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1. Country and Sector Background

Nicaragua's health profile reflects the country's high prevalence of poverty—and in particular its high rate of absolute poverty. Despite progress in reducing poverty over the past decade, with a per capita income of $710 Nicaragua remains one of the poorest countries in Latin America. Although from 1993 to 2001, poverty declined from 50% to 46%, and extreme poverty fell from 19% to 15%, the gains were characterized by significant geographic differences. [1] In 2002, 44% of the population still lived in rural areas where the prevalence of extreme poverty was 25%, more than four times the rate of urban areas. On average, poorer households have higher fertility rates and larger families, as well as higher maternal, infant and child mortality. In addition, tuberculosis, which remains a persistent public health problem, has become largely a disease of the poor.

Nicaragua has made considerable progress in improving the health status of its people over the last decade. Life expectancy has reached 69 years, and since 1990, infant and child maternal mortality rates have fallen by 29 and 32 percent, respectively.[2] A recent study of 165 countries that predicted life expectancy and infant mortality based on GDP, found that health status of Nicaraguans exceeds what one would anticipate, given the country's per capita income. While Central America as a whole did better than predicted on both of these two key health indicators, among the Central American republics, Nicaragua had the largest positive deviations between its

[1] World Bank, *Nicaragua Poverty Assessment – Raising Welfare and Reducing Vulnerability*, December 2003, p. i

[2] The 2002 Joint IDA/IMF Annual Progress Report of the Nicaragua PRSP recorded major gains in 12 of 13 of the intermediate health indicators, and results ranging between 85% and 130% of the planned targets. The only health indicators that did not improve was the prevalence of diarrhea incidence among children under 5 years.

actual and predicted life expectancy and in the case of infant mortality was second only to Costa Rica.

Life Expectancy and Infant Mortality in Central America:

Actual and Predicted Levels Based on Worldwide Analysis of the

Relationship Between GDP per Capita and These Two Indicators

	Life Expectancy, 2000			Infant Mortality, 2000		
Country	Actual	Predicted	Percent Difference	Actual	Predicted	Percent Difference
Costa Rica	78	72	8%	10	18	-43%
Panamá	75	69	7%	20	25	-21%
Nicaragua	69	61	13%	33	52	-37%
Honduras	66	61	8%	35	51	-32%
El Salvador	70	67	5%	29	32	-10%
Guatemala	65	66	-1%	39	37	6%

Source: Todd & Hicks, 2003

These recent advances hide, nevertheless, the fact that the poor have benefited much less than the wealthiest, as the table in annex 1 shows. Notwithstanding its relatively good recent record of improving health, Nicaragua continues to confront many of its traditional health challenges. The disease profile of Nicaragua is one of a country in the early phases of the epidemiological transition. Infectious diseases remain major health concerns, and the illnesses of early childhood—malnutrition, acute respiratory and diarrheal diseases in particular—continue to dominate the public health agenda. Moreover, unless current trends are accelerated, it is unlikely that Nicaragua will achieve the MDG goals of reducing maternal mortality and the prevalence of chronic malnutrition. Maternal and child health care, therefore, remain at the top of Nicaragua's human development agenda. In addition, the overall fertility rate—one of the highest in LAC at 3.2—is a particularly pressing social problem, and the adolescent pregnancy rate is second to none in the region.[3]

	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.

With respect to health financing, the level, stability and composition of MOH financing are causes of concern. From 1999 to 2003, MOH expenditures constituted 14% of total national budget expenditures (i.e., national funds plus external financing). While the level and sources of

[3] A 2001 national survey found that 25% of women aged 15-19 had already been pregnant at least once.

MOH financing were erratic over this period, in real, absolute terms, its 2002-2003 total was 8 percent less than its 1999-2000 total.

MOH is heavily dependent upon external financing (both grants and loans). From 1999 to 2003, external financing grew in real terms from US$22.9 million to US$30.8 million. Although the level of external financing has fluctuated annually, it has generally grown —from 18% of total MOH expenditures 1999 to 24% in 2003— at the same time that the level of real financing provided by national funds has fallen by an annual average of 7% since 1999. In effect, the Government of Nicaragua (GON) has substituted external funds for national funds to finance MOH expenditures. The composition of MOH resources is also a cause of concern as the allocation of public expenditures by department is generally inversely related to the severity and level of poverty (SANIGEST 2004: 90). A critical challenge for Nicaragua and the international community is to modify existing patterns of public health expenditures so that they no longer reinforce, but help address Nicaragua's unequal health and poverty profiles.

