



**Application for GAVI Alliance Health System Strengthening (HSS):**

**“Support for Maternal and Infant Health System Strengthening in the Republic of Nicaragua”**



**October 2007.**

## Table of Contents

	<b>Page</b>
Abbreviations and Acronyms.....	3
Executive Summary .....	4
Section 1: Application Development Process .....	6
Section 2: Country Background Information.....	11
Section 3: Situation Analysis / Needs Assessment.....	14
Section 4: Goals and Objectives of GAVI HSS Support.....	16
Section 5: GAVI HSS Activities and Implementation Schedule .....	18
Section 6: Monitoring, Evaluation and Operational Research.....	20
Section 7: Implementation Arrangements.....	27
Section 8: Costs and Funding for GAVI HSS .....	32
Section 9: Endorsement of the Application .....	33
 <b>Annexes</b>	
ANNEX 1 Documents Submitted in Support of the GAVI HSS Application.....	35
ANNEX 2 Banking Form.....	36

## Abbreviations and Acronyms

CNS	: National Health Council
DGPD	General Bureau of Planning and Development
DGSS	: General Bureau of Health Services
ENDESA	: Nicaraguan Survey of Demography and Health
EPV	: Vaccines Preventable Diseases
ERCERP	: Reinforced Strategy of Economic Development and Reduction of Poverty
JPNS	: National Popular Health Campaign
INIDE	: National Institute of Development Information
MAIS	: Integral Health Care Model
MCSS	: Health Sector Coordination Roundtable
MHCP	: Ministry of Treasury and Public Credit
MINREX	: Ministry of External Affairs
MINSA	: Ministry of Health (MOH)
NVR	: Registered live births
OMS	: World Health Organization (WHO)
ONG	: Non Governmental Organization (NGOs)
OPS	: Pan American Health Organization
PND	: National Development Plan
PNI	: National Immunization Plan
PNS	: National Health Plan
SICO	: Community Information System
SILAIS	: Integral Health Care Local Systems
SINEVI	: Vital Statistics National System
SETEC	: Technical Secretariat for the Presidency
SPD	: Development Partners
UNICEF	: United Nations Children's Fund
VPCD	: Monitoring and promotion of children's growth and development

## Executive Summary

Nicaragua has a population of 5,603,241 inhabitants, based on the population estimates<sup>1</sup> of the National Institute of Development Information (INIDE) for the year 2006. Its population is predominantly young, since 37.6 percent is under the age of fifteen years. Based on the projections, fundamental foreseen changes in the population pyramid for the following ten years will be: the increase in the old age group and the decrease in the proportion of minors under five years old.

In the distribution by sex, the female population accounts 50.7 percent, the natural growth rate of the population of the country is currently 2.6 percent, which is considered one of the highest in Latin America. Among the main health determinants in Nicaragua, poverty is the most important; according to official estimates, in 2005, the proportion of population living in general poverty was of 48.3 percent and in extreme poverty, 17.2 percent. The same estimates point out that poverty in Nicaragua predominates in the rural area (five times higher than urban areas), as well as in the outskirts of the principal cities of the country.

When health problems such as infant mortality are analyzed, it is identified that the probability of occurrence of this problem, is higher in the lower well-being quintile population groups, (infant mortality rate: 35 per 1,000 NVR) than in the top well-being quintile group (infant mortality rate of 19 per 1,000 NVR)<sup>2</sup>.

The Ministry of Health (MOH), with technical support from PAHO/WHO and other development partners prepared this request to GAVI for the strengthening of the health system and services, with emphasis on maternal and child comprehensive care. The preparation of the proposal stemmed from the most recent evaluations of the health system, subsequently there were carried out consultations with SILAIS personnel, central level officials of the Ministry of Health and with the main stakeholders who support and/or undertake community work in the territories. Consensus was built from the consultations on the main problems to address, lines of action, strategies/activities and expected results. During the formulation process and for the final design of the proposal, several members of the Health Sector Roundtable were involved. The final proposal was presented by the MOH General Bureau of Planning and Development to the Roundtable Technical Committee, for their comments and support. This structure involves officials from the Ministry of Health, the Ministry of Foreign Affairs, The Ministry of Finance and liaisons from donor and cooperation agencies.

The formulation process for the GAVI HSS proposal was carried out jointly with the preparation of other proposals for GAVI ISS and NVS. At the beginning of the process, a strategic diagnostic and planning exercise was held with the participation of SILAIS technicians and MOH Central Level officials from different technical areas in order to analyze the main difficulties and situation of immunization coverage at different levels: country, SILAIS, and municipalities. 44 municipalities for priority intervention were identified using the Pentavalent vaccine third dose coverage achieved during the development of National Popular Health Campaigns (municipalities that managed to obtain coverage higher than 12%), this was contrasted with the coverage obtained at the end of the years 2005 and 2006 in each of the 152 municipalities of the country, those which also presented coverage less than 85% were selected for intervention (see annex 1). 16 of the 44 priority municipalities have indigenous population, according to INIDE's 2005 census.

As mentioned before, this proposal was prepared at the same time with the proposal for Strengthening of Immunization Services. For the construction of the problem tree both proposals start from a common central problem: "Difficulty in maintaining coverage greater or equal to 95%,"

<sup>1</sup> Nicaragua. Instituto Nacional de Información de Desarrollo (INIDE). Poverty Profile and characteristics in Nicaragua. 2007.

<sup>2</sup> Nicaragua. Encuesta Nicaragüense de Demografía y Salud (ENDESA) 2006 -2007. Preliminary Report, Managua, 2007.

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 5 years National Immunization Plan. In the following review process with the technical areas of the Ministry of Health, the activities to be supported by each GAVI type of support were selected, taking into account that upon strengthening the health services, the Expanded Program on Immunizations will be also strengthened.

Within the framework of the National Health Plan, two major challenges that should be faced by the Health System in the long run have been identified for intervention: 1) To increase care coverage, especially actions for prevention and protection with high impact on main health population issues and 2) to achieve the aware and active involvement of citizenship in health sector tasks, contributing to a better governance, through the development of community capabilities to keep healthy environments and good health practices. This proposal will support actions aimed to face these challenges in selected municipalities.

The total amount of funds for activities to be carried out with GAVI support is US dollars 1,387,334.50. Implementation of the activities will take four years (2008-2011).

The main goal of the proposal is to help to reach and maintain coverage rates greater or equal to 95%, with all vaccines and at all levels in the country, through the strengthening of: organization of community work, health services management, social participation based on local planning, and support for maternal and child basic services delivery in remote areas.

**Areas of intervention :**

1. Health Services Management
  - Information systems:
    - i. The quality of the information is inadequate from the local level to the central level
    - ii. Partial utilization of basic program information for programming and decision-making
  - Supervision and Monitoring: Inadequate process of supervision and monitoring to the operational units.
2. Delivery of services: Remote communities do not receive care on a systematic and periodic way.
3. Involvement of Civil Society
  - Insufficient use, at the local level, of the advantages and strengths of social actors.
  - Lack of/low level of community organization.

**Lines of action:**

1. Training processes directed to health workers and members of the community network.
2. 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 program in the health units.
3. Strengthening the processes of civil society participation and involvement in the health sector response to prioritized problems.

**Objectives:**

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.

### Activities

1. Visits to selected communities conducted in a comprehensive and systematic way.
2. Human resource's training on collection, analysis, and use of statistics.
3. Development of a municipal quality assurance program; using self training modules from the Course "Promoting a quality culture in health institutions."
4. Improved supervision and monitoring to operational units
5. Complete the process of "sectorization" and assignment of basic health teams<sup>3</sup> responsible for each territory (sector)
6. Civil society stakeholder's training on social participation mechanisms in health management
7. Health community worker's comprehensive education.

It is expected that the GAVI HSS support will help to achieve the following National Health Plan results :

1. Maternal, infant and child mortality reduction

Health Issue	Baseline 2006	Year 2010
Maternal Mortality	95.8x1000.000 NVR	63 x 100,000 NVR
Infant Mortality	29 x 1000	24 x 1000 <sup>4</sup>
Under-five Mortality	35 x 1000	30 x 1000

2. Increased coverage of maternal and child health interventions.

Health Intervention	Baseline 2006	Year 2010
Early pregnancy control care	38.4	48.7
Prenatal care coverage	80.6	92
Institutional birth attendance	60.8	75.7
Pentavalent vaccine 3rd dose coverage	87.2	96.5
MMR coverage (measles, mumps, rubella)	97.2	98

3. 44 selected municipalities deliver timely and properly statistical data accomplishing the stipulated route: Health posts-Health Centres-SILAIS- MOH Central level.
4. Actions to develop a "quality culture" implemented. At least one Quality Circle each year functioning at every municipal level.
5. At Least 95% of the recommendations from supervision visits to operational units have been addressed by the corresponding level.
6. Community networks functioning.
  - 100% of family files updated at the end of the third year (pregnant women, complete vaccination series in children under 1 year, among other relevant information).
  - Data Analysis activities at community level held twice a year. One activity held at the time of the Participatory Annual Planning Process, another one for follow-up and community feedback.
7. Local citizen participation in health councils functioning and incorporating health issues in the municipal and departmental development plans at 44 municipalities.

<sup>3</sup> MAIS describes the composition of Basic health teams. (See annex 2)

<sup>4</sup> Infant Mortality data base on ENDESA 2005.

## Section 1: Application Development Process

### 1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

Health Sector Coordination Round Table (*Mesa de Coordinación del Sector Salud, MCSS*)

HSCC operational since:

The HSCC (MCSS) is operational since February 28<sup>th</sup>, 2003. It was created by Presidential Decree Number 71-2003.

Organisational structure (e.g., sub-committee, stand-alone):

The Health Sector Coordination Round Table is led by the MOH, presided by their maximum representative (the Minister of Health herself) and it is composed by three structures:

- The sectoral roundtable in full
- The Technical Committee
- Thematic Working Groups (3).

Frequency of meetings:<sup>5</sup>

Rules of procedure of the MCSS established that the roundtable should meet at least four times a year on an ordinary basis, and when required by special circumstances through extraordinary convocations (Article VII, Manual of Procedures, MCSS). Although, the sectoral roundtable in full has been meeting only twice a year.

The Technical Committee meets once a month and sometimes more often if needed, to follow up on roundtable agreements or to prepare MCSS meetings.

Overall role and function:

- Coordinate, harmonize and promote synergy of actions between institutions and the participant organisms in line with national policies and the National Health Plan, independently of their financial cooperation mechanism.
- Analyze, follow-up and evaluate in a joined way the implementation of the five-year and Annual Health Plans as well as the health situation analysis.
- Share information on cooperation activities.
- To give suggestions to the better fulfilment of results and to meet the defined goals for agreed indicators.
- To define key topics of interest and operational agenda, including the calendar of meetings.
- Designate the members of the Technical Committee, Technical Secretariat and Working Groups.
- It is expected that in the future the MCSS will become a unique space that integrates contributions from missions and bilateral meetings of all members.

<sup>5</sup> Minutes from HSCC meetings related to HSS are attached with the supporting documentation, together with the minutes of the Technical Committee of the HSCC when the application was discussed and endorsed (see Annex 3). Minutes from the meetings are not usually signed but a special endorsement form is presented for documentation.

## 1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The Application was written by a technical inter institutional committee designated by the Minister of Health. The committee consisted by :

- Director, MOH General Bureau of Planning and Development (Coordinator )
- Chief, National Expanded Immunization Program (EPI).
- A technical official from the MOH 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).

Oversight was gathered from several consultations with different technical units at the MOH, community based organizations, NGOs and bilateral and multilateral cooperation entities, including USAID and UNICEF.

Who led the drafting of the application and was any technical assistance provided?

The drafting of the proposal was led by the inter-institutional team under the coordination of the MOH. PAHO/WHO Country Office and Regional advisors provided technical support. The proposal formulation process also benefit from the GAVI technical support for proposal development trough which the MOH contracted the support of two national consultants.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

1. November 17, 2006. Expression of interest and proposal development support requested to GAVI Secretariat.
2. March 13-15, 2007. Nicaragua Participation in the PAHO/WHO Regional Workshop: "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.
3. March 27, 2007. Health Sector Coordinating Roundtable Meeting. The Ministry of Health informed that Nicaragua was a beneficiary country for the GAVI Alliance, and that the government had decided to proceed in the formulation of proposals for HSS, ISS and INV support. The MOH 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.
4. April, 2007. Selection and contracting of two national consultants (one to support the formulation of HSS proposal and another one for the ISS and NVS proposals).
5. May 31, 2007. First National Workshop: "Strategic Analysis for the formulation of Nicaragua's proposals to the GAVI Alliance". Participants to this workshop included: 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. A first draft of the HSS proposal containing: problem definition, strategies, interventions and areas of action was obtained from this workshop.
6. June 14, 2007. Working session between technical personnel of the Ministry of Health (Planning, Health Services and Immunization), and staff members of PAHO/WHO for the review and improvement of the draft proposal. All relevant background documents were compiled at an internet portal (SharePoint) for easy access to all involved in the proposal formulation.



NICARAGUA GAVI HSS Application 2007

7. July 7, 2007. Second National Workshop for community insight. The proposal was presented and discussed with grassroots organizations, civil society, cooperation agencies and partners for development in order to validate it and improve it.
8. August 8, 2007. Presentation of the proposal to the MCSS Technical Committee.
9. September 17, 2007. Presentation of the proposal to the MOH Executive Management (Minister of Health and General Directors).
10. September 17-18. External Peer review of the proposal in the context of the PAHO/WHO Second Regional Workshop for GAVI Alliance Proposal Formulation. The workshop was held in Managua, Nicaragua. The external peer review group was composed by: 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.
11. September 20, 2007. Presentation of the proposal to the National Technical Committee for Public Investment<sup>6</sup>.
12. September 19-24. Endorsement of final proposal from all parties.

Who was involved in reviewing the application, and what was the process that was adopted?

The different drafts were examined and commented by the Technical Committee through e-mail and working sessions following the national workshops and the different presentations of the proposal, to incorporate inputs from workshop participants and authorities. PAHO/WHO GAVI HSS Regional Focal Point provided comments on the later drafts of the proposal. The external peer review group provided sound contributions for the improvement of the proposal. The National Public Investment Committee (Technical Secretariat of the Presidency) also reviewed the final proposal.

Who approved and endorsed the application before submission to the GAVI Secretariat?

The final proposal was reviewed and approved by the MOH 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.

### 1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
<b>Health Sector Coordinating Roundtable Technical Committee</b>			
Jaime Gonzalez	MOH	Yes	Endorsement. General Director. Bureau of Administration and Finance
Liana Vega	MOH	Yes	Review and Endorsement. General Director. Bureau of Health Services.
Carolina Siu	MOH	Yes	Endorsement. External Cooperation and SWAP Technical Secretary.

<sup>6</sup> Composed by: Ministry of Finance and Public Credit, Central Bank of Nicaragua, Technical Secretariat of the Presidency and Ministry of Foreign Affairs.

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
<b>Health Sector Coordinating Roundtable Technical Committee</b>			
Julio Zapata	Technical Secretariat of the Presidency	Yes	Review and Endorsement. Social Sector Coordinator.
Maura Rodriguez	Ministry of Finance and Public Credit	Yes	Review and Endorsement. Official delegate to the Sector Roundtable.
Helena Reutersward	Embassy of Sweden. First Secretary	Yes	Endorsement Bilateral Partners Liaison to the Technical Committee.
Deborah Sequeira	Ministry of Foreign Affairs	Yes	Endorsement Official delegate to the Sector Roundtable.
Coleen Littlejohn	World Bank	Yes	Endorsement. Multilateral partners Liaison to the Technical Committee.
Mario Cruz Penate	PAHO/WHO	Yes	Review and Endorsement. United Nations partners Liaison to the Technical Committee.
<b>Technical Team for Proposal Development</b>			
Dr. Alejandro Solis Martinez	MOH	Yes	Coordinator Proposal Formulation. Sector Roundtable Technical Committee Coordinator. General Director. Bureau of Planning and Development.
Dr. Carlos Cruz Lesage	MOH	No	Proposal Formulation Evaluation Officer. Bureau of Planning and Development
Dr. Leopoldo Espinoza	MOH	No	Proposal Formulation Technical Officer. Bureau of Health Services
Dr. Omar Malespin	MOH	No	Proposal Formulation Chief. National Expanded Program on Immunization
Dr. Maria Cristina Pedreira	PAHO/WHO	No	Technical Support Epidemiologist. EPI Advisor.
Dr. Maria Angelica Gomes	PAHO/WHO	No	Technical Support Advisor on Health Policies, Systems and Services.
Dr. Marta Reyes	Consultant	No	Technical Support National Consultant ISS
Dr. Roger Montes Flores	Consultant	No	Technical Support National Consultant HSS
Dr. Mario Cruz Penate.	PAHO/WHO	Yes	Technical Support Programme Officer

## 1.4: Additional comments on the GAVI HSS application development process

As mentioned before civil society organizations were consulted for the formulation of the proposal, NGOs and grassroots organizations from the departments to be intervened were invited to provide inputs for the proposal. Besides providing sound advice from their community work experience, civil society organizations committed to participate and support activities in the implementation of GAVI HSS support. There has been very limited participation of the private sector; the only participation came from QAP, a private consultants firm under a USAID contract (See Annex 3 for Aide Memoir of this meeting).

## Section 2: Country Background Information

### 2.1: Current socio-demographic and economic country information

Information	Value	Information	Value
Population	5.603.241 (2007, INIDE <sup>7</sup> )	GNI per capita	958.6 \$US (2006, Central Bank of Nicaragua)
Annual Birth Cohort	136.160 (2007, INIDE)	Under five mortality rate	35 x 1000 rlb** (2006, ENDESA)
Surviving Infants*	135.043 (2007, INIDE)	Infant mortality rate	29 x 1000 rlb (2006, ENDESA)
Percentage of GNI allocated to Health	3.4% (2005, Central Bank of Nicaragua)	Percentage of Government expenditure on Health	14.9% (2005, Central Bank of Nicaragua)

\* Surviving infants = Infants surviving the first 12 months of life

\*\* Registered live births (*NVR, Nacidos vivos registrados*)

### Current socio-demographic and economic sub-national data

No.	DEPARTMENT MUNICIPALITIES	Human Development Index <sup>8</sup>	Poverty <sup>9</sup>	Extreme Poverty
	<b>NICARAGUA</b>	<b>0.635</b>		
	<b>BOACO</b>	<b>0.569</b>		
1	San Jose	0.541	72.7 %	35 %
2	San Lorenzo	0.557	75.4 %	37.4 %
	<b>CHONTALES</b>	<b>0.625</b>		
3	El Ayote	Sin Datos	82.2 %	46 %
4	El Coral	0.532	74.3 %	35 %
5	Juigalpa	0.703	50.1 %	20.5 %
6	La Libertad	0.531	71 %	36.6 %
7	Muelle de los Bueyes	0.523	62.8 %	28.3 %
8	Nueva Guinea	0.502	71.9 %	33.5 %
9	El Rama	0.482	67.6 %	31.7 %
10	San Pedro de Lovago	0.640	60.9 %	27.9 %
11	Santo Domingo	0.541	71.9 %	37.5 %
12	Villa Sandino	0.559	65.7 %	31.2 %

<sup>7</sup> INIDE, National Institute of Development Information is the stewardship authority in the country for statistics and census.

<sup>8</sup> El Desarrollo Humano en Nicaragua 2002, Las condiciones de la Esperanza. PNUD

<sup>9</sup> PRSP 2001

NICARAGUA GAVI HSS Application 2007

No.	DEPARTMENT MUNICIPALITIES	Human Development Index <sup>8</sup>	Poverty <sup>9</sup>	Extreme Poverty
	<b>GRANADA</b>	<b>0.690</b>		
13	Granada	0.720	45.6 %	14.2 %
	<b>MANAGUA</b>	<b>0.827</b>		
14	Managua	0.827	17.6 %	3%
15	San Rafael del Sur	0.713	29.8 %	6.2 %
16	Tipitapa	0.751	28.8 %	5.9 %
17	Villa Carlos Fonseca	0.635	32.7 %	6.3 %
	<b>REGION AUTONOMA ATLANTICO NORTE</b>	<b>0.497</b>		
18	Rosita	0.533	66.1 %	33.2 %
19	Siuna	0.417	76.5 %	41.2 %
20	Waspan	0.466	83 %	64.1 %
	<b>REGION AUTONOMA ATLANTICO SUR</b>	<b>0.506</b>		
21	Bluefields	0.662	34.6 %	9.2 %
22	Kukra Hill	0.461	67 %	27.4 %
23	Tortuguero	0.415	73.8 %	39.9 %
24	La Cruz de Rio Grande	0.410	80 %	43
	<b>RIO SAN JUAN</b>	<b>0.528</b>		
25	Morrito	0.530	69.2 %	34.2 %
26	San Miguelito	0.500	73.8 %	39.7 %
27	Almendro	0.495	70.5 %	32.8 %
	<b>CHINANDEGA</b>	<b>0.649</b>		
28	El Realejo	0.614	54.5 %	17.9 %
29	San Pedro del Norte	0.506	79.8 %	34.8 %
	<b>JINOTEGA</b>	<b>0.503</b>		
30	Concordia	0.602	69.7 %	29.2 %
31	El Cua	0.423	76.9 %	43.8 %
	<b>MADRIZ</b>	<b>0.580</b>		
32	Las Sabanas	0.569	80.1 %	41.2 %
33	San Lucas	0.530	83 %	43.5 %
34	Telpaneca	0.479	80.5 %	41.4 %
	<b>MATAGALPA</b>	<b>0.579</b>		
35	Paiguas	Sin Datos	79.4 %	42.2 %
36	Esquipulas	0.566	70.9 %	33.4 %
37	Matiguas	0.470	75.6 %	38.8 %
38	Muy Muy	0.508	74.7 %	37.4 %
39	Rio Blanco	0.498	73 %	35.9 %
40	San Dionisio	0.519	77.5 %	37.6 %
41	Terrabona	0.578	77.3 %	36 %
42	La Dalia	0.456	77.7 %	38.7 %
43	Waslala	0.443	78.4 %	43 %
	<b>NUEVA SEGOVIA</b>	<b>0.573</b>		
44	Wiwili	Sin Datos	Sin Datos	

## 2.2: Overview of the National Health Sector Strategic Plan

The National Health Plan is the guide for future fundamental reforms of the Health System. The path for this transformation is marked by three processes: 1) MOH re-organization, which will have a sensitive impact in health system institutions, 2) implementation of the Comprehensive Health Care Model (MAIS), which will become the new reference for health services delivery in the country, and 3) adjustments to the financial sources and mechanisms of health interventions, aim to increase equity on a sustainable manner<sup>10</sup>.

<sup>10</sup> See Annex 4. National Health Plan 2004-2015, page 51.

The National Health Plan guides the implementation of the National Health Policy<sup>11</sup>. The Plan is based on a situation analysis that defined: health priorities, sector challenges and expected results for health situation improvement. The Plan describes the efforts that will be undertaken in the following years, listing strategies and interventions that will be conducted by sector institutions.

Priority setting was driven by: 1) Policy guidelines contained in the National Development Plan (which also embraces the Millennium Development Goals) 3) the analysis of health determinants and health conditions of the population 3) an evaluation of health interventions that were implemented in the past years, along with the health system performance and inputs and 4) problem prioritization criteria (magnitude, relevance, vulnerability, cost and feasibility). The result was the identification of twelve health problems<sup>12</sup>. The premises for the selection of strategies and interventions in the National Health Plan come from three specific scopes: 1) the health sector legal framework (recently reformed, 2003), 2) a wide consultation process with all health sector stakeholders and 3) the Government's National Health Policy 2007-2011.

The main goal of the National Health Plan is to guarantee the right to access a universal and equitable basic health services ensemble for all people, in order to improve life expectancy and quality of life of Nicaraguan citizens.

The objectives of the National Health Plan are:

1. To increase the access to and quality of health services, in accordance with the MAIS.
2. To make stronger inter-sector actions for health promotion, protection and prevention of damage to the health of people, families, communities and to the environment; through the implementation of the Primary Health Care Strategy.
3. To improve health sector governance, through the construction of a stronger MOH for stewardship role fulfillment, and more social and institutional participation (with focus on ethnic groups and indigenous communities, and gender and generation balance).
4. To deepen the National Health System reform processes to achieve more efficacy, efficiency and effectiveness.
5. To execute innovative strategies for the Nicaraguan Caribbean Coast Autonomic Regions.

In order to achieve these objectives, mayor challenges that the health sector must face were described:

1. To direct interventions on the basis of population needs and priorities, eliminating barriers for basic services including health.
2. To increase care coverage, especially actions for prevention and protection with high impact on main health population issues.
3. To develop a prevention and health promotion culture within the society.
4. To achieve the aware and active involvement of citizenship in health sector tasks, contributing to a better governance, through the development of community capabilities to keep healthy environments and good health practices.
5. To implement key reform elements to improve the performance of the Health System (for a detail lists of interventions, please see Annex 4 , pages 56-58.).

<sup>11</sup> See Annex 5. National Health Policy 2007-2011.

<sup>12</sup> See Annex 4. National Health Plan, pages 29-35.

## Section 3: Situation Analysis / Needs Assessment

### 3.1: Recent health system assessments<sup>13</sup>

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Evaluation Report. Annual Operative Plan 2006.	MOH Development partners	Qualitative evaluation of objectives, guidelines and strategic actions of the Annual Operative Plan 2006. Quantitative evaluation of budget and investment program execution. Qualitative and Quantitative evaluation of key indicators for follow up of the Health Sector Five Year Plan 2005-2009.	January-December 2006.
EPI Five Year Plan Review 2006.	MOH	Vaccination coverage National Popular Health Campaign Assessment. Evaluation of achievements of MMR Follow up and Rubella eradication campaigns. Situation and surveillance of vaccine preventable diseases. Situation analysis of Cold chain, EPI logistics and financial resources.	2002-2006.
EPI International Evaluation	MOH PAHO/WHO	Overall status of the Expanded Program on Immunization and epidemiologic surveillance in Nicaragua.	November 2003.
Nicaragua Chapter. Health in the Americas 2007.	PAHO/WHO	Every 5 years the Pan American Health Organization conducts a deep health situation and health system analysis in all its member countries and the Region of the Americas in general. A preliminary draft of the Nicaragua Chapter of the publication: "Health in the Americas" was also used to identify bottlenecks of the health system.	October 2007

### 3.2: Major barriers to improving immunisation coverage identified in recent assessments

1. Inter-institutional support is often restricted to the National Popular Health Campaigns, which are carried out only once a year.
2. Due to the absence of cases (vaccine preventable diseases) or outbreaks, some sectors and institutions give no priority to the EPI.
3. Operative programming is not always based on epidemiological risk criteria.
4. Basic EPI information is partially used for programming and decision making.
5. Most health units use INIDE population estimates for goal setting in their programming. These estimates are not always accurate for local levels (municipalities and communities) and in some cases population is overestimated or underestimated.

<sup>13</sup> Within the last 3 years four assessments have been conducted. Documents in full of three of them are attached in Annex 8. Nicaragua Chapter of the PAHO/WHO Publication "Health in the Americas" is the fourth document. This document will be available for public use first week of October 2007 and will be available on line at: <http://www.paho.org>

6. Hard to reach communities do not receive health care in a periodic and systematic way.
7. The flow of financial resources for outreach programs has suffered delays. These funds do not cover all areas adequately.
8. There is a deficit of means of transportation to attain activities in the field in areas with difficult access.
9. There are constrains in time and mobilization resources for personnel to visit hard to reach communities.
10. There is a high rotation of human resources.
11. Operational units lack of an adequate supervision process.
12. Absence of Preventive and corrective maintenance plans for equipment and vehicles.
13. Health services delivery does not take advantage of civil society stakeholders' strengths.
14. There is a low level of community organization.

### 3.3: Barriers that are being adequately addressed with existing resources

- *Inter-institutional support is often restricted to the National Popular Health Campaigns, which are carried out only once a year. Government's programs to fight poverty (such as Hambre Cero) are looking forward a stronger inter-institutional action for poverty reduction; interventions comprise health activities, vaccination included.*
- *Due to the absence of cases (vaccine preventable diseases) or outbreaks, some sectors and institutions give no priority to the EPI. By using a real and potential risk management approach for strategic planning, vaccine preventable diseases have been reconsidered as a public health priority to protect the achievements.*
- *The flow of financial resources for outreach programs has suffered delays. These funds do not cover all areas adequately. The country is conducting a national effort to service coverage extension. As part of this effort, oriented by a Sector Wide Approach (SWAP), 115 of the total 152 municipalities have been selected to receive direct transfer of funds in a periodical basis. There is a new public financial administration law, at the beginning of its implementation several problems occurred due to lack of prevision and planning ahead for the needed adjustments. It is expected that this difficulties will disappear. Besides, the new law incorporates innovations that will reduce bureaucratic procedures; it will permit to register transfers to SILAIS as executed funds, and decentralize the custody of documentation to the SILAIS for accountability.*
- *There is a deficit of means of transportation to attain activities in the field in areas with difficult access and absence of Preventive and corrective maintenance plans for equipment and vehicles. Starting in 2007, as part as the Coverage Extension Strategy, the 115 priority municipalities will count with operational funds for transportation and maintenance.*
- *There are constrains in time and mobilization resources for personnel to visit hard to reach communities. A special program to provide personnel for difficult areas – The Social Supplementary Fund- is ending, but actions will continue with fiscal funds and un-earmarked budget support. Also, on a smaller scale, the possibility to hire human resources with the Coverage Extension Strategy funds also exists.*
- *There is a high rotation of human resources. Internal rotation is been address with the implementation of MAIS, the designation of basic care teams for health territories and to make them responsible for outcomes is a key element of the model. External rotation is been address by a civil service law and salary policy initiative for the health sector.*

### 3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

Not all barriers that are not being adequately addressed have been selected for GAVI HSS support due to budget constraints, the gaps will be analysed with development partners. Problems to be addressed with GAVI HSS support are:

1. Operative programming is not always based on epidemiological risk criteria.
2. Basic EPI information is partially used for programming and decision making.
3. Most health units use INIDE population estimates for goal setting in their programming. These estimates are not always accurate for local levels (municipalities and communities) and in some cases population is overestimated or underestimated.
4. Hard to reach communities do not receive health care in a periodic and systematic way.
5. Operational units lack of an adequate supervision process.
6. Health services delivery does not take advantage of civil society stakeholders' strengths.
7. There is a low level of community organization.

## Section 4: Goals and Objectives of GAVI HSS Support

### 4.1: Goals of GAVI HSS support

The main goal of the proposal is to help to reach and maintain coverage rates greater or equal to 95%, with all vaccines and at all levels in the country, through the strengthening of: organization of community work, health services management, social participation based on local planning, and support for maternal and child basic services delivery in remote areas.

#### Areas of intervention:

1. Health Services Management
  - Information systems:
    - i. The quality of the information is inadequate from the local level to the central level
    - ii. Partial utilization of basic program information for programming and decision-making
  - Supervision and Monitoring: Inadequate process of supervision and monitoring to the operational units.
2. Delivery of services: Remote communities do not receive care on a systematic and periodic way.
3. Involvement of Civil Society
  - Insufficient use, at the local level, of the advantages and strengths of social actors.
  - Lack of/low level of community organization.

#### Lines of action:

1. Training processes directed to health workers and members of the community network.
2. 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 program in the health units.
3. Strengthening the processes of civil society participation and involvement in the health sector response to prioritized problems.



**Objectives:**

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.

**Activities**

1. Visits to selected communities conducted in a comprehensive and systematic way.
2. Human resource's training on collection, analysis, and use of statistics.
3. Development of a municipal quality assurance program; using self training modules from the Course "Promoting a quality culture in health institutions."
4. Improved supervision and monitoring to operational units
5. Complete the process of "sectorization" and assignment of basic health teams responsible for each territory (sector)
6. Civil society stakeholder's training on social participation mechanisms in health management.
7. Health community worker's comprehensive education .

