



Nicaragua



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Nicaragua is made up of 17 departments in three macro-regions: the **Pacific** region, an area of high ecological risk and high population density (Managua, 398 inhabitants/km² versus 45.8 inhabitants/km² countrywide); the **Central** region, a predominantly rural area with an agricultural economy and little road development; and the **Atlantic** region, covering 46% of the country, a mostly rural jungle area with low population density (5.9 inhabitants/km²), large indigenous population, low indices of schooling, limited access by road, and few links with the rest of the country. Despite a decline in the poverty rate, the absolute figures have been rising, with poverty concentrated in rural and peri-urban areas. Nicaragua has one of the poorest macroeconomic indicators, import/export, and income/expenditure figures in the subregion. High levels of unemployment and migration (both internal and external, mainly to Costa Rica and the United States of America (USA)), have repercussions for family development, health, and access to services. The greatest contribution to the gross domestic product (GDP) comes from agriculture; industrial development is still in its infancy. Remittances from Costa Rica and the USA are a major source of income; in some areas, narco-trafficking is responsible for illegal inflows of foreign exchange.^a The Pan American Health Organization (PAHO)/WHO Strategic Plan 2003-2007 designates Nicaragua a priority country, which implies intensified technical cooperation to bridge the health gaps, both internally and with other countries in the Region of the Americas.

Total population (2005) ¹	5 483 447
% under 15 years (2005) ¹	39
Population distribution, % rural (2005) ¹	40.96
Life expectancy at birth (2004) ¹	69.5
Mortality in children under 5 per 1000 (2001) ²	45
Maternal mortality ratio per 100 000 live births (2004) ³	88.2
Total health expenditure as a % GDP (2004) ⁴	7.6
Government health expenditure, health as a % of total government expenditure (2004) ⁵	13.6
Human development index ranking among 177 countries (2003) ⁶	112
Gross National Income (GNI) per capita US\$ (2005) ⁷	850.3
% population living below the national poverty line (2001) ⁵	45.8
Adult literacy rate (15+) (2003) ⁸	76.7
% of the population with sustained access to a source of drinking water (2004) ⁹	74.5
% of the population with sustained access to sanitation services (2002) ⁹	46.3

Sources:

- ¹ Nicaraguan Institute of Statistics and Censuses
- ² Nicaraguan Health Survey. DHS 2001
- ³ Ministry of Health of Nicaragua
- ⁴ WHO data on the National Health Accounts
- ⁵ Technical Secretariat of the Presidency of the Republic. Political, Social and Economic Report 2004, August 2005
- ⁶ Human Development Report 2005
- ⁷ Central Bank of Nicaragua, Report on Economic Indicators, Preliminary Figures
- ⁸ UNESCO Institute of Statistics
- ⁹ Nicaraguan Water Supply and Sewerage Systems Company. Analysis of the Drinking Water and Sanitation Sector of Nicaragua, November 2004

HEALTH & DEVELOPMENT

The Ministry of Health (MOH), other ministries (Defense and Government), and the Nicaraguan Social Security Institute (INSS) are public providers that cover 67% of consultations, although only 60% represent free services^b; 31% of consultations are with private providers, who receive direct payment from users.

There are inequities in access to health services due to geography, socioeconomic status, gender, and ethnicity. Only 6.3% of the population is insured (INSS)^c. Out-of-pocket expenditures constitute a serious barrier for the poor and ethnic minorities^d, over and above the lack of access in rural areas.

Perinatal mortality remains high in the poorest departments and is associated with respiratory diseases, neonatal sepsis, congenital malformations, and diarrhoea. The main causes of death among children under-5 years in poor and indigenous communities are respiratory diseases, diarrhoea, malnutrition, and meningitis.

Maternal mortality remains high in disadvantaged groups (rural areas, indigenous populations, the poor, adolescents, and women with low levels of schooling), even though the total fertility rate has fallen. Some 55% of women in rural areas give birth at home; 65% are illiterate. Maternal mortality remains high in these populations, and adolescents account for approximately one-third of maternal deaths.

Some 22% of children in the most disadvantaged quartile of the urban area suffer from malnutrition versus 0.4% in the richest quartile; 9% of births produce infants with low birthweight.

Communicable diseases continue to increase. Malaria (*Plasmodium falciparum*) is concentrated in municipalities with indigenous populations. Tuberculosis is prevalent in the poorest, most inaccessible areas. The incidence of HIV/AIDS is rising, especially among the female population; the ratio of males to females with HIV/AIDS has gone from 5:1 in 1999 to 3:1 in 2005^e. Vaccine-preventable diseases are under control, with coverage rates between 84.7% and 97.6%.

Noncommunicable diseases result in high morbidity and mortality; the leading causes of mortality are cardiovascular disease, diabetes, external causes, and cancer. Traffic accidents, suicide, drowning, injuries from external causes, and leukemia are the leading causes of death in young people (10-19 years). Mental illness, neurosis, alcoholism, general violence and domestic violence have increased, primarily in urban areas.

Growing environmental degradation, vulnerability, and risk of disasters; rapid, irresponsible economic development, the indiscriminate felling of trees, and the deterioration in production conditions, habitat, and soils have heightened the risk of man-made disasters and increased the vulnerability to natural disasters (earthquakes, volcanic eruptions, hurricanes, landslides, droughts).

^a Health Situation Analysis, proposed health plan of the autonomous regions of the Atlantic Coast of Nicaragua, 2004
^b Demographic and Health Survey (ENDESA) 2001
^c Nicaraguan Social Security Institute. Statistical Yearbook 2004
^d PAHO Inequity in Health-Ethnicity Project, Nicaragua 2004
^e Ministry of Health National STD/HIV/AIDS Programme

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> • National Development Plan 2004-2015 seeks to reduce social fragmentation and inequities • Strengthened Strategy for Economic Growth and Poverty Reduction includes an index of poverty and economic vitality for the allocation of resources • The General Health Law, Comprehensive Health Care Model (MAIS), and National Health Plan 2004-2015 • The opening of opportunities for social and community participation • Culmination point in the Heavily Indebted Poor Countries Initiative (HIPC II) in 2005, in its debt relief process. 	<ul style="list-style-type: none"> • Achieving greater equity among regions and social groups in the country in terms of social protection in health and overcoming the fragmentation and segmentation of the health system • Increasing investment in health and its determinants, as a means of overcoming poverty • Helping to lower health service access barriers and improve the quality of care • Improving information systems to monitor progress and the attainment of the Millennium Development Goals • Overcoming the critical shortage of human resources and their limited development.

PARTNERS

International cooperation (in the form of donations or loans) remains critical to the health sector.

Multilateral cooperation is provided by the European Union, the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), the Inter-American Development Bank, the World Bank, and the agencies of the United Nations (UN) system (UNDP, UNFPA, UNICEF, PAHO/WHO and WFP). Bilateral cooperation is provided by Austria, Canada, Finland, France, Germany, Ireland, Italy, Japan, the Netherlands, Norway, Sweden, Spain, the United Kingdom of Great Britain and Northern Ireland and USA.

Nongovernmental organizations offer services in areas inaccessible to public services, mainly through community action - these include the American Red Cross, CARE, Doctors of the World, Doctors without Borders, the International Red Cross, *Movimondo* and Save the Children.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> Expanded sector-wide approach (SWAp) for coordinating bilateral cooperation The Government has requested the UN to serve as the Secretariat of the Global Roundtable for coordinating cooperation Health Sector Roundtable and Interagency Health Sector Support Committee. 	<ul style="list-style-type: none"> Institutional strengthening of the Ministry of Health for directing cooperation and exercising the steering role in the sector Strengthening the SWAp in health, especially the scope and depth of participation and the policy dialogue between the Government and other key actors.

PAHO/WHO STRATEGIC AGENDA (2004-2008)

The main areas of PAHO/WHO cooperation include: People and communities, towards whom PAHO/WHO will direct its actions to complete the unfinished agenda in health; the national health system, with the MOH at its head, will seek to improve the integrated response to the health needs of the population; Other actors in national health development, facilitating coordination and optimal use of the available resources; and, finally, the PAHO/WHO Representative Office, accelerating changes in the cooperation model towards the intensified action required for a priority country. The strategic agenda consists of:

- **Revival of Health for All and Primary Health Care (PHC).** Emphasizing the importance of the goal of Health for All and the Primary Health Care Strategy as essential components of the Organization's work in Nicaragua in the medium term, implying a renewed commitment to implementing the values of PHC.
- **Promotion of equity and inclusion in health.** Combating inequity and exclusion in health through the health system by bolstering the sector's capacity to expand coverage and improve the quality of health services through a rights-based approach. It also calls for exercising of the steering role and the development and implementation of sectoral policies, as well as improvements in service delivery, financing, and insurance coverage for vulnerable groups by the national health system. PAHO/WHO will support intense social dialogue and advocacy with the principal social and political actors.
- **Emphasis on health care and disease determinants.** Improving health and achieving the goal of Health for All will become a reality if health determinants are analyzed and managed within the context of State policies and social and territorial development plans; and if sectoral reforms are conceived and developed with an inclusive intersectoral approach. The critical health and health services situation and the burden imposed by health determinants beyond the sector (standard of living, nutrition, access to water and sanitation, education, communications, etc.), requires the expansion of PAHO/WHO cooperation in the medium term, using a multisectoral, multidisciplinary approach to health as an integral component of national development, and the strengthening of the Ministry of Health's capacity to intervene.
- **Development of health information and intelligence management.** PAHO/WHO will give priority to the generation, analysis, and dissemination of information on the health situation, services, and health determinants. This implies developing closer ties with universities and research centres and strengthening national capacity and the capacity of the PAHO/WHO Representative Office itself. PAHO/WHO will also promote the use of information for decision-making on health policies and programmes.



ADDITIONAL INFORMATION

WHO country page <http://www.who.int/countries/nic/en/>
PAHO/WHO Country office web site <http://www.ops.org.ni/>

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