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PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: AC922

Project Name	HEALTH SERVICES EXTENSION AND MODERNIZATION SWAP (2nd APL)
Region	LATIN AMERICA AND CARIBBEAN
Sector	Health (100%)
Project ID	P078991
Borrower(s)	REPUBLIC OF NICARAGUA
Implementing Agency	Government of Nicaragua
Environment Category	[ ] A [X] B [ ] C [ ] FI [ ]
Safeguard Classification	[ ] S_1 [ ] S_2 [ ] S_3 [ ] S_F [ ] TBD (to be determined)
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1. Key development issues and rationale for Bank involvement

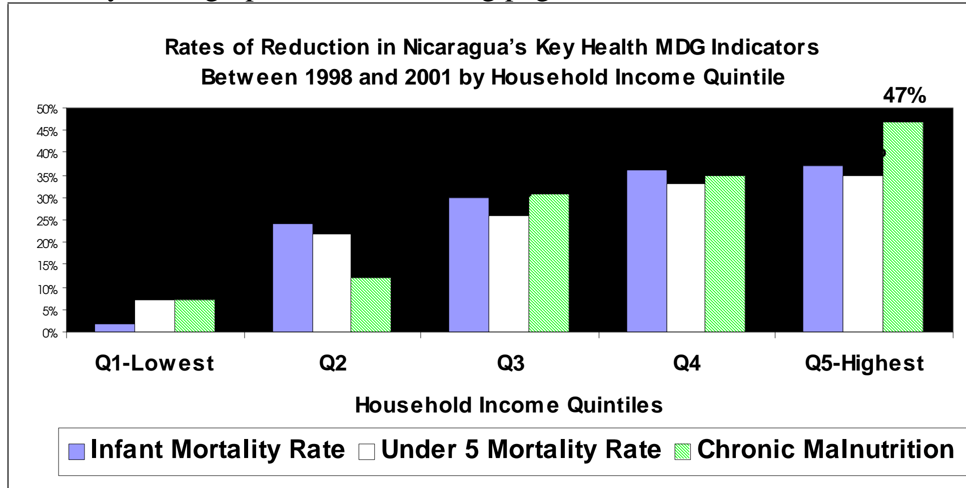
Nicaragua has among the lowest MDG health indicators in Latin America. Although there has been considerable progress in improving these indicators over the last ten years—particularly infant and child mortality rates—it is unlikely that Nicaragua will achieve either its maternal mortality or its chronic malnutrition MDG goals for 2015, unless significant additional efforts are made to accelerate current trends. The fertility rate, one of the highest in LAC at 3.2, is a particularly pressing social problem: Nicaragua's adolescent fertility is the highest in the region.

	Current	*Goal for 2005*		*PRSP 2015*	
Indicator	Status (2001)	Target	On track	Target	Likelihood of Achieving
Infant Mortality	31	32	Yes	20	Possible
Child mortality	40	37	Partly	24	Possible
Maternal mortality	125	129	Yes	40	Unlikely
Chronic Malnutrition	17.8	16	Yes	7	Unlikely
Global Fertility Rate	3.2				

Source: PRSP, LSMS 2001, PRSP First Progress Report, Poverty Assessment 2003.

Moreover Nicaragua's national health indicators hide tremendous inequities in the level of health status that exist within the country, as well as in the progress that has been made in the past few years. As may be seen in the graph below, there is a direct relationship between the amount of improvement that was made between 1998 and 2001 in household income quintile and the rate of reduction in the (a) infant mortality rate, (b) the under-five mortality rate and (c) the prevalence of chronic malnutrition among children 12-59 months old. The poorest benefited the least from the improvement of health indicators, the wealthiest benefited the most. As a result, these health problems have become increasingly concentrated among the poor. The prevalence of poverty and the absolute number of poor are found disproportionately in the rural areas of the North and the Atlantic Coast. As a result, as these health problems have become increasingly concentrated

among the poor, they have concomitantly become increasingly concentrated in these geographic areas of the country. The graph on the following page shows how:



Source: DHS 1998 and 2001 data.

With a 2002 per capita GNI of US$710, Nicaragua is one of the poorest countries in LAC (WDI, 2003). Although the rate of poverty declined between 1993 and 2001, the absolute number of Nicaraguans in poverty increased by nearly 300,000 (World Bank, 2003:3). Poverty and health are transactionally related. Nicaragua's 2003 Poverty Assessment empirically established the importance of living conditions, health inputs and demographic factors as key determinants of health status in Nicaragua. Living conditions that characterize impoverished populations are important factors contributing to poor health, at the same time that poor physical and mental health, poor health practices —including premature births, short child-spacing intervals and large family size—and high out-of-pocket expenditures on health impede the ability of a family to rise up out of poverty. For Nicaragua to make better progress in reducing poverty, it will need to do a better job in improving health status.

