



Building Hope and Health through Dialogue

A STORY OF COMPANY-COMMUNITY
DISPUTE RESOLUTION IN NICARAGUA

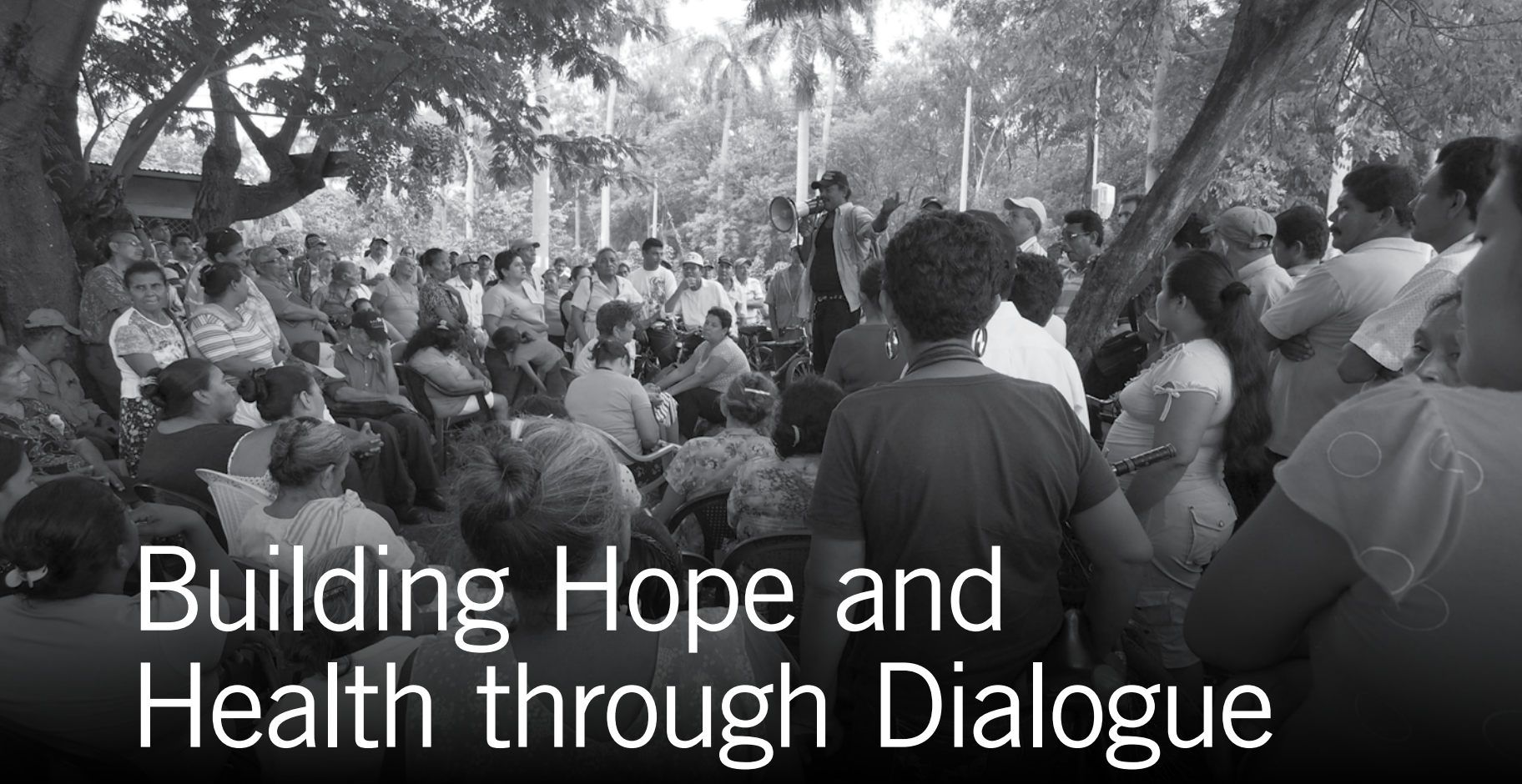


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The Office of the Compliance Advisor Ombudsman (CAO) is the independent accountability and recourse mechanism for the International Finance Corporation (IFC) and the Multilateral Investment Guarantee Agency (MIGA), the private sector lending and insurance arms of the World Bank Group. CAO addresses complaints from people affected by IFC and MIGA projects with the goal of improving social and environmental outcomes on the ground and fostering greater public accountability of IFC and MIGA. CAO reports directly to the President of the World Bank Group.

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Office of the Compliance Advisor Ombudsman (CAO)
World Bank Group
2121 Pennsylvania Avenue NW
Washington, DC 20433 USA
Telephone: + 1 202-458-1973
Web site: www.cao-ombudsman.org
e-mail: cao@worldbankgroup.org

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Office of the Compliance Advisor (CAO)
2121 Pennsylvania Avenue NW
Washington, DC 20433 USA
Fax: +1 202-522-7400
e-mail: cao@worldbankgroup.org