Although the coverage of the health program of the Nicaraguan Social Security Institute (INSS) has expanded by one-third over the past five years, it still provides coverage for only 9% of the population, the lowest proportion of any Central American country. Moreover, 70% of its beneficiaries are from the wealthiest 40% of the population. With private health insurance covering a mere 1% of Nicaraguans, the poor are forced to rely overwhelmingly on a combination of Ministry of Health services and self-treatment. Out-of-pocket purchases of medicines have grown steadily in recent years and now constitute 49% of all health expenditures.

In summary, high fertility rates, child malnutrition, poor health and lack of financial protection against illness still prevail for significant groups of the population, and all of them are strong determinants of the poverty trap for today's and tomorrow's poor in Nicaragua. Existing patterns of public expenditure mirror these inequalities, posing a challenge for public policy to reverse these inequities as a principal tool for combating poverty and fostering human development.

The GON is well aware of many of the shortcomings of the health sector, and over the course of the last five years has accelerated the pace of reform. A few years ago it passed the General Health Law (2002) and its Regulation Decree (2003), important steps in the modernization and institutional capacity-building of the MOH. These legal instruments set up: (i) the organization of a national health system based on two financial regimes, contributory and non-contributory, their respective benefit plans, institutional responsibilities and financing mechanisms; (ii) the principle of separation of functions, reinforcing the MOH stewardship role and the instruments to do so (i.e.: national health plan, quality assurance mechanisms and sector planning mechanisms), (iii) a decentralized model of governance and management; (iv) the basis for devolution of power to the Autonomous Governments of the Atlantic Coast; and (iv) the consideration of the special needs and conditions of the indigenous and afro-descendant population. The Ministry is now implementing these reforms and developing its institutional capacity to address the sector challenges, with the financial support of an IDB loan and the IDA's APL first-phase credit (NI-3084).

The other key health care organization in the country, the Nicaraguan Social Security Institute (INSS), has also made notable advances since 2000. In 2002, it separated financing from the

management of its health and pension regimes. Between 2000 and 2004, it expanded the number of beneficiaries of its health program by 32%, and introduced a new Elderly Health Program (EHP) for its retired affiliates. The INSS, which buys all medical services for its affiliates from private providers (EMPs), has also devised and implemented a provider certification system, and has reviewed the methodology for fixing the capitation payment paid to the EMPs.

Looking ahead, the GON has agreed with a group of significant donors, including IDA, to increase their effort to coordinate and harmonize official development aid by sponsoring a series of Sector Wide Approaches (SWAp) in a number of sectors, including health. Nicaragua has done a substantial amount of work in health policy reform that serves as a strong foundation for the proposed SWAp: in October 2004, the GON released an Operational National Development Plan to update the 2001 Poverty Reduction Strategy Paper (PRSP); in mid-2004 the MOH released the ten-year National Health Policies and its accompanying 2004-2015 National Health Plan (NHP), outlining how it plans to achieve the health goals set out in its PRSP; in November 2004 the MOH released a draft Five-Year Implementation Plan (FYIP) detailing how it would operationalize the aforementioned NHP. The fundamental goal set up by the FYIP is the increased access of the poor people of Nicaragua to effective maternal and child health care. This would be achieved by expanding access to a package of basic health services (BPHS) in the most deprived and rural municipalities of the country through a combination of performance-based incentives to public providers and purchasing of services from private providers. In December 2004 the MOH convoked an extraordinary session of the SILAIS and local area health networks (*municipios*) to present to them the NHP and national priorities for the FYIP and to assist them in establishing their annual operating goals for each year in the FYIP, and thereby produce a detailed, bottom-up plan for programming and budgeting the FYIP.

These national plans have also received the backing of the international financial community. All of the cooperating partners in the SWAp have agreed that the FYIP will serve as the operational framework for the SWAp, thereby ensuring that the SWAp will be fully aligned with government policy. By its being the based on the product of the still nascent local annual programming system, it is hoped that the SWAp will help to nurture the further development of local level planning and programming capability, and thereby help to institutionalize this new approach and with it, the effective decentralization of the MOH.