**4.2: Objectives of GAVI HSS Support**

Trough the accomplishment of the aforementioned objectives, it is expected that the GAVI HSS support will help to achieve the following National Health Plan **results**:

1. Maternal, infant and child mortality reduction

Health Issue	Baseline 2006	Year 2010
Maternal Mortality	95.8x1000.000 NVR	63 x 100,000 NVR
Infant Mortality	29 x 1000	24 x 1000 <sup>14</sup>
Under-five Mortality	35 x 1000	30 x 1000

2. Increased coverage of maternal and child health interventions.

Health Intervention	Baseline 2006	Year 2010
Early pregnancy control care	38.4	48.7
Prenatal care coverage	80.6	92
Institutional birth attendance	60.8	75.7
Pentavalent vaccine 3rd dose coverage	87.2	96.5
MMR coverage (measles, mumps, rubella)	97.2	98

3. 44 selected municipalities deliver timely and properly statistical data accomplishing the stipulated route: Health posts-Health Centres-SILAIS- MOH Central level.
4. Actions to develop a "quality culture" implemented. At least one Quality Circle each year functioning at every municipal level.
5. At Least 95% of the recommendations from supervision visits to operational units have been addressed by the corresponding level.

<sup>14</sup> Infant Mortality data base on ENDESA 2005.

6. Community networks functioning.
  - 100% of family files updated at the end of the third year (pregnant women, complete vaccination series in children under 1 year, among other relevant information).
  - Data Analysis activities at community level held twice a year. One activity held at the time of the Participatory Annual Planning Process, another one for follow-up and community feedback.
7. Local citizen participation in health councils functioning and incorporating health issues in the municipal and departmental development plans at 44 municipalities.

## Section 5: GAVI HSS Activities and Implementation Schedule

### 5.1: Sustainability of GAVI HSS support

Sustainability of interventions partially supported by GAVI situates in their incorporation in the 5 Year Health Plan, the Immunization 5 year Plan and Medium Term Expenditure Framework. All this planning instruments are being used by the health Sector Wide Approach.

Plans and MTEF are updated each year to have a three year future scenario. Nicaraguan legislation has incorporated these requirements in order to improve predictability and continuity of resources for priority interventions within the fixed ceilings for each sector.

Actions to be supported by GAVI HSS have priority to reach higher levels of efficacy. 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. The Health Sector Coordinating Roundtable follows up the flow of funds and institutional arrangements for planned priorities.

Activities that will receive GAVI HSS support are part of institutional processes and will be the responsibility of career public servants. No parallel structures will be created, to guarantee the technical continuity of actions.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)				Year 4 (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<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.																
<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.																
<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."																
Activity 3.2: Improved supervision and monitoring to operational units. Support for mobilization of 10 SILAIS teams to local levels four times a year.																
<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 proces of "sectorization" and assignment of basic health teams responsible for each territory (sector)																
Activity 4.2: Civil society stakeholder's training on social participation mechanisms in health management.																
Activity 4.3: Health community worker's comprehensive education																

## Section 6: Monitoring, Evaluation and Operational Research

### 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 a challenge as trying to rise them.

## 6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value <sup>16</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 1-4 years old with second time VCPD controls	Estimated population 1-4 years age group.	Daily registration report	25.2 (61-8)	MOH Office Statistics	2006	100	2011
5. VPCD coverage in < 1 year.	Number of children 1-4 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

<sup>16</sup> National value is presented. Between parenthesis the actual range of indicator status at the municipalities to be intervened are presented. To evaluate progress

<sup>17</sup> Evaluacion de Compromisos Gestion Enero /Octubre 2006 MOH

<sup>18</sup> VPCD stands for Monitoring and Promotion of Children's Growth and Development

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 of 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

NICARAGUA GAVI HSS Application 2007

---

committees	committees							
------------	------------	--	--	--	--	--	--	--

## 6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
<b>Impact and outcome</b>			
1. National DTP3 coverage (%)	It is registered in the vaccine dose application form. Information is consolidated in the monthly immunization report which is submitted to the SILAIS.	Data is analysed comparing it with monthly goals in management commitments	EPI Public Health Surveillance Program
2. Number of districts achieving =80% DTP3 coverage	Data is registered in the immunizations book at health units, then consolidated for the municipal level	The coverage indicator is calculated using under one year old population with 3 <sup>rd</sup> DTP dose. Data is compared with monthly, quarterly, semester and year goals	EPI Public Health Surveillance Program
3. Under five mortality rate (per 1000)	Data is registered in death certificates and deaths books	Indicator is calculated on an annual basis and compared with past years indicators.	MOH Executive Management Bureau of Health Services Child Care Program
4. Maternal mortality rate (per 100.000 registered live births)	Data is registered in death certificates and deaths books. Every time a woman dies for pregnancy related causes a special card is filled out and sent to the MOH central level.	Indicator is calculated on an annual basis and compared with past years indicators. A quarterly analysis of every case is done using maternal mortality cards.	MOH Executive Management Bureau of Health Services Maternal Care Program
5. Infant mortality rate (per 1000 registered live births)	Data is registered in death certificates and deaths books	Indicator is calculated on an annual basis and compared with past years indicators.	MOH Executive Management Bureau of Health Services Child Care Program
6. MMR coverage in < 1 year old children	It is registered in the vaccine dose application form. Information is consolidated in the monthly immunization report which is submitted to the SILAIS.	Data is compared with monthly goals	EPI Public Health Surveillance Program



Indicator	Data collection	Data analysis	Use of data
<b>Output</b>			
1. Early inscription to antenatal care	Data is registered in the daily registration report and then consolidated each month.	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
2. Antenatal care coverage	Data is registered in the daily registration report and then consolidated each month.	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
3. Coverage of institutional birth attendance	Data is registered in the births book and birth certificate	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
4. Percentage of children 1-4 years old with second VPCD control	Data is registered in the daily registration report and then consolidated each month.	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
5. VPCD coverage in < 1 year.	Data is registered in the daily registration report and then consolidated each month.	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
6. Percentage of women with 4 antenatal care controls	Data is registered in the daily registration report and then consolidated each month.	Data is compared with monthly goals	MOH Executive Management Maternal and Child Care Programs
7. Percentage of municipalities presenting statistics reports on time	Reception Report prepared at SILAIS	Statistics Reports are review at SILAIS level. There are fixed dates for the reception of each report. Corrective measures are taken in case of delays or deficiencies.	MOH Statistics Office SILAIS and municipalities Directorates
8. Percentage of municipalities with at least one quality circle in implementation	Semester municipal performance evaluation (quality assurance component of the Health Plan)	Quality circles under implementation are monitored by the Quality Management Program	Bureau of Planning and Development Bureau of Health Services SILAIS and municipalities Directorates

Indicator	Data collection	Data analysis	Use of data
9. Percentage of addressed supervision visits recommendations	Supervision visits reports reviews.	Comparison of follow up reports in subsequent supervision visits.	SILAIS and municipalities Directorates
10. Percentage of municipalities with updated family files	MAIS implementation reports reviews.	Status of created family files. Use of the information for the design of strategies aimed at improving mother and child health care, including immunization	Bureau of Planning and Development Bureau of Health Services Public Health Surveillance Program SILAIS and municipalities Directorates
11. Percentage of municipalities that have carried out two community meetings for health data analysis each year	Semester municipal performance evaluation (stewardship and social participation component of the Health Plan)	Results analysis.	Bureau of Planning and Development Bureau of Health Services SILAIS and municipalities Directorates
12. Percentage of municipalities with working local participation committees	Semester municipal performance evaluation (stewardship and social participation component of the Health Plan)	Results analysis. Problems and priorities identified by communities.	Bureau of Planning and Development Bureau of Health Services SILAIS and municipalities Directorates

#### 6.4: Strengthening M&E system

The MOH has recently developed a unified tool for supervision visits 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 been trained for its application, and teams for educational supervision have been conformed. The departmental team (SILAIS) should carry out quarterly visits but scheduled visits are not being accomplished in a systematic way due to the lack of resources for mobilization.

GAVI HSS will support educational supervision team’s mobilization. Also, at the local and SILAIS level training concerning quality improvement of data and analysis of the information will be conducted to support clinical and public health management.

Monitoring and evaluation of indicators selected for GAVI HSS support’s follow up will rely on existing systems. For indicators 1 to 9, there is no need to set up new mechanisms of collection and data analysis. For indicators 10, 11 and 12 (which are related to the implementation of MAIS and the consequent reorganization health services networks), the implementation of the proposal will support the necessary minor adjustments.

## 6.5: Operational Research

Nicaragua is planning to develop two lines of operational research in the context of this proposal implementation:

- a. Studies of the quality of care provided at health units, in order to make available feedback for the work of quality circles. This line of research will specially consider cultural adequacy of services to different ethnic groups and indigenous community's needs in order to diminish access barriers.
- b. Studies on the improvement of the registry, analysis, and statistical use of the data in health units using auto evaluation techniques of the quality of data. This line of research will considered the introduction of new technologies as a means to improve quality of data.

## Section 7: Implementation Arrangements

### 7.1: Management of GAVI HSS support

Management mechanism	Description
Dr. Alejandro Solis, General Director Ministry of Health Bureau of Planning and Development	Unit responsible for managing GAVI HSS implementation
Health Sector Roundtable Thematic Working Group on Public Health and organized response	M&E of GAVI HSS implementation as the specialized structure that is part of the HSCC in the context of SWAP implementation.
Health Sector Coordinating Roundtable. Mechanism for coordinating GAVI HSS with other system activities and programs	As the technical secretariat of the SWAP, the MOH Bureau of Planning and Development is responsible for consolidating local plans and coordinate with all technical areas within the Ministry of Health. GAVI HSS Support will be considered another partner in the SWAP process supporting the implementation of the 5 year Health Plan.

### 7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Alejandro Solis Martinez. General Director Planning and Development	MOH	Yes	GAVI HSS implementation manager.

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Carolina Siu. Technical Secretary SWAP	MOH	Yes	Responsible for coordinating GAVI HSS with other system activities and programs.
Carlos Cruz Lesage. Evaluation Officer	MOH	NO	Responsible for M&E of GAVI HSS implementation.
Jaime Gonzalez. General Director Bureau of Administration and Finance	MOH	Yes	Financial and budget control for proposal implementation. To approve transfers of fund in accordance with programmed activities and execution advance.
Liana Vega/ Leopoldo Espinoza. Bureau of Health Services	MOH	Yes/No	Oversight of operations at the SILAIS and municipal level.
Omar Malespin. EPI manager	MOH	No	Technical advisor for implementation.
Health Sector Roundtable Thematic Working Group on Public Health and organized response members	Development partners (donors and cooperation agencies including PAHO/WHO, UNICEF and the World Bank)	Yes	M&E and technical support.

## 7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	Funds will be received in the "FONSALUD" <sup>19</sup> United States Dollars Account at the Central Bank of Nicaragua. By request of the Ministry of Health, the Central Bank will exchange dollars into Cordobas (National Currency) and transfer them to the General Treasury of the Republic (Ministry of Finance and Public Credit) in order to be channelled to the Ministry of Health.
Mechanism for channelling GAVI HSS funds from central level to the periphery	On the basis of the quarterly programming, the Ministry of Health will request to the MHCP the resources that are required in order to carry out planned activities. Funds will then be transferred in accordance with the MOH request to bank accounts of MOH Central Level, SILAIS or municipal level or as appropriate.
Mechanism (and responsibility) for budget use and approval	The formulation of the budget will follow the guide of programming and budgeting established by the MHCP in accordance with the Annual Budget Law. The annual budget of the GAVI HSS support will be presented by the MOH Bureau of Planning and Development as part of the MOH general budget at the annual programming meeting of the Sectoral Table. At such meeting the MCSS endorses the budget proposal of the Ministry of Health that subsequently is approved by the National Assembly. The Division of Planning will administer the funds.
Mechanism for disbursement of GAVI HSS funds	In accordance with the approved budget and the Annual Plan of Operation, executing units (central level, SILAIS and municipalities) will present quarterly programming of funds to carry out activities to the General Director of Administration and Finance. After completing the activities, executing units will send a report to the division of planning, at the latest 20 days after each quarter. The division of planning will send the consolidated report of physical activities execution to the administration and finance division and will request them, the next transfers to the executing units. The Administration and Finance Division is responsible for internal audits and supervising procurement procedures.
Auditing procedures	Expenditures vouchers will remain under guard of the executing units and will be subject to the financial audits established for the FONSALUD fund. These include an internal audit in charge of the Office of the Comptroller of the Republic of Nicaragua and an external audit in charge of an auditing company under contract for that purpose.

<sup>19</sup> FONSALUD is the joint budget support fund established for SWAP implementation.

#### 7.4: Procurement mechanisms

Procurements will be carried out under the established procedures of Law 323 “Law for procurement and contracting of the State of Nicaragua”. The law, in its Chapter IV obliges to the creation of Procurement Units at every public institution, these normative units keep all the records and are responsible for planning, give advise to bid committees and monitor all administrative procedures for procurement and contracting .

According to Chapter V, legal procurement mechanisms are the following:

Public Tender: for contracting that surpasses an equivalent of US\$130,000.00

Bidding by registry: for contracting higher than an equivalent of US\$370,000.00

Restricted Bidding: for contracting higher than an equivalent of US\$5,300.00

Purchase by value: for that contracting that does not surpass the amount equivalent to US\$5,300.00.

The second section of the same chapter describes common provisions to all procedures and the content of any bidding call, Name and address of the adjudicative entity, nature and quantity as well as the place of delivery of the goods, advisable or necessary term for the supply of the goods, the date and way of obtaining the specifications, the price that collects the entity bidder, the currency, and method of payment, place, and term for the delivery of bids and the origin of the funds with which the bidding is financed.

In the case of a public tender, the celebration of a meeting of the committee is mandatory to analyse all the offers. This meeting should take place no longer than ten days after the call for proposals. The awarding committee use standard criteria or parameters to evaluate all offers, prepares a detailed comparison report and recommends the granting of the bidding to the supplier that best adjust to the requirements in the competition basis and conditions.

#### 7.5: Reporting arrangements

In the context of SWAP implementation in Nicaragua, every year the Ministry of Health through the General Division of Planning prepares an Annual Report on the advancement of the Operative Annual Plan. This report will demonstrate: proof of appropriate accountability for use of GAVI HSS funds, financial audit and proper procurement (in line with national regulations for FONSALUD); efficient and effective disbursement (from national to sub-national levels; in the context of the SWAp mechanism); and evidence on progress on whether expected annual output targets and longer term outcome targets are being achieved. The Ministry of Health will send copy of this report to all the Partners for Development, including GAVI, in April of every year fulfilling the GAVI requirement to present reports no later than May 15.

**7.6: Technical assistance requirements**

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Plans monitoring at local level	4 years	Quarterly	PAHO/WHO UNICEF Other SWAp partners
2. Strengthening of information systems and data quality, DQS methodology developed by PAHO/WHO.	2 weeks	Every two years	PAHO/WHO
3. Training for operational research.	2 weeks	Every year	Local (Universities)
4. Development of studies of quality of care at health units, in order to provide feedback to the work of quality circles.	4 weeks	Every two years	PAHO/WHO UNICEF USAID QAP
5. Translation of reports.	1 week	Every year	PAHO/WHO

## Section 8: Costs and Funding for GAVI HSS

### 8.1: Cost of implementing GAVI HSS activities

Area for support	Cost per year in US\$					
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	TOTAL COSTS
	2007	2008	2009	2010	2011	
<b>Activity costs</b>						
<b>Objective 1</b>	-	<b>112.692</b>	<b>160.000</b>	<b>155.000</b>	<b>160.300</b>	<b>587.992</b>
Activity 1.1	-	112.692	160.000	155.000	160.300	587.992
<b>Objective 2</b>	-	<b>32.900</b>	<b>0</b>	<b>19.400</b>	<b>19.000</b>	<b>52.300</b>
Activity 2.1	-	32.900	0	19.400	19.000	52.300
<b>Objective 3</b>	-	<b>50.000</b>	<b>55.000</b>	<b>32.505</b>	<b>34.842</b>	<b>172.347</b>
Activity 3.1	-	25.000	25.000	0	0	50.000
Activity 3.2	-	25.000	30.000	32.505	34.842	122.347
<b>Objective 4</b>	-	<b>105.000</b>	<b>103.395</b>	<b>100.400</b>	<b>107.400</b>	<b>416.195</b>
Activity 4.1	-	30.000	20.000	0	0	50.000
Activity 4.2	-	50.000	42.995	50.000	47.000	189.995
Activity 4.3	-	25.000	40.400	50.400	60.400	176.200
<b>Support costs</b>	<b>41.600</b>	<b>43.000</b>	<b>28.000</b>	<b>40.500</b>	<b>47.000</b>	<b>158.500</b>
Management costs <sup>20</sup>	41.600	0	0	0	0	0
M&E support costs	-	18.000	18.000	18.000	22.000	76.000
Technical support	-	25.000	10.000	22.500	25.000	82.500
<b>TOTAL COSTS</b>	<b>41.600</b>	<b>343.592</b>	<b>346.395</b>	<b>347.805</b>	<b>349.542</b>	<b>1.387.334</b>

### 8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Allocation per year (US\$)					
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	TOTAL FUNDS
	2007	2008	2009	2010	2011	
Birth cohort	136,160	137,467	138,558	139,122		
Allocation per newborn	2.5	2.5	2.5	2.5		
<b>Annual allocation</b>	<b>343.592</b>	<b>346.395</b>	<b>347.805</b>	<b>349.542</b>		<b>1.387.334</b>

Source and date of GNI and birth cohort information:

GNI: Central Bank of Nicaragua. Nicaragua Figures, May 2007.

Birth cohort: INIDE, 2006. Nicaragua: Population estimates and projections by sex, year and age, 2007-2010.

<sup>20</sup> Management costs for implementation will be provided by the country. Funds for year of application correspond to technical support provided by GAVI Secretariat through WHO.



**8.3: Sources of all expected funding for health systems strengthening activities**

Funding Sources	Allocation per year (US\$)				
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	TOTAL FUNDS
	2008	2009	2010	2011	
<b>GAVI</b>	343.592	346.395	347.805	349.542	1.387.334
<b>Government</b>	87.079.946	90.166.087	109.790.272	122.198.261	409.234.565
<b>FONSALUD</b>	7.786.590	7.786.590	7.786.590	NA	23,359.528
<b>PAHO/WHO</b>	,200.000	200.000	200.000	200.000	800.000
<b>GAVI/Government</b>	<b>87,423.538</b>	<b>90,512.482</b>	<b>110,138.077</b>	<b>122,547.803</b>	<b>410,621.900</b>
<b>Total Other</b>	7,986.590	7,986.590	7,986.590	200.00	24,159.770
<b>TOTAL FUNDING</b>	<b>95,410.128</b>	<b>98,499.072</b>	<b>118,124.667</b>	<b>122,747.803</b>	<b>434,781.670</b>

Source of information on funding sources:

GAVI: HSS GAVI Proposal

Government: MTEF/MHCP

FONSALUD: Contracted commitments with SWAP partners (Netherlands, Finland, Austria, Spain, UNFPA, World Bank, IDB)

PAHO/WHO: PAHO/WHO Country Office estimates.

UNICEF: .....

Total other: .....

**Section 9: Endorsement of the Application**

**To the applicant:**

- Representatives of the Ministry of Health and Ministry of Finance, and the Chair of the Health Sector Coordinating Committee (HSCC), or equivalent, should sign the GAVI HSS application.
- All HSCC members should sign the minutes of the meeting where the GAVI HSS application was endorsed. This should be submitted with the application (numbered and listed in Annex 1).
- Please give the name and contact details of the person for GAVI to contact if there are queries.

*Note: The signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.*

### 1.3 9.1: Government endorsement

The Government of Nicaragua commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

**Ministry of Health:**

Name: Maritza Cuan Machado

Title / Post: Minister of Health

Signature:



MINISTRA  
DE SALUD

Date: 25/09/07

**Ministry of Finance:**

Name: Alberto Guevara Obregon

Title / Post: Minister of Finance and Public Credit

Signature:



Date: 25 de Septiembre 2007

### 1.4 9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on August 8th 2007. The signed minutes are attached as Annex 1.

**Chair of HSCC (or equivalent):**

Name: Maritza Cuan Machado

Post / Organisation: Ministra de Salud

Signature:



MINISTRA  
DE SALUD

Date: 25 Septiembre 2007

### 9.3: Person to contact in case of enquiries:

Name: Alejandro Solis Martinez

Title: General Director. Bureau of  
Planning and Development

Tel No: 505 2897152

Address: Complejo de Salud  
Dra. Concepcion Palacios, costado  
oeste Colonia Primero de Mayo  
Managua Nicaragua

Fax No. 505 2897152

Email: [dgpd@minsa.gob.ni](mailto:dgpd@minsa.gob.ni)

**ANNEX 1 Documents Submitted in Support of the GAVI HSS Application**

<b>Document (with equivalent name used in-country)</b>	<b>Available (Yes/No)</b>	<b>Duration</b>	<b>Attachment Number</b>
National Health Sector Strategic Plan (or equivalent)	YES	11 YEARS	Annex 4
National Health Policy		2007-2011	Annex 5
cMYP	YES	5 YEARS	Annex 6
MTEF	NO		
PRSP	YES		Annex 7
Recent Health Sector Assessment documents	YES		Annex 8
HSCC minutes, signed by Chair of HSCC	YES		Annex 3
Proposal formulation selected meetings minutes			Annex 9
MAIS conceptual framework			Annex 2
List of priority municipalities			Annex 1

Annex 2 : Banking Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION

Banking Form

Section 1 (To be completed by payee)

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunizations dated 26/09/07, the Government of Nicaragua hereby requests that a payment be made via electronic bank transfer, as detailed below:


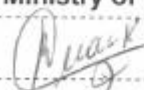
Name of institution: (Account Holder)	Ministry of Health, MINSAs		
Address:	Complejo Nacional de Salud "Dra. Concepción Palacios", costado oeste Colonia Primero de Mayo.		
City and country:	Managua Nicaragua		
Telephone:	(505)2894412	Fax:	(505)2897505
Amount in USD:	(To be filled in by GAVI Secretariat)	Currency of the bank account:	
For credit to:	.....		
Bank account's title	MHCP-RE/FONSALUD-DON.EXTERNA-MINSA		
Bank Account No.:	Account Number: 51398		
At:..... Bank's Name	Central Bank of Nicaragua		

Is the bank account exclusively to be used by this program?

YES ( ) NO ( x )  
General comptroller of Nicaragua  
and the audit firm  
PricewaterhouseCoopers

By whom is the account audited?

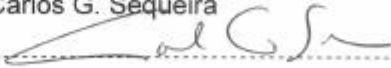
Signature of Government's authorizing official :

Name:	Maritza Cuan Machado	Seal:	
Title:	Ministry of Health		
Signature:			
Date:	26/09/2007		

**Section 2 (To be completed by the bank)**

FINANCIAL INSTITUTION		CORRESPONDING BANK <i>(in the United States)</i>	
Name of the bank:	Central Bank of Nicaragua	Federal Reserve Bank of New York	
Name of the branch:			
Address:	Carretera Sur KM. 7 1/2	33 Liberty Street New York	
		New York 10045 USA	
City & country:	Managua, Nicaragua	United States of America	
SWIFT code:	BCNINIMA	FRNYUS33	
Sort code:			
ABA No. :	021086948		
Telephone #:	(505) 255-7171		
Fax No. :	(505) 2652274		

I certify that the account No. 51-398 is held by Ministry of Finance and Public Credit. Republic of Nicaragua. Beneficiary Customer: Ministry of Health.

<p><b>The account is to be signed jointly by at least ..... of the following authorized signatories:</b></p> <p>Juan José Montoya</p> <p><b>1 Name:</b></p> <p><b>Title:</b> General Treasurer</p>	<p><b>Name of bank's authorizing official:</b> Carlos G. Sequeira</p> 
	<p><b>Signature:</b></p> <p><b>Date:</b> September 26, 2007</p>
	<p><b>2 Name:</b> Iván Adolfo Acosta Montalván</p> <p><b>Title:</b> General Secretary</p> <p><b>3 Name:</b></p> <p><b>Title:</b></p>



**Organización  
Panamericana  
de la Salud**

Oficina Regional de la  
Organización Mundial de la Salud

TO: GAVI – Secretariat  
Att. Dr Julian Lob-Levyt  
Executive Secretary  
C/o UNICEF  
Palais de Nations  
CH 1211 Geneva 10  
Switzerland

*On the 26 September 2007 I received the original of the BANKING DETAILS form, which is attached.*

*I certify that the form does bear the signatures of the following officials:*

	Name	Title
Government's authorizing official	<i>Maritza Cuan Machado</i>	<i>Ministry of Health</i>
Bank's authorizing official	<i>Carlos G. Sequeira</i>	<i>Manager International Central Bank of Nicaragua</i>

**Signature of WHO Representative:**

Name *Socorro Gross Galiano*

Signature

Date

*26 September 2007*

<http://www.ops.org>

Complejo Nacional de Salud Dra. Concepción Palacios  
Apartado postal 1309- Managua, Nicaragua  
Teléfono: (505) 289-4200  
Facsimil: (505) 289-4999

# Annex 1 Prioritized municipalities



**SELECTED MUNICIPALITIES HSS GAVI SUPPORT FOR NICARAGUA**

<b>No.</b>	<b>DEPARTMENT/ SILAIS</b>	<b>Quantity</b>	<b>NAME</b>
1	Boaco	2	San José, San Lorenzo
2	Chontales	10	El Ayote, El Coral, Juigalpa, La Libertad, Muelle de los Bueyes, Nueva Guinea, El Rama, San Pedro de Lovago, Santo Domingo y Villa Sandino
3	Granada	1	Granada
4	Managua	4	Managua, San Rafael del Sur, Tipitapa y Villa Carlos Fonseca
5	Región Autónoma Atlántico Norte RAAN	3	Rosita, Siuna y Waspan
6	Región Autónoma Atlántico Sur RAAS	4	Bluefields, Kukra Hill, Tortuguero y La Cruz del Rio Grande
7	Rio San Juan	3	Morrito, San Miguelito y Almendro
8	Chinandega	2	El Realejo y San Pedro del Norte
9	Jinotega	2	Concordia y El Cua
10	Madriz	3	Las Sabanas, San Lucas y Telpaneca
11	Matagalpa	9	Paiwas, Esquipulas, Matiguas, Muy Muy, Rio Blanco, San Dionisio, Terrabona, La Dalia y Waslala
12	Nueva Segovia	1	Wiwili
	<b>Total</b>	<b>44</b>	

Annex 2  
MAIS Conceptual framework

## Conceptual Framework of the Comprehensive Health Care Model

(MAIS)

Local Comprehensive Health  
Systems  
(SILAIS)



# 1st Series MAIS

N  
WA  
546  
1965  
2007

Nicaragua. Ministerio de Salud. Gobierno de Reconciliación Nacional. Marco Conceptual del Modelo de Atención Integral en Salud (MAIS): Rol del sistema local de atención integral en salud (SILAIS)/  
MINSA: Managua -2ed. Marzo 2007. (Serie No.1 MAIS)

61 p.  
(Contiene Anexos Acuerdos Ministeriales N° 88 2004)

- 1.- EQUIDAD EN SALUD
- 2.- SERVICIOS DE ATENCIÓN EN SALUD
- 3.- CALIDAD DE ATENCIÓN EN SALUD
- 4.- ATENCIÓN PRIMARIA EN SALUD
- 5.- POLÍTICA SOCIAL

©MINSA

Ficha elaborada por la Biblioteca Nacional de Salud

## **FOREWORD**

The Ministry of Health, acting in its capacity of health sector governing body, in compliance with the Constitution of the Republic of Nicaragua, by virtue of the powers vested by the General Health Act, hereby does proudly presents the Comprehensive Health Care Model (MAIS), which gathers countless years of experience gained by the Ministry of Health in serving the Nicaraguan people, supported by donors and social actors.

MAIS is the path we need to walk on to achieve equalization throughout the health sector; this is a challenge that makes us ensure access to health care and narrow existing gaps. It must meet the public expectations to build healthcare services with quality, warmth and respect, guaranteeing the right to health and enforcing the principles of gratuitousness, universality, and solidarity, prioritizing each Nicaraguan family, particularly the underserved. It focus the spotlight on the individual and his/her life cycle as a non-stopping process with interrelated moments of health promotion and protection, recovery and prevention-oriented rehabilitation, as well as actions aiming at the individual, the family, the community and the environment.

This Healthcare Model is based on the PHC principles and assumes the political, social and economic vision of the State towards the health sector. Thus, it becomes the organization of intra and extra sectorial actions and their implementation in a specific changing geographical and demographical zone, in line with local prevailing characteristics. It also guides the organization of health facilities in linked networks to deliver comprehensive services.

This paper includes the SILAIS functions and powers as the entity that enforces the regulatory framework, policies, plans and programs at local levels.

These two papers undoubtedly shall help further the Health Sector Reform oriented to imbue health services with equalization, technical quality and dignifying treatment.

**Dr. Maritza Cuan Machado**  
Minister of Health

# CREDITS

**Dr. Maritza Cuan**

Minister of Health

**Dr. Guillermo González**

Deputy Minister of Health

**Dr. Adrian Zelaya**

General Secretary

**Alejandro Solís Martínez**

Planning and Development Division Chief

## **Technical Team, 2<sup>nd</sup> Edition**

Marisol Gutiérrez Serrano

Dr. Dinora Corea

Ligia Juárez

Dr. Alba L. Solórzano Gaitan

## **Technical Consultation Participants, 2<sup>nd</sup> Edition**

Dr. Mariano Cáceres

Dr. Marta Pastora

Ana L Alvarado

Dr. Fátima Quiroz Narváez

Dr. Juan F Darce

Dr. Teresa Chávez

Dr. Ena Barrillas

Dr. Teresa López

Eng. Maritza Obando

Dr. Luisa Amanda Campos

Dr. Francisca Marin

Bertha Blandón

Maritza Cáceres

Rosário Gaitan

Dr. Martha Galo

Dr. Alfonso Porta

Carla Gutiérrez

Héctor Collado

Dr. Jorge Orochena Santana

Dr. Mariano Lacayo

Dr. Carlos Saenz

## Technical Consultation Participants, 1<sup>st</sup> Edition

Marina Isabel Avilés  
Dr. Carlos Cruz  
Dr. Lissette Selva  
Dr. María Delia Espinosa  
Dr. Leopoldo Espinosa  
Rosario Hernández  
Miguel Medina  
Dr. Indiana Herrera  
Marisol Gutiérrez  
Nubia Orozco  
Hector Collado  
Dr. Douglas López F  
Dr. Leonor Morín  
Dr. Benjamín Urizar T  
Dr. Francisco Escobar  
Dr. Isidro Valle González  
Dr. María Angélica Gómez  
Dr. Mario Cruz Peñate  
Dr. Carlos Fletes  
Dr. Wilmer Beteta López  
Dr. Verónica Gaitán  
Dr. Carlos Pacheco  
Dr. Yelba Logo  
Dr. Carmen María García  
Dr. Adalgisa Dávila

Dr. Jaime Hernández  
Maritza Rizo  
Dr. Donald Jiménez  
Juana Ortega  
Josefina Medrano  
Dr. Martha Reyes Álvarez  
Dr. Mario Lacayo  
Dr. Pedro León Pérez  
Ligia Rodríguez  
Dr. Rene Mendieta  
Dr. Norman Herrera M  
Ligia Juárez  
Reyna Castillo  
Dr. Lucy Villagra  
Ana Cecilia Silva  
Dr. Sonia Doña  
Dr. Ximena Gutiérrez  
Dr. Martha Pastora  
Dr. Guillermo Alfaro B  
Dr. Maria Martha Solórzano  
Dr. Luisa Amanda Campos  
Dr. Mauricio Dinarte  
Dr. Fernando Reyes  
Georgina Miranda  
Dr. Mario Ortiz

# CONTENTS

<b>FOREWORD</b> .....	<b>A</b>
<b>CREDITS</b> .....	<b>B</b>
TECHNICAL CONSULTATION PARTICIPANTS, 2 <sup>ND</sup> EDITION.....	B
TECHNICAL CONSULTATION PARTICIPANTS, 1 <sup>ST</sup> EDITION.....	C
<b>I. ....</b>	<b>INTRODUCTION</b>
.....	<b>1</b>
<b>II. ....</b>	<b>BACKGROUNDS</b>
.....	<b>2</b>
<b>III.....</b>	<b>RATIONALE</b>
.....	<b>4</b>
<b>IV. MANDATE</b> .....	<b>5</b>
<b>V. ....</b>	<b>OVERVIEW</b>
.....	<b>8</b>
5.1 DEFINITION.....	8
5.2 MODEL PURPOSES.....	8
5.3 MODEL OBJECTIVES.....	8
5.4 PRIMARY HEALTH CARE AND THE MAIS.....	10
5.4.1 Healthcare Model Principles.....	10
5.4.1.1 Accessibility to health services.....	10
5.4.1.2. Comprehensiveness of actions in health services.....	10
5.4.1.3 Longitudinal nature in the health care process.....	11
5.4.1.4 Coordination between health care levels.....	11
5.4.1.5 Cross-cutting principles in the health care model.....	12
<b>VI. ....</b>	<b>HEALTHCARE MODEL COMPONENTS</b>
.....	<b>12</b>
6.1 CARE COMPONENT /RENDERING OF SERVICES.....	12
6.1.1 Elements of provision.....	12
6.1.1.1 Population groups.....	13
6.1.1.2. Individuals receiving care.....	16
6.1.1.3 Set of Health Services.....	17
6.1.1.4. Forms of service delivery.....	19
6.1.1.5 Organization for providing services.....	21
6.1.2 Key aspects to develop the provision component.....	25
6.2 MANAGEMENT COMPONENT.....	27
6.2.1 Roles and functions of management levels.....	27
6.2.1.1. Governing body.....	27
6.2.1.2 SILAIS.....	29
6.2.1.3 Citizen participation.....	31
6.2.2 Operations control.....	32
a) <i>Agreements, commitments, contracts, and understandings</i> .....	32
b) <i>Information system</i> .....	32
c) <i>Control panel</i> .....	33
d) <i>Inspection system</i> .....	33
e) <i>Operations control and citizen review</i> .....	33
6.2.3. Key aspects to develop management component.....	33
a) <i>Decentralization of resources</i> .....	33



b) <i>Quality guarantee</i> .....	33
c) <i>Social participation</i> .....	33
d) <i>Management and leadership capacities</i> .....	34
6.3 FUNDING COMPONENT .....	34
6.3.1 Funding from non-tax collection system .....	35
6.3.2. Funding from the tax collection system .....	37
6.3.3. Funding from voluntary system .....	37
6.3.4. Key aspects to develop funding component .....	38
a) <i>Change in the allocation and payment mechanisms</i> .....	38
b) <i>Capacity to explore and identify opportunities for funding</i> .....	38
c) <i>Developing technological capacity for financial-administrative control</i> .....	38
<b>ANNEX</b> .....	<b>39</b>
ROLE OF THE LOCAL COMPREHENSIVE HEALTH CARE SYSTEM (SILAIS) .....	40
I. Introduction .....	40
II. Background .....	40
III. Rationale .....	41
IV. Frame of reference.....	42
V. Concept of SILAIS .....	44
VI. Functions.....	44
VII. Glossary .....	46
MINISTERIAL AGREEMENT NO. 88-2004 .....	49
MINISTERIAL AGREEMENT NO. 89-2004 .....	50

## I. INTRODUCTION

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.