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CONTENTS

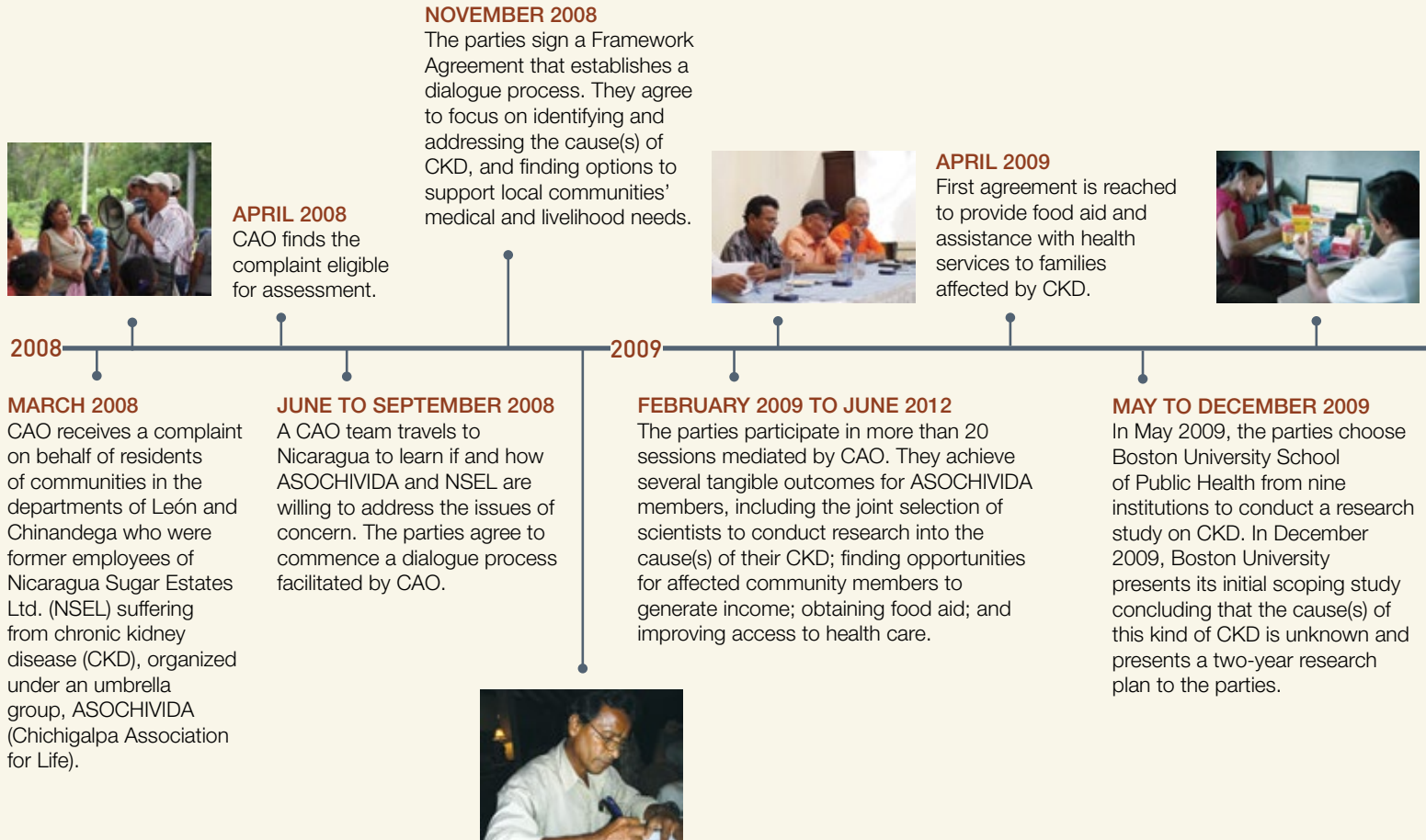
Case Timeline	iv
Overview	1
Background: Country Context	2
The Complaint	3
Assessment	6
Understanding the Conflict	6
A Decision for Dialogue	7
Representation of the Parties in the Dialogue Process	9
Dispute Resolution	11
Building Community Capacity at the Dialogue Table	11
Areas of Focus for the Dialogue Table	13
From Talk to Action	15
Outcomes	16
Health Care	16
Food Aid	18
Housing	18
School Materials and Other Donations	18
Microcredit and Microleasing	19
Industrial Poultry Production Project	19
Scientific Knowledge on CKD	20
Building Sustainability: Partnerships and Challenges	23
Reflections	25
In Memoriam	27
Notes	29
Acknowledgments	30

FIGURES	
Figure 1. The Stakeholders	4
Figure 2. Designing an Independent Research Study and Communicating the Findings	13

MAP	
Map 1. Chichigalpa and Surrounding Areas in Nicaragua	3

BOXES	
Box 1. Designing a Framework for Engagement	8
Box 2. The Role of Advisors	12
Box 3. The Scientific Process versus the Urgent Demand for Answers	21

CASE TIMELINE





AUGUST 2011 TO JUNE 2012

Boston University conducts an industrial hygiene and occupational health assessment; and provides recommendations for NSEL to improve work practices to prevent risk factors associated with heat stress and chronic dehydration. Through June 2012, Boston University concludes another set of studies on occupational and nonoccupational factors in CKD. All studies are available at www.cao-ombudsman.org.

JUNE 2012 TO AUGUST 2015

CAO monitors implementation of the agreement and explores opportunities to back the parties' efforts to engage national and international institutions such as the Pan American Health Organization (PAHO) to support a public health response.

JANUARY 2010

The parties appoint a business development expert funded by CAO to support income-generation projects.



2010

2011

2012

2015

JULY 2010 TO JUNE 2012

NSEL supports various initiatives. NSEL, the Nicaraguan Ministry of Health (MINSa), and DEG, a member of the German Development Bank (KfW), agree to support health center improvements in Chichigalpa. DEG also partners with NSEL to support community projects.



JUNE 2012

Parties sign a final agreement bringing the dialogue process to an end. The agreement includes ongoing provisions related to health care improvements, income-generation projects, and continued support for Boston University's research.

AUGUST 2015

CAO closes the case and releases a public conclusion report. Ongoing research into CKD in Central America is being conducted by Boston University and Harvard University, among others. PAHO is closely coordinating with Nicaragua's Ministry of Health to play a more active role in diagnosis, treatment, and steps to prevent the disease. NSEL and ASOCHIVIDA are continuing their dialogue and collaboration.



Sugar cane workers learn that it is important to stay hydrated in the hot sun (Felix Davey/CAO).



OVERVIEW

In 2008, the Office of the Compliance Advisor Ombudsman (CAO) received a complaint from former workers of Nicaragua Sugar Estates Limited (NSEL)—a client of the International Finance Corporation (IFC)—claiming they were suffering and dying from a kidney disease that in their opinion was related to their work at NSEL. It was a disease about which they had little information. The workers further claimed that their ability to feed their families, generate income, and improve their living conditions was severely compromised because of the disease. People were dying, and a cycle of mistrust, recrimination, and denial characterized the relationship between the group of complainants and NSEL. Tensions ran high among groups of former NSEL workers, who were protesting outside the company facility, and several court actions had been filed against NSEL. This was the situation

when the complainants requested CAO's intervention to promote dialogue to address these issues with NSEL. From 2008 to 2015, CAO convened a dialogue process for the group of complainants suffering from this chronic disease, and NSEL, to find joint solutions.

This case study tells the story of what happened. Through the dialogue process, stakeholders were able to focus on local, practical, effective, and sustainable outcomes for all involved. The challenge was for stakeholders to move beyond making judgments and finding fault. With time and through dialogue, the focus for some began to shift from communities' demand for compensation to forward-looking efforts to obtain scientific information on the causes of their chronic kidney disease, achieve sustainable outcomes for the community, raise awareness about CKD, and generate

“With the CAO process, we have changed almost 100 percent the way we fought for those suffering from CKD. ASOCHIVIDA and the company have agreed to be part of a dialogue having CAO as a mediator. The outcomes of this process have been good, and even after the process ended we continue to see results.”

Salvador Soto, Board Member of ASOCHIVIDA

solutions to address a public health issue that scientists and the Pan American Health Organization (PAHO) now consider an epidemic affecting Nicaragua and other countries in Central America.¹

BACKGROUND: COUNTRY CONTEXT

More than 80 percent of Nicaragua's poor live in rural areas—many in remote communities where access to basic services is still a daily challenge.² This is the case of the communities where the complainants live.

In 2006, IFC, the private sector lending arm of the World Bank Group, extended financing to one of the main companies in Nicaragua working to develop the sugar cane sector, Nicaragua Sugar Estates Limited (NSEL). NSEL owns an agro-energy complex located 120 kilometers northwest of Managua, in Chichigalpa, in the Department of Chinandega. The company employs thousands of people during the harvest season. The IFC financing was used to expand production and processing of sugar cane at the San Antonio Sugar Mill, established in 1890 and operated by NSEL.