2. Objectives

The overall APL program development objective, as approved by the IDA Board in 1998, is to improve health outcomes in Nicaragua, particularly among the poor, by raising the efficiency, effectiveness, equity and sustainability of the Nicaraguan health system. In this second phase of the APL, IDA financing will contribute, alongside funds from the MOH and other SWAp partners, to improve maternal and child health in the poorest municipalities of Nicaragua, concentrating roughly half of the Nicaragua's poor. By improving the health status of this population, health inequities should reduce, as shown by disparities in maternal and infant mortality indicators across geographical areas and income groups. These goals will be achieved through the operationalization of three strategic objectives, as set up in the sector Five-Year Implementation Plan, namely: (i) the extension of coverage of a package of basic health and

nutrition services to the poorest areas of the country, via the new integrated model of health care; (ii) the physical and functional strengthening of the health service facilities network, focusing on maternal-infant care, so as to provide a seamless path of essential services in the target areas; and (iii) institutional strengthening and capacity-building, concentrated specifically on developing the purchasing, monitoring and evaluation capacities of the MOH, its leadership role to enhancing donors' alignment and harmonization, and the management capacity of MOH decentralized units and Autonomous Governments of the Atlantic Coast.

A common set of results indicators accompanies the FYIP and will be closely monitored by the MOH and the SWAp partners. These indicators, along with its corresponding targets, are fully described in annex 3 and include the following:

Results related to improved access to maternal and child essential services in targeted areas:
1. Beneficiaries of the expansion of essential health services 2. Institutional delivery rate 3. Child immunization rates 4. Coverage of early prenatal care 5. Coverage of complete prenatal care 6. Utilization rates of safe family planning methods 7. Additional number of INSS beneficiaries
Results related to strengthening the health services network in targeted areas:
8. Number of pregnant women admitted to Womens Centers (*Casas maternas*) 9. Hospital admission rate 10. Number of hospitals with critical path services certified by MOH 11. Percentage of hospitals satisfying targets set in their service agreements 12. Percentage of maternal deaths audited
Results related to improved sector stewardship and institutional strengthening
13. Percentage of MOH budget transferred to local systems as purchase of services 14. Percentage of MOH budget directly administered by the Atlantic Regions Autonomous Governments. 15. Reduction of the inequity gap in per-capita public health expenditure in the targeted areas

The Government of Nicaragua's 2001 Poverty Reduction Strategy Paper (PRSP), which is the basis of the World Bank's Country Assistance Strategy (CAS) for Nicaragua, emphasizes the need to improve public sector management and the coordination of foreign aid. The health SWAp supports three of the PRSP's four pillars by targeting vulnerable populations, focusing on institutional strengthening and capacity-building and encouraging greater and better human capital investment in the poor. In particular the SWAp will primarily seek to improve the maternal and child health of a significant proportion of the Nicaraguan poor and, therefore, also reduce the rural-urban health inequities. Easier and more affordable access to health, nutrition and family planning counseling and services will, in turn, positively contribute to reduce child malnutrition, protect household income and facilitate women's empowerment. The SWAp will also improve the Nicaragua health sector effectiveness, efficiency and sustainability by improving the MOH's stewardship role, fostering alliances with private (NGOs and others) and official institutions (INSS), broadening the capacity of decentralized units to manage resources and evaluate performance, and streamlining the contribution of external donors. Each of these high level development objectives are fully aligned with the NHP and its FYIP as well as IDA's APL program development objectives.

3. Rationale for Bank Involvement

The primary rationale of the CAS is to support the GON's development goals as outlined in the PRSP. The Adaptable Program Credit (APL) for the health sector modernization project, approved by the Board in 1998, supports three of the four 2001 PRSP pillars: (i) greater and better investment in the human capital of the poor, (ii) better protection for vulnerable populations, and (iii) good governance. The most significant IDA support to Nicaragua consists of the poverty reduction support credits (PSAC and PRSCs). These credits contain health conditionalities that are fully aligned with the PRSP. This proposed new SWAp would build upon the work accomplished under the first phase of the adjustable programmatic loan (APL), concluded in December 2004, and directly contribute to the goals established in the PRSP synergistically with the PRSCs.

The Bank's involvement in the SWAp builds upon its previous work in Nicaragua by broadening the policy dialogue on poverty reduction and promoting further reforms in the modernization of the Nicaraguan health sector. Since September 2003, the Bank has been working closely with MOH to develop the NHP and the FYIP. The first phase of the Bank's APL health sector credit has satisfactorily achieved its development objectives. The MOH—with the support of the World Bank and the IDB through the health modernization project—has developed sound institutional tools and regulations to improve the Ministry's regulatory and management roles, as described in the previous section. Extensive evaluations of most of the first phase interventions supported by the APL, together with cross-evaluations with other donor's programs and past national health policies, have been carried out over the past two years. The results of these evaluations have been used to inform new sector policies and have assisted the MOH in making strategic decisions about how best to harmonize donor contributions and design the SWAp[4]. The vast majority of the SWAp's planned activities consists of efforts to scale-up activities that were pilot-tested, evaluated, deemed successful, and (generally with some modifications) worthy of replication and expansion.