The GON is fully committed to the 2001 PRSP, and is now preparing its second stage PRSP. The Bank's CAS main rationale is to support the GON's PRSP. Two of the four PRSP pillars are closely related to the proposed project: (i) greater and better investment in the human capital of the poor, and (ii) better protection for vulnerable populations. The largest financial support of IDA to Nicaragua is the budget support provided by the PSAC and PRSCs. These credits include health conditionalities that are fully aligned with the PRSP, whose achievement is supposed to be supported by a new health investment project which corresponds to the second phase of the current health project, the Health Modernization Program, which is an adjustable programmatic loan (APL).[1]

The MOH has recently completed the *National Health Policies 2005-2015*, in which it formally presents its vision of how it intends to achieve the health goals established in the PRSP. The Ministry is now working on the elaboration of a long-term *National Health Plan: 2005-2015*, and a more detailed and operational companion document, the *Five-Year Implementation Plan, 2005-2009*.[2] **Five Cooperating Agencies and the MOH have a signed agreement that the**

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[1] Phase I of the current project ends in December 2004, at which time it is anticipated that 100 percent of project funds will have been spent.

[2] The Ministry is committed to completing these documents by August 2004 and November 2004, respectively.

Ministry's *Five-Year Implementation Plan, 2005-2009* will be the operational framework for the proposed SWAp (sector wide approaches), thereby assuring that the SWAp will be fully aligned with Government policy.

The first phase of the APL has consisted of a substantial number of pilots, as have the projects of the IDB and Sweden. Evaluations have already been completed of the Women's Centers (*Casas Maternas)*, the 14 primary health care interventions and of the health policies of 1997-2002. Additional evaluations are currently in various stages of preparation, including: hospital modernization, primary care extension via the purchase of NGO services and via the Maternal-Child Insurance Fund, the institutional modernization of MINSA and the community-based nutrition program. The Ministry is planning to use the evaluations to aid it in making strategic decisions as to how best to harmonize donors' programs and to design the SWAp. Several of these evaluations, for instance, will provide input into the design of the Integrated Health Care Model that the Ministry is currently constructing, and that it intends to use as the implementing vehicle of the National Health Plan. The lessons learned in the modernization of hospital management of the first phase will be consolidated into a formal hospital management model that will be extended under the second phase of the project to the rest of public hospitals. Likewise, the institutional modernization evaluation will provide lessons to adjust those efforts, which will also be continued throughout the second phase of the project.

Nicaragua has been recipient of a massive amount of foreign aid, particularly after natural disasters such as Hurricane Mitch (October 1998). Without denying the contribution that this aid has made in helping to bridge the gap in health services availability and the health financing shortfall in the country, it is evident that this amount of foreign resources has come at a price. It has resulted in 36 distinct projects, with different purposes, priorities and strategies. No less important, this proliferation in foreign projects has limited the leadership and stewardship role of the MOH, and, by virtue of the lack of adequate coordination, it has contributed substantially to inefficiencies in the health sector, at the same time that it has foisted excessive demands for project supervision and monitoring on the Ministry. This has been a major motivation for the Ministry's efforts over the past two years to promote a health SWAp, together with the support of the like-minded group of donors. This particular moment—when IDA, IADB and Sweden (a major donor in the health sector in Nicaragua), are all in similar phases of the traditional project cycle and need to define their investment support to the health sector for the next four to five years—provides a unique opportunity to develop a health SWAp under the leadership of the MOH. Other donors with ongoing health projects—the Netherlands and Finland--have expressed their willingness to participate in the SWAp both with additional funds and by progressively aligning their own projects within the same operational framework, while USAID and Canada, who have been participating in the preparatory workshops, have also stated their interest in having their projects and country strategies supporting the SWAp. UN agencies, including UNFPA and PAHO/WHO, have been approached by the MOH and IDA and have indicated their interest in supporting the sectoral approach. Finally, the MOH is seeking to integrate a bilateral donors' fund (Canada, Finland and DfID), which is currently devoted to sexual and reproductive health, into the overall SWAp.