Map 1. Chichigalpa and Surrounding Areas in Nicaragua



THE COMPLAINT

In March 2008, 673 residents of communities in León and Chinandega (map 1) filed a complaint with CAO with the assistance of the Center for International Environmental Law (CIEL), an international nongovernmental organization (NGO) based in Washington, DC.³ Many of these residents are formally organized under the Asociación Chichigalpa por la Vida (ASOCHIVIDA), a local organization created by former workers of the San Antonio Sugar Mill who are suffering from chronic kidney disease (CKD).

The complaint raised concerns related to health impacts—specifically, the widespread incidence of CKD, which has affected the lives of hundreds of former sugar cane workers and their families. In their opinion, this was related to their labor conditions and work as sugar cane cutters.

The community members claimed that they had tried all the mechanisms available to them in Nicaragua, including filing several lawsuits. As a last resort, they considered bringing a complaint to CAO.

CAO found the complaint eligible for assessment in April 2008. A CAO team travelled to Nicaragua to meet with ASOCHIVIDA's Board of Directors, their members, representatives of NSEL, the Ministry of Health, and other relevant stakeholders (see figure 1).

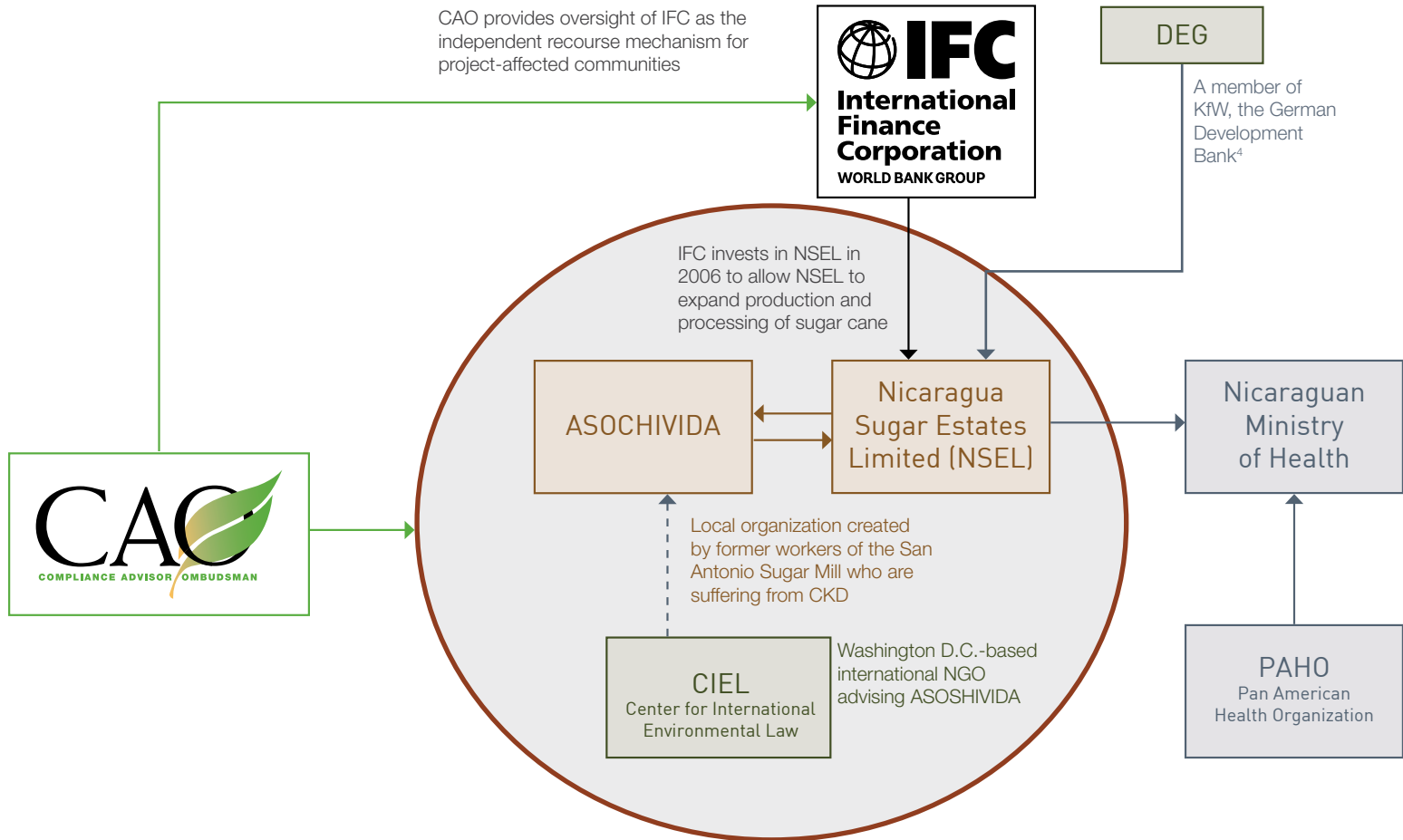
“Before CAO arrived, the conflict was very difficult. The company was not open to talk and we were on the street protesting about our disease.”

Salvador Soto, Board Member of ASOCHIVIDA



Members of ASOCHIVIDA were concerned about their health, future and the widespread incidence of CKD impacting many in their community.

FIGURE 1. THE STAKEHOLDERS



A woman displays her late husband's ASOCHIVIDA membership card. Many women are members of ASOCHIVIDA because they have lost their husbands or children to chronic kidney disease (Felix Davey/CAO).



ASSESSMENT

UNDERSTANDING THE CONFLICT

There had been a difficult history between the company and former workers affected by CKD. A dialogue had not been attempted since 2003, when nearly 1,300 former workers—including some people who are now members of ASOCHIVIDA—had benefited from \$2 million in humanitarian aid provided by the company voluntarily. However, this settlement had not resolved the fundamental problem.

In 2004, the Nicaraguan government passed a law establishing CKD as a labor-related illness, following joint work done by PAHO and the Nicaraguan Congress. In subsequent years, ASOCHIVIDA members organized a *plantón*—a protest camp—outside the entrance of the San Antonio Sugar Mill in Chichigalpa, conducting protests and blockading roads, to pressure the company to address their claims for compensation.



Given that history, CAO conducted an assessment from April to October 2008 to understand whether parties were open to resolving the issues raised in the complaint, and if so, how. ASOCHIVIDA's Board expressed their desire for dialogue on CKD from the start. However, NSEL expressed its reservations: namely, NSEL had concerns about how representative ASOCHIVIDA was within the community, since other local groups were confronting the company as well and claiming to represent the same people.

However, as the CAO assessment progressed, a number of factors would motivate the parties to agree to dialogue.

A DECISION FOR DIALOGUE

At the time CAO received the complaint, not only was there very limited information in the public domain about the prevalence of CKD in Nicaragua, but ASOCHIVIDA felt CAO's intervention was the only option available at that stage to address their concerns.

The company also began to see that a dialogue process mediated by a third-party neutral could be helpful and would unlock an opportunity to look into the cause(s) of CKD. Previously, the company had commissioned studies to try to understand the cause(s) of the disease and had tried to engage research institutions without success. These realities resulted in a joint decision between NSEL and ASOCHIVIDA representatives to pursue a dialogue process under the auspices of CAO.