While the health modernization program, has made significant advances, much work still needs to be done to improve the health status of the population and the country's health system. Inequity persists and the health reform and decentralization agenda is not yet completed. In addition, there is a dire need to improve accountability, transparency and governance throughout the sector.

The Bank's expertise in SWAps, as well as its extensive experience with designing effective, pro-poor health strategies, complement the contribution of the other stakeholders in the SWAp. Moreover, the Bank has accrued important experience in the health sector of Nicaragua working closely with other donors and financiers. The Bank has played a pivotal role encouraging the MOH's to develop a more cohesive sector policy and institutional structure, thereby promoting the Ministry's institutional effectiveness and enhancing its leadership role in coordinating donors' aid. The Bank is also part of the Budget Support Group (BSG) in Nicaragua. The BSG,

[4] A summary table of the evaluation results is presented in Annex 1-A.

along with all the bilateral donors financing the health SWAp, has jointly agreed on a harmonized set of policy actions and results (including health) that will serve as key inputs to the SWAp.

4. Description

The Five-Year Implementation Plan (2005-2009) provides the strategic framework for all SWAp partners to join efforts to achieve the stated results. While the FYIP has a national scope and incorporates all MOH activities, it has been agreed with the MOH that the FYIP, and its consecutive annual action plans, will clearly identify a subprogram of activities aimed specifically at achieving the targets and strategic initiatives set out hereafter. The two first strategic objectives within this program are aimed at the 76 municipalities with the greatest health needs. As long as new funds are available or new partners become SWAp donors, this list of municipalities or priority activities may increase accordingly. Therefore, the FYIP sets up the strategic actions to achieve the following three strategic objectives:

Strategic Objective 1: Extension of health care coverage to the poorest population (US$36.5 million)

Extension of the Basic Package of Health Services to vulnerable rural populations at the community-level

A package of basic health care services (BPHS), focusing on maternal and child health, will be offered to the most deprived population of Nicaragua. Vulnerable populations and localities for the extension of coverage have been identified based on the following criteria: current access to health services, poverty level, and health status. A multiple-tier targeting process has been used. First, the 12 most vulnerable departments have been identified, using the targeting criteria explained in annex 4. Second, 76 municipalities within the 12 most vulnerable departments have been selected using the same criteria. In total, these localities account for 47% of the poorest Nicaraguans. Third, within these 76 municipalities, the rural and indigenous communities will be prioritized. The formulation of the basic health care services package (BPHS) further focuses this intervention by targeting specific diseases and health problems, maternal and child health along with a few other prevalent diseases of the adult, that have their greatest impact on the poor. In summary, it is estimated that the BPHS will be extended over the next five years to 472,500 inhabitants living in the most deprived municipalities of the North and Atlantic Coast of Nicaragua.

The new integrated health care model (MAIS), developed by the MOH to integrate different models of health care delivery and management implemented in the country over the past years, will be used for the expansion of the BPHS. The MAIS already drafted by the MOH includes all the necessary technical instruments to implement this strategy. It sets up the delivery model (including consideration of different delivery modalities according to social and geographical characteristics of the population to cover), the benefits plan, focalization mechanism, contracting and payment instruments, social participation strategies and supervision and monitoring arrangements). Itinerant health service delivery teams will be organized for reaching the poor living in the most remote areas of the country. The BPHS will be tailored, in content and delivery modalities, to the special conditions of the indigenous and afro-descendant population.

These accommodations are currently been working out between the MOH and the tho Autonomous Governments of the Atlantic Coast, where most of these groups live.

The delivery of the BPHS will be achieved through formal contractual agreements with non-institutional healthcare service providers (NGOs), incremental performance-based payments to public providers, and expansion of social security coverage to new beneficiaries. The SWAp's proceeds will finance the purchasing of the package of basic services for maternal and child care, including outreach strategies, necessary transportation, essential drugs, nutrition advice, IEC activities, reproductive and sexual health services and limited essential health services for adults. In the case of private providers, a per capita payment, complemented with performance incentives, will be passed on to them, based on a competitive tendering process. In the case of public providers, the supply of the BPHS to the targeted population will become part of the service agreements between the MOH and the respective SILAIS and public local providers, transferring performance-based incentives, calculated to cover the marginal cost needed to achieve the expansion of the BPHS targets. All these contracting arrangements already exist, but will be adapted and scaled up with the SWAp funds.

