PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA23927

Project Name	Nicaragua Strengthening the Public Health Care System (P152136)
Region	LATIN AMERICA AND CARIBBEAN
Country	Nicaragua
Sector(s)	Health (100%)
Theme(s)	Child health (10%), Health system performance (40%), Injuries and non-communicable diseases (20%), Population and reproductive healt h (30%)
Lending Instrument	Investment Project Financing
Project ID	P152136
Borrower(s)	Government of Nicaragua, Ministry of Finance and Public Credit (MHCP)
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	02-Apr-2015
Date PID Approved/Disclosed	09-Apr-2015
Estimated Date of Appraisal Completion	22-Apr-2015
Estimated Date of Board Approval	04-Jun-2015
Appraisal Review Decision (from Decision Note)	

I. Project Context

Country Context

Over the past few years, poverty has declined in Nicaragua and is one of the outliers in the Latin America and Caribbean (LAC) region on improving shared prosperity. The second half of the last decade brought a notable reduction in poverty and inequality, concentrated mostly in rural areas. In contrast to the period between 2001-2005 in which poverty essentially stayed constant at 48 percent, the country saw a significant reduction in the poverty headcount by nearly 6 percentage points (equivalent to around 230,000 fewer poor people), reaching a national rate of 42.5 percent in 2009. Meanwhile, extreme poverty fell from 17.2 to 14.6 percent between 2005 and 2009 . Poverty remains a largely rural problem. By 2009, more than 63.3 percent of Nicaraguans living in rural areas and 26.8 percent of Nicaraguans living in urban areas were officially classified as living below the poverty threshold. The Gini coefficient fell for the whole country from 40.5 percent in 2005 to 37.1 percent in 2009 and was similar in both urban and rural parts of the country. Nicaragua is one of LAC’s least developed countries with a Gross National Income per capita of US$1,780 in 2013 . Nicaragua had a 5.1 percent income growth rate in 2011, the highest in a decade, which

surpassed the average regional performance for LAC and Central America (4.0 percent and 0.6 percent, respectively).However, challenges remain on poverty reduction and shared prosperity given that most of the poor live in rural areas and many in remote communities where access to basic services is still constrained by very limited infrastructure. The country is also considered vulnerable in terms of natural disasters, extreme climate and epidemics.

Social spending as a percentage of GDP has increased in Nicaragua in the last seven years. Total social spending went from 10.4 percent in 2007 to 12.1 percent in 2012 Health spending alone increased from 0.6 percent of GDP in 2007 to 4.4 percent of GDP in 2012. This increase in health spending is consistent with the government's commitment to provide free access to health care services, which is one of the pillars of the Political Change. Despite this increase, Nicaragua invests 126 dollar per capita on health expenditure, which is among the lowest in Central America, surpassing only Guatemala and Honduras in per capita health expenditure.

The Government of Nicaragua's (GON) attention to the social sector and in particular to the health sector is reflected in the country's progress on MDG targets. Data from the 2012 Demographic and Health Survey (Encuesta Nicaragüense de Demografía y Salud-ENDESA) shows clear achievements in the reduction of mortality for children under five years of age from 35 to 21 per 1,000 live births (2006-07 to 2011/12) (MDG 4). However, progress on achieving MDG 5 - reducing maternal deaths from 190 maternal deaths per 100,000 live births in 1990 to 40 maternal deaths per 100,000 live births by 2015 - – is slow. Despite steady improvements in decreasing risk factors contributing to maternal deaths, such as the number of attended births and the percentage of women receiving prenatal checkups, national data reported 62.5 maternal deaths per 100,000 live births in 2009. The rate of adolescent pregnancy decreased from 25.9 percent in 2006/07 to 24.4 percent in 2011/12, but continues to be a main challenge in Nicaragua due to its contribution to maternal mortality and neonatal deaths. To target adolescent pregnancy, the government has supported the implementation of the National Strategy for Integral Health and Development of Adolescents (2012 – 2017 – ENSDIA) which promotes long term behavioral changes in the adolescent population and provides more efficient access and delivery of healthcare and social services to young mothers.

The country faces what is called a Triple Burden of Disease: an unfinished agenda of communicable diseases, malnutrition and Sexual Reproductive Health (SRH) problems; the growth of external causes and the relative predominance of chronic diseases and their risk factors. From the traditional emphasis on maternal – infant mortality and extensive efforts on preventing and treating infectious diseases, the country now needs urgently to lay emphasis on morbidity and mortality caused by chronic diseases. In this context, Nicaragua proposes to readdress the services provided by the public health system by implementing a more comprehensive MOSAFC model. The health model will increase focus to include care for a greater spectrum of diseases on the primary and secondary health prevention, health promotion, interagency work, effective curative care, and rehabilitation.

Sectoral and institutional Context

Since 2007, the Government of Nicaragua has been implementing the Family and Community Healthcare Model (MOSAFC) based on the Primary Health Care Strategy. MOSAFC implementation is supported by the Constitution of the Republic, Article 105. MOSAFC provides free coverage and access to healthcare services, with an emphasis on health promotion and

prevention for individuals. MOSAFC relies heavily on family and community involvement by enhancing the role individuals play in promoting public health awareness.

MOSAFC implementation drastically influenced the supply of services and lifted access barriers, consequently affecting the production of healthcare services. The number of medical doctors doubled from 2,182 to 4,659 and the number of nurses grew from 4,329 to 7,271 from 2006 to 20013. In the same way, the number of primary healthcare consultations increased from 8,503,987 in 2006 to 16,753,819 in 2013; and hospital-based consultations rose by 125% (from 1,351,908 in 2006 to 3,104,814 in 2013), while hospital discharges increased by 46% and surgical performances rose by 120% between 2006 and 2013 . MOSAFC improved equal access to healthcare services: the number of institutional births in the poorest quintile of the population grew from 41% in 2006 to 65% in 2013.

During these changing times, the World Bank has provided timely support to the Government of Nicaragua in its efforts to implement MOSAFC. The relationship forged in these years has contributed to MOSAFC implementation through: (i) institutional strengthening to assist in the transition from a historic budget management system to a results-based budget at municipal and national referral hospital levels by managing social agreements; (ii) development and implementation of improved primary health care quality concept across 66 municipalities, which have been eventually reinforced and expanded to 156 municipalities nationwide; (iii) reviewing, assessing and investing in hospital waste management improvement in Managua's hospitals, which also fostered a dialogue with municipalities around non-hazardous waste management and disposal of hazardous wastes; this is foreseen to be expanded nationwide; (iv) health equity envisioned for different ethnic groups, which also focused on selected municipalities and will be reinforced and integrated with western medicine and traditional medicine; (v) progress towards Millennium Development Goals 4 and 5 (MDGs 4 and 5) through primary health care and the preparation and implementation of the Adolescent Sexual and Reproductive Health Strategy, which is expected to be expanded nationwide; (vi) support during epidemiological alert situations; and (vii) an ongoing review of MOSAFC progress to respond to the country's changing epidemiological prospects, a pending theme in the health agenda.

II. Proposed Development Objectives

The Project Development Objectives (PDO) are to: (a) strengthen quality and access to health services offered at the Ministry of Health (MOH) public health care network; (b) contribute to adapting the public health system to the country's changing epidemiological profile; and (c) secure financial support in case of Public Health Alert or Public Health Emergency.

III. Project Description

Component Name

Component 1: Strengthen the quality and access to health services

Comments (optional)

This component seeks to strengthen the quality and supply of the public health care services delivered nationwide through the following subcomponents: Subcomponent 1.1 Improvement of quality health care delivered at municipal level through marginal funding of per capita health care service fee; and (b) Subcomponent 1.2 Strengthening and expanding the provision of basic health care services.

Component Name

Component 2. Strengthen the MOH response to the country's changing epidemiological profile

Comments (optional)

The purpose of this component is to contribute to adapting the public health system to the country's changing epidemiological profile. It consists of two sub-components supporting interventions to address the increased mortality and morbidity caused by chronic diseases and traumas, as follows: (a) Subcomponent 2.1 Strengthen the MOH to effectively prevent and respond to chronic diseases; and (b) Subcomponent 2.2 Strengthening the MOH to effectively prevent and respond to trauma cases.

Component Name

Component 3. Contingency Funds for Public Health Alerts and Public Health Emergencies

Comments (optional)

This component would provide funding to prevent and respond to a public health alert or a public health emergency. It also includes funding to prevent and control outbreaks, epidemics, and other potential risk factors involving the handling of general and medical waste. It has three subcomponents: (a) Subcomponent 3.1 Financing operating costs related to a Public Health Alert or a Public Health Emergency; (b) Subcomponent 3.2 Strengthening Health Epidemics and Outbreaks Preventive Actions; and (c) Subcomponent 3.3 Strengthening capabilities and implementing measures to reduce environmental pollution affecting the population's health.

Component Name

Component 4. Project Management

Comments (optional)

This Component is financing the Strengthening of the Ministry of Health capacity to manage Project implementation and to fund the annual financial external audits.

IV. Financing *(in USD Million)*

Total Project Cost:	60.00	Total Bank Financing:	60.00
Financing Gap:	0.00		

For Loans/Credits/Others	**Amount**
BORROWER/RECIPIENT	0.00
IDA Grant	60.00
Total	60.00

V. Implementation

In line with the Government mandate, the Ministry of Health (MOH), as lead agency, will implement the proposed Project. This Project will benefit from the expertise gained by the MOH in implementing the ongoing Improving Community and Family Health Care Services Project (P106870) as well as other WB-funded health projects and grants during the past ten years. The MOH is staffed with a fiduciary and procurement unit, which is familiar with the WB fiduciary and procurement procedures. The fiduciary office has operating capacity to manage the capitation arrangements as well as the fee-for-product payment mechanisms.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	**Yes**	**No**

Environmental Assessment OP/BP 4.01	×	
Natural Habitats OP/BP 4.04		×
Forests OP/BP 4.36		×
Pest Management OP 4.09		×
Physical Cultural Resources OP/BP 4.11		×
Indigenous Peoples OP/BP 4.10	×	
Involuntary Resettlement OP/BP 4.12		×
Safety of Dams OP/BP 4.37		×
Projects on International Waterways OP/BP 7.50		×
Projects in Disputed Areas OP/BP 7.60		×

Comments (optional)

VII. Contact point

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