Before the dialogue started, NSEL wanted to know more about what issues would be discussed and who was going to represent each party in the discussions. CAO worked with the parties to design a process they were comfortable with. In November 2008, the parties signed a Framework Agreement that defined how the dialogue process would take place, including who would sit at the table, and how outcomes from the dialogue would be communicated to the broader community (see box 1).



ASOCHIVIDA's Board met regularly to keep members informed about the dialogue process. Donald Cortez speaking to ASOCHIVIDA's members before he died from CKD in 2013.

BOX 1. DESIGNING A FRAMEWORK FOR ENGAGEMENT

When parties agree to enter into dialogue, there are often many aspects of the process that are new and unpredictable to them. Structuring a framework to guide the dialogue before embarking on the process can be extremely helpful. Such a structure helps define the kind of interactions the parties will have; the issues they will discuss; how and where the meetings will take place; who will sit at the table or represent and advise the parties; and how agreements will be implemented. In some instances, defining ground rules—general principles that guide how parties will engage—is sufficient. In other cases, parties must discuss and agree upon a more detailed framework before commencing dialogue. The design of the CAO dispute resolution process is flexible and aims to respond to the needs of the parties in each case. CAO, as a third-party neutral, brings to the process interpersonal and conflict-management skills, experience, and capacity to handle complex and sensitive issues.

In Nicaragua, both the company and community wanted to know what was causing CKD and how to deal with its impacts. This became the focus for the dialogue. When ASOCHIVIDA and NSEL representatives signed a Framework Agreement in November 2008, it established a structure to guide a dialogue focused on finding solutions to the problem of CKD in the impacted communities—specifically, finding its cause(s) and exploring initiatives to support the health and livelihood needs of affected community members. The Framework Agreement allowed the parties to envisage a clear structure and roadmap for the CAO dialogue, and provided a level of comfort and predictability to embark on the process.

“The presence of CAO in this dialogue process was fundamental. The team was very professional, very objective, and I very quickly overcame the concerns I had at the beginning.”

Alvaro Bermudez, Managing Director, NSEL



ASOCHIVIDA's Board reporting to and discussing developments with its members at a General Assembly.

REPRESENTATION OF THE PARTIES IN THE DIALOGUE PROCESS

As NSEL noted, representation for the community was complicated by the existence of other organizations representing people affected by CKD in Nicaragua. The Association of Cane Cutters of Chichigalpa had negotiated the settlement for humanitarian aid with NSEL in 2003, and many of their members were also members of ASOCHIVIDA. The Nicaraguan Association of People Affected by CKD (ANAIIRC) had organized a protest camp in Managua across from offices affiliated with NSEL, and was also advocating for compensation. The focus of their international campaign included boycotting NSEL's sugar cane products. This group did not want to participate in the dialogue process because in their view, there was nothing to be discussed about the cause(s) of CKD. The fact that CKD had been declared an occupational disease by law in Nicaragua was sufficient, in their view, to entitle them to economic

compensation. A third group was La Isla Foundation, an NGO focused on research and policy related to public health and human rights to address CKD among sugar cane workers in Latin America.

The CAO dialogue process remained focused on the complainant group represented by ASOCHIVIDA that had requested CAO's involvement. However, CAO did reach out to the other groups and offered to keep them updated on progress.

ASOCHIVIDA and NSEL agreed that any community member who wanted to be part of the CAO dialogue process could join ASOCHIVIDA at any time. They also agreed that, to the extent possible, their work through the dialogue table would aim to benefit all people affected by CKD.

At the beginning of the dialogue process ASOCHIVIDA had over 600 members. By the end of the dialogue process ASOCHIVIDA members numbered more than 2,200.

“We made the commitment to have a respectful and fluid dialogue in order to have these conversations with the company and continued to find solutions to a problem that is affecting us so much.”

Cecilio Ferrufino, Board Member of ASOCHIVIDA

ASOCHIVIDA meets with the CAO mediation team and the Boston University team (Felix Davey/CAO).



DISPUTE RESOLUTION

BUILDING COMMUNITY CAPACITY AT THE DIALOGUE TABLE

As the dialogue process started, the parties began to realize the pivotal role they needed to play to move the discussion along. They also had to determine the role that advisors would play in the dialogue process (see box 2). The CAO mediation team helped the parties navigate the way forward.

From the beginning of the process, ASOCHIVIDA was clear about its members' immediate health and livelihood needs. The challenge for their representatives was deciding what to prioritize and how to negotiate. Initially, this is where CAO's mediation team was able to help them the most. CAO facilitated internal discussions with ASOCHIVIDA's Board of Directors and Assembly of members to help them come to the dialogue table with clear priorities. Food for themselves and their

families was a basic concern, since those suffering from the disease could no longer work in labor-intensive activities, and there were very few alternatives in the area of Chichigalpa to access work beyond the sugar cane fields. Thus food aid was their first priority.

It soon became clear to the parties and the CAO team that the case also required external experts—in science, medicine, and business—who could help the parties navigate the complexities of the health issues and the search for solutions. External experts were crucial as the parties engaged in a joint selection process to identify scientists to conduct research into the disease that was impacting the communities, and to find options to support local communities' medical and livelihood needs.

BOX 2. THE ROLE OF ADVISORS

The role of observers and advisors is extremely important and determining their precise role is a joint decision that parties must make in any CAO dispute resolution process, since the design of the process is reached through mutual agreement.

In the case of this dispute, CIEL supported the community members in filing the complaint to CAO and became an essential advisor for ASOCHIVIDA, providing legal advice as the dialogue process commenced. ASOCHIVIDA valued the care, commitment, and advice CIEL provided to community members. Initially, ASOCHIVIDA asked to have CIEL present at the dialogue table, but NSEL did not even want them in the room. The parties agreed to allow CIEL to be present, but ASOCHIVIDA and NSEL would be the only parties able to sit and speak at the dialogue table. However, this arrangement was not without its challenges. For CIEL, the fact that while they were advising ASOCHIVIDA, but could not sit at the table with ASOCHIVIDA as their legal advisor, was perceived as a lack of balance since NSEL had their own lawyer present. However, this format resulted in strengthening the capacity of ASOCHIVIDA members to speak for themselves and empowered them to represent their own interests. Whenever ASOCHIVIDA needed CIEL's advice, a recess was requested.

As the process moved along, NSEL began to appreciate the role CIEL had in supporting the community, despite the company's initial push back and resistance to their presence.

As per CAO's Operational Guidelines, CAO seeks to work directly with a project-affected community.⁵ CAO believes communities have the right to self-determination and they need to be empowered to represent their own interests, when possible. But as in this case, CAO welcomes the positive role that advisors can play in the dialogue process.



ASOCHIVIDA'S Board and their advisor work closely together every step of the dialogue process.