The main efforts by the State aim to improve the quality of benefits in the social sector, particularly in education and health. These are enduring a difficult transition situation, towards a government that acknowledges the limited ability for funding, wishing to improve equity in the service delivery, efficiency, and quality.

With financing from the funds set for the non tax-paying system (funds of the Treasury of the Republic, donations, etc.), vulnerable groups must be favoured, prioritizing the mother-child group, the elderly, handicapped people, and the groups covered by welfare programs.<sup>1 & 2</sup>

The Ministry of Health (MINSa) is the governing body in the health sector, as stated therein the **General Health Act N° 423**. The **Bylaws of General Health Act N° 423** outline that the organization of a Comprehensive Health Care Model (MAIS) includes public, private facilities and the community. This makes the MAIS a sectoral model.

An analysis of the current health situation indicates problems in efficiency, equity as to access, funding, and quality. In this context where needs are on the rise with more and more limited resources, the Ministry of Health has to formulate a proposal for a Comprehensive Health Care Model to be more efficient, equitable, effective, and efficient than the current model.

This document outlines the main lines on a sector-wide transformation to health care, way of delivery, decision making, and necessary funding for its implementation and development. This initiative boosted by MINSa is called Comprehensive Health Care Model (MAIS).

In its first section, the document contains background and justification for a required change to take place in the Nicaraguan health sector. These refer to the main legal principles so that MINSa assumes a leading role in formulating such initiative.

Later, it covers definition, intentions, objectives, and principles of the MAIS, describing finally the core of the proposal in its three components: provision of services, management, and funding.

MINSa will conduct such process. It must have consultations, on a permanent basis, before the relevant bodies or levels in civil society and health sector to reach some

---

<sup>1</sup> Nicaragua. General Health Act N° 423. The Official Gazette, year CVI, N° 91 of 17 May 2002, Articles 5 and 50; pp 3474 and 3483

<sup>2</sup> Nicaragua. Bylaws of the General Health Act, Decree N° 001-2003, Official Gazette year CVII N° 7 of 10 January 2003, Article 6; p 106

agreements or consensus in such development, encouraging implementation and participatory transition with an spirit and intention so that beneficiaries of the Nicaraguan health sector improve their health status, joining and managing such process. Knowing that the technical challenge is big, involvement of all the actors to be invited is expected.

## II. BACKGROUNDS

Early in the 20th Century, health care was provided by family doctors in main urban areas. Hospitals were health centres to help destitute people, and these centres were run by religious orders, with philanthropic support from well-off people in society and the disinterested professional collaboration of local physicians. Public health actions, mainly aimed at communal hygiene, were ruled by the Police Bylaws, published by decree of 25 October 1880 and modifications of May 1938. Large population groups were served by traditional agents such as midwives, healers, and wizards.

The Health Sector Reform got started with the Act or Law that created the State Ministries in November 1948 (creating the 'Ministry of Public Health'), and it continued in 1955 with the 'Law of Social Security,' organizing the institutions in such sector according to the population characteristics and the kind of care to be provided. Thus, such Health Ministry was in charge of public health and hygiene aspects, and the 'Nicaraguan Social Security Institute' was responsible for providing ambulatory and hospital care for those workers affiliated with this institution or agency and its beneficiaries.

The 'Local Welfare Work Committees.' which were working in each province in the country, were presided over by a board of dignitaries. Facilities were managed by religious orders, providing "pensioner services"<sup>3</sup> to the people that could pay for such use; likewise they continued providing care to destitute people.

The 'National Board for Health Care & Welfare Work' was responsible for coordination of institutions in this sector. Private medicine continued with its liberal practice.

In 1979, as a result of transformations caused by the Sandinista revolution, a 'National Universal Health System' is created. The system unified under the rule of the Ministry of Health all the facilities that provided health services, both public facilities and the private ones that were confiscated.

For this reason, MINSa became almost an exclusive provider of health services to all the population. In the light of those reforms, such sector boosted a process to extend coverage, mainly as for primary care services in view of the then adopted goal, that is, to health for everybody in 2000 and the Primary Health Care strategy. In this period, development of social participation was determinant for coverage extension. The National Health Council was established.

With the changes made in 1990, elements were introduced to make a third generation of health reforms in Nicaragua. This introduces objectives such as equity and efficiency in the National Health System, identifying for such end the need to separate functions of

---

<sup>3</sup> Such pensioner services consisted of provision of beds in public hospitals with different comfort conditions, including the infirmary care and diagnosis and treatment services (clinical laboratory, X-rays, operating rooms, pharmacy, and others) to people that could pay for such comforts. As a rule, these services did not include the medical schedules that were agreed bilaterally by patients.

stewardship, funding, and provision of services. This reform has been in force up to now, and its construction is adjusting to the country's ongoing political, social, and economic changes.

The first important contributions of the current process of reforms have been:

- Creation of the SILAIS, in 1991.
- Organization and development of social participation bodies (the national, provincial, municipal councils, and consultation committees in hospitals).
- Development of Comprehensive Care Model to serve Women and Children as of 1995.

The comprehensive care model to women and children has a conceptual framework of a comprehensive care model focused on woman-child. This was intended to: (i) break vertical positions and fragmentary programs; (II) reduce lost opportunities; (III) increase health care coverage; (IV) optimize human, material, and financial resources; (v) strengthen the State modernization processes; (vi) introduce new care-giving approaches to prioritized groups; and (vii) facilitate active community participation<sup>4</sup>.

Assessments made to the development of this model<sup>5</sup> indicate that comprehensiveness was not achieved, remaining within the framework of woman-child care, with extension only to adolescents, failing to address other components in the cycle of life. Vertical and parallel programs with insufficient inter-programmatic coordination were kept.

In spite of deficiencies found, it is possible to point out that the actions carried out in the framework of this model have contributed to reduce maternal-child mortality in the nation, but efforts still remain to be made to diminish it. Another aspect that must improve is equity in the access to such services.

Implementation took place in various manners depending on the geographic territory, but there is no systematization of it.

Important contributions in this stage of reform have been attained in the sectoral modernization framework with preparation of the General Health Act, Law 423, and its Bylaws, having legal instruments to ensure equity and assurance in health matters. Strategies have been promoted to guarantee access and improve funding for health care to population groups, in extreme and high poverty conditions, that live far away from health facilities. There have been institutional processes leading to improve efficiency in terms of increasing availability of the existing limited resources. Work has been done on the definition and implementation of management mechanisms and procedures to set up a modern hospital in Nicaragua, which is intended to show self-management, competitiveness, and high degree of efficiency.

---

<sup>4</sup> Nicaragua. Ministry of Health. Programa de capacitación sobre el modelo de atención integral a la mujer y la niñez. Proyecto de desarrollo de un modelo de atención integral materno-infantil PAHO/WHO-PL-480. Managua 1995 (mimeographed).

### III. RATIONALE

Health facilities in the country historically have focused on healing or curative care with tendency to specialized care. In 1994, MINSA started implementation of a comprehensive care model that highlighted actions for the mother-child binomial, impacting on morbidity-mortality of this population group.

The health expenditure<sup>6</sup> in Nicaragua accounts for 7.5% to the 2002 Gross Domestic Product. This is equivalent to U\$57 dollars per capita. This ratio is similar to that in other Central American countries. The health expenditure for the year 2002 is assumed mainly by the households (58%) and funding of the treasury (29%). Compared with the last decade, the household contribution is increasing, whereas the government portion has been reduced.

According to the last survey on the living conditions in 2001, the population living in poverty accounts for 45.8%, of which the population in extreme poverty is 15.1%. Rural extreme poverty is 5 times higher than that in urban areas.

In terms of coverage according to data from the 2001 'Nicaraguan Demography and Health Survey' (ENDESA)<sup>7</sup>, in spite of the high level of prenatal care in Nicaragua, only 2 out of each 3 births has professional care in childbirth. Even though the percentage of immunization coverage by biology turns out to be satisfactory, the percentage of children aged one year old with complete vaccine scheme is 63%, which is lower than the optimal coverage.

From a geographic point of view, a critical factor interfering in access of the population to the health facilities is the population density, which ranges between 7 and 530 inhabitants per square kilometre. This has made, in some places, the population use only community resources to meet their needs.

From a health perspective, in accordance with the 2001-ENDESA results, the poorest quintile of the population in relation to 20% of the population with more income shows the following differences:

- Likelihood of child mortality is three times higher;
- Total fertility rate is three times higher;
- Chronic undernourishment is seven times more likely;
- Percentage of undernourished women is four times higher;
- The use of the public health care services in childbirth is three times less;
- Pattern in the fulfillment of vaccination schemes is 10 points less;
- Prevalence of Acute Diarrheic Diseases (EDA) and Acute Respiratory Diseases (IRA) is twice more frequent;
- The use of modern contraception methods is one third less;

This situation requires innovative approaches to improve equity, quality, and efficiency in rendering health services in order to create community participation spaces to focus on health expenses and optimize financial, technological, and human resources available

---

<sup>6</sup> Nicaragua. Ministry of Health. Informe de Cuentas Nacionales de Salud, 2002.

<sup>7</sup> Nicaragua. Ministry of Health & 'Nicaraguan Institute for Statistics & Census.' Encuesta Nicaragüense de Demografía y Salud. Managua. 2001.

locally, generating participatory processes that shape a prototype care model in the health sector.

As progress is made in the health sector reform process, a need arises to adopt a health care model which guarantees access to health services. This model has to be able to reduce the gaps in the health situation between population groups by level of poverty, sex, age, ethnic group, and other identified characteristics in such human groups, in order to eliminate the main problem in health, that is, inequality.

## IV. MANDATE

In addition to the political context, there exists a legal framework that facilitates the design of a health care model that is efficient, equitable, effective, and participatory.

According to **Article 59 in the Constitution**, "*Nicaraguans have the right to health, on an equal basis. The State shall establish basic conditions for health promotion, protection, recovery, and rehabilitation.*

*It is responsibility of the State to manage and organize the health programs, services and activities, promoting grass-roots participation to be advocates of health. Citizens have must abide by the sanitary measures to be determined "*

Another responsibility is that the "*State shall try to set programs to benefit the handicapped for their physical, psycho-social and professional rehabilitation and job placement.*" (**Art. 62 of the Constitution**)

These articles have been supplemented by the **General Health Act**, Law No. 423, in which the purpose of it is set forth in article 1: "*to protect the right of every person to enjoy, keep, and recover health, in harmony with the legal provisions and special rules in force*". Likewise, the said law, in its Article 5, states the basic principles. These are: "*free of charge, universal nature, solidarity, comprehensiveness, social participation, efficiency, quality, equity, sustainability, responsibility of the citizens*".

**The Law of Medicines and Pharmacies**, Law 292, in its article 3, stipulates that: "*The Ministry of Health is the competent body of the State to execute, implement, and enforce the current Law.*

*The necessary technical and administrative actions to ensure evaluation, registration, control, monitoring, execution, verification in the quality and sanitary monitoring of medicines, medicated cosmetics, and medical devices to be used by human beings shall be carried out through the corresponding level and its quality control laboratory. "*

**The Statute of Autonomy of the Regions on the Atlantic Coast of Nicaragua**, Law 28, indicates that: "*The Autonomous Regions hereby established by this statute are people with legal capacity and of public law. They follow the corresponding national policies, plans, and orientations. They have through their administrative agencies the following general duties: Number 2. To manage programs in health, education, culture, supplying, transport, community services, etc., in coordination with the corresponding State Ministries*".

**The Law of Citizen Participation**, the purpose of Law No. 475 is: *“to promote full exercise of citizens in political, social, economic, and cultural spheres, by creating and using institutional mechanisms that allows for a fluent interaction between the State and Nicaraguan society, contributing so to strengthening of freedom and a representative and participatory democracy stated at in the Constitution of the Republic.”*

In addition to the legal ground already mentioned in the Comprehensive Health Care Model, it is based on the **National Development Plan** in which three guidelines are set for the health sector: *i) increased coverage and quality, II) to promote changes in the behaviour of households to increase prevention; and III) to deepen sectoral reforms vital to MINSA, as part of the modernization process.* “

Based on the current legislation and the **National Development Plan**, the Health care model has been prepared. This is intended not only to extend coverage of health services, rearrange and optimize the use of human and physical resources in this sector, but also to improve equity, quality, effectiveness, and efficiency, enhancing satisfaction of its users and providers in such sector.

This can be achieved by means of changes in the care approach and the model for allocation of resources and responsibilities, in the case of the public sector; in spreading out the offer and labour specialization, according to well-defined care levels; and inclusion of the organized community into process of planning, control and evaluation of health services.

This model is also expected to contribute to make a change in attitude in the population, with respect to health. So that health is no longer seen and addressed as an exclusively individual problem, but rather as a collective and multifactor phenomenon, where everybody has responsibility to keep and improve health, as set forth in **Art. 13** of the **General Health Act**, stating that: *“The purpose of health promotion includes the actions that must be undertaken by the people, communities, and the State in order to create, keep, and improve desirable health conditions for all the population, encouraging in individuals proper attitudes and practices for healthy life styles and motivating their participation in favour of individual and collective good health”*. This article gets everybody involved for health benefits.

The **Law of Consumer Advocates**, Law No. 182, under article 1, guarantees that consumers or users purchase better quality goods or services, in their commercial transactions, through a friendly, fair, and equitable treatment from individual or collective public or private enterprises. A patient as a user, consumer of health services, demands a guarantee in the quality of such services.

### **National policy framework**

The current National Health Policy is aimed to harmonize performance of public and private institutions and organizations that impact on health, creating effective articulation mechanisms for developing actions that find solutions to the health problems felt by the population, under the leadership and stewardship of the Ministry of Health (MINSA).

The general guidelines in the national health policy are aimed to change the health situation of the people, households, community and their surroundings, emphasizing on promotion and prevention, as well as in a respectful and human treatment in the health services under conditions of equity, solidarity, social participation, and access to health

care. Such policy tends to strengthening of a new health care model, taking as a point of departure a comprehensive and modern conception of health care.

In this context, the National Health policies state:

1. To develop preventive health actions, articulating efforts of the state institutions, with broad active participation of the community and different voices from the civil society.
2. To change the curative or healing and individual care model moving towards a household care model that includes addressing community and environmental issues, highlighting health education, prevention, promotion, and recovery, implemented interventions differentiated to the people living in poverty conditions, rural areas difficult to be reached and urban marginalized zones with deteriorating hygienic-sanitary conditions.
3. To revert privatization, eliminate charges, ensure a free of charge and comprehensive health care with humanized treatment in such public services.
4. To increase medical supplies and replacement materials to overcome the deficit faced by the health units.
5. To adapt health interventions to the geographic, political, cultural, and ethnic characteristics, rediscovering the use the popular and traditional medicine and other non-western medicine.
6. To improve basic infrastructure in the health service network and basic conditions in hospitals.
7. To develop to a broad education and training program for the health personnel to attain sustainability of interventions according to the new health care model.
8. To regulate operations of 'previsional' (private clinics or hospitals serving INSS beneficiaries) medical firms to provide quality services to the workers and their beneficiaries are dependents, encouraging affiliation to the social security system known as INSS.
9. To articulate and harmonize foreign corporation based on the health policies and the urgent necessities of the population.

Realization of such policies will enable to create new conditions to provide care to the population more efficiently, so that such impact on health issues contributes to the country's development.



## V. OVERVIEW

### 5.1 Definition

The Comprehensive Health Care Model, as stated in Law 423, is the health instrument containing the political and economic vision of the State within the sphere of the health sector. It is a form of organization of intra and inter-sector operations, as well as its equitable and efficient implementation in a given geographic-population area, variable according to its characteristics.

It must define the manner in which the population and service provider interact, indicating the population groups and their areas of care, including how providers get organized so that care provided comply with the principles set forth in Law 423 and its Bylaws, and the way of funding and managing resources to be able to provide quality services equitably and efficiently.

The Comprehensive Health Care Model is the set of rules, procedures, instruments, manuals, and provisions that present the action lines for their implementation. It focuses on people seen as an on-going process, with interrelated moments in promotion and protection of their health, recovery, and rehabilitation when the population or a person gets sick or suffers from handicaps, all of this with a broad preventive approach and actions targeted at a person, family, community, and the surrounding environment.

The New Comprehensive Health Care Model must generate initiatives for change in the culture and structures of the health sector to meet the needs and exercise human rights, contributing to improve the quality of life throughout this cycle.

### 5.2 Model purposes

The purpose of the Comprehensive Health Care Model is to contribute to health improvement among the Nicaraguan population, diminishing mortality and premature handicap, preventable morbidity, throughout the cycle of life of the population by means of:

- Reducing the gaps in the health situation and access to such health services among population groups by level of poverty, sex, age, ethnic group, and other characteristics shown by such human groups.
- Meeting the expectations of the population in connection to nonclinical process of services: quality care, warm feeling, respect to people, and guidance to users.
- Reducing the financial risk taken by each family when incurring in health costs, protecting particularly the most vulnerable ones, furnishing free health services in the publicly-owned facilities, and improving the quality and capability of solution.

### 5.3 Model Objectives

In accordance with the Bylaws of the **General Health Act**, the Comprehensive Health Care Model<sup>8</sup> has the following objectives:

---

<sup>8</sup> Nicaragua, Reglamento, Ley General de Salud (Bylaws, General Health Act). op. cit. Art. 39

1. *To improve the health conditions of the population, generating timely, effective, quality activities, with warm feeling, capable of making personal, family, and community changes, focusing on health prevention and promotion.*

This objective confirms the purpose of the health sector: to improve health conditions of the population in this country.

Through this objective, it is pursued to redirect the health actions from an essentially healing logic towards another one, focusing on health promotion and protection and prevention of complications and consequences of diseases in people, their family members, and their communities. It is especially important to foster self-care of the people and care provided by the same family members, mutual help between community members strengthens solidarity bonds in the same community.

2. *To satisfy health service needs among the population.*

Improving health conditions among a population takes into consideration their health needs and their expectations, starting as of the results of user satisfaction surveys. This entails the consensus nature that must have a health care process, identified as what is known as “social health delivery,” in which the population far from being seen as an object to the health care, the population becomes the main participant.

3. *To protect the population from epidemics*

The health care model emphasizes on promotion and prevention. Its priority is prevention of epidemics, both those caused by communicable diseases and those non-communicable ones. It means that intervention must take place on risk factors both in the environment and in those related to habits and behaviours that have direct or indirect bearing on health.

4. *To improve the service quality, responding to expectations of the population receiving quality health services, with a human warm feeling.*

Improvement in service quality, based on promotion for an integral development of human resources in the health sector, affects the health labour market and the application of the health regulation for quality control in delivering health services in the different facilities, meeting so the expectations of the population in receiving quality health services and a human warm feeling.

The direct care provided to the population in publicly-owned health facilities must be delivered free of cost and with quality, which must include: inputs for promotion and prevention, basic medicines, laboratory studies, as well as other therapeutic means that use surgical services.

5. *To strengthen articulation between the different members in the health sector, as well as the inter-institutional and inter-sectoral coordination.*

This objective means strengthening of the response capacity in public services through articulation of the different health care levels, as well as coordination/consensus forming in the State bodies in the different administrative levels with different social actors (institutions, sectors, citizen participation bodies and citizens) in the planning, implementation and control of interventions and their outcomes for health improvement.

Because health is neither the outcome from a MINSA action nor from a sector in particular, the Comprehensive Health Care Model includes both an inter-institutional

and inter-sector approach in terms of synergy of the different actions carried out by everyone.

In addition, a multidisciplinary and multi-professional approach is ensured to impact, in the best possible way, on the health situation of the different human groups in the country.

## 5.4 Primary Health Care and the MAIS

The Comprehensive Health Care Model will be based on the primary health care strategy<sup>9</sup>, understood as “the essential health care based on methods and practical technologies, scientifically based and socially accepted, made available to everybody and families in such community, through full participation and at a cost that the community and country can afford in every stage of their development, with a spirit or sense of responsibility and self-determination<sup>10</sup>.”

In order to improve health, primary care focused on people’s health in the contexts of other determinants, that is to say, in the physical and social setting in which people live, study, work, and entertain themselves, more than on specific diseases.

### 5.4.1 Healthcare Model Principles<sup>11</sup>

#### 5.4.1.1 Accessibility to health services

Ordering of the health services will be based on criteria of geographic, cultural, gender, economic accessibility, etc. that ensure to open a door to favour the first contact with users, including the indigenous communities and ethnic groups, in order to foster trust and credibility in such services.

The Comprehensive Health Care Model must specify the principles of free, universal health, solidarity and equity<sup>12</sup>. Also, it is assumed that the accessibility principle of the **National Population Policy**<sup>13</sup>, passed in 1997, that acknowledges:

- *“Respect for legal, cultural, moral and religious principles of the population”.*
- *“The integrating role of the family with relations based on respect, solidarity, and absolute equality in the rights and responsibilities between men and women”.*
- *“Respect for ethnic diversity and the right each community has to keep and develop its own cultural identity”.*

#### 5.4.1.2. Comprehensiveness of actions in health services

The Comprehensive Health Care Model will consider a person as a bio-psychosocial being that belongs to a family and community, with duties and rights for conscious and systematic decision-making concerning his/her health, members of his/her family, community as well as for protection and improvement in the surrounding environment.

---

<sup>9</sup> Ibid. Art. 40. p. 112

<sup>10</sup> World Health Organization. Alma-Ata Declaration. International Conference on Primary Health Care. September 1998. Paragraph VI.

<sup>11</sup> Nicaragua. Bylaws of the General Health Act. op. cit. Art. 40.

<sup>12</sup> Nicaragua. General Health Act. Law 423. op cit. Art. 5.

<sup>13</sup> Nicaragua. Ministry of Social Action. Política de Población. Managua 1996.á

It means the orientation of care towards a comprehensive solution to health problems, with an approach to health promotion, disease prevention, protection, care, and rehabilitation. It means to assure that different services are delivered at the same time and in the territories where people and/or groups need it. This means territorial and population responsibility on the part of the manager-provider entity.

For this reason, comprehensiveness requires to identify adequately a whole range of health needs of the users, identifying factors, for example, both existing risk<sup>14</sup> and health protectors in them, their families and communities, and having resources to handle them, considering their cultural interests and characteristics.

#### **5.4.1.3 Longitudinal nature in the health care process**

This is a long term personal relation established between care providers and users of health service. This characteristic in the care model means that there is a place, a person, or a working team that provides care to users in the course of time, whether for prevention or diagnosis actions and treatment.

Longitudinal care means users belonging to a population identify a facility as theirs, a team or person in charge of providing services also means that a personal provider (personally or working team) must give regularly care to users, focused on the person (not on a disease). The principle indicates that the user-provider relation remains during a finite or indefinite period of time, if is not modified explicitly.

The Longitudinal nature in care-giving means that the health team taking care of users is concerned with comprehensive care in different sector levels. And this characteristic of the Nicaraguan care model is one of the pillars to assure articulation between the different care levels and for cohesion of the health service network in the country and thus referral and counter-referral.

#### **5.4.1.4 Coordination between health care levels**

The Nicaraguan health sector, when getting organized in service network by care level and with health facilities of diverse complexities, requires identifying clearly the population to be served. They can go and have access to such facilities to be served in diverse aspects of their health needs. Coordination must be sufficiently effective concerning how to guarantee effective access and continuity of care-giving.

Coordination is the cornerstone for articulation of services and its organization to be responsive to the framework defined by the Nicaraguan Comprehensive Health Care Model. This means to evolve towards new forms of care shared between professionals with different profiles, specialization degree, located in facilities with different care levels.

This must be based on a clear understanding of a user, personnel that refers to another service or facility in the network, as well as a clear understanding among personnel that receives him/her, regarding the importance and responsibility of assuring continued care of such user.

---

<sup>14</sup> WHO, in its Report on the Health in the World 2002, defines the risk as a probability of an adverse result, or a factor that increases such probability".

#### 5.4.1.5 Cross-cutting principles in the health care model <sup>15</sup>

The principles of free of charge, universal nature, solidarity, social participation, efficiency, quality, sustainability, and responsibility of citizens set forth in the General Health Act must be considered in a cross-cutting manner as part of such Model.

## VI. HEALTHCARE MODEL COMPONENTS

The Bylaws of the General Health Act indicates that the Comprehensive Health Care Model has three components: **provision, management, and funding**.

In its most visible aspects, the Comprehensive Health Care Model is the product of a dynamic interaction in the care levels (provision) with management levels in the health sector (management) and with the different funding schemes.

The expected outcome is effective and efficient health service, which generates an equitable improvement in the health situation of such population and gradually higher satisfaction levels among users, assuring a financial protection in the face of risks concomitant to the cost of services.

### 6.1 Care component /rendering of services

Provision of services is the set of specific, defined, and organized activities provided to the population and environment, through an articulated **service network**.

Providing services includes criteria of distribution for the population to be served and the principles relating to the care process, developing the processes of **clinical management and care management**, focusing on the satisfaction of users.

Providing services considers carrying out activities to promote healthy habits and life styles, protection from diseases, health recovery and rehabilitation when having handicaps.

The provision component incorporates as a core premise, health promotion<sup>16</sup>. This is a process through which people and communities own the means and instruments required to be able to have a greater control of health determinants, and thus improving their health status.

#### 6.1.1 Elements of provision

The elements included in this component are:

---

<sup>15</sup> General Health Act, Art. 38.

<sup>16</sup> The approaches and strategies for health promotion were submitted in the declaration of the International Conference on Health Promotion held in Ottawa, 17-21 November 1986, known as "the Charter of Ottawa." This declaration was taken in the declaration of the International Conference on Health Promotion held in Santafé de Bogota, 9-12 November 1992, under the auspices of PAHO/WHO and the Ministry of Health of Colombia, to which the Nicaraguan Ministry of Health adhered as a participant to such conference.

- a) The population groups, defined according to the cycle of life of people and their vulnerability.
- b) Health care scenarios that include health actions targeted at people, families, community and physical and ecological environment.
- c) Set of Health Services.
- d) Forms of service delivery.
- e) Organizing networks

Rendering services is focused on comprehensive care to people. Likewise, for the purpose of conducting activities, the differentiated situation of the population groups is considered according to the cycle of life in a child, adolescent, adult, and elderly person, taking into consideration the epidemiological pattern, risk, gender differences, and vulnerability of the population group.

When making contact with the health sector, every person must be approached from a member perspective, of her/his inclusion in a family unit and a community to which she/he belongs. In addition, attention must be paid to the environment in which she/he is developing.

#### **6.1.1.1 Population groups**

Specific forms of health action will be considered consistent with groups and segments of the population, due to their age, sex, ethnic group, customs or disease that require special practices. These must favour the comprehensiveness of benefits and adaptation to peculiar conditions of people, as well as changes in the spheres of activity (family, school, community), according to their nature and complexity<sup>17</sup>.

Every person lacking the means to meet basic needs to his/her human development, as well as special groups of people according to bio-psychosocial factors, among others, the mother-child binomial, the elderly, and the handicapped are considered vulnerable population<sup>18</sup>.

To identify vulnerable groups, these must be focalized, based on the following criteria of risk:

- Geographic accessibility.
- Access to basic services.
- Communities with minimum level of development.
- Income inequalities
- Gender disparities.
- Incomparable opportunities between (handicap) people.

In addition to vulnerable groups and special populations, the following population groups are defined by cycle of life, as target populations in the Health Care Model:

##### *1) Children*

---

<sup>17</sup> PAHO/WHO. Review and Development of Health Care Models. May 1995)

<sup>18</sup> Nicaragua. General Health Act, op. cit. Art.8, subsections 2 and 3

This group begins at the moment a human being is conceived, and it includes individuals up to 10 years of age. Children are the most helpless population group in society because they are dependent on different degrees.

Childhood periods and the importance in each one of them.

**Embryonic and fetal period**, care or caring of children in this period is given through prenatal care to the mother. This period ends at birth, since then satisfaction of its needs will be less automatic than in the womb of a mother, requiring so a greater care.

**Neonatal or Newborn baby**, this begins at birth and it ends after 28 complete days (0-28 days) since the time of birth. This period includes the early neonatal lasting up to 7 complete days (0-6 days) after the birth, period in which many serious problems are shown associated with care from childbirth and immediately to the same newborn baby<sup>19</sup>.

**Post-neonatal**, this goes from the 29th day to the first one year of life.

**Small suckling infants** are children under one year of age, and it is in this period of life when there is a higher mortality as a result of preventable causes. Usually statisticians and demographers call it zero-year old children

**Preschoolers** are boys and girls 1 to 4 years of age. This period is very important for healthy development and adequate growth of these children. Big suckling infants belong to this group, and they are children aged 2 to 3. It is during the first two years of life in which there is a danger of chronic undernourishment to human beings. The intellectual capital of individuals may be protected in a better way in this period, preventing in them irreversible damage left due to malnutrition.

**Students**, children aged 5 to 9, it is a particularly difficult period because they face a great number of accidents. The importance in this period is the possibility of instilling and reinforcing in them habits, attitudes, and practices that favour their development.

Emphasis in the care of this population group should be put in keeping track of growth and development of children, nutritional food surveillance, including promotion exclusive breastfeeding until six months of age, early detection and timely treatment of prevalent diseases and care-giving to children in difficult circumstances.

It should be kept in mind that childhood is a period in which many life styles are learned and acquired. These life styles will be reproduced in adulthood, and they will determine the health and disease situation of each individual. Also, the main vehicle in this upbringing is the family, having the important support of the school.

## 2) *Adolescents*

This population group includes people aged 10 to 19, and two periods may be distinguished: those aged 10 to 14 that undergo their puberty stage and those aged 15 to 19 that are beginning their youth. Providing services must aim its activities towards prevention of addictions, early and unplanned pregnancy, promoting healthy life styles and mental health.

---

<sup>19</sup> Pan-American Health Organization. International Statistical Classification of Health-Related Diseases and Problems. Tenth revision. Vol 2. Instructions Manual, Scientific Publication No. 554. Washington D.C. 1995. p 132.

