PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

NICARAGUA

COMMUNITY HEALTH PROGRAM FOR RURAL MUNICIPIOS

(NI-L1095)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Emmanuelle Sánchez-Monin (SPH/CNI), Ricardo Pérez-Cuevas (SPH/CME), Project Team Co-leaders; Meri Helleranta (SPH/CNI); Santiago Castillo and Juan Carlos Lazo (both FMP/CNI); Sobeyda Castillo (CID/CNI); José Luis De La Bastida (VPS/ESG); Mónica Centeno-Lappas (LEG/SGO); Martha Guerra (SCL/SPH).

This document is being released to the public and distributed to the Bank's Board of Executive Directors simultaneously. This document has not been approved by the Board. Should the Board approve the document with amendments, a revised version will be made available to the public, thus superseding and replacing the original version.

CONTENTS

PROJECT SUMMARY

I. DESCRIPTION AND RESULTS MONITORING 1

A. Background, problem to be addressed, and rationale 1
1. Health disparities 1
2. Expanding coverage, access, and quality: progress of the Family and Community Health Model (MOSAFC) 2
3. Program rationale and lessons learned from Bank programs 6
B. Objectives, components, and cost 9
C. Key outcome indicators 11

II. FINANCING STRUCTURE AND MAIN RISKS 12

A. Financing instruments 12
B. Environmental and social risks 12
C. Fiduciary risks 13
D. Other project risks 14

III. IMPLEMENTATION AND MANAGEMENT PLAN 15

A. Summary of implementation arrangements 15
B. Summary of arrangements for monitoring results 17

APPENDIXES

Proposed resolution

ANNEXES	
Annex I	Development Effectiveness Matrix (DEM) - Summary
Annex II	Results Matrix
Annex III	Fiduciary Agreements and Requirements

ELECTRONIC LINKS

REQUIRED

1. Multiyear execution plan
2. Monitoring and evaluation plan
3. Environmental and social management report
4. Procurement plan

OPTIONAL

1. Theory of change
2. Technical background
3. Organization of services and human resources
4. Economic analysis
5. Annotated index and relevant content of the Operating Regulations
6. Safeguard policy filter and safeguard screening form for classification of projects

ABBREVIATIONS

CFHT	Community and family health team
CHNP	Community Health and Nutrition Program
DALY	Disability-adjusted life years
EONC	Essential obstetric and neonatal care
ESMP	Environmental and social management plan
ESMR	Environmental and social management report
FSO	Fund for Special Operations
HTOP	Human Talent Optimization Plan
IHCN	Integrated health care networks
INSS	Instituto Nicaragüense de Seguridad Social [Nicaraguan Social Security Institute]
MHI	Mesoamerican Health Initiative
MINSA	Ministry of Health
MOSAFC	Family and Community Health Model
NCCAR	North Caribbean Coast Autonomous Region
NCD	Noncommunicable disease
OC	Ordinary Capital
PAHO	Pan American Health Organization
SILAIS	Sistemas Locales de Atención Integral en Salud [Local Comprehensive Health Care Systems]
WHO	World Health Organization

Project Summary
Nicaragua
Community Health Program for Rural Municipios

(NI-L1095)

Financial Terms and Conditions

Borrower: Republic of Nicaragua

Executing agency: Ministry of Health (MINSA)

Source	Amount (US$)	%
IDB (OC):	27,000,000	26.2
IDB (FSO):	18,000,000	17.5
Local Counterpart:	58,233,762	56.3
Total:	**103,233,762**	100.0

	Ordinary Capital (OC)	Fund for Special Operations (FSO)
Amortization period:	30 years	40 years
Disbursement period:	5 years	5 years
Grace period:	6 years	40 years
Inspection and supervision fee:	[b]	N/A
Interest rate:	Single Currency Facility [a]	0.25
Credit fee:	[b]	N/A
Currency of approval:	United States dollars drawn from the Ordinary Capital	United States dollars drawn from the Fund for Special Operations

Project at a Glance

Program objective/description: Reduce health disparities and accelerate reductions in maternal and infant morbidity and mortality in priority Local Comprehensive Health Care Systems (SILAIS) in the North Caribbean, Jinotega, Matagalpa, and the Dry Corridor Region, specifically by broadening and improving access to and coverage of high-quality health promotion and health care services under the family and community health model (paragraph 1.18).

Special contractual conditions precedent to the first disbursement of the loan proceeds: MINSA will submit evidence that: (i) it has approved the Operating Regulations previously agreed upon with the Bank and they are in force, together with all updated annexes; any change to the annexes of the Operating Regulations will be agreed upon beforehand with the Bank (paragraph 3.1); (ii) it has the additional staff to comprise the minimum technical-operational team working full-time on execution of Bank-financed programs (paragraph 3.1); (iii) it has effectively complied with the environmental management system and the environmental management framework designed under the Integrated Health Care Networks program (paragraph 2.2); (iv) it has complied with the corrective action plan agreed upon (April 2016) during the program's environmental supervision (Annex 1 to the Environmental and Social Management Report—ESMR) (paragraph 2.2); and (v) prior to the first disbursement under Component 1, (a) it has the Bank's no objection to hiring the evaluator who will conduct the independent performance evaluation, with a view to certifying the volume and quality of care reported under that component (paragraph 3.6); and (b) it has agreed with the Bank on the amount of financing per person served during the first year (paragraph 2.1).

Special contractual conditions for execution: MINSA will submit: (i) evidence every six months that it has complied with the requirements: (a) set forth in Section VI of the ESMR (paragraph 2.2) by the agreed dates; and (b) of the Management Safeguards Plan in force and agreed upon updates to it (paragraph 3.1); (ii) prior to 31 March of every year, the programming of resources for the current year and the report on the execution of the general budget of the Republic from the previous year with regard to health promotion and disease prevention activities, as well as primary care, broken down at the municipio level for the 54 priority municipios and at the SILAIS level for the rest of the country (paragraph 2.8); (iii) annually, the update of financing per person served agreed upon with the Bank based on a review of actual costs (paragraph 2.1); and (iv) evidence that retirements have taken place in accordance with the provisions of the Operating Regulations upon presentation of Human Talent Optimization Plan payments (paragraph 2.5).

Exceptions to Bank policy: N/A.

Strategic alignment

Challenges:[c]	SI ☑	PI ☐	EI ☐
Crosscutting themes:[d]	GD ☑	CC ☐	IC ☐

[a] The borrower will pay interest on the outstanding balances of this portion of the Ordinary Capital at a LIBOR-based rate. When the outstanding balance reaches 25% of the net approved amount or US$3 million, whichever is greater, the base rate will be set on that balance.

[b] The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with applicable policies.

[c] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[d] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. Description and Results Monitoring

A. Background, problem to be addressed, and rationale

1. Health disparities

1.1 Over the last decade, health has been a priority for public policy and government budgets, with emphasis on expanding coverage of essential services, resulting in a notable improvement in national health indicators. Life expectancy increased from 68 years to 75 between 2005 and 2015, and the Millennium Development Goals on infant and maternal mortality were reached.[1] Thus, 2014 ended with 54 maternal deaths in the whole country, compared to 119 in 2005.[2] Neonatal mortality (during the first month of life) also declined from 16 (2007) to 8 deaths per 1,000 live births (2011), although it accounts for 47% of infant mortality (during the first year). Still, challenges persist: These improvements are not equally distributed across Nicaragua. The North Caribbean Coast Autonomous Region (NCCAR), the departments of Jinotega, Matagalpa, Madriz, Nueva Segovia and north Estelí, León, and Chinandega still face significant social disadvantages. In these regions, 67% of the population is rural (44% nationwide), more than 50% is in the poorest quintile, and 27% of the rural homes lack indoor plumbing.[3] This geographic area includes the Dry Corridor Region, which suffers from food insecurity due to chronic droughts.[4] Geographical dispersion and poverty are barriers to access to health services,[5] while poor health is a risk factor for infectious diseases and, together with food insecurity, contributes to worsening malnutrition.[6] A significant portion of maternal and neonatal mortality is related to access: Where access is more limited, perinatal care is lower and maternal and neonatal mortality rates are consistently higher.[7] Adequate access to essential health services for poor rural populations is thus critical for reducing health disparities.

1.2 A better overall level of health helps the country deal with the challenges of an aging population and the increase in chronic noncommunicable diseases (NCDs). It also helps rural departments—where the epidemiological transition is not as far along—shoulder a double burden: chronic NCDs account for 50% to 65% of deaths in those departments (versus more than 72% nationally), yet communicable diseases and nutritional and perinatal disorders still account for more than 20% of deaths and up to 37% in the North Caribbean, versus less than 12% in the country as a whole.[8] These afflictions have medium-term

---

1 Economic Commission for Latin America and the Caribbean. Latin America and the Caribbean: Looking ahead after the Millennium Development Goals.

2 MINSA. Health Management Report 2014.

3 National Development Information Institute (INIDE). Encuesta Demográfica y de Salud 2011/12 [Demographic and Health Survey 2011-2012], Final Report. 2014, source for sociodemographic and sanitary data unless otherwise indicated.

4 Agua, agricultura y seguridad alimentaria en las zonas secas de Nicaragua [Water, agriculture, and food security in dry areas of Nicaragua], Bendaña García, G., 2012.

5 Optional Link 1 presenting the corresponding evidence.

6 Ibid. This is a vicious circle: malnutrition leads to a greater propensity to contract infections, which exacerbate malnutrition.

