DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

NICARAGUA

IMPROVING MATERNAL AND CHILD HEALTH

PERFORMANCE-DRIVEN LOAN

(NI-L1001)

LOAN PROPOSAL

This document was prepared by the project team consisting of Gustavo Zuleta (RE2/SO2), Project Team Leader; Jennifer Adams (COF/CNI); Amelia Cabrera (RE2/SO2); Javier Cayo (LEG/OPR); Juan Carlos De La Hoz (RE2/SO2); Catalina Gómez (RE2/SO2); and Nelson Hernández (consultant).

CONTENTS

Proposed resolution

Electronic Links and References	
Basic socioeconomic data	http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata
Status of loans in execution & approved loans	http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=432453
Tentative lending program	http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=432462
Information available in the RE2/SO2 technical files	http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=432466

IMPROVING MATERNAL AND CHILD HEALTH
PERFORMANCE-DRIVEN LOAN
(NI-L1001)

ACRONYMS AND ABBREVIATIONS

CFAA	Country Financial Accountability Assessment
CPAR	Country Procurement Assessment Report
DGAF	División General Administrativa y Financiera [Administration and Finance Department]
DGPD	División General de Planificación y Desarrollo [Planning and Development Department]
ENDESA	Encuesta Nicaragüense de Demografía y Salud [Nicaraguan Demographic and Health Survey]
ERCERP	Estrategia Reforzada de Crecimiento Económico y Reducción de la Pobreza [Enhanced Economic Growth and Poverty Reduction Strategy]
ESS	Enfoque Sectorial de Salud [Sector Approach to Health]
FIV	Inspection and supervision fee
FONMAT	Fondo para la Maternidad e Infancia Segura [Fund for Safe Maternity and Childhood]
FSO	Fund for Special Operations
GDP	Gross domestic product
ICD	International Classification of Diseases (WHO)
MAIS	Modelo de Atención Integral en Salud [Comprehensive Health Care Model]
MDG(s)	Millennium Development Goal(s)
MINSA	Ministry of Health
ONG	Nongovernmental organization
PBSS	Paquete Básico de Servicios de Salud [Basic Health Services Package]
PCU	Project coordination unit
PDL	Performance-driven Loan
PPMR	Project Performance Monitoring Report
SECEP	Secretaría de Coordinación y Estrategia de la Presidencia [Coordination and Strategy Secretariat of the Office of the President]
SIGFA	Sistema Integrado de Gestión Financiera [Integrated Financial Management System]
SILAIS	Sistemas Locales de Atención Integral en Salud [Comprehensive Health Care Systems]
SIMINSA	Sistema de Información del Ministerio de Salud [Information System of the Ministry of Health]
SNIP	Sistema Nacional de Inversión Pública [National Public Investment System]
VMS	Viceministerio de Salud [Office of the Deputy Minister for Health]

PROJECT SUMMARY

NICARAGUA
IMPROVING MATERNAL AND CHILD HEALTH

PERFORMANCE-DRIVEN LOAN
(NI-L1001)

<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="3">Borrower: Republic of Nicaragua
Executing agency: Ministry of Health (MINSA)</td><td>Amortization period:</td><td>40 years</td></tr>
<tr><td>Grace period:</td><td>10 years</td></tr>
<tr><td>Disbursement period:</td><td>Minimum: 36 months
Maximum: 60 months</td></tr>
<tr><td>Source</td><td>Amount US$</td><td>%</td><td>Interest rate:</td><td>1% during the grace period and 2% thereafter</td></tr>
<tr><td>IDB (FOE)</td><td>30.0</td><td>90</td><td>Inspection and supervision fee:</td><td>1%</td></tr>
<tr><td>Local</td><td>3.5</td><td>10</td><td>Credit fee:</td><td>0.5%</td></tr>
<tr><td>Total</td><td>33.5</td><td>100</td><td>Currency:</td><td>U.S. dollars</td></tr>
</table>

Project at a glance

Project objective:

The general objective of the operation is to improve health conditions for the country's poorest people, by helping to reduce the profile of maternal and infant morbidity and mortality from avoidable causes that especially affect people living in poor rural areas with a heavy concentration of indigenous people, and in peri-urban zones, thereby moving towards attainment of the millennium health goals and reducing disparities between these indicators and the national averages.

Special contractual conditions (paragraph 3.28):

Within no more than 12 months from the entry into force of the loan contract, the Bank will commission an independent special evaluation to review progress with the institutional strengthening of MINSA in the areas of procurement, financial management, and internal control.

Exceptions to Bank policies (paragraph 3.12):

The borrower has requested an exception to Bank policy (document GN-2278-2) so that in this specific case the initial disbursement is discounted proportionately against all the tranches of the performance-driven loan.

Project consistent with country strategy: Yes [X] No [ ]

Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [ ]

Procurement (paragraphs 3.8 and 3.9):

For goods and related services valued at the equivalent of US$350,000 or more, and for works valued at the equivalent of US$1 million or more, international competitive bidding procedures will be used. Consulting contracts equivalent to US$200,000 or more will be subject to international competitive bidding.

Date of CESI verification: Project concept: 27 August 2004

Project report: 22 October 2004

I. FRAME OF REFERENCE

A. Socioeconomic framework

1.1 The country's improved economic performance can be appreciated from performance of principal macroeconomic indicators in 2003. The downward trend in GDP (gross domestic product) was reversed, and the economy grew by 2.3%. The combined public-sector deficit, including grants, declined to 4.4% of GDP, reflecting both higher revenues and lower spending in the context of the new Fiscal Equity Act. Inflation remained stable at around 6%, and the balance of payments strengthened. Government efforts suggest that by the end of 2004 GDP will be growing at an annual rate of around 5%, and that the other basic macroeconomic variables will remain sound.

1.2 Nicaragua has made progress in reducing poverty. Since the beginning of the 1990s there has been a drop in poverty (from 50.3% in 1993 to 45.8% in 2001) and extreme poverty (from 19.4% in 1993 to 15.1% in 2001) levels. Health indicators in particular are lagging, and there is a need to increase the coverage of health services. Preliminary estimates show that, to maintain progress to date and to achieve the Millennium Development Goals (MDGs) by 2015, annual social spending will have to rise by 3.3% of GDP. This should be possible with sustained GDP growth of around 5%.

B. The health sector

1. The health situation in Nicaragua

1.3 Nicaragua has 5.4 million inhabitants. The epidemiological situation reveals a combination of avoidable and nonpreventable health problems that impact people in different ways, depending on their socioeconomic status. The two key indicators of the country's health situation are the high rates of maternal and child mortality, which represent major challenges to the Enhanced Economic Growth and Poverty Reduction Strategy (*Estrategia Reforzada de Crecimiento Económico y Reducción de la Pobreza,* ERCERP*)*.

1.4 These challenges are also core elements of the country's MDGs: to meet the goal of cutting the child mortality rate (among children under five years) by two thirds between 1990 and 2015 means reducing that rate from 66 to 22 deaths per 1,000 live births, according to IDB estimates.[1] In terms of maternal mortality, the 2015 goal is to reduce the 1990 level by three quarters, which would mean cutting the number of maternal deaths per 100,000 live births from 160 to 40, according to those same estimates. With respect to the trend for the first five-year period now ending, the World Bank's "World Development Indicators 2003" show that the

[1] The Millennium Development Goals in Latin America and the Caribbean: Challenges, Actions and Commitments. IDB Sustainable Development Department (2004).

infant mortality rate considered in the MDGs for Nicaragua stood at 41 per 1,000 live births in 2000, and maternal mortality for that year was 230 per 100,000 live births. The latter value is significantly higher than the 1990 baseline, reflecting a sharp improvement in the registration of births and deaths and, therefore, a more reliable figure.

1.5 The 2001 Nicaraguan Demographic and Health Survey (ENDESA) showed that more than 50% of maternal deaths are due to avoidable obstetric complications, the most important of which are postpartum hemorrhaging, puerperal sepsis, and gestational hypertension. According to the IDB source cited above, these critical characteristics are related to access to health care programs and services during pregnancy, delivery, and the postnatal period, and to the quality of care pregnant women receive through prenatal checkups, obstetric and delivery care by specialized personnel, as well as subsequent routine checkups to prevent post-pregnancy complications.

1.6 The ENDESA identified several risk factors for infant mortality, most of them avoidable, that increase the likelihood of death in the first year of life: being male, having a birth interval of less than 2 years, low birth-weight, having a mother with little schooling, and lack of proper prenatal care or professional assistance at childbirth (this last factor reinforces the relevance of the concern over the maternal mortality indicators described above). At the same time, statistics from the Ministry of Health (MINSA) for 2001 show that respiratory and cardiac complications specific to the perinatal period (from the twenty-second week of gestation to six days after birth) account for slightly over one third of infant deaths. In the case of neonatal deaths (from seven days to 27 days after birth), the major causes are infections (sepsis and pneumonia), respiratory distress syndrome, asphyxia, and congenital deformities. In the post-neonatal period (from 28 days to 11 months after birth), the major causes of death are pneumonia and diarrhea.

1.7 Data from the above-cited IDB source show that in 2000 the infant mortality rate in Nicaragua was heavily influenced by socioeconomic status and access to services. While infant mortality in urban areas stood at 28 deaths per 1,000 live births, the rural figure was 43. These disparities are confirmed by the 2001 ENDESA in terms of welfare quintiles. Inter-quintile comparisons show a dramatic drop in infant and child (under 5 years of age) mortality rates as social well-being increases. Table I-1 shows the differences by income quintile, pointing to the need for targeted interventions in the country's poorest areas.

Table I-1
Infant and child (under five years) mortality by income quintile

Mortality (per 1,000 live births)	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile	Total
Infants	50	41	32	26	16	35
Children under 5 years	64	52	39	32	19	45

Source: 2001 ENDESA

2. The health sector

1.8 **Institutional structure**. The health sector consists of two subsectors: the public health subsector, consisting primarily of MINSA and the Nicaraguan Institute of Social Security; and the private health subsector, involving businesses and nonprofit NGOs that provide basic health services in remote areas of the country. The Local Comprehensive Health Care Systems (SILAIS) provide a regional technical and administrative presence for MINSA and help coordinate the system of regional hospitals and local health centers.

1.9 With a current coverage of 60% of the population, the MINSA network is the main supplier of health services, which are offered at two levels. The first level-primary healthcare consists of 177 health centers (27 of which have beds) and 843 health clinics and offers almost all services related to health promotion and illness and health risk prevention. The second level consists of 31 hospitals that can provide more intensive treatment but are not always sufficiently integrated with the primary facilities to ensure access and proper referral and counter-referral of patients when the complexity of the case so warrants.

1.10 Public social spending per capita in Nicaragua remains among the lowest in Central America, although it rose by more than 50% during the 1990s, from US$49 at the beginning of the decade to US$75 in 2000. The health sector receives 38% of total public social spending, representing annual per capita spending in current dollars of US$27, which is far below the annual US$33 that the World Bank and the World Health Organization have set as the minimum for guaranteeing access to basic services. According to IDB figures for national health accounts, estimated in comparative international terms using purchasing power parity (based on an average exchange rate in dollars), annual per capita health spending in Nicaragua is US$43, a level that exceeds only those of Haiti and Ecuador within Latin America.

1.11 The last two years have seen some significant changes in the institutional framework for the sector. In early 2002, the Legislative Assembly approved a new Health Act, the recently-issued regulations to which deal with: (i) the operation, financing and benefit plans for the new contributory and noncontributory systems;

(ii) citizen participation in the management and advisory bodies of institutions providing services; (iii) models for promoting decentralization, deconcentration and delegation of responsibilities within the health sector; and (iv) a system of quality assurance, including approval and accreditation of service providers. These regulations have laid the basis for orderly implementation over the medium term.

1.12 On the decentralization front, it has been decided that the SILAIS, which were created in 1990, will gradually take over responsibilities and funding for organizing and supervising the provision of services. The process has already begun in some hospitals, up to four of which will be given budgeting and implementation discretion during 2004, within a general framework of programs to improve management and implement electronic file support for resource administration.

1.13 MINSA has also taken an important step towards adjusting healthcare models by developing a Comprehensive Health Care Model (MAIS). This model calls for organizing outpatient and hospital services to meet the public's needs more effectively through networks consisting of a series of community establishments, both public and private, with varying degrees of complexity, levels and modalities of care. The central strategy for providing services through the MAIS will involve putting together a Basic Health Services Package (PBSS) for expanding and improving coverage through its constituent elements (prioritizing services, and mechanisms for contracting, payment and supervision).

1.14 **Executing capacity.** During project preparation, KPMG provided a technical opinion on the eligibility conditions for a performance-driven loan (PDL) that would allow the use of national contracting procedures: (i) the entities involved must apply procurement practices and procedures that are compatible with the principles of competition, economy, transparency, equity, publicity, and due process; (ii) the country must have a legal framework governing the presentation, processing and settlement of protests by firms participating in the bidding, and this framework must be adequately enforced; and (iii) the entities involved must have strict and well-functioning systems of financial management, accounting and control. The KPMG report, available in the technical files, emphasizes that the country has successfully fulfilled the first two conditions, and that the third condition is fulfilled as far as centralized procurement is concerned, although the report makes a series of recommendations on internal financial control to be resolved directly by MINSA.

1.15 The Bank's Regional Operations Support Office reviewed the KPMG report and other background information such as the Country Procurement Assessment Review (CPAR) and Country Financial Accountability Assessment (CFAA), as well as the Project Performance Monitoring Report (PPMR) on loan 1064/SF-NI to improve efficiency and transparency in government procurement. It concluded that there are a number of aspects that the country is now revising and updating but that, since they will not be completed when this operation is approved, it will not be

possible to move forward with a PDL using domestic procedures for all purchases regardless of amount.

1.16 Given this situation, the country has agreed that in the specific case of this PDL, Bank policies and procedures will apply to the procurement of goods, services and works. MINSA in fact has previous experience in executing projects under Bank procedures: it has been implementing the hospital modernization program (1027/SF-NI) since October 1999, with annual disbursements averaging US$6.8 million, with a project coordination unit (PCU) that has at the same time been coordinating execution of a project financed by the World Bank. During this time the PCU has acquired the institutional strength to apply Bank procurement policies and procedures, and it has improved its financial, accounting and internal control systems.

1.17 The opinion of the external auditors (Grant Thornton) on the financial statements to 31 December 2003 was unqualified, and noted that the processes for the procurement and contracting of works, goods and services were implemented in conformity with applicable rules, and the supporting documentation is presented in due form and represents valid expenditures eligible under the program. The auditors also said that, with respect to the internal control structure, some aspects relating to the internal control system were worth reporting, but none of these should be considered significant shortcomings". In light of this, the Bank's Country Office in Nicaragua recently approved ex post review procedures for procurement in amounts below US$10,000 for goods and services, and US$8,000 for consulting services.

1.18 These findings reflect efforts at institutional strengthening and at the gradual transfer of responsibilities to the formal organizational structure of MINSA. These efforts have covered several operating areas. In procurement, the PCU has combined the provisions of the Operations Manual for program 1027/SF-NI to focus decisions on bidding documents and awards in procurement committees. These committees are established for each procurement process, and consist of three permanent representatives (legal, administrative and strategic) and two ad hoc representatives, including the requester of the good or service and a technical expert. Experience with these procurement committees has been positive in matching procurement to the needs of the requesters and focusing responsibility within MINSA's formal structure. Decisions of the committees have not been seriously challenged, and it has not been necessary to submit any dispute to the Bank's Procurement Committee.

1.19 With respect to financial control and the preparation of audited financial statements for the program, the PCU has migrated to the Integrated Financial Management System (SIGFA), now used nationwide, to record program transactions for budgetary and accounting purposes. To date, the audited financial statements have been provided on schedule.

1.20 **Experience in monitoring results.** MINSA has launched a management-by-results effort under the ERCERP, identifying a set of intermediate indicators related to reducing maternal and child morbidity and mortality. Those indicators are: (i) early monitoring of pregnancy through prenatal checkups; (ii) institutional childbirth; and (iii) immunization of children under one year. Annual intermediate targets were defined for these indicators, as well as a system for constant monitoring and evaluation of the process, with Bank support, through a social sector operation as detailed below. This particular case involved a number of SILAIS that were given priority on the basis of information recorded by the respective statistics offices. This information served as a general reference point for establishing the baseline and setting realistic goals in light of the number of cases that were reviewed by MINSA's Planning and Development Division (DGPD), in cooperation with the respective technical areas.

1.21 As part of this new approach, MINSA has been making constant efforts to refine its data collection and analysis systems, so that there is timely information available on progress towards the proposed targets. The primary sources of data are the health centers and clinics and the hospitals: information is usually taken from the daily logs and the consolidated municipal reports. These data are sent to the SILAIS for validation and improvement of quality. The SILAIS then send the consolidated monthly data to the MINSA Statistics Department for input into the Health Ministry Information System (SIMINSA).

C. The country strategy in the health sector

1.22 The central element of the country's health strategy is the new national health policy, which, starting with the guidelines in the National Development Plan and the challenges of the ERCERP and the Millennium Development Goals (MDGs) as points of reference, establishes a set of policy guidelines to address the problems and challenges in the health sector that are to be implemented in a five-year development plan for the period 2005-2009. Among the strategic priorities of the national health policy are: (i) expanding the coverage of quality health care, targeted at vulnerable groups, with a particular focus on delivering a PBSS to mothers and infants, and on complementarity between public and private providers; (ii) strengthening primary care, and channeling resources to promotion, prevention and communication as critical elements of behavioral change; and (iii) consolidating the national health system, with the greatest political and financial effort going into decentralizing the healthcare network supervision and organization capacities to the SILAIS, within the operational framework of the Comprehensive Health Care Model (MAIS).

1.23 Under MINSA's political leadership, the international community—represented by the bilateral cooperation of the Netherlands, Sweden and Finland plus the World Bank, the Pan American Health Organization and the Inter-American Development Bank—is now promoting the *Enfoque Sectorial de Salud* [health sector approach]

(ESS), designed as a gradual approach that will take several years to implement. The first stage reflects the commitment of all participants to work together to support health policy priorities in the country, particularly as they relate to expanding and improving coverage for mothers and children in the poorest segments of the population.[2] As a result of this effort, public spending on health is expected to improve significantly above current low levels over the medium and long terms, and to become more efficient in terms of its targeting on the most vulnerable groups and in the achievement of desired health outcomes.

D. Bank strategy in the sector

1.24 **Bank strategy in Nicaragua.** The objective of the strategy is to support the Government of Nicaragua in establishing and executing actions to achieve the ERCERP targets in three priority strategic areas: economic development, governance, and productivity of the poorest. By focusing its support on achieving certain key outcomes for reducing the profile of maternal and child morbidity and mortality among the most vulnerable groups, the operation will have a direct bearing on the third strategic thrust, and will also relate to meeting the government's ERCERP targets in the health area.

1.25 This program is consistent with the Bank's social development strategy (document GN-2241-1), which gives priority to helping countries accelerate social progress and achieve the MDGs. In the health sector, that strategy calls for the Bank to emphasize specific MDG-related reforms to their health systems to address the specific health needs and objectives of the beneficiary countries. It also calls for the Bank to consider each country's epidemiological profile, so that it can focus its attention on injuries, contagious diseases, or noncommunicable diseases as appropriate. In countries like Nicaragua, where contagious diseases are the dominant concern, the Bank will give priority to maternal mortality, neonatal mortality and morbidity, and contagious diseases. This performance-driven operation is a key element in helping the country reduce maternal and infant mortality, representing two of the principal MDG targets on health.

1.26 **Previous experience and lessons learned**. As noted earlier with respect to MINSA's execution capacity, the Bank has been financing the hospital modernization program (1027/SF-NI), in execution since 1999 (83% completed), supporting modernization of hospital management, institutional strengthening of MINSA and its decentralized bodies, and establishing a Safe Maternity and Infancy Fund (FONMAT), which has begun to expand coverage through special incentives for public service providers. Implementation of that program has provided a number of lessons: (i) having MINSA's formal structure assert a sense of ownership over the changes is an indispensable condition for success, which means that the

[2] A representative of the United States Agency for International Development (USAID) also participates in this process as an observer.

line units must assume greater leadership in implementation; (ii) management agreements have facilitated relations between the central level, the SILAIS, and the hospitals, and are now considered a key element for consolidating the decentralizing role of the SILAIS, while the FONMAT strategy of delivering funds directly to the municipios is beginning to strengthen the management capacity of local governments; (iii) evaluations have shown that the design and complexity of the operation exceeded local institutional capacities and led to dissipation of efforts, and thus of outcomes. This led MINSA to propose less complex interventions, with more targeted objectives to enhance outcomes; and (iv) the public emphasis of the FONMAT produced significant gains in terms of coverage and cost-effectiveness, but compromised quality.

1.27 The Bank provided further support to the country with the social policy reform loan (1114/SF-NI), the second and final tranche of which is about to be disbursed. That loan has given a boost, in the specific case of the health sector, to the process of issuing regulations for the Health Act, to the decentralization to the SILAIS, and to the development of the MAIS. It combined conventional conditions for policy changes with disbursement conditions tied to meeting the intermediate targets of the ERCERP, which were identified as indicators for tracking progress towards the 2015 MDG health targets for maternal and infant mortality. That experience showed that focusing on outcomes can mobilize government efforts beyond the scope of the conventional production input focus. It also showed that the country is building an infrastructure for monitoring outcomes, which will be reinforced with a new social sector operation (NI-0183).

E. Coordination with other donors

1.28 As noted earlier, the ESS headed by MINSA is an effective tool for coordinating efforts by the international community, and for supporting Nicaragua's progress towards the MDG health targets. The Bank has therefore decided to support this joint effort with an innovative instrument such as a PDL. Specifically, a PDL is the best instrument for working within this coordination framework offered by the ESS at this initial stage of its implementation, where donors share the focus on health policy priorities and outcomes, and it offers the possibility of moving toward a common monitoring and evaluation system where intermediate and final program indicators become an important subset of that system. Progress in this direction is being made through the preparation of framework proposals for cooperation and harmonization of these joint efforts, such as the Statement of Intentions, the Code of Conduct and the Memorandum of Understanding that are expected to be finalized at a later stage of the ESS, and that could be in full force for the following five-year period, 2010-2014.

II. THE PROGRAM

A. Objectives and description

2.1 The general objective of the operation is to improve health conditions for the country's poorest people, by helping to reduce the profile of maternal and infant morbidity and mortality from avoidable causes that especially affect people living in poor rural areas with a heavy concentration of indigenous people, and in peri-urban zones, thereby moving towards attainment of the millennium health goals and reducing disparities between these indicators and the national averages. Specifically, as a PDL, the operation is designed to improve a set of tracking indicators associated with the effort to expand the coverage and improve the quality of health services, such as checkups during pregnancy, childbirth in an institutional setting with qualified staff, and hospitalization for the most prevalent maternal and infant pathologies, such as hemorrhaging and asphyxia, respectively. In addition, support will be provided for the institutional strengthening of MINSA in the areas of procurement, financial management and internal control, to ensure that the conditions necessary for the proper execution of programs like this PDL are maintained.

2.2 The target population for the program is comprised of women of childbearing age and children under the age of five, living in rural communities within the 76 most vulnerable municipios of the country in the 12 priority SILAIS. The SILAIS have been selected through the use of geographic targeting criteria based on available census data, updated with standard-of-living surveys and the Nicaraguan Demographic and Health Survey (ENDESA), to consider poverty levels (percentage of the population in the poorest quintile) as well as factors related to difficulties encountered by the population in gaining access to health facilities (percentage of people living more than one hour from the nearest health center), and the health situation (maternal and infant mortality rates). With the municipios, the same methodology was applied for defining vulnerability, but it was restricted in this case to poverty and access criteria.

2.3 Intermediate and final outcome indicators for improved maternal and infant health have been established for this specific group, with a view to targeting interventions so as to reduce inequalities in access to health services, and economic and geographic disparities in comparison with national averages. As of 2003, the target population numbered approximately 450,000 people, using the targeting criteria established.[3]

[3] The total population of the 12 priority SILAIS is 3,250,928, of whom 1,873,834 live in poverty. The 76 municipios that have been given priority have a total population of 1,960,168, of whom 1,146,884 live in poverty.

B. Structure of the program

1. Selected indicators

2.4 The program is structured to achieve final outcomes in terms of reducing the main burden of maternal and infant morbidity and mortality from avoidable causes, and intermediate outcomes relating to the coverage of preventive and promotional activities such as pregnancy checkups, together with the expansion of childbirth facilities with qualified staff. These tracking indicators were selected with the technical criterion of addressing the comprehensive cycle of pregnancy, childbirth and postnatal care where the main causes of maternal and child mortality are avoidable and subject to greater control through the health system. Table II-1 shows the five indicators that will be used to measure program outcomes and the short-, medium- and long-term objectives.

Table II-1
Summary of outcome indicators

Final outcome indicators	**Medium- and long-term objective**
Percentage of deaths from postpartum hemorrhage (ICD-10 O42) in the 10 hospitals covered by the program.	Reduce maternal and infant mortality for the most vulnerable population, and reduce disparities of these indicators against national averages.
Percentage of deaths from neonatal asphyxia (ICD-10 P21) in the 10 hospitals covered by the program.	
Intermediate outcome indicators	**Short- and medium-term objective**
Number of pregnancies detected in the first 3 months.	Increase coverage of pregnancy checkups and institutional childbirth for the most vulnerable population.
Number of pregnancies recorded as covered by the fourth checkup.	
Number of childbirths in health facilities with qualified staff.	

2.5 Table II-2 contains the program outcomes matrix, with the agreed intermediate and final outcome indicators. The baseline and associated performance-driven disbursement targets have been defined in light of previous experience with monitoring intermediate indicators for the ERCERP, realistic criteria, an initially gradual process until the ESS is in full operation, and time for the initial investments to mature that are needed to achieve the outcomes. The technical files for this operation contains the Manual of Indicators that specifies the definition of each selected indicator and its information sources, together with a description of the process for recording, consolidating and aggregating the information at the different management levels.

2.6 In terms of expected final outcomes, the maternal morbidity-mortality goal is to reduce postpartum hemorrhaging so as to prevent death and illness from this cause,

which accounted for 27% of all maternal deaths in Nicaragua in 2002, and at the same time to provide active care for mothers during the postnatal period. With respect to infant morbidity-mortality, the goal is to reduce neonatal asphyxia, which is one of the principal causes of infant deaths and complications, accounting for 38% of deaths of children under the age of one in 2002. Proper application of care standards for safe childbirth and initial care of the newborn child will also be ensured. Both indicators will be calculated as an aggregate for the 10 hospitals that serve as regional facilities in the 12 priority SILAIS. Those indicators have been defined as percentages, because both the numerator and the denominator are drawn from observational sources and are not estimates.

2.7 In terms of intermediate outcomes, the goal is to: (i) increase the coverage of prenatal monitoring of pregnant women, ensuring that they are identified and begin receiving care early in their pregnancy, so that their risk level can be classified and any complications prevented; (ii) increase the coverage of pregnant women with at least four checkups during pregnancy in order to improve the identification of obstetric risks and provide timely referrals for preventing mother and newborn injury and death; and (iii) extend the coverage of institutional childbirth to ensure proper care and assistance by qualified personnel in a health facility. For all these indicators obtained for the aggregate of the 76 municipios on which the program is targeted, it has been agreed to use absolute numbers, recognizing that, with percentages, there is a risk of variations in the population estimates for the denominator. Moreover, the population estimates made by the National Statistics Institute could be significantly affected by the results of the next census.

2. Establishing the baseline

2.8 As noted earlier, the general approach to estimating the baseline was to consider previous experience in monitoring the intermediate indicators for the ERCERP, which worked on the basis of the observed trend from previous years. In the specific case of the final indicators, the baseline was estimated from the average values observed during the 2000-2003 period for the percentage of deaths from postpartum hemorrhaging and neonatal asphyxia in the group of hospitals selected. Those values were validated by MINSA's Hospitals Office with the medical teams of the hospitals involved. The consolidated value of the baseline for these final indicators was taken from the average of the estimated values for the 10 hospitals selected.

2.9 With respect to the intermediate indicators, the baseline was defined from MINSA data records for the 2001-2003 period in the 76 priority municipios. The criterion for estimating the baseline was to determine, for each SILAIS, the trend in the aggregate of pregnancies identified in the first trimester, the number of pregnant women receiving the fourth checkup, and the number of institutional childbirths. The specific value of the baseline is the greatest value observed during this period, and consequently the benchmark value reflects the greatest possible effort that the

health care facilities attached to each SILAIS are capable of making, with the available resources, in identifying and caring for pregnant women. The consolidated value of the baseline for each intermediate indicator was taken from the sum of the estimated values in the 12 priority SILAIS.

3. Definition of intermediate and final targets

2.10 The targets were designed in light of the expected impact of program interventions and the gradual expansion of coverage in rural areas with limited access to services. With respect to the final indicators, the target for reducing postpartum hemorrhaging was defined by aggregating the individual targets for the 10 hospitals selected, on the basis of a projection that took into account improvements in infrastructure, equipment and management that the ESS and the program will introduce, with the expectation of an average reduction of 29% by the end of the program, compared with the baseline. In turn, the target for reducing neonatal asphyxia was defined by MINSA through consultations with neonatologists in the selected hospitals, and in light of the improvements in infrastructure, equipment and management that the ESS and the program will finance, aiming at an average reduction of 27% by the end of the program, in comparison with the baseline.

2.11 For the intermediate indicators, the expected growth for each of the indicators was specifically analized. For the early detection of pregnancy, despite the stable tendency of recent years, it is considered that to close the maternal mortality gap between the priority municipios and the national average will require increases ranging from 2% in the first tranche to 7% in the fourth. Consequently, during program execution the average increase in the identification of pregnancies will be around 4.3% for the aggregate of the 76 municipios on which the ESS and the program are targeted. With respect to pregnancies with four checkups, recent growth has been close to 5%, and the idea is that, given the recent high growth figures, the projected increases per tranche will be 1% in the first, 2% in the second, 2.5% in the third, and 3.2% in the fourth. Lastly, the number of institutional childbirths has been growing slowly in recent years,[4] and program interventions are expected to increase this growth by 2% in the first tranche, and by 5.1% by the fourth tranche.

[4] The annual average growth rate for the 1995-2002 period was 1.2%.

Table II-2
Program Outcomes Matrix

Indicator	Unit of measure	Base-line	Targets by tranche			
			I	II	III	IV
Final indicators						
Deaths from postpartum hemorrhage	Percentage	0.87	-	-	-	0.62
Deaths from neonatal asphyxia	Percentage	2.57	-	-	-	1.88
Intermediate indicators						
Early detection of pregnancies	Number of pregnancies	26,578	27,110	27,923	29,598	31,670
Pregnancies recorded as prenatal care by the fourth checkup	Number of pregnancies	28,656	28,943	29,521	30,259	31,228
Institutional delivery (coverage)	Number of deliveries	27,978	28,538	29,394	30,628	32,190

C. Eligible financing

2.12 To achieve the proposed targets, MINSA is coordinating support from internal and external funding sources through the ESS, with a view to maximizing the budget resources earmarked for the strategy to expand health coverage for the target population. Within the coordination framework called for in the ESS, the contribution of this program will be earmarked for financing the following eligible expenditures, targeted at the 76 selected municipios of the 12 priority SILAIS.

2.13 In the first place, the loan will finance the provision of a preventive, curative and promotional PBSS (basic health services package), with emphasis on care for the mothers and children, using two types of financing. Funds may be used to purchase institutional services from public providers that make an additional effort to expand coverage through management agreements for delivery of the PBSS, and funds may also be used to purchase noninstitutional services through management contracts for providing the PBSS.

2.14 As a second line of eligible expenditures, financing will be provided for the construction, upgrade or rehabilitation, plus operating costs, of "maternity homes" for pregnant women from remote areas of the country, to enable them to be closer to a health facility or hospital. This will improve the integration of first- and second-level services by extending coverage of prenatal checkups and postnatal care, as well as that of institutional childbirth and the treatment of any health complications for the mother and the newborn. At the same time, a set of activities associated with an investment program will be financed for first-level health facilities and second-level hospitals to upgrade or add new infrastructure and medical and industrial equipment, such as water heaters, autoclaves, kitchens, incinerators, and refrigerators, as well as to purchase medical inputs such as drugs,

replacement supplies, reagents, hemoderivatives, medicinal gases and hospital gowns. Expenses related to the maintenance and/or support of infrastructure and equipment will also be eligible.

2.15 In the third place, technical assistance, consulting services, training, information systems and computer equipment will be eligible for financing, to ensure the institutional strengthening of MINSA to continue improving its execution capacity in the areas of procurement, financial management, and internal control. At the same time, this category of eligible expenses will ensure the continuous operation of a system for monitoring and evaluating outcomes against the intermediate and final indicator targets, and will permit a comprehensive evaluation of the process of expanding health coverage for achieving those outcomes. Such spending may cover technical assistance and consulting services for developing and applying healthcare protocols and proper mechanisms of referral and counter-referral between the first and second levels of care. Financing will also be provided for training at the central and decentralized levels responsible for achieving the expected outcomes, and for innovative approaches to social oversight by the local community.

2.16 Technical assistance, consulting services and training will also be financed for the design and implementation of a communications and media plan to publicize outcomes and to sensitize the public about preventive and promotional approaches to health. User satisfaction surveys will also be eligible for financing, as will dissemination activities via media that is technically determined to be the most appropriate.

2.17 Loan funds may be used to cover program administration expenses, including fees for technical and support personnel, computer equipment and supplies, not to exceed 10% of the total loan. The purchase of transportation equipment (vehicles, ambulances and motor launches) for use in monitoring and evaluating the project and for transferring patients will also be deemed eligible for program funding provided the cost does not exceed 2% of the total loan.

2.18 Loan funds may also be used to cover the independent performance audit and the external financial and operations audit during program execution, together with the loan's financial costs (interest and inspection and supervision fee).

D. Cost and financing

2.19 Within the ESS framework, the program will contribute a total of US$33.5 million to the combined internal and external budget sources that MINSA will devote to achieving the agreed intermediate and final outcomes for the target population. Consistent with the Bank's classification matrix for a D country like Nicaragua, the Bank loan will cover 90% of financing, and the local counterpart contribution, the remaining 10%. The amount of financing has been sized according to the estimate of eligible expenses needed to achieve the outcomes, and will represent a portion of

the total funding that MINSA will devote to these purposes from its own sources and from bilateral cooperation and World Bank funding.

Table II-3
Eligible expenditure categories and means of verification

Categories of eligible expenses	Means of verification	
1. Purchase of institutional and non-institutional services	Management agreements or contracts with service providers.	
2. Infrastructure, equipment and inputs	Agreements or contracts, progress reports, clearance certificates and evidence of acceptance by the health facility receiving the goods.	
3. Maintenance and/or support of infrastructure and medical and industrial equipment.	Agreements or contracts, invoices, evidence of acceptance of works.	
4. Training, consulting services and technical assistance targeting institutional strengthening of MINSA on a priority basis	Agreements or contracts, invoices, consulting services and technical assistance reports, evaluation reports, records of events and lists of participants.	
5. Program administration.	Contracts and invoices.	
6. Transportation equipment	Invoices and proof of purchase.	
7. Audits	Contracts, invoices and final reports.	
8. Financial costs (interest and FIV)	Bank reports	
Source of financing	**Amount (US$ millions)**	**%**
IDB	30.0	90.0
Local	3.5	10.0
Total	33.5	100.0

2.20 It has been confirmed that the World Bank is planning a two-phase, five-year program loan of US$23 million (US$7 million in the first, two-year phase, and US$16 million for the second phase), approval of which is scheduled for the first quarter of 2005, to support priorities under the MINSA five-year development plan in pursuit of ESS and program objectives. By the end of the first quarter of 2005, Sweden is expected to approve budgetary support estimated at US$20 million over five years. The Netherlands is expected to approve budgetary support of US$1 million for 2005, to be approved by the end of the first quarter of 2005, with similar annual amounts expected for the remainder of the five-year period. Finland has earmarked US$8 million for the health sector over the period 2005-2009. Lastly, according to its own budget projections, MINSA expects to have US$2 million available in its budget each year earmarked specifically to finance eligible expenditures to achieve the planned outcomes.

2.21 The figures on available funds for the next five years according to the various sources of financing, including this new Bank loan, are relatively equivalent to the

amounts that MINSA has been investing to improve primary and secondary health care services over the 2000-2004 period. What is different now is that, by targeting funds at the country's poorest communities, coordinating efforts among the various sources of financing within the ESS, and working on the basis of intermediate and final trading outcomes, these activities will be more efficiently managed overall, and the country will be in a better position to achieve the millennium health goals, especially with the expected reduction in maternal and infant mortality.

2.22 The performance-driven loan approach is justified in light of the objectives of the operation, which in general seeks to expand and improve the coverage of basic health services for the country's poor, and specifically to achieve a series of intermediate and final outcomes in the area of maternal and child health. As well, this form of financing allows for closer coordination with multilateral and bilateral cooperation agencies that are supporting the ESS, through the monitoring and evaluation of a broader set of intermediate indicators and final targets that MINSA has undertaken to achieve. The outcome indicators and the respective targets for this program have been agreed with the other cooperating agencies, and are part of the monitoring and evaluation system, with the difference that in the case of this PDL disbursements are subject to attaining the targets.

III. PROGRAM EXECUTION

A. Borrower and executing agency

3.1 The borrower will be the Republic of Nicaragua. MINSA will act as executing agency, through the Office of the Deputy Minister for Health (VMS).

B. Project execution and administration

3.2 In agreement with the ESS, the VMS will have overall executive and policy responsibility for the overall strategic management of the ESS and of this program in particular. The VMS will create an advisory body to support this function and to facilitate ongoing coordination, which will be comprised of the Coordination and Strategy Secretariat of the Office of the President (SECEP), and the line departments of MINSA involved in execution. This advisory body will facilitate coordination and the exchange of information among all entities participating in the ESS, to support implementation of the five-year development plan and achievement of its objectives, and to encourage dialogue for the gradual harmonization of procedures among the various donors and multilateral agencies.

3.3 Technical and operational responsibility for implementing the ESS and the program will lie with MINSA's Planning and Development Department (DGPD), which is the line unit most directly involved. This will promote the sense of institutional ownership of the key processes such as, for example, ongoing administration and operation of the outcomes monitoring and evaluation system. For these purposes, the DGPD will coordinate the technical efforts involving physical and financial programming of all activities aimed at achieving the objectives, especially expansion of basic health services coverage, integration of the health services network, and strengthening of institutional capacities for monitoring, supervising and evaluating the entire process, and attainment of the agreed targets for maternal and infant health, with adequate administrative and financial monitoring.

3.4 More specifically—and always under the coordination structure with the ESS—the DGPD will fulfill the following functions to ensure optimal program execution: (i) with MINSA substantive and support divisions, guide, coordinate and supervise all project activities; (ii) prepare annual work plans for all activities needed to achieve the objectives, in coordination with MINSA's relevant line units; (iii) prepare regular technical reports; (iv) prepare terms of reference for specialized consulting, technical assistance and training activities eligible for program financing, in coordination with MINSA's relevant line units; (v) oversee fulfillment of the action plans for achieving the outcome targets; (vi) maintain and strengthen MINSA's information systems for monitoring and evaluating outcomes and financial and operational performance; (vii) prepare all documentation to meet the contractual conditions; (viii) hire and oversee firms and individuals supplying

goods and services, in coordination with MINSA's relevant line units; and (ix) report periodically on progress towards the agreed outcome targets.

3.5 To this end, the DGPD will make technical coordination arrangements with MINSA's line units involved in the process: the Human Resources Directorate, the Primary Health Care Division, the Secondary Health Care Division, the Infrastructure and Technological Development Division, and the Administrative and Financial Division (DGAF). Specifically, the DGAF will support the program's administrative and financial management, thereby allowing the DGPD to establish the relationship with the Bank and ensure adequate maintenance of accounting records, timely processing of disbursements, and preparation of financial reports, and related activities, in accordance with Bank procedures, so that the use of program resources can be identified at all times. The DGAF will also make payments for activities approved by the DGPD.

3.6 In light of the intense technical, administrative and financial support that will be required, the DGPD will be reinforced with technical and administrative teams from the Coordination Unit for the program under loan 1027/SF-NI, which is now being wrapped up, so as to draw upon experience and lessons learned from that program. This will be especially important for the divisions responsible for providing specialized support to the other MINSA line units involved in execution and coordination with multilateral and bilateral agencies during the life of the ESS, and with the Bank in particular during execution of this operation. The DGAF will be administratively and financially strengthened to ensure a timely and efficient flow of information of this type required by the Bank.

3.7 Lastly, at the local level, the SILAIS will be responsible for expediting the flow of information on the program's progress in the beneficiary municipios and communities, and will support local planning in terms of needs identification, supervise the quality and timeliness of service delivery, and monitor progress in the field towards the agreed targets. First- and second-tier divisions will undertake the necessary coordination efforts to gather such data. Consistent with its technical and operational capacities, the DGPD may also appoint a technical liaison person with the SILAIS, to coordinate operations and link ESS and program interventions with management at the local level.

C. Procurement of goods and services

3.8 For this PDL, procurement of goods, works and related services will be subject to the Bank's bidding procedure. For goods and related services valued at the equivalent of US$350,000 or more, and for works valued at the equivalent of US$1 million or more, international competitive bidding procedures will be used. Procurement involving lesser amounts will be governed by national legislation, provided it is compatible with Bank principles. Except for procurement contracts requiring international competitive bidding, which the Bank will supervise ex ante

(i.e., before signature of the contracts) , the Bank will supervise competitive bidding and other forms of procurement on an ex post basis (i.e., after signature of the contract).

3.9 Similarly, the contracting of consulting firms, specialized institutions or individual experts will be subject to the Bank's policies and procedures contained in document GN-2220-10 of February 2004. Consistent with that procedure, consulting contracts equivalent to US$200,000 or more will be subject to international competitive bidding, while those for lesser amounts will be governed by Bank procedures, except that in such cases, an open prequalification process is not required to make up the short list of providers of such services. Except for consulting contracts requiring international competitive bidding, which the Bank will supervise ex ante (i.e., before signature of the contracts) by the Bank, the Bank will supervise these contracts on an ex post basis (i.e., after signature of the contract).

D. Execution period and disbursement schedule

3.10 The execution period for the program is estimated at four years, with a maximum disbursement period of five years. According to the tentative net disbursement plan shown below, there will be one initial disbursement and four subsequent tranches.

Table III-1
Tentative net disbursement plan (US$ millions)

Source	Initial	Tranche I	Tranche II	Tranche III	Tranche IV	Total
IDB/FSO	6.0	6.0	6.0	6.0	6.0	30.0
%	20.0	20.0	20.0	20.0	20.0	100%

3.11 The initial disbursement of up to 20% of the loan will become effective when the loan contract enters into force and the conditions precedent to the first disbursement have been met. This advance of funds will be used to cover the initial management agreements and contracts that are key to achieving the outcomes, such as launching the expansion of coverage, implementing the investment plan for maternity homes, primary health facilities and hospitals, and ensuring continuity in the monitoring and evaluation system.

3.12 In accordance with document GN-2278-2, which approved the PDL approach on an experimental basis, this initial advance will be subtracted from the subsequent disbursements. In this regard, the borrower has requested an exception to the policy so that in this specific case, where Bank procurement procedures will apply, the initial disbursement would be subtracted proportionately from all performance-based tranches. The rationale is that a major investment effort will be required in the early years in order to achieve the final outcomes, and the country has a low margin of incremental budget resources that would make it possible to stabilize

initial financing flows. If the initial advance has to be subtracted from the next disbursement, this will severely compromise MINSA's ability to invest further towards the subsequent outcomes, because the net disbursement of resources in the first performance-driven tranche will be low, since the reimbursement for eligible expenses incurred with resources from the initial disbursement can for the most part be justified. On the other hand, the option of subtracting the initial disbursement proportionately from the subsequent tranches, i.e. at a rate of US$1.5 million per tranche, makes it possible to stabilize the flow of funds at up to US$6 million net for each tranche of financing.

3.13 If this requested exception is approved, each of the four disbursement tranches of the PDL will be in the amount of up to US$6 million net, representing reimbursement of eligible expenses, which will become effective when the respective outcome targets have been met and a favorable performance audit report has been issued. As a general approximation, the financing tranches are expected to be disbursed at the beginning of the respective calendar year, at which time statistics will be available on the fulfillment of the agreed intermediate and final indicator targets.

3.14 For all the performance-driven tranches, supporting information for the disbursements will be reviewed on an ex post basis. As noted above, on the basis of experience with loan 1027/SF-NI, MINSA has sound financial management, accounting and internal control systems which make this approach to documentation review appropriate, and indeed it is already in use for minor amounts (see paragraphs 1.16 to 1.19).

E. Monitoring and evaluation

3.15 In order to measure program outcomes and propose any needed corrections or reorientation, a robust system of monitoring and evaluation is proposed. It will strike an appropriate balance between MINSA’s existing internal capabilities, the use of independent auditors to review results, innovative measures of social control by the community based on the user satisfaction survey, and the Bank's monitoring and evaluation mechanisms.

1. Monitoring and evaluation of MINSA

3.16 MINSA has planned a series of mechanisms to ensure ongoing monitoring of project execution, scheduled activities, and the achievement of the planned outcomes, as detailed in the technical files for the operation. Those mechanisms include the matrix of program outcomes, the manual of indicators, the performance audit, social control, and regular supervision over service providers. With respect to information systems, the ministry will continue using its existing institutional systems, such as SIMINSA for sector activities, and the National Public Investment System (SNIP) and SIGFA for budgetary, financial and accounting records. In a

complementary manner, specific information will be generated by public and private providers that underpin the expansion of basic health services coverage, and this information will be integrated into the institutional systems.

3.17 Monitoring and evaluation will take place at the central level, at the SILAIS level, and at the local level. At the central level, the DGPD will be in charge of coordinating system administration and the information flow from service providers and the SILAIS, and producing periodic monitoring reports on the program, with respect to physical and financial execution and to the achievement of performance targets and indicators. It will also serve as counterpart to the performance audit technical teams. Within the DGPD, there will be two working teams to coordinate the monitoring and evaluation system. The first will cover information systems, and the second will cover monitoring and evaluation. The first will manage the information collection and dataflow process, while the second will supervise and oversee quality, the preparation of quarterly execution reports, coordination with MINSA's technical units, and technical assistance to the executing units.[5]

3.18 At the regional level, the SILAIS will represent and run the program in the departments and will coordinate the collection and compiling of information, both manually and using the SIMINSA automated system. The SILAIS will verify and validate information records to guarantee the quality of the data. Within the SILAIS, the Office of the deputy manager of the SILAIS will be responsible for administering data on the system and for recording program outcomes, and it will serve as a liaison and departmental coordinator for all issues relating to program supervision and monitoring.

3.19 Information on the output of services and the implementation of activities under the program will be generated and consolidated at the municipal level. Information will be generated in the health clinics and health centers, and will then be compiled and consolidated at the municipal level, while information from hospitals will be consolidated at the SILAIS level. When it comes to processing and consolidating information, the most important role will fall to the statistics from the health centers and the hospital statistics departments. Within these local units, the directors of health centers and hospitals will be responsible for quality review and analysis of the information reported.

3.20 As the administrator of the monitoring and evaluation system, the DGPD will work with the SILAIS to organize inspection visits to verify the information reported and to review the information consolidation and flow processes. This review process will also serve to: (i) provide information and feedback to the local executing units on progress and results under the program; (ii) generate a culture of performance

[5] The staff working on monitoring and evaluation tasks at MINSA headquarters is comprised of 10 people, there are two people in each of the 12 priority SILAIS devoted to these tasks, one person for each hospital selected, and at least one person involved in this area in each of the 76 priority municipios.

measurement within the program in executing units (health clinics, health centers, hospitals and SILAIS); (iii) establish a structured and systematic process for monitoring the program; and (iv) improve the information quality control mechanisms.

2. Performance audit

3.21 To ensure independence in the verification of fulfillment of the outcomes associated with each disbursement—except the initial disbursement—attainment of the respective goals will be reviewed by means of performance audit that will examine and evaluate the quality of the data generated by the outcomes monitoring systems, and examine the accuracy, reliability, relevance, validity and credibility of the data. As part of the performance audit, the Bank, MINSA and the audit team will hold quarterly meetings to review progress against the targets, to identify any problems of data consistency and validity, and to propose corrective measures to support program execution and achievement of the goals.

3.22 This independent performance audit will be conducted by an international entity (a private consulting firm, a university, or an independent international organization) selected and hired by the Bank and paid for with proceeds from the loan. The terms of reference for this performance audit are in the technical files for this operation and will be an integral part of the loan, recording that the payments to that entity will be independent of the program disbursement structure.

3. Social control

3.23 MINSA is planning to conduct periodic user satisfaction surveys in communities of the 76 selected municipios that will benefit from the expansion of maternal and child health services. The results of the surveys will help to improve the basket of services provided, and to establish a system of incentives and disincentives for NGOs providing health services. For example, if an NGO is well regarded by the community, delivers its contracted services, and provides adequate care, while at the same time recording and compiling the information needed for monitoring and evaluation of outcomes under its responsibility, it may receive an additional bonus for quality of care. On the contrary, if the community rates its performance poorly, and if it does not meet the other criteria of proper care, the NGO's compensation may be trimmed. If the community is severely dissatisfied, and if the NGO has failed to fulfill its contractual commitments, its registration could even be canceled.

4. Monitoring and evaluation by the Bank

3.24 The Bank will monitor the program with the active participation of Headquarters and the Country Office in Nicaragua, using inspection and supervisory procedures suited to the experimental nature of a PDL. The borrower will be expected to cooperate with the Bank by providing the necessary assistance and information. To

this end, support from administration missions will be considered and will take place as often as deemed appropriate.

3.25 Thirty days after the loan contract enters into force, the Bank, with support from MINSA, will evaluate the borrower's administrative procedures through the institutional capacity evaluation system and the procurement capacity verification tool (procurement checklist). The baselines for indicators to monitor the institutional strengthening of MINSA in the areas of procurement, financial management, and internal control will be established as a result of the application of these tools, as will the targets related to these indicators, which are to be reached within the first 12 months of program execution.

3.26 The executing agency will submit semiannual execution reports to the Bank, covering progress towards achieving program outcomes, as evaluated on the basis of the intermediate and final indicators in the matrix of outcomes (Table II-2). These reports will spell out the progress towards monitoring indicators and objectives for the institutional strengthening of MINSA agreed upon during the period preceding the entry into force of the loan contract, through the instruments described in the preceding paragraph. Information will also be included on outlays under each eligible category made for purposes of achieving those results. In each case, the reports will note measures taken by the executing agency to make up for any slippage in the original schedule of outcomes, institutional strengthening indicators and eligible expenses.

3.27 On the basis of all this information, the Bank will update the project performance monitoring report (PPMR) periodically. Because this is a PDL, the PPMRs will be amended to emphasize monitoring of program outcomes and the institutional strengthening indicators, in order to report in a timely way on the measures taken by the executing agency in case of any significant shortfalls against the agreed targets for each of the disbursements. They will also take account of the periodic reports of the external auditors on financial and operational aspects during program execution.

3.28 Within a period of 12 months from the entry into force of the loan contract, the Bank will commission a special independent evaluation to review the progress of MINSA's institutional strengthening in the areas of procurement, financial management and internal control. If the evaluation shows that the agreed progress has been achieved, the loan may continue to be executed as a PDL with Bank procedures. If not, the Bank and the borrower will agree on appropriate measures in accordance with the terms of the loan contract. Such measures may include actions to be adopted for purposes of continuing with project execution through the use of a different financing modality than the one envisaged in this loan proposal.

3.29 If the proposal continues to be executed as a PDL, the Bank will also conduct regular annual reviews, a midterm evaluation, and a final evaluation, using as their

principal input the outcomes achieved in terms of the intermediate and final indicators agreed in the matrix of outcomes (Table II-2) for each stage, as reported semiannually by the executing agency and in the respective PPMR. The intermediate evaluation will look at the intermediate indicator trends as they relate to the baseline, while the final evaluation will consider intermediate and final indicator trends against the baseline, for input to the project completion report. These two evaluations could also contain an evaluation of MINSA's progress in expanding coverage, and especially its success with the user satisfaction surveys for strengthening innovative forms of social control. In all instances, MINSA's institutional strengthening progress in the areas of procurement, financial management and internal control will continue to be reported.

3.30 Consistent with current policies and procedures, the Nicaraguan authorities were consulted regarding their willingness to conduct an ex post evaluation of the program. They indicated that they would prefer not to do such an evaluation, but they undertook to maintain the necessary information on the outcome indicators and make it available to the Bank so that, if deemed necessary, the latter could conduct an ex post evaluation of the program later in order to provide empirical evidence on the impacts from program activities to reduce maternal and child morbidity and mortality from avoidable causes. Given the special nature of a PDL, the findings and results of an ex post evaluation could show what happens to the outcomes after the project is completed, making it possible to track improvements or setbacks and to identify any technical causes of one or another type of response and ways of promoting the sustainability of targets and outcomes achieved.

F. External audit

3.31 The external audit of entities involved in program execution will be done by a firm of independent auditors acceptable to the Bank, in accordance with Bank policies and procedures (AF-200). This will be a financial and operational audit, designed to ensure that program funds have been used to cover eligible expenses necessary for achieving the planned outcomes, and that Bank procedures have been followed. To this end, there will be an ex post review of all supporting documentation for disbursements under each tranche. The financing of the external audit will fall under the category of eligible technical assistance and consulting services expenses.

3.32 For these purposes, the executing agency will submit annual financial statements for the program to the Bank, based on terms of reference previously approved by the Bank (AF-400), and audited by a firm of external auditors. Within 60 days after each disbursement request, the executing agency will submit a comprehensive ex post review of disbursement processes subject to this modality, as well as the supporting documentation for the request, according to terms of reference previously approved by the Bank (AF-500).

IV. FEASIBILITY AND RISKS

A. Institutional feasibility

4.1 In terms of procurement, there has been significant progress in MINSA's experience with Bank procedures through loan 1027/SF-NI, now nearing completion. At the same time, it has significant experience with management by results in the context of monitoring the ERCERP indicators under sector operations supported by the Bank, which have helped to strengthen that institutional capacity and to promote a change of organizational culture, shifting the emphasis from inputs and outputs to a focus on results.

4.2 Another important aspect for the institutional feasibility of this operation has to do with the implementation mechanisms that have been worked out giving technical and operational leadership to MINSA's DGPD, which is the line unit most directly involved in implementing the ESS as a whole, and this operation in particular. Its performance will be bolstered with specialized technical and administrative support directly responsible to it from the project just being completed. This means that MINSA will now have a more permanent institutional management capacity and that the knowledge acquired can be applied more widely, avoiding duplication of functions and potential organizational conflicts arising from the existence of separate coordination units.

B. Socioeconomic feasibility

4.3 As detailed in the matrix of program outcomes, coverage indicators are expected to improve over the short and medium terms, specifically those relating to reducing the profile of maternal and child morbidity and mortality, such as pregnancy monitoring and institutional childbirth. At the same time, tracking indicators, represented by hospital treatment of the most prevalent maternal and infant pathologies, i.e. maternal hemorrhaging and neonatal asphyxia, are expected to improve. Over the medium and long terms, such progress will result in lower maternal and infant mortality rates, provided it is accompanied by improvements in the country's overall demographic, economic and social conditions, thereby producing significant savings for the health system and a better basis for human capital formation through efforts at prevention, improved care, and results-based management. In this way, the country will be in a better position to achieve the MDG targets in health, its population will be healthier and thus more productive, and it can generate significant cost savings through management by results and a preventive and promotional approach to health care.

C. Financial feasibility

4.4 The financial feasibility and sustainability of the ESS and of this program are assured by the five-year development plan that MINSA has adopted for the health sector, giving operational effect to public health policies and priorities relating specifically to the extension of maternal and child services to the country's vulnerable population, together with the decisive support shown by the international community, through multilateral and bilateral cooperation agencies, and the likelihood that the country will be able to allocate further budgetary resources to health or even reallocate resources over the next five years. As well, the possibility of linking disbursements to outcomes in terms of intermediate and final indicators will have a significant impact on the sustainability of these efforts beyond the next five years, recognizing that, if the planned outcomes result in a concrete improvement in maternal and child health, this will facilitate the continued flow of external and internal funding for the health sector.

D. Social and environmental impact

4.5 This operation qualifies as a social equity-enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704). The operation also automatically qualifies as a poverty-targeted investment (PTI), since its eligible expenses support the expansion of primary health care coverage for the country's poor, and is targeted specifically at mothers and children, using criteria of poverty, access problems, and health conditions.

4.6 In terms of cultural relevance, it is important to note that MINSA has a legislative, policy and technical framework (primarily the Health Act and Regulations, the Comprehensive Health Care Model (MAIS), and the national health policy) that gives special consideration to the country's ethnic groups. With respect to primary health care in rural areas, to be delivered through NGOs, MINSA has clear guidelines and special criteria for selecting these service providers, especially in the indigenous communities of the Atlántica Norte Autonomous Region (RAAN) and the Atlántica Sur Autonomous Region (RAAS). These criteria have to do with an NGO's presence and recognition in the beneficiary communities, the local support it enjoys, and its approach to gender and language considerations, all of which are key aspects for strengthening ownership over the provision of services and improving their quality.

4.7 With specific reference to maternal and child care, since 1998 MINSA has been working with maternity homes, which have been a successful model for reducing maternal and neonatal mortality by improving access to institutional childbirth and neonatal care in remote communities without health care services nearby and with high concentrations of indigenous people. The maternity home model involves promoting community participation and relies on local organizations to run the homes, applying their knowledge of local culture and conditions. The maternity

homes rely on a community health network to deliver basic services, with volunteers and midwives trained to support the services. The proposed program will continue to support this model.

4.8 From the gender perspective, the operation gives priority to expanding health services for mothers and children from poor families, thereby promoting greater equality of access to such services for the target population. In addition, program monitoring and evaluation will stress intermediate and final indicators for measuring progress in basic care, such as the coverage of pregnancy monitoring and institutionalized childbirth, which have an important impact on the health of mothers, and that of children in their first months of life.

4.9 From the environmental viewpoint, the program will incorporate existing regulations relating to environmental licenses for handling hospital wastes into all loan-financed public works and equipment contracts financed as eligible expenses. All loan-financed service contracts will contain clauses requiring contractors to comply with environmental regulations.

E. Benefits and beneficiaries

4.10 Support for expanding health coverage to poor people who today have little or no access to medical services represents a great investment in human capital that should have a significant impact on social cohesion and productivity by making the population healthier, reducing the burden of maternal and child morbidity and mortality, and addressing other priority health problems that today threaten the country's economic and social development prospects. Mothers and children in poor families will be the principal beneficiaries of this initiative, which seeks above all to improve their health situation through a firm commitment to achieve intermediate and final health coverage goals for this target population. The program will place special emphasis on achieving these outcomes among the indigenous population, by encouraging alternative care models that will reduce the cultural barriers they now face.

F. Risks

4.11 The major risk to this operation is the possibility that the intermediate and final outcomes needed to trigger disbursements will not be achieved, for reasons beyond the control of the operation itself, such as unforeseen epidemiological events that might divert care services or affect the final outcomes, together with political instability that could lead to changes in public health policies and priorities. Both of these situations could jeopardize the implementation of the program and the achievement of its development objectives. As a mitigating factor, it should be noted that MINSA has a health services network that will be strengthened under the ESS in ways that will permit better control of unforeseen epidemiological events and allow the system to simultaneously remain focused on maternal and child

health care priorities. Efforts under the ESS have produced a health policy with clear priorities and a national health plan that is built upon a strong consensus in civil society, and the ESS is now recognized as "State policy." These factors provide the best assurance of continuity against any possible political shifts.

4.12 Another potential risk refers to the possible negative outcome of the independent evaluation on progress with the indicators of MINSA's institutional strengthening, which will be conducted no later than 12 months after the entry into force of the loan contract. If that evaluation indicates lack of fulfillment or partial fulfillment of the agreed targets, both parties will agree on measures they deem appropriate in accordance with the terms of the loan contract. Such measures may include actions to be adopted to continue with project execution by means of a financing modality other than the one envisaged in this loan proposal. To mitigate this risk, the institutional capacity evaluation system and the procurement capacity verification tool (checklist) will be used and a specific and realistic action plan in the area of procurement, financial management and internal control will be agreed upon, so that MINSA can achieve its goals in a timely way. In addition, periodic progress reviews are expected to make it possible to identify areas requiring more attention and correct them before the independent evaluation is conducted.

4.13 Lastly, an additional risk in the operation has to do with maintaining a close alignment of interests on the part of all the multilateral and bilateral agencies involved with the ESS: this will be essential if the resources committed to the five-year development plan are actually to materialize, and if MINSA is not to be restricted in its ability to earmark funding for the main priority of expanding maternal and child health care services to the country's most vulnerable population, a situation that could jeopardize attainment of the goals of the ESS and the program. On this point, the technical leadership that MINSA has shown in its conduct of the ESS and in making explicit its public health policy and priorities, as well as its implementation of the five-year development plan, will mitigate the risk of lack of coordination, minimize the likelihood of competing pressures from ESS partners, and ensure that their financing remains focused on their priorities to achieve the goals of the ESS and the program.