Strengthening planning, accountability and social participation for the delivery of the BPHS

The SWAP's resources will fund technical assistance necessary to develop institutional capacity at the SILAIS and local provider levels (*municipios*) for implementing the expansion of the BPHS. While local providers will progressively take up broader management responsibilities for the delivery of services and management of resources, SILAIS will develop a supporting role to the MOH central purchasing unit, helping out in the planning, formulation, monitoring and supervision of annual health plans, service contracts with private providers and management agreements with public local providers. This capacity building support activities will entail capacity assessment, training, development and implementation of contractual, management and clinical instruments, and information technology necessary to effectively plan for the expansion of services, improve and control quality, manage resources at local level, and monitor results.

Both public and private health care providers will work closely with the communities, jointly identifying the community's health needs, and programming community and health sector actions to address their health problems. This work will constitute the MOH-community interface portion of the Ministry's ongoing decentralization efforts. To date, MOH's decentralization has been exclusively an intra-institutional process. A key element of the process has been the recent development of local MOH networks' (*municipios*) annual programming and budgeting exercise, whereby they develop annual operating plans, which then aggregate up to the SILAIS level to become the heart of the SILAIS annual plan. The SWAp will help taking this process to the next step, and will incorporate private sector itinerant health teams and representatives of civil society (as well as MOH's hospitals) into the planning, monitoring and evaluation/feedback cycle. The civil society will play an active role on auditing the actual delivery and quality of services to the community. A community committee will advise and ultimately endorse the provider annual working plan and periodically (e.g., quarterly) provide monitoring feedback to the provider and the supervisory SILAIS.

Strategic Objective 2: Strengthening the network of services in targeted areas to support the implementation of the BPHS (US$27,8 million)

This component of the SWAp is designed to support the extension of coverage, and to complement its MCH-related activities. Activities in this area are aimed at creating an effectively structured and functioning referral system that will provide a more complete continuum of MCH care to rural communities, while increasing their access to secondary care and improving the overall quality of health care.[5] Bringing such a system to fruition will require improving three different types of facilities that comprise the MCH delivery system located in the same geographical areas selected for the expansion of essential services:

Women Homes (Casas Maternas)

Casas Maternas (CMs) are low cost, assisted living arrangements that usually have around 10 beds and are located next to a hospital. The physical facilities are usually contributed by the community. Communities get also involved in co-financing and managing these homes. The CMs are designed to lodge pregnant women living in remote villages in the last few days of their pregnancy, to ensure that the women have ready access to an institutional facility when labor work starts. Women usually stay in these facilities for a few days after delivering. Services provided in these *Casas* also expand to provide family planning and child nutrition counselling, as well as other education activities for empowering women. Selected communities will be trained and supported to manage and maintain their CMs. It is envisaged that 50 additional units will be added to the existing network of CMs. Funding will be provided for the rehabilitation of existing premises or (on an exceptional basis) the construction of new homes, the acquisition of basic equipment and furnishings for the homes, timebound (and declining) recurrent costs, activities aimed at empowering women staying in the homes, and the promotion of family planning.

Primary Health Care Centers

This part of the program is aimed at improving the infrastructure and renovating existing primary health care centers in the targeted geographical areas and ensuring they are sufficiently equipped. The centers will also be stocked with the medical supplies required by the essential package of health and nutrition services (BPHS). A needs-assessment will be prepared as part of the pre-investment phase of the SWAp.

Hospitals

The twelve district hospitals in the areas targeted for extension of coverage will be rehabilitated and equipped with medical and industrial equipment necessary to improve the quality and safety of the maternal and child care critical path. Specifically, investments will revamp emergency

[5] It is expected that the extension of primary care through the BPHS will increase the demand for and referrals to the secondary care.

rooms, operating rooms, obstetric and paediatric wards and related ambulatory facilities, support clinical services (image and lab departments). The SWAp will also improve other essential general hospital facilities, including laundry, steam and water, catering and waste management. It is expected that, although the investment will prioritize the maternal and child care critical path, it will also have a positive spill over impact on hospital services rendered to other patients by upgrading these general and support hospital facilities. Investments in physical infrastructure (remodelling only) and equipment will be accompanied by investments to improve the management of those facilities. The SWAp will build upon the experiences of the health modernization project (APL first phase) and will extend and replicate the support given to the first phase pilot hospitals in order to improve the management capacity and systems in the ten targeted hospitals. The management support strategy includes direct technical support to the hospital directors by itinerant management support teams, under the supervision of the MOH central Hospital Directorate, training, information technology and implementation of institutional management systems (i.e.: MOH information, procurement and financial management systems). Special support will be given to the preparation and implementation of hospital waste management plans, complying with applicable national standards and policies acceptable to IDA, control of hospital infectious diseases and implementation of quality improvement strategies.