7 Ibid.

8 MINSA, data report to the Inter-American Development Bank (IDB), March 2016.

consequences for the development of chronic NCDs.[9] Lastly, the country is highly vulnerable to natural disasters and periodically faces epidemic outbreaks (mainly dengue, chikungunya, and now zika), both of which put greater pressure on health services. These circumstances present the challenge of meeting simultaneous complex demands for care, a challenge that requires the consolidation of an integrated service network that ensures continuity of care from the community level up to the secondary care level.

1.3 **Child health indicators reflect the magnitude of existing disparities.** Neonatal mortality in rural areas is double that of urban areas (10 versus 5 per 1,000 live births). In the Department of Madriz, chronic malnutrition in children under 5 is 29.5% while in the NCCAR it is 23%, compared to 17% nationally and 12.8% in urban areas. In the Caribbean, full vaccination coverage for children ages 18 to 29 months is 76.3% (versus 85.3% in urban areas). In Jinotega, medical care is sought for less than 60% of children with diarrhea and respiratory infections; as a result, up to 18% of children with diarrhea suffer complications, while 32.5% of respiratory infections develop into pneumonia and require hospitalization.[10] This situation contributes to infant mortality of 33 per 1,000 live births, while that rate is 12 in Managua and 17 nationwide.

1.4 **Health indicators for adolescent girls and women of child-bearing age over 20 reflect the size of the gaps in coverage and quality.** Teen pregnancy is a risk exacerbated by cultural practices of hiding the pregnancy and therefore not seeking timely prenatal care. In the regions mentioned in paragraph 1.1, the maternal mortality ratio (2012-2014) was 67 per 100,000 live births, while in 2014 the nationwide indicator stood at 37 per 100,000 live births. The sexual and reproductive health of adolescents involves specific challenges: This is an at-risk health group, with high rates of maternal mortality and of neonatal and infant mortality among its offspring. For adolescents, the fertility rate is high (rural 117 and urban 74 per 1,000), and only 36% use some form of contraceptive. Consequently, 31% are either mothers or pregnant (23% nationwide). Among women of child-bearing age over 20 in the North Caribbean, 62% use modern contraceptive methods (77% nationwide). In that region, close to 30% of pregnant women receive insufficient prenatal care (with no check-ups or fewer than the standard minimum of four), versus 12% nationwide. As far as the quality of care, 61% of deliveries are attended by medical personnel, compared to 87% nationwide. Nationwide data show that of the 54 maternal deaths that took place in 2014, 46 were due to direct obstetric causes, which are avoidable[11] with good quality of care during pregnancy and delivery.

2. Expanding coverage, access, and quality: progress of the Family and Community Health Model (MOSAFC)

1.5 The government has taken actions through the Ministry of Health (MINSA) to expand coverage of, access to, and quality of health care and reduce inequities, "prioritizing the most vulnerable sectors."[12] There is financial support for the

[9] Optional Link 1.

[10] MINSA, op. cit. footnote 8.

[11] Optional Link 1.

[12] MINSA National Health Policy, 2008, p. 5.

prioritization of these actions, as the 2016 budget for health is 2.85 times what it was in 2005, rising from 2.5% to 3.44% of GDP during that time period.[13] Total per-capita spending on health in 2013 was US$382, more than triple the amount in 2006 (US$107).[14] MINSA has five key strategies for increasing supply, expanding coverage, and improving service quality: (i) implementation of sectorization as a basis for the MOSAFC; (ii) optimization of human resources, to improve the mix of staff profiles, ages, and geographic distribution; (iii) community empowerment through involvement of volunteers (the "protagonists") as agents promoting health and health care in their communities; (iv) establishment of integrated service networks for improving care access, coordination, and continuity; and (v) use of technology for training and service management.

1.6 **Sectorization as a basis for the model.** To lay the foundation for delivering health care services, MINSA is starting with primary health care. Since its launch in 2008, MOSAFC[15] has emphasized community-based promotion and prevention, along with offering essential health services free of charge. The "sector" is the organizing unit on which primary health care is based. A "sector" is a defined geographic territory whose population is served by a community and family health team (CFHT) comprising three health care workers (a doctor, a nurse, and an assistant). CFHTs serve the population from their "headquarters," either a community base house[16] or a health post; they conduct a risk evaluation, i.e., collect families' health histories to detect health risks and update the registry of pregnant women, children under 5, and chronically ill patients. Through scheduled visits to the community, they coordinate their work with a network of advocates (volunteer workers or *brigadistas*, midwives) who conduct health promotion and detection activities. To improve coverage, MINSA is increasing the number of sectors, aiming for the population served by a CFHT to be able to reach a sector headquarters in four hours or less. This requires a significant increase in attending staff: There are currently 1.5 doctors and nurses per 1,000 inhabitants, versus 1.2 in 2005. However, in the geographic area in question for this operation, some 70% of CFHTs are incomplete, having only one or two workers. There is a deficit of more than 800 health workers for the rural CFHTs despite the progress described in the following paragraph. Also, the distances involved require frequent rotation of medical personnel, making it hard to fully staff CFHTs in these areas.

1.7 **Human resources optimization.** To meet this need, MINSA has launched a human talent optimization plan (HTOP) to foster generational turnover and redistribution of personnel according to geography and profile, with support from the Dry Corridor Region program (paragraph 1.13). The HTOP will make it possible to pay the buyouts established by MINSA's Wage and Collective

[13] Ministry of Finance and Public Credit, Informe de Liquidación del Presupuesto [Budget Settlement Report] 2005-2015.

[14] World Health Organization (WHO): www.who.int/countries/nic/en and Pan American Health Organization (PAHO), Evaluación Institucional del Sistema de Financiamiento de la Salud Nicaragüense [Institutional Evaluation of the Nicaraguan Health Financing System], 2009.

[15] MINSA. MOSAFC Documents, 2008-2010.

[16] Community base houses are simple structures in rural areas, provided to MINSA by the municipio for community health activities and where CFHTs are housed in the absence of a health post.

Bargaining Agreement for employees who have worked there for more than 20 years and are over 60 (or with 30 years employment and over 50) in exchange for their voluntary retirement. The most experienced medical personnel tend to be the most specialized, work in the secondary level, and work in urban centers. With the hiring of new staff members stalled between 1989 and 2007, leading personnel with longer tenures to be overrepresented on MINSA's payroll, making it difficult to implement the MOSAFC.[17] The payroll freed up by the HTOP enables the hiring of nurses and assistants whose profiles are more suited to the needs in rural and remote areas. The HTOP is a requirement of the MOSAFC strategy to transfer care responsibilities to personnel who are less specialized or technically oriented, some of whom may even be volunteers (paragraph 1.8). This strategy effectively increases coverage as long as the transfer includes robust, ongoing training and is accompanied by higher levels of care (paragraph 1.9).[18] The HTOP was launched in 2014, and so far more than 92% of eligible workers have accepted the buyouts. The first cohort of 662 retirees freed up salary resources that, together with the general budget increase, funded more than 2,200 new social service nursing and physician jobs in 2015, which were allocated to the CFHTs. By the end of 2016, 380 MINSA workers over the age of 50 are projected to be eligible for the HTOP. If 350 of them accept during a new round of buyouts under the HTOP between 2017 and 2020, it will make it possible to hire 500 assistants, nurses, and general practitioners for the CFHTs (Component 2, paragraph 1.20).

1.8 **The MOSAFC promotes strategies for community empowerment** that include peer counseling (for changes in behavior), identification, and start of care for and/or referral of the population by the advocates based on their knowledge of warning signs. These strategies include: (i) community health and nutrition standards, known as the Community Health and Nutrition Program (CHNP), which deals with monitoring the nutrition of pregnant women and children under 2, as well as community case management; the program was formerly known as Integrated Community Management of Childhood Illnesses (IMCI-C); (ii) community delivery of contraception that includes counseling, first-level referrals and subsequent community family planning care, and differentiated care for adolescents; and (iii) the maternity homes strategy, which offers housing to pregnant women from remote areas while they receive higher-quality prenatal checkups and access to essential obstetric and neonatal care during delivery (paragraph 1.10). The national network of maternity homes grew from 74 to 169 between 2010 and 2015 (with capacity of more than 2,000 beds), providing more than 40,000 women from rural areas institutional care during delivery in 2014 (26% of births that year).[19] The care to be supported under Component 1 (paragraphs 1.14 and 1.19) includes these three community strategies.

1.9 **The MOSAFC is an integrated network model** that seeks to foster continuity with and coordination between the community teams and the institutional network

---

[17] Optional Link 3.

[18] Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. WHO, 2013.

[19] MINSA, Op.Cit. footnote 2.

and other levels of the network.[20] MINSA staff receive community referrals and then refer or counter-refer the patient to primary-care facilities (health posts, health centers, and primary hospitals) and centers for specialized care: polyclinics, departmental and regional hospitals, and hospitals with national referral services. The health directorate in each municipio organizes services and supervises the CFHTs (at community meetings) and health center and primary hospital personnel. The municipal directorate is overseen by the General Directorate of the Local Comprehensive Health Care System (SILAIS), and the MINSA delegation in each department. The SILAIS supervises the departmental referral hospital. Consolidation of capacity to manage the network—including physically (infrastructure) and clinically (medical personnel)—is critical for proper resource distribution and for providing quality care with continuity in a timely manner. With the generational turnover in process, the sustainability of Nicaragua's model depends on forming a critical mass of managers trained in the model. MINSA is training the first cohort of physicians who are MOSAFC management specialists (80 physicians are in training). This operation would provide a shorter training period for nonspecialists on managing the model. Lastly, MINSA adapted institutional management agreements into social contracts for community health and well-being. They include identifying risks and pro-health community actions that the municipal health directorates and communities agree to carry out jointly. Component 3 would support the network's physical capacity (paragraph 1.21), while Component 4 would support management, including of the social contracts (paragraph 1.22).