The GON requested a PHRD grant for the preparation of the second phase of the APL, which was approved in February 2004 and signed-off on in May 2004. The PHRD will be managed by

the MOH, and its action plan is fully consistent with this PCN. Under the PHRD, a financial analysis of the sector will be prepared in the next few months and a detailed estimation of the cost of the Five-year Implementation Plan for the National Health Plan will be developed. These analyses will provide a sectoral economic and financial framework that will identify the required financial contributions of the Government and its SWAp partners.

Much preparatory work for the SWAp has already been done. Over the course of the past year and a half, IDA, IADB and the Nordic countries have conducted four joint missions, which have included the development and signing of joint *Ayuda Memorias*. In addition, there have been two SWAp workshops, including a week long event in May 2004, to clarify and to define goals, objectives, expectations and methods. These have been important, Ministry-led events with substantive, technical discussions and the active participation of Ministry line personnel and donor representatives. This process has helped to harmonize donors and has nurtured good working relationships between all involved.

Some of the groundwork that has been done for the SWAp has been the product of the institutional modernization that has been achieved in the past three or four years, particularly in the area of financial planning and management, and in the development of information systems for monitoring and evaluation. The SWAp is now feasible, in large part, because of these significant developments. The development of the SIPLA—an algorithm-based health activity planning tool—and the SIAFI—a program- and activity-based budgeting and accounting system—are major accomplishments. Furthermore, they have been implemented in a manner that has made an important contribution to the decentralization of MINSA. It is noteworthy that the design of the SWAp is helping to further institutionalize the use of these tools and will be based on a decentralized plan that will be constructed from the bottom-up.

2. Proposed objective(s)

The Health Sector Modernization Program (HSMP), of which this project is the second phase, seeks to improve the efficiency, effectiveness and equity of the Nicaragua health system by: (i) strengthening first level care and nutrition; (ii) modernizing the hospital network; (iii) developing the institutional capacity of the Ministry of Health; and (iv) supporting the social security reform. The second phase of this APL will seek the attainment of this program's objective by: (i) focusing on the extension of the integral model of health care to the poorest areas of the country; (ii) improving delivery and management of hospital services and Women Centers related to the extension of services; (iii) strengthening the MOH capacity to steward and evaluate a more equitable and efficient health system; and (iv) expanding coverage and quality of services guaranteed by the social security.

3. Preliminary description

The SWAp will finance the Five Year Plan of the National Health Plan. The Ministry's National Health Plan will identify the specific health priorities and goals, and will establish specific benchmarks for each SILAIS—regional health units. Each SILAIS will, in turn, use the SIPLA together with the SIAFI to develop annual operating plans for achieving its benchmarks. The plans will consist of specific types and quantities of activities and services, and their required inputs and estimated costs. The sum of these plans will provide an estimate of the cost of a major component of the Five Year Health Plan (it will not include the hospitals' component or the

MINSA Central Office component). It would be a relatively straightforward process to transform these individual SILAIS annual operating plans into management agreements/contracts with the SILAIS, since all SILAIS and municipalities are now working under these management agreements, thereby enabling the introduction of performance-based contracting for some portion of the Phase 2 activities later on.

Within the abovementioned planning framework, the SWAp will support three major sets of activities or investment areas: (1) the expansion of coverage of the basic health services to the most vulnerable populations, (2) integration of the health care network so as to strengthen institutional birthing services and (3) institutional strengthening

Investment Area #1:
Though the specific targets have not yet been identified, we foresee a substantial amount of money going to support specific MCH activities in targeted SILAIS. **The focus of the SWAp will be the expansion of basic health and nutrition services to most vulnerable populations using the new Integrated Healthcare Model (IHCM)**. The IHCM will include and integrate successful piloted programs such as PROCOSAN[3], FONMAT[4], NGO's contracted services[5], PHC management model[6], reproductive and sexual health[7], Women's centers[8] and PROSILAIS[9]. The model will be implemented through different tailored strategies, such as contracting NGOs in remote areas or through demand-incentives to public facilities (where they exist). The IHCM will include two components, one focusing on health services and one focused on management systems. The health care component will define the package of services, the outreach strategy, the professional team and service standards as well as the system of referral to specialized care. The management component will entail the consolidation of service agreements, performance monitoring mechanisms, payment and reward systems, as well as conditions essential for strengthening the stewardship and contracting roles of the SILAIS and the MOH. Finally, the IHCM will incorporate social participation and social control mechanisms to assure that care is responsive to local priorities and expectations.