Adolescence is the beginning of sexual maturation, psychological development, and socialization. Adolescents are a particularly vulnerable group and most of them are marginalized both in education and health care. Deficiencies are identified in social programs that lead to adopt a healthy life styles and acquisition of habits, attitudes, and practices that favour their healthy development. This entails present and future serious risk and damage due to general untreated morbidity, addictions, prostitution, unplanned pregnancies, sexually transmitted diseases, violence, suicide, crime, etc.

Traditionally, little importance is obviously given to this evolutionary stage in the process of growth and development, as well as the biological approach to services rendered. This hampers research on important problems that are psycho-social in the adolescents, as well as strategy implementation for primary prevention of problems faced by them. Such problems are linked with life styles that are adopted or reinforced.

### *3) Adults*

This age group includes people aged 20 to 59. This should be divided at least into two sub-groups: people 20 to 49 years of age and those 50 to 59. Providing services must be aimed at early detection of risk factors in health problems prioritized in this population group, as well as actions intended to improve their sexual and reproductive health.

It is a productive and reproductive age group whose health problems are originated at an early age mainly due to unhealthy habits and life styles, occupational accidents, and exposure to environmental factors whose effects are only detected after long period of time, which imposes extreme requirements for care.

Health care aimed at adults must develop a round health prevention and promotion approach, introducing the preventative nature of the model into the healing care, preventing disease progression or subsequent damage. As a rule, care is focused on a person outside of his/her environment and usually attention is paid only to a disease, which contributes to disintegration of the care process in this age group.

With respect to women, traditionally priority is given to guarantee care in the maternity stage, getting round those problems derived from their social and family role, as well as their need for accomplishment beyond their function as a mother. It is necessary to address also women's physical problems related to the psycho-social adjustments and their sexual and reproductive integrity.

### *4) The elderly*

This population group includes people aged 60 and over. As an essential and vulnerable group in society the elderly must live with dignity and keep maximum possible functional capacity, regardless of the setting in which the health care is provided.

Care must be focused not only on the elderly, but on the family and community, parallel to the work done by the involved relevant institutions.

In this stage of the life emphasis will be put on preventive actions, so that this reduces psychological crises such as retirement, loss of capacities and adaptation, dependency, empty nest, self-esteem as well as complications generated by non-communicable diseases, which enable comprehensive care, providing all the care that contributes to improve their quality of life.



### **6.1.1.2. Individuals receiving care**

In providing services to be effective and efficient, an individual is highlighted as a person immersed in a family environment, a community, and in a physical and ecological setting that favours or hinders his/her health.

#### *1) Care focused on individuals*

Rendering services is focused on the care and self-care of individuals, but not on care to “diseases.” For this reason, actions are organized in terms of a healthy development of people, according to the age group they belong.

It is important to stress the *cultural aptitude* on care. This means to identify the different needs of members in special populations by their ethnic, racial, cultural or any other characteristics. When designing a variety of services available, but mainly upon delivery, these special needs must be identified and handled appropriately.

#### *2) Care focused on the family*

A family is the essential social institution. A family is a decisive point departure in the socialization process of new renovating generations in society<sup>20</sup>.

In the bosom of the family that are different roles and functions like conveyance of values and behaviors, cultivation of both affective and emotional bonds and interaction with the social system. It is in the family where health is fostered or disease is generated.

A family-focused care approach leads a provider to learn about what factors in the user's family members are influencing on health problems and which problems a family and its members are having because of a user. Factors concerning risk and damage in the bosom of the family are identified, including living conditions and other elements determining (determinants) their health, in order to train them on health self-care and support between such members, trying to solve everybody's health problems as an organic unit.

#### *3) Care focused on community*

Users' health needs are modified by their socioeconomic context. For this reason, identification of such needs requires to learn about that particular context.

Community-oriented health services must have updated knowledge of health needs and priorities assessed from both technical and community viewpoints. On this, health personnel, providers participate in community matters, and they have specific knowledge on existing social and solidarity support systems, including recreational, religious, and political ones.

In this process, a community and its members will participate both in management spaces in the health units and in actions that strengthen their own health like the health campaigns or drives, initiatives for healthy surroundings (schools, markets, spaces or municipalities,

---

<sup>20</sup> Silva Gomez, Edelmira, et al. Influencia del medio ambiente en la organización familiar. Universidad Santo Tomás de Aquino. Bogota. 1975. p.33

and labor environment), campaigns scheduled with the community for early detection of diseases that threaten health of such members, health fairs, among others.

For ethnic groups, indigenous villages are the geographic units, bases of their organization. These are their insurance for survival, because at such level dwellers keep and repeat their worldview, harmonic relations between members of their community and nature. Through such relations, a deep spirituality and cultural values driving life in the community have passed down from generation to generation.

This view obviously affects the health-disease conception that indigenous communities have. Therefore, health has to do with the social organization, economic development, standard of living, resources allocation, and natural and social environment in such communities. In the health-disease process in a community, there are relations between patients, 'sukias,' prophets, healers, and the community in which the backbone of relations is trust<sup>21</sup>.

#### *4) Care of physical and ecological environment*

In providing health services, an environmental action strategy is adopted. This is basically a preventive and participatory strategy in the localities, observing the right of human beings to live in a healthy and adequate environment. Inhabitants must be informed on the environmental risks concerning their health, well-being, and survival<sup>22</sup>.

Environmental risk factors to people's health are present in every locality, although there are different connotations. Given to the interdependence between human beings and the environment, it may be said that most diseases are in a certain manner, environmental diseases.

Part of providing services to physical and ecological environment is a community that actively participates in the search for a healthy environment and conscientious effort in monitoring risk factors. To the end, inter-sectoral and inter-institutional coordination, including an organized community, are required.

#### **6.1.1.3 Set of Health Services**

A Set of Health Services (SET OF HEALTH SERVICES)<sup>23</sup> is a set of health benefit services for the population. This includes prevention, protection, treatment, and rehabilitation for all the population. This is aimed at people and environment, taking into account the particularities of each population group, epidemiological pattern, risk, availability of sectoral and social resources, as well as ethnic and cultural characteristics, physical and ecological environment.

The benefits of such Set of Health Services are classified according to the contexts defined in the Bylaws of the General Health Act, in three groups:

---

<sup>21</sup> University of the Autonomous Regions on the Nicaraguan Caribbean Coast. op. cit. p. 23.

<sup>22</sup> Pan-American Health Organization; 'Environmental Primary Care' (APA). PAHO/HEP/98.1. Washington D.C. 1998. p. 24.

<sup>23</sup> Nicaragua. Bylaws of the General Health Act. op. cit. Art. 49.

1. **Public health services:** Group of benefits and actions in public health, monitoring, promotion, and education intended to encourage favorable habits, practices, and behaviors to health in a person, family and community.
2. **Services in health protection and prevention:** These are actions aimed to prevent damage, keeping the well-being of the population.
3. **Services in timely treatment or care of damage:** These actions are aimed at recovery and rehabilitation of people's health.

The health actions to be conducted by scope of the set of health services will be defined by cycle of life and scope of care, identifying those with better cost and better effectiveness to find a solution to the country's health situation.

The contents in the set of health services will be funded as stated in the Bylaws<sup>24</sup>. In accordance with this, the set of public services, considered to be public property<sup>25</sup>, of the set of health services will be funded through the non-tax collection system. The other groups will be funded to populations, according to the system to which they belong. No system may provide its beneficiaries with fewer benefits than those listed ones in the set of health services.

For the purpose of identifying the vulnerable population, focalization mechanism and its identification are defined and applied.

<b>Public Health Services</b>
1. Hygiene education
2. Health education
3. Immunizations
4. Promoting health
5. Prevention and control of the main communicable and tropical diseases
5. Surveillance and monitoring of water, food, solid and liquid waste, medicines and other health-related products, toxic and hazardous substances
6. Surveillance, research, and epidemiological, epizootic and entomological control

<sup>24</sup> Nicaragua. General Health Act, op. cit. Arts. 39, 40 and 41.

<sup>25</sup> Public property: good or service producing high externality

#### **Services in Health Protection and Prevention**

7. Prenatal care, childbirth, and postpartum
8. Immediate care to newborn baby
9. Nutrition care
10. Early detection of the cervical and breast cancer
11. Familiar planning
12. Promoting mouthwash
13. Monitoring and promoting growth and development

#### **Services in Timely Care of Damage**

14. Care for the handicapped
15. Prevalent diseases in children
16. Medical emergency and follow-up
17. Ambulatory morbidity
18. Chronically ill patients
19. Newborn problems
20. Community-based rehabilitation
21. Psychiatric disorders

#### **6.1.1.4. Forms of service delivery**

Delivering health services to a population in sufficient quantity and quality to meet basic health needs and address the main consequent damage, requires a differentiated treatment according to population characteristics, for example, poverty levels, geographic and cultural access to health services, as well as the cost of service delivery in terms of quality and coverage.

Health services effectiveness requires suitable combinations in delivery forms of such services, so that there is a synergy between the community and institutional performance, the intra and external action by service providers, partnering between private and public providers, as well as preventative and healing actions to focus health services towards vulnerable groups.

The health facilities will cultivate bonds with the community, mainly in the population groups benefiting from non-tax collection system and being prioritized due to accessibility

problems and high poverty rate, to develop actions defined in a set of essential services for coverage extension.

Mechanisms for transport must be organized for patients and referral of patients from a community to health facilities, which is required to find a solution to the health problem according to its degree of complexity. Coordination and support from the mayors' offices and other social and institutional actors are highly important to conduct these actions.

Maternal shelters, working as facilities of a community and civil society supported by MINSA, will be developed to improve access of pregnant women in distant areas away from the childbirth care provided by qualified personnel in order to prevent damages and maternal deaths and orphans. Such maternal shelters will be part of a network service in the places where a need is identified.

**Institutional care provided to distant communities** as for delivery of the Set of health services, for coverage extension, will take place through scheduled, regular, and systematic visits all year round. This should be coordinated by community leaders in order to ensure with them a bigger likely coverage. This care should be provided at grass-roots houses (casas bases) as long as conditions permit so.

This care should be targeted at special population groups for health surveillance and promotion, as in the case of pregnant women and children. Also, it should include care or treatment to common affection suffered by the population in general.

Care provided to the poor population in distant communities will be ensured by allocating necessary resources. In turn, specific and clear incentives are considered both for coverage extension to groups defined as for the quality of the service delivered and its strong monitoring system.

A form of delivery of these services consists of operations conducted by mobile brigades of public health facilities. Such brigades are supported by covering operating expenses and incentives to them by performance in terms of coverage and service quality to prioritized groups, treating also common ailments among the population in such localities.

**The primary health care facilities** should meet reasonable care demands of the people living nearby such facilities, in order to guarantee their coverage extension, using strategies such as sectioning, coordination with leaders in the community in terms of reaching groups and families, organization of the work in such units both outside and in the community to ensure the highest efficiency.

Support and incentive must clearly be intended to guarantee coverage and service quality to the population benefiting from the non-tax collection system, and in each age group (according to cycle of life), to implement, as a priority, most cost-effective actions with a hierarchical structure that prefers health promotion and development and timely prevalent disease treatment to the healing or palliative highly expensive and poorly-effective actions to such health situation.

Care for those benefiting from the non-tax collection system in the hospitals (**secondary and tertiary care facilities**) is aimed to support in finding a solution to prioritized health problems in the country, shown in the Set of Health Services that have been defined.

In these facilities, “critical areas” are prioritized as for infrastructure rehabilitation, provision of equipment, diagnostic means, provision of medical supplies, and care protocol preparation in order to provide a highly-complex quality service and opportunity to patients.

#### **6.1.1.5 Organization for providing services**

Providing health services means getting organized in networks, based on the care levels set forth in the General Health Act.

##### a) Network organization

An organized service health network includes a set of community resources, public and private facilities with diverse complexity and forms of care, sharing common objectives and interrelating each other, to be able to meet most health demands of a population in a territory. They may be municipal or inter-municipal.

To organize the service network, the following criteria must be considered:

- Accessibility.
- Characteristics of the population.
- Type and number of existing health facilities articulated in networks in such territory.

To ensure care effectiveness and opportunity, the functional organization of a service network will be comprised by:

- Providers of primary and secondary care level.
- Resources of a community involved in promotion and prevention actions in favour of health.

The main characteristics of health service networks must be:

- Focused on patient and user.
- Community-based primary care approach.
- Tendency towards care-giving at home and short hospital stay.
- Organizational model from less to more complexity.
- Emphasis on health promotion and prevention actions.
- Hospitalization reserved for cases with technical justification.
- Rational and efficient use of available resources.
- Clear definition of sectoral and extra-sectoral roles and responsibilities.

Its purpose is to increase accessibility to health services, reduce care gaps, and improve continuity of care and health care.

Organizing local service networks is responsibility assumed by the SILAIS. It is guarantor of the number and quality of benefits and the proper management of public funds made available to such networks<sup>26</sup>.

---

<sup>26</sup> Nicaragua. Bylaws of the General Health Act. op. cit. Art. 23.

Health service networks provide care under two forms. These are namely care in the **community** and care in the **health facility**.

*a.1) Care in the community*

The objective is to foster preventative health and contribute to diminish risks, improving the quality of life of the population.

The community care will be both through community leaders and agents and basic community units, grass-roots houses, maternal shelters, NGOs, or any other form of community organization.

Community care is sustained by three performance mechanisms:

- To carry out organizational activities strengthening self-care to foster health in a person, family, and community, as well as the make-up and strengthening of civil society organizations for mutual help.
- To carry out systematic activities for specific health promotion and protection, as well early detection of damage in a person, family, and community.
- To conduct health surveillance, identifying risks and damage to implement timely epidemiological measures.

*a.2) Care in health facilities*

Development of health network facilities requires that different providers have:

- a. Territorial and population responsibility (sectioning)
- b. Communication channels.
- c. Information systems.
- d. Means of transport for patients.
- e. Referral and counter-referral mechanisms.
- f. Ordering of services being provided by complexity level.

These facilities must be articulated, whether they are public or private ones.

Care will be provided in the different health facilities:

1. Institutional ones

- Health post
- Health centre without bed
- Health centre with bed
- Polyclinics
- Hospital
- 'Monoprofile' Centres

## 2. Private ones

- Clinic
- Doctor's office
- Hospital
- 'Previsional medical enterprise'

## 3. Others

- Facilities of the Ministry of Government (MIGOB) and Nicaragua Army
- Religious medical clinics
- Doctor's offices of personnel
- Non-Governmental Organizations (NGOs)

### b) Care levels

Care levels are organizational forms in health services delivered to the population. They are based on their technology complexity, which provides them with capacity to meet needs and find solution to health problems. This type of organization is essential for cost-efficiency reasons, benefiting the public and medical profession "(Lord Dawson of Penn<sup>27</sup>).

Each level of care is a set of health actions, both to preserve and recover health, using scientifically founded and socially accepted practical methods and technologies, put within the reach of every person and family in a community.

The health facilities, under the pertinent rules, may simultaneously develop exclusive actions at one level of care and two or more levels (specialized care and sub-specialties). The current legislation defines three levels: primary care, secondary care, and tertiary health care.

Common functions or duties at these three levels of care are the following:

1. Development of administrative functions in planning, organization, implementation, and control in health operations or actions, coordination and joint responsibility with the family, community, and other social actors.
2. Coordination with the rest of network units through Patient Referral and Counter-referral scheme.
3. Continuous improvement in quality, by experience sharing between such care levels, training of human resources, and management of new technologies, among others.
4. Health surveillance.

### *b.1) Primary care*

---

<sup>27</sup> Dawson Report on future of medical and similar services 1920. Provisional report submitted to the Ministry of Health of Great Britain in 1920 by the Consultation Council for medical and similar services. Published by PAHO/WHO in scientific Journal No..93 Washington D.C. 1961. paragraph 4.



It is the first link in the organization of a comprehensive health care model, and it is aimed to find solution to the most frequent basic health needs of the population, considering that these needs are met by simple, low-complexity, and effective technologies.

It addresses the most frequent problems of a community, and it provides services in promotion, prevention, cure, and rehabilitation, capable of enhancing health and well-being of the population. Such services in this level are furnished to a person, family, and community.

The competencies in primary care are seen in a range of services classified in three groups:

1. **Services in promotion and protection of people's health.** There is health information, education, and communication aimed to establish habits, practices, and behaviours favourable to health and to unlearn and modify life styles harmful to health, hygiene activities to community, including to watch a suitable elimination of trash and water, monitoring water quality for human consumption, encouraging household sanitation and personal hygiene, food hygiene, including control to processing plants, retailers, and those who handle food, sanitation in meeting places, control of tropical disease transmitting vectors, a set of services in unspecified and specific health promotion and protection.
2. **Services to foster healthy development in vulnerable population groups.** This includes those referred to monitoring and promotion of growth and development of children, prenatal care actions, timely care of low-risk childbirths and the postpartum period, services intended for healthy development of adolescents based on counselling aimed at specific issues, protection against immuno-preventative diseases, family planning, and those targeted at the elderly. It includes preventive environmental (physical and ecological) actions.
3. **Services in early detection, timely care and adequate rehabilitation of the main health problems that people suffers** There should be mentioned prevalent diseases among children, sexually transmitted diseases including HIV/AIDS, vector transmitted diseases, tuberculosis, gynaecological cancers, care or referral to emergency, chronic diseases (diabetes, hypertension, asthma, etc.), community-based rehabilitation.

#### *b.2) Secondary care*

It is the organizational level that gives continuity to care started in primary care. The users of secondary care face health problems that because of their complexity and/or technological (diagnostic and therapeutic) requirements cannot be solved in such preceding level or primary care, and thus requiring specialized care.

Admission in this level can be requested from a primary care level, either through inter-consultation or referral. An emergency is taken care directly, with no need to see first a physician in primary care.

Competencies in secondary care are shown in a range of services classified as:

1. Ambulatory services: To treat morbidity through medical consultation in specialties and other diagnostic therapeutic and/or procedures.

2. Admission services: For specialized care of acute pathological condition, surgical operations, emergency care, childbirths, worsening of chronic cases, and case study.
3. Rehabilitation Services.
4. Comprehensive promotion and prevention.

#### *b.3) Tertiary care*

This level is responsible for providing health services in every high-complexity sub-medical and surgical specialties. It furnishes diagnostic and therapeutic support, which deserves high technology and greater degree of specialization. It develops scientific activities intended for technological development and generation of new knowledge applicable to the reality in this country.

#### *c) Health service providers*

Health service providers are natural or legal, public, private, or mixed, national, or foreign people duly authorized. Their objective is to provide services in health promotion, protection, recovery and rehabilitation demanded by the population. It includes any other provider, whose activity is to render services that affect, directly or indirectly, a user's health.

Providing health services requires a number of basic resources. This includes health personnel and community members, medical facilities and goods to be used, including medicines, as well as their organization.

The number and quality of services made available to a community depend to a great extent on the call capacity of sectoral management levels, to move and use the resources of the society through different health service providers.

Facilities delivering services must be properly enabled or authorized. Their categorization will be defined in accordance with what is set forth by MINSA.

Such providers will offer their services within a city and in the community having some interaction with it. Interaction with the community will take place through the existing community network. To this end, each health facility will have identified its network, and it will have established systematically coordination mechanisms.

### **6.1.2 Key aspects to develop the provision component**

#### *a) Definition and update of contents in the Set of Health Services*

For each of the scopes in the set of health services defined in Law 423, the content of health services to be provided will be defined, taking into account the epidemiological pattern, intervention priorities, cost-effectiveness in services and interventions, and availability of financial resources.

What is included (content) in a service is specified by cycle of life, scope of care, and level of care. According to technological advances and changes in the epidemiological pattern, this Set of Health Services will be updated.

Standards in consumption of vital and essential medical supplies according to the health service portfolio will be defined (SET OF HEALTH SERVICES)

b) Implementation of focalization mechanisms

Applying focalization mechanisms to identify who are and where the vulnerable groups are located will contribute to equity and service coverage to reach those in great need.

Implementing focalization mechanisms has a monitoring and evaluation scheme that enables to identify changes in equity of care with funds from the non-tax collection system.

c) Typifying health units

There is a health unit classification that defines the population to be covered, services provided, type of resources available and their enabling or working criteria for forecast and orderly development of a network.

d) Organizing networks

Defining a structure and organization of service networks -which provide directly such services- must be an orderly and systematic process, so that fulfillment of the MAIS principles is ensured.

A challenge in organizing networks is to keep articulation between the different providers and attain community participation for health promotion and the search of not only sanitary solutions but also improvement in people's health.

e) Health communication and Community Action Strategy (ECACS)

An essential backbone for service delivery will be the ECACS, taking into consideration its three main pillars:

*e.1) advocacy to strengthen inter-institutional and multi-sectoral coordination in terms of the prioritized health problems;*

*e.2) improvement in performance and community action to improve in providing quality services with a warm feeling, improved skills of providers in interpersonal and community communication, and a increased community participation in defining the quality of a service.*

*e.3) health communication in order to enhance knowledge, attitudes, and practices that improve the capacity of families and communities to prevent diseases, prioritizing those ones that cause early mortality and those that are preventable.*

## 6.2 Management component

The management component enables to identify who and upon what resources, decisions are to be made to fulfill the MAIS objectives, putting together a set of systems, processes, procedures and activities. The purpose is to facilitate the most efficient combination of resources from the different actors in this sector for an effective rendering of services.

Elements included in the management component are: definition of roles and functions of the administrative structures, running of resource management systems to provide services, definition of management mechanisms with service providers.

The management component incorporates as the main premise decentralization, which is an effective process to:

- Improve allocation and use of resources.
- Facilitate local combination of factors involved in providing health services, for continuous quality improvement.
- Increase activity efficiency and effectiveness in the health sector.
- Bring closer decision-making of the sector to direct providers and rendering of services to users.
- Rationalize or streamline the range of action, functions, and responsibilities of the different elements in the health sector.

In order to develop and deepen the MAIS implementation, MINSA will coordinate and promote participation in the public and private sector.

Decentralization and administrative decentralization<sup>28</sup> are basic processes intended for management to be more effective and efficient. The 'management agreement' is an instrument through which a relation between the governing body and the local network organization is made operational. Then internal management agreements will be made with the public providers, including service contracts with private providers that define clearly the delivery goals (specific quantity and quality of products and/or services), the payment methods and control to assure provision.

### 6.2.1 Roles and functions of management levels

According to Law N°423<sup>29</sup>, MINSA as a governing body in this sector, has to coordinate, organize, supervise, inspect, control, regulate, order and watch over the health actions, regardless of the functions it must perform before institutions in the health sector, in accordance with the special legal provisions.

#### 6.2.1.1. Governing body

The governing body is at MINSA headquarters, and it is the organizational level in charge of making decisions on what to do and how to conduct interventions in the Health System. Its main competencies are:

---

<sup>28</sup> Nicaragua. Law 290, Organization, Competence and Procedures of the Executive Branch op. cit. Art. 4

<sup>29</sup> Nicaragua. General Health Act, op. cit. Art. 4.

- To conduct a process of formulation, management, implementation, and evaluation of policies, plans, programs, and projects, as well as development and implementation of comprehensive management information system.
- To coordinate and guide the process of technical and administrative regulation for care and organization of service networks.
- To coordinate with institutions training human resources in health.
- To develop technical capacity of the SILAIS in its new roles.
- To develop a quality assurance program.
- To develop and disseminate scientific knowledge.
- To develop a health surveillance system that includes risk indicators (social and economic, cultural environments, and financial conditions) and damage to health.
  
- To ensure funding (including allocation mechanisms, payment methods, and design for incentives to providers) for services and benefits from the non-tax collection system.
- To ensure, promote, and facilitate inter-sector and inter-institutional citizen participation spaces.
- To prepare and approve the care standards for providers.
- To prepare with broad participation of professionals and approve the clinical guides and care protocols for providers.
- To assess and manage health technologies to be incorporated, with an approach based on scientific evidence.
- To authorize the practice of health professionals, individually or as members of medical brigades from abroad.
- To follow procedures for customs clearance of donations from other countries and registration of NGOs.

On assurance of resources, the duties of the governing body are to:

Physical capital:

- Define a master plan for investment.
- Define rules for managing resources.
- Standardize the introduction, allocation, and distribution and use of medical equipment, instruments in order to protect service users, both to get safely quality services and so that providers reduce their induced demand.
- Define rules for management and use of goods, works, and services of the public network.
- Manage resources to the different sources of funding.

Supplies:

- Define and controls the quality assurance system for medical supplies,
- Lay down rules for introduction, allocation, distribution, and use of medicines, agents diagnoses, medical supplies for dentistry use, medical devices, antiseptic solutions, prostheses, orthosis/functional aids in order to protect service users, both to get safely quality services and so that providers reduce their induced demand.
- Lay down rules for introduction of other health-related products to protect users from risks and damage to health.
- Prepare national lists for medical supplies and national medicine form.
- Purchase medical supplies for the public sector by schedule to the different health facilities, paying attention to an economy of scale.

- Prepare and implement technical-administrative standards and methodologies for integral management and appropriate use of medical supplies.

Developing human talent:

- Define rules to manage human talent.
- Formulate the policies and guidelines for planning and development of human talent.
- Coordinate with the institutions training human resources in health, according to a strategic plan, development of health human resources (HR) to take part in the process of education, distribution, and use of HR, reverting the tendency in the health labour market.
- Identify the needs of health education in HR to meet the demand and quality of health services.
- Manage the national registry of health professionals and technicians.

**6.2.1.2 SILAIS**

The facility named Comprehensive Health Systems (SILAIS)<sup>30</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.

This means the sectorial leadership and enforcement of the legal framework, for which it has:

- To fulfill and enforce the established policies, plans, and rules.
- To lead this organization and keep track of the fulfillment of development plans, providers' networks, with organized participation of society.
- To authorize and keep track of establishments producing or distributing health goods and services.
- To regulate articulation (including referral and return) in the service networks in accordance with the rules stipulated by the governing body.
- To ensure care towards vulnerable population groups defined in the national health policies
- To apply monitoring and supervision tools, conducting actions for inspection, check, and surveillance that enable analysis on the effectiveness, efficiency, and quality of the public and private service delivery.
- To assure services considered to be public property of a nation.
- To ensure health surveillance.
- To ensure an integral information system management in place.
- To provide technical assistance to the health service providers.
- To watch over enforcement of internal control rules.
- To apply and supervise enforcement of administrative rules for physical resources, supplies, and human talent development.
- To supervise the practice of health professionals, individually or as members of foreign medical brigades providing care in the territory.

SILAIS is the entity responsible for furnishing health services from MINSA facilities for a given territory. Therefore, it makes decisions on the use of resources for their best combination in terms of quality and efficiency.

---

<sup>30</sup> Nicaragua. General Health Act. op. cit. Art. 59.

Institutional health services are provided by every hospital, health centre with its health post network (municipalities or districts) in the country.

To make service delivery operational to the population, health service providers are organized in networks to guarantee access to services and optimize the use of resources.

Articulation between hospitals and health centres, with their health posts, takes place effectively through the SILAIS by means of decentralized resource management in terms of the outputs agreed in the Management Agreements with headquarters.

Health facilities as service providers have the following duties:

- a. To develop activities for promotion, prevention, care, and rehabilitation to individuals, family, community and environment.
- b. To promote social and community participation in management and health provision.
- c. To deliver a Set of Health Services to those benefiting from the non-tax collection system.
- d. To apply the rules defined in conducting such actions.
- e. To have health surveillance.
- f. To formulate, reach agreement and regulate its planning, budgeting, and programming with citizen participation.
- g. To articulate or coordinate effectively with the network providers.
- h. To authorize and regulate from a health perspective the operations of establishments that produce or distribute food, beverage, and other products and services that may affect health conditions.

In regard to assurance of resources, the duties of a provider are to:

### **Physical capital**

This refers to the resources allocated for investment and infrastructure maintenance, medical equipment, means of transport and communication available to provide health services.

- Define the needs and formulate a plan for investments and maintenance in order to fulfill the standards for operations and institutional development.
- Manage resources to the investment and maintenance plans before mayors' offices, NGO, companies, community, and others.
- Execute the investment and maintenance plans.

### **Supplies**

Rendering services requires developing forms to deliver medical and non-medical supplies that promote timely service delivery to the population. The management of supplies must encourage local management development, taking into account opportunities given in an economy of scale in procurement.

- It plans the requirements of goods and services as agreed in the Management commitments with SILAIS.
- It procures goods and services in conformity with the effective rules and procedures and they are not linked with economy of scale.
- It stores and distributes goods according to rules.

- It manages inventory of goods.
- It ensures rational use of goods and services, focusing on medical supplies.

#### Developing human talent

This refers to both the very same health personnel and another type of personnel, which requires a specific and recognized technical qualification, and it includes:

- Assigning positions according to the rules.
- Managing personnel
- Developing human talent to guarantee in health units a quality care program and humanized treatment.
- Developing research.

#### **6.2.1.3 Citizen participation**

Joint societal participation in health management will favour the establishment of a true national health-oriented coalition, which is present through inter-sector, inter-institutional, and citizen participation.

##### *c.1) Inter-sector participation*

It will be attained through coordination and strategic alliances that diverse sectors establish within their sphere of competence, concerning fulfillment of objectives, implementation and evaluation of health policies, plans, and programs being developed under the stewardship and leadership of MINSA. To this end, the existing structures will be used as the Provincial and Municipal Health Councils.

##### *c.2) Inter-institutional participation*

It is developed through coordination and strategic alliances, having as a departure point the identification of common objectives to conduct promotion and prevention actions.

Inter-institutional participation will attempt to close or reduce the gap as to coverage of basic programs and services, to improve effectiveness and perceived and technical quality of health services.

##### *c.3) Citizen participation*

In order to have citizen participation with responsibility in health development, there are legally created spaces that permit to develop some socially-oriented control in the health management, through the National Health Council, provincial and municipal health councils, and consultation committees in hospitals.

Such participation is defined in the sphere of:

- Consultations for design, monitoring, social supervision and evaluation of health policies, plans, and programs.
- Information and submission of suggestions to competent authorities concerning irregularities or deficiencies that are noticed in providing health services.



- Boosting activities aimed to obtain resources to strengthen rendering of health services.
- Socially-oriented control to health management, including the definition of care quality from the point of view of the community, proposing intervention priorities to competent authorities.

## 6.2.2 Operations control

The operations control in the Comprehensive Health Care Model is based on processes of surveillance, supervision, monitoring and evaluation of plan development and objective fulfillment, ensuring compliance with the policies, functions, and goals in the health system.

It means a logical process based on systematic, objective, and timely statistical and operational information, which is contained in principles, rules, plans, goals, standards, procedures, and outcome monitoring and evaluation mechanisms.

The tools to be used in operations control are the following:

### a) **Agreements, commitments, contracts, and understandings**

*Management agreement:* It is an instrument that records the commitments made by the SILAIS and the obligations at Headquarters level (financing entity). It contains the specific goals for processes and outcomes, as well as interventions for continuous quality improvement, the volume of resources to be delivered and other required support to ensure the agreed outcomes.

*Management commitment:* It is an instrument that records the commitments made by the health service provider and the obligations of SILAIS. It contains specific goals in service delivery and interventions for continuous quality improvement and the volume of resources to be delivered to ensure the agreed provision and the incentive system to be used.

*Service contract:* It is understood as a relationship of bargain and sale stated thereof in a contractual framework, a legal relationship, between a financial entity and a private health service provider (noninstitutional), with defined instalments, for the purpose of having a service portfolio that was previously defined with its costing, having set products and outcomes. It defines the number of products to be delivered, and it encourages through an incentive a better fulfillment in such service and sanction when failing to do so.

*Management agreements:* They consist of a number of commitments intended to articulate health services. They are made between similar units (peer agreement) or complementary ones (between units with less and more care complexity), on an internal basis, by providers.

### b) **Information system**

It is an integrated set of mechanisms that guarantee timely information availability for the health system development. It includes epidemiological, demographic information, service

delivery, resources, regulation, and guarantee of quality, among others<sup>31</sup>, generated by the different entities that are integral parts of such sector.

**c) Control panel**

The control panel is a tool that uses systematic, objective, and timely information on accounting (costs), statistics, and quality aspects turned into management indicators, for managerial control and decision-making (production, quality, and costs).

**d) Inspection system**

It is a system based on evaluation of management in favour of effective service delivery.