Strategic Objective 3: Improving Stewardship, Institutional Strengthening and Decentralization (US$ 17,8 million)

The MOH recognizes that to fulfil the vision set forth in the NHP and effectively lead the SWAp, it will need to undertake a variety of institutional reforms. These include: (i) strengthening the Ministry's management capacity necessary for planning, contracting and supervising the expansion of the BPHS (e.g., programming and planning, information and reporting) and the rest of institutional fiduciary systems (financial accounting, procurement, auditing) so the SWAp can progressively adopt these national systems instead of donors' procedures; (ii) strengthening the GON's capacity to monitor and evaluate health sector performance, efficiency and equity; (iii) supporting the MOH's coordination role as executor and overseer of the GON's population policy; and (iv) developing a strong purchasing function at the MOH, including the identification of beneficiaries for the expansion of essential services, adjusting payment mechanisms, overseeing service quality, contract design and monitoring.

The FYIP also includes under this objective activities to advance the decentralization policy established by the National Health Policies. In particular, the SWAp will support decentralization by: (i) providing advocacy and technical assistance to municipal government to undertake public health responsibilities[6]; (ii) supporting the devolution of responsibilities to the two Autonomous Governments of the Atlantic Coast over the organization and management of their regional health systems; (iii) offering technical support to MOH department offices (SILAIS) to carry out their annual planning and contracting functions; (iii) decentralizing management of the MOH human resources function to the SILAIS and hospitals. The over-riding goal will be to improve the performance of MOH—increasing its effectiveness, efficiency and

[6] A recently passed Law by the National Assembly requires the central Government to transfer an increasing proportion of the GON's budget to municipal governments. It is expected that municipal governments will take up some public health responsibilities nowadays delivered by the MOH. But this assumption of functions requires raising awareness and capacity in these institutions to execute those responsibilities.

the degree of equity in access to and expenditures on health care—by improving incentives and accountability.

Finally, the FYIP calls for an expansion of the INSS coverage among targeted groups of the population (increasing the coverage age for INSS affiliates' dependants, informal workers, retired). It also expects INSS to affiliation fraud among formal workers. The SWAp will support this strategy by providing the INSS with technical assistance to carry out feasibility studies, pilot projects, and strengthening the corporate responsibility to steward and oversee the provision of its disease and maternity plan.

5. Financing

SOURCES OF FUNDS. FIVE YEAR PLAN. US$			
Partner	External Funds	Counterpart Funds	Total
IDB	30	3	33
Sweden	20		20
IDA	11	1.1	12.1
The Netherlands	10.6		10.6
Finland	6.5		6.5
TOTAL	**78.1**	**4.1**	**82.2**

6. Implementation

Partners in the SWAp are Sweden, The Netherlands, Finland, USAID and the IDB. Some bilateral donors (Finland, Sweden and The Netherlands) will provide unrestricted budget support to the MOH. Sweden will be contributing US$20 million over the next five years. Netherlands will contribute US$2 million in 2005 and continue inputting at least similar amounts on an annual basis. Finland estimates its contribution will be US$6.5 million between 2005 and 2009. The IDB has approved in December 2004 a $30 million performance-based credit to be disbursed over five years. The IDB credit, although using IDB procurement procedures, resources the same five-year action plan, disburses against a subgroup of the SWAp's result targets, relies on the MOH institutional structure to execute the project, and will be jointly supervised with the rest of the SWAp partners. USAID, another big player in Nicaragua health sector, has been participating in all the SWAp preparation missions and although unable to pool funds with the rest of the donors, has committed to also support the FYIP, and particularly those activities aimed at institutional strengthening and sector governance. The total SWAP envelope for the five-year timeframe amounts to US$ 82.2 million, including MOH counterpart funds for the IDB and IDA credits but not USAID support, which has not been valued yet.