Investment Area #2:

[3] Programa Comunitario de Salud y Nutrición. PROCOSAN is the program which was piloted by the APL first phase and, as of June 2003, became the national nutrition and child growth program integrating other donors' nutrition programs.
[4] Fondo de Maternidad e Infancia Segura, sponsored by the IADB loan promotes increased production of MIC services through an incentive scheme to public and private providers in eligible geographic areas.
[5] Pilots sponsored by the World Bank credit contracting basic health services with NGO's in two very remote areas in the North and Atlantic Coast.
[6] A management model implemented under the APL first phase, which involves better managerial practices and services agreements with health centers.
[7] There is now a National Sexual and Reproductive Health Program which integrates previous separate programs. The new National Program is being funded by three bilateral donors and administered by MOH with technical and administrative support from UNFPA. The MOH has committed to include this program and funding within the sector-wide program.
[8] Community managed shelters located next to health centers that provide housing for women immediately before and after birth delivery. These centers also provide health education, family planning advise and other gender empowerment counseling.
[9] A long lasting program sponsored by Sweden and PAHO which promotes strengthening of primary health care services and management capacity at decentralized MOH offices (SILAIS).

The SWAp will also include targeted investments in hospital services as well as the expansion of Womens' Centers (which after being evaluated have become a national strategy to increase institutional deliveries in remote areas). Investments in hospitals will be related primarily to the strengthening of maternal and child care, predominantly in areas of the extension of services, and general hospital support services (laboratories, maintenance, waste management, water and steam supply, etc.).

Investment Area #3:
Another SWAp priority will be the continued support of the institutional reform of the MOH. Priorities for the second phase will likely be the human resource policies, the expanded implementation of the Health Management Information System (SIMINSA) prepared under phase 1, and the complete implementation of the Financial Administration Information System (SIGFA). The project will also need to beef-up the MOH's procurement capacity. Human resource policy, the implementation of SIGFA and strengthening Government's procurement capacity, together, form part of the objectives of another World Bank project (PSTAC) aimed at strengthening GON public management and working on them simultaneously is likely to yield synergistic gains in terms of impact.

It is also expected that the SWAp will support core MOH programs, namely the prevention and control of HIV/AIDS and vector-borne diseases, together with the population policy action program.

A likely third portion of investment area #3 will consist of the continued expansion of efforts to extend coverage of the Nicaraguan Social Security Institute (INSS), and the provision of services by the Previsional Health Firms (Empresas Médicas Previsionales, EMPs) which INSS currently contracts to provide services.

4. Safeguard policies that might apply

Environmental Assessment (OP/BP 4.01) The expansion of basic health and nutrition services to most vulnerable populations using the new Integrated Healthcare Model (IHCM), the investments in hospital services, the expansion of women centers, as well as the continued support of the institutional reform of the MOH, will lead to an increase on the generation of Health Care Waste and are expected to generate environmental impacts during construction activities. These events will require the development of a set of guidelines and procedures for new facilities, in order to mitigate environmental impacts caused by construction on any sensitive areas. The health care waste management plan will focus in a set of guidelines and procedures to enhance the quality of sorting, managing, transport and disposing of the hospital waste at National and Regional level. The plan will include training activities for involved personnel and institutions. Indicators to monitor its implementation will be developed and enforced through Bank supervision activities.

Indigenous Peoples (OD 4.20) Given that the Swap will target the most vulnerable groups including the Indigenous and Afro-descendants, an Indigenous Peoples Plan will be included. The social assessment for the Health Services Extension and Modernization Swap includes a stakeholder evaluation and beneficiary assessments of ongoing services (Women's Centers, PHC, Hospital services) in order to capitalize on good practices and lessons learned. Particular attention is being given to most vulnerable regions (Jinotega, RAAN, RAAS, Río San Juan and

other) and high-risk groups (women and children ages 0-5). The social strategy for the project will ensure a participatory strategy and social auditing mechanisms are in place for the project components. The strategy will include the participation of Central and Regional MOH, NGOs, Women's Associations, community networks, midwive's and health promotor's networks, etc. Based on the positive experience with Women's Centers (particularly on the Atlantic Coast and isolated areas) the project will support Government's efforts to expand on 100 new locations country-wide.

Cultural Property (draft OP 4.11 - OPN 11.03)

Given the fact that construction/refurbishing activities will take place, chance find procedures will be included in the construction guidelines.

5. Tentative financing

Source:		($m.)
BORROWER/RECIPIENT		0
INTERNATIONAL DEVELOPMENT ASSOCIATION		7
	Total	7

6. Contact point

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