AREAS OF FOCUS FOR THE DIALOGUE TABLE

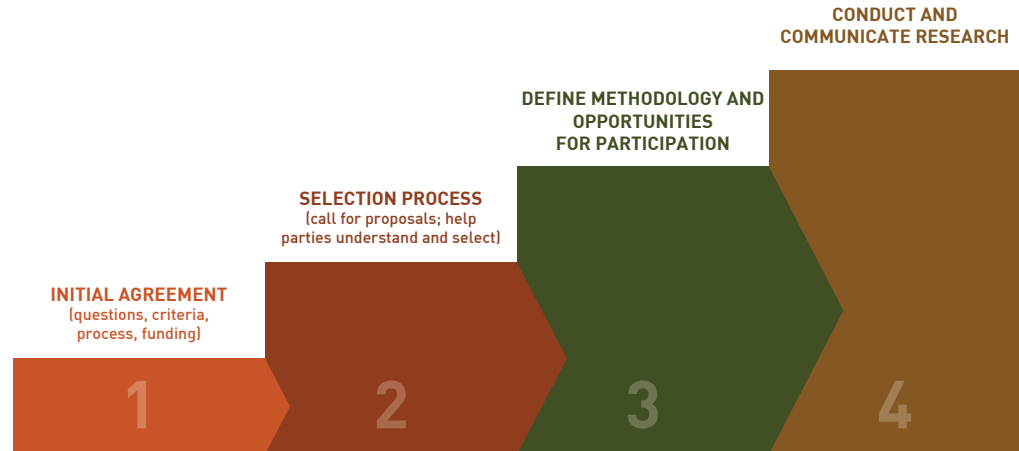
Research into CKD

The initial dialogue meetings focused on framing a way forward to establish the cause(s) of CKD in order to stop the disease (figure 2). Parties initiated their dialogue in February 2009, and met on average every four to six weeks to continue discussions.

The dialogue process helped the parties jointly define what criteria a study on CKD in the region would need to include to be trustworthy. The parties then defined the questions that needed to be answered:

1. What are the causes of CKD in the Western Zone of Nicaragua, an area that includes NSEL's San Antonio Sugar Mill and its sugar cane plantations?
2. Is there any relationship between the practices of the San Antonio Sugar Mill and the cause(s) of CKD?

FIGURE 2. DESIGNING AN INDEPENDENT RESEARCH STUDY AND COMMUNICATING THE FINDINGS⁶



The parties agreed that the study must be conducted by a team from an international institution, with proven scientific capacity and experience, with neutrality being paramount.

With these criteria, CAO prepared Terms of Reference (ToR) for an epidemiological scoping study for CKD in Nicaragua.

With agreement from the parties on the ToR, CAO solicited proposals from public agencies; universities in North, South, and Central America and Europe; and private consulting institutions. Nine proposals were presented from internationally recognized universities and private consulting firms. ASOCHIVIDA and NSEL worked with CAO to choose experts they felt were qualified and they could trust. Ultimately, this process enabled ASOCHIVIDA and NSEL to select three finalists. In April 2009, the parties jointly selected Boston University School of Public Health to conduct the research.

The selected Boston University team conducted the following studies: hygiene and occupational health assessment (August 2010); the investigation of water quality (August 2010); the qualitative analysis of interviews with physicians and pharmacists (February 2012); the pilot cohort study (February 2012); the investigation of biomarkers in workers (April 2012); and the investigation of urinary biomarkers in adolescents (June 2012). All these

studies are available on CAO's website, www.cao-ombudsman.org. For study results, please see pages 20-21.

Assessing health and livelihood needs

The parties were very much aware that they needed to explore options to improve immediate and long-term care for people suffering from CKD. With limited local health care options and lack of access to dialysis, the medical situation of CKD sufferers was dire. It was difficult for former workers who were sick to provide basic necessities for their families.

In 2009, CAO engaged an independent doctor to provide a general overview of the health and livelihood needs of ASOCHIVIDA members. The assessment indicated that those priorities included: improvement in the diagnosis, monitoring, and treatment of CKD; support in accessing end-stage treatment such as dialysis and renal transplant; complementary measures such as access to food and better knowledge about CKD for local communities and patients;



An ASOCHIVIDA member working at a local bakery. The dialogue process sought to bring sources of income and employment to the area.

and improved efforts to prevent this kind of CKD from occurring in the future. As a result, the dialogue table participants initiated discussions on what specific short-term support they could agree upon. In addition, the parties began discussing options to help the families affected by CKD gain access to sources of income and employment that would be sustainable over time.

FROM TALK TO ACTION

The parties reached their first agreements in March and April 2009, and implementation followed immediately. Reaching agreements early in the process helped build confidence and increase the comfort of the parties. Over the next three years, the parties continued to meet regularly at the dialogue table to learn about Boston University's findings and follow up on opportunities to improve health care for affected people and explore income generation activities to support livelihoods. Further agreements were reached in each of these areas. By June 2012, the parties were able to sign a final agreement that summarized all these previous agreements and captured further provisions related to health care, livelihood support and CKD research. The 2012 agreement officially brought the dialogue process to an end, and CAO entered a monitoring phase. For the next three years, CAO continued to monitor implementation

by the parties. In August 2015, CAO closed the case after confirming with parties that all agreements had been fully implemented.

CAO's dialogue table enabled ASOCHIVIDA and NSEL to address needs that went beyond a local dispute. It laid the foundation for a broader institutional engagement and a public policy approach to address the problem.

ASOCHIVIDA evolved from a small group demanding compensation into an organization with more than 2,200 members, running diverse projects. Company representatives are continuing to work with the public and private sectors in overcoming the impacts of CKD. When the conditions are right for dialogue, building collaborative relationships in a complex and highly charged setting becomes possible.



ASOCHIVIDA's Board signing the final agreement in June 2012.

OUTCOMES

HEALTH CARE

Specific outcomes related to health care started early in 2009. NSEL acquired an ultrasound machine for the Chichigalpa Health Center to detect the disease and aid in treatment, and recruited a radiologist to operate it.

Access to medicines and treatment

The parties also agreed that NSEL would supplement the supply of medicines to the health center, and provide two hemodialysis machines. The machines were initially rejected by ASOCHIVIDA's Assembly, who did not trust hemodialysis⁷ at the time.

In addition, ASOCHIVIDA created a fund to buy medicine. NSEL tripled every dollar ASOCHIVIDA members put into the fund. In cooperation with the organization Instituto de Acción Social Juan XXIII,⁸ ASOCHIVIDA now sells low-cost medications to its members. Medicine is delivered to



members at ASOCHIVIDA's pharmacy, located at their office in Chichigalpa. This arrangement has continued past the time that CAO closed its case.

More broadly, NSEL and ASOCHIVIDA agreed to work together, with CAO's support, to call on other institutions to make more comprehensive improvements

to the health system. Two assessments were conducted, which provided a set of recommendations.⁹ One of these recommendations was to improve the community health center. NSEL and DEG donated funds to the government of Nicaragua for this initiative. The renovations were completed by the end of 2015.¹⁰

Short-term health care initiatives

While progress with the Nicaraguan Ministry of Health (MINSa) was slow, the parties have implemented other initiatives with funding from NSEL.