**e) Operations control and citizen review**

This is based on the process of citizen participation. It consists of follow-up on health indicators of the public administration, which defines a 'socially-oriented control commission.' Such indicators are defined together with the participating bodies (National Health Council, Provincial Health Council, Municipal Development Council, and Local Health Commissions).

### **6.2.3. Key aspects to develop management component**

**a) Decentralization of resources**

Decentralization of resources is understood as a form of administrative organization in which a centralized body confers technical autonomy on a subordinate body so that it has a limited competence and decision-making for certain matters or territory. It is the prevailing strategy in the public sector.

Separation of functions or duties with definition of the roles, systems, processes, procedures, and activities for the different management levels are vitally important to push decentralization of resources.

**b) Quality guarantee**

Health service providers must ensure application of rules and processes defined by the governing body and under SILAIS. The quality guarantee includes enforcement of health care rules or standards, health registry, regulation of professionals, medical audit, bioethics courts, preparation or equipment, to support accreditation, certification, and management in the appropriate use of medical supplies, and pharmacy-surveillance.

The functional organization of health providers must facilitate program formulation for continuous quality improvement tending to fulfill the care standards or rules. Working teams (quality groups) will be made up to ensure design and redesign of processes for quality improvement at every level of care.

**c) Social participation**

---

<sup>31</sup> Nicaragua. Bylaws General Health Act, op. cit. Art. 370

The health management at different administrative levels must have citizen participation in the bodies to be made up. To have an effective participation, it is necessary to define, guide, and regulate implementation of mechanisms for effective social participation in the planning, implementation (seen as a shared effort for actions, from the position of the Constitution that health is must for all citizens), and operations control, identifying equity, efficiency, and effectiveness of health interventions based on outcomes.

**d) Management and leadership capacities**

Developing management and leadership skills in managerial and technical personnel, at administrative levels, requires a training program, update, and evaluation in such skills.

### **6.3 Funding component**

The Comprehensive Health Care Model must guarantee coverage of service to all the population, laying down the rules to attain equity in delivering service to the population. Funding is provided in three schemes<sup>32</sup>, which define the forms of allocation and payment methods, the benefit programs to which one may have access whenever the corresponding conditions to each one are fulfilled:

- Tax collection system
- Non-tax collection system
- Voluntary system

Funding of the three schemes must include at least to services and benefits of the Set of Health Services. For the purpose of funding such Comprehensive Health Care Model, it is necessary to consider, particularly equity, three essential components:

- Funding sources: The origin of the funds is defined. It answers the question: who pays the bill? The state, money from households, or other funding entities.
- Manner of allocating funds: This is about how funds are allocated or distributed. Financial resources constraints are a reality present in every country. For this reason, certain programming priorities are defined to allocate such funds in terms of the health problems and risks and prioritized populations, which determines the outcomes to be reached in these two spheres. It answers the question, on what to invest or spend the available resources in order to improve health of the population.
- Payment mechanisms: It is about the way in which the financial resources, either transfer or payment to a health service provider in relation to outcome parameters set. Payment mechanisms must promote efficiency and quality in such provision, as well as development of healthy communities. It answers the question in connection with what, in terms of outcomes to improve health among the population, payment to service providers.

---

<sup>32</sup> Nicaragua. General Health Act, op. cit. Art. 38

### **6.3.1 Funding from non-tax collection system**

The resources from the non-tax collection system are allocated to finance services set forth in the General Law<sup>33</sup> of Health and its Bylaws<sup>34</sup>, prioritizing health services identified as public property of the nation<sup>35</sup>. A second priority is funding for services to vulnerable population groups, as defined in the protection and prevention group and those with timely care or treatment to damage. The third priority is for programs to treat highly expensive diseases and emergency programs.

The SILAIS are responsible for fulfilling plans and programs contained in the management and commitment agreements.

#### **6.3.1.1 Funding source**

The non-tax collection system will be funded by:

- 1.- Appropriations of the general budget of the Republic, as well as any other contribution of special allocations.
- 2.- It includes income obtained by the 'Nicaraguan Social Security Institute' (INSS) billing for services provided to its beneficiaries in public facilities.
- 3.- Donations, contributions, grants, and other financial resources given by natural, artificial, public or private persons, nationals or foreigners, under the provisions of the General Budget Law of the Republic of Nicaragua.
- 4.- Specifically earmarked external loan resources that are parts of the non-tax collection system.
- 6.- Other resources as stated in other applicable laws and rules.

The governing body defines the procedures for collection, management, and control of funds from the non-tax collection system.

#### **6.3.1.2 Allocation mechanisms**

The specific criteria for allocation of resources are the following:

- Population:
  - Territorial analysis: This should consider population density in the territory demanding services, without exclusively following the administrative-political division of provinces (departmentos) and autonomous regions in the country, for the purpose of considering also access to such services according to the system of roads available.
  - Demographic structure: These are positive discrimination criteria, child population, women of childbearing age, and the elderly.
- Socioeconomic level: Poor population, focusing on high and severe poverty.
- Epidemiological pattern: Allocations of resources must consider the health situation of the population (including existing factors that affect health of individuals, family, community, and environment) and incidence and prevalence of different diseases.

<sup>33</sup> Nicaragua. General Health Act. op. cit. Arts. 40, 49 through 52

<sup>34</sup> Nicaragua. Bylaws of the General Health Act. op. cit. Arts. 349 through 352

<sup>35</sup> See Set of Health Services item 6.1.1.3 in this document

- Productivity: Optimizing the use of financial resources allocated to the implementing unit must be taken into account.
- Level of solution-finding at such facilities and service networks.

Procedures for allocation of resources will be defined by MINSA, through manuals. Similarly, the manner and regularity in the measurement of impact on equity will be defined.

Among allocation mechanisms, there are:

1. Assignment of category by line or prospective budget: This allocation mechanism links resources with production or delivery at the facility (providing health services) to which resources are allocated, applying strict control on the use of resources in connection with eligible items to each expense line.
2. Simple per-capita: Allocation based on the number of inhabitants in the population to be covered.
3. Per-capita adjusted by risk: As information and resources are available, it will be possible to allocate, taking into account the conditions of poverty, urban, rural perspective, demographic structure, incidence and prevalence of diseases.

### **6.3.1.3 Payment methods**

Implementation of payment methods that generate efficiency in rendering of services and encouraging positive outcomes in the health situation will be promoted.

- Payment by outcome: Payment by outcome will be established. It will be defined as of fulfillment of quality standards in rendering services and/or scope of goals set forth in the agreements or management commitments. For example, reduction in mortality and morbidity indicators and reduction of risk factors until reaching development of healthy communities.
  - Per-capita: This payment method will be the first choice in case of programs for services that contracted with public funds are provided by public and private entities in order to extend coverage.
  - Payment by service or event: A rate will be fixed by expenditure, differentiating medical or surgical cases, emergency or outpatient consultations, using the table of relative units set by the governing body, moving toward diagnosis-related groups.
  - Mixed payment: The governing body will set the criteria and pay rates that combine the above methods, seeking to diminish perverse effects and increase efficiency and quality in service delivery.

Funding from the non-tax collection system is linked with socially-control processes. They will be made operational by management agreements, commitments and contracts, which contain incentives to performance as for efficiency and quality of such services.

### **6.3.2. Funding from the tax collection system**

The tax collection system includes a set of benefits and services, to which beneficiaries (tax-paying employees, employers, and the self-employed with optional insurance) in the INSS' systems may have access when previously hired by private or public companies or enterprises.

This system must fund the actions considered by the Set of Health Services in its health protection and prevention groups and timely treatment to damage. The INSS must extend its package of services, extend coverage to its affiliates and those with such right, contributing to funding the highly expensive disease program and emergency program according to the rules.

#### **6.3.2.1 Funding source**

- INSS rates paid by affiliates to schemes for common disease, maternity, and occupational risks as stated in the Organic Law of Social Security.
- Goods and rights that since its creation have been assigned by the State.
- Financial return earned by managing its liquidity surplus.
- Other goods and rights legally acquired by any other title.

#### **6.3.2.2 Assignment manner and payment method**

To provide medical care to those paying INSS rates in the labour system, the INSS contracts the facilities of service providers according to its regulation.

Both assignment and payment must guarantee access to beneficiaries of the health service provision, in a homogenous and equitable manner.

### **6.3.3. Funding from voluntary system**

#### **6.3.3.1. Funding source**

Voluntary system resources come from the very same users, relations, or companies, and they include:

- Contributions of those affiliated with this system, which are allocated to fund additional plans to those established as obligatory ones in the General Health Act and the Law of Social Security for the obligatory tax collection system.
- Financial return earned by managing its liquidity surplus.
- Moderating joint payments and rates delivered by its affiliates and beneficiaries.
- Direct payments.

#### **6.3.3.2. Allocation mechanisms and payment method**

Economic relations will be regulated by MINSA.

#### **6.3.4. Key aspects to develop funding component**

**a) *Change in the allocation and payment mechanisms***

One of the major challenges in the MAIS development is to improve equity and efficiency in rendering of services. Changes in the allocation mechanisms and payment methods are the basis to achieve these two objectives. To this end, it is required to identify, monitor and evaluate indicators to measure progress. To implement such changes, all the actors such as the Ministry of Treasury or Finance, Secretariat of the Presidency, MINSA, providers' network get involved.

**b) *Capacity to explore and identify opportunities for funding***

In order to close gaps in funding corresponding to the investment plans and other identified needs, the managing teams are required to review and make use of the defined funding sources, having a broad vision on those opportunities for funding to be able to make the most of them.

Capacity development to analyze costs, definition of tariffs or rates and mechanisms for billing will be an important factor for funding.

**c) *Developing technological capacity for financial-administrative control***

Financial-administrative control in terms of identifying the transparent and efficient use of financial resources requires continuity to develop expeditious, simple, and auditable systems.

## **ANNEX**



# **ROLE OF THE LOCAL COMPREHENSIVE HEALTH CARE SYSTEM (SILAIS)**

## **I. Introduction**

The mission of the Ministry of Health (MINSA) is to achieve the best possible level of physical and mental well-being in individuals, family, and community. Among the new challenges that MINSA faces is to fulfill the guideline in the State's social policy and the National Health Policy, that is, a more accessible health system to the population (equitable and efficient), boosting a reform process that improves delivery of health services.

In this effort, MINSA promotes, as one of its main strategies for institutional modernization, separation in functions of stewardship and provision of services to ensure that bodies in it have clearly defined roles in a coherent management framework to achieve outcomes. It also acknowledges or recognizes the advantages of a decentralized model as a premise to guarantee more allocation efficiency in the system, assigning locally the competences and resources and giving incentive to optimize their use.

In this context, the intervention stages in the chain of rendering health services are reviewed. This also entails to review the role of the Local Comprehensive Health Systems (SILAIS) in the new sphere of action defined in the General Health Act and its Bylaws, the decentralization policy, and Comprehensive Health Care Model, which become more responsive to the health issues of each territory in particular.

This document outlines again such functions, including the very same duties and competences derived from the legal framework, as well as other supplementary ones.

## **II. Background**

MINSA conceived SILAIS as health political-administrative entities in a given territory, based on the concept of the Local Health Systems (SILOS). They were created in April 1991 through Ministerial Resolution No. 91, being the most appropriate strategy to continue progressive development in the health sector under a new perspective of decentralization, sectoral joint responsibility, authority level, regulation, and evaluation. SILAIS arise out of a complex scenario characterized, generally speaking, by a high birth rate and nutrition problems in the population –particularly children-, insufficient rendering of health services, deterioration of physical infrastructure, inadequate distribution of specialized personnel, shortage of medicines and nonmedical supplies, as well as constraints of resources for current expenses and investments.

Upon creation of SILAIS, nineteen of them were considered (one per province and three in Managua), starting in the autonomous regions on the North and South Atlantic coast of Nicaragua their own representations, beginning to relocate the political, technical, and administrative officials from the headquarters to such localities, introducing into their range of action the programs and resources for nonpersonal goods and services (02 and 03)<sup>36</sup>,

---

<sup>36</sup> The set of expenses 02 refers to “non-personal services” and 03 “materials and supplies”.

except basic medicines and services (electric power, water, telephone), as a first step in the decentralization process.

The capacity of the SILAIS to make decisions with respect to hiring and use of its productive factors was restricted, since the only budgetary resource managed by SILAIS were transfers to fund groups 02 and 03, whereas the budget for HR continued under the control of the Treasury or Ministry of Finance (MHCP).

As a result of this practice, on the one hand, the real expenses incurred by service providers, and on the other hand, the SILAIS administrative structures were not known. Also, at this level there were serious difficulties to coordinate health actions between different levels of care and allocation of financial, material and human resources, which were not consistent with health needs of the population in such territory, with the consequent deterioration of their representative nature in their respective provinces.

Important achievements have been reached with respect to planning of resources linked with the health priorities by implementation programming and budgeting, encouraged in the framework the MINSA decentralization and reaching objectives and goals by making management commitments and agreements in some pilot units. Aspects such as allocation of financial, material and human resources are still topics of interest to be finalized in a medium-term period, in the pursuit of effectiveness in providing health services.

In this sense, it is necessary to review the current performance of SILAIS with respect to its primary network, hospitals, and headquarters, so that these have a bigger leading role in the decentralization process, and thus the assigned competences are assumed in an effective and responsible manner.

### **III. Rationale**

One of the modernization strategies promoted MINSA is the formulation of a sectoral legal framework to encourage and facilitate required institutional changes, so that this sector as a whole performs harmonically in terms of finding solution to health needs of the Nicaraguan population. In turn, this strategy is subsumed under the modernization reform process, which is promoted by the Nicaraguan State with support from international organizations, to improve management and efficiency in rendering public services.

In this context, the purpose of the General Health Act<sup>37</sup> is to “protect the right of every person to enjoy, keep, and recover health, thereby regulating the principles, rights, and obligations, actions regarding health, sanitation of environment, public health inspection on products and services concerning health, as well as the administrative, safety, emergency measures to be applied grounded on such regulation”.

To this end, MINSA is authorized to perform a function as a governing body in this sector, which means to coordinate, organize, supervise, inspect, control, regulate, order, and watch over health actions under the basic principles that the very same law states. Nevertheless, it is clear that for fulfillment in the competences and duties assigned, it is necessary to adjust the current organizational structure and its functionality. This review

---

<sup>37</sup> Nicaragua: Law No. 423 “General Health Act” and Decree 001-2003 “Bylaws of the General Health Act”.

includes all the structures in MINSA, referred to in this section with regard to operations of the structure named SILAIS.

The above is based on the necessity to separate the functions and responsibilities under normative centralization that must be enforced by the governing body, as in the case of the administrative decentralization\* and rendering of services concerning the very same SILAIS.

#### **IV. Frame of reference**

In order to incorporate what has been defined as functions in the different levels or bodies that make up MINSA, including SILAIS, approaches approved regarding the legal framework are submitted, as it is stated also in the new modernization initiatives such as the decentralization policy and the MAIS and institutional restructuring.

This framework will contribute to determine the functions to be carried out by SILAIS. This is an important link in separating functions or duties, particularly with regard to decentralization.

##### **4.1 Legal framework**

The legal grounds that mandate the functions of SILAIS are contained in the General Health Act and its Bylaws and by the reforms and amendments to the Bylaws of Law No. 290 “Law of Organization, Competences, and Procedures of the Executive Branch”.<sup>38</sup>

As defined by the General Health Act, MINSA is, among its competences and duties, responsible for issuing the rules of the organization, structure, and operations of SILAIS and all those aspects essential for the organization and operations, and its implementation when deemed to be proper.

Regarding SILAIS, it is defined as the “administrative and operational unit, where there is a set of sectoral and inter-sector resources, under one single management responsible for health development, in a given territorial area and population, according to territorial priorities and needs to be set, justifying such institutional development”.<sup>4</sup>

For one thing, reforms and incorporations or amendments to the Bylaws of Law 290, referred to in Art. 26, Chapter II of Title VI, incorporation of SILAIS facilities as part of the MINSA structure, stating the delegation or representation functions in the territory covered by SILAIS.

##### **4.2 MINSA decentralization policy**

Another instrument required to be analyzed in this framework for redefinition of SILAIS functions is the decentralization policy. It is expected that there will be participation (particularly service providers in primary care units and hospitals) in the exercise of competences inherent to health promotion, as well as care and rehabilitation in the terms and conditions that will gradually be defined, under the principles of economy and

---

\* Administrative decentralization includes: assignment of competences, responsibilities and (physical, human and financial) resources

<sup>38</sup> Executive Decree No. 118-2001. Published in The Official Gazette No. 2 of 3 January 2002.

<sup>4</sup> Art. No. 59 of the General Health Act.

efficiency, autonomy, technical and administrative unit, legal status of the units rendering health services, sectoral stewardship and the principle of normative centralization and operational decentralization.

The principle of normative centralization and operational decentralization establishes that MINSA headquarters will have mainly normative functions, and the decentralized units those of operations and application of the rules stated by the former. In the same vein, the policy sets out the coordination criterion under which decentralized functions shall be thereof coordinated between every administrative level, so that the SILAIS and network of health service providers perform functions consistent with those carried out by MINSA through headquarters.

Another criterion that incorporates the MINSA decentralization policy is planning, which sets forth that decentralization will take place in a coherent framework, where national health priorities are harmonized with local priorities. This also sets forth that every process of assigning competences and functions towards SILAIS and, in turn, these to health facilities, will be accompanied by the corresponding resources, so that decentralization be viable, ensuring funding to exercise such competences.

#### **4.3 Comprehensive Health Care Model**

In fulfillment of the mandate in the General Health Act and its Bylaws, MINSA has formulated the MAIS<sup>39</sup>, whose objectives are to improve the health conditions of the population, generating timely, effective, quality activities with warm feelings, to satisfy the health service needs of the population, to protect the population from epidemics and strengthen articulation between the different members of the health sector, as well as inter-institutional and inter-sector coordination.

The MAIS defines three components: provision, management, and funding, provided that the model is a product of a dynamic interaction in the care levels (provision), with management levels in the health sector (management), and with the different systems (funding).

With regard to organizing networks to provide health services, the component of rendering of services in the MAIS<sup>40</sup> establishes that running the service networks is the operational realization of the health care model and application of the principles of comprehensiveness, accessibility, longitudinal nature, and coordination, resulting in higher efficiency in the allocation and management of resources.

Likewise, MAIS sustains that a local organization of service networks and administrative structuring are responsibility of the Local Comprehensive Health Care Systems. In this sense, SILAIS is a guarantor of the number and quality of benefits and management of public funds made available to such networks.

In its management component, based on separation of functions for regulation, provision, and funding, it defines the SILAIS delegation headquarters as the administrative and operational unit of the Health System in the territory. This is the health authority in the territory, and in this capacity it sees that the policies, rules, and procedures established by the governing body are fulfilled.

---

<sup>39</sup> Comprehensive Health System Model (MAIS), Ministry of Health. May 2004

<sup>40</sup> Ib. 4. p 32

MAIS considers that decentralization is a basic process in place for management to be efficient and effective. And it concludes that the management agreement and commitment is the instrument through which the relation between the regulatory body and SILAIS is made operational. For this reason and for the purpose of facilitating decentralization processes in managing resources, it sets forth that the function of hiring or purchasing health services in MINSA should be created and developed.

SILAIS, as a health authority in the territory, is responsible for the function of administration and operations, control, supervision of compliance with laws, rules, regulations, by applying the planning, monitoring, inspection, and surveillance tools for analysis on efficiency and quality in service delivery.

The different systems<sup>41</sup>, which fund benefit programs to guarantee coverage to all the population, are included in the MAIS funding component, considering funding sources, way of allocating funds and payment mechanisms, either public or private providers, in each one of the different systems and levels of care.

## **V. Concept of SILAIS**

In accordance with the General Health Act, Law 423, SILAIS is defined as the “administrative and operational unit, where there is a set of sectoral and inter-sector resources, under one single management responsible for health development, in a given territorial area and population, according to territorial priorities and needs to be set, justifying such institutional development”.

## **VI. Functions**

Starting as of the frame of reference stated in section IV, the functions to be carried out by SILAIS are the following:

### **6.1. General functions**

The general functions are framed within a new process approach for restructuring MINSA, to abide by mandates in the General Health Act, as well as other laws relating to this sector. They are focused on follow-up and verification of the legal framework, policies, control in the efficient and transparent use of resources, public health surveillance, keeping track of risk and damage to health, stating this as follows:

1. To represent MINSA politically and administratively.
2. To apply the Law, its Bylaws, and other legislation in force.
3. To develop health policy and help in its application.
4. To monitor, supervise, and assess the fulfillment of rules issued by the health authority.
5. To coordinate for application of the care model, with private and public facilities and health service providers.
6. To watch over the fulfillment of plans and programs in the non-tax collection, tax collection, and voluntary system in the health service network.

---

<sup>41</sup> As stated in chapters I, II, III and IV of General Health Act and its Bylaws

7. To authorize operations in facilities providing health services.
8. To authorize rendering of services by foreign providers.
9. To prepare proposal for operational and budgetary planning that must be followed or conducted by public network facilities
10. To articulate public health strategies between primary and secondary health care, other social actors in this sector.
11. To work as a liaison office with the autonomous regions, to coordinate with regional health authorities.

## **6.2. Specific functions**

1. Application of legal framework.
2. Health surveillance.
3. Operations control
4. Quality control.
5. Social Participation.

### **6.2.1 Application of legal framework**

SILAIIS, as a health authority in such territory, applies and encourages compliance with the General Health Act, its Bylaws, and other effective legislation<sup>42</sup> related to providers of health products (goods) and services, health professionals, supplies, producing, distributing, storing establishments, or sellers of goods or services impacting on health.

#### **6.2.1. Public health surveillance**

- Making timely decisions in the face of eventualities making impact on public health.
- Promoting surveillance in public health, control of risks and damage to health.
- Furnishing technical assistance for application of rules in disaster prevention and mitigation.
- Coordinating health actions for disaster response.

#### **6.2.2. Operations or management control**

- Managing the organization and structuring networks of health service providers.
- Supervising fulfillment of goals, plans, and programs.
- Following up and assessing management contracts and agreements.
- Providing technical assistance to improve rendering of services, work organization, managerial and leadership techniques.
- Running and implementing management information system.
- Following up on management and implementation of foreign cooperation projects of providers.
- Watch over and control an efficient and transparent use of resources from the non-tax collection system.
- Doing supervisory work in the application of policies, rules, and basic administrative procedures to human resources.

#### **6.2.3. Quality control**

- Conducting special medical audits, watching over, and supervising fulfillment of the corrective measures issued by SILAIIS.
- Supervising performance of medical audits in health facilities.
- Supervising and assessing quality in the process of providing care.

---

<sup>42</sup> Ib. 7. number 2.

- Keeping track of quality in vital and health statistics of its territory for operations control.
- Checking certification of professionals, technicians, and authorization of non-professionals of its locality.
- Verifying the fulfillment of quality standards in the facilities to start operations.
- Conducting sanitation quality control on products registered in the production process and commercialization chain.
- Supervising and controlling quality of services rendered by public and private health service providers.

#### 6.2.4. Social participation

- Coordinating and promoting sectoral and non-sectoral participation in its territory.
- Promoting citizen participation for socially-oriented control of operations or management.
- Promoting citizen joint responsibility in actions for improvement of living conditions and quality of life of the population.
- Presiding over provincial health council<sup>43</sup>.
- Participating the hospital consultation committees.\*
- Promoting coverage extension for certification of the vital statistics.

## VII. Glossary

**Audit of medical care quality:** It is a systematic and retrospective assessment of the quality (content) of the medical attention, which is based on analysis of the clinical records.

**Certification:** This refers to professional accreditation that proves that individuals and/or services fulfill established academic requirements and competence standards for public health professional practice. Such certifications state the competences in the exercise of activities or services provided.

**Citizen joint responsibility:** Mutual acknowledgment between municipal elected authorities and organized citizens as solidarity and responsible partners in the challenge of facing appropriately every phase in the diverse specific projects, intended to be carried out as agreed. This means in its identification, hierarchical structuring and time frame, its detailed preparation, in search of and commitment for the necessary resources, its implementation, its evaluation, and finally in its later sustenance.

**Decentralization:** Process of assignment or transfer of the health administration, competences, responsibilities, functions, resources, authority, and power to make decisions from the headquarters to the localities.

**Enabling or Authorizing:** Process by which a set of requirements is assessed in order to authorize operations of a facility that provides health services.

**Facilities, health service providers:** These are places where activities are intended essentially for health promotion, prevention, recovery, and rehabilitation. These facilities

---

<sup>43</sup> Art. 10 in the General Health Act and its Bylaws

\* Art. 7, Subsection 3 in the General Health Act and its Bylaws and Ministerial Agreement 59-2003

are authorized or enabled by MINSA, and they provide health services in any of the systems referred to in the Law and its Bylaws.

**Funding schemes:** They are the systems that fund benefit programs in the health sector.

**Health service providers:** They are natural, artificial persons, public or private or mixed ones, which having been authorized by MINSA, their purpose is to provide services in the phases of health promotion, protection, recovery, and rehabilitation.

**Health professionals:** Human resources educated in health areas or disciplines, duly certified by any duly known higher education or technical institution.

**Legal framework:** What is subject to legal provisions. More specifically, this framework is defined as a declaration of the expected quality, set forth as rules or standards for implementation, specifications, clinical practice guides or protocols, administrative or managerial procedures.

**Levels of care:** They are organizational forms of health services that are rendered to the population, and they are based on the complexity of their technology, which enables them with capability to find solution to health problems.

**Management commitments:** It is an instrument that records the commitments made by the provider and obligations of the financing entity. It contains the specific goals for production or delivery of services and the interventions for continuous quality improvement, as well as the volume of resources to be delivered to ensure the agreed provision and the incentive system to be applied.

**MINSA decentralization policy:** General guidelines defining the responsibility transfer process on the necessary resources and local decision-making.

**National health council:** It is the one in charge of advising the governments on health matters and similar socio-economic matters affecting the whole the country.

**Network of health facilities:** It is a set of community resources, public and private facilities with diverse complexity and forms to provide care. These share common objectives, articulating with each other to meet the demand for health of a population in a certain territory.

**Non-tax collection system:** It includes a set of benefits allocated to fund the services pointed out in the General Health Act<sup>44</sup> and its Bylaws<sup>45</sup>, to which vulnerable populations (women, children, adolescents, the elderly, and those in extreme poverty) may have access.

**Operations control:** They are processes for monitoring, supervision, surveillance, and evaluation of plan development and objective fulfillment, ensuring compliance with the policies, functions, and goals in the health system.

---

<sup>44</sup> Nicaragua. General Health Act. op. cit. Articles 40, 49 through 52

<sup>45</sup> Nicaragua. Bylaws of the General Health Act. Op. Cit. Articles 349 through 352



**Provider:** It is a body or entity, in a given territory, responsible for developing qualifications or competences that are assigned by the SILAIS. These are health promotion, prevention, care, and rehabilitation, as well as decentralized resource management to provide services.

**Public health inspection:** It is a number of actions in order to have the best security against spread of diseases, with minimum restrictions to facilitate the movement of people, products, vehicles, objects, or others.

**Public health surveillance:** It is defined as the follow-up, systematic collection, analysis and processing of data on health events or health-related conditions to be used in planning, implementation and evaluation of public health programs, including as a basic element the dissemination of such information among people that need to know it. It includes the following main elements: (a) demographic surveillance, (b) surveillance of health events, (c) surveillance of the Health System, and (d) monitoring the opinion of the population and the degree of satisfaction.

**Quality of care:** It is a guarantee to improve continually the health situation of the population in its different phases and levels of care, according to availability of resources and existing technology, to provide the best benefit and satisfaction with the least cost and likely risk.

**Rendering of services or Provision of services:** It is a set of specific, defined, and organized activities provided to the population and environment, through an organized service network.

**Social participation:** Process of getting social actors, individually or collectively, involved in order to impact and participate in decision-making, management, and design of public policies in the different levels and forms of the country's administration, for the purpose of attaining sustainable human development with joint responsibility with the State.

**Socially-oriented operations control:** It means that individuals and communities participate in decision-making on operations conducted by public or private institutions of which they are users, so that services provided and these institutions are consistent with expectations of such community and the country's traditions in political, social, cultural, and administrative matters.

**Standard:** It is an expected and attainable performance level that may be compared with the current performance level.

**Tax collection system:** It includes a set of benefits and services, to which beneficiaries (tax-paying employees, employers, and the self-employed with optional insurance) in the INSS' systems may have access.

**Voluntary system:** It includes the benefits and services to which users, relations, or companies, by their own means, may have access.



# Ministry of Health Government of the Republic

## MINISTERIAL AGREEMENT No. 88-2004

**JOSE ANTONIO ALVARADO CORREA**, Health Minister, by virtue of the Powers vested on me by Law No. 290 "Law of Organization, Competition, and Procedures of the Executive Branch or Power", published in the Official Gazette, Number 102 on 3 June 1998, Decree No. 118-2001 "Reforms and Amendments to Bylaws of Law 290 Law of Organization, Competence, and Procedures of the Executive Power, Published in the Official Gazette, No. 003 and 004 dated 3 and 4 January 2002, respectively, law No. 423 General Health Act, published in the Official Gazette, No. 91 of 17 May 2002. Decree No. 001-2003 "Bylaws of the General Health Act", published in the Official Gazette, No. 07 and 08 dated 10 and 13 January 2003, respectively.

### WHEREAS

I

In Article 59 of the Political Constitution of the Republic of Nicaragua, its main parts state that, **"Nicaraguans have the right of health on an equal basis. The State shall create basic conditions for health promotion, protection, recovery and rehabilitation. It is responsibility of the State to manage and organize health programs, services and activities."**

II

Law No. 423, "Law of Organization, Competence, and Procedures of the Executive Power", in its Art. 26 item b), sets forth that the Ministry of Health must "coordinate and guide the execution of the State health policy concerning health promotion, protection, recovery, and rehabilitation".

III

The "General Health Act N° 223, Article 1 sets forth that the purpose of this law is to protect the right that every person has to enjoy, keep, and recover health, in harmony with the legal provisions and special rules. Likewise, **its Article 2 states and clearly sets forth that the Ministry of Health is the competent body to prepare, approve, apply, supervise, and assess technical standards, to formulate policies, plans, programs, projects, manual, and instructions manuals that are necessary to apply them.**

(Seal)  
Ministry of Health  
Government of the Republic



# Ministry of Health Government of the Republic

## **MINISTERIAL AGREEMENT No. 89-2004**

I, José Antonio Alvarado C., incumbent Minister of Health, by virtue of the powers vested in me, hereby do

### **ENACT:**

- FIRST:** The document titled "ROLE OF LOCAL COMPREHENSIVE HEALTH SYSTEMS"(SILAIS), is approved, and it is an integral part of this Ministerial Agreement, as Annexes A, B and C, including Annex D. Recommendations for its implementation.
- SECOND.** The Division in charge of regulating Health Facilities, Health Professionals, Medicines and Foods, is hereby authorized to make known the passed regulations or rules to the different bodies in connection with such subject matter. Likewise, it ensures implementation, follow-up, evaluation, and due application of the said rules or regulations.
- THIRD.** This Ministerial Agreement shall be in force upon its date of execution.
- FOURTH.** Any provision contrary to this Ministerial Agreement hereto is hereby repealed.

Issue this document to whom it may concern

Managua, this 14<sup>th</sup> day of May 2004.

(Sign & Signature)  
JOSÉ ANTONIO ALVARADO CORREA  
HEALTH MINISTER

# Annex 3

## HSCC Meetings



**Republic of Nicaragua**

**Ministry of Health**

**Functional Manual for the  
Nicaraguan Health Care Fund  
(FONSALUD)**

**Annex 2**

**Managua, Nicaragua, August 2005**

## Table of Contents

1) Introduction .....	3
2) Definition of FONSAUD and the FONSAUD Committee.....	3
3) FONSAUD Committee Members .....	3
4) Functions of the SWAp Technical Secretariat .....	4
5) Functioning of the FONSAUD Committee .....	4
6) Fiduciary mechanisms.....	6
7) Procurement procedures.....	8
8) Reports .....	8

# **FONSALUD Functional Manual**

## **1) Introduction**

- a) This manual describes the essential aspects and necessary documents related to the functioning of FONSALUD based on the implementation of the provisions set forth in the Memorandum of Understanding between the Government of Nicaragua and the Signatory Partners in Development (hereinafter MOU) in relation to the Nicaraguan Health Care Fund (hereinafter FONSALUD). This manual supplements the provisions of the MOU.

## **2) Definition of FONSALUD and the FONSALUD Committee**

- a) Pursuant to Article 2 of the Memorandum of Understanding, “FONSALUD is a financial mechanism for supporting the Five-Year Plan of the Ministry of Health, the resources of which shall be managed by MOH in accordance with domestic laws and procedures. It shall be managed by the FONSALUD Committee, comprised of all the signatories of this MOU (hereinafter FONSALUD Partners), or delegates thereof.”
- b) The Committee is the organ of FONSALUD responsible for consultation and negotiation. Its attributes are defined in article 23 of the MOU.

## **3) FONSALUD Committee Members**

- a) The FONSALUD Committee (hereinafter “the Committee”) is made up of the legal representatives of the institutions that have signed the MOU: ministries of the Government of Nicaragua (Ministry of Health, Ministry of Foreign Relations, Ministry of Finance and Public Credit, Secretary of Coordination and Strategy of the Presidency of the Republic) , donor countries and cooperation agencies.
- b) The legal representatives may delegate their responsibilities to not more than two persons. This delegation of responsibilities must be notified in writing to the Minister of Health of Nicaragua, who shall inform the other FONSALUD Partners.
- c) If a representative delegates to two persons, both or one of them shall interchangeably represent the FONSALUD Partner in the meetings of the Committee. The delegates shall participate, on behalf of the institution they represent, in the votes that eventually take place and each institution shall have the right to one vote, regardless of the number of delegates present at the meeting.
- d) The Minister of Health of Nicaragua shall chair the Committee.
- e) The Secretary of the SWAp Technical Secretariat (hereinafter SWTS) shall serve as the Secretary of the Committee, who shall participate in the meetings without right to vote.

#### **4) Functions of the SWAp Technical Secretariat**

- a) The SWTS forms part of the General Directorate of Planning and Development (hereinafter GDPD). Its Secretary is named by the Minister of Health and reports directly to the presidents of the Health Sector Coordination Table and the Committee. The Secretary's functions and job conditions will be known to the FONSALUD Committee. The SWTS team is comprised of members of the GDPD. The functions of the SWTS concern maintaining the impetus of the Sector Wide Approach in the health sector and fulfilling the MOH's own commitments, without, at any moment, substituting for the institutional units responsible for each of the commitments.
- b) The functions of the SWTS are as follows:
- Participate in GDPD planning processes, especially the Five-Year Plan and annual operational plans at central, SILAIS and local levels.
  - Prepare the reports that fall under the responsibility of the GDPD for the Health Sector Coordination Table and FONSALUD Committee meetings.
  - Accompany and assist the General Administrative and Financial Division in all aspects of their work relating to the Sector Wide Approach, especially the preparation of reports for the Health Sector Coordination Table and the FONSALUD Committee.
  - Establish the necessary coordinating mechanisms in order to work with other government authorities in order to advance with the Sector Wide Approach and fulfilment of commitments.
  - Design and implement, in collaboration with all MOH divisions, information and awareness raising strategies with regard to the Sector Wide Approach, targeting the MOH itself, other actors within the sector, civil society and the development cooperation community.
  - Fulfil the responsibilities of the Secretariat with regard to the Health Sector Coordination Table and FONSALUD Committee.
  - Accompany and report on any advances in the Sector Wide Approach.

#### **5) Functioning of the FONSALUD Committee**

- a) The decisions of the Committee regarding the agenda items set forth for each regular or special meeting shall be approved by consensus by the FONSALUD Partners attending the meeting. In exceptional circumstances, if consensus is not reached, decisions may be approved by at least two-thirds of FONSALUD partners, as long as said two-thirds include all members of the government that form part of the Committee.
- b) In the event that a FONSALUD Partner is unable to attend a Committee meeting, the decisions unanimously approved by the other Partners attending the meeting shall be effective in all aspects not affecting bilateral agreements between the absent FONSALUD Partner and the Government of Nicaragua or disbursements previously established.



- c) The FONSALUD Partners shall communicate amongst themselves in a timely and expeditious manner regarding any aspects they may deem fit and shall use communications via email or letter to express their opinions and positions in relation to any matters that may be of interest for FONSALUD and that should be taken into account in the decision-making of the Committee.
- d) The dates and fixed agenda items for the regular Committee meetings are those set forth in article 38 of the MOU, to which may be added an item of "other matters". This "other matters" item will give all FONSALUD Partners the opportunity to bring up those matters that they consider relevant and, eventually, submit them to a vote.
- e) The SWTS shall be responsible for managing all aspects that may be necessary to ensure the sound functioning of the Committee, including distribution of relevant information, calls to regular and special meetings, delivery of documents and drafting the aid memoir of the meetings.
- f) Meetings shall be called by the Secretary of the SWTS not less than 10 calendar days in advance. Notice of the meeting shall be delivered to all FONSALUD Partners, along with the draft agenda and any documents required for the meeting.
- g) Additional items shall be included in a meeting's agenda at the request of the chair of the Committee or when the proposal has been supported by at least three FONSALUD Partners. Proposals for additional agenda items should reach the SWTS at least 7 days before the date of the meeting and will be communicated to all FONSALUD Partners in advance of the meeting in question.
- h) The last item at the Committee meetings shall be the signing of the respective aid memoir. In exceptional cases, if the FONSALUD Partners who are present shall so decide, a draft of the aid memoir shall be forwarded by email within an established period and signed by the FONSALUD Partners at their respective headquarters.
- i) Special meetings of the Committee may be convened if any of the circumstances provided in Sections 9, 10, 11 or 12 of the MOU arise.
- j) Special meetings shall be convened by the Secretary of the SWTS upon request of the Committee Chair or by the FONSALUD Partners by simple majority. Notice of the meeting shall be delivered not less than 7 days in advance, along with the draft agenda and other relevant documents.
- k) Special meetings shall be considered valid if at least two-thirds of FONSALUD Partners are represented. If it is not possible to convene two-thirds of the FONSALUD Partners, decisions will be considered accepted if supported by email or regular post following the same criteria as those set forth for regular meetings.
- l) In addition to the FONSALUD Partners, or delegates thereof, other persons proposed by the chair or at least 3 FONSALUD Partners may be invited to participate in the FONSALUD Committee meetings. The invitation will be extended by the SWTS. Those other persons invited will have the right to participate, but not to vote.

- m) If any circumstance arises that justifies, according to MOH criteria, the use of the FONSALUD resources in an activity or expenditure not foreseen in the respective AOP, yet contemplated in the Five-Year Plan, and which necessitates modifications to the Annual Procurement Plan; MOH shall inform upon and distribute copies of the Plan, plus all supporting documents, to FONSALUD Partners.
- n) Upon receiving said request and the respective supporting documents, the FONSALUD Partners shall give their approval via email or request that a special meeting of the Committee be called within 7 calendar days after receipt thereof. Any such request to change the use of the resources shall only be considered accepted upon approval by at least two-thirds of all FONSALUD Partners.
- ñ) The mechanism relating to the incorporation of new FONSALUD Partners is set forth in section 11 of the MOU.
- o) The terms of reference for evaluations, performance or financial audits, reviews or other reports that require inputs from FONSALUD Partners shall be sent to said partners 10 days before the regular meeting in which they will be discussed and accepted.

## **6) Fiduciary mechanisms**

- a) Section 4 of the MOU, "Contributions and Disbursements", sets forth the fiduciary mechanisms to be followed in the execution of FONSALUD.
- b) The formulation, programming, execution and assessment of the MOH budget is a comprehensive process that includes all sources of financing (treasury, grants, external loans and specifically earmarked revenues), which is governed by the budget execution and control rules and procedures established by the Ministry of Finance and Public Credit (hereinafter MHCP). These rules and procedures are available at the following website: <http://www.hacienda.gob.ni>.
- c) The extension of coverage consists of the purchase of health services from institutional and non-institutional providers in the areas or regions of the country that MOH has targeted. This strategy comprises the calculation of a *per capita* budget assignment based on the size of the target population to be attended by means of the management agreements with the SLIAIS, who in turn sign management agreements and service contracts with institutional and non-institutional providers respectively.
- d) The mechanisms for the disbursement of the resources of FONSALUD financiers to the MOH are as follows:
  - i) The MHCP shall open an account at the Central Bank of Nicaragua (hereinafter BCN), under the name of 'TGR-MINSA-FONSALUD-External Cooperation', for depositing all resources contributed by those FONSALUD Partners who elect to use a joint account. Individual accounts shall be opened under the name 'TGR-MINSA-FONSALUD-Name of relevant FONSALUD Partner' for those FONSALUD Partners electing to identify the how their resources have been utilized. The resources payable to these accounts shall be in US dollars or Euros, as previously established. MOH intends to advance as much as possible towards the exclusive use of the joint account.

- ii) Auxiliary accounts shall be opened in the Treasury Single Account (hereinafter CUT) for each of the accounts described above in paragraph c) i).
  - iii) At the request of the MOH, the MHCP will debit the relevant account in the BCN and register the resources in córdobas in the corresponding auxiliary account of the CUT.
  - iv) MOH shall submit to the FONSALUD Partners annual statements describing the deposit and debit flows in the BCN and CUT auxiliary accounts.
- e) Three mechanisms exist in order to execute MINSAs funds; direct payments to providers, rotating funds and *per capita* transfers. With regard to direct payments and the formulation of funds, the following requirements must be fulfilled: the existence of budgeted credit, the expenditure must be foreseen in the approved quarterly budget, and it should be an earmarked expense when applicable.

**e) 1. Direct payments:**

Contractual agreements between executing units and third parties concerning the purchase of goods or services.

- i) Executing units remit requests of payment to providers to the Administrative and Financial Directorate of the MOH (hereinafter DAF-MOH), along with copies of supporting documentation.
- ii) DAF-MOH, upon receipt of requests, reviews, approves and registers them in the Integrated Financial, Administrative and Auditing Management System (hereinafter SIGFA) with the purpose of requesting the relevant payment by the MHCP from the relevant financier's account.
- iii) The General Treasury of the Republic of the Ministry of Finance and Public Credit (hereinafter TGR-MHCP) receives said requests from MOH, approves them, and prepares a cheque payable to the provider. The cheque is then made available to the MOH treasury that collects it from the TGR-MHCP cashier's office.
- iv) MOH receives the cheques through its treasury and distributes them to the executing units in order to make payment to the provider.
- v) When the financial obligation is at a local level, the executing units not only make payment through the delivery of the cheque to the provider, but also file the original documentation, with the purpose of providing the information to the corresponding authorities when required.
- vi) When the financial obligation is of an institutional nature, the MOH treasury should make payment to the provider and consequently submit the supporting documentation to the MOH Central Accounting office in order to register the payment.

This procedure takes approximately 20 working days.

**e) 2. Rotating Funds:**

- i) MOH, through SIGFA, and in accordance with the rules and procedures of Execution and Budget Control, formulates an institutional rotating fund on the basis of the various requests of the executing units and the budgetary credits approved by the distinct financing sources.
- ii) The MHCP approves the request of the fund created in SIGFA and transfers the identified resources to a bank account opened by MOH for such a purpose at a commercial bank.

- iii) Once confirmed, the identified funds are transferred to the bank accounts of the executing units in accordance with the amounts established and approved by the MOH. A notification form confirming the funds have been deposited is sent to the executing units, with a copy being kept by the MOH central accounting office in order to track the transaction.
- iv) The executing units make payment at the local level, debiting the appropriate bank account, in accordance with the Technical Rules of Internal Control. Once the resources have been executed they are reported in the DAF-MOH, which, in turn, reports the expenditure by way of SIGFA to the MHCP and requests renewal of the fund.
- v) The original documents are kept by the executing unit should they be required for any auditing process or other appropriate purpose.
- vi) At the end of the year all funds are closed and the fiscal year's budget is liquidated.

This procedure takes approximately 12 working days.

**e) 3. Per capita transfers:**

Extension of coverage shall be carried out through transfers calculated on a *per capita* basis to institutional providers and by direct payments to non-institutional providers as dictated by the management agreements and service contracts signed between the SILAIS and the institutional providers.

- f) MOH shall present its reports in córdobas and US dollars, using the exchange rate corresponding to the last day of the month before the preparation of the report.

**7) Procurement procedures**

- a) Procurement of goods, works and services with FONSAUD resources shall be carried out as set forth in article 33 of the MOU.
- b) MOH shall publish its Annual Procurement Program as provided in Government Procurement Law 323. Prior to the publication of said program, sufficient budget credits shall be available for its implementation.
- c) MOH, through the Procurement Unit, shall prepare and deliver to the FONSAUD Partners written drafts of the terms and conditions for tenders.

**8) Reports**

- a) All reports shall include an analytical section identifying the most relevant findings, describing the underlying reasons and indicating, where necessary, any measures to be taken in order to solve them or to adjust to the respective plans. In the case of evaluations, performance audits or revisions of the AOPs or Five-Year Plan, the analytical sections shall be especially orientated towards evaluating the impact on health and its social and environmental determinants, increases and equity in access to services, quality and acceptance of services by the population, efficiency in the use of resources, and consideration of the transversal themes of gender, respect for the cultures of indigenous populations and the environment.

- b)** The reports on the AOP shall include a matrix reflecting the objectives, strategic guidelines, strategic actions, expected outputs, critical activities at each level, quarterly execution, financial resources and sources of financing, programmed goals for each indicator and the results obtained during the period, if appropriate.
- c)** Semi-annual and annual financial reports shall be issued by SIGFA on a quarterly basis as provided in section 8 of the MOU. The reports shall contain detailed information regarding financial execution by source<sup>1</sup> and respective link with the goals set forth in the AOP. These reports shall include cash flow, budget execution and bank reconciliation.

---

<sup>1</sup> Source of financing refers to the accounts opened by MHCP at BCN in the name of TGR-MINSA-External Cooperation and TGR-MINSA+ name of FONSALUD Partner.



**Memorandum of Understanding  
(MOU)**

**between the**

**Government of Nicaragua, represented by the  
Ministry of Foreign Affairs and Ministry of Health**

**and the**

**Signatory Partners in Development supporting the Health Sector**

**in relation to the**

**Nicaraguan Health Fund  
(FONSALUD)**

**Managua, Nicaragua, August 2005**

Whereas:

1. The Government of Nicaragua, represented by the Ministry of Foreign Affairs, has requested support from the Partners in Development (PDs) supporting the Health Sector to finance the 2005-2009 Five-Year Health Plan (hereinafter Five-Year Plan) of the Ministry of Health (hereinafter MOH), for purposes of executing the National Development Operational Plan, 2004-2015 National Health Policy and 2004-2015 National Health Plan. To this end, the Nicaraguan Health Fund (hereinafter FONSALUD) has been created. The Partners in Development shall contribute to FONSALUD and hereinafter shall be referred to as "Signatory PDs".
2. FONSALUD is a financial mechanism for supporting the Five-Year Plan of the Ministry of Health, the resources of which shall be administered by MOH in accordance with domestic laws and procedures and those established in this MOU. It shall be managed by the FONSALUD Committee, comprised of all signatories of this MOU (hereinafter FONSALUD Partners), or delegates thereof. The characteristics and functioning of FONSALUD are described in this MOU and in the FONSALUD Functional Manual.
3. This MOU is intended to serve as an instrument for implementing the National Alignment and Harmonization Plan in the health sector and coordinating all support provided by the Signatory PDs and other Partners in Development who wish to support the Five-Year Plan in the future by channeling resources through FONSALUD.
4. The Ministry of Finance and Public Credit (hereinafter MHCP) hereby agrees to provide financing to MOH in accordance with the General National Budget and, as of 2006, in accordance with the Multi-Annual National Budget. MHCP further agrees to maintain or increase the percentage share of MOH in national spending on poverty reduction. The Signatory PDs have agreed to support the Five-Year Plan by providing financial assistance through FONSALUD at the request of MOH.
5. Contributions to be provided by the Signatory PDs shall be agreed through bilateral agreements and loan agreements entered into by the Government and each Signatory PD. Disbursements shall be approved in accordance with internal procedures applicable to each Partner in Development.
6. The FONSALUD partners have agreed to the principles of coordination, alignment, harmonization and transparency set forth in the Code of Conduct signed by the Partners in Development and the Government and have agreed to harmonize their efforts around the budgetary, treasury, accounting and procurement systems and laws of the Republic of Nicaragua that govern MOH. At the meetings of the FONSALUD Committee (the structure and functions of which are described in Section 3 of this MOU), the members shall review the execution of this agreement and shall make timely recommendations to advance in the achievement of the objectives set forth hereunder.
7. The FONSALUD partners have agreed on common procedures for consultation and decision-making, disbursement mechanisms, monitoring, reviews and evaluations, audits, financial management and reporting, sharing of information and cooperation

amongst the Signatories, pursuant to provisions in this MOU. These procedures are described in the FONSALUD Functional Manual, attached as Annex 3 to this MOU.

8. Respect for human rights, democratic principles, gender equity, the rule of law and good governance enshrined in the internal and international policies of the Government of Nicaragua and the bilateral donors constitute the fundamental principles which inspire the commitment of the Government of Nicaragua and the bilateral donors; signatories of this MOU.

Now, therefore, the Signatories have agreed as follows:

### **Section 1 Purpose and Scope of this Memorandum of Understanding**

9. The purpose of this MOU is to establish common rules governing the financing mechanism for the Five-Year Health Plan named FONSALUD, which shall be used by all Signatory PDs and shall serve as a framework for an ongoing dialogue regarding joint performance reviews and planning, disbursement, procurement, evaluation and audit procedures.
10. The Five-Year Plan shall execute the 2004-2015 National Health Plan and comprises the mission, vision, institutional policies and the respective short and medium-term objectives, strategic guidelines, costs and goals.
11. The Five-Year Plan shall be executed through the Annual Operating Plans (hereinafter AOPs). The AOPs shall be formulated in accordance with the availability of resources allocated to MOH by the State or international cooperation agencies under the FONSALUD modality or otherwise.
12. The core objectives of the Five-Year Plan are: (i) To extend health services, (ii) To strengthen the health service network and (iii) To steward development, institutional strengthening and decentralization.
13. The Government and each Signatory PD shall enter into bilateral agreements and loan agreements, which shall be consistent with the spirit and provisions of this MOU and the parties shall not establish any conditions that contradict or disagree with this MOU. If any inconsistency or conflict arises between the terms and conditions of this MOU and any bilateral agreement or loan agreement, the provisions of such bilateral agreements and loan agreements shall prevail.
14. The Signatory PDs shall base their support on the progress achieved in the execution of the Five-Year Plan. Progress shall be measured by using intermediate and results indicators. These indicators have been jointly agreed based on the indicators selected by MOH for monitoring the Five-Year Plan and described in Annex 4 of this MOU. Progress monitoring and evaluation shall be shared with all the countries and agencies cooperating in the health sector through the Health Sector Coordination Table. As of 2006, the indicators shall be disaggregated and presented by gender, when appropriate.



15. The Signatory PDs may support other state institutions and civil society organizations whose activities contribute to the performance of the health sector and citizen participation therein. This support shall be provided under other joint financing agreements or bilateral agreements. The Signatory PDs agree to timely inform MOH regarding the scope and progress of such support, seeking to include it in the Five-Year Plan, when appropriate.

## **Section 2 Responsibilities**

16. MOH shall be responsible for implementing the Five-Year Plan and the respective Action Plans and for managing all monetary contributions to FONSALUD. Contributions to FONSALUD shall be solely used for expenditures included in the respective Action Plan, respecting the conditions of the bilateral agreements signed with each Signatory PD.
17. MOH shall maintain accurate and complete financial records of the receipt and disbursement of all contributions received in accordance with domestic laws, including the Budgetary Regime Law, Annual Budget Law, SIGFA 44 – 98 Decret, National Public Investment System (NPIS) Law, Public Procurement Law, Organic Law of the Office of the Comptroller General of the Republic, Decree 44-98 regulating Article 21, subparagraph H, of Law 290, MHCP Budget Execution and Control Guidelines, international accounting principles, and other relevant rules and regulations. MOH applies and shall apply the Integrated Financial, Administrative and Auditing Management System (hereinafter SIGFA) and Financial Management Information System (hereinafter SIAFI), with the objective of maintaining accurate accounting information regarding the financial execution in accordance with the structure of the 2005-2009 Five-Year Plan and the respective AOPs.
18. MOH and the Signatory PDs agree to continue and intensify institutional strengthening, especially MOH's planning, monitoring, evaluation, procurement and administrative-financial management capacity. These strengthening efforts shall be fundamentally geared to upgrade human capacity within the framework of the Five-Year Plan and AOPs, taking into account the Civil Service and Administrative Career Law, and maintaining close Affairs with other national training programs.
19. The FONSALUD Partners shall extensively cooperate and communicate amongst each other in a timely manner with respect to all matters concerning the execution of the FONSALUD funds and this MOU. The FONSALUD Partners shall share information regarding the flow of funds, technical reports and any other relevant documents or initiatives related to the execution of the 2005-2009 Five-Year Plan and AOPs, as appropriate.
20. MOH shall promptly inform Signatory PDs with regard to any circumstance that interferes or threatens to interfere with the successful execution of the Five-Year Plan or AOPs, with a view at finding a solution. When appropriate, MOH shall call special meetings to consult with the Signatory PDs any corrective actions to be taken in accordance with the procedures described in the FONSALUD Functional Manual.

21. In all matters related to the implementation of this MOU, MOH's highest authority, or delegate thereof, shall represent the Government of Nicaragua. The representatives of each Signatory PD shall be designated in the respective bilateral agreements.

### **Section 3 Organizational Structure, Consultations and Decision-Making**

22. The guiding principles and bodies in charge of the political and technical dialogue, monitoring, evaluation and audits of the Five-Year Plan and AOPs are defined in the Code of Conduct and in this MOU.
23. All consultations and negotiations regarding FONSALUD shall be conducted through the FONSALUD Committee. The FONSALUD Functional Manual, attached as an annex to this MOU, describes the mechanisms to be used by the FONSALUD Committee.

The FONSALUD Committee shall have the following powers:

- To approve the terms of reference of the FONSALUD audits, external evaluations and missions.
- To approve and monitor the disbursement plan of the FONSALUD Partners.
- To analyze the AOPs and progress evaluation reports with respect to the Five-Year Plan.
- To analyze the income and expenditure flows plan for the execution of the AOP.
- To analyze the administrative, financial and procurement reports regarding the implementation of FONSALUD.
- To make recommendations geared to improve the effective use of the FONSALUD resources.
- To propose amendments to this MOU, taking into account Article 57 in Section 11 of this MOU.

### **Section 4 Contributions and Disbursements**

24. FONSALUD shall be funded by annual disbursements transferred by the Signatory PDs and counterpart funds provided by the Government.
25. Funds provided by the Signatory PDs shall be transferred in accordance with the budget execution and control guidelines issued by MHCP, those established by MOH and provisions set out in the bilateral agreements and loan agreements entered into with the Signatory PDs.
26. MOH agrees to carry out the necessary procedures in order to include the contributions provided by the Signatory PDs in the General Budget of the Republic.
27. Each Signatory PD shall make disbursements in US dollars or euros to the "TGR – MINSA – FONSALUD" accounts opened at the Central Bank of Nicaragua (BCN) for such purpose. Said funds shall be transferred to the Treasury Single Account, upon prior request from MOH to MHCP, in order to meet payment requests by the health units or health providers contemplated in the AOP and approved budget.

28. The Treasury of the Republic shall inform MOH in writing not more than 72 hours after the funds are deposited at the Central Bank of Nicaragua, specifying the amount and type of currency. Likewise, the Signatory PDs shall inform MOH when said funds are transferred. MHCP shall guarantee the payments and transfers requested by MOH not more than 48 hours after MOH complies with all requirements set forth in the respective guidelines.
29. The Signatory PDs shall inform the MOH in the month of April with respect to the amounts earmarked to finance the next budget period, these amounts shall be confirmed one week after the planning meeting in August and not later than August 31<sup>st</sup>.
30. If the level of execution is not as scheduled, disbursements provided by the Signatory PDs may be modified according to agreed criteria and bilateral agreements in force, informing the Committee accordingly of these modifications.
31. Any funds provided to MOH that have not been used by the end of each bilateral agreement or loan agreement shall be negotiated with the Signatory PDs to be applied in the next period of execution of the Five-Year Plan, in accordance with provisions in said agreements.
32. The use of FONSALUD resources for any activities or expenditures not explicitly included in the AOP for the current year shall be subject to the prior approval of the FONSALUD Committee in accordance with the respective procedures described in the FONSALUD Functional Manual. To this end, MOH shall request and justify such alternative use, indicating how the original budget will be offset.

## **Section 5 Procurement**

33. Procurement of goods and services with FONSALUD funds shall comply with the rules set forth in the Public Sector Procurement Law and regulations thereof (Law 323 of the Republic of Nicaragua). As a transition and exceptional measure for those Signatory PDs that have signed bilateral donation or credit agreements predating this MOU, the procedures described in those agreements will take precedence, according to the terms established in section (f) of Article 3 of Law 323.
34. Procurement of goods and services shall be carried out through the MOH Procurement Unit. The Government hereby agrees, through its regulatory bodies and MOH, to strengthen human and technical capacities in the MOH Procurement Unit. To this end, the necessary resources and activities have been included in the Five-Year Plan. The national procurement system shall be strengthened throughout the duration of this MOU, in close coordination with existing national institutional strengthening programs and the donor community, with the objective of applying it as the only procurement system in this MOU.

35. MOH shall publish its Annual Procurement Program at the beginning of each budget period (January) after the general budget of the Republic has been approved, ratified and published.
36. The annual procurement program may be amended if any unforeseen need arises. In these cases, MOH shall notify the FONSALUD Partners and justify such decision and such amendment shall be published in the official government gazette or two national newspapers of wide circulation.
37. MOH shall provide semi-annual and annual reports to the FONSALUD Partners regarding the implementation of the procurement plan, explaining the progress achieved in the implementation of the plan. These reports shall be submitted at the April and August meetings. The report characteristics are included in the FONSALUD Functional Manual.

## **Section 6    Reviews and Evaluations**

38. The FONSALUD Committee shall meet twice a year. At the annual review meeting (April), the Committee shall review the performance during the previous year (activity progress and achievement of goals set forth in the AOP based on the agreed indicators and achievement of the Plan for Strengthening the MOH Procurement Unit). Financial resource forecasts for the next year shall be identified at this meeting. At the annual planning meeting (August), the Committee shall discuss the overall progress achieved during the first semester (in relation to the AOP for the current year) and the proposal for the next year's AOP. Based on this discussion, the Signatory PDs shall confirm their commitments for the next year not later than August 31<sup>st</sup>. The reviews shall be based on the reports mentioned in Article 48 of this MOU.
39. MINSA will contract an independent performance evaluation in order to evaluate the progress of the 5 Year Plan. The TORs for this evaluation shall be determined in conjunction with Signatory PDs. The review processes shall be scheduled in such way as to facilitate the national planning and budgeting cycle.
40. Two evaluations shall be conducted. A mid-term evaluation (MTE) shall be carried out two and a half years after the implementation of the Five-Year Plan begins (second semester of 2007) and a final evaluation shall be performed at the end of the Five-Year Plan (at the end of 2009). The terms of reference shall be approved by the FONSALUD Partners at the previous meeting. This evaluation shall examine the financial aspects, results obtained and performance. Special attention shall be given to the efficiency of the support provided through FONSALUD, the political and technical dialogue, monitoring and accompaniment, the effects on the administration of the resources provided, as well as the effects on the institutional processes of international cooperation in the sector and the transaction costs involved.
41. The Signatory PDs shall not conduct any unilateral reviews or evaluations regarding the implementation of the Five-Year Plan.

## **Section 7 Audits**

42. External financial audits regarding the execution of the FONSAUD funds shall be submitted three months after the budget period ends.
43. MOH shall hire an independent auditing firm, accredited by the Office of the Controller General (hereinafter CGR) and acceptable to all Signatory PDs, to perform an external financial audit of the FONSAUD resources. The audit shall be performed in accordance with the procedures and guidelines issued by CGR and the terms of reference approved by the FONSAUD Committee.
44. MOH shall provide copies of the external financial reports to all the members of the FONSAUD Committee as soon as they become available.
45. CGR and/or the MOH internal auditing unit may include special audits in their annual programs, which shall be borne by FONSAUD, to verify compliance or monitor and evaluate internal controls. These audits shall be agreed in advance with the Signatory PDs.
46. The Signatories reserve the right to perform unscheduled audits, as they may deem fit, upon agreeing on the terms of reference with the other members of the FONSAUD Committee, who may also co-finance said audits. These audits shall not be funded with FONSAUD funds.
47. The audit reports and any other related information shall be discussed at the joint meetings of the FONSAUD Committee.

## **Section 8 Reports**

48. MOH shall provide all pertinent information to the Signatory PDs regarding the execution of the Five-Year Plan, which shall be based on the performance reports prepared by MOH. The reports shall be based on the agreed indicators and shall include a results analysis. MOH shall send the reports and other necessary documents to the FONSAUD Partners not less than 10 days prior to the April and August meetings. The following reports shall be prepared by MOH:

Reports to be submitted in April:

- ✓ Performance audit
- ✓ Financial audit
- ✓ Implementation of the AOP, Annual Procurement Plan, flow of funds and budget execution during the previous year.
- ✓ The AOP, Annual Procurement Plan and flow of funds during the current year.
- ✓ Progress report regarding institutional strengthening of procurement unit.

Reports to be submitted in August:

- ✓ Financial execution during the first quarter of the current year.
- ✓ Execution of the Annual Procurement Plan during the first semester of the current year.

- ✓ Flow of funds during the first semester.
- ✓ Preliminary AOP for the next year.
- ✓ Progress report regarding the institutional strengthening of the procurement unit.

## **Section 9 Non-performance, *Force Majeure***

49. If the FONSALUD resources are used to finance activities not contemplated in the Five-Year Plan, without prior justification, or if other circumstances arise that breach the fundamental principles or the terms of this MOU, the Signatory PDs may suspend future outlays to FONSALUD, upon prior justification and notice thereof, and claim refund of the transferred funds in whole or in part.
50. If a Signatory PD intends to suspend future disbursements or claim any transferred funds, the Signatory PD shall call a meeting to inform the FONSALUD Committee of such intent to suspend or discontinue its support and to reach a common agreement regarding any corrective actions or other measures required.
51. In the event of any anomalies in the procurement of goods and services, and notwithstanding any actions taken by CGR, each partner may adopt the measures established hereunder and may decide, upon consultation with the other FONSALUD Partners, to suspend, in whole or in part, its contributions.
52. The Signatory PDs may suspend or reduce disbursements if any extraordinary circumstances arise, beyond the control of MOH, which put at risk the effective implementation of the Five-Year Plan. If the Signatory PDs intend to suspend disbursements, they shall consult MOH in advance. Such suspension shall be lifted as soon as the circumstances cease or MOH implements other actions to cure such circumstances.

## **Section 10 Anti-corruption**

53. The GoN will require that its staff and officials not offer third parties, or seek, accept or be promised from or by third parties, for themselves or for any other party, any gift, remuneration, compensation or profit of any kind whatsoever, which could be interpreted as an illegal or corrupt practice.
54. All cases of corruption and any other illegal practice shall be addressed by the competent institution within its legal mandate in accordance with the laws and regulations of the Republic of Nicaragua.
55. MOH shall timely inform the other FONSALUD Partners regarding any case of corruption as referenced in this section.

## **Section 11 Modification, Accession or Withdrawal of Signatory PDs**

56. Any amendment or modification to the terms and provisions of this MOU shall become effective upon written agreement of the FONSALUD Partners.
57. The FONSALUD Partners shall review and discuss each year the execution, application and effectiveness of the procedures outlined in this MOU and in the Functions and Procedures Manual of the FONSALUD Committee..
58. The FONSALUD Partners express their explicit desire that FONSALUD be open to accession by other Partners for Development who wish to support the Five-Year Health Plan under the terms of this MOU at any time during its tenure.
59. When a Partner in Development requests in writing his accession to FONSALUD and accepts the terms and conditions of this MOU, MOH shall authorize in writing the accession of said Partner in Development, who shall be included in the annex to this MOU. MOH shall promptly inform and deliver a copy of the letter of acceptance to the other FONSALUD Partners.
60. A Signatory PD may withdraw and/or terminate its support to FONSALUD upon written notice to the other FONSALUD Partners not less than six months in advance. If a Signatory PD intends to withdraw and/or terminate its support, it shall call a meeting to inform its decision to the other FONSALUD Partners and shall consult with them regarding the consequences of such decision with respect to the Five-Year Plan.
61. Disbursements for a budget period may not be suspended after they are confirmed one week after the meeting of the FONSALUD Committee in August of the previous year.

## **Section 12 Settlement of Disputes**

62. Any dispute arising among the FONSALUD Partners with respect to the interpretation, application or execution of this MOU shall be amicably resolved by the parties.

## **Section 13 Entry into Force**

63. This MOU enters into force for each Signatory on the date of their signature and shall remain in effect until the 31st of December 2009. Two versions of this MOU shall be signed, one in Spanish and another in English; of which there will be ten copies in each language - in accordance with the number of signatories. If any conflict arises between both versions, the Spanish version shall prevail.
64. This MOU may be renewed or extended for such period as the FONSALUD Signatories may determine.

Managua, Nicaragua, on the twelfth day of August of the year two thousand and five.

By Signatory Development Partners:

By Government of Nicaragua:

BILATERAL DONORS

**THE KINGDOM OF THE NETHERLANDS**

*MATTHIJS WOLTERS*  
FIRST SECRETARY, IN CHARGE OF COOPERATION  
ROYAL EMBASSY OF THE NETHERLANDS

**SWEDEN**

*MIKAEL ELOFSSON*  
CHARGÉ D'AFFAIRES, A.I.  
EMBASSY OF SWEDEN

**FINLAND**

*MARJA LUOTO*  
CHARGES DES AFFAIRES  
SWEDISH EMBASSY

**AUSTRIA**

*MICHAELA ELLMEIER*  
DIRECTOR  
COORDINATION OFFICE FOR DEVELOPMENT  
COOPERATION  
AUSTRIAN EMBASSY

MULTILATERAL AGENCIES

**WORLD BANK**

*AMPARO BALLIVIAN*  
REPRESENTATIVE OF  
THE WORLD BANK IN NICARAGUA

**MINISTRY OF FOREIGN AFFAIRS**

*MAURICIO GÓMEZ*  
VICE MINISTER SECRETARY OF ECONOMIC  
AFFAIRS AND COOPERATION

**MINISTRY OF HEALTH**

*MARGARITA GURDIAN LÓPEZ*  
MINISTER OF HEALTH

**MINISTRY OF FINANCE AND PUBLIC CREDIT**

*MARIO ARANA*  
MINISTER OF FINANCE AND PUBLIC CREDIT

**SECRETARY OF COORDINATION AND STRATEGY OF  
THE PRESIDENCY OF THE REPUBLIC**

*JUAN SEBASTIAN CHAMORRO*  
SECRETARY OF THE PRESIDENCY FOR  
STRATEGY AND COORDINATION



**Annexes:**

1. Code of Conduct
2. Functional Manual for FONSALUD
3. Indicators for Monitoring Five-Year Plan
4. Glossary of Terms and Acronyms



**REPUBLIC OF NICARAGUA  
MINISTRY OF HEALTH**

**CODE OF CONDUCT GOVERNING  
RELATIONS BETWEEN  
THE GOVERNMENT OF NICARAGUA,  
THROUGH THE MINISTRY OF HEALTH,  
AND ITS  
PARTNERS FOR DEVELOPMENT**

**Annex 1**

**Managua, Nicaragua - January 2005**

---

**INTRODUCTION**

Since 2002, the Government of Nicaragua has strived to promote a joint initiative with other governments and international development agencies focused on advancing towards the alignment and harmonization of international cooperation efforts.

One of the priorities of this initiative is the implementation of Sector Wide Approaches. Within this context, the Ministry of Health has invited other governments and international development agencies that provide development assistance to the health sector to cooperate in moving forward with this process; a proposal that has been well-received on their part.

The Nicaraguan Ministry of Health and those governments and international development agencies that share the principles of alignment, coordination and harmonization, have felt it necessary to adopt a Code of Conduct, demonstrating their mutual commitment to such principles. Upon signing, this Code of Conduct will be taken into account in all agreements between signatory parties in matters concerning the development of health in Nicaragua and the efficiency of future cooperation within the sector.

Within the wider scope of the health sector, this Code of Conduct includes agreements and commitments that regulate relations with the Ministry of Health and the Nicaraguan Institute for Social Security (INSS - as per abbreviation in Spanish).

The governments and international development agencies that sign this Code of Conduct will henceforth be referred to as “Partners for Health Development” (SPD - as per abbreviation in Spanish); thereby highlighting their recognition of the importance of the leadership role of the Ministry of Health and commitment to its institutional strengthening, their exclusive support to the Five-Year Health Plan in the actions that they carry out within the areas of competence of the Ministry of Health and the INSS, as well as the mutual confidence and transparency that will form the basis for this new mode of association.

The Ministry of Health and the SPD are convinced that fundamental changes are required to improve efficiency in development cooperation in the health sector. These changes must reinforce the leadership role of the Ministry of Health and support its policies, plans and priorities, as well as its capacity to manage the resources available to the sector.

The Ministry of Health has a Health Policy and a National Health Plan, both of which cover the period until 2015. It also has a Five-Year Plan that includes a five-year expenditure framework, estimations on income for the same period, and annual operational plans specifying annual goals and their costing. These policies and plans are coherent and respond to the National Development Plan (PND – as per abbreviation in Spanish), and its Operational Plan, which in turn reflect the national priorities to achieve the Millennium Development Goals (MDGs).

These commitments do not limit the possibilities for SPD, within the scope of bilateral and multilateral cooperation, to support civil society organizations that have proven efficient and effective in their actions within the health sector, as long as this support coherent with the framework for priorities and interventions defined in the Five-Year Plan or in national plans and policies.

In signing this Code of Conduct, the Ministry of Health and the SPD agree to act in accordance with the good practices inferred from the Monterrey Consensus (2002), the Rome Declaration (2003), and the Declaration of Managua (2003), with respect to coordination of interventions, the alignment of strategies, priorities and instruments, and the harmonization of procedures to be used in improving the effectiveness of actions and interventions within the sector. These principles will be developed under the leadership of the Ministry of Health.

The Parties to this Code will actively participate in the strategic development of the health sector in Nicaragua, as well as in the design and implementation of the Sector Wide Approach.

The Ministry of Health and those SPD that, in addition to accepting the principles in this Code of Conduct, are willing to advance further in the harmonization of administrative and financial procedures, will adopt a Memorandum of Understanding which will have clearly defined goals, plus mechanisms detailing how such goals will be achieved; including aspects relating to organization, finances, acquisitions, and monitoring and evaluation, as considered appropriate.

## **CODE OF CONDUCT OBJECTIVES**

The Code of Conduct defines the good practices in relations between the Ministry and the SPD, through the coordination, harmonization and alignment of cooperation. This Code of Conduct seeks to optimize the effective use of official development cooperation resources so as to better respond to country priorities and the international commitments acquired by the Government of Nicaragua as expressed in the policies and plans of the Ministry of Health and the Government.

The Code of Conduct creates conditions to consolidate the leadership and governing role of the Ministry of Health in guiding and managing the sector according to the laws and procedures of the Republic of Nicaragua.

## **PRINCIPLES FOR COLLABORATION**

The Ministry of Health and the SPD base the establishment of this Code of Conduct on the following principles:

***Coordination:*** A coordination mechanism for international cooperation will be developed and agreed upon to ensure complementary actions amongst signatory partners, and thus avoid duplication of efforts in the execution of the Five-Year Plan and the annual operational plans. The mechanism will permit monitoring, tracking and evaluation by results, based on health sector goals.

***Alignment:*** The SPD will align their actions in accordance with the institutional policies, plans and programs of the Government of Nicaragua and the Ministry of Health.

***Harmonization:*** The SPD will advance, in accordance with their specific circumstances, towards the simplification and unification of their procedures in order to improve efficiency and

reduce transaction costs in the management of international cooperation resources. In addition, they will seek to progressively adopt national procedures wherever possible.

**Transparency:** The relation between the Ministry of Health and the SPD in reference to the scope of the Code of Conduct will be based on decisions being made in the most transparent manner possible. To this end, adequate information and communications mechanisms will be established.

## **JOINT COMMITMENTS**

The present Code of Conduct establishes the following commitments between the Government, through the Ministry of Health, and the SPD:

1. Acceptance of this Code implies SPD participation in the strategic development of the sector and in the implementation and development of the Sector Wide Approach in Health in Nicaragua.
2. For the period comprising 2005 – 2009, the Sector Wide Approach in the health sector is limited to the scope of the Five-Year Health Plan and the annual operational plans.
3. The signatory parties to this Code of Conduct will consider as joint results any successes, as well as any difficulties, that form part of the process of advancing with the Sector Wide Approach.
4. All signatory parties will have the same rights and obligations within the framework of this Code of Conduct, allowing no distinctions for the manner or quantities of cooperation assistance provided.
5. The necessary mechanisms will be established to guarantee transparency in decision making processes and the management of resources on the parts of the Ministry of Health and the SPD, who are united in expressing their rejection of any corrupt practice.
6. The parties will make all possible efforts to progress in the alignment and harmonization of their instruments and procedures with those of the Ministry of Health, with the objective of strengthening institutional leadership and reducing transaction costs. Priority will be given to the following areas of competence:
  - a. Support, to the exclusion of other options, an integrated system for the implementation and monitoring of health sector policies, plans and programs.
  - b. Actively contribute to consensus building in order to arrive at common agreements with the Government on future policies, plans, programs and goals.
  - c. Ensure that future cooperation agreements related with the health sector address the implementation of sector policies, plans and programs.

- d. Advance progressively, within the capacity of each SPD, towards the adoption of the administrative financial regulations and procedures of the Ministry of Health and the Government of Nicaragua. This includes the gradual adoption of forms and procedures used for advance reports, financial and audit reports, as defined by common agreement between the Ministry of Health and the SPD.
    - e. Reach commitments on estimated multi-annual disbursements and their gradual adapting to the governmental fiscal year in terms of the preparation, allocation and disbursement of cooperation resources.
    - f. Work in accordance with the structure of the Ministry of Health in order to strengthen the Institution's leadership and management capacity to comply with the its policies, plans and programs, avoiding the creation of parallel structures.
7. The signatory parties will support the development of transparent and unique information mechanisms to monitor the progress of sector policies, plans and programs, especially in the following areas of competence:
  - a. Agree on a limited number of performance indicators to jointly monitor the Five-Year Plan and annual operational plans, based on the indicators defined by the Ministry of Health in said Plan. These indicators will include those used to monitor the National Development Operational Plan and the Millennium Development Goals.
  - b. Ensure that information on all relevant interventions in the sector, including studies and consulting reports, new programs, projects or other cooperation actions, evaluations and missions, is made available to the Ministry of Health and the SPD.
  - c. Disseminate information on the plans, programs, projects or other actions under execution in the health sector, including the resources involved and their state of execution, regardless of disbursement and contracting procedures.
  - d. Report to the Ministry of Health and all other SPD with regard to any other plans, programs, projects or other cooperation actions under execution, or planned for execution, in conjunction with other institutions within the sector, be they public or private, that are not integrated within the organic structure of the Ministry of Health or INSS.
8. The parties will target technical and financial assistance towards compliance with the policies, plans and programs of the Ministry of Health according to the following guidelines:
  - a. Respond to the priorities of the health sector.
  - b. Respond in a timely manner to the requirements for technical and financial assistance that arise in the Ministry of Health and INSS.
  - c. Strengthen public institutional capacity, giving priority to the transfer of skills to State officials that perform functions relevant to health sector priorities, taking into

account the capacity for the absorption and appropriation of technical assistance expertise.

- d. Give priority to the contracting of national consultants, employing international consultants only in those cases where they contribute knowledge and expertise that are not available within the national sphere, and ensuring that, in such cases, the exchange and assimilation of experiences is facilitated.

9. The Partners for Development (SPD) commit themselves to:

- a. Allow the Government access to their policies, knowledge and international expertise.
- b. Record as bilateral and multilateral cooperation expenditure relevant to the Ministry of Health and INSS, only those actions that effectively respond to agreements with the Government, within the framework of its multi-annual and annual plans.
- c. Promote joint actions, as well as delegated cooperation when possible, as complementary ways of using less amount of time pertaining to public officials and reducing transaction costs.

10. The Ministry of Health commits itself to:

- a. Adopt all of the reform and internal organization measures necessary to consolidate its leadership in the decision making process, and increase its efficiency, executive capacity and levels of information.
- b. Promote health service decentralization to the autonomous regions, RAAN and RAAS, in accordance with the respective Laws of Autonomy, in addition to administrative decentralization to the other local health systems (SILAIS), in both cases including relations with international cooperation entities.
- c. Continue to develop multi-annual and annual plans that establish priorities, goals, interventions and indicators for the health sector, in accordance with the financial resources available.
- d. Facilitate conditions to take into consideration the technical contributions of the SPD in the definition of its policies and plans.
- e. Keep the PSD informed on progress in the evolution of activities contributing to the further development of the Sector Wide Approach, especially those relating to planning, programming, budget elaboration and annual plan execution, as well as programs and projects.
- f. Strengthen local systems (SILAIS) in order to further the assimilation and appropriation of the Sector Wide Approach in health, through dissemination and

training on the concepts, mechanisms and instruments employed as well as the advances attained.

- g. Reflect resources allocated to the Five-Year Plan to the program for expenditures, budget and government accounting.
- h. Maintain or increase public expenditure in the sector, in such a way that international cooperation does not substitute the important social responsibility of the State, thereby strengthening the performance of the State system, the stability of human resources, efficiency in the use of financial resources and efforts seeking to reduce inequity gaps.
- i. Establish coordination with other State institutions with respect to established priorities in order to avoid duplication and exaggerated dispersion of interventions, as well as internal competition for international cooperation resources.

#### **FUNCTIONAL ENTITIES RELEVANT TO THE COORDINATION AND COMMUNICATION OF THE SECTOR WIDE APPROACH IN HEALTH (ESS – as per abbreviation in Spanish)**

**The entity for technical and executive coordination of the Sector Wide Approach will be the Technical Secretariat**, a functional entity within the Ministry of Health, consisting of staff from the aforementioned Ministry and under the direction of the General Planning and Development Division. Its director will be appointed by the Maximum Authority of this Institution. The Secretariat will have access to the technical support necessary specified in the work plan aimed at progressing with the Sector Wide Approach.

**The National Health Council, and the Departmental and Municipal Health Councils** will function as organs of communication, assessment and consultation in conjunction with local authorities and civil society. The Ministry of Health will ensure that these entities actively participate in policy formulation and the monitoring and evaluation of the relevant policies' implementation.

**The Coordinating Committee for the Health Sector**, created by Presidential Decree No. 71-2003, is the inter-institutional coordinating organ of the Ministry of Health, the cooperating governments and international development agencies that operate in the health sector, and a forum for dialogue and the exchange of information between Government institutions, the Ministry of Health, the INSS and the SPD. As part of its functions the Committee will seek to further the participation of its members in the Sector Wide Approach through the endorsement of this Code of Conduct, and by aligning its actions with the Five-Year Plan.

The parties to this Code commit themselves to respect its contents, as well as the will, principles and objectives that it embraces.

We sign two originals, in the City of Managua, on the twenty-eighth day of the month of January, of the year two thousand and five.



The Parties to this Instrument, sign on behalf of:

**SWEDEN**

*EVA ZETTERBERG*  
AMBASSADOR OF SWEDEN

**FINLAND**

*MARJA LUOTO*  
CHARGES DES AFFAIRS  
SWEDISH EMBASSY

**THE KINGDOM OF THE NETHERLANDS**

*MATTHIJS WOLTERS*  
FIRST SECRETARY, IN CHARGE OF COOPERATION  
ROYAL EMBASSY OF THE NETHERLANDS

**THE WORLD BANK**

*AMPARO BALLIVIÁN*  
REPRESENTATIVE OF  
THE WORLD BANK IN NICARAGUA

**THE INTER AMERICAN DEVELOPMENT BANK**

*EDUARDO BALCARCEL*  
REPRESENTATIVE OF  
THE INTER AMERICAN DEVELOPMENT BANK  
IN NICARAGUA

**THE MINISTRY OF FOREIGN AFFAIRS**

*MAURICIO GÓMEZ*  
VICE MINISTER SECRETARY OF  
ECONOMIC AFFAIRS AND COOPERATION

**THE MINISTRY OF HEALTH**

*MARGARITA GURDÍAN LÓPEZ*  
MINISTER OF HEALTH

**SECRETARY OF THE PRESIDENCY FOR  
STRATEGY AND COORDINATION**

*MARIO DE FRANCO*  
SECRETARY OF THE PRESIDENCY FOR  
STRATEGY AND COORDINATION

The Health Sector Coordination Board is ***the official and ideal room to implement and systematize the 5-year Health Plan*** because all bilateral and multilateral donors play a part, developing working groups' operations.

I urge every stakeholder to join this process and sign the Code of Conduct. The MINSA Planning and Development Division is the right authority that leads the health sector wide approach and may provide you with any information you need.”

On the other hand, donors expressed some considerations, which are summarized below:

**UNFPA:** Pedro Pablo Villanueva, UNFPA country representative in Nicaragua, announced the UN System would shortly join the process to sign the Code of Conduct and legitimize even further their position as Partners for Development.

Dr. Hugo Gonzalez acknowledged in general the efforts and accomplishments made by Ministry of Health institutionally, but its role to be played as health governing body needs to be defined.

**Sweden:** It believes that in the next meeting held by the Coordination Board, all donors should disclose the amount of their contributions.

**PAHO:** The Coordination Board should become the hub between FONSALUD and all health-related stakeholders. Thus, a wider vision would help Nicaragua accomplish the MDGs, because there are prioritized actions with no funding available and, on the other hand, there are other non-relevant fully funded actions. Then, it is about support financially those prioritized actions, securing their implementation.

**AID:** This agency has adopted the priorities set forth in some strategic actions, in coordination with MSH and NICASALUD. AID is going to abide by the MINSA guidelines, including the Health Policy, the 5-year Health Plan and Operation Plans.

**Donors** in General believe MINSA should strive to arrange before MHCP and National Assembly increased public spending to narrow existing gaps.

**SECEP** thinks that at governmental level, efforts are being made to narrow the budget deficit. However, the National Development Plan goes through a similar situation. Therefore, resources should be allocated and employed more efficiently.

**INSS:** Strengthening coordination with MINSA is critical. It reports that its agenda includes topics such as health prevention and promotion. It is also necessary to discuss more deeply some aspects with MINSA professionals, as there are restraints found when dealing with some topics.

The Minister Margarita Gurdian stressed on the importance to strengthen relations with health stakeholders. This would require to plan during the



REPUBLIC OF NICARAGUA  
MINISTRY OF HEALTH



**AIDE MEMOIRE**  
**HEALTH SECTORIAL BOARD (MESA SECTORIAL) MEETING**

Managua, October 18<sup>th</sup> 2005, 9:00 a.m. – 12: 00 p.m.

**I. PARTICIPANTS:**

- Government Agencies
- Donors
- MINSA Departments and Divisions

**II. PURPOSE**

This meeting is intended to inform the members of the Health Sector Coordination Board about the institutional processes under way, including planning and monitoring instruments, Health Sector-wide Approach progress rate, new work approaches adopted by MINSA and new challenges to deal with.

**III. MEETING DEVELOPMENT :**

The meeting was open when the Minister of Health, Mrs. Margarita Gurdian thanked the participants for their attendance and thanked the Donors for their systematic support throughout all processes undertaken by the Ministry of Health.

“We need to move forward to an **improved work planning** to achieve greater impacts on health. Therefore, I request collaboration from all health-related stakeholders, including donors by supporting the 5-year Health Plan and the MINSA Operations Plan.

The government of Nicaragua and MINSA are striving together to promote the health sector-wide approach. In this context, four countries and the banks (Sweden, the Netherlands, Finland, Austria, IADB and WB) have signed the Code of Conduct, with the common purpose to improve public health conditions.

Likewise, a Memorandum of Understanding was signed with four countries, including Sweden, Finland, Austria, the Netherlands and the World Bank to create new cooperation approaches, whereby funds are pooled in the single treasury account through FONSALUD.

Note that the Ministry of Health is very interested in increasing assistance impact and resource effectiveness by harmonizing and aligning cooperation through common working mechanism.

The Health Sector Coordination Board is ***the official and ideal room to implement and systematize the 5-year Health Plan*** because all bilateral and multilateral donors play a part, developing working groups' operations.

I urge every stakeholder to join this process and sign the Code of Conduct. The MINSA Planning and Development Division is the right authority that leads the health sector wide approach and may provide you with any information you need.”

On the other hand, donors expressed some considerations, which are summarized below:

**UNFPA:** Pedro Pablo Villanueva, UNFPA country representative in Nicaragua, announced the UN System would shortly join the process to sign the Code of Conduct and legitimize even further their position as Partners for Development.

Dr. Hugo Gonzalez acknowledged in general the efforts and accomplishments made by Ministry of Health institutionally, but its role to be played as health governing body needs to be defined.

**Sweden:** It believes that in the next meeting held by the Coordination Board, all donors should disclose the amount of their contributions.

**PAHO:** The Coordination Board should become the hub between FONSALUD and all health-related stakeholders. Thus, a wider vision would help Nicaragua accomplish the MDGs, because there are prioritized actions with no funding available and, on the other hand, there are other non-relevant fully funded actions. Then, it is about support financially those prioritized actions, securing their implementation.

**AID:** This agency has adopted the priorities set forth in some strategic actions, in coordination with MSH and NICASALUD. AID is going to abide by the MINSA guidelines, including the Health Policy, the 5-year Health Plan and Operation Plans.

**Donors** in General believe MINSA should strive to arrange before MHCP and National Assembly increased public spending to narrow existing gaps.

**SECEP** thinks that at governmental level, efforts are being made to narrow the budget deficit. However, the National Development Plan goes through a similar situation. Therefore, resources should be allocated and employed more efficiently.

**INSS:** Strengthening coordination with MINSA is critical. It reports that its agenda includes topics such as health prevention and promotion. It is also necessary to discuss more deeply some aspects with MINSA professionals, as there are restraints found when dealing with some topics.

The Minister Margarita Gurdian stressed on the importance to strengthen relations with health stakeholders. This would require to plan during the

Coordination Board meetings the status presentation of each stakeholder to obtain the whole picture of health investments in Nicaragua.

Finally, the topic relating to working groups required for implementing the 5-year plan and the Operation Plan was discussed, in line with the matters of interest of the board members.

## **AGREEMENTS**

MINSA will revise the 5-year Health Plan to adjust it to the unfunded actions set forth in the priorities .

MINSA will also strive to devise a funded Plan of Action to identify and narrow gaps.

MINSA in coordination with working groups will propose donors to disclose their contribution amounts.

MINSA and INSS will jointly present the plans developed by that Institution in the next meeting held by the Health Sector Coordination Board.

Coordination Board meetings the status presentation of each stakeholder to obtain the whole picture of health investments in Nicaragua.

Finally, the topic relating to working groups required for implementing the 5-year plan and the Operation Plan was discussed, in line with the matters of interest of the board members.

## **AGREEMENTS**

MINSA will revise the 5-year Health Plan to adjust it to the unfunded actions set forth in the priorities .

MINSA will also strive to devise a funded Plan of Action to identify and narrow gaps.

MINSA in coordination with working groups will propose donors to disclose their contribution amounts.

MINSA and INSS will jointly present the plans developed by that Institution in the next meeting held by the Health Sector Coordination Board.



REPUBLIC OF NICARAGUA  
MINISTRY OF HEALTH



**AIDE MEMOIRE**  
**HEALTH SECTORIAL BOARD MEETING**

Wednesday, November 1<sup>st</sup> 2006

**PARTICIPANTS:**

- Government Agencies
- Donors
- MINSA Departments and Divisions

**INTRODUCTION**

The Ministry of Health held jointly with the members of the Health Sectorial Board (Mesa Sectorial) a working meeting this 1<sup>st</sup> day of November 2006 to render a progress report on health strategic actions and a new working methodology to foster the Health Sector-wide Approach (SWAP).

This meeting was attended by the Minister Margarita Gurdian and the MINSA Divisions Directors, the Minister of MIFAMILIA Mrs. Ligia Teran, representatives of MINREX, SETEC and MECD, as well as Partners for Development (SPD) on behalf of Donors.

A list of attendance hereto enclosed contains both the meeting agenda and information for a fluent communication.

**AGENDA**

**1. Words of Welcome by Margarita Gurdían López, Minister of Health**

**I want to express my thankfulness and appreciation to Donors** for accompanying and supporting the Ministry of Health in devising and completing the National Health Policy, the National Health Plan (2004-20015) and the 5-year Health Plan (2005-2009) as basic tools for the Health Sector wide Approach. Gratitude goes also for their role played in solving the medical strike, providing people with health services at health units, developing dialogue and consultations to draft the Public Health Administration and Compensation Policy Bill. Gratefulness goes to PAHO for valuable technical and financial assistance to accomplish this effort. The Public Health Administration and Compensation Policy Bill will be submitted to you.

**Key prevention-oriented health care processes** have been strengthened, including the Institutional Reorganization, the Integrated Healthcare Model (MAIS), the Expanded Coverage, etc. In this half year, some arrangements are to be made still, so population becomes aware of these benefits. The ECACS (Health Community

Action and Communication Strategy) has been strengthened, developing message guides to address health concerns and increase health investments effectiveness.

Institutionalizing the National Health Policy, the National Health Plan (2004-20015) and the 5-year Health Plan (2005-2009) requires everyone becomes familiar with them. If you know it, then you may demand it. It is a long way to go.

Now, we are organized through the Mesa Sectorial with a result-oriented vision, a lot of support is needed. Inter-institutional coordination has made remarkable progress. Partnerships and alliances are critical. For instance, during the massive methanol poisoning situation, there was a harmonic coordination between the Police, the Nicaraguan Army, Civil Defense, Local Governments, Private Sector, INSS, Health Insurance Institutions (EMS) and Donors – all targeting at a single bull's eye and keeping teamwork spirit through coordination and partnership.

This year has also seen other achievements such as the *Immunization Program* and the rubella immunization results. Appreciation was acknowledged by PAHO Immunization Coordinator. The rotavirus vaccine was launched too. Despite of major restraints, the Ministry of Health could achieve successful accomplishments. With that spirit, expected goals may be attained.

This Mesa Sectorial has to set *goals and share* bad and good things. One of the most important goals is the institutionalization of health policies and plans and strengthening the harmonization and alignment process.

Finally, I thank Ligia Teran, the incumbent Minister of the Family (MIFAMILIA) and representatives of Iceland for sharing your time with us. Thanks for harmonizing and putting AECI in line with national health policy and plans by signing the Code of Conduct

## **2. HIV/AIDS Strategic Plan and Policy and Decentralization Strategy**

The health status updated by September, the health Policy and the HIV/AIDS Strategic Plan were outlined; they identified the strategic interventions aimed to improve regulatory aspects, bio safety conditions for health personnel and medical supplies secured to increase diagnosis testing and treatment coverage. Technical team was strengthened by qualified staff trained to provide technical assistance and accompanying locally to facilitate decentralized care, improve information reporting and recording and exchange experiences to foster the program development.

## **3. Expanded Coverage Strategy Progress**

The Expanded Coverage Strategy objective, target municipalities, financial resources transferred from Central MINSA to local levels and health indicators outcomes were disclosed.



### ***Recommendations :***

- Define health indicators showing health service quality
- Select health indicators revealing birth defects
- Assess impact from resource allocation
- Reflect support from health investments, strengthening and social audit
- NGOs to be hired?
- Collateral effect from expanded coverage on other programs?
- Foster multi-sectorial approach to cope with maternal and infant mortality
- It is necessary and important the Ministry of Health makes a statement regarding midwives. Confusion and insecurity are in the air. It is critical to train midwives, help them develop their work so critical in rural and remote areas. Midwives are a key link to address maternal mortality and accompany and take care of pregnant women.

#### **4. Health Indicators and Performance Evaluation Progress Report**

A progress report on the 5-year Health Plan Indicators was presented, making emphasis on 2005 performance. Charts and graphs were used to illustrate how main health indicators have evolved from year 2000 through 2005, including the first 8 months 2006. The presentation highlighted the following: i) Institutionalization of the 22 indicators contained in the 5-year Plan; ii) 9 health indicators were fully accomplished in 2005, 7 had partial accomplishment and 6 on pending measurement E.g. Infant Mortality is measured by ENDESA; iii) Improved health indicators is the overall trend.

### ***Recommendations :***

- Break down analysis per SILAIS for relevant cases e.g. Maternal Mortality.
- Encourage indicators follow-up among working groups

#### **5. 2006 Budget Execution**

73% (C\$2,392.7 million cordobas) out of total annual budget (C\$3,282.6 millions) goes to current expenses and remaining 27% goes to Capital Expenses (C\$889.9 millions). In view of the foregoing, budget execution by October is 72.9% (C\$2,392.7 millions).

Current Expenses have been spent by 80.4% while Capital Expenses have been spent by 46.2%.

Remaining unrestricted funds at the date of this meeting are C\$889.9 millions.

#### **6. 2007 Budget. How is it structured?**

MINSA solicited C\$4,688.2 millions as public health spending to the Ministry of the Treasury and Public Credit, equivalent to US\$254.8 million dollars (average exchange rate C\$18.40 x US\$1.00), out of which C\$3,037.2 millions are Current Expenses, and C\$854.2 millions are Capital Expenses.

Information is broken down per source of funding and type of expense in the presentations hereto attached.

## **7. MINSA Expected Outcomes - December 2006**

Donors were told about the main efforts to be undertaken by MINSA technical teams for the rest of the 2006. The expected outcomes are the following:

- Allocation estimated per source of funding, management level and budget deficit calculation.
- 2007 Health Investment Plan devised
- Plan of Action for the proposed Compensation Policy developed
- Health indicators (2000-2005) accomplishment rate evaluated and 2006 progress rate assessed
- Operational Manual for implementing the Integrated Health Care Model developed
- Millennium Development Goals (MDG) baseline data ratified
- 2005 Census-based demographic goals and estimates for 2007 established
- Expanded Coverage Strategy experience assessed
- Internal Control Technical Norms and Regulations (NTCI) adjusted
- 2002 – 2005 Progress Report, updated until September 2006 developed

## **8. APO Guidelines 2007 – Institutional Strengthening Plan**

The Annual Plan of Operations (APO) will be structured as follows: three objectives with guidelines and strategic actions per each objective describing how to achieve expected outcomes. Participants were required to enlighten about donors' unrestricted funding required to support the APO and calculate the impact of outcomes based on all sources of funding available.

## **9. Confirming Foreign Funding to Support 2007 APO**

During the meeting, the intention to have 21.6 million dollars and 9.95 million Euros at MINSA's disposal was declared. In terms of loans, they total 11.3 million dollars (5.0 million dollars from the WB and 6.3 million dollars from IADB, including 0.3 millions for technical assistance to devise and implement the new health service network strengthening). A table broken down per source of funding is hereto attached.

## **10. Public Health Administration and Compensation Policy Progress**

The Public Health Administration and Compensation Policy bill so far has a work plan with working committees already organized. They have been introduced to the National Health Council.

## **11. MAIS Implementation Design Progress**

The Integrated Health Care Model implementation paper is being developed.

## **12. New Mesa Sectorial Work Approach and Working Groups**

This work approach takes into consideration the organization and role played by a technical committee that helps prepare information needed to fulfill work schedule and accomplish expected outcomes, in line with the Code of Conduct, the Memorandum of Understanding and the Mesa Sectorial Manual.

The Mesa Sectorial is deemed critical because it has become a standing coordination, harmonization and dialogue room relating to the implementation, monitoring and evaluation of health policies, plans and programs.

The Health Sector Coordination Board holds ordinary meetings at least three times a year attended by all its members in full: government agencies and Partners for Development – SPD (bilateral and multilateral donors) that support health sector in Nicaragua.

A responsibility distribution proposal for the three Mesa Sectorial working groups was raised: i) Economy and Health; ii) Public Health and Organized Response to Health Issues; iii) Sectorial Leadership, Decentralization, Social Participation and Institutional Management

### **Why Working Groups are important?**

They should become in rooms for analysis enriched by assigned specialists inputs, whose conclusions and recommendations are to be transmitted to the Technical Committee and from here to the Health Sector Coordination Board in full.

Considering their critical inputs for addressing major health concerns (maternal and infant mortality, nutrition, safe water supply and sanitation, etc.), the involvement of those institutions, which according to the items on the agenda, are related to the health sector, is a must.

