



1. Project Data

Project ID P164452	Project Name NI - Integrated Public Provision HCS	
Country Nicaragua	Practice Area(Lead) Health, Nutrition & Population	
L/C/TF Number(s) IDA-61990	Closing Date (Original) 30-Aug-2023	Total Project Cost (USD) 59,940,893.51
Bank Approval Date 15-Mar-2018	Closing Date (Actual) 28-Feb-2025	
	IBRD/IDA (USD)	Grants (USD)
Original Commitment	60,000,000.00	0.00
Revised Commitment	60,000,000.00	0.00
Actual	59,940,893.51	0.00

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2. Project Objectives and Components

a. Objectives

The project objectives, according to the Financing Agreement (April 2, 2018), were to extend the coverage and improve the quality of care for the most prevalent health conditions, with an emphasis on vulnerable groups. This ICR Review departs from the ICR's approach, which assessed achievement of two distinct objectives: extending coverage and improving quality of care. The ICR instead assesses achievement of coverage and quality under a single objective, as most project activities, and their associated indicators, supported outcomes of both coverage and quality.



b. Were the project objectives/key associated outcome targets revised during implementation?

No

c. Will a split evaluation be undertaken?

No

d. Components

The project had four components

Component 1: **Results-based financing for quality improvement in prevention and provision of health care services to the poorest 66 municipalities** (Appraisal: US\$14.0 million; Closing \$13.8 million). The purpose of this component was to ensure quality in the prevention of disease and the provision of care for communicable diseases and non-communicable diseases (NCDs) at the primary health care level in the public sector, for the 66 most vulnerable municipalities of the country. Specifically, the component financed results-based capitation payments from the Ministry of Health to municipalities to support the improvement of maternal and child health care services and to promote the prevention of NCDs. Capitation payments were to fund the widespread coverage of health promotion efforts, prevention of diseases at the primary and secondary levels, and the prevention of risk factors. The component was also to finance government monitoring of the quality of health care services provided by municipal health networks through the use of performance agreements specifying a Quality Health Care Plan and performance indicators to be used to measure the progress made by each municipal health network.

Component 2: **Support to the implementation of National Health Strategies for the provision of quality health services under the Family and Community Health Model (MOSAFC) (Appraisal: \$44.5 million; Closing \$43.75 million)**. Several national strategies were to be supported through this component, including:

- National Chronic Disease Strategy
- National Entomological Surveillance Program
- National Immunization Program
- National Medical Waste Program
- National Water Quality Management Program
- National Program for Inclusion of Holistic Medicine and Traditional Therapeutic Medicines
- National Intersectoral Adolescent Health Strategy for the Prevention or Delay of Adolescent Parenthood

This component was to finance goods, consulting and non-consulting services, minor works, training, and operation costs to implement the strategies. In addition, it was to fund structural design and procurement of equipment for a planned hospital in the Caribbean coastal region, as well as training programs for health workers at the central and local levels; strengthening of the Medical Equipment Maintenance Center; and ensuring that the Ministry of Health's (MINSA's) information systems at all levels of care were connected and compatible.



Component 3 (Contingency): **Provision of contingency financing in the case of a Public Health Alert, or a Public Health Emergency (Appraisal: no funds allocated; Closing: US\$1.0 million)**. This component was triggered in November 2019, in response to a public health alert declared for dengue, zika, and chikungunya. In a Level 2 restructuring, the World Bank approved the reallocation of US\$1.0 million from Category 3 (goods, works, services, and operating costs under Component 2) to Category 4 (eligible expenditures under Component 3) to finance emergency response activities.

Component 4: **Project management (Appraisal: \$1.5 million; Closing: \$1.4 million)**. This component was to finance efforts to strengthen the capacity of MINSA to administer, implement, supervise, and evaluate project activities, including support for carrying out external financial audits.

e. **Comments on Project Cost, Financing, Borrower Contribution, and Dates**

The project was to be financed by a US\$60 million International Development Association Credit, of which US\$59.94 million was disbursed. There was no associated borrower contribution. The project was approved on March 15, 2018, and became effective on June 20, 2018. A midterm review was held in June of 2020. There were two restructurings. In November of 2019, in response to a public health alert for dengue, zika, and chikungunya, the Bank reallocated US\$1.0 million in financing from Component 2 to Component 3. A second restructuring in April 2023 extended the project's closing date from August 30, 2023, to February 28, 2025, to complete key activities that had been delayed due to the COVID-19 pandemic. The project closed on February 28, 2025.

3. Relevance of Objectives

Rationale

The project was responsive to country conditions identified and targeted prevalent health conditions amongst vulnerable groups in Nicaragua. Overall, NCDs were found to be the most prevalent health condition in Nicaragua, accounting for approximately three quarters of the burden of disease. However, the project also targeted health conditions which, while not prevalent nationwide, were particularly acute in lagging regions. While health indicators in general have been improving thanks to the country's sustained economic growth and consequent increased public health sector spending, there were marked discrepancies between regions. Nicaragua had almost halved maternal mortality between 2009 and 2014, but due poor quality of care and inequities, some local systems had up to four times the national average for maternal mortality. Similarly, there were striking differences in the reduction of under-5 mortality rates. While the national average under-5 mortality rate declined from 42 to 17 live births per 1,000 between 1998 and 2011-2012, mortality rates in rural areas remained 10 percentage points higher than the national average, with particular discrepancies in the neonatal period. This in turn was partially due to high rates of adolescent births. Given these disparities, the project addressed both maternal and child health concerns and NCDs under the mantle of "most prevalent health conditions," in order to take into account the objectives' focus on "vulnerable groups."

The project was fully in line with the latest Country Partnership Framework (CPF, 2018-2022). The project contributed to the CPF's Objective 2: Improved Health and Early Childhood Development, under Pillar 1: Investing in Human Capital in Particular for Disadvantaged Groups. Building on many years of the



Bank's investment in the health sector, the CPF named strengthening public health systems for integrated quality and sustainable efficient delivery of health services as the key issue for Bank support (CPF, p. 13). More specifically, the project directly addressed several issues of concern cited in the CPF, including improving the quality of health care services (both prevention and provision) for the most common health conditions; a decentralized, community-based approach for rural areas; development of systems to address climate-sensitive diseases (malaria, dengue, zika and chikungunya); prevention and control of major chronic diseases; inclusion of traditional therapies and implementation of strategies to delay adolescent parenthood; and hospital services in the underserved Caribbean region (p. 19). CPF milestones focused on an increased proportion of institutional births for adolescent mothers, increased percentage of pregnant women receiving prenatal care in lagging municipalities, and an increased percentage of health centers certified for hypertension screening in selected municipalities. The 2022 Performance and Learning review of the CPF confirmed the relevance of these goals.

The PDO were aligned with and directly supported national health strategies. The project supported the rollout of several complementary national strategies aimed at improving quality of care, including those focused on chronic disease management, holistic medicine and traditional therapeutic medicine, adolescent health, and continuing medical education. These strategies were in line with the National Plan for Poverty Reduction and Human Development 2022-2026 (ICR, p. 8).

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Extend the coverage and quality of care for the most prevalent health conditions with an emphasis on vulnerable groups

Rationale

The project's theory of change held that the objectives were to be achieved in two ways. First, through results-based capitation payments to the 66 poorest municipalities in the country contingent on their performance against tracer indicators agreed in annual Quality Health Care Plans, coverage would be increased while ensuring quality (ICR, p. 3). Second, the project was to provide support to several national health strategies aimed at improving the quality of care for selected conditions nationwide, including hypertension, epidemics and health emergencies, holistic and traditional medicine, and adolescent health. Taken together, these interventions plausibly and logically were connected to achievement of the objective, improved coverage and quality of care.

The emphasis on vulnerable groups mandated by the objective statement was to be achieved in three ways. First, the project as a whole supported the government's MOSAFC, which provides free access to health care



services to the poorest and most vulnerable segments of the population. Second, within the project, the 66 poorest municipalities were to be targeted (PAD, p. 38). Third, the project defined vulnerable groups as indigenous peoples, children, adolescents who are pregnant or at risk of becoming pregnant, and those at risk of acquiring NCDs in the poorest municipalities (PAD, p. 13). This emphasis was to be evident both in the types of interventions supported by the project and in the choice of results framework indicators. Of the two components, the first component, "Results-based financing for quality improvement in prevention and provision of health care services to the poorest 66 municipalities," focused on the geographic definition of vulnerability, whereas the second component, "Support to the implementation of national health strategies for the provision of quality health services under the MOSAFC," addressed challenges particularly affecting those in the third definition of vulnerability (as above). The project's results framework employed a tiered system for target municipalities, with separate baselines and targets for three defined groups of municipalities, grouped according to their level of achievement of coverage and performance indicators, at appraisal. Specifically, funded municipalities in Group 1 (G1) (the lowest performers) were expected to increase coverage and improve the quality of their care; those in Group 2 (G2) were expected to improve the quality of their care; and those in Group 3 (G3) were expected to demonstrate the sustainability of the improvements that they have already made (ICR, p. 6).

The results framework for the project, while largely adequate for assessing the project's efficacy, did not differentiate between intermediate results indicators (IRIs) and PDO-level indicators (PDOIs) in a way that was fully consistent with the theory of change. Specifically, some outcome-level results were listed as IRIs and vice versa. As a result, this Review presents indicators below based on a logical analysis of the theory of change, regardless of whether they were written in the results framework as intermediate outcomes or project development outcomes.

Outputs

Quality Health Care plans were implemented as planned in the 66 participating municipalities, with their level of performance tracked and verified by the Project Verification Commission.

Physical investments and purchases were completed, including:

- Rehabilitation and provision of medical and non-medical equipment in secondary-level health units in critical areas such as operating rooms and emergency departments.
- Improvements to sanitary infrastructure in 10 primary hospitals.
- Rehabilitation and equipping of 19 specialized laboratories.
- Rehabilitation and equipping of 22 teaching spaces.
- Rehabilitation of 10 mobile clinics.
- Purchase of vaccines for children and older adults.
- Supplies and medicines to treat cases of cervical cancer.

Intermediate Outcomes

- The percentage of health centers certified to screen hypertension increased, between 2019 and 2024 in G1 from 64 percent to 100 percent, in G2 from 65 percent to 100 percent, and in G3 from 63 percent to 100 percent.
- The national laboratory for the assessment of residual waters was refurbished as per target, facilitating an increase in the lab's output by 20 percent.



- The number of health facilities with updated and implemented waste management plans rose from a baseline of 27 to the targeted 63.
- 10 entomology areas were fully equipped and providing services, as per target, along with the training of 38 health workers in medical entomology. According to the ICR (Table 3), these improvements have decentralized entomological techniques and diagnostics, bolstering epidemiological surveillance and timely vector control.
- The target for increase in the number of municipal health units implementing traditional medicine was greatly surpassed, with the establishment of 315 specialized clinics nationwide against a target of 48 and a baseline of 12. Over 17,373 health professionals were trained, enhancing the overall capacity of the health care system. This initiative also led to the development of 12 integration plans in Local Systems of Integral Health Care (SILAIS), with these communities incorporating local customs and practices. As a result, there was a 63 percent increase in complementary therapy services between 2020 and 2023, resulting in over 1.4 million consultations. Additionally, 30,920 community promoters were trained, who then disseminated knowledge on the safe use of medicinal plants and self-care practices within their communities. The efforts were further supported by the active involvement of more than 9,944 community leaders, traditional agents, and health personnel in the implementation of these plans (ICR, Table 3).
- 5,300 health personnel received training against a target of 1,000, including training of central support staff and maintenance personnel on maintenance of health equipment, records, and statistics.
- The national Chronic Disease Standard was revised and disseminated with project support, thereby advancing the strategic objectives of the National Chronic Disease Program at the national level. With the support of technical assistance funds from the Bank, the first national survey on cardiovascular diseases, diabetes, and their risk factors among the population aged 10 years and older was conducted in 2020.
- A total of 10,600 Chronic Disease Brigadiers were certified. These workers played a key role in the establishment of chronic disease circles to provide support and information to chronic disease sufferers. These circles convened weekly to engage in discussions on topics relevant to self-management, nutritional guidelines, the use of glucometers, and pharmacological compliance, and they facilitated the sharing of experiences with long-term patients. In addition, monthly evaluations were conducted to review urgent cases associated with severe hypertension, symptomatic hyperglycemia, and severe hypoglycemia (ICR, p. 12). In 2019, a national non-attendance rate of 32 percent was documented, which decreased to 5 percent by the end of 2024. In the SILAIS that participated in the project, the non-attendance rate was reduced from an average of 32 percent to 6 percent. Development of these circles by Chronic Disease Brigadiers has significantly reduced absenteeism in monthly health check-ups, ensuring that more than 90 percent of registered patients receive monthly check-ups and medication deliveries (ICR, p. 17).

Outcomes

- Targets for the percentage of children under 1 year receiving three doses of pentavalent vaccine were all surpassed. G1 (Baseline: 86 percent, Target: 89 percent, Result: 100 percent). G2 (Baseline: 95 percent, Target: 95 percent, Result: 100 percent). G3 (Baseline: 97 percent, Target: 97 percent, Result: 100 percent).
- The target for the percentage of women having at least four prenatal care visits was also surpassed for all groups. G1 (Baseline: 54 percent, Target: 58 percent, Result: 98 percent). G2 (Baseline: 67 percent, Target: 72 percent, Result: 91 percent). G3 (Baseline: 71 percent, Target: 78 percent, Result: 99 percent).



- The targets for increase in the number of women between 20-49 years of age with screening for cervical cancer was surpassed. G1 (Target: 1 percent, Result:122 percent). G2 (Target: 2 percent, Result: 56 percent). G3 (Target: 3 percent, Result: 77 percent).
- The targets for percentage of adolescents (under 20 years of age) with institutional birth delivery was surpassed for all groups. G1 (Baseline: 44 percent, Target:50 percent, Result: 95 percent). G2 (Baseline: 76 percent, Target: 82 percent, Result: 99 percent). G3 (Baseline: 80 percent, Target:88 percent, Result: 95 percent).
- Under Component 3, which disbursed US\$1 million to support the response to the 2019 public health alert declared for dengue, zika, and chikungunya, over 10.7 million home visits were conducted to promote awareness on prevention of vector-borne diseases in 2019, compared with a baseline of 5 million to 2014

Overall, the ICR found that the project had a higher impact on low-performing municipalities (G1 and G2) than on the better-performing ones (G3). Specifically, the performance gap between G1 and G3 municipalities decreased significantly or was fully closed. Similarly, the performance gap between G2 and G3 municipalities was fully closed for all indicators with the exception of prenatal coverage, for which the performance gap increased by 4 percentage points, as coverage of prenatal care increased at a slower pace in G2 municipalities relative to G3 ones.

Rating
 High

OVERALL EFFICACY

Rationale

The project was highly effective, with all targets being achieved or exceeded. Over the course of the project, there were significant expansions in coverage and quality improvements in care for the most prevalent health conditions and primary health care services in general, plausibly due, at least in part, to project support. Results are supported by a clear causal chain between project-financed activities (results-based capitation payments, health infrastructure and equipment, training, and technical assistance) and improvements in both coverage and quality of care of the most prevalent health conditions. Performance in reaching the most vulnerable was relatively higher among G1 (more vulnerable) municipalities compared to G2 and G3 ones, thus significantly reducing the performance gap between these municipalities.

Overall Efficacy Rating

High

5. Efficiency



The project outperformed economic efficiency projections. The economic rate of return was estimated at appraisal 13.60 percent and in the ICR at 21.0 percent. The revised economic analysis done at project closure shows a net present value of US\$32.75 million at a 10 percent discount rate. The estimated cost-benefit ratio was 1.84, indicating that every dollar invested generated nearly two dollars in social value. The analysis was based on credible assumptions, though it did not quantify reductions in hospital costs—a key benefit of strengthened primary health care—and therefore the results likely represent a conservative estimate of total benefits (ICR, p. 16).

Implementation efficiency was also strong overall. Among the contributors to implementation efficiency was the use of performance-based capitation payments. This payment mechanism was designed to improve the efficiency of public expenditures by linking disbursements to performance, thereby encouraging more strategic use of resources and supporting long-term cost control through the delayed onset and reduced burden of chronic diseases (ICR, p. 21). Both restructurings (2019 and 2023) were well managed and did not negatively affect outcome achievement or disbursement efficiency. The project disbursed 99.98 percent of its total US\$60 million Credit proceeds. Administrative costs were kept low at 2.3 percent of total costs, primarily because the project was implemented directly through the MINSA, without a parallel implementation unit. Efficiency was further supported by having additional staff in the General Administrative and Financial Directorate (ICR, p. 16).

Project delays were caused by the COVID-19 pandemic, necessitating an 18-month closing date extension, as well as issues related to the Siuna Hospital construction. There were delays in the procurement and construction of the Medical Equipment Maintenance Center during the COVID-19 pandemic. However, no cost overruns were incurred. This is notable given that most other civil works globally during the same period experienced cost increases due to inflation, supply chain disruptions, and broader market constraints. In addition, there was a need to reassign the budget initially planned for the study and equipping of the Siuna Hospital. The project, under Component 2, included a feasibility study of the construction and equipping of a second-level hospital to be built in Siuna (Northern Caribbean Coast) and the financing of acquisition of medical equipment for said hospital. However, these plans did not materialize due to delays in the donation process of the land, which took over a year. Following the land acquisition, the bidding process for the study would have taken twelve months, and the financing arrangements for hospital construction were projected to span no less than 36 months. In summary, it was not possible to complete the goals within the established Credit term. Therefore, the amount of US\$11.5 million was reassigned to other activities within the same component (ICR, p. 23).

These shortcomings in implementation efficiency are assessed as moderate. Overall project efficiency is rated Substantial.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	13.60	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	21.00	100.00 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.



6. Outcome

The outcome rating for this operation is Satisfactory, with High relevance and efficacy and Substantial efficiency. While overall the project was successful, delays led to some project funding being reprogrammed.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

There is some risk to development outcomes, mostly due to budgetary uncertainty. According to the ICR (p. 27), the activities financed in this project, including for training and monitoring systems, may not continue to receive adequate budgetary support in the medium to long term. Ensuring ongoing implementation of these activities requires either increased government allocations or continued support from development partners. The ICR notes that the sustainability of staffing, supervision, and monitoring gains will depend on the availability of adequate and predictable financing for human resources. In addition, infrastructure and service continuity, especially in rural and remote areas, is vulnerable to natural disasters such as hurricanes, earthquakes, landslides, and prolonged drought.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was well designed, based on two decades of World Bank-financed support for the Nicaraguan health system, and firmly aligned with the country's own health strategies. The project directed its funding through the government's own systems, both through capitation payments to municipal health systems and through provision of funding for government health strategies that were relevant to the PDO. The mechanism of results-based capitation provided a strong incentive framework that aligned municipal performance with national health priorities, increased coordination among directorates, and enhanced local accountability. This system was bolstered by robust monitoring and quality assurance mechanisms, as detailed in Section 9a. In addition, due to the strength of MINSA, it was possible to implement the project without the need for a Project Implementation Unit, thereby enabling greater capacity development and increasing the likelihood of sustainability of results (ICR, p. 21).

Project design was rooted in lessons learned in previous and ongoing World Bank and donor-funded projects in Nicaragua and internationally. These lessons included the use of performance agreements to reinforce accountability, the need for contingency funds to respond to possible disasters or other emergencies, and the use of national-level technical and administrative directorates and councils to



monitor project activities, foster ownership of project activities, build local technical capacity, and ensure the sustainability of outcomes (PAD, p. 20).

The PAD appropriately assessed key risks and provided necessary risk mitigation strategies. Key risks were assessed as: (i) the country's limited capacity to administer the system of capitation payments and output-based disbursements; (ii) the sustainability of improvements made to the quality of services provided in the public health care network; and (iii) the potential environmental and/or social risks associated with the construction of the hospital in the Siuna municipality. To address these risks, the following mitigating measures were planned: (i) strengthening the technical units of MINSA through capacity building and technical assistance; (ii) promoting ownership of the quality of care improvement process at the local level by ensuring the participation of community representatives in the Project Verification Commission; and (iii) close supervision to oversee compliance with the Bank's safeguard policies, including during the construction phase of the hospital in Siuna.

The results framework, while overall of high quality, was lacking in certain baselines, and often had very low targets that were ultimately, in some cases, achieved over eightfold. In conversation with IEG, the Bank Team explained that "in several instances, baseline data for certain indicators (e.g., cervical cancer, non-communicable diseases) were not available, necessitating the construction of new baselines or reliance on similar historical data. This limitation hindered the contextualization of results relative to other interventions." Similarly, when asked by IEG about the pronounced over-achievement of some targets, and whether this suggested that more ambitious goals should have been incorporated from the outset, the Bank team responded: "This is a fair comment. However, some indicator data were not available, and therefore it was difficult to establish realistic targets. Regarding the indicator for cervical cancer screening, for example, baseline data by age group and standardized measurement procedures were not available at the project's inception."

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The Bank team supported timely, cost-efficient project implementation through many crises and challenges. The early phase of project implementation coincided with a challenging macroeconomic and political environment, including a sharp contraction in real gross domestic product (by 4 percent in 2018 and by 3.9 percent in 2019). These external shocks posed considerable potential risks to implementation capacity and service delivery. In response, the Bank demonstrated strong contextual responsiveness by increasing technical support across critical areas such as health care quality, infrastructure, equipment, training, and monitoring of the project's Operational Plan. This helped maintain implementation momentum in a volatile setting. Subsequently, the Bank team was able to support the government through an urgent public health emergency (dengue, zika, and chikungunya) by shifting funds for contingency response, and through COVID-19, by postponing the project end date to enable completion of civil works, equipment procurement, and training.

The Bank team was able to respond to major barriers to advancement in ways that ensured that funding was used in an effective manner. Specifically, when it became apparent that it would be impossible to complete the planned feasibility study of the construction and equipment of the second-level



hospital in Siuna (Northern Caribbean Coast) due to significant delays in the land donation process, the Bank team reassigned the amount of US\$11.5 million to other lines within the same component through a No Objection from the Bank granted on January 12, 2020.

Bank supervision was proactive and sustained, with 14 formal implementation support missions complemented by regular videoconferences. During this period, technical assistance was provided in various aspects including public health issues, operational aspects (monitoring of indicators, training, equipment and infrastructure), safeguards, and fiduciary aspects. This continuous support facilitated timely identification and resolution of implementation bottlenecks (ICR, p. 27). Supervision was well documented through Aide Memoires and Implementation Status and Results Reports that candidly reflected problems detected and identified appropriate actions. These reports were triangulated with semi-annual reports from MINSA and certification reports from the Pan American Health Organization (PAHO). The Bank also ensured compliance with environmental and social safeguards, including satisfactory receipt and review of the Post-Closure Action Plan, which was satisfactorily completed during the project's grace period.

Quality of Supervision Rating

Highly Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project integrated a comprehensive and multi-layered quality assurance system to promote accountability, performance monitoring, and continuous improvement in service delivery. Several layers of oversight and stakeholder engagement were involved in data collection. Specifically: (i) municipalities were required to submit semi-annual self-evaluation reports to the SILAIS; (ii) the SILAIS were responsible for reviewing these municipal reports and presenting their findings to both the Technical Council and the Citizen Council; (iii) the Project Verification Commission conducted field verification visits to the municipalities; (iv) the National Institute of Statistics validated annual population projections for each municipality, ensuring data accuracy; and (v) PAHO was engaged to independently certify the achievement of the agreed-upon indicators and the implementation of the Quality Health Care Plans through regular field visits. These visits targeted lower-performing municipalities, while visits to higher-performing municipalities were conducted on a random basis. PAHO's collaboration from 2018 to 2022 not only reinforced the credibility of the certification process but also contributed to capacity building, technical support, and peer learning. These quality assurance mechanisms, carefully established during project preparation, proved to be a key enabling factor for effective implementation and results achievement.

The project's results framework was generally robust, mostly corresponding to the project's theory of change, but was lacking in adequate baselines, was at times under-ambitious, and did not always correctly differentiate between intermediate outcome indicators and PDO-level outcome indicators. Particularly helpful was the breakdown of baselines and targets into three sub-groups, enabling differentiation of monitoring between vulnerable, more vulnerable, and most vulnerable



municipalities. However, the selection of PDOIs was limited, with a mere two PDOIs accompanied by other IRIs that were effectively at the same results level as the PDOIs. The two PDOIs reflected two of the priority areas for project achievements, one with a particular focus on one "highly vulnerable" population (pregnant teens) and another on a key issue of concern (hypertension screening). Arguably, the hypertension PDOI was actually an intermediate measure ("Percentage of health centers certified on screening of hypertension") rather than an outcome measure such as number of people screened. Conversely, outcomes for other priority areas of endeavor were listed as IRIs (for example, "Percentage of women receiving prenatal care coverage"). Moreover, as mentioned in Section 8a, baseline data were at times lacking, and targets were often notably unambitious (for example, the target of only a 1-3 percentage increase in women between 30-49 years of age with screening for cervical cancer).

b. M&E Implementation

According to the ICR (p. 25), project M&E was timely and comprehensive. The Directorate of Information Technology carried out the necessary coordination so that each municipality could directly enter their improvement plans and data in real time. The training of responsible personnel with a built-in culture of constant quality improvement was a key factor in achieving M&E goals. With technical assistance from the Bank, MINSA created a Situation Room where teams evaluated in real time the information collected nationwide.

c. M&E Utilization

The ICR does not provide information on M&E utilization. When asked about utilization, the Bank Team responded that "the agreements from supervision missions for project implementation served as a tool for monitoring and follow-up."

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The ICR (p. 25) states that "safeguards compliance is rated Satisfactory." The project triggered OP/BP 4.10 on Indigenous Peoples, due to the presence of indigenous peoples in the project area. The project updated and disclosed an Indigenous Peoples Plan (IPP) that was developed as part of a previous Bank-financed health care project. The IPP was implemented by the Directorate of Health and supervised by the National Coordination of Indigenous Peoples and Traditional Medicine. The project



included financing for implementation of the National Program for the Inclusion of Holistic Medicine and Traditional Therapeutic Medicines, to support Nicaragua in moving towards the integration of traditional ancestral medicine into Western health systems. Consultations and assessments were undertaken during project preparation to ensure that the project's maternal, adolescent, child, and reproductive care activities took into account the cultural practices of indigenous groups.

The project triggered OP/BP 4.01 on Environmental Assessment because it financed minor rehabilitation works, including minor pre-installment works for the medical and non-medical equipment to be purchased by the project for health facilities and technical studies for the construction of a hospital in Siuna. In addition, even though Bank funds did not finance the construction of the Siuna hospital, the Bank oversaw compliance with safeguard policies during the construction phase, as part of project supervision, since Bank funds had financed the structural design and the Environmental and Social Impact Assessment of the hospital. For these reasons, the project was classified as Category B. An Environmental and Social Management Framework (ESMF) was updated based on one prepared for two previous Bank-financed projects (P106870 and P152136). Additional measures by MINSa included the training of personnel on safeguard policies, supervising the implementation of Environmental Management Plans for works (renovations and new constructions) by contractors, and operating a participatory mechanism for complaints, requests, suggestions, and commendations that allowed for the continuous improvement of health services, among other things. According to the MINSa team, the environmental and social safeguards added value that, over time, enhanced the understanding of the importance of these requirements, and capacity was created and institutionalized within MINSa, as well as in 63 health facilities across the territory (ICR, p. 26).

The project also supported the development of Safe Hospital Waste and Occupational Health and Safety Plans for 63 hospitals. Dedicated hospital-level committees were established to monitor safeguard compliance, contributing to improved management of medical and solid waste, greater adherence to the use of Personal Protection Equipment (PPE) protocols, and enhanced occupational health and safety practices.

b. Fiduciary Compliance

Fiduciary risk was rated as moderate, with no major issues during implementation. MINSa had a fiduciary unit and a procurement unit which were both familiar with the World Bank's procedures from previous projects. The Bank considered the audited financial statements for each fiscal year to be satisfactory and accordingly issued favorable opinions. Additionally, the unaudited financial statements submitted semiannually on time by the executing unit were deemed acceptable, in line with the financial reporting requirements set forth in the Financing Agreement. No major issues arose in contracting processes or contract management (STEP). At the end of the project's grace period, all contracts and their supporting documents except one (project audit) were properly recorded in the management system (STEP). According to the Bank team, "the Project Technical Committee acted as a structured platform for continuous information sharing and critical feedback among the Procurement, External Cooperation, and Administrative Financial Divisions. This collaborative mechanism was instrumental in optimizing the preparation of bidding documents, conducting thorough bid evaluations, awarding contracts, monitoring contractual compliance, and securing approvals from the Bank in an efficient and effective manner. The procedural steps were executed with precision, with comprehensive documentation entered into STEP, all deadlines consistently met, and marked improvements observed in the technical competencies of MINSa's



executing units at every administrative level, as well as in the capacity of the fiduciary team. This approach not only ensured procedural rigor but also contributed significantly to institutional strengthening and project success."

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	High	Substantial	Shortcomings in design of M&E indicators and targets.
Quality of ICR	---	Substantial	

12. Lessons

Lessons from the ICR (p. 28):

Results-based financial incentives can help promote behavioral changes among institutional actors, particularly through capitation payments linked to municipal performance on quality standards. These payments fostered alignment with MINSA’s efforts, advancing the universal provision of selected health care services and standardizing care and reporting across municipalities. Combining these incentives with timely technical assistance from the World Bank, training, and development of M&E tools at the municipal level can reinforce change.

Engaging national-level technical and administrative directorates and councils to offer clinical leadership, as well as overseeing and evaluating project activities, can foster ownership, enhance local technical expertise, and contribute to the long-term sustainability of project outcomes. Among other responsibilities, central units should have a supervision plan and a methodology for evaluating progress against targets.

When a maintenance strategy for equipment is implemented and supported by an information system, it enables continuous monitoring of the operational status of assets, which facilitates the planning and timely execution of preventive maintenance. This technological integration not only optimizes the use of physical resources, extending their lifespan



and reducing downtime in health units; it also provides precise, real-time data that strengthen strategic decision-making. Additionally, it helps to improve operational efficiency, reduce costs associated with unexpected failures, and guarantee the sustainability of productive processes. The development and implementation of the Medical Equipment Information System was a key innovation in the MINSA Maintenance Strategy to ensure the functionality and sustainability of medical and non-medical equipment within the public health service network. The MINSA Maintenance Strategy established a robust foundation to address future challenges, creating a more efficient, resilient, and sustainable health system with a focus on continuous improvement. As a result, equipment availability increased, and the problem-solving capacity of the SILAIS and health establishments across the country was strengthened.

By integrating traditional medicine into the health system, a country's health model can be strengthened, and a harmonious, complementary approach promoted. Incorporating ancestral practices into the primary care service network helps expand coverage and deliver more efficient and effective care to patients. The successful national scale-up of an innovative model integrating Traditional Ancestral Medicine into the National Health System demonstrates the value of culturally appropriate approaches to care. By promoting coordination between the formal health system and local Indigenous and Afro-descendant communities, and by training health personnel to recognize and respect traditional knowledge and beliefs, the model strengthened the delivery of comprehensive, community-centered health services.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was overall of adequate quality, with a few notable gaps. First, where the ICR pointed out shortcomings, there was at time a lack of specification of the exact nature of the shortcomings referred to. For example, Efficiency was downgraded to Substantial in the ICR due to "constraints in accessing the data needed to perform a more comprehensive cost-benefit analysis," without any detail provided about what data were unavailable and why that led the reviewer to believe that there were problems with project efficiency. Second, the assignment of ratings did not always correspond with the narrative. For example, the ICR at several points discussed the inadequacy of the results framework and yet awarded the project a High rating for M&E. In addition, no information was given on utilization of M&E. Similarly, Quality of Supervision was given a Substantial rating without the ICR providing any information on the ways in which supervision was sub-optimal. Finally, the Lessons section of the ICR did not present lessons generalizable to other projects but rather findings about the project, which could serve as the basis for recommendations but were not recommendations in and of themselves.

a. Quality of ICR Rating

Substantial