1.10 Reducing maternal and neonatal morbidity and mortality requires better access to and quality of care during the preconception and prenatal periods, and especially during the perinatal period (45 days before, during, and after delivery). One third of delivery complications are not associated with risks that are detectable during pregnancy, and these complications have an impact on the mother and the baby; two thirds, meanwhile, take place during the perinatal period. Having a unit nearby that offers essential obstetric and neonatal care (EONC) is critical for avoiding the second of the so-called "three delays."[21] Thus another novel element of the MOSAFC is the concept of the primary hospital, which offers only some of the services provided in general hospitals. Their services include emergency care and EONC in a much smaller unit so that pregnant women do not have to travel more than a day from their communities. Component 1 will support care for women and children in the institutional network, including EONC (paragraphs 1.14 and 1.19), and Component 3 includes building two primary hospitals (paragraph 1.21).

1.11 **Technology to improve training and management.** MINSA is increasing the connectivity of its facilities. The Broadband Program (NI-L1090) will connect 190 health units in municipal and departmental seats by 2018. This will enable the use of information and communications technologies to efficiently meet the ongoing training requirement mentioned in paragraph 1.7. This program proposes expanding the use of virtual classrooms and access to the electronic library of technical references for health personnel even in remote postings, as

[20] Integrated Health Service Delivery Networks. PAHO 2010.

[21] Optional Link 1.

well as multiplying the number of video connections between care units so as to provide a greater number of consultations (telemedicine) and virtual training via remote observation of care procedures (paragraph 1.20).

1.12 Primary-level epidemiological and production records are not kept by name (i.e. are not nominal). This makes it more difficult to provide care (e.g. the referral and counter-referral process) and manage services (e.g. coverage estimates). MINSA's community information system, protocol, and IT system for recording community care are all nominal (registry—or management census—of children and pregnant women as monitored by the Community Health and Nutrition Program). In the municipios included in Mesoamerican Health Initiative operations and the Community Health Program in the Dry Corridor Region, the advocates have started to send census information using preset text messages from a cellular phone provided by MINSA. The scope of the system connected to the internet and via cellular phones is still very limited, and community and primary health care record-keeping is still not coordinated, thus missing an opportunity to move forward with nominalization (Optional Link 1). This operation proposes digitizing the medical records kept by CFHTs and coordinating them with the community censuses, which are already digital, thus gradually filling out CFHT records. The proposal with the community network is to expand use of cellular phone technology to improve monitoring of the health of women who are pregnant or have recently given birth and of children ages 0 to 5, thereby strengthening the ability to communicate obstetric and neonatal emergencies, Component 4 (paragraph 1.22).

3. Program rationale and lessons learned from Bank programs

1.13 The Bank has increasingly supported the health sector under the two latest country strategies, under which the following programs were successively approved:[22] (i) Improving Family and Community Health, the objective of which is to improve maternal and infant health through an innovative mechanism of transfers to MINSA per person served; the program is complemented by Mesoamerican Health Initiative operations that promote demand incentives and quality assurance; (ii) Integrated Health Care Networks 2 (IHCN) aimed at developing strategies and management standards for the MOSAFC and implementing the master plan for investing in priority SILAIS; (iii) Strengthening of Community Health and Extension of Health and Nutrition Services in Communities in the Dry Corridor Region, which supports the HTOP and the extension of community strategies in that region; and (iv) Modernization of Hospital Infrastructure and Management—West Region, which, complementing the Mesoamerican Health Initiative, supports improving quality. The map that follows shows the targeting of the portfolio. Each new operation builds an integrated program, making progress on closing gaps that restrict the financial and time scope of each individual operation, and incorporates the lessons learned. Next, we will highlight the main lessons, while Optional Link 1 presents the progress made for each operation.

[22] (i) NI-L1054 (loan 2527/BL-NI); MHI NI-G1001 and NI-G1005 (grants GRT/HE-13118 and GRT/HE-14850-NI); (ii) NI-L1068 (loan 2789/BL-NI); (iii) NI-L1081 (loan 2986/BL-NI); and (iv) NI-L1082 (loan 3306/BL-NI).

Project Targeting Map

1.14 **Transfer per person served: incentivizing coverage, targeting, and quality.** In 2012, to support extending institutional coverage of mothers and their children, the Improving Family and Community Health program launched a mechanism for making transfers to MINSA per person served. Since 2015, this has been applied to community strategies in targeted municipios in the Dry Corridor Region. In both programs, the eligible expenditure is the transfer to MINSA for each person served, while the output is the care effectively provided. This is in contrast to traditional financing mechanisms in which the eligible expenditure covers inputs for care without any service necessarily being provided. The new mechanism ensures effective coverage, as the transfer is made upon nominal registration of care, known as "tracer" indicators. These elements—part of a package of services—are once a year events (e.g. "third dose of pentavalent vaccine"). Thus the mechanism in particular incentivizes provision of tracer services, which also must meet certain quality standards: The payment is therefore only made on registration of timely early prenatal checkups or care during delivery in facilities that offer EONC. Between 2012 and 2014, the Improving Family and Community Health Program achieved a 47% increase in coverage of deliveries in units offering EONC in the priority area, thanks to the synergy with the IHCN under which eight maternity homes, nine health posts and health centers, and five new primary hospitals were delivered in that area during that period, and three referral hospitals were rehabilitated. The evaluation of the Mesoamerican Health Initiative reports gains in quality[23] as a result of that synergy: from early 2013 to late 2014, the percentage of primary units in the area with all the supplies required by child care standards rose from 63% to 100% (Optional Link 1). In this operation, a new tracer would break down community delivery of contraceptives between adolescents and adults, allocating greater financing for the former

[23] Nicaragua Report. Survey at 18 months. Mesoamerican Health Initiative 2015.

(paragraph 1.4). Coverage is verified through a semiannual performance evaluation that, in addition to confirming that the services were provided, assesses their quality. This operation would take advantage of this evaluation to generate plans for improving care, making it a "teaching" evaluation.

1.15 The Bank's financing is incremental: it consists of a percentage of the total cost of care, equal to or less than the financial gap required to expand existing coverage at the start of the program. As the per-person cost is covered partially, the financing is an incentive for MINSA to channel its own resources toward prioritizing highly cost-effective care and toward areas of greatest need. This operation proposes consolidating the institutional and community package of care for women and children and moving forward in the mechanism's targeting and sustainability, as the percentage of financing will be differentiated between municipios based on their initial coverage levels and will decrease over time (paragraph 1.19).

1.16 **Coverage and quality are necessary for effectiveness and also require integration of interventions.** Explicit mechanisms are thus needed for establishing multidisciplinary teams at all levels to ensure integrity, both for implementation (paragraphs 2.4 and 3.1) and in the interventions themselves: for example, in applying an environmental perspective during preinvestment or investment maintenance, or in the efforts to ensure continuous quality improvement. This operation therefore includes environmental management, fighting epidemics, and gender inclusion as crosscutting issues, with interventions or a perspective integrated across all components,[24] and considers MOSAFC management an explicit component.

1.17 **Strategic alignment and intervention strategy.** The Country Strategy with Nicaragua 2012-2017 (document GN-2683) prioritizes reducing chronic malnutrition in children under 3 and maternal and neonatal mortality in poor rural areas. It proposes consolidating and adjusting interventions by integrating the experience of preceding operations to contribute to these goals by: (i) broadening coverage of community and institutional reproductive health services and services for children under 5; (ii) improving access by redistributing staff; (iii) building, refurbishing, and equipping primary care facilities; and (iv) strengthening the technical and management capacities of health services. The program is consistent with the Update to the Institutional Strategy 2010–2020 (document GN-2788-5) and aligned with the social inclusion and equality development challenge through the Corporate Results Framework indicators on reducing maternal and infant mortality and increasing the indicator of number of people benefiting from health services. The program is also in line with the crosscutting area of gender equality and diversity, especially through health promotion for adolescents in a framework of rights and equality, as it is expected to improve access to health information and education and services for adolescents to thereby lower the teen pregnancy rate. The selection of integrated, cost-effective interventions and the support for community health

[24] For example, a reserve for contingencies would enable it to respond quickly to emergency situations without disrupting the project structure, SILAIS and municipio capacity-building, provision of equipment for hazardous waste disposal, implementation of maintenance plans (to streamline water and power use), and strengthening local environmental management.

considerations and the integrated primary health care-based network in the MOSAFCs are fully consistent with the Health and Nutrition Sector Framework Document (document GN-2735-3).

B. Objectives, components, and cost

1.18 The objective of this operation is to reduce health disparities and accelerate reductions in maternal and infant morbidity and mortality in priority SILAIS in the North Caribbean, Jinotega, Matagalpa, and the Dry Corridor Region, specifically by expanding and improving access to and coverage of high-quality health care and promotion services under the MOSAFC. The beneficiary population is 1,857,000 people, including 481,000 women of child-bearing age and 378,000 children under 6.

1.19 **Component 1. Expanding community and first-level care (US$12,705,062).** This component will support 54 priority municipios in extending care packages to the community including risk assessment, community delivery of contraception and the CHNP (paragraph 1.8), as well as maternal-child services in the institutional network (paragraph 1.9), all while monitoring quality (paragraphs 1.22 and 3.6). The interventions to monitor pregnant women and promote infant nutrition are key for reducing the risk of developing chronic NCDs in later years, and conducting risk assessments on families will increase the availability of care for patients with chronic illnesses. As described in paragraph 1.13, financing will be provided in the form of a fixed transfer per person served, paid out based on records of tracer care for the direct beneficiary population of women of child-bearing age (including adolescents) and children under 6. The Economic Analysis details the specific care and cost. Optional Link 5 includes the Coverage Expansion Manual (draft), which establishes the percentage of the total cost that will be financed (between 15% and 30%, declining over time and differentiated by municipio) and will be an integral part of the Operating Regulations (paragraph 3.1). The average per-patient cost per year is estimated at US$31.32 per woman of child-bearing age and US$37.12 per child.