- ASOCHIVIDA offers its members the daily services of a nurse, who provides assistance with injections, serum, and blood pressure tests.
- ASOCHIVIDA provides economic support to cover transportation costs for 68 members who are receiving hemodialysis treatment.
- ASOCHIVIDA implemented a peritoneal dialysis¹¹ pilot project aimed at raising awareness about the benefits of this kind of treatment. It highlighted the need to develop the capacity of local surgeons to adequately implant catheters for peritoneal dialysis. This need is being addressed through support from PAHO.
- A dental care unit from Universidad Nacional Autónoma de Nicaragua (UNAN)-León visits ASOCHIVIDA on a weekly basis to provide services to members.



A sugar cane worker goes for a check-up at the new NSEL mobile clinic.

Progress continues

The dialogue process played a very important role in changing negative perceptions about hemodialysis—people were scared of the treatment; they didn't think it would work; and they hadn't seen successful outcomes among ASOCHIVIDA's members. Currently, 68 members are receiving hemodialysis, and their lives have been prolonged.

In 2013, PAHO was given a mandate by its member-states to work on CKD. In Nicaragua, PAHO is working with the Nicaraguan government to set up a CKD surveillance system, expand access to dialysis, and explore new treatment options. PAHO's leadership and government collaboration may lead to more opportunities to find long-term solutions.

FOOD AID

One of the first agreements reached by the parties in 2009 related to food aid. The company initially agreed to provide food aid to 1,100 households of ASOCHIVIDA members for two years at an annual cost of \$300,000. NSEL has expanded its provision of food aid since 2009 and now covers more than 2,500 families (well beyond the original agreement, which stipulated an increase of this program to a maximum 1,800 households at a cost of \$500,000 per year). By 2015, NSEL had provided over \$5 million in food aid. This agreement has continued past the time that CAO closed the case.



More than 2,500 families are receiving food aid, which is helping to provide for their families.

“The outcomes may seem arbitrary, but the Board of ASOCHIVIDA negotiated each one of them to respond to the needs of its members. When you are sick with CKD, you can’t work and there aren’t any other economic activities in that part of the country. Former workers were very concerned about providing for their families, so food aid helps their family survive.”

Kris Genovese, former Senior Lawyer for the CIEL, currently at the Centre for Research on Multinational Corporations (SOMO), the Netherlands

HOUSING

By 2015, 100 new houses had been built for ASOCHIVIDA members who were living in poor conditions, with joint contributions from NSEL, the Inter-American Development Bank (IDB), the Colmena Foundation,¹² the National Housing Institute (INVUR), and the Municipality of Chichigalpa. In addition, materials have been periodically provided by NSEL to members of ASOCHIVIDA to repair existing homes. According to NSEL, the total budget for these initiatives has exceeded \$600,000.

SCHOOL MATERIALS AND OTHER DONATIONS

Another outcome agreed through the dialogue table was the distribution of school materials to more than 1,500 children under the age of 18 at the start of the school year. NSEL has distributed school materials to the children of ASOCHIVIDA members since 2009. This initiative is also continuing past the time CAO closed the case.

In addition, the engagement between ASOCHIVIDA and NSEL resulted in support from the American Nicaraguan Foundation (ANF),¹³ which has made several donations to ASOCHIVIDA, including clothing for adults and children, toys, beds, mattresses, personal hygiene products, and housewares.

MICROCREDIT AND MICROLEASING

In January 2010, CAO committed the services of a business development expert to work with ASOCHIVIDA members to develop business projects and alternative sources of employment in the area. While the expert explored different options,

the parties agreed that NSEL should set up a revolving small credit facility that ASOCHIVIDA members could access to develop their own business projects. The income-generating activities vary from loans to members for microcredit projects to microleasing projects.¹⁴

INDUSTRIAL POULTRY PRODUCTION PROJECT

In 2012, NSEL purchased an industrial poultry production facility for about \$250,000. Since June 2012, all profits generated by the facility have accrued to ASOCHIVIDA. Since 2013, this project has been generating a monthly profit of \$1,500 for ASOCHIVIDA, and

is expected to increase to \$2,000 per month. ASOCHIVIDA uses the profits to grow its medication fund, support members undergoing hemodialysis, help those who have lost a family member, and cover general operational costs of the organization. As agreed by NSEL and ASOCHIVIDA, NSEL will eventually transfer full ownership and administration of the facility to ASOCHIVIDA.

“We had made many commitments to ASOCHIVIDA and those have continued and have even gone beyond the commitments we originally made. We never tried to avoid our commitments because this community surrounds the sugar mill and we want the people who live there to be well.”

Alvaro Bermudez, Managing Director, NSEL



The industrial poultry production project. ASOCHIVIDA uses the profits from this project to support its members.

SCIENTIFIC KNOWLEDGE ON CKD

Perhaps one of the greatest challenges of the dialogue process was for the parties to understand the research process that Boston University undertook to look at the underlying cause(s) of CKD.

There was a clash of expectations. ASOCHIVIDA's expectation had been that Boston University would quickly determine that agrochemicals were the cause of CKD and that would open the door for them to

negotiate economic compensation with the company. It was hard for the community to understand why the research would take so long to determine the cause(s). In their view, it did not look that complicated, as they believed they had gone to work healthy and had come home sick. On the other side, the company's expectation was that the disease had no link with its operations, but they also focused on getting to a conclusive answer regarding causality, whatever that might be.

Boston University's research in Nicaragua and the work of other scientists show that CKD prevalence with strikingly similar characteristics is evident in other Central American countries such as Costa Rica, El Salvador, and Guatemala, as well as in other tropical regions, such as Sri Lanka and India. Boston University is continuing to investigate both occupational and nonoccupational factors with a broader geographic scope. For this effort, they have developed partnerships with many other scientists and research groups, including Harvard University.

The independent research studies conducted by Boston University under the auspices of the CAO dialogue process have contributed to building new scientific information on the causes of CKD affecting communities in Nicaragua and elsewhere in Central America.¹⁵ This information has been disseminated to ASOCHIVIDA, NSEL, to families and individuals impacted by CKD, and to the scientific and public health community at large.



BOX 3. THE SCIENTIFIC PROCESS VERSUS THE URGENT DEMAND FOR ANSWERS

Boston University's research efforts built on previous work done by local researchers, and took it much further in terms of scope and resources. Not only did they have unprecedented access to medical files, workers, and facilities at the San Antonio Sugar Mill for scientists to conduct necessary research for the first time, but they also launched a regional study in different countries and industries, which is under way.

The findings of Boston University's initial research started to signal that the cause(s) were not obvious and was most likely the result of a combination of both occupational and nonoccupational factors. How long it would take to determine the cause(s) was hard to predict. The research required looking at a range of other industries and countries to better understand and compare the nature of CKD in different environments, and find the scientific evidence to determine the cause(s) of the disease. This would be time consuming and costly.

In response to Boston University's first round of scientific studies, ASOCHIVIDA and NSEL accepted proposals for specific technical studies seeking causality. They included a water quality study and research that looked at the incidence of CKD among workers in other industries in Nicaragua, including the ports, construction, and mining industries.

Improvements in Workplace Practices

In 2010, Boston University identified heat stress as an occupational risk factor for CKD and made a number of workplace recommendations to help prevent CKD. In response, NSEL introduced changes in its workplace practices to reduce the effects of heat stress and dehydration on workers on the sugar plantations. NSEL also reported that they had reduced the hours of field work allowed, and introduced two mandatory rest breaks, in addition to the voluntary breaks workers can take during the day. Sugar cutters now work on average 4.5 to 5 hours per day; they are not allowed to work past mid-day. NSEL has also established a 10 to 15 day period for workers at the beginning of the harvest, to acclimate to the tasks at hand.

NSEL indicated they were more alert to the need to hydrate their workers more frequently, but also were measuring specific times when liquids and electrolytes were being consumed to see what impact these hydration measures were having. According to NSEL, these measures have helped current workers and are relevant preventive measures.

Since putting these measure in place, NSEL reports the number of new yearly CKD cases in its workforce has decreased, but this has yet to be independently verified.

The process promoted dialogue, trust and engaged parties in meaningful and difficult conversations.



BUILDING SUSTAINABILITY: PARTNERSHIPS AND CHALLENGES

What seemed at first to be a dispute between a specific company and its former workers soon proved to be a local manifestation of a much larger public health issue. CKD has now been recognized by Central American countries and PAHO as a serious public health problem.

Since CAO's first assessment trip, it became clear that the health issue impacting the community of Chichigalpa could not be resolved solely by CAO creating a safe space for community-company dialogue. For their part, the complainants and NSEL realized that CAO could only make its best effort to invite other stakeholders to help address CKD—it could not compel them.

Throughout the CAO process, several efforts were made by CAO to invite the government of Nicaragua to meet with the dialogue table participants and engage

with them on this issue, and to keep the government informed of progress at the dialogue table. It was crucial to engage the national government to sustain CAO's efforts.

After CAO approached the Nicaraguan Ministry of Health (MINSa) about the problem, CAO reached out to other national, regional, and international agencies, including PAHO, IFC, and the World Bank. However, CAO encountered greater difficulties engaging these entities than anticipated. This represented a particular challenge for CAO, which has had to carefully manage expectations about how far CAO could go with its facilitating role—both to ensure that ASOCHIVIDA and other parties understand the limits of CAO's mandate, but also to bring the necessary support to achieve sustainable outcomes from the process.

DEG quickly understood CAO's role, saw the value of the CAO-convened process, and has engaged in the search for solutions with its client and affected community members. DEG's support has been essential to the sustainability of outcomes on the ground.

With respect to IFC, their involvement in this case has been limited to the following:

- In April 2014, IFC reported that it had provided advice to NSEL on the poultry production project to make the operation financially self-sustainable. IFC sent an industry expert to review the project, who concluded that the poultry unit was doing well, but that opportunities for scaling up and/or replicating the business were not obvious at this stage.

- Based on lessons learned from CAO's dialogue process and Boston University's research, IFC has stated that CKD management is now an explicit part of IFC's due diligence in all its agribusiness and nonagribusiness investments in Central America, with a strong focus on preventive and remedial measures, where applicable. IFC also states that its occupational health and safety appraisal now includes an evaluation of pre-employment screening for CKD; monitoring and management of the disease during employment; and procedures to address prevention, education, and mitigation of CKD in the workforce and in the supply chain. IFC indicates that, in accordance with its Performance Standards, it also requires its clients to implement employee and community grievance mechanisms.
- IFC reports that it has developed a set of best practices and behaviors related to CKD, based on measures implemented by clients in Nicaragua and inputs from IFC specialists, with the aim of raising awareness and improving outcomes

and quality of life for those living with CKD. Currently, IFC is in discussions with DEG to develop an educational tool to prevent and control risk factors for CKD and improve overall management of the disease.

CAO has not monitored or verified IFC's action items relating to implementation of improvements on occupational health and safety in future IFC projects, as they were not a result of engagement with the parties through the CAO dispute resolution process.

After concluding its mediation role in June 2012, CAO continued trying to involve development organizations to cooperate on ensuring the sustainability of outcomes achieved. CAO began to look for opportunities to support a transition toward a public policy response that would fit the magnitude of the problem and that would be led by national and international institutions with the appropriate mandate. That reality has changed for the better. Since 2013, the leadership shown by PAHO in Nicaragua has been bringing a more holistic response to CKD.





A child of the community attends the plantón meeting with her father, a former sugar cane worker.

REFLECTIONS

CAO's intervention in this case has brought lessons for CAO's own dispute resolution practices:

- CAO has become aware of the need to reach out early in the process to other international agencies when the magnitude of the problem may extend beyond the local dispute.
- In terms of scientific research, managing parties' expectations about a research study is critical. Perhaps it could have helped if the process had engaged the scientists initially to address the issue of whether the questions being asked by the parties required uncovering new scientific knowledge, and how long it could take to find answers.
- CAO has become more alert to the need to pay critical attention from the outset as to how scientific processes

“This is not a disease related to a country or a territory any more, but rather a group of countries that consider that a disease of this magnitude is a public health problem.”

Dr. Socorro Gross, Pan American Health Organization (PAHO)

and findings should be effectively communicated to the community represented at the table and the public at large. Communicating well about process and outcomes to either party's constituents is as important as the research itself.

- Engaging with governments continues to be a challenge CAO faces in its dispute resolution interventions.

While governments confront many competing and conflicting needs, CAO continues to reflect on how it can better involve governments where relevant, so they can also be part of the process to seek solutions.

- CAO also grappled with a perception among different institutions that lack of scientific certainty about the disease implied that nothing could be done to prevent risk factors through work-practice improvements.

CAO recognizes that the needs are great, and believes other regional and

international organizations need to play a leading role in Nicaragua to help those affected by CKD get the treatment they need, work to prevent the disease, and at the local level, continue to improve the livelihoods of ASOCHIVIDA's members.

Meanwhile, other sugar cane companies, other industries, and other countries in Central America are seeing the effects of CKD in their communities and workforce. Scientists throughout Central America and in other parts of the world are working together to better understand the causes of CKD.¹⁶

“I see the future without this disease. I hope it will disappear, or that there is medicine available, or that a vaccine exists to save more lives, that more kidney transplants are conducted, and that we will have more machines since we still have time.”

Alejandro César Soto, Board Member of ASOCHIVIDA

IN MEMORIAM

DONALD CORTEZ

Donald Cortez was the president of ASOCHIVIDA from 2010 to 2013. He was a former sugar cane cutter for NSEL who grew up in Chichigalpa. He demonstrated incredible dedication and commitment to sustaining the success of the CAO dialogue process. Sadly, Donald died on July 16, 2013 at the age of 41 after suffering from end-stage CKD, leaving behind his wife and three children.

Despite his own struggle with the disease over a number of years, Donald fought relentlessly to secure benefits for the 2,200 members of ASOCHIVIDA and to find the cause(s) of the disease affecting so many in his community. Donald played a key role in helping to secure many benefits negotiated with NSEL through the dialogue process, including improved health care for patients; the monthly distribution of food aid; income generation projects benefiting more than 300 ASOCHIVIDA members; a new peritoneal dialysis program; and the 100 new houses constructed for the poorest of the community.

Donald's legacy will not be forgotten. In every decision he made, he put the interests of his community before his own. If science is at all closer to finding the cause(s) of CKD in Chichigalpa, some of this progress can be attributed to Donald's tireless efforts. In appreciation and recognition of his legacy, ASOCHIVIDA's pharmacy is named in his honor.



FÉLIX ZELAYA

Dr. Félix Arturo Zelaya Rivas was considered one of the frontrunners in the detection of the high incidence of renal insufficiency. He emphasized that CKD is an endemic disease of the Pacific Coast of Nicaragua.

Dr. Zelaya held degrees in internal medicine, clinical hematology, and public health and medical science. He led research teams focused on water quality studies, the environment, and personal hygiene habits, documenting and supporting his theory that the disease was found nationally, mainly in men working in agriculture. In 2000, as the Occupational Health Specialist of San Antonio Sugar Mill, he did a number of studies at the mill on the cause of the disease, and was one of the first physicians in the area to conduct biopsies on kidneys.

During his stay in San Antonio, he participated in the first dialogue sessions in collaboration with ASOCHIVIDA, NSEL, and CAO, gaining the respect and appreciation of everyone. Dr. Zelaya was committed and devoted to his patients, and transferred these humane qualities to his many students. Dr. Zelaya died in Managua on May 20, 2011.



NOTES

- (page 1) See <http://www.paho.org/blogs/dc-52/?p=853> and http://iris.paho.org/xmlui/bitstream/handle/123456789/4401/CD52_8eng.pdf?sequence=1&isAllowed=y.
- (page 2) World Bank Group, overview on Nicaragua. See <http://www.worldbank.org/en/country/nicaragua/overview>.
- (page 3) A group of students from Yale University worked with community members in Nicaragua to raise their concerns with CIEL. The complaint to CAO raised concerns related to health impacts on local communities, including CKD and respiratory problems, which complainants claimed were a result of sugar cane activities; labor and working conditions; land acquisition in relation to Indigenous communities; offsite environmental impacts, including water contamination, air pollution, and pesticide effluence; and compliance with IFC Performance Standards, policies, and procedures. No dialogue was facilitated with the communities based in the Department of León, regarding issues other than CKD.
- (page 4) DEG's stated mission is to promote business initiatives in developing and emerging market countries as a contribution to sustainable growth and improved living conditions of the local population. See <https://www.deginvest.de>
- (page 12) CAO Operational Guidelines, 3. Dispute Resolution, 3.1. Principles of and Approach to Dispute Resolution, page 18. See http://www.cao-ombudsman.org/documents/CAOOperationalGuidelines2013_ENGLISH.pdf.
- (page 13) Based on J. Dumas, "Trust, Science and Dispute Resolution in World Bank Projects: The Case of Nicaragua." Presentation delivered at CAO Participatory Approaches Session for World Bank Group knowledge sharing on January 11, 2016.
- (page 16) Dialysis is a way of cleaning the blood when the kidneys can no longer do the job. It gets rid of the body's wastes, extra salt, and water, and helps to control blood pressure. In hemodialysis, a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean the blood. To get the blood into the dialyzer, the doctor needs to make an access, or entrance, into the blood vessels. This is done with minor surgery, usually to the arm. See <https://www.kidney.org/atoz/content/hemodialysis>.
- (page 16) Instituto de Acción Social Juan XXIII is a social action institute of Central American University (UCA)—a Jesuit university that promotes social justice and helps solve affordable housing, health, and development problems in Nicaragua. See <http://www.juanxxiii.org.ni/index.php>.
- (page 16) These efforts built on the recommendations in two assessments conducted by independent consultants: a 2009 assessment of health care needs regarding options to improve immediate and long-term care for people suffering from CKD; and a 2010 assessment of the Chichigalpa community health center and dialysis options for CKD patients. For more information, see http://www.cao-ombudsman.org/cases/document-links/documents/FINAL_MedicalNeedsAssessmentandGapAnalysis_May272011.pdf and http://www.cao-ombudsman.org/cases/document-links/documents/October_2009_NeedsAssessmentReport_ENG.pdf.
- (page 16) NSEL brought in one of its other financiers, the German development agency, DEG, in 2010. DEG offered to donate \$320,000 to the Ministry of Health (MINSa) to support the health center. After slow progress in discussions with MINSa, the process moved forward, and the donation was finally made by DEG and NSEL in July 2015. Since then, the government of Nicaragua has been implementing improvements to the health center with funds provided by NSEL and DEG.
- (page 17) In peritoneal dialysis, the inside lining of the stomach acts as a natural filter. Wastes are taken out by means of a cleansing fluid called dialysate, which is washed in and out of the stomach in cycles. See <https://www.kidney.org/atoz/content/peritoneal>.
- (page 18) Colmena Foundation is a nonprofit organization whose main objective is to develop housing programs and living conditions in the service of communities in Nicaragua. See <http://fundacioncolmena.org/fo/>.
- (page 19) American Nicaraguan Foundation was founded by Alfredo Pellas Jr., Theresa Pellas, and Father León Pallais to help mitigate the effects of poverty in Nicaragua. See <http://www.anfnicaragua.org/index.php?lang=en>.
- (page 19) NSEL donated \$165,000 for a revolving small credit facility. ASOCHIVIDA controlled these funds for loans to members for microcredit projects. While nearly 350 families benefitted from this program, only around 100 had repeatedly taken loans and paid them back. In light of this, a shift from microcredit to microleasing was adopted in 2011. NSEL and DEG each provided additional financial support—about \$87,000 each. The funds have been used to implement a project designed and directed by a local microleasing organization, NITLAPAN, to support ASOCHIVIDA members in designing and developing business initiatives. Microleasing support has been extended to 125 families for their business initiatives. The model has been very successful, with only four percent of beneficiaries experiencing brief delays in making lease payments.
- (page 20) With the agreement of ASOCHIVIDA and NSEL, Boston University's research activities were cofinanced by CAO and the Comité Nacional de Productores de Azúcar de Nicaragua (the National Association of Sugar Producers from Nicaragua, CNPA), a civil nonprofit association that aims to promote entrepreneurial activity related to the Nicaraguan sugar industry. Sugar mills that make up the CNPA are SER San Antonio, Monte Rosa, South Sugar Company, and Montelimar. See <http://www.cnpa.com.ni/>. CAO administered the funds. CNPA had no role in the design or implementation of the studies. In total, about \$1 million for research on the cause(s) of CKD was marshaled at the initial stage, which has been followed by nearly \$1.7 million from CNPA and Los Azucareros del Istmo Centroamericano (Central American Sugar Producers, AICA), a civil nonprofit association that promotes entrepreneurial activity related to the sugar industry in Central America, to continue and expand ongoing research.
- (page 26) See <http://www.regionálnephropathy.org/>.

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Credits

Author: Andrea Repetto Vargas

Contributors: Gina Barbieri and Juan Dumas

Editors: Emily Horgan and Anita Gordon

Photography: Felix Davey and CAO

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2121 Pennsylvania Avenue NW
Washington, DC 20433 USA
Telephone: +1 202-458-1973
Fax: +1 202-522-7400
e-mail: cao@worldbankgroup.org
Website: www.cao-ombudsman.org