Based upon inputs provided by the Health Sector Coordination Board, final decisions are made by the Ministry of Health as governing body.

This new work approach introduces:

1. Meeting Schedule to hold meetings with donors to enter into agreements
2. Next Steps to be taken

### **Economy and Health**

- Budget allocation estimated per source of funding, management level and budget gaps
- 2007 Health Investment Plan devised
- Action Plan for Compensation Policy proposal developed

### **Public Health and Organized Response to Health Issues**

- Health Indicators performance (2000-2005) and 2006 progress rate evaluated
- Integrated Health Care Model Operations Manual developed
- Millennium Development Target baseline data ratified
- 2005 census-based goals and demographic estimations for 2007 established
- Expanded Coverage Strategy experience assessed

### **Sectorial Leadership, Decentralization, Social Participation and Institutional Management**

- 2007 Annual Plan of Operations (APO)
- Internal Control Technical Standards (NTCI) adjusted
- Progress Report for 2002-2005 period and year 2006 updated to September

### **Remarks**

UNFPA suggested the Technical Committee should be integrated by signatories of the Code of Conduct. This topic will be discussed in the next meeting.

### **AGREEMENTS:**

1. The new work approach approved
2. Donors (SPD) to confirm unrestricted funds to support the Annual Plan of Operations (APO – 2007)
3. MINSA will present the disbursement program to secure APO – 2007 implementation
4. Share via email the Progress Report, the APO- 2006 Evaluation Report and the Performance and Financial Audit Findings Report.

Managua, this 1st day of November 2006



## Meeting Agenda

### MINSA – Mesa Sectorial- FONSALUD Committee

Managua, Wednesday 1<sup>st</sup> and Thursday 2<sup>nd</sup> November 2006

Hour	Item	Key Person
<b>Wednesday 1<sup>st</sup> November: Mesa Sectorial Meeting</b>		
08:30 – 09:00	<b>Sign-in</b>	
09:00 – 09:30	<b>Words of Welcome</b>	Lic. Margarita Gurdían L.
09:30 – 10:15	HIV/AIDS Strategic Plan and Decentralization Strategy	Dra. María Delia Espinoza
10:15 - 10:45	Expanded Coverage Strategy progress	Dra. Aurora Velásquez P.
10:45 – 11:00	<b>Break</b>	
11:00 - 11:35	Health Indicators Progress Report and Performance Audit Results	Dr. Mauricio Dinarte
11:35 – 12:00	<b>2006 Budget Execution and Financial Audit Progress Report</b>	Lic. Danilo Yescas
12:00 - 12:20	<b>MINSA Expected Outcomes - December 2006</b>	Lic. Marina Avilés
12.20 - 13:30	<b>Lunch</b>	
13:30 – 14:00	<b>2007 Budget. How is it structured?</b>	Lic. Danilo Yescas O.
14:00 – 14:30	<b>APO Guidelines 2007 – Institutional Strengthening Plan</b>	Lic. Marina Avilés M.
14:30 – 15:00	<b>Confirming Foreign Funding to Support 2007 APO</b>	Cooperantes en General
15:00 - 15:30	<b>Public Health Administration and Compensation Policy Progress</b>	Dr. Carlos Cruz L.
15.30 – 15:45	<b>Break</b>	
15:45 – 16:15	<b>MAIS Implementation Design Progress</b>	Dr. Carlos Cruz L.
16:15 – 16:45	<b>New Mesa Sectorial Work Approach and Working Groups</b> Meeting Schedule to hold meetings with donors	Lic. Eliseo Aráuz P.
16.45 – 17:00	Agreements and Next Steps to be taken	Everybody
<b>Thursday 2<sup>nd</sup> November: FONSALUD Meeting</b>		
08:30 – 09:00	<b>Sign-in</b>	
09:00 – 09:30	New work approach and implications for FONSALUD	Lic. Marina Avilés M.
09:30 – 10:00	First Semester 2006 PACC Implementation	Lic. Maria Marta Solórzano
10:00 – 11:00	If needed, further discuss any topic addressed the meeting before	
11:00 – 12:00	Agreements review and Aide-Memoire signing	Dr. Rodolfo Correa
12.00 – 13:00	<b>Lunch</b>	

**AIDE MEMOIR 1  
SECTORIAL BOARD JOINT MEETING  
(Acronyms in Spanish)**

**INTRODUCTION**

The Sectorial Board constituted by the Ministry of Health (MINSA), the Ministry of the Treasury and Public Credit (MHCP), the Ministry of Foreign Affairs (MINREX), the Ministry of Education (MINED), the Ministry of the Family, Childhood and Adolescence (MIFNA), the Nicaraguan Institute of Social Security (INSS), the Technical Secretariat of the Presidency (SETEC) and Partners for Development (SPD) carried out its first ordinary working session on Tuesday, March 27 and Wednesday, March 28 of the year 2007, in accordance to working timetable, which was approved in Sectorial Board session in the month of November 2006, Code of Ethics, Memorandum of Understanding and other documents, which are fundamental for directing the Sectorial Board of Health Sector and strengthening work of Health Sectorial Approach (ESS).

Above working session had the participation from the MINSA, the Minister of Health, Dr. Maritza Cuan and its General Directors, representatives from other State Institutions; International Cooperation and Partners for Development (SPD) that work in the sector. A list of participants is annexed.

MINSA Joint Meeting Schedule – Sectorial Board

<b>Time Schedule</b>	<b>Activity</b>	<b>Person Responsible</b>
<b>First Day: Tuesday March 27</b>		
08:30-9:00	Registration	DGPD
09:00-9:15	Welcome	General Director
09:00-9:45	Health conditions	DGVS – Dr. Juan José Amador
09:45-10:15	Strategic Plan for ITS/VIH/SIDA and report administration and progress of arrangements of CONCASIDA	DGSS – Dr. Sara Moraga
10:15-10:35	Integration of process of Planning and Budget for medium term	DGPD – Dr. Indiana Herrera
10:35-10:50	Break	
10:50-11:40	Results from POA Evaluation 2006	DGPD – Ms. Marina Avilés
11:40-11:55	Questions and answers	
11:55-12:25	Cash flow and execution of 2006 budget	DGRFF – Ms. Leonor Corea
12:25-12:40	Report on results of financial auditing	DGRFF – Ms. Patricia Silva
12:40-13:00	Questions and answers	
13:00-14:00	Lunch	
14:00-14:20	New National Policy on Health	General Director
14:20-14:50	Procedure for Implementing Integral Healthcare Model	DGPD – Dr. Alejandro Solís
14:50-15:10	Report on Auditing Performance 2006	DGRFF – Dr. Mauricio Dinarte
15:10-15:30	Report on PAACC Evaluation 2006	DGRFF – Ms. Leonor Corea

1530-15:45	Report on progress of Institutional Strengthening of Acquisition Unit	DGRFF – Ms. Leonor Corea
15:45-16:00	Questions and answers	
16:00-16:15	Break	
16:15-16:35	National Plan for Harmonization and Alignment in Health Sector	DGPD – Ms. Marina Avilés
16:35-16:50	Questions and answers	
16:50-17:10	Summary and Agreements	DGPD

## **SCHEDULE DEVELOPMENT**

### **Revision of Agreements in Working Session of Sectorial Board on Nov. 2, 2006**

1. A new way of working was approved. Work was implemented with Technical Committee; timetable of work was fulfilled and lacks the start of operation of Working Groups.
2. Donors (SPD) will confirm financial availability which supports Annual Operative Plan (POA-2007). Financial availability programmed was confined for SPDs for the year 2007.
3. MINSA will present scheduled of disbursements to warrant operation of POA-2007. This issue was presented and discussed at this meeting.
4. Share by means of e-mails Administrative Report, evaluation of POA-2007 and report of results of Financial and Audit Performance. Documents were sent through e-mails and report was presented at this meeting.

#### **1. Welcome by Dr. Alejandro Solís, General Director of Planning and Development**

He expressed his gratitude and appreciation to the Cooperating Community for its solidarity to the Ministry of Health in order to work for the Government Program of Reconciliation and National Unity, the new National Policy of Health and the Annual Operational Plan for this year.

For this year, the purpose of public policy is to warrant access and gratuitousness of services to the Nicaraguan people. There is disposition to work in strategic processes, such as the implementation of Integral Healthcare Model (MAIS), the Institutional Reorganization, development of strong manner of citizenry participation in health activities.

The level of organization which has been achieved by being close to the Sectorial Board, has enable dialog and collaboration in order to reach expected results, so that we can share certainties and uncertainties in regards to lessons learned, which allow us to move toward everyone, and what is most important, achieve institutionalization.

It is the will of the General Directory to strengthen and enlarge the role of the National Council of Health.

Finally, he welcomed everybody and appreciated their assistance.

#### **2. Health Conditions**

Dr. Juan José Amador started his speech with information about demographic situation, social and sanitary, pointing out that 1.6 millions inhabitants live under high and extreme poverty; expenditures on health per capita is US\$22.70 annually; life expectancy is 69.5 years, as follows: Men 65.7 years and women 70.4 years. Rate of Maternal Mortality is 89.6-95.6 per 100,000 born alive; Rate of Infant Mortality is 38 per

1,000 born alive (2005). In relation to the main health problems, he mentioned the persistence of high rate of maternal/infant mortality, high rate of specific morbidity by respiratory infections, diarrhea diseases and those transmitted by vectors. The most vulnerable are women and children, population of Caribbean Coast and regions of Central and North of the country. Trend of chronic diseases to increase are as follows: cardiovascular, diabetes and malignant tumors. High load of morbidity and mortality due to preventable causes are as follows: Car accidents, intentional injuries, force majeure and labor accidents. He also mentioned that Malaria is on forthright descent. He ended his presentation with main strategic processes of the Institution, making reference to the Modernization, Institutional Reorganization, Sectorial Approach of Health Sector and Legal Framework.

### **3. Strategic Plan for ITS/HIV/SIDA and report administration of progress of arrangements of CONCASIDA**

#### *Strategic Plan for ITS/HIV/SIDA:*

Dr. Sara Moraga made her presentation on Health Conditions, Public Policy and Strategic Plan of VIH/SIDA; she identified strategic interventions to improve regulation aspect, conditions of bio-security of health personnel, assurance of materials to improve coverage of diagnosis tests and treatment for the purpose of progressing with decentralization of the Program; further recording information and interchange experience to enable program development.

### **6. Cash Flow and Budget Execution for 2006**

#### Cash Flow

Funds for scheduled SPD for the year 2005 only received reimbursements from Sweden and BID. During the year 2006 disbursements were received during the IV semester of the year. This delay was due to the implementation of the Law 550. UNFPA disbursed in December 2005, though such funds were not withdrawn until March 2006. The second disbursement from UNFPA was made on September 18, 2006 (see attached table).

#### Budget Execution 2006

From total annual budget of C\$3,286.6 millions, 95.6% was executed, which corresponds to Current Expenses, that is to say, C\$2,544.7 millions and Capital Expenses were C\$593.6 millions.

The percentage of execution per category of expense was 99.6 for current expense and 82.6% for capital expense.

Available balance for the beginning of 2007 from source of external funds is C\$144.3 millions.

### **7. Report from Results of Financial Audit**

It was disclosed that the General Comptroller's Office of the Republic (CGR) is performing a general auditing on expenses for the year 2005 of MINSA, including all sources (national and external).

It was reported that Reference Terms were approved and that it was under process of undersigning contract to perform financial audit for funds from World Bank. Contracting respective firms to perform such external audit can only be done until CGR approves it.



It was suggested to retrieve the agreement from Sectorial Board of last year, which would review Reference Terms in order to make one single audit for all financial sources (loans, donations).

The Inter-American Development Bank (IDB) recommended for future audits to broaden Reference Terms of the financial audit firm in order to perform one single audit for all financial sources.

In order for Finland to make disbursement during the year 2007, it would be necessary to present results from financial audit.

To move forward on the job of sharing the same topics of program included in the Memorandum of Understanding (MoU) with Sectorial Board, it was suggested to submit to revision the scope of contents and responsibilities described in the MoU.

### **8. New National Policy on Health**

The Minister of Health in her explanation stated that the main activities of the year 2006 in health sector were: Healthcare charges became history under the public system of health; Popular Work of Health had and will have full participation of the people; people were and will be guarantor of Healthcare Quality received under public system of health. We will attend people wherever we are needed.

### **9. Process of Implementation of Integral Healthcare Model of Health (MAIS)**

Objectives of the Model are as follows: Improve health conditions of the people, satisfy needs of health services, protect from epidemics, improve quality of services, and strengthen inter-institutional and sectorial communication.

### **Elements were mentioned to be implemented immediately**

Component of administration were included, such as plan, organization, medical supplies, administration of healthcare for the people, information system, monitoring, supervision and preparation of budget procedure.

A list was made on main results expected for 2007 at different levels, such as municipal and districts, hospitals, SILAISs and central level. See presentation in Web page of MINSA.

### **10. Report on Auditing Performance for 2006**

In order to know about the health conditions and how it contributed for development of activities or interventions of the Annual Operative Plan, is important to know the facts or behavior of indicators around the country not only in regards to 89 municipalities, which benefited from financial or compromised with bank loans.

It was agreed on that is important to know variables in accordance to data from the Census of the year 2005, knowing the difference between services production objectives of the Ministry and objectives of the country; for example, data of maternal mortality.

It is necessary to define, what goals and indicators will be used at national, departmental and municipality level?

It is important to make an analysis of inter-dependency of intermediate indicators regarding goals. How and why can it be explain that despite of maternal mortality interventions, it does not decrease?

The importance of knowing health conditions was requested through a set of data from 2002-2006 and report of results from ENDESA 2006.

#### **11. Report on Progress of Strengthening Plan for Acquisitions Unit**

The PACC is made from needs of contracting, which are identified by Requesting Units (US), starting to appreciate established instruments. This exercise is done between August and the first week of January the following year. The Annual Program of Purchases and Contracts of MINSA 2006 contemplate Projections of Contracts focused on fulfilling the quinquennium Plan of Health 2005-2009, which was characterized for contracting on six big categories.

#### **12. National Plan of Harmonization and Alignment in Health Sector**

The process of alignment and harmonization (A&A) for Aid Development (AOD) has opened a route toward a change of relationships between developed countries and Underdeveloped Countries Receptors of Aid (PVDRA) recognizes that only under [leadership and appropriation](#) from receptor countries is possible to move forward to development.

Moreover, A&A points out the need of **cutting costs of transactions significantly** of AOD and proposes alignment of objectives and activities and harmonization of procedures with those of the government.

Likewise, these countries have compromised to continue being **more efficient and clear on public administration**, because these are fundamentals of national and international co-responsibility.

In this context, **the Ministry of Foreign Relations, in coordination with the sectors, have been making efforts to utilize more efficiently resources originated from international cooperation**, promoting conditions to articulate a portfolio of integral programs as an alternative to achieve a greater economic and social impact in Nicaragua. In this sense, within the framework of international agreements, such as encouraging and deepening in Alignment and Harmonization; one of the strategies of institutionalizing this procedure was the preparation of a National Plan for Harmonization and Alignment as basic instrument of coordination between cooperating members and the country.

In order to warrant this Plan's functionality, it is necessary prepare sectorial plans, where it is considered development of concrete activities per sector, in accordance to its policy and priorities.

Framed in these processes, the Ministry of Health is one of the sectors that has had significant progress, and now it **has proposed to start preparing A&A Plan, in coordination with the cooperating community and other major actors**, according to a working meeting on April 12.

#### **13. Presentation of POA 2007**

It was disclosed that POA structure would be as follows: Three objectives remain for each one, which will be described its alignment and strategic activities in order to achieve expected results. Participants were requested to report financial availability from [cooperating community](#) to consider the cost of POA and estimate the scope of results with all sources.

#### **14. Cash Flow for 2007**

During working session, it was discussed the intention of placing at disposal of the Ministry the amount of 21.6 millions of dollars and 9.95 millions of euros. As loan 11.3

millions (BM = 5.0; BID = 6.3, out of which 0.3 for technical cooperation to prepare new operation of strengthening network of services). Detail is presented as annex for Financial Source. See presentation on Web page of MINSA.

#### **15. Budget for 2007**

Numbers on budget approved for the year 2007 for MINSA is C\$4,028 millions, equivalent to US\$254.8 millions (average rate of exchange C\$18.40 per one American dollar), out of which it corresponds to Current Expenses C\$3,162.7 millions and capital expense C\$865.5 millions. Detail per financial source and expense classification is presented in annexes to the present [guiding document](#)

#### **16. Presentation of PACC for 2007**

Ms. Leonor Corea presented the annual plan for purchases and acquisitions for the year 2007 for an amount of C\$429,675,530.16; this amount was shown as [pro-modalidades](#) of purchases and financial source, classified in Assets for C\$364,792,172.15, Public Works C\$64,781,358.32, and services C\$102,000.00.

#### **17. Health Expense in Nicaragua Financed by World Bank**

Due to delays in developing the program and lack of time, presentation was not carried out. But the specialist on this subject matter from the World Bank has prepared presentation, which will be requested and later will be distributed among members of the Board.

#### **18. Report on Global Alliance of Vaccines and Immunizations (GAVI)**

It was reported that Nicaragua has been designated a beneficiary country of Alliance GAVI and that the Ministry of Health has decided to initiate preparation of proposals for the following windows: 1) Strengthening immunization services (flexible support for increasing coverage of vaccination based on results, US\$20.00 for each third dose of DPT in children less than one year old up to three years) to support extension support of coverage; 2) Strengthening of health services up to an amount of US\$1.17 millions in three years (US\$2.5 per child born alive) to support implementation of Integral Healthcare Model; and 3) Introduction of new vaccines (heptavalent conjugated vaccine, including neumococcica disease).

Support was requested from Sectorial Board for members of GAVI to participate, who are in the country for procedure of preparation proposals and legal advising before global level for each agency that supports proposals of Nicaragua, which will be presented at the respective period in October 2007. For this, it was anticipated that respective working group (public health and organized response to health problems) supports MINSA in developing proposals.

#### **19. Expected Results from MINSA as of June 2007**

It was shared with Cooperating Community that main efforts with technical equipment from the Ministry for the month of June are the following expected results:

- a. Operative Manual for implementing Integral Healthcare Model.
- b. Operation of National Commission on Wage Policy
- c. Plan on proposal action of Wage Policy
- d. Estimate appropriation of financial source per administration level and estimate on budget gaps.

- e. Medium Term Plan prepared in regards to Budget Framework of Medium Term for 2008-2010.
- f. Compliance of health indicators evaluated for 2006, progress for 2007 and projected objectives for 2008.
- g. Ratify data of base year for goals, regarding Objectives for Development of the Millennium.
- h. Annual Operative Plan and Annual Budget for 2008 prepared.

Technical committee is responsible to follow-up and report to every member of the Sectorial Board.

## **20. New Working Way and Working Group of the Sectorial Board**

In the year 2006, it was considered and approved organization and operation of a Technical Committee of the Sectorial Board for the aim of making available the preparing the information, fulfilling with work timetable and achieve results expected in conformity to what is established in Code of Ethics, Memorandum of Understanding and Manual of Responsibilities for Sectorial Board, as well as following up agreements made at working sessions.

Part of the agreements made last year was to setting up three Working Groups of the Sectorial Board, which are: i) Economy and Health, ii) Public Health and organized response to health problems, and iii) Sectorial Conduction, Decentralization, Social Participation and Institutional Administration.

It was discussed that the importance of working groups was to constitute in areas of analysis, input of specialists in subject assigned, which conclusions and recommendations must be taken to the Technical Committee and from here, to the Coordination Board of Health Sector. In that respect, a proposal of plan or topics to be developed for each of the groups was prepared.

## **21. Agreements**

1. Organize working sessions to review POA 2007 and invite to participate in Programs and Projects that work in health topics, such as sexual reproductivity, ITS/VIH/SIDA, nutrition quality, indicators and information system.

Unit Responsible: General Division of Planning and Development in coordination with Directorate of Health Services.

2. It is important to understand variables according to Census 2005 data, knowing the difference between services production objectives of the Ministry and objectives of the country; for example, data of maternal mortality.

Unit Responsible: General Division of Planning and Development.

3. On April 12, a working meeting will be called to discuss the Plan of Harmonization and Alignment.

4. MINSA, through the General Division of Physical Financial Resources (DGRFF) will disclose to SPDs financial auditing reports performed.

Unit Responsible: Financie-Administration Directorate.

5. Invite working groups of the Sectorial Board to start performing their works. Each group will define its own topics of interest. The topic of analysis of results of health situation will be shared with all members of the Sectorial Board.

Unit Responsible: General Division of Planning and Development.

6. Distribute among members of the Board presentation on a Study of Expense on Health in Nicaragua, financed by the World Bank.

Unit Responsible: Technical Secretariat ESS

Signed at the city of Managua on March 28 of the year 2007

**Annexes**

N°	Indicador	Period	Observations
1	Rate of maternal mortality	Annual	
2	Coverage of institutional childbirth	Annual	
3	Captación premature pregnancy	Annual	
4	Percentage of pregnancies with four prenatal controls	Annual	
5	Rate of usage of secure contraceptive methods in women in fertile age	Quinquennium	ENDESA
	Coverage of family planning	Annual	
6	Percentage of women under institutional care of childbirth that presented post-childbirth hemorrhage	Annual	
7	Rate of infant mortality (per 1000 born alive)	Annual	
8	Coverage of pentavalent in children one year old	Annual	
9	Coverage of vaccination with MMR in children on year old	Annual	
10	Percentage of institutional outpatient due to neonatal asphyxia in institutional childbirths	Annual	
11	Number of persons prioritized receiving PBEC	Annual	
12	Number of women coming from Maternal Houses	Annual	
13	Rate of annual incidence of malaria (parasite annual index)	Annual	
14	Rate of incidence of flu	Annual	
15	Percentage of patients carrying VIH/SIDA secure with treatment	Annual	
16	Rate of hospital out patients per department	Annual	
17	Number of healthcare centers that have complied with service of critical route furnished (25 hospitals)	Annual	
18	Percentage of healthcare centers that have fulfilled satisfactorily their commitments process	Annual	
19	Percentage of maternal deaths audited	Annual	
20	Percentage of MINSAs budget transferred to SILAIS prioritized through regional budget 248 (redistributed for services) and group 579 (current transferences)	Annual	
21	Percentage of budget appropriated to Autonomous Regions processing decentralization.	Annual	

N°	Indicator	Period	Observations
22	Appropriation increase per capita per SILAIS (increase is proposed to be in absolute terms)	Annual	

**MINISTRY OF HEALTH**  
**FINANCIAL DISBURSEMENTS COMMITMENT TO SUPPORT APO - 2007**

In millions

Wednesday 1<sup>st</sup> November 2006

Donors	Currency	Amount		Remark
		EUROS	U\$S	
WB	U\$S		5.0	
AIDB	U\$S		6.0	
AIDB			0.3	Technical assistance
Sweden	U\$S		5.0	
Sweden	U\$S		0.6	Obstetrical Nurses Training Project
Finland	EUROS	2.0		
Finland	EUROS	1.0		SARED Project. Beneficiaries: SILAIS Carazo and Chontales
Austria	EUROS	1.0		
Austria	U\$S		0.85	Horizon 3000 Project
The Netherlands	EUROS	2.75		HIV/AIDS, Capacity Building, SRH incorporated
The Netherlands				SRH, CaCU, HIV/AIDS, Social Marketing Project
USAID				Beneficiaries : MINSA-MIFAMILIA- Private Sector
UNICEF	U\$S		0.35	
PAHO/WHO	U\$S		1.0	
AECI	EUROS	2.5		
Canada			1.5	Estimates . U\$5.0 CRN (PROCOSAN) +U\$ UPOLI (Obstetrical Nurses Training Project)
UNFPA	U\$S		1.0	To by confirmed by year end
EU	EUROS	0.7		2.1 millions of Euros for three years RAAN-MADRIZ-NSEGOVIA-Chinandega
Total		9.95	21.6	

Contribution per source of funding:

Loans	0	11.3
Donations	9.95	10.3
Total	9.95	21.6





# Gobierno de Reconciliación y Unidad Nacional

*El Pueblo, Presidente!*

## AIDE MEMOIR

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

### Participants

#### From the Ministry of Health (MoH):

Carolina Siu – DGPD (General Bureau for Planning and Development) and Secretary for SWAp  
Patricia Silva, Unit for External Fund Coordination  
Magaly Echegoyen – DGPD – External Cooperation  
Carlos Cruz, Director Health Service Assurance  
Marina Aviles – Director of Planning

#### Other Government Institutions:

Deborah Sequeira/ MINREX (Ministry of Foreign Relations)  
Maura Rodríguez / MHCP (Ministry of Finance)

#### Liaisons with Development Partners

Helena Reutersward, First Secretary, Embassy of Sweden  
Maria Angélica Gómez, PAHO/WHO

#### Not in attendance:

Alejandro Solís – Director General of Planning, MoH  
Director General of Administration and Finance, MoH  
Julio Zapata, Coordinator of the Social Area, Technical Secretariat of the Office of the President (SETEC)  
Colleen Littlejohn, Senior Country Officer, World Bank

#### Agenda for the Meeting of the SWAp Committee

- Review of agreements from the meeting of June 8
- Presentation of the First Management Report for 2007
- Progress in:
  - Formulation of the Medium-Term Budget Frame for 2008 – 2010
  - Sector Roundtable working groups
  - Financial audit
  - Formulation of the GAVI proposal
  - Review of the activities calendar and other points.



**Ministerio de Salud**

Complejo Nacional de Salud "Dra. Concepción Palacios", costado oeste Colonia Primero de Mayo, Managua, Nicaragua.  
Teléfono PBX: (505) 289 4700 • Apartado Postal 107

## **Progress of the meeting**

The meeting began by addressing the first point on the agenda, the review of agreements reached by the Committee during its meeting of 08 June 2007.

Regarding agreement # 4, MoH informed that they are waiting for the World Bank to send them the latest version of the draft Health Expenditures document so that they may contribute their opinions and comments. The agreed upon date for sending this document is 08 September 2007.

Regarding agreement # 6, it was reported that correspondence was sent to the FONSALUD members asking them to indicate if they agree with the letter of adjustments to the Memorandum of Understanding. These modifications had already been discussed, pending review of the content. Sweden indicated that it has not yet reviewed the correspondence.

Proceeding to the second point of agenda, the Medium Term Budget Frame for 2008-2010 was presented. Marina Aviles addressed the constraints encountered during its formulation as well as the progress that has been made in the process.

The importance of the Partners being more effectual in the provision of information regarding the amounts to be assigned for the budget formulation process was discussed. The MoH indicates that the information requested in order to prepare realistic scheduling has not been provided in a timely fashion.

It was suggested that during future Sector/MINREX and country/organisation negotiations, a clause should be included in the bilateral agreements with Nicaragua stipulating that the delivery of budgetary information shall be made according to a schedule agreed upon between the MoH and the Partners.

It was further stated that compliance must be promoted with the principles and agreements on harmonisation and alignment found in the Paris Declaration. It was also stressed that additional strategies should be sought to raise awareness among the donors.

The MoH held that effectual collaboration in the planning process requires from the donors:

- Flexibility in the pre-conditions;
- Scheduling of disbursements; and
- A fluid flow of funds.



There was also discussion of the need for the Government to overcome constraints in the information system. SIGFA (the Information System for Financial and Administrative Management) and SNIP (the National System for Public Investment) are not compatible. SIGFA does not respond to the new “Results-Based” planning; it generates Annual Operational Plan results only according to budget lines, without reflecting specific targets.

Regarding the working groups, it was suggested that the MoH maintain the existing working groups, which are: Health Economics, Public Health and an Organised Response to Health Problems, and Sector Leadership and Institutional Management.

It was explained that the working groups address the specific issues that have been defined by the MoH. Partners’ participation in the topic of interest is optional. Additional topics were suggested that are of great importance for institutional strengthening of the MoH, including human resource development and MHPMHP.

Committee members voiced the need for MoH to both assume effective leadership of the working groups and designate those divisions, entities or officials who will work with these groups. The members also took notice of the absence of Dr. Alejandro Solís, Director General of Planning and Development and the Administrative and Financial Director of the MoH in the Sector Roundtable’s Technical Committee meetings. Their systematic presence is requested, given that the meetings are a space in which some decisions can be made.

Regarding the financial audit, it was reported that in the tripartite meeting held on 31 July 2007, it had been agreed that the MoH would circulate a letter of no objection addressed to the auditors and indicating acceptance of the report. The process of circulating this letter among the development partners for their signatures is now underway.

Next, Dr. Carlos Cruz explained the process through which the MoH is preparing the project proposals that will be presented to the Board of the GAVI Alliance. One project is to strengthen the health system with emphasis on women and children; another is to strengthen immunisation services in municipalities that have been selected based on low coverage of integrated care for their populace and difficulties in access to service; and a third is for the introduction of the pneumococcal vaccine.

The GAVI Alliance has provided financial support and the Pan-American Health Organisation has provided technical support for the preparation of the project proposals. The projects are in the final stage of preparation. It is expected that MoH structures will implement them completely. The funds will be executed using the administrative and financial structures of MINADA and the national procedures for accounting, reporting and procurement. The financial support will be channelled through the FONSALUD common fund and thus will be subject to the single audit procedures used for all the funds administered by the MoH.



The Committee members stated that although progress has been made in the harmonisation processes, the preparation of this type of project requires a tremendous effort from government officials, which should not be the case. It would be more practical to use the funds to support the existing MoH plan, which already includes interventions to address the prioritised problems. One of the GAVI requirements is the broad participation of civil society and development partners. For this reason, the MoH requests that the development partners review the projects and give their suggestions and comments for enhancing them. The partners are also asked to back the projects when they are presented to the GAVI board for approval.

Finally, it was generally agreed to coordinate preparation for the upcoming October meeting of the Coordinating Roundtable.

## **AGREEMENTS**

1. The MoH will request the latest version of the Health Expenditures document from the World Bank and will circulate it for comment among the Roundtable members.
2. Both the MoH and Partners will seek alternatives for coordinating budgeting periods.
3. The MoH will inform Donors regarding the issues to be addressed in the frame of the established Working Groups.
4. Carlos Cruz will send the GAVI Alliance project proposals so that they may be forwarded to the Bilateral and Multilateral Partner liaisons for their review, comments, and support for approval by the GAVI Board of Directors.
5. The MoH/DGPD will organise a preparatory meeting on 28 August for the Sector Roundtable to be held in October of this year.



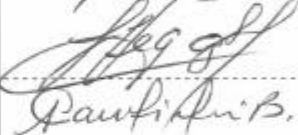



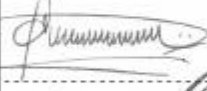




## ENDORSEMENT HEALTH SECTOR COORDINATING COMMITTEE

We the members of the **Health Sector Coordinating Roundtable Technical Committee**, having analyzed the following proposals to be submitted by the country to the GAVI Alliance:

- Support to Immunization Services, Nicaragua 2007-2011.
- Support for the introduction of new vaccines, Nicaragua 2008-2011.
- Maternal and Child Health System Strengthening in the Republic of Nicaragua, 2008-2011.

Hereby endorse these proposals. It is established that the follow up of the proposals will be in charge of the Sector Roundtable's Working Group on Public Health and Organized Response, which will constitute the Immunizations' Interagency Coordinating Committee (ICC).

Unit/Organization	Name/Position	Signature
General Bureau of Planning & Development Ministry of Health	Dr. Alejandro Solís M. Health Sector Coordinating Roundtable Technical Committee Coordinator.	
General Bureau of Administration & Finance Ministry of Health	Jaime González General Director	
General Bureau of Health Services Ministry of Health	Liana Vega Mejía General Director	
General Bureau of External Cooperation Ministry of Health	Carolina Siu External Cooperation and SWAP Technical Secretary	
Ministry of Foreign Affairs	Deborah Sequeira Official Delegate to the Sector Roundtable.	
Technical Secretariat Presidency of the Republic of Nicaragua	Julio Zapata Social Sector Coordinator	
World Health Organization/Pan American Health Organization	Mario Cruz Penate Liaison of UN Organizations on the Technical Committee	
Officer World Bank, Nicaragua Representation	Coleen LittleJohn Liaison of International Financial Organizations on the Technical Committee	
First Secretary, Embassy of Sweden Ministry of Finance and Public Credit	Helena Reutersward Liaison of Bilateral Partners on the Technical Committee	

  
 DIVISION GENERAL  
 DE PLANNIFICACION Y DESARROLLO  
 MINISTERIO DE SALUD