1.20 **Component 2. Development of human talent for health care expansion and quality (US$8,620,250).** To further sectorize and follow up on the Dry Corridor Region Program, this component will finance the continuation of the HTOP to maintain the buyout offers to eligible workers (paragraph 1.7 and Optional Link 3), reaching an estimated 350 workers. It will also finance the training of 500 additional health aids and refresher training for physicians and community personnel by using innovative virtual classroom methods. This will improve the network's response capacity and the quality of care as the component addresses a dimension (staff training) not covered by the per-capita funding of the first component. The training of primary network attending staff in care standards and protocols will be supported, with emphasis on: (i) child and reproductive health; (ii) chronic NCD care through risk assessment and CFHT monitoring of chronic patients; (iii) public health, with a focus on dengue, chikungunya, and zika, emphasizing messages targeted at pregnant women—infection prevention—and timely detection of complications; and (iv) MOSAFC management by municipal directorate personnel. This component also includes training for the advocates in health promotion, environmental management, and community hygiene. These

interventions, in synergy with the first and third components, promote use and improve response capacity, by enabling expansion of quality services.

1.21 **Component 3. Improving the physical capacity of departmental service networks[25] (US$16,116,000).** Complementary to strengthening human resources and to provide continuity to the IHCN program, the following will be financed in the same locations as the first component: (i) replacement of two primary hospitals currently operating with sub-standard infrastructure;[26] (ii) renovation of approximately 100 community institutions known as *casas bases* into sector headquarters to meet the sectors' urgent needs stemming from reorganization of the sectors (paragraph 1.6); (iii) equipping of up to 50 primary units with a full cold storage network to ensure the quality and effectiveness of the vaccines administered; (iv) equipping 20 critical primary units with for diagnostic capacity to increase availability of care, especially in remote areas far from secondary-level units, as well as for monitoring of and response to epidemic outbreaks; (v) light modes of transportation (motorcycles and boats) in the 54 municipal networks to ensure personnel located in the municipio center can support CFHTs and advocates; and (vi) equipping five regional networks for handling and disposal of hazardous waste. With counterpart resources, Nicaragua will finance the annual plan for maintaining these investments and the projects delivered under the IHCN program. These actions will strengthen the service infrastructure network and consolidate sectorization.

1.22 **Component 4. Strengthening MOSAFC management (US$3,052,566).** This component seeks to have an impact on the organizational capacity of the services and the quality assurance of priority SILAIS, with an emphasis on the municipal directorates and their support for CFHTs and advocates, highlighting: (i) the strengthening of community management, supporting the standardization of community meetings, expanding signature of the Community Social Contracts, and providing support with educational materials and safety equipment, as well as community hygiene actions; (ii) the development and gradual implementation of the ambulatory care records based on information from the community censuses, enabling digitalization and nominalization of the information starting from identification of the local population, for which purposes technical assistance, pre-programmed mobile messaging devises for protagonists, and tablets for the CFHTs will all be financed. The expectation is that by the end of the operation it will be covering 10 sectors of each municipio; (iii) implementation by municipal directorates of the primary-level quality assurance strategy;[27] (iv) the primary-level implementation of the automated inputs management system called "el Galeno,"[28] currently used in hospitals; (v) implementation of environmental management plans by municipal directorates supporting the training of those responsible for environmental management (among current staff), and the provision of material for signage and waste classification (among other things) in

[25] Optional Link 5 includes a description of the scope of the projects.

[26] MINSA has prioritized the Quilalí primary hospital for 2017, while for 2018 it is looking at replacing the primary hospitals in Jalapa, Waslala, Wiwilí, and Waspan. All of these are in priority areas, and their replacement is justified based on their current conditions and on demand.

[27] Developed under the Mesoamerican Health Initiative, paragraph 1.16.

[28] Automated inventory management system implemented by MINSA in 2015.

primary-level units; and (vi) the external performance evaluation of the program will also be financed. This will cover training, as well as certification of care provided and evaluation of care quality, and with this evaluation the management cycle will conclude (paragraph 3.6).

1.23 An additional US$4,506,122 for other costs completes the financing (Table II.1 and Multiyear Execution Plan). They include: (i) **a reserve fund for handling health emergencies** (for events that are unexpected prior to activation). The reserve fund is designed to contain the impact of epidemic outbreaks or other health emergencies beyond the efforts to strengthen the healthcare system. It can be activated only once per calendar year and up to five times over the life of the program to finance prevention or control actions once signs of emergency risk have been detected, with up to US$200,000 used in each instance. Procedures are spelled out in Annex III, and mechanisms for use will be detailed in the Health Emergency Response Manual (annex to the Operating Regulations, paragraph 3.1); (ii) administration costs and additional personnel, as detailed in the Management Safeguards Plan (paragraphs 2.4 and 3.1); (iii) financing costs; and (iv) other contingencies.

C. Key outcome indicators

1.24 **The Results Matrix** includes indicators of the impact on the health of children under 5, adolescents, and men and women of reproductive age. For children, the focus will be reducing malnutrition and hospitalization due to severe complications from diarrhea and respiratory infections (pneumonia). In addition to improving the health of their mothers, the impact on children will be accomplished through an increase in primary care services coverage, including implementing the vaccination program and by monitoring growth and development. The impact on women's health is achieved by improving access to primary sexual and reproductive health services; greater availability and quality of information and education for adolescents on sexual rights and availability of health services tailored to that age group. The impact will be reflected in a reduced teen pregnancy rate and a sustained reduction in maternal mortality attributable to direct obstetric causes thanks to a reduction of barriers to access and improvement of the quality of care of institutional delivery (safe motherhood). The package includes care that is known to be effective at reducing maternal and neonatal mortality and severe childhood morbidity, as well as at reducing risk of chronic NCDs in adulthood by providing proper metabolic development during childhood. Strengthening community and institutional management will enable risk reduction and mitigate the impact of any health emergencies, thus sustaining essential services coverage.

1.25 **In the Economic Analysis**, the expected gains from extending essential care to the target population for four years—projected using data and a methodology from the World Health Organization—were estimated at 858,000 disability-adjusted life years (DALY) at an estimated cost of US$112 per DALY gained. Compared with other progams to increase coverage or with per-capita GDP in Nicaragua, this cost seems an affordable investment for the country.

II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing instruments

2.1 The program is financed through an investment loan of US$45 million drawn from the Ordinary Capital (60%) and the Fund for Special Operations (40%). The Government of Nicaragua will continue contributing treasury resources through the general budget of the Republic for an estimated US$57.7 million to finish covering the cost of care in the priority area during the program period, as well as US$483,480 to finance the maintenance of the investments financed under this operation and under the IHCN program. The total cost of the program is US$103.2 million. The treasury resources in this first component will be reported as counterpart funds (necessary for delivering the corresponding outputs) but will not be included in the financial statements, nor will they be included in the scope of the external financial audit, as both the total cost of care and the care provided will be verified. This will provide proof that the complementary portion of the cost will have been covered by additional MINSA resources (audited within the budget). **As a special contractual condition precedent to the first disbursement of Component 1, MINSA will have agreed with the Bank on the amount of financing per person served during the first year,** and annually, as a condition of execution, agreed upon the update of that amount based on a review of actual costs.

Table II.1. Summary of Costs Table

Components / Subcomponents	IDB	%	Government of Nicaragua	Total
1. Expansion of primary-level and community care	12,705,062	28	57,750,282	70,455,344
2. Development of human talent for health care expansion and improved quality	8,620,250	19		8,620,250
Buy-outs for voluntary retirements	5,600,000			
Training	3,020,250			
3. Improving the physical capacity of departmental service networks	16,116,000	36	483,480	16,599,480
Improvements to primary units	14,616,000			
Waste disposal equipment	1,500,000			
Maintenance			483,480	
4. Strengthening MOSAFC management	3,052,566	7		3,052,566
Other costs	4,506,122			4,506,122
Administration (includes additional personnel)	1,477,000	3		
Contingencies (includes reserve for health emergencies)	1,904,122	4		
Finance charges	1,125,000	3		
	45,000,000	**100**	**58,233,762**	**103,233,762**

B. Environmental and social risks

2.2 In accordance with the Environment and Safeguards Compliance Policy (document OP-703)—Directive B.03—this is classified as a category B operation, as the potential negative impacts and socioenvironmental risks are localized and short-term, and the mitigation measures are well understood and easy to

implement. The most relevant socioenvironmental risks are related to the operations stage of the primary hospitals as follows: greater demand for power and potable water, water quality, and sanitation; effluent discharge from the hospital; generation of hazardous solid waste from hospitals; and occupational health and safety for employees, patients, and visitors. The Social and Environmental Analysis has been presented, and its results can be found in the Environmental and Social Management Report (ESMR). The Operating Regulations' annexes will include the ESMR. **The loan agreement will include the following as special contractual conditions precedent to the first disbursement: (i) MINSA has effectively complied with the Environmental Management System and the Environmental Management Framework, designed under the IHCN program; and (ii) MINSA has complied with the corrective action plan agreed upon during environmental supervision (April 2016) of that program** (Annex 1 of the ESMR), focused on accelerating implementation of measures for hospital waste disposal set forth therein. As a special condition of execution, MINSA will present evidence once every six months that it has complied with the actions set forth in Section VI of the ESMR by the agreed-upon dates. The operation does not involve the resettlement of persons or economic displacement during construction of the works; should such a situation arise, an Involuntary Resettlement and Compensation Plan will be implemented in keeping with the Involuntary Resettlement Policy (OP-710).

C. Fiduciary risks

2.3 The most recent review (September 2015) of procurement under the operations being executed confirms that MINSA's management of the processes is generally satisfactory, permitting as it does the procurement of goods and works contracted through national competitive bidding or price comparison, with competitive contracting of individual consultants, subject to ex post review. The program requires procurement processes of medium complexity, mainly for Component 3's works and equipment. However, the personnel dedicated to executing the procurement plans of a growing portfolio of Bank financing do not seem sufficient in terms of their number or experience with donor policies, and they are not organized in a way that allows them to consolidate implementation experience between operations. With regard to financial capacity, a review was carried out under the Institutional Capacity Assessment System in late 2011. Its results have been reviewed and updated under the 2015 fiduciary supervision plan. Additionally, semiannual reviews have been conducted, along with reviews of the external audit of the operations in execution, as MINSA has a low level of financial management risk. Disbursements will therefore be reviewed ex post, while advances of funds can be made to cover real liquidity needs for periods of up to six months. The organization of the External Funding Coordination Unit should also be improved. This unit is involved in the financial management of the programs and ensures proper allocation of personnel and systemic application of the mechanisms agreed upon in the Operating Regulations and its annexes, including the Management Safeguards Plan (paragraph 3.1). Overall fiduciary risk is considered medium.

D. Other project risks

2.4 The portfolio of programs in MINSA has grown in volume and complexity and requires coordination of many areas. The implementation scheme is based on institutional structures (with no ad hoc unit), an element that favors sustainability. This puts pressure on implementation timing, especially because the government is trying to control allocation of centrally located and administrative staff, making it increasingly difficult for MINSA to maintain the quality of execution so far achieved. To mitigate this situation, paragraph 3.1 describes the measures established in the Management Safeguards Plan, such as allocation of additional full-time staff, as stipulated in the Operating Regulations, in order to build a multidisciplinary team comprising different institutional areas.

2.5 The HTOP is a key element for institutional reform of MINSA, as it enables more and better care with the same payroll, following the community model. However, it does involve the same risks inherent to any retirement program. In 2013, the HTOP Implementation Manual was approved as an annex to the Operating Regulations to ensure orderly and transparent execution. In order to avoid more employees applying than could be covered by the financing, the manual stipulates proceeding by inviting certain cohorts in descending order by age and time employed. The Manual has supported successful execution between 2013 and 2015, with more than 92% of invited candidates accepting the buyout, even though the voluntary retirement and severance (via full and immediate payment) were the same as found in the Collective Bargaining Agreement. As a condition of execution, when presenting expenses related to the HTOP buyouts, MINSA must include evidence that the retirements occured in accordance with the regulations and procedures established in the Operating Regulations.

2.6 As far as sustainability, financing buyouts under the HTOP is justified because it is a temporary expenditure necessary for accomplishing the program's objective. When liquid resources are not available, MINSA will continue to honor its obligations to aspiring retirees by making the payments in installments, as it did prior to 2013. But by retiring a large cohort and maintaining the sector's growth, the relative weight of those over 50 will not return to pre-HTOP levels.[29] The analysis of the HTOP's impact on the health budget and on the Nicaraguan Social Security Institute (INSS) was updated, as it could present a fiscal risk. Assuming that 350 people will retire on top of the 2,000 that retired from 2013 to 2016, the plan will have produced savings for the health budget by enabling the hiring of staff with no seniority. Savings are estimated at more than US$3.6 million in 2017, while the increase in INSS expenditures due to payment of pensions for retirees over 60[30] during that same time would be between US$4.6 million and US$6.8 million, resulting in a net impact of between US$1 million and US$3.2 million for that year, equivalent to between 0.25% and 0.8% of public spending on health in 2015.

2.7 Regarding Component 1, its annual financing is equivalent to 0.7% of the institutional budget, while the investments under Component 3 to extend the network of primary-care units and expand the sectors will involve an increase in

[29] Ibid.

[30] Ibid.

expenditures on staff, operations, and primary healthcare inputs. The impact of this program on the budget would be around 1.4%, far less than the annual increase of more than 5% approved in the Medium-term Budget Framework for the next three-year period.[31] The interventions will improve efficiency and contain the increase in expenditures, as more extensive coverage of effective community and basic services reduces hospitalizations, especially preventable ones.[32] Likewise, optimizing human resources will increase productivity in priority areas (paragraph 1.7).

2.8 The risk that financing with national resources for beneficiary municipios is displaced by external financing is avoided because the financing is partial. This enables mobilization of fiscal resources to muncipios where MINSA will receive additional resources. Monitoring will be conducted to ensure aggregate fiscal financing does not decline. As a special contractual condition of execution, prior to 31 March of each year, MINSA will submit its resources programming for that year and the execution report on health promotion and disease prevention and first-level care activities from the previous year's budget of the Republic, broken down at the municipal level for the 54 priority municipios and at the SILAIS level for the rest of the country. Finally, the risk of staff turnover in remote areas, which mainly affects medical staff, will be mitigated by recruiting and training the new staff locally from the time they are being trained and through the strategy on transferring responsibilities.[33]

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of implementation arrangements

3.1 The disbursement period will be five years starting from the entry into force of the contract.[34] MINSA is the program's executing agency. The External Cooperation Office will handle the general coordination of the programs, with support from the corresponding directorates, the general administrative, financial, and procurement divisions, and the SILAIS. The Operating Regulations for operations with IDB financing establish mechanisms for timely execution, including monitoring every 15 days of the annual work plan by the operating committee, as well as the assignation of a technical adviser. As an annex to the Operating Regulations, the Management Safeguards Plan defines the minimum required technical and fiduciary team (including the technical adviser) to be contracted as incremental staff using resources from this operation to ensure they are working full-time on this project (paragraph 2.4). The following should also be included with the Operating Regulations as annexes: The Health Emergency Response Manual (paragraph 1.23), the HTOP Implementation Manual (updated, paragraph 2.5), including the update of the current Wage and Collective Bargaining Agreement, the Coverage Expansion Manual (paragraph 1.19), the ESMR and Environmental

[31] Year-on-year growth 2016, 2017, and 2018, in current U.S. dollars: 4.85% and 5.36%. Ministry of Finance.

[32] Optional Link 1.

[33] Optional Link 3.

[34] Execution of the first component is expected to take four years, with an additional year to cover the period up until project eligibility and closing.

Management Framework (paragraph 2.2). **As a special contractual condition precedent to the first disbursement, MINSA will present evidence that it has approved the Operating Regulations previously agreed upon with the Bank and they are in force, together with all its updated annexes; any change to the annexes of the Operating Regulations will be agreed upon beforehand with the Bank. It will demonstrate that it has the additional staff to comprise the minimum technical-operational support team working full-time on execution of Bank-financed programs.** Optional Link 5 presents the Annotated Table of Contents and content relevant to the Operating Regulations in force. As a special condition of execution, MINSA will present evidence once every six months that it has complied with the requirements of the Management Safeguards Plan in force and agreed on updates to that plan. If during one six-month period the Bank and the borrower determine that the Management Safeguards Plan has substantially not been followed, this operation will be placed on alert status.

3.2 **Procurement and financial management.** The program will be implemented according to a procurement plan managed through the Procurement Plan Execution System. It will be governed by the policies on the procurement of works and goods financed by the IDB and the policies on selection and contracting of consultants financed by the IDB (documents GN-2349-9 and GN-2350-9). The thresholds indicated in Annex III, which details anticipated operating expenses, will apply. MINSA will negotiate the amount of the operating expenses related to connectivity and telephony services for keeping records of community care with the company or companies that offer coverage in the priority areas.

3.3 Annex III also indicates that single-source selection is expected: (i) for continuation of the services of the auditing firm engaged in 2015 to audit the financial statements of the operations with IDB financing, pursuant to paragraph 3.1(a) of document GN-2350-9; and (ii) of the Pan American Health Organization as a specialized agency for the external performance evaluation of the program, in consideration of the exceptional value of its experience certifying coverage of services and its epidemiological advisory services (paragraph 3.1(d)).

3.4 MINSA will use the SIGFAPRO country systems for financial execution of the program and SISCAE to disseminate the contracting processes. MINSA will receive advances sufficient to cover projected disbursements for the period of up to six months following the advance, pursuant to the financial plan in force. For Component 1, MINSA will present a breakdown of the expenditures from the disbursement requests in the form of an accounting of the total number of people served for each tracer indicator, broken down by municipio. The expenditures made with resources from these transfers must be recorded. The ex post review of the disbursements will analyze the eligibility of the expenditures made with resources from the financing according to whether: (i) they were made for reasons predefined as eligible; and (ii) in the case of Component 1, they indicate that an eligible municipio was the object of the expenditure. The financial audit will be annual and its scope will be agreed upon based on the results of the financial oversight.

B. Summary of arrangements for monitoring results

3.5 MINSA will prepare the annual work plans on the structure of the outputs stipulated in the Results Matrix and Multiyear Execution Plan as well as the structure for managing the program, the quarterly progress reports, and the semiannual reports (Monitoring and Evaluation Arrangements and Operating Regulations). The semiannual reports will describe the achievements and progress in extending coverage, the optimization of human resources and improvement of care capacity, the physical investment, and the improvement in management capacity. They will also suggest challenges for the next six-month period and updates to the next semiannual or annual plan.

3.6 **External performance evaluation. As a special contractual condition precedent to the first disbursement of Component 1, MINSA will present evidence that it has the Bank's no objection to hiring the evaluator who will conduct the external performance evaluation, with the objective of certifying the volume and quality of care reported under that component.** The evaluation will compare a sample of aggregated service data reported to the IDB by MINSA against primary-source information broken down by individual interactions, complementing this information with community surveys and observation. In the event of consolidation errors, adjustments will be made where necessary in the rationale for the advance. Once per year, the performance evaluation will include an assessment of the quality of the services financed per capita, conducted via observation, surveys of the population, and other means, in line with the quality assurance operating strategy. Finally, based on an analysis of that information, the contracted entity will propose improvement plans consistent with said quality strategy (paragraphs 1.14 and 1.16). The terms of reference of the external performance evaluation will be annexed to the Operating Regulations.

3.7 Resources from the loan will be used to finance an **independent reflexive evaluation** that will consist of a midterm evaluation five semesters after eligibility, along with a second evaluation nine semesters from eligibility. The objective is to document program outcomes according to the Results Matrix and go into more depth on the factors influencing performance. Given that the effectiveness of the selected interventions has been demonstrated, the emphasis is on documenting the quality of the implementation while at the same time verifying the trustworthiness of the records and estimating outcomes in the area in contrast to nationwide levels. The evaluation will use official statistics on morbidity and mortality in the beneficiary municipios and for the nation as a whole; reports and additional information from MINSA; data collected independently during the performance evaluation; and additional quantitative and qualitative information. Starting with the midterm evaluation report, the IDB and MINSA will agree on corrective actions or adjustments to the Results Matrix that will contribute to reaching the corresponding targets during the rest of the program. The final evaluation will document achieving the agreed-upon impact targets, placing this in the context of lessons learned on the factors that influenced performance, to be shared at program close. Likewise, it will include a re-calculation of the impact in terms of DALY that can be associated with the coverage progress documented at the time (ex post evaluation of cost effectiveness).

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity**		
Regional Context Indicators			
Country Development Results Indicators	**-Beneficiaries receiving health services (#)***		
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2683**	**Reduce chronic malnutrition among children in the 1,000 day window in poor rural and urban fringe communities.**	
Country Program Results Matrix	**GN-2849**	**The intervention is included in the 2016 Operational Program.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	**Evaluable**	**Weight**	**Maximum Score**
	8.7		**10**
3. Evidence-based Assessment & Solution	**10.0**	**33.33%**	**10**
3.1 Program Diagnosis	**3.0**		
3.2 Proposed Interventions or Solutions	**4.0**		
3.3 Results Matrix Quality	**3.0**		
4. Ex ante Economic Analysis	**8.8**	**33.33%**	**10**
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	**4.0**		
4.2 Identified and Quantified Benefits	**2.4**		
4.3 Identified and Quantified Costs	**1.2**		
4.4 Reasonable Assumptions	**1.2**		
4.5 Sensitivity Analysis	**0.0**		
5. Monitoring and Evaluation	**7.3**	**33.33%**	**10**
5.1 Monitoring Mechanisms	**2.5**		
5.2 Evaluation Plan	**4.8**		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Low**		
Identified risks have been rated for magnitude and likelihood	**Yes**		
Mitigation measures have been identified for major risks	**Yes**		
Mitigation measures have indicators for tracking their implementation	**Yes**		
Environmental & social risk classification	**B**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	**Yes**	**Financial Management: Budget, Accounting and Reporting. Procurement: Information System, Contracting individual consultant.**	
Non-Fiduciary	**Yes**	**Environmental Assessment National System.**	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project			
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan			

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The objective of the project is to reduce health disparities and accelerate the reduction of morbidity and maternal and infant mortality in prioritized Local Systems of Comprehensive Health Care (SILAIS) in the North Caribbean, Jinotega, Matagalpa and Corredor Seco. Specifically, the project seeks to attain these objectives by expanding and improving access and coverage of health promotion and health care quality under the Family and Community Health Model (MOSAFC). In order to achieve this, the program performs a series of activities focused on expanding health care at the community level; the development of human resources; the improvement of physical equipment of departmental service networks; and strengthening the management of the MOSAFC. The program is expected to benefit 1.85 million people, including 481,000 women of childbearing age and 378,000 children under six years in the prioritized regions.

The logical framework presented is consistent, covering inputs, outputs, outcomes and impact. The results matrix includes indicators for major outputs, outcomes and impacts of the program. The indicators in the results matrix meet the SMART criteria and include baseline and target values. Final impact indicators to capture the improvement in the nutritional status of children include the percentage of children under five suffering from chronic malnutrition and anemia. Severe impacts on morbidity in childhood will be measured by the rate of hospitalization for diarrheal disease and pneumonia in children under five years. Maternal mortality and unwanted pregnancies are measured with a three-year maternal mortality indicator and the teen birth rate.

An economic analysis of cost-effectiveness was made, calculating the effectiveness of the program in terms of years of disability adjusted life. Monitoring of the results of the program will be implemented by the Ministry in coordination with the Bank, and external evaluations will be also conducted. The monitoring and evaluation activities have been budgeted and planned. Data sources for monitoring include administrative systems of the Ministry and semiannual progress reports. In addition, the program plans a midterm reflexive external evaluation without attribution, and another one at the end of the project.

RESULTS MATRIX

Program objective	Reduce health disparities and accelerate reductions in maternal and child morbidity and mortality in priority Local Comprehensive Health Care Systems (SILAIS) in the North Caribbean, Jinotega, Matagalpa, and the Dry Corridor Region, specifically by broadening and improving access to and coverage of high-quality health promotion and health care services under the family and community health model (MOSAFC).

EXPECTED IMPACT [1]

Indicator	Unit of measure	Baseline		Targets		Means of verification	Observations[2]
		Value	Year	Value	Year		
EXPECTED IMPACT: Improvements in child nutrition.							***Targets related to the priority SILAIS unless otherwise indicated***
Chronically malnourished children under 5.	Percent	20.3	2011-2012	17.2	2020	Integrated Nutritional Surveillance System (SIVIN) ENDESA[3]	The Demographic and Health Survey (ENDESA) reflects the year or years in which data were collected, thus the baseline is 2011-2012.
Children under 5 with anemia	Percent	38.8	2013	23.8	2020	Mesoamerican Health Initiative (MHI) evaluations SIVIN Final evaluation	Baseline from MHI.
Reductions in severe childhood morbidity							
Hospitalization for acute diarrhea in children under 5.	Rate per 1,000 children under 5	8.34	2014	7	2020	National Statistics Office (ONE) - MINSA	
Hospitalization for pneumonia in children under 5.	Rate per 1,000 children under 5	19.24	2014	12.7	2020	ONE-MINSA	
Reduced maternal mortality							
Maternal mortality over a three-year period	Deaths per 100,000 live births	43	2014 (2012-2014)	39	2020 (2018-2020)	MINSA	Three-year indicator: final year indicated (average for three-year range).
Reduced unwanted pregnancies							
Teen births	Rate (%)	24.3	2011-2012	19.6	2020	ENDESA	

[1] Optional Link 1 (Theory of change) describes the evidence underlying the targets and their order of magnitude.

[2] The Monitoring and Evaluation Plan lays out the definitions and formulas for the indicators.

[3] National Development Information Institute (INIDE), Encuesta Nicaragüense de Demografía y Salud [Nicaraguan Demographic and Health Survey] (ENDESA) 2011/12 Final Report.

EXPECTED OUTCOMES[1]

Indicator	Unit of measure	Baseline		Intermediate		Final target		Means of verification	Observations
		Value	Year	Value	Year	Value	Year		
EXPECTED OUTCOME: Increased access to sexual and reproductive health and safe motherhood									
Births in a facility that offers emergency obstetric care.	Percent (%)	71	2015	73.5	2018	76	2020	ONE-MINSA ENDESA	The baseline data for "institutional delivery" includes facilities that do NOT have EONC.
Women of child-bearing age with unmet family planning needs.	%	14	2011-2012			11	2020	Final evaluation. ENDESA	Baseline from ENDESA.
Access to health information, education, and services for adolescents									
Adolescent women of child-bearing age in a relationship with contraception needs met.	%	89	2011-2012			92	2020	Final evaluation. ENDESA	
Increased primary care coverage for children									
Children ages 19 to 29 months with age-appropriate vaccinations complete.	%	87	2011-2012			87	2020	ENDESA Final evaluation	The age range is aligned with ENDESA measurements.
Children under 24 months served by community nutritional monitoring.	%	11	2015	16.7	2018	22	2020	External performance evaluation	The baseline is for the Dry Corridor Region.
Children ages 6 to 24 months who received daily micronutrients for two months during the biological year.	%	13.8	2011			18.9	2020	External performance evaluation	Baseline estimated using data on vitamin A supplementation in rural areas (ENDESA).
Primary-care staff assigned to rural areas and community network expanded									
Gap in staff assigned to the Community and Family Health Team in the priority SILAIS.	%	20.31	2015			11.70	2020	MINSA (DGRRHH / DGSS / DGPD)	