The principles of the SWAp planning, executing, monitoring and coordination mechanisms are contained in a Code of Conduct that has been agreed between the MOH and the SWAp partners. Those principles will be further detailed in a Memorandum of Understanding that the MOH will agree with the SWAp partners before credit effectiveness. As outlined in that Code of Conduct (already signed by all SWAp partners), and the drafted MOU, the MOH will lead the implementation and execution of the SWAp. The *Mesa Sectorial de Salud* (MS), comprised of

all cooperating agencies in the health sector and all the health-related government agencies, will be the principal forum for cooperation, information exchange and dialogue for the overall health sector development. The MOH and all the SWAp partners will constitute a *Coordinating Committee* in charge of overseeing the planning and execution of the FYIP and its annual action plans, and reviewing periodically (at least biannually) the attainment of its targets. Technical support and internal coordination within the MOH will be provided by a SWAp Technical Secretariat directly reporting to the Minister of Health. The director of the Technical Secretariat will be appointed by the Health Minister, under TORs, employment conditions and appointment subjected to approval by all the SWAp partners.

The Health Planning and Development General Directorate (DGPD) will be the starting purchasing entity for the SWAp funded expansion of services, until the MOH sets up a devoted purchasing unit within its formal structure. This office will purchase services from public and private providers to achieve the expansion of services objectives with the SWAp defined funds. It is also the MOH's intent that the purchasing unit to be created will gradually take over the purchasing of heath services throughout the country using MOH resources through the annual management agreement signed with all SILAIS, local providers and national hospitals. The DGPD will also be responsible for the annual planning and budgeting of the FYIP. These functions, purchasing services and planning the FYIP, will be done with the operational and technical support of SILAIS. The Financial Administration General Directorate will be responsible for budgeting, accounting and reconciliation matters, providing support to the DGPD on mid- and short-term financial planning of the SWAp. The DGPD will in turn provide technical support to the SWAp Technical Secretariat on other SWAp execution matters.

Flow of Funds

The MOH will set up a special fund, the Nicaragua Health Fund (FONSALUD, by its Spanish acronym), that will pool funds from all the SWAp donors, except USAID. The MOH will, however, be able to track the source of funds using SIGFA current capabilities. FONSALUD will resource all the SWAp activities included in each Annual Action Plan. The MOH will purchase the BPHS from private providers through service contracts, and will transfer payments to them according to the payment mechanisms established in the contract (partly on a prospective per capita basis, partly on a retrospective performance-based mechanism). The MOH will also enter into management agreements (*Convenios*) with the 12 targeted SILAIS, specifying at least the number of beneficiaries for the expansion of the BPHS coverage, performance targets by municipality and the additional payments (performance-based incentives) established to complement the fiscal resources allocated to those SILAIS for achieving the expected results. The funds to be transferred to the SILAIS, accompanying the management agreements, will include the performance-based payments for public providers, and funds necessary to carry out the activities programmed for the strengthening of the health service network at local level (strategic objective 2 in the Annual Action Plan for that SILAIS). Funds will be retained and executed centrally by the MOH to carry out capacity-building activities at central level (Strategic Objective 3), and for purchasing works, goods and services for which the procurement plan requires central bidding.

IDA's funds will be disbursed periodically to FONSALUD upon approval of the corresponding annual action plan, based on financial management reports (FMRs). FONSALUD, in turn, will transfer funds to each targeted SILAIS through a budget line which has been already incorporated into the 2005 MOH budget for purchasing of services. Fiduciary arrangements for the operation of FONSALUD are described in annexes 7 and 8.

An Operational Manual for the purchasing of the BPHS with FONSALUD funds will be prepared by the MOH before credit effectiveness. More information on the institutional arrangements is described in annex 6.

7. Sustainability

The MOH has demonstrated its commitment to health sector reform and modernization through its performance in the first phase of the APL credit and throughout the preparatory phase of the SWAp. During these stages, the MOH has adopted a new regulatory framework, organizational and functional structure through an incremental process of institutional modernization.

The layout of the health sector strategy for the next ten years has been released and endorsed by the GON and the SWAp partners, after thorough consultation. Most of the FYIP strategies have proven successful, though will be continuously adjusted and improved according to experience accrued with the implementation of the SWAp. In summary, the essential groundwork for the implementation of the SWAp has already been completed.

The sustainability of the SWAP relies mainly on the financial capacity of the MOH to keep up with the running cost of delivering extended services once the FYIP is over. This seems feasible, though, because: first, no major new infrastructure will be undertaken in the five-year implementation plan; second, it is expected that the GON's fiscal situation will improve through HIPC debt relief, forecasted economic growth, and increased external budget support, making more likely the GON's injecting of new funds into the MOH budget. To that end, one of the SWAp target results requires from the GON at least maintaining the per capita MOH expenditure, in real terms, over the SWAp life cycle. Third, through improved MOH purchasing and stewardship capacity over the health sector, it is expected that allocative efficiency of GON and external funds for health will improve, therefore making the sustainability of increased access to essential services more affordable for the GON. Finally, there is an implicit agreement among external donors that support to the Nicaraguan health sector will continue as long as its poverty rates remain high and the health sector performance improves over time.

