



# Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 26-Sep-2017 | Report No: PIDISDSC22781



**BASIC INFORMATION**

**A. Basic Project Data**

|  |  |   |  |
|--|--|---|--|
| Country<br>Nicaragua                                 | Project ID<br>P164452                    | Parent Project ID (if any)                            | Project Name<br>NI - Integrated Public Provision of Health Care Services (P164452) |
| Region<br>LATIN AMERICA AND CARIBBEAN                | Estimated Appraisal Date<br>Dec 06, 2017 | Estimated Board Date<br>Jan 30, 2018                  | Practice Area (Lead)<br>Health, Nutrition & Population                             |
| Financing Instrument<br>Investment Project Financing | Borrower(s)<br>Ministry of Finances      | Implementing Agency<br>Ministry of Health - Nicaragua |  |

**Proposed Development Objective(s)**

The objective of the Project is to implement primary and secondary prevention of diseases through early identification of risk factors in the provision of quality health care services.

**Financing (in USD Million)**

| Financing Source                            | Amount       |
|---|--------------|
| International Development Association (IDA) | 60.00        |
| <b>Total Project Cost</b>                   | <b>60.00</b> |

|   |  |
|---|--|
| Environmental Assessment Category<br>B-Partial Assessment | Concept Review Decision<br>Track II-The review did authorize the preparation to continue |
|---|--|

Other Decision (as needed)



## B. Introduction and Context

### Country Context

1. **Nicaragua's economic growth over the past fifteen years has been moderate, with a slight acceleration observed in the past five years.** From 2001 to 2015, Nicaragua's gross domestic product (GDP) growth averaged 3.6 percent, slightly below the Central American average of 3.9 percent for the same period. Along with El Salvador and Honduras, Nicaragua was one of the countries in the LAC region most affected by global food, fuel, and the 2008 financial crises. In 2009, GDP declined by 2.4 percent. However, thereafter GDP growth increased, averaging 4.7 percent over the 2010 to 2015 period, slightly surpassing the LAC region average of 4.2 percent.

2. **The country's economic growth has contributed to the most substantial reduction in poverty in Central America and slowed the growth of inequality.** Nicaragua was one of the poorest countries in the LAC region in the 1990s. In 1993, half of the population was living below the national poverty line, while in rural areas poverty rates reached over 75 percent. Poverty rates remained relatively stagnant until 2005, after which they started to decline faster than in previous years. Between 2005 and 2014, the poverty headcount declined from 48 to 30 percent. This reduction was seen in rural and urban areas alike. Rural poverty showed a substantial decline from 70 to 50 percent, while urban poverty was cut in half, declining from 31 to 15 percent. Despite the significant progress made in reducing poverty, inequality increased slightly during this period, as Nicaragua's Gini coefficient grew from 45.7 in 2009 to 47.1 in 2014. Importantly, inequality in Nicaragua grew at a slower pace than all other Central American countries apart from El Salvador.

3. **In addition, the economic growth has been reflected in the increased shares of public spending in the health sector, both as a percent of GDP and as a share of total social spending.** As a share of GDP, social public spending increased from 10 percent in 2007 to 13.5 percent in 2014. By 2014, social spending in Nicaragua was almost at the Central America average of 13.9 percent, though it is still among the lowest in the LAC region in per capita terms (US\$145 dollars). From 2007 to 2014, total public expenditure on health increased from 3.81 to 5.1 percent of GDP, representing a 34 percent increase, placing the country just below Costa Rica among Central American countries. This increase was also reflected in total public expenditure on health as a share of total social expenditures, which increased by 36 percent (from 38 percent in 2007 to 52 percent in 2013), making the share of total social expenditures allocated to health the highest in Central America.

4. **The increase in public spending on health contributed to the decrease in out of pocket expenditures (OOPS) as a share of total health expenditures though it remains substantial.** OOPS as a share of total health expenditures declined by 11 percent, from 53 percent in 2007 to 47 percent in 2013. Of the households that incurred OOPS in 2014, over 55 percent of them paid for medicines. This lower OOPS is partly a result of the Government's policies of: (a) providing free access to health services in public health facilities; and (b) increasing coverage by the Social Security Sickness Program.



Sectoral and Institutional Context

5. **Since 2007, the Government has been implementing the Family and Community Health Care Model (*Modelo de Salud Familiar y Comunitario* or MOSAFC) based on its Primary Health Care Strategy.** MOSAFC provides free coverage and access to health care services to the population of Nicaragua, with an emphasis on maternal and child health and health promotion and prevention. In fact, data from the 2011–2012 Demographic and Health Survey (*Encuesta Nicaragüense de Demografía y Salud* - ENDESA) show that clear progress has been made towards achieving MDG 4 (reducing the infant mortality rate) as the under-five mortality rate declined from 35 to 21 per 1,000 live births between 2006/07 and 2011/12. However, despite steady decreases in the risk factors for maternal death, such as the number of unattended births and the percentage of women who do not receive any prenatal checkups; the MDG5 was not achieved and the UN reported 150 per 100,000 live births in 2015. The pregnancy rate among girls 10 to 19 years of age showed a small decline from 26 percent in 2006–07 to 24 percent in 2011–12,<sup>1</sup> but remains high. Adolescent pregnancy affects female exit from school: many young girls either drop out of school and become pregnant or drop out of school due to pregnancy, thus facing a vicious cycle of poverty<sup>2</sup>.

6. **In addition, the country faces what is called a triple burden of disease which includes infectious diseases, chronic diseases and injuries.** While there is an unfinished agenda related to communicable diseases (e.g. Dengue, Chikungunya, Zika), malnutrition, and sexual/reproductive health, the burden of disease is shifting towards chronic diseases and injuries, with increasing numbers of deaths related to vascular diseases, cancer, and major traumas. Mortality rates due to chronic diseases and injuries are higher than those due to infectious and perinatal diseases. The trend in mortality rates from 1975 to 2015 show that infectious and perinatal diseases decreased over time while chronic diseases (cancers and vascular diseases) and injuries increased and remained high. Public Health Activities (*Actividades en Salud Pública* or PHAs) such as vaccination programs and fumigation efforts have played a pivotal role in the curbing infectious diseases, including vector-borne diseases. The new epidemiological profile of the population has driven the health system to shift its emphasis on maternal and child care and infectious diseases to one more appropriate for dealing with the morbidity and mortality caused by chronic diseases and injuries. Given the triple burden of disease that Nicaragua now faces, PHAs currently play an even bigger role in promoting behavioral changes at the community level aimed at preventing or reducing risk factor for all diseases.

7. **Nicaragua has also seen improvements in nutrition, but there continues to be challenges ahead.** Nicaragua witnessed improvements in chronic malnutrition and total undernutrition among children under five years of age. From 1998 to 2011–12, chronic malnutrition decreased by 8 percentage points and total undernutrition decreased by 15 percentage points. However, Nicaragua is now reporting a different type of

<sup>1</sup> Latest available data from the National Demographic and Health Survey which has nationally representative data. All other available data are only administrative data from the Ministry of Health. This data cannot be compared over the years because the MOH only recently started collecting data from all health centers.

<sup>2</sup> The national issue of adolescent pregnancy prompted MINSa to support the preparation and implementation of the National Strategy for Integral Health and Development of Adolescents 2012–2015, which calls for: (i) more efficient access to and delivery of health care services to young mothers; (ii) an increase in the number of maternal houses in areas with dispersed rural populations; (iii) a multi-sector response from the Ministry of Education, the Ministry of the Family and the Ministry of Youth; and (iv) carrying out training of trainers for teachers from fifth to twelfth grade, among others



malnutrition: increasing rates of overweight and obesity, particularly among children and women of reproductive age. The prevalence of overweight<sup>3</sup> among boys and girls under 20 years of age is 15 percent and 23 percent, respectively. Overweight prevalence was much higher among men and women over 20 years of age, at 43 percent and 68 percent, respectively.<sup>4</sup> Poor nutrition perpetuates the cycle of poverty and malnutrition through three main routes: direct losses in productivity from poor physical status, losses caused by disease linked with malnutrition, and indirect losses from poor cognitive development.

8. **The implementation of MOSAFC has significantly increased the supply of health services and reduced a number of barriers to access, which in turn has increased the production of health care services.** Under MOSAFC, the number of medical doctors in the public sector doubled from 2,717 in 2005 to 5,794 in 2015, while the number of nurses grew from 2,228 to 4,726, representing at least a 50 percent increase for both groups during this period.

9. **The World Bank has supported the Government in its efforts to implement MOSAFC.** World Bank financing has provided support for the expansion of coverage, modernization of the provision of health care and lately the systematic introduction of quality improvement plans in the municipal health networks, including: (a) institutional strengthening to help transition from a historic budget management system to a results-based budget for municipal and national referral hospitals; (b) development and implementation of improved primary health care quality in 66 municipalities; (c) assessment and investment in hospital waste management improvement in Managua's hospitals, which also fostered a dialogue about non-hazardous waste management and the disposal of hazardous waste; (d) improvement of health equity for different ethnic groups; (e) expansion of access to primary health care and preparation and implementation of the Adolescent Sexual and Reproductive Health Strategy to contribute to MDGs 4 and 5; (f) epidemiological preparedness and alert situations ; and (g) review of MOSAFC's progress in responding to the country's changing epidemiological profile, which is a pending theme on the health agenda. In addition, this new Project proposes to advance the model supporting: (i) the expansion of coverage in remote locations, including las Minas; and (ii) the early identification of risk factors for communicable diseases including maternal, prenatal and nutrition conditions, and non-communicable diseases as defined by the international classification of diseases in 66 selected municipalities.

#### Relationship to CPF

10. **The proposed Project will contribute to the Twin Goals of the World Bank Group and the SDGs, and is aligned with the World Bank's Country Partnership Strategy FY2013-2017 for Nicaragua.**<sup>[1]</sup> The proposed Project builds on the World Bank's earlier support of MOSAFC and will contribute to Nicaragua's progress on furthering shared prosperity for all and on achieving SDGs 3.1 (maternal mortality), 3.2 (child mortality), 3.3 (communicable disease), 3.4 (noncommunicable diseases). Through MOSAFC, the poor and most vulnerable

<sup>3</sup> Overweight is defined as having a body mass index (BMI)  $\geq 25$  to  $< 30$  kg/m<sup>2</sup> in adults aged  $> 18$  years. In children classification is based on the International Obesity Task Force definition.

<sup>4</sup> Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study (2013). Murray et al. (2014).

<sup>[1]</sup> Report No. 69231-NI, discussed by the Executive Directors on November 13, 2012



segments of the population are provided with free access to health care services, thus protecting them from falling further into poverty as a result of catastrophic health expenditures. MOSAFC has shown promising results in improving health indicators thus far, and more support is needed to ensure improvement in the efficiency and quality of the services to address communicable and non-communicable diseases in the country. The proposed Project is fully aligned with the World Bank's Country Partnership Strategy FY2013-2017, which focuses on two strategic objectives: (a) raising welfare by improving access to quality basic services; and (b) raising incomes by improving competitiveness. The Project is aligned with the 2017 Nicaragua Systematic Country Diagnostic (SCD, Report no 116484-NI). The SCD highlights the uneven progress in reducing gender disparities including reproductive health and teen pregnancy, and gender-based violence. The proposed Project will include specific activities to address these two challenges from a multi-sectoral perspective. The proposed Project is also aligned with the Health Nutrition and Population goals of achieving Universal Health Coverage and financial protection as it contributes to improving the quality of health and other social services with a focus on women, children, indigenous peoples, the elderly, and vulnerable families.

### C. Proposed Development Objective(s)

The objective of the Project is to implement primary and secondary prevention of diseases through early identification of risk factors in the provision of quality health care services.

#### Key Results (From PCN)

- Percentage of adolescents (10-19 years of age) receiving prenatal care coverage (at least four visits). The number of adolescents who received prenatal care by any provider four or more times during their pregnancy divided by the total number of pregnant women, multiplied by 100. The data source will be the ambulatory care records.
- Percentage of adolescents (10-19 years of age) with institutional delivery. The number of adolescents with institutional delivery divided by the total number of deliveries among adolescents. The data source will be the hospital delivery records.
- Percentage of women between 30-49 years receiving a pap smear. The number of women between 30-49 years of age receiving a pap smear divided by the total number of women 30-49 years of age multiplied by 100. The data source will be the ambulatory care records.
- Percentage of adults with follow up treatment for hypertension. The number of adults with follow-up treatment of hypertension divided by the total number of adults diagnosed with hypertension multiplied by 100. The data source will be the ambulatory care records.

### D. Concept Description

#### Project Components

11. **Component 1: National Integration of quality of health care services for communicable and non-communicable diseases.** The purpose of this component is to ensure the integration of health care provision



at the primary health care level nationwide, including: (a) early identification of health risk factors; and (b) monitoring the provision of quality health care in 66 municipalities. Activities will include: (i) promotion, (ii) prevention, (iii) provision of care for the country's major causes of death and disease. This component will finance capitation payments to 66 selected municipal health networks. The Local Systems of Integrated Health Care (*Sistema Local de Atención Integral de Salud - SILAIS*) will maintain annual municipal agreements (*Acuerdos Sociales por la Salud y el Bienestar con el nivel Municipal*) with the municipal health networks for the provision of services. The per capita amount is estimated to be US\$5.05 based on the incremental recurrent expenditures of these services and on the size of the rural population in each municipality. The per capita amount will be transferred by the MOH to the municipalities every year using a 60/40 percent formula linked to compliance with mandatory indicators and quality of health care based on certified public health activities (PHA).

**12. Component 2: Strengthening the MOH Institutional capacity to expand, integrate and provide quality health care services.** The purpose of this component is to strengthen the capacity of the MOH for the implementation of National Health Strategies towards the provision of quality health services.

**13. Sub component 2.1 Support to the implementation of MOH National Health Strategies.** This subcomponent will support the expansion and implementation of national strategies aimed at supporting an integrated health care provision, including: (a) the implementation of the national chronic disease strategy to promote good health practices and prevent and control major chronic diseases and risk factors; (b) the implementation of the national entomological surveillance program for the prevention of arbovirus related diseases; (c) the national immunization program at the primary level of health care; (d) the national program for the management of medical waste; (e) the national program for the inclusion of holistic medicine and traditional therapeutic medicines; and (f) the national intersectoral adolescent health strategy for the prevention of risk factors among adolescents.

**14. Sub component 2.2 Support the MOH capacity to expand and improve quality of health care services.** This component would include: (a) strengthening the connectivity of information systems of the MOH at all levels of care; (b) enabling the capacity of the National Direction for equipment Maintenance of the MOH; (c) providing all levels of training programs for health workers at the central and local level; and (d) the structural design and procurement of equipment for the Hospital las Minas.

**15. Component 3. Project management.** This component will finance the strengthening of the MOH capacity for administering, implementing, supervising, and evaluating Project activities, including support for carrying out external financial audits.

## SAFEGUARDS

### A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)





In regards of the environment, minor civil works are expecting to finance with the Project and the potential negative environmental impacts are not significant. The project will continue support the Hospital Waste Management Plan (HWMP) supported in the on-going project (P152136) in order to improve the waste management of water discharges, potable water, air quality, disposal of sanitary waste, among others; and assure the compliance of the legal environmental law and the bank's standards.

Component 1 will cover the population in 66 municipalities in 10 selected Local SILAIS and the indigenous territory of Alto Wangky-Bocay (AWB) that have the largest number of poor and vulnerable population, including indigenous peoples and rural population. The MoH has adapted the standard set of basic health and nutrition services as defined under the Community and Family Health Model (MOSAFC) to ensure that they are culturally appropriate to these communities, based on a study that described the traditional health practices and customs and how these could be integrated in the public health care systems.

Components 2 and 3 will focus on the institutional strengthening of the MOH and has a national scope.

Component 2.1 supports the implementation of MOH National Health Strategies for the provision of quality health services, including the national program for the inclusion of holistic medicine and traditional therapeutic medicine; and Component 2.2 Supports the MOH capacity to expand and improve the quality of health care services, including provision of training programs for health workers at central and local levels. Both subcomponents include intercultural health activities that are presently being implemented on the Pacific, Center and Northern Indigenous and Ethnic Communities, as well as in AWB, and three municipalities of RAAS on the Caribbean Coast.

## **B. Borrower's Institutional Capacity for Safeguard Policies**

The MoH and specifically the Environmental Management Unit (UGA in Spanish), has prior experience on Bank's safeguards, and has actively engaged technical assistance in order to comply with the safeguard policies during project implementation. In order to improve the environmental and social capacity building of the MoH, a Safeguard Strengthening Plan (SSP) will be prepared during the project preparation. The capacity building effort includes comprehensive occupational health and safety training, including exposure to diseases, medical waste, and the use of certain equipment with radiation.

For the previous Project an Environmental and Social Management Framework (ESMF) was prepared and approved by the MOH on April 10, 2015. In addition, a Diagnosis of the handling of dangerous waste management was done in the main Hospitals in Managua. Nine (9) Hospital Waste Management Plans (HWMP) are under implementation with the on-going Project. These environmental instruments improved the capacity building of the MoH in regards of the environmental management in the sector. The ESMF will be reviewed and updated during the project preparation, in order to include new legislation and lesson learned in the last years.

When preparing both the previous health Project (Nicaragua Community and Family Health Care Project - P106870) and the current (Nicaragua Strengthening the Public Health Care System Project P152136) an Indigenous Peoples Framework and an Indigenous Peoples Plan were prepared, consulted and disclosed in March 2015. The implementation of the IPP for the current project is being managed successfully by the Directorate of Health, and supervised by the National Coordination of Indigenous Peoples and Traditional Medicine (part of the Ministry of Health). Therefore, the same Indigenous Peoples Plan will continue to be implemented under the new project. Additionally, the proposed Project will benefit from the same MOH managerial structure presently implementing the IPP activities of the current project.





Once the safeguard instruments (ESMF, IPPF and IPP) have been revised and updated, a consultation and participation activities should be developed in accordance with the Bank’s guidelines.

Social Safeguard Consultant: Ximena Traa-Valarezo.

**C. Environmental and Social Safeguards Specialists on the Team**

John R. Butler, Social Safeguards Specialist

Marco Antonio Zambrano Chavez, Environmental Safeguards Specialist

**D. Policies that might apply**

| Safeguard Policies                  | Triggered? | Explanation (Optional)  |
|-------------------------------------|------------|---|
| Environmental Assessment OP/BP 4.01 | Yes        | <p>This policy is triggered because the Project will support minor rehabilitation works in health care facilities, minor pre-installment works for the medical and non-medical equipment to be purchased by the Project, and technical specifications for the structural design of “Las Minas” Hospital located in the North Caribbean Region. The potential negative impacts are localized, minor, and reversible. In this regards the project was classified as Category B according with the OP/BP 4.01.</p> <p>An Environmental and Social Management Framework (ESMF) was prepared for the previous Bank’s Projects (P106870 and P152136) and this instrument will be updated during the project preparation stage. This updated version of the ESMF and an Action Plan will be consulted according with the Bank’s guidelines and disclosed in-country and in the World Bank’s website prior to Project Appraisal.</p> <p>In regards of Hospitals Waste Management Plans (HWMP), 9 Plans are currently under implementation and additional ones (tbd) will be implemented with the new Project. These Plans include the WBG EHS Guidelines for Medical Facilities; and procedure to manage radioactive waste associated to the medical equipment acquired under the projects.</p> <p>In regards of the support of the technical specifications for the structural design of “Las Minas” Hospital located in the North Caribbean Region, a</p> |



|  |     |  |
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|  |     | specific Environmental Management Plan (EMP) should be prepared, consulted and disclosed in-country and in the World Bank's website prior to Project Appraisal.  |
| Natural Habitats OP/BP 4.04            | No  | This policy is not triggered given that the project's interventions are not located within or in the proximity of natural habitats; hence no conversion or degradation of natural habitats is expected.  |
| Forests OP/BP 4.36                     | No  | This policy is not triggered since the project activities are not expected to impact forested areas, forest dependent communities or involve changes in management of forests.   |
| Pest Management OP 4.09                | No  | This policy is not triggered given that the project's activities do not include the use of pesticide.  |
| Physical Cultural Resources OP/BP 4.11 | No  | This policy is not triggered given that the projects activities do not affect any physical or cultural resources.  |
| Indigenous Peoples OP/BP 4.10          | Yes | <p>There are indigenous peoples, as defined by the policy, present in the Project area. The current project Nicaragua Strengthening the Public Health Care System Project (P152136) includes an Indigenous Peoples Plan (IPP) that was developed after the Indigenous Peoples Framework prepared previously for the Nicaragua Community and Family Health Care Project – (P106870). The ongoing IPP was prepared, consulted and disclosed in March 2015 and is currently under successful implementation by the Directorate of Health, and supervised by the National Coordination of Indigenous Peoples and Traditional Medicine. The latter is part of the Ministry of Health, and has the power to approve or reject any activities concerning Indigenous and Afro-descendant peoples health and wellbeing at the national level. Therefore, no further consultations of the ongoing IPP document will be needed.</p> <p>The activities in component 1 are a continuation of the activities in the on-going Strengthening the Public Health Care System Project (P152136) for which IPPs were consulted in 2015 to ensure that there was continued broad community support for this project in the ten SILAIS and the indigenous territory of Alto Wangky- and Bocay. Under component 2.1 the national program for the inclusion of holistic medicine and traditional therapeutic medicines will be implemented. The MOH will continue to provide</p> |



training and awareness courses for nurses, auxiliary nurses, MDs and pharmacists in natural medicine, cultural sensitivity, vital energy, including a Certification in Phytotherapy. In addition, the Institute for Alternative Therapy in Managua provides training to medical staff on key aspects of the integration of traditional and western health systems including the use of medicinal plants for medical treatment. The country is moving towards the integration of traditional ancestral medicine with the western health systems. The implementation of the current IPP will benefit from the holistic approach of the new project sub-components. Consultations and assessments will be undertaken during Project implementation to ensure Maternal, Adolescent, Child and Reproductive Care activities take into account the cultural practices of Indigenous Groups. The results of intercultural health practices supported by the project could be shared as models with other countries.

Involuntary Resettlement OP/BP 4.12                      No

This policy should not be triggered given that the project will focus on strengthening the access and improving the quality of health care services. The project will, however, finance minor pre-installment works for medical and nonmedical equipment, for which no land acquisition will be required and for which no impacts covered under OP 4.12 (i.e. resettlement of social units or economic activities) are expected.

Safety of Dams OP/BP 4.37                                      No

This policy is not triggered given that the project will not support the construction or rehabilitation of dams.

Projects on International Waterways  
OP/BP 7.50    No

This policy is not triggered given that the project will not affect international waterways as defined under the policy.

Projects in Disputed Areas OP/BP 7.60                      No

This policy is not triggered given that the project will not affect disputed areas as defined under the policy.

**E. Safeguard Preparation Plan**

Tentative target date for preparing the Appraisal Stage PID/ISDS

Aug 31, 2017



Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

September 15, 2017

**CONTACT POINT**

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**APPROVAL**

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|----------------------|-----------------------------|
| Task Team Leader(s): | Amparo Elena Gordillo-Tobar |
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**Approved By**

|                           |                 |             |
|---------------------------|-----------------|-------------|
| Practice Manager/Manager: | Daniel Dulitzky | 02-Oct-2017 |
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| Country Director: | Seynabou Sakho | 11-Oct-2017 |
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