OUTPUTS

Outputs[4]	Unit of measure	Year 1 2017	Year 2 2018	Year 3 2019	Year 4 2020	Year 5 2021	Final target[5]	Means of verification[(6)]
Component I: Expansion of community and primary care in priority municipios								
1.1 Families with health history updated during the reporting period.*	Families	21,346	60,355	66,390	73,029		73,029	Monthly reports of municipal directorates validated by SILAIS, General Directorate of Health Services, and Office of Planning.
1.2 Adolescents who are provided with a method included in the community delivery of contraception (CDC) strategy.*	Adolescents	4,047	5,881	6,266	6,401		6,401	
1.3 Men and women of child-bearing age over 20 who are provided with a method under CDC.*	Men and women	33,504	90,992	93,950	10,485		10,485	
1.4 Pregnant women and women who have recently given birth in the priority municipios provided with monitoring and nutritional counseling under the standards of the Community Health and Nutrition Program (CHNP).*	Pregnant women and women who recently gave birth	5,983	9,317	15,322	20,368		20,368	
1.5 Pregnant women who received their first prenatal checkup in the first trimester.*	Pregnant women	25,926	30,281	39,837	47,525		47,525	
1.6 Live births in health units that offer essential obstetric and neonatal care.*	Live births	23,312	27,566	32,384	38,116		38,116	
1.7 Women discharged from a maternity home who received a newborn visit.*	Women	15,794	23,087	32,027	35,095		35,095	
1.8 Women with nearby access to post-natal care.*		24,074	29,383	41,414	46,793		46,793	
1.9 Children under 2 provided with monitoring and monthly nutritional counseling according to the CHNP.*	Children	11,283	17,101	19,307	21,408		21,408	
1.10. Children under 1 who receive their third dose of the pentavalent vaccine.*		27,381	35,982	35,855	35,420		35,420	
1.11 Children under 5 who receive care and/or referrals for illnesses, according to the CHNP.*		256,255	346,901	347,506	348,038		348,038	
1.12 Children ages 1 to 4 who received their second growth and development promotion and monitoring (VPCD) visit of the year.		85,418	122,861	137,554	145,016		145,016	

[4] **Outputs 1.2, 1.3, 1.6, 1.10, and 1.12 contribute to the Corporate Results Framework target of persons benefiting from health services.**

[5] **The annual targets of the outputs marked with an asterisk (*) reflect progress in production levels and should not be added together.**

[6] Delivery documents (works, goods) or final report (training and technical assistance), unless otherwise indicated.

Outputs[4]	Unit of measure	Year 1 2017	Year 2 2018	Year 3 2019	Year 4 2020	Year 5 2021	Final target[5]	Means of verification[(6)]
Component II: Development of human talent for health care expansion and improved quality								
2.1 Eligible workers covered by the Retirement Plan.	Workers	350					350	Buyout report (see POD, paragraph 2.7).
2.2 Technical staff trained for the CFHTs.	Technical staff			250	250		500	
2.3 Health staff trained on standards and manuals for service delivery.	Health staff	225	200	200	200		825	
2.4 Advocates trained on community health strategies	Advocates	800	1,200	1,800	1,084		4,884	
2.5 Management staff in the field certified in service management.	Management staff	84	27	27	27		165	
2.6 Staff trained/certified in environmental management.	Health staff	80	40	10			130	
Component III: Improving the physical capacity of departmental service networks								
3.1 Remodeled health centers	Health centers		4				4	
3.2 Posts built and remodeled	Health posts		4	4			8	
3.3 Community institutions (*casas bases*) established.	Community institutions	30	50	20			100%	
3.4 Maternity homes expanded, remodeled, or replaced.	Maternity homes		3	2			5	
3.5 Primary units with cold storage equipment completed.	Primary units	20	20				40	
3.6 Primary units equipped to improve diagnoses.		15					15	
3.7. Municipal networks provided with means of transportation for implementing the MOSAFC.	Municipal networks	23	31				54	
3.8 First primary hospital in operation	Hospital			1			1	
3.8.1 First hospital built			1				1	
3.8.2 First hospital equipped				1			1	
3.9 Second primary hospital in operation					1		1	
3.8.1 Second hospital built				1			1	
3.8.2 Second hospital equipped					1		1	
3.10 Regional networks provided with equipment to improve handling and disposal of hospital waste.	Regional networks		5				5	
3.11 Annual maintenance plan for primary-level infrastructure implemented.	Plans		1	1	1	1	4	
Component IV: Strengthening the MOSAFC management component								
4.1 Sectors that implement the community management strengthening plan*	Sectors	23	54	54	54	54	54	
4.1.1 Community meetings held	Meetings	300	528	528	528	150	2,034	
4.1.2 Technical visits to aid with community management (from the municipio to sectors and communities)	Visits	1,200	2,000	3,000	4,000	1,000	11,200	
4.1.3 Sectors implementing the community health and environmental sanitation plan	Sectors	100	360	475	700	1,000	2,635	

Outputs[4]	Unit of measure	Year 1 2017	Year 2 2018	Year 3 2019	Year 4 2020	Year 5 2021	Final target[5]	Means of verification[(6)]
4.2 Sectors that report their production digitally*	Sectors	8	120	230	380	540	540	
4.2.1 Standards for sector-level statistical record-keeping adjusted to strengthen coordination between identification and care	Standards	4					4	
4.2.2 Applications to support community and primary care developed, validated, and put into effect.	Applications	1	5				6	
4.2.3 Users of record-keeping standards (care) and applications trained	Users	24	80	120	160	192	576	
4.3 Municipal health directorates implementing the quality assurance strategy*	Municipal directorates	15	30	40	54	54	54	
4.3.1 Health staff trained to implement the quality assurance strategy	Health personnel	60	150	94	192	80	576	
4.3.2 Improvement plans implemented	Plans	15	30	40	54	54	54	
4.4 Municipios certified in the use of the "el Galeno" system for managing inputs*	Municipios	15	30	40	54	54	54	Inventory reports generated by the system.
4.5 Municipios that implement the environmental management monitoring plan*	Plans	15	30	40	54	54	54	Report to the SILAIS.
4.6 Performance evaluation reports	Reports	2	2	2	2	2	10	Reports from the external entity.
4.6 Reflexive evaluation reports	Reports	1		1		1	3	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Nicaragua
Project number:	NI-L1095
Name:	Community Health Program for Rural Municipios
Executing agency:	Ministry of Health (MINSA)
Fiduciary team:	Santiago Castillo; Procurement Senior Specialist (FMP/CNI); and Juan Carlos Lazo; Financial Management Senior Specialist (FMP/CNI)

I. EXECUTIVE SUMMARY

1. Procurement management was evaluated based on supervision of operations executed by MINSA (the executing agency) and financed by the Bank (loans 1897/BL-NI (closed in 2014), 2527/BL-NI, 2789/BL-NI, 2986/BL-NI, and 3306/BL-NI).

2. With the evaluation of the National Public Procurement System under the OECD/DAC methodology, Nicaragua has established a strategic plan to modernize its procurement system. The Bank is working toward this in coordination with the Ministry of Finance's General Directorate for Government Procurement. The executing agency's fiduciary management has been strengthened through the adoption of recommendations issued in the framework of the aforementioned operations.

3. The executing agency has ample financial management experience and has demonstrated that it handles such operations adequately. Targeted training will be conducted to improve controls and to continue applying the ex post disbursement review modality. Financial management has recently been affected by the volume of operations (see Section III). The Bank is mapping the flows of financial management processes to detect potential areas for improvement during execution that would be reflected as actions under the Management Safeguards Plan (Loan Proposal, paragraphs 2.4 and 3.1).

4. The program does not include financing from other multilaterals.

II. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

1. MINSA's procurement division manages all its procurement needs, with the exception of procurement through processes financed with national resources involving purchasing through quotations. Such procurements are handled through the decentralized Local Comprehensive Health Care Systems (SILAIS) and hospitals in Nicaragua. The executing agency must maintain the balance between management capacity and workload. The staff that will be responsible for program procurement have profiles and technical competencies that are appropriate to the complexity of the program; however, they must be closely supervised by the Bank.

III. Fiduciary Risk Evaluation and Mitigation Actions

1. The risk associated with the procurement function has increased at the executing agency due to the following: (i) portfolio growth; (ii) all procurement management for operations is carried out by staff in the executing agency's Procurement Division structure, which also handles processes for the institutional plan; and (iii) the staff has varying levels of experience applying external procurement policies and procedures. Significant time is invested in the processes, causing execution delays and setbacks in the procurement plan. The executing agency must ensure that all procedures are well-managed. Pursuant to the Management Safeguards Plan, it must: (a) promote the use of process guidelines prepared by or with the support of the Bank, conduct market research, and keep the procurement plan up to date; (b) use program resources to strengthen the procurement area by hiring two additional specialists for the current team of five analysts and specialists who have experience applying the policies of multilateral entities; (c) provide a procurement expert, working part-time on the program, to support key MINSA staff by documenting the experience with the processes carried out; (d) designate, within the MINSA organizational structure, a specialist from the group mentioned in item (ii) to serve as the point person for executing and updating all the Bank-financed procurement plans; and lastly (e) assign process coordination under those procurement plans exclusively to specialists and analysts contracted with resources from the operations.

2. Financial management risk has also increased due to the number of operations that the External Funding Coordination Unit of the General Administrative/Financial Division is managing. Reporting has recently been slower. It is therefore recommended that an accounting and financial specialist be hired to supplement the four currently on staff who have experience managing the Integrated Financial Management and Audit System—Projects (SIGFAPRO).

3. **The overall fiduciary risk for the project is considered medium.**

IV. Considerations for the Special Provisions of Contracts

In order to streamline contract negotiation by the project team and the Bank's Legal Department in particular, the agreements and requirements to be considered in the special considerations are listed below:

a. Use the borrowing country exchange rate in force on the date on which the executing agency converted the funds into córdobas; and

b. Under the current Management Safeguards Plan, the following are conditions precedent to the first disbursement: (i) MINSA will present evidence that it has the additional staff to form a minimal technical-operative support team working full-time on execution of Bank-financed programs: at least six full-time procurement analysts and specialists, and at least five full-time financial analysts and specialists; (ii) prior to the first disbursement of Component 1 (a) has the Bank's no objection to hiring the evaluator who will conduct the independent performance evaluation; and (b) has agreed with the Bank on the amount of financing per person served for the first year of the program;

c. During execution compliance with the actions in the Management Safeguards Plan and the Operating Regulations will be verified every six months.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

These agreements establish provisions that apply to the program's expected procurement execution.

1. **Procurement execution**

   a. **Procurement of works, goods, and nonconsulting services:** Contracts for works, goods, and nonconsulting services under the program and subject to international competitive bidding will be executed using standard competitive bidding documents issued by the Bank. The processes subject to national competitive bidding will use national bidding documents agreed upon with the Bank. The team leader will be responsible for reviewing the technical specifications for procurements during the preparation of selection processes.

   - **Procurement of information technology systems**: N/A.
   - **"Turnkey" procurement (supply and installation)**: N/A.
   - **Procurement with community participation**: N/A.

   b. **Selection and contracting of consultants.** Contracts for consulting services generated under the program will be executed using the standard request for proposals issued by or agreed upon with the Bank. The team leader will be responsible for reviewing the terms of reference for contracting consulting services.

   - **Selection of individual consultants:** In some cases, contracting of individual consultants can be sought through local or international announcements to build shortlists of qualified individuals.
   - **Training:** N/A.

   c. **Use of country procurement system:** The country procurement (sub)system approved by the Bank, SISCAE, will be used to announce calls for expressions of interest and/or bids. Any system or subsystem approved subsequently will be applicable to the program.

   - **Strengthening measures:** Training activities for MINSA staff will be conducted.

   d. **Recurring expenditures:** Expenditures required to put the project into operation during its useful life are considered recurrent, operational, and maintenance expenditures. They will be financed by the program within the annual budget approved by the Bank and carried out according to the executing agency's administrative procedures—which have been reviewed and accepted beforehand by the Bank—as long as they do not violate the fundamental principles of competitiveness, efficiency, and affordability. Operating costs do not include the salaries of public servants. Recurring or operating expenses are expected to include the following:

   - Expenditures on enrollment, internships/fellowships, and training logistics, per diem expenses, and reproduction of **technical** material for the training events planned for both program components, for a total estimated cost of US$3,020,250;

- Payments for data network and cellular telephone and text messaging service usage for the community **network** and primary-level health care staff, for an estimated US$600,000; and
- Per diems, fuel, vehicle **maintenance**, and reproduction of materials for the supervision activities planned under the four components, for an estimated US$1,125,000.

e. **Commercial practices:** N/A.

f. **Advance procurement/Retroactive financing:** N/A.

g. **Domestic preference:** N/A.

h. **Other:**

- Prior to beginning construction of the works, the executing agency must have procured of the land, rights, and rights-of-way necessary to execute the program.
- In the execution of public health emergency response activities, the policies for emergencies (use of price comparison and single-source selection) will apply, and whenever the reserve is activated, a supporting document will be presented of the amount transferred, certified by an authorized public accountant. (Annex to the Operating Regulations)
- The Pan American Health Organization will be contracted directly to conduct the external performance evaluation (Loan proposal, paragraph 1.14).
- The technical operating staff needed to form the minimum support team in the areas indicated in the Management Safeguards Plan will be hired as additional personnel under the procedures normally used by MINSA’s human resources department and that must be agreed upon previously with the Bank and set forth in a manual annexed to the Operating Regulations.
- A coordinator for the procurement specialists will be assigned.

2. International competitive bidding and international shortlist thresholds (US$ thousands)

Method	ICB works	ICB goods and nonconsulting services	International consulting services shortlist
Threshold	>1,500	>150	>200

3. Main procurement

Activity	Selection method	Estimated issue/invitation date	Estimated amount US$
Goods			
Equipping for hospital waste management	ICB	First quarter 2019	1,500,000
Transportation (motorcycles, boats)	ICB	Third quarter 2018	1,080,000
Equipping of primary care hospitals	ICB	Second quarter 2018	1,600,000
Works			
Replacement of Jalapa and Waspan primary care hospitals (tentative)	ICB	Second quarter 2017	7,900,000
Replacement or construction of health posts	NCB	Second quarter 2017	656,000
Nonconsulting services			
Mobile telephones for community agents	SSS	Third quarter 2017	600,000
Firms			
Specialized agency, performance evaluation	SSS	First quarter 2017	291,400
Independent auditing firm. Financial auditing	SSS	First quarter 2017	250,000
Individuals			
Developers of health care records applications	IC	Second quarter 2017	115,200

* Click here for the 18-month procurement plan.

4. Procurement supervision

The supervision method will be determined for each process, by default ex ante, except where the procurement plan calls for ex post review. The supervision plan will include ex post reviews every six months, with at least one physical inspection visit and the physical inspection of no less than 10% of the contracts reviewed, selected from the processes subject to ex post review.

Ex post review threshold		
Works	**Goods**	**Consulting services**
US$150,000	US$25,000	US$200,000

Note: Thresholds for ex post review are applied based on the executing agency's fiduciary capacity for execution and can be modified by the Bank should that capacity change.

5. Special provisions

a. **Measures for reducing the probability of corruption:** The provisions contained in documents GN-2349-9 and GN-2350-9 on prohibited practices and ineligibility of companies and individuals will be followed.

b. **Other special procedures:** N/A.

6. Records and files

Each of the procurement units must designate a person responsible for this activity, have a specific area for storing documents, and ensure that documentary evidence of payments made to suppliers and contractors is recorded in the case files. The physical archive should be maintained for three years. The formats or procedures agreed upon and described in the

program Operating Regulations are to be used to prepare and archive program reports.

VI. Financial Management Agreements and Requirements

1. **Programming and budget.** The public sector's country system is established by the financial administration and budgetary regimen law and in the national public investment system. In line with the approval cycle for the general budget of the Republic, MINSA will manage allocation so as to have sufficient credit in the budget to meet each year's execution commitments. It will use SIGFAPRO—a financial/accounting system acceptable to the Bank. Should changes be made as a result of upgrades to the administrative system, management would immediately move to the new system.

2. **Disbursements and cash flow.** Disbursements will be made from the IDB to the executing agency through a single treasury account with a sub-account for financial control. Disbursements will be made pursuant to the program's actual liquidity needs (financial planning). The Bank will be presented with a request for disbursement together with a program of expenditures per activity under the annual work plan for a maximum term of six months. Justification of at least 80% of the disbursements will be agreed upon in order for a new advance of funds to take place. The advance must be in line with the program execution plan, annual work plan, and procurement plan. Cash flow can take into account payments of interest during the execution period with funds from the financing, in keeping with the amount established in the program's annex.

3. **Accounting and financial reports.** Program financial statements are to be issued in accordance with International Accounting Standards and the financial management guide (document OP-273-6). They are to be audited annually by an independent firm deemed eligible by the Bank. SIGFA/SIGFAPRO will be used for financial accounting records. **Internal control and internal audit.** The environmental and/or control activities, communication and information, and monitoring of MINSA activities will be governed by the country's internal technical control standards. The executing agency has an acceptable internal control system, with defined manuals and procedures; it has internal auditing, and, to the extent possible, the audit unit's annual planning is expected to include a review of the execution of the program's components. The Bank will hold annual sessions to train and update the staff dedicated to financial issues, to ensure compliance with the aforementioned standards and policies.

4. **External control and reports.** The executing agency will contract an independent auditing firm deemed eligible by the Bank according to its procedures. At the proper moment, the scope of the independent auditing firm currently auditing operations in execution can be extended. The program's external audit reports and the ex post review of procurement processes and disbursement requests will be presented 120 days after each fiscal year during the disbursement stage and 120 calendar days after the original disbursement term or its extensions, taking into consideration International Standards on Auditing. The annual audited financial statements will be prepared in keeping with the Financial Reporting Guide and external auditing for Bank-financed programs.

5. **Financial supervision plan**

a. For financial monitoring, the executing agency will use audited and unaudited financial reports. For its part, the Bank will encourage the following actions: (i) prior to the first disbursement of the loan, a start-up workshop will be held to train personnel in charge of executing the program, in keeping with fiduciary management regulatory instruments; (ii) it will make financial accounting visits to confirm the progress of the execution of and compliance with the measures for internal control, emphasizing the survey of financial execution processes, quality and timeliness of the accounting records, and suitability of supporting documentation; and (iii) review of disbursement requests will be ex post, with the auditor and Bank staff in charge of verification.

b. **Execution mechanism.** The executing agency will manage fund advances through the External Funding Coordination Unit and with approval of the General Administrative/Financial Division. Payments and commitments drawn on the program will be processed by that unit.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/16

Nicaragua. Loan ____/BL-NI to the Republic of Nicaragua
Community Health Program for Rural Municipios

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Nicaragua, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a community health program for rural municipios. Such financing will be for the amount of up to US$27,000,000 from the resources of the Single Currency Facility of the Bank's Ordinary Capital, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on _________, 2016)

LEG/SGO/CID/IDBDOCS#40288931
NI-L1095

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/16

Nicaragua. Loan ____/BL-NI to the Republic of Nicaragua
Community Health Program for Rural Municipios

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Nicaragua, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a community health program for rural municipios. Such financing will be for the amount of up to US$18,000,000 from the resources of the Bank's Fund for Special Operations, corresponds to a parallel loan within the framework of the multilateral debt relief and concessional finance reform of the Bank, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on _________, 2016)

LEG/SGO/CID/IDBDOCS#40288941
NI-L1095