8. Lessons Learned from Past Operations in the Country/Sector

The FYIP supported by the SWAP scales up the successful programs piloted under the APL first phase, based on feedback obtained from evaluations of its components. This is particularly evident in three elements of the strategy. First, the development of a unified, institutionally endorsed delivery and management model for primary health care was prompted by the existence of at least 14 different donor-sponsored primary health care programs. The Integrated Healthcare

Model (MAIS) developed by the MOH as preparation for the SWAp integrates already piloted successful programs, like the community nutrition and growth program (PROCOSAN), sexual and reproductive health services programs and the contracting out of essential services from NGOs for remote communities. The MAIS has been designed after the results of an evaluation of the mentioned 14 PHC projects and an evaluation of the health modernization project's components.

Second, in view of the fact that evaluations of the *Casas Maternas* show that these facilities have made a substantial contribution to reducing maternal mortality and improving other reproductive health indicators in their areas of operation[7], the FYIP seeks to expand the existing network of CMs. Based on findings from evaluation reports, collaboration between the CMs and local community service organizations and the integration of the CM network with the formal health care system, which were found to be successful elements of the strategy, will be pursued.

Third, lessons from the operation of the Safe Maternity and Infancy Fund (FONMAT) highlights the positive results of using performance-based payments to public providers for increasing the production of services. Former experience in expanding services in Nicaragua, and elsewhere, show that supply and demand interventions are equally and simultaneously needed. The Nicaragua SWAp will apply specific incentives to public and private providers for increasing performance, and at the same time will improve the health services network and community infrastructure, and mobilize health professionals to work in underserved communities. The key results identified regarding the implementation of the Health Sector Modernization Program 1st. phase, as well as lessons drawn from other relevant evaluation studies undertaken recently are presented in annex 1-A.

Furthermore, the SWAp collects the knowledge and expertise of several key bilateral and multilateral donors with substantial historical experience in the Nicaraguan health sector and different comparative advantage and expertise. It also builds upon the relationships established during IDA's previous collaboration with the IDB, NORAD and NDF in the supervision and evaluation of the Health Sector Modernization Project.

9. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[ ]
Pest Management (OP 4.09)	[ ]	[ ]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[ ]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[ ]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[X]	[ ]
Forests (OP/BP 4.36)	[ ]	[ ]

[7] The Nicaragua *Casas maternas* initiative has been showcased and recognized as best practice by the World Bank Gender Network in 2004.

Safety of Dams (OP/BP 4.37)	[ ]	[ ]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[ ]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[ ]

10. List of Factual Technical Documents

National Health Policies 2004-2015
National Health Plan 2004-2015
Five Year Implementation Plan
Modelo de Atención Integral de Salud (MAIS)
Code of Conduct (last draft)
Poverty Assessment
Análisis de situación del sector salud (MOH 2004)
Financial Analysis of the Nicaragua Health Sector (Avendaño)
Financial Analysis of the Nicaragua Health Sector (Meerhoff, 2004)
Evaluation of PHC projects (Bitran y Asociados)
Evaluation of the MOH Strengthening Component under the PMSS (Fernando Marin, 2004)
Evaluation of the PMSS Hospital component (Carlos Martín 2004)
Evaluation of the PHC Component of the PMSS (Roser Fernandez, 2004)
Evaluation of Casas Maternas (Maria Elena Ruiz Abril)
Evaluation of the National Health Policies 1997-2002 (Sanigest)
ENDESA 2001
Public Expenditure Review 2001
Social Assessment
Environmental assessment
Costing of the FYIP (Fabio Duran)
Definición del Paquete Básico de Servicios de Salud a proveer por el Ministerio de Salud bajo el Régimen no contributivo (Fabio Durán 2004)
Nicaragua Salud y Equidad (Magdalena Rathe, Dayana Lora. Fundación Plenitud, 2003)
Royal Netherlands' Embassy, Nicaragua Strategy Document: Health sector Development (2003)
IDB Loan proposal for Strengthening Maternal and Child health in Nicaragua. A Performance based loan. December 2004.

11. Contact point
Contact: Jesus Maria Fernandez Diaz
Title: Sr Public Health Spec.
Tel: (202) 458-4806
Fax: (202) 522-0050
Email: jfernandezdiaz@worldbank.org

12. For more information contact:
The InfoShop
The World Bank

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-5454
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop