MEASURE EVALUATION SR-15-118F

Family Planning in Nicaragua

The Achievements of 50 Years

April 2015

Roberto Santiso-Gálvez, MD
Victoria M. Ward, PhD
Jane T. Bertrand, PhD, MBA

USAID FROM THE AMERICAN PEOPLE

MEASURE Evaluation

Family Planning in Nicaragua

The Achievements of 50 Years

Roberto Santiso-Gálvez, MD

Victoria M. Ward, PhD

Jane T. Bertrand, PhD, MBA

MEASURE Evaluation is funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement AID-OAA-L-14-00004. MEASURE Evaluation, whose staff provided editorial, formatting, and distribution assistance, is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in association with Futures Group, ICF International; John Snow, Inc.; Management Sciences for Health, and Tulane University. The opinions expressed in this publication do not necessarily reflect the views of USAID or the United States government.

April 2015 ISBN 978-1-943364-06-0 SR-15-118F

Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years.* As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

http://www.cpc.unc.edu/measure/publications/tr-15-101

Acknowledgments

We want to thank the individuals who provided invaluable historical insight for this case study including Carolina Arauz, Guadalupe Canales, Freddy Cárdenas, Marianela Corriols and Edgard Narvaez. In addition, Freddy Cárdenas and Marianela Corriols reviewed a previous version of this case study.

The co-authors owe a debt of gratitude to three individuals who devoted vast amounts of their time and energy to this case study and to the larger main report: Kime McClintock and Jerry Parks (lead research assistants at Tulane University School of Public Health and Tropical Medicine) and Maria Cristina Rosales (editorial assistant in Guatemala). Their dedication in conducting background research, fact checking, verifying references, and editing text greatly enhanced the quality of the final product. In addition, we thank Nicole Carter, Alejandra Leyton, and Maayan Jaffe for their contributions as research assistants to specific sections of the main report and/or case studies. Mirella Augusto and Maria Carolina Herdoiza provided valuable administrative and logistics support to this effort. At the University of North Carolina at Chapel Hill, we thank Erin Luben, Elizabeth T. Robinson, and Nash Herndon for their editorial assistance; as well as Denise Todloski, who designed the cover.

The USAID Latin America and the Caribbean Bureau (USAID/LAC) commissioned this work and provided constructive technical guidance in its development. We wish to thank Kimberly Cole for her skillful management of the process and detailed synthesis of reviewer comments. Other reviewers of this case study from USAID/LAC included Maggie Farrell, Amber Hill, Lindsay Stewart, Verónica Valdivieso and Mary Vandenbroucke. Finally, the authors thank a number of Latin American/Caribbean specialists from within and outside of USAID who reviewed the main report and are acknowledged by name in that document.

Suggested citations:

Bertrand JT, Santiso-Gálvez R, Ward VM. *Family Planning in Latin America and the Caribbean: The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso-Gálvez R, Ward VM, Bertrand JT. *Family Planning in Nicaragua. The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Contents

OVERVIEW
COUNTRY SITUATION

Nicaragua, the largest country in Central America, has an area of 129,500 square kilometers and a population of 6.1 million.[1] The population growth rate is 1.27 percent,[2] and a third of the population is under age 15. Nicaragua has a population density of 48 inhabitants per square kilometer, and the majority (55.9 percent) live in urban areas. More than 40 percent of the population lives in poverty and about 15 percent live in extreme poverty.[3] The official language of Nicaragua is Spanish; however, approximately 15 percent of the population is indigenous or of African descent and speaks the Miskito, Mayagna, Kriol, or Garífuna languages.

Nicaragua is classified by the World Bank as a country with a lower-middle income economy; its macro-level indicators have improved significantly in recent years.[4] The country is committed to strengthening its development capacity, particularly in regard to poverty alleviation and macroeconomic policies. Health and education are considered to be human rights.[5,6]

Family planning is seen as one of the most successful development programs in Nicaragua. According to local experts, this is a result of favorable public policies, complemented by a comprehensive health care model that has received support from both national and international sources.

According to data from the Encuesta Nicaragüense de Demografía y Salud (ENDESA, National Demographic and Health Survey), the total fertility rate decreased from 4.6 children per woman in 1992-93 to 2.4 children per woman in 2011-2012 (as shown in table 1). The contraceptive prevalence rate is 80.4 percent for all methods, which places Nicaragua well ahead of other countries in the region with similar or better economic indicators. From 1992-93 to 2011-12, the modern contraceptive prevalence rate (MCPR) increased from 44.9 percent to 77.3 percent.

As can be seen in figure 1, the contraceptive method mix has varied over time. Female sterilization remains the method of choice among family planning (FP) users in Nicaragua (37.1 percent). Use of injectables has increased significantly, from 2.5 percent in 1992-93 to 32.3 percent of the method mix in 2011-12, which undoubtedly helped increase the contraceptive prevalence rate (CPR). Use of long-acting reversible contraceptive methods, such as the copper

[1] Instituto Nacional de Información de Desarrollo (INIDE). 2012. *Población Total, Estimada al 30 de Junio del Año 2012*. Managua, Nicaragua: INIDE; 2012. Retrieved from: http://www.inide.gob.ni/estadisticas/Cifras%20municipales%20a%C3%B1o%202012%20INIDE.pdf.

[2] Centro Lationamericano y Caribeno de Demografia (CELADE). *Long Term Population Estimates and Projections 1950-2100*. Managua, Nicaragua: CELANDE; 2011. Retrieved from: http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

[3] INIDE, 2012.

[4] World Bank. *Country and Lending Groups*. Washington, DC: World Bank; 2014. Retrieved from: http://data.worldbank.org/about/country-and-lending-groups.

[5] Organization for Economic Co-operation and Development (OECD). *Declaración de París sobre la Eficacia de la Ayuda al Desarrollo, Plan de Acción 2005-2008*. Paris, France: OECD; 2005. Retrieved from: http://www.oecd.org/dac/effectiveness/34580968.pdf.

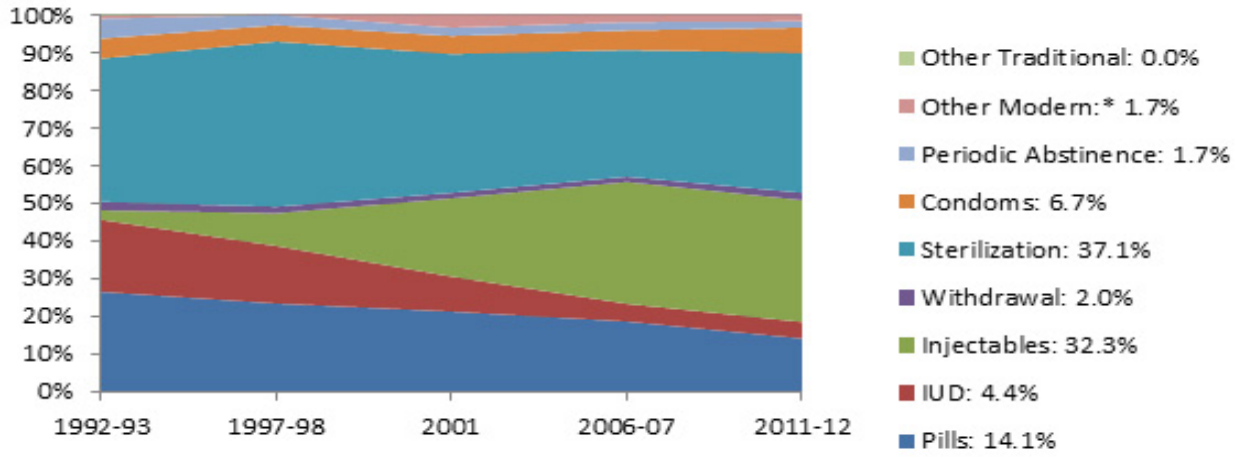
[6] Ministerio de Salud. *Estrategia del Enfoque de Diálogo Programático con la Cooperación*." Managua, Nicaragua: Ministerio de Salud; 2011. Retrieved from: http://www.minsa.gob.ni/index.php/division-coorperacion-externa/presentacion-cooperacion-externa.

T intrauterine device (IUD) has decreased, although the IUD is still available and providers have received training to strengthen the provision of this method.

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/In-Union Aged 15-49, 1992-2012, Nicaragua

	1992-1993	1997-1998	2001	2006-2007	2011-2012
Total Fertility Rate	4.6	3.6	3.2	2.7	2.4
Contraceptive Prevalence Rate (%)	48.7	60.3	68.6	72.4	80.4
Modern Contraceptive Prevalence Rate* (%)	44.9	57.4	66.1	69.8	77.3
Unmet Need (%)		17.9	14.6	10.7	

Sources: ENSF (1992-93) and ENDESA (1997-98, 2001, 2006-07, 2011-12 preliminary report) data.[7] The data presented in this table were obtained through DHS Statcompiler for the following years: 1997-98, 2001, and 2006-07. Data for 1992-93, and 2011-12 in all categories were not available in Statcompiler and instead were obtained directly from Demographic and Health Surveys (DHS) and Reproductive Health Surveys (RHS).
Note: * MCPR includes lactational amenorrhea method (LAM).



Source: ENSF (1992-93) and ENDESA (1997-98, 2001, 2006-07, 2011-12) data; percentages in legend refer to the most recent survey (2011-12).
Note: *Includes male sterilization, vaginal methods, and LAM.

Figure 1: Method mix (Nicaragua, 1992-2012).

[7] Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta Nicaragüense de Demografía y Salud (ENDESA) 2011/12. Informe Preliminar*. Managua, Nicaragua: Ministerio de Salud; 2013. Retrieved from: http://www.unfpa.org.ni/wp-content/uploads/2013/12/INFORME-PRELIMINAR-ENDESA-2011-12.pdf.
Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta Nicaragüense de Demografía y Salud (ENDESA) 2006/07. Informe Finale*. Managua, Nicaragua: Ministerio de Salud; 2008. Retrieved from: http://www.inide.gob.ni/endesa/Endesa_2006/InformeFinal06_07.pdf.
Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta Nicaragüense de Demografía y Salud (ENDESA) 2001. Informe Finale*. Managua, Nicaragua: Ministerio de Salud; 2001. Retrieved from: http://dhsprogram.com/pubs/pdf/FR135/FR135.pdf.
Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta Nicaragüense de Demografía y Salud (ENDESA) 1997/98. Informe Finale*. Managua, Nicaragua: Ministerio de Salud; 1998.
Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta sobre Salud Familiar (ENSF) 1993/93. Informe Finale*. Managua, Nicaragua: Ministerio de Salud; 1993.

The urban-rural gap in use of modern contraceptive methods decreased over time (as shown in table 2). Increased access to voluntary surgical contraception (VSC) and the widespread use of injectables has contributed to this improvement.

Table 2: Reduction in the Urban-Rural Gap in Modern Contraceptive Use in Women Married/In-Union Aged 15-49, 1992-2012, Nicaragua

	1992-1993	1997-1998	2001	2006-2007	2011-2012
Urban Use (%)	54.9	62.8	70.7	71.3	79.0
Rural Use (%)	31.3	49.3	60.0	68.0	75.3
Urban-Rural Gap (Percentage Points Difference)	23.6	13.5	10.7	3.3	3.7

Sources: ENSF (1992-93) and ENDESA (1997-98, 2001, 2006-07, 2011-12).

In contrast, adolescent pregnancy remains a major challenge. The adolescent fertility rate dropped from 106 per 1000 women ages 15-19 in 2007 to 92 per 1000 in 2011-12. However, it is still the highest in Latin America, followed closely by Honduras. Although adolescent fertility has declined nationally, there are areas where it has increased, particularly in the poorest regions of the country.[8]

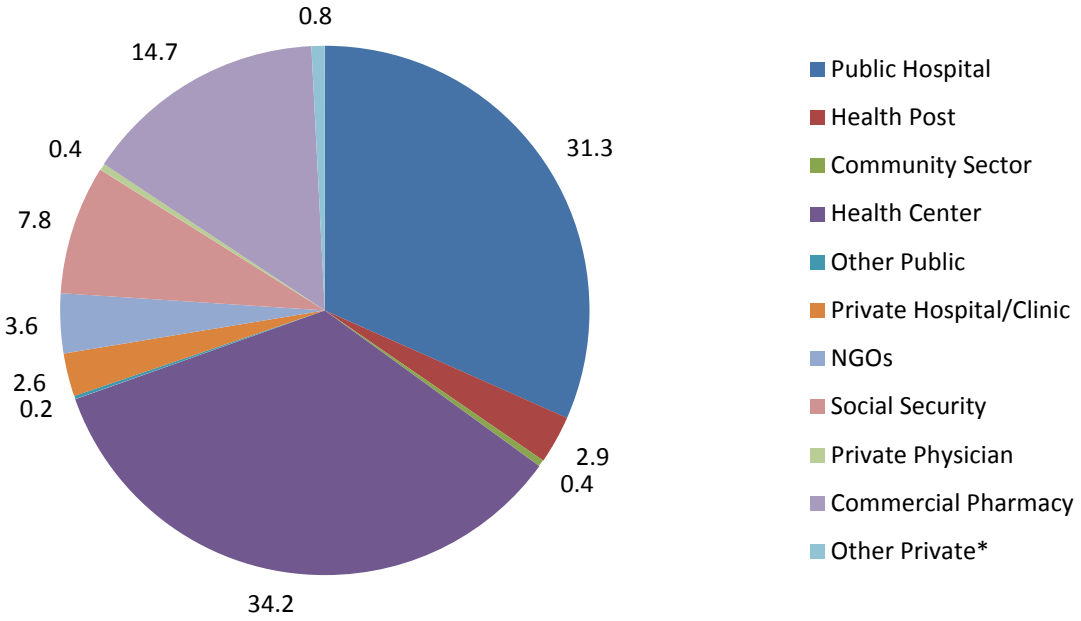
The source of modern contraceptive methods has varied over time (figure 2). The public sector has been the main provider since 1998, increasing its participation gradually from 62.0 percent in 1998 to 67.8 percent in 2007. According to the preliminary report for the 2011-12 ENDESA, over two-thirds of users (68.6 percent) obtain their contraceptives from public facilities (including public hospitals, health centers, health posts, and police or army institutions). The private sector provides contraceptives to 29.9 percent of FP users. Commercial pharmacies are the largest provider in the private sector. The percent of users obtaining methods from pharmacies has increased (11.4 percent in 1998 to 14.7 percent in 2012). The Empresas Médicas Previsionales (EMP) provides contraceptives to 7.8 per cent of FP users. Nongovernmental organizations (NGOs, including PROFAMILIA) have gradually declined as a source of contraception (from 11.9 in 1998 to 3.6 percent in 2012).

The important strides made in FP over the past four decades – and especially in the past 20 years — result from multiple activities which include increased attention to quality of care based on clients' needs, training of service providers, and the establishment of standards, norms and guidelines for delivery of contraceptive methods. In addition, improvements have been made in the administration and financial management of contraceptive logistics and information systems, as is discussed later in this case study.

The lead donor for FP has varied over time. In the late 1960s and most of the 1970s, the U.S. Agency for International Development (USAID) and International Planned Parenthood

[8] Instituto Nacional de Información de Desarrollo (INIDE). *Encuesta Nicaragüense de Demografía y Salud (ENDESA) 2011/12. Informe Preliminar*. Managua, Nicaragua: Ministerio de Salud; 2013.

Federation (IPPF) were the primary donors. However, IPPF and UnitedNations Population Fund (UNFPA) took the lead during the Sandinista regime (1979-1990). With a change in administration in 1991, USAID once again became the lead donor and continued that role through 2003. Since then, UNFPA, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank have also provided valuable support for FP in Nicaragua.[9]



Source: ENDESA, preliminary data, 2011-2012.
Note: *Supermarket, health promoters.

Figure 2: Method source (Nicaragua, 2012).

THE EARLY YEARS (1967-1978)

In 1967, the country members of the Organization of American States (OAS) signed the Declaration of the Presidents of America, which committed to improving maternal and child health (MCH). This document paved the way for Latin American countries, including Nicaragua to begin planning FP efforts within the context of MCH. In 1968, the Nicaraguan MOH began providing FP information and clinical services in collaboration with the Moravas Clinics and with the support of USAID. The Programa Pro-Bienestar de la Familia (Program for Family Welfare) was created within the Maternal Health Division of the MOH, which was staffed by nurses and nurses' aides. The objective was to protect the health of mothers and their children.

In 1969, also with support from USAID, the INSS (Instituto Nicaragüense de Seguridad Social) began providing FP information and services for affiliated workers through the Family Orientation Program. Private FP efforts began in 1970, with the establishment of the nongovernmental association (NGO) Asociación de Demografía Nicaragüense (ADN,

[9] USAID/DELIVER Project. 2014. *Informe de Evaluacion del Programa de Salud 2008-2013*. Arlington, VA: John Snow Inc.; 2014.

Nicaraguan Demographic Association). The ADN created awareness of MCH issues, promoted responsible parenthood, and distributed FP IEC materials and services in Managua, the capital city. ADN became an associate member of the International Planned Parenthood Federation (IPPF) in 1975.[10]

In 1972, an earthquake almost completely destroyed Managua. Following the earthquake, in 1973, ADN opened a model clinic with IPPF funding and requested international help in developing new programs to support the MOH and INSS. In the following years, USAID provided assistance for the construction of 55 new health centers and ten rural hospitals in which FP information and services were provided.[11] A total of 1,650 health workers received training in FP service provision and contraceptive technology; 105 health centers offered FP services to 63,000 women, and 28 community health organizations were established. USAID´s financial assistance for FP in Nicaragua from 1968-1982 totaled US$2 million dollars.[12] .

During the early years, ADN promoted family planning as a means to prevent maternal mortality due to unsafe abortion and to improve the general health and well-being of women. Information, education, and communication (IEC) activities were carried out with USAID and IPPF assistance and the MOH's authorization. In 1972, the first national radio campaign on FP education, supported by USAID, ran for a year. ADN organized a series of conferences and seminars for diverse audiences to raise awareness of the impact of population growth on development. In addition, the Central American Business Administration Center (INCAE) held the first Central American workshop on family planning management for executive directors of Central American Family Planning Associations (FPAs).

In 1976, five of the six ADN clinics were transferred to the MOH, despite the fact that the MOH had low overall coverage and did not strongly support family planning. ADN refocused their work in FP on a community-based distribution (CBD) program which used midwives to provide contraceptives. They also began to perform outpatient VSC in the late 1970s.[13]

The main obstacles during those early years were the lack of government support for family planning, difficult access to rural and marginalized urban areas, and machismo, particularly in the rural areas, where women often had to use contraceptives without their partners' knowledge. Opposition from conservative and religious groups, especially on the Atlantic coast, was also a challenge. On the political front, the Nicaraguan people had grown tired of a 45-year Somoza family dictatorship. Several attempts were made to overthrow the dictatorship since the 1950s; in 1978, these efforts intensified.

---

[10] International Planned Parenthood Federation (IPPF). Nicaragua [Web page]. London, United Kingdom: IPPF; 2012. Retrieved from: http://www.ippf.org/our-work/where-we-work/western-hemisphere/nicaragua.

[11] USAID Deliver Project. *Informe de Evaluacion del Programa de Salud 2008-2013.* Arlington, VA: John Snow Inc.; 2014.

[12] USAID Deliver Project, 2014.

[13] Profamilia. Hechos históricos [Web page]. Managua, Nicaragua: Profamilia; 2013. Retrieved from: http://www.profamilia.org.ni/?page_id=9.

PROGRAM CONSOLIDATION (1979-2000)

The health system in Nicaragua in the late 1970s was influenced by two major events: On July 19, 1979, the Frente Sandinista de Liberación Nacional (FSLN, National Liberation Sandinista Front) overthrew President Anastasio Somoza and took power in Nicaragua. FSLN remained in power from 1979 to 1990. The Sandinista government encompassed a broad ideological spectrum of social democratic, socialist, and Marxist-Leninist components, influenced by the Liberation Theology movement. In 1978, the Alma Ata International Conference influenced international health by promoting the strategy of implementing primary health care as a necessary component for achieving the goal "health for all in the Year 2000".

The new Sandinista government implemented several socioeconomic and political reforms. One such reform followed the Alma Ata strategy by integrating the health system into a primary health model and merging the MOH with the INSS. Extension of coverage and free provision of health care became official policies. The government built health care units in municipal capitals throughout the country and hired as many physicians as possible. Family planning became a part of this comprehensive health care system.

Health care providers, including traditional midwives, were trained to follow standards of care. The MOH implemented plans, strategies and programs in an inclusive health model with the government's commitment to improve the health of all Nicaraguans. The extension in coverage and improvements in health indicators that Nicaragua has today can be attributed, in part, to input from the international community and to that fundamental change in the health model that received strong grass-roots support and voluntary participation.

The Sandinista health system relied heavily on community-level volunteers to provide services, including extensive use of home visits. The government undertook a massive community-level effort to clean up neighborhoods and houses, as well as to offer free preventive health care. A national immunization day took place every year that mobilized the entire country. This event offered an opportunity to distribute flyers promoting the benefits of family planning and to provide readily available contraceptive methods. UNFPA provided free contraceptives through the Pan American Health Organization (PAHO).

The U.S. government suspended all economic aid to Nicaragua from 1979 until 1990, when a new government was elected. During those years, USAID did not support family planning programs; ADN's services were reduced to two clinics, including one housed in the same building as its headquarters. At this time, ADN worked with the support of IPPF and its donors, which were mostly European countries. On December 3, 1988, ADN changed its name to PROFAMILIA.[14] According to people who lived the experience, when representatives of one of USAID's cooperating agencies (CAs) came to Nicaragua in 1990 to do an analysis of family planning, they were surprised by the progress that had been achieved. Two aspects in particular caught their attention: the absence of a vertical family planning program and the fact that every nurse that they talked to was well-informed and knew how to prescribe contraceptives.

[14] On December 3, 1988, ADN changed its name to PROFAMILIA, which will be the name used from now on.

The new administration of Violeta Chamorro (1990-1997) transformed the government and replaced many Sandinistas in leadership positions. Searching for new options, women who had acquired experience in gender equity and rights began to organize and started the NGO movement in Nicaragua. They began looking for funding from donors who knew their previous work and were willing to support their efforts to defend women´s sexual and reproductive rights. The International Conference on Population and Development (ICPD) in 1994 in Cairo further reinforced the goals of more than 300 women's NGOs working on human rights, women and health, and other health related issues, which enabled them to obtain financial support to continue their work in family planning/sexual and reproductive health (FP/SRH).

International donor support was extremely valuable for FP during this period of consolidation. IPPF (with funding from multiple sponsors) and UNFPA were the main donors during 1979-1990. Subsequently, starting in 1991, USAID took the lead in providing technical and financial support to health programs in Nicaragua and has since invested more than $200 million in them. One-third of this funding was earmarked for provision of family planning and reproductive health services through Profamilia and the MOH. This support further increased when Nicaragua was severely affected by Hurricane Mitch in 1998.[15]

Following the hurricane, USAID funded the creation of the Federación NICASALUD (Nicaraguan Networks) project for reconstruction of the most affected areas. This funding continued until September 2013. USAID's technical and financial assistance to maternal and child health has continued to several projects. One such project is FamiSalud, implemented by 10 NGOs of the NICASALUD network. FamiSalud focuses in improving quality of services at different levels, increasing coverage of community health activities, and supporting the implementation of the national Family and Community Health Model (MOSAFC). USAID activities have directly contributed to the improvement in health indicators, reported by the Nicaraguan MOH, including a reduction of maternal mortality, an increase in institutional deliveries, and an increase in the percent of pregnant women receiving prenatal care. Community health programs reach more than 280,000 people in the 78 poorest municipalities in the country.[16]

The government of Nicaragua, the private sector, and many NGOs have received support from USAID to train health providers, managers and administrators on a range of topics: contraceptive technology, establishment of standards, guidelines and protocols for FP service delivery, contraceptive logistics, and information systems. Attention was also given to quality of care, improving services and expanding coverage. The high levels of MCPR have contributed directly to the marked reduction in maternal mortality in the past five years.[17]

Nicaragua has followed a comprehensive approach to health and has maintained strong coordination among donors, including various United Nations agencies (e.g., PAHO, UNFPA,

[15] Avila G, Gutiérrez V, Corriols M, Cole K. *Family Planning Graduation Strategy Final Evaluation Report October 2012*. Washington, DC: United States Agency for International Development; 2012.
[16] USAID/Nicaragua. Health [Web page]. Manugua, Nicaragua: USAID/Nicaragua; 2014. Retrieved from: http://www.usaid.gov/nicaragua/health.
[17] Avila et al., 2012.

UNICEF), the World Bank, the Inter-American Development Bank (IDB), as well as IPPF. European donors include the Netherlands, Finland and Sweden, among others.

In recent years, women's NGOs have gone through a crisis of financial sustainability for multiple reasons. While the number of NGOs has diminished, those that have remained have continued to keep women's reproductive rights on the public agenda and in the political arena. The participation and leadership of these groups have sustained SRH gains during the last 20 years, and have contributed to improving access and quality of FP services for all women, especially for those living in the rural areas.

THE GRADUATION PROCESS

In 2003, Nicaragua hosted an international meeting that launched the Disponibilidad Asegurada de Insumos Anticonceptivos Initiative (commonly known as DAIA, Ensured Availability of Contraceptive Products) for eight Latin American countries. Nicaragua established its DAIA Committee in 2004 with USAID support. The MOH coordinates the DAIA Committee, with participation of the INSS, EMPs, the commercial pharmaceutical sector, the Red NICASALUD Federation, PROFAMILIA, UNFPA and USAID and several of its contractors. From its creation until 2012, a USAID-supported project held the technical secretariat of the DAIA Committee. Its objective, like those of other committees in the region, is to improve overall contraceptive security.[18] The DAIA established four working groups for logistics, policy and advocacy, market segmentation, and financing.

In 2007, a USAID/Washington team visited Nicaragua to develop a graduation strategy with the USAID/Nicaragua mission and senior officials from the MOH, INSS, the private sector, NGOs, advocacy groups, and other donors. The local USAID officials strongly supported the graduation process since they agreed that the government of Nicaragua had made tremendous strides in establishing health policies, improving primary health care, reducing maternal mortality and getting health services that included FP to the rural areas.[19] A situation analysis identified the main issues to be addressed for successful graduation from USAID assistance: historical dependence on donations for all contraceptive supplies, limited market segmentation, weaknesses in health system governance, inequities in service access and quality, and a shortage of human, institutional and financial resources for conducting health surveys. Facilitated by the DAIA Committee, in 2005 the MOH developed a contraceptive security plan for 2005 to 2008. It was adopted in 2006 and became the basis for the DAIA's work until graduation.[20,21] Following an evaluation of this plan, a second plan (2009-2012) was developed and implemented.

---

[18] Contraceptive security is defined as the point at which every person is able to choose, obtain, and use quality contraceptives, condoms, and other necessary reproductive health supplies for family planning and for the prevention of HIV/AIDS and other sexually transmitted infections.

[19] Bertrand JT. USAID *Graduation from Family Planning Assistance: Implications for Latin America*. Washington, DC: Population Institute; 2011. Retrieved from: http://www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf.

[20] Bertrand, 2011.

[21] USAID/Health Policy Initiative. *Contraceptive Security Committees: Their Role in Latin America and the Caribbean*. Washington, DC: Constella Futures; 2007. Retrieved from: http://www.healthpolicyinitiative.com/Publications/Documents/404_1_404_1_CS_Committees_Case_Study_English_FINAL_acc.pdf.

The graduation process was not without challenges. However, in 2006 after considerable deliberation, an agreement was signed by USAID, UNFPA and the government of Nicaragua for the purchase of contraceptives. Starting in 2007, the government took on a greater level of responsibility for the FP program.[22]

USAID supported the Family Planning Graduation Strategy in Nicaragua from October 1, 2007 to September 30, 2012 with an estimated budget of US$13.5 million. It was divided into two phases: a health system strengthening phase (2008-2009) and a sustainability development phase (2010-2012). The strategy included five components: (1) contraceptive security, (2) market segmentation, (3) health system strengthening, (4) improved services and quality of care, and (5) strengthening the information system for decision-making. Seventeen performance indicators were established to measure results.[23] During the development of this strategy, USAID provided significant support to reinforce each of these components.

DAIA Committee achievements reflect a successful outcome from the graduation process. The results of an evaluation in October 2012 showed that 15 of the 17 indicators had been achieved and the remaining two (involving market segmentation and MOH and INSS participation in the market share) were in the process of being achieved. Nevertheless, the process has been challenging and several aspects of the system still need to be strengthened.[24]

POLICY, LEADERSHIP, AND GOVERNANCE

As mentioned above, health reform in Nicaragua intensified the focus on prevention. Maternal and child health was included in the 1987 constitution, with family planning as a component of integrated health services. Family planning is now an important part of the government's strategy to reduce maternal mortality and prevent adolescent pregnancy. It also appears in several family, community health, and human development plans and in the national population policy.

In 2007, the National Health Policy mandated that all health services were to be offered free of charge, allocating resources and expanding coverage of the public health system, which currently provides care for about 80 percent of the population. This policy includes the Marco Conceptual del Modelo de Salud Familiar y Comunitario (MOSAFC, Family and Community Health Model), which is based on equitable access to health services. It seeks to reduce gaps in health care for marginalized populations and emphasizes SRH and disease prevention. It represents a new comprehensive health care paradigm, with strong emphasis on the local level.

In 2008, the MOH adopted the National Reproductive Health Strategy as part of the National Development Plan, which includes nine specific objectives related to universal access to reproductive health services and contraceptive security.

Nicaragua has a sound public health policy. It has ratified and adhered to international treaties and declarations, such as the Declaration of the Millennium Development Goals (MDG), the

[22] Bertrand, 2011.
[23] Avila et al., 2012.
[24] Avila et al., 2012.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the International Conference on Population and Development (ICPD) Program of Action. This policy dialogue has been key to the success of family planning.[25] In addition, Nicaragua was one of the few Latin American countries included in the initial round of the Paris Declaration on Development Aid Effectiveness, in which donors and governments committed themselves to ensuring effective, accountable and transparent management of development assistance.[26]

As a result of political will and the vigorous overall legal framework, major progress has been achieved in government policies; the country has worked to improve primary health care, reduce maternal mortality, and take family planning services to more remote areas. However, financial and logistical constraints could jeopardize these gains.

FAMILY PLANNING AND THE HEALTH SYSTEM

Health services in Nicaragua are mainly provided by the public sector, which is financed by general taxes. The primary health provider is the MOH, officially covering 80 percent of the population. The INSS provides health care to formal sector workers, covering about 10 percent of the population. Only a small percentage of Nicaraguans receive private health care services.

The Sistema Local de Atención Integral en Salud (SILAIS, Local Integrated Health Care System) is a decentralized health unit created by the MOH in 1990 for the purpose of providing free, high-quality preventive and curative health services, with preferential attention to the low-income population.[27] SILAIS focuses on rural and geographically isolated areas, where maternal and child health indicators are the lowest in the country.

In 2008, the MOH launched the National Reproductive Health Strategy as part of the National Development Plan. Its objectives include universal access to family planning methods. USAID supported this strategy with advocacy activities through the Health Sector Roundtable and the Nicaraguan Fund for Health (FONSALUD).[28] Specifically, the plan includes access to contraception as a process indicator and the contraceptive prevalence rate (CPR) as an impact indicator in monitoring progress.

USAID supported a strategy to strengthen the health system in its different components. The strategy included six building blocks, namely: (1) Policy (leadership and governance); (2) health care financing; (3) health work force; (4) logistics (medical products and technology); (5) service delivery (coverage and quality); and (6) information and research.

---

25 Avila et al. 2012.

26 OECD, 2005.

27 Government of Nicaragua, 2013. SILAIS Managua [Web page]. Managua, Nicaragua: Government of Nicaragua; 2013. Retrieved from: http://silaismanagua01.es.tl/SILAIS-MANAGUA--.htm.

28 FCG International Ltd. Evaluation of FONSALUD and institutional plans of the Ministry of Health of Nicaragua [presentation]. Presented to the Ministry for Foreign Affairs of Finland, 2013. The Fondo Nicaragüense para la Salud (FONSALUD, Nicaraguan Health Fund) is a financial mechanism established in Nicaragua to support the institutional plans of the MOH and improve the effectiveness of aid for development. FONSALUD has been implemented in Nicaragua to coordinate, harmonize and align aid in the health sector among the MOH and its development partners.

Service Delivery (Institutions, Methods, and Service Models)

Nicaragua has had a policy of integrated health services which have included family planning. The MOH and INSS were unified under the Sandinista government and separated again in 1990 when the Chamorro government came into power.

MOH — The MOH is the main service provider and governing body for the sector. It offers free clinical services in the country's 15 departments through SILAIS in hospitals, health centers and health posts nationwide.

Although nationwide stock-outs are rare, there are still minor stock-outs for some methods, particularly in areas where access is difficult.

At the end of the 1990s, the Atención Post Evento Obstétrico (APEO, Postpartum and Postabortion Contraception Strategy) was promoted by UNFPA and later received DAIA committee support. This strategy has proven to be effective because it provides women with an opportunity to receive information and counseling about contraception and to opt for a method before leaving the hospital or health center after giving birth. Often this is their first exposure to FP information and services.

INSS — INSS covers private sector and formal sector employees. It has its own network of medical facilities, but contracts services through the EMPs and the Clínicas Médicas Previsionales (CMPs, Social Security Medical Clinics) which buy contraceptive methods from PROFAMILIA.

In 2007, during the Daniel Ortega administration, these CMPs were seconded to the MOH as state-owned enterprises with administrative and financial autonomy. In that same year, INSS authorities changed the name of CMPs to Instituciones Provisoras de Servicios de Salud (IPSS, Health Service Provider Institutions), which include public and private providers. INSS increased its delivery of family planning services in 2007, raising its market coverage from 3.6 percent in 2007 to 7.8 percent in 2011 and diminishing the burden on the MOH to offer services to this population.

As an alternative source of financing and to ease the burden on the MOH, the INSS provides services to its affiliates at MOH hospitals.[29]

Between 2004 and 2007, USAID implemented the Banking on Health project to enhance the role of the private sector to provide FP and reproductive health (RH) services through the INSS. The project initially trained personnel from two commercial banks, Finarca and BanPro, to understand better the market for health services in Nicaragua and to give access to credit to IPSSs that offer services to INSS clients. The training covered financial management, identifying profitable projects, procurement processes, as well as the benefits of FP as a preventive health

[29] USAID/DELIVER Project. *Nicaragua: Una Alianza Modelo entre El Instituto Nicaragüense de Seguridad Social y el Ministerio de Salud*. Arlington, VA: John Snow Inc.; 2010. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/logisticsbriefs/NI_UnaAlianModelo.pdf.

activity for users and providers alike. INSS staff also received training to improve their ability to evaluate and certify commercial vendors on financial criteria.

This project sparked the interest of INSS and the IPSSs to invest in FP/SRH services. The participating institutions increased the number of users and improved the quality of their services while strengthening their relationship with INSS. Users expressed their satisfaction with the improvements. INSS made policy changes to strengthen its system and contemplated providing social security coverage to informal sector workers; however, the government leadership changed while the project was being implemented. The new administration did not support this plan; therefore, it was never successfully implemented.[30]

Private sector — The private sector is also involved in the provision of services, mainly through pharmacies, EMPs, PROFAMILIA with its network of 17 clinics located throughout the country, clinics and private hospitals, PASMO, supermarkets, markets, and promoters. To a lesser extent, FP/SRH services are also provided by two nonprofit feminist organizations working to defend reproductive rights for women: the Centro de Mujeres Ixchén, (Ixchén Center for Women), and the Asociación de Servicios Integrales para la Mujer (Si Mujer, Association of Comprehensive Health Services for Women). Si Mujer has an additional focus on adolescents.

Social marketing — Social marketing began in Nicaragua in the late 1990s and served a useful role when USAID was financing PROFAMILIA to implement this strategy. While social marketing is no longer used as a strategy, ten years after USAID funding ended, PROFAMILIA continues to provide contraceptives for low income users at the community level, financing them with its own funds. According to the 2011-12 ENDESA, PROFAMILIA has a 2 percent market share, which is encouraging, given that it is not receiving any financial assistance from USAID.

PASMO, a regional social marketing institution established with USAID funding, began activities in the region in 1997; it has worked with the government to improve coverage in rural areas and, in recent years, has added the HIV/AIDS dual protection approach, improving access to condoms. Currently, PASMO runs a medical project known as Redes Seguras (Secure Networks), which promotes long acting reversible methods (e.g. IUDs and Jadelle implants).

Community based distribution — Contraceptive distribution at the community level began in the late 1990s with participation of health volunteers. This was a local initiative to increase access to contraceptive methods in those remote communities where health facilities and personnel were scarce.

After analyzing its experience with PROFAMILIA's community-based distributors, USAID began supporting the MOH to develop a contraceptive delivery strategy known as Entrega Comunitaria de Métodos Anticonceptivos (ECMAC, Community-based Contraceptive Delivery). ECMAC was implemented in three stages (2006-2012), jointly with the NICASALUD Network Federation as part of FamiSalud/USAID project; it covered 917 communities in 12 SILAIS centers.

[30] Banking on Health Project. *The Banking on Health Project End of Project Report*. Bethesda, MD: Banking on Health, Abt Associates Inc.; 2009.

Because of the success of this strategy, starting in 2011, ECMAC was used to improve access to contraception for adolescents, particularly sexually active adolescents not living with a partner who are not as likely to visit health facilities. Service delivery guidelines, known as ECMAC-Adolescent, were developed with UNFPA support to improve contraceptive distribution, particularly condoms, through peers. This approach has proven valuable for preventing sexually transmitted infections (STIs), in those who are less likely to visit health facilities.

Human Resources

The staff who deliver and manage family planning services in Nicaragua include physicians, nurses, social workers, counselors, logistics specialists, administrators, and other support staff.

Major efforts were made from 2007 to 2012, as part of the graduation process and with support of USAID and other international agencies, to train and monitor personnel providing FP/SRH information and services. Close to 13,000 people benefited from this training, including staff members of the MOH, medical clinics and INSS providers, NGOs, and community counselors. Training focused on establishing and implementing service delivery guidelines and protocols to improve the quality of services.

In addition, a training package focused on logistics, counseling and quality improvement, called maletas pedagógicas (teaching kits), was developed for universities and nursing schools. Based on national standards and officially adopted by the MOH. Since 2012, USAID support has gone to universities and nursing schools in Nicaragua to integrate FP content into the curricula and to provide pre-service training to MDs, including leadership and management for FP programs.

Nicaraguan public universities, with support from USAID, have incorporated content on the MOH logistics system into their academic curriculum in an effort to develop a cadre of health professionals to manage this system in future years. The University of Managua's School of Pharmacy is now successfully training students in logistics and rational drug use. The project is working with faculty from other local universities (schools of medicine and pharmacy, other academic institutions) to continue to train students in the MOH logistics system.[31]

The integration of FP/SRH into the medical curriculum is a major achievement, of particular benefit to rural areas that are generally served by recent medical graduates performing their required year of rural service. Until recently, graduates served for one year, but their term of service has been increased to two years, allowing for more continuity in the field. The inclusion of MOH standards in the educational curricula of medical schools provides graduating doctors with the knowledge and skills needed to implement appropriate service delivery guidelines.

[31] USAID/DELIVER Project. *Sustainability Through Pre-Service Training*. Arlington, VA: John Snow Inc.; 2013. Retrieved from: http://deliver.jsi.com/dhome/countries/countrynewsdetail?p_item_id=26840480&p_token=0E901B6AA9291BE26FEC59F378A69BDE&p_item_title=Sustainability%20through%20Pre-Service%20Training&p_persp=PERSP_DLVR_CNTRY_NI.

USAID has also funded a Master's Degree in Sexual and Reproductive Health at the Universidad Nacional Autónoma de Nicaragua (UNAN, National Autonomous University of Nicaragua) with a focus on gender and reproductive rights.

While all medical, nursing and pharmacy schools have incorporated FP in pre-service training, critics argue that the dissemination of these guidelines to health workers does not take place consistently throughout the system Also, many communities do not have a doctor and instead rely solely on nurses' aides who have not had exposure to these guidelines.

With the continuous generation of new knowledge, it is essential to periodically update service delivery standards and guidelines, as well as train staff to be up-to-date in FP. These areas still require attention.[32]

USAID's two decades of support for staff training has been very important in improving the standards of FP services in Nicaragua. Notwithstanding, human resource constraints still exist in the health sector in terms of the number and capacity of personnel, quality of services, and deficiencies in the information and logistics system. These, and other remaining challenges, such as turnover, low levels of motivation, and lack of incentives still need to be addressed.

Information Systems

Since 1998, USAID has provided technical and financial assistance to the MOH and Profamilia to help establish logistics information systems.[33]

Until 2003, the MOH had six logistics systems that worked in parallel with the traditional system of procurement. This led to the duplication of information at the local and central levels, coordination and communication difficulties, delays, inventory control problems, and related issues.

In 2005, the MOH, with USAID and UNFPA support, initiated a process to integrate contraceptive distribution into the system for essential medicines. This process capitalized on the strengths of each of the existing systems, which have been improving since 2008. HIV test kits and antiretrovirals were added in 2011. The new system, Proyecto Automatizado del Sistema de Información para la Gestión Logística de Insumos Médicos (PASIGLIM, the Automated Information System Project for Logistics Management of Medical Supplies), provides information on contraceptive consumption and stocks throughout the country's service network. It makes it possible to monitor availability at any given time and provides steps to ensure an adequate supply chain. When last measured in January 2013, the system reported stock-out levels to be less than one percent, a dramatic reduction from the 36 percent stock-out level reported in 2007.[34]

---

[32] Avila et al., 2012.

[33] USAID/DELIVER Project. *Nicaragua: Final Country Report*. Arlington, VA: John Snow Inc.; 2007.

[34] Republica de Nicaragua Ministerio de Salud. *Manual de Procedimientos del Sistema de información para la Gestión Logística de Insumos Médicos*. Managua, Nicaragua: Government of Nicaragua; 2007. Retrieved from: http://minsamunicipioesteli.files.wordpress.com/2010/03/6-insumos-medicos-manuales.pdf.

USAID´s assistance supported the evolution of the contraceptive logistics system from a vertical system to an integrated information system, which included essential drugs and contraceptives in five SILAIS. The contraceptive logistics system served as the basis for the integrated system because of its successful implementation. According to USAID reports, the integrated system has contributed to the strengthening of postpartum FP services in 22 mother and child health care hospitals.[35]

The ENDESA represent another important source of information for programming, implementation, monitoring and decision making. USAID sponsored the first four ENDESAs with technical support from CDC Atlanta. The last USAID-supported survey was the 2006-2007 ENDESA. The most recent study (ENDESA 2011-12) was carried out under the auspices of the National Development Information Institute (INIDE) and the MOH, with technical and financial support from the Global Fund, World Bank, UNFPA, and UNICEF. Data from the recently published preliminary report have been used throughout this case study. In addition, ENDESA has been a valuable tool for monitoring two important indicators on progress in meeting the Millennium Development Goals: reducing fertility and infant mortality.

Commodities and Medical Supplies

Five contraceptive methods are included in the MOH list of essential medicines: male condoms, IUDs, one-month injections, three-month injections, and combined oral methods. Male and female VSC are also available.

According to the annual survey on contraceptives and essential SRH drug availability, the percentage of MOH health units offering at least three modern contraceptives with no stock-outs during the last six months, increased from 67.0 percent in 2008 to 96.9 percent in 2012. Availability of at least three to five life-saving SRH and maternal health medicines in units offering services was 99.6 percent in 2012. These data reflect the effects of both the increased public financing for procurement of modern contraceptive methods and improved supply systems. [36]

The MOH has maintained its commitment to procuring and providing contraceptives to the entire Nicaraguan population. To improve the procurement process, the government entered into an agreement with UNFPA as a purchasing agent. This was one of the few legal alternatives, as procurement through local tenders was more costly. Consumption needs were estimated according to the populations served by each public institution. This enabled the MOH to request other institutions, such as the INSS, to promote and offer FP services in all facilities, public and private.

However, since Nicaragua is a country with limited resources, there is concern that the growing demand for contraceptive services and supplies and the financial hardships often faced by the government could threaten contraceptive security. Hence, communication and advocacy activities are needed at different levels to maintain and strengthen government support for FP

[35] USAID/DELIVER Project, 2007.
[36] Republica de Nicaragua Ministerio de Salud, 2007.

and SRH. The DAIA was renamed Comité para la Disponibilidad Asegurada de Insumos Anticonceptivos y de Salud Sexual y Reproductiva (AISSR, Committee to Ensure Availability of Contraceptives and Sexual and Reproductive Health Products) to reflect the inclusion of sexual and reproductive health in its activities.

Members of USAID´s LAC CS Initiative, among them Nicaragua, met in Lima, Peru, in May 2011 and agreed on the need to begin implementing new procurement options, with a focus on market studies to better understand the suppliers, commodities, and prices that may be available to the public sector.[37]

Financing

In 2006, Nicaragua's MOH financed one percent of the country's total contraceptive requirements. Its contribution has grown steadily since then to 74 percent in 2011. The remaining percentage continues to be donated by UNFPA, despite its original end date of late 2012. For contraceptive procurement to be sustainable, the MOH must be able to cover 100 percent of the purchase through tax funds or specific projects. One option under discussion is to increase the efficiency of procurement by using UNFPA's procurement and information service, AcessRH (revolving fund), which is permitted by the current legislation. However, critics maintain that this system has not worked in the past.

Although there is a line item in the MOH budget for contraceptive procurement, the funds required each year vary and the amount needed has increased from year to year. Therefore, it is necessary to improve procurement efficiency and to make medium- and long term-projections.

LOOKING TO THE FUTURE

Nicaragua successfully completed the process of graduating from USAID FP assistance in 2012. There are promising signs that sustained delivery of FP and SRH supplies and services will continue.

Nicaragua has made significant progress in improving its macro-level primary health care indicators, reducing maternal mortality and increasing contraceptive prevalence. There has also been increased INSS participation in providing family planning services and commodities, thus reducing the burden on MOH facilities. The government has shown its strong commitment to comprehensive services to improve the health of the population.

The main challenges for family planning and sexual and reproductive health in Nicaragua can be summarized as follows:

[37] USAID/DELIVER Project. *Update: LAC CS Regional Initiative Workshop Summary*. Arlington, VA: John Snow Inc.; 2011. Retrieved from: http://deliver.jsi.com/dhome/countries/countrynewsdetail?p_item_id=26504155&p_token=C93E40B3909108873D44DA50566058BB&p_item_title=Update%3A%20LAC%20CS%20Regional%20Initiative%20Workshop%20Summary%20&p_persp=PERSP_DLVR_CNTRY_NI.

a. availability of government funds to guarantee procurement of 100 percent of the contraceptives needed for the population covered by the MOH;
b. expansion of INSS FP coverage and provision of contraceptives to the uninsured (while major strides have been made in access to FP, there is still a need to improve the ability of the public health system to adequately reach remote rural areas to address the urban/rural inequities in the provision of services, quality of care, and services for vulnerable populations);
c. reduction of unmet need, particularly among adolescents (adolescent pregnancy continues to be a major challenge for Nicaragua; 18 percent of adolescents are mothers, and an additional 5 percent are pregnant with their first child; this important segment of the population continues to grow and will create even more demand for family planning and reproductive health services in the future);
d. improved quality of family planning services;
e. sufficient skilled personnel to consolidate progress and sustainability of the contraceptive logistics system (Nicaragua has strengthened its logistics information system for contraceptive methods and medical supplies; in addition, health services have been able to retain trained personnel to provide FP/RH; the establishment of the DAIA Committee [now AISSR], plus advocacy by the ongoing donor and agency working group, have been key in ensuring that the government take responsibility for providing contraceptives with public funds or by incorporating FP in health projects);
f. retention of skilled and motivated personnel to provide family planning services; and
g. strengthened private sector participation affordably priced contraceptives (improved market segmentation will make it possible in the future to implement strategies to reduce unmet needs for FP at the national level).

Since the 1990s, FP/SRH in Nicaragua has been included in the health policy of the Nicaraguan government with a new approach based on gender equality and human rights. Promotion of actions to improve women´s health has become a national priority. Access to family planning methods has expanded, under the principle of respect for sexual health and reproductive rights of the individual and the couple. The political context for FP in Nicaragua bodes well for the country's successful graduation from USAID assistance for family planning.

MEASURE Evaluation

Carolina Population Center
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, NC 27517

http://www.measureevaluation.org