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BELIZE

MESOAMERICA HEALTH 2015

(BL-G1001)

NONREIMBURSABLE FINANCING PROPOSAL

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ELECTRONIC LINKS	
REQUIRED	
2.	Multi-year Execution Plan (MEP) and Annual Operation Plan (AOP) (18 months) http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36379666
3.	Monitoring and Evaluation Arrangements http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36388531
4.	Procurement Plan http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36372686
OPTIONAL	
1.	Project Description and Implementation and Management Scheme http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36388545
2.	Targeting Note http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36380550
3.	Detailed Budget http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36372808
4.	Ex ante Cost Effectiveness Analysis http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36383210
5.	Literature References http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36369517
6.	Safeguard and Screening Forms http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36369561
Country-Specific Evidence Package (CSEP) Studies	
8.	Supply and Demand Side Barriers to Health Services http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36372881
9.	Costing of MHF2015 Health Services http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36369513
10.	Health Spending and National Health Accounts http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=36379196

ABBREVIATIONS

BHIS	Belize Health Information System
CHW	Community Health Worker
CP	Counterpart Funding
DALY	Disability-Adjusted Life Year
DHT	District Health Team
GDP	Gross Domestic Product
HECOPAB	Health Education and Community Participation Bureau
IDB	Inter-American Development Bank
IT	Investment Tranche
LBW	Low Birth Weight
LQAS	Lot Quality Assurance Sample
LSMS	Living Standards Measurement Survey
MHF	Mesoamerica Health Facility
MHF2015	Mesoamerica Health Facility 2015
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NHI	National Health Insurance
ORS	Oral Rehydration Solution
PCP	Primary Care Provider
PFP	Pay for performance
PMU	Project Management Unit
PSA	Prostate Specific Antigen
PT	Performance Tranche
QI	Quality Improvement Manager
QIF	Quality Innovation Fund
RBF	Results-Based Financing
SLA	Service Level Agreement

PROJECT SUMMARY
BELIZE - MESOAMERICA HEALTH 2015
BL-G1001

Financial Terms and Conditions				
Beneficiary: Belize			Financing type	Non reimbursable
Executing Agency: Ministry of Health (MOH)			Disbursement Period	18 months ¹
Source	Amount	%		
Investment tranche (IT) - MHF	US\$500,000	40		
Counterpart Funding (CP)	US\$500,000	40		
Subtotal investment (IT+CP)	US\$1,000,000	80		
Performance tranche (PT) - MHF	US\$250,000	20		
Total (IT+CP+PT)	US\$1,250,000	100	Currency:	US Dollars
Project at a Glance				
<p>Project Objective/Description: The general objective of the program, which consists of three individual operations, and the first individual operation is to contribute to the reduction of maternal, infant and child mortality in the poorest districts of the country through interventions that strengthen primary health care services. The specific objective is to improve maternal and infant, child and reproductive health in terms of access, usage and quality. The Belize program is part of the Mesoamerica Health 2015 Initiative, which intends to improve the health of women and children under five years of age in the poorest populations of the Mesoamerica region. The first individual operation will be focused on the poorest districts of the country: Corozal, Orange Walk, Toledo and Cayo (¶ 1.16).</p>				
<p>Special contractual provisions regarding the Investment Tranche: Conditions prior to the first disbursement: (i) the hiring of the Quality Improvement (project) Manager; and (ii) the approval of the project Operations Manual. Special provisions for project implementation: The requisites indicated in the MHF2015 Operating Regulations and, in compliance with paragraph 1.27 b. and c. of Annex 1 to the MHF2015 Operating Regulations, the MOH shall remit annually, up to two (2) years after the disbursement of the Performance Tranche a report on the amount of resources expended on the public primary health care services (¶ 3.1 and 3.2).</p>				
<p>Special contractual provisions regarding the Performance Tranche The PT will be disbursed when the minimum score regarding the goals agreed by the Beneficiary and the Bank in the Performance Framework (Annex IV) is met.</p>				
<p>Procurement: The contracting of required consulting services and the procurement of goods and related services financed with the resources of the IT carried out by the MOH will follow the Bank's procurement policies and procedures, including "Policies for the Selection and Contracting of Consultants financed by the Bank" (GN-2350-9), and "Policies for the Procurement of Goods and Works (GN-2349-9) of March 2011. The PT will not be subject to the Bank procurement policies.</p>				
<p>Exceptions to Bank policies: None</p>				
<p>Project qualifies for: SEQ <input checked="" type="checkbox"/> Sector <input checked="" type="checkbox"/> Geographic <input checked="" type="checkbox"/> Headcount <input type="checkbox"/></p>				

¹ Calculated as of the date of the declaration of eligibility for disbursements issued by the Bank.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, Problem Addressed and Justification

- 1.1 **Population health status.** Similar to other countries in Latin America and the Caribbean, Belize is undergoing a demographic and epidemiological transition resulting in a higher prevalence of chronic, non-communicable disease alongside persistent infectious disease associated with social determinants such as poverty, sanitation, environmental conditions and malnutrition. This is creating the well-known “double burden” of morbidity and mortality, evident in the leading causes of death, for example, where acute respiratory infections still rank just below hypertensive diseases. A progressive decline in the fertility rate (currently 2.7) and a growing life expectancy (75 years)² have caused overall population aging, which underlies the changes in the population and health profiles.
- 1.2 Although chