SWAp and harmonized with other development partners suggests that it contributes to rather than instigates a catalytic effect. Given its modest proportion of total HSS funds available in Nicaragua GAVI HSS is unlikely to have a significant impact alone, however, the fact that GAVI HSS is being discussed during Health Sector Coordination Roundtables should help to ensure a focus on the Health systems strengthening agenda.

### 3.7 Is GAVI HSS Results Oriented?

In the absence of the 2008 APR it is not possible to answer this question fully. However, based on information in the HSS proposal the GAVI HSS results framework appears to be results oriented and well integrated with the national HMIS. GAVI HSS funds will also be used to carry out additional operational research<sup>15</sup> that will serve to inform future programming decisions.

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<sup>14</sup> The only participation came from QAP, a private consultants firm under a USAID contract

<sup>15</sup> Operational research includes two studies: **A) Studies of the quality of care** provided at health units, in order to gather information / feedback for the work of quality circles (*Output 8: Percentage of municipalities with at least one quality circle in implementation*); and **B) Studies on the improvement of the registry, analysis, and statistical use of data** in health units using auto evaluation techniques of the quality of data.

6.1: Impact and Outcome Indicators<sup>15</sup>

Indicator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	EPI Reports MOH Statistics Office	87.2 %	EPI Reports MOH Statistics Office	2006	96.5	2011
2. Number of districts achieving =80% DTP3 coverage	EPI Reports MOH Statistics Office	108 / 152	EPI Reports MOH Statistics Office	2006	152 / 152	2011
3. Under five mortality rate (per 1000)	MOH Statistics Office based on INIDE estimations	35 per 1000	MOH Statistics Office based on INIDE estimations	2006	30 per 1000	2011
4. Maternal mortality rate (per 100.000 registered live births)	INIDE estimations MOH Statistics Office based on INIDE estimations	95.8 per 100.000	MOH Statistics Office based on INIDE estimations	2006	63 per 100.000	2011
5. Infant mortality rate (per 1000 registered live births)	MOH Statistics Office based on INIDE estimations	29 per 1000	MOH Statistics Office based on INIDE estimations	2006	24 per 1000	2011
6. MMR coverage in < 1 year old children	EPI Reports MOH Statistics Office	97.2%	EPI Reports MOH Statistics Office	2006	98%	2011

<sup>15</sup>Indicators and targets correspond to the National Health Plan. In the country context, to keep actual levels of coverage is almost as big as a challenge as trying to rise them.

## 6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value <sup>18</sup> (municipalities range)	Source	Date of Baseline	Target	Date for Target
1. Early inscription to antenatal care	Number of pregnant women registered during the first quarter of pregnancy	Total number of expected pregnancies	Daily registration report Clinical files	38.4 (53-9) <sup>17</sup>	MOH Office Statistics	2006	48.7	2011
2. Antenatal care coverage	Number of pregnant women registered for the first time	Total number of expected pregnancies	Daily registration report	80.6 (203-7)	MOH Office Statistics	2006	92	2011
3. Coverage of institutional birth attendance	Births attended at health units	Total number of expected births	Health Units Births Book	60.8 (50-6)	MOH Office Statistics	2006	75.7	2011
4. Percentage of children 14 years old with second VPCD <sup>18</sup> control	Number of children 14 years old with second time VPCD controls	Estimated population 1-4 years age group.	Daily registration report	25.2 (81-8)	MOH Office Statistics	2006	100	2011
5. VPCD coverage in < 1 year.	Number of children 14 years old registered for the first time for VPCD	Estimated population < 1 year age group	Daily registration report	98.2 (300-40)	MOH Office Statistics	2006	100	2011
6. Percentage of women with 4 antenatal care controls	Pregnant women with 4 antenatal care controls	Total number of pregnant women registered	Daily registration report Clinical files	53.6 (57-5)	MOH Office Statistics	2006	70	2011

3.8

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
7. Percentage of municipalities presenting statistics reports on time	Number of municipalities dispatching statistics reports on time	44 municipalities selected for intervention	Statistics reports	NA	MOH Statistics Office	2006	100%	2011
8. Percentage of municipalities with at least one quality circle in implementation	Number of municipalities that are implementing at least one quality circle	44 municipalities selected for intervention	Semester performance reports from SILAIS and municipalities	NA	MOH Planning Office, SILAIS	2006	100%	2011
9. Percentage of addressed supervision visits recommendations	Number of addressed supervision visits recommendations in each municipality	Number of total supervision visits recommendations in each municipality	Supervision guidelines Recommendations Book	NA	Municipal Director, MOH	2006	95%	2011
10. Percentage of municipalities with updated family files	Number of municipalities that have created family files and keep them updated	44 municipalities selected for intervention	MAIS implementation reports	0	SILAIS Director, MOH.	2007	100%	2011
11. Percentage of municipalities that have carried out two community meetings for health data analysis each year	Number of municipalities that have carried out two community meetings for health data analysis each year	44 municipalities selected for intervention	Semester performance reports from SILAIS and municipalities	NA	MOH Planning Office, SILAIS	2006	100%	2011
12. Percentage of municipalities with working local participation	Number of municipalities with working local participation	44 municipalities selected for intervention	Semester performance reports from SILAIS and municipalities	NA	MOH Planning Office, SILAIS	2006	100%	2011

In the results framework (above) the majority of objectives and activities are clearly outlined and indicators (6 outcome / impact and 12 output level) are also clear and linked to objectives. The HSS proposal outlines how each indicator integrates into the national data collection system and where they are not, it explains GAVI HSS support will help them to integrate going forward. Baseline figures and targets for each year are also included, which is not the case in several other GAVI HSS country results frameworks. The improvements in immunisation coverage at the end of the HSS grant are likely to be modest given that there were high immunisation coverage rates in Nicaragua at the time of the design stage<sup>16</sup> and also given that ‘In the country context, to keep actual levels of coverage is almost as big as a challenge as trying to raise them<sup>17</sup>.’

Monitoring and evaluation of indicators selected for GAVI HSS support will rely on existing country systems and tools. The MINSA recently developed a unified tool for supervision visits, for example, that includes all health care technical areas. The tool is called “Assessment tool for a Health Care Improvement Approach” (AMAS). Personnel at the departmental and municipal levels have already been trained on its application, and teams for educational supervision have been confirmed. The departmental team (SILAIS) should carry out quarterly visits but scheduled visits are not being accomplished in a systematic way due to a lack of resources. GAVI HSS interventions will support these activities as well as strengthening national M&E expertise through Objective 3: Strengthening of quality management processes, with emphasis on the managerial capabilities and leadership of local teams, through the development of a monitoring and supervision program.

### 3.8 GAVI HSS Sustainability issues

Due to the nature of its design and close alignment with National Health Plans, GAVI HSS support promises to contribute to sustainability efforts<sup>18</sup>. The sustainability of these

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<sup>16</sup> E.g. 87.2% DTP3 coverage; 71% of districts already achieving ≥80% DTP3 coverage; 97.2% MMR coverage in < 1 year old children

<sup>17</sup> Footnote to results table from HSS proposal, page 25 of this report

<sup>18</sup> The majority of GAVI HSS funds (as shown in Table 1) are being used to strengthen supervisory and monitoring functions at local levels, improving data quality management through

interventions partially supported by GAVI is also promoted through their incorporation in the 5 Year Health Plan, the Immunization 5 year Plan and Medium Term Expenditure Framework. These planning instruments are all being used by the health Sector Wide Approach; they are updated each year and have a three year rolling projection for future. Nicaraguan legislation has adopted these requirements in order to improve predictability and promote continuity of resources for priority interventions within the fixed ceilings for each sector.

Since those areas of intervention chosen to be supported by GAVI HSS (see Table 1, page 13-14) already have a priority status within the MINSA, many of them will find continuity within institutional strengthening and health services development interventions led by the Ministry of Health with its own resources, and with budget support from partners in the context of the health SWAP. No parallel structures will be created for GAVI HSS which should also serve to guarantee the technical continuity of actions.

### **3.9 Does HSS funding help improved equity**

GAVI HSS interventions should serve to improve equity since it is intentionally targeting a number of municipalities with low immunization coverage. Pentavalent vaccine third dose coverage was used as a criterion for selection of municipalities of GAVI HSS focus during the proposal formulation process. As a first qualifier, municipalities that managed to obtain coverage higher than 12% during National Popular Health Campaigns were eligible for inclusion. This list was compared with the coverage obtained at the end of years 2005 and 2006 in each of the 152 municipalities of the country, and those which showed a coverage of less than 85% were selected for intervention; a total of 44. 16 of the 44 priority municipalities have indigenous population, according to National Institute of Development Information 2005 census. Since typically indigenous populations tend to be among the poorest populations in countries it is logical to assume that GAVI HSS efforts will have an impact upon the poorest and in doing so address equity issues<sup>19</sup>. All

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training; and promoting a quality culture in health institutions through modular training courses; all contributing to long-term institutional capacity of the health system.

<sup>19</sup> *"Indigenous peoples remain on the margins of society: they are poorer, less educated, die at a younger age, are much more likely to commit suicide, and are generally in worse health than the rest of the population"*. (Source: The Indigenous World 2006, International Working Group on Indigenous Affairs (IWGIA), ECOSOC Consultative Status, p10)

of those regions cited in the National Health Policy<sup>20</sup> as having the greatest unmet need are being targeted by GAVI HSS funds.

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<sup>20</sup> “Extreme poverty hits indigenous populations, Atlantic Coast and Border communities harder. The poor access to health services affects around 35% - 45% of total population. The health unmet needs are greater in the Northern Atlantic Coast Autonomous Region (RAAN), Southern Atlantic Coast Autonomous Region (RAAS), Rio San Juan (RSI), Jinotega and Matagalpa.” Page 4, Nicaragua National Health Policy

## Annex 1 List of References

AIDE MEMOIRE, HEALTH SECTORIAL BOARD (MESA SECTORIAL) MEETING, Managua, October 18<sup>th</sup> 2005, 9:00 a.m. – 12: 00 p.m., November 1<sup>st</sup> 2005

AIDE –MEMOIRE, *NICARAGUA - COUNTRY PROPOSAL FOR GAVI ALLIANCE REVIEW WORKSHOP*, May 31<sup>st</sup> 2007

Nicaragua National health Policy 2007-2011

Nicaragua National Health Plan 2004-2015

Conceptual Framework of the Comprehensive Health Care Model (MAIS)

AIDE-MEMOIRE, GAVI PROJECT TECHNICAL MEETING, PAHO – MANAGUA. May 28<sup>th</sup> 2007

AIDE MEMOIR, Meeting of the Technical Committee of the Sector Roundtable Tuesday, 07 August 2007

Functional Manual for the Nicaraguan Health Care Fund (FONSALUD), Republic of Nicaragua Ministry of Health, August 2005

Nicaragua HSS Proposal Review, IRC Report November 2007

GAVI Board decision letters: 28 November 2007 & And 18 February 2008

2007 and 2008 GAVI APRs

## **Annex 2 List of People approached**

1. Dr Claudia Castillo, focal point for GAVI in Washington
2. Dr Cristina Pedreira, EPI focal point WHO, Nicaragua
3. Dr. Solis, (Director General of Planning, MoH at the time of writing the proposal)
4. Dr. Roger Montes (Health Systems and Services, WHO Nicaragua)
5. Dr. Maria Angélica Gómez, Advisor for Health Systems and Services (not in country during study period), WHO, Nicaragua
6. Dr. Malespin (EPI Manager at the time of writing the proposal)
7. Dr. Miguel Orozco, CIES - Centro de Investigaciones y Estudios de la Salud de la Universidad Nacional Autónoma de Nicaragua

## Annex 3 Summary GAVI HSS Evaluation Approach

### The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop [five In-depth country case studies](#). These are structured in such a way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be [complemented by the results of 6 on-going GAVI HSS Tracking Studies](#) being conducted by the JSI-In Develop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to [develop a database of HSS countries](#). All these sources of information put together will aim to answer the five study questions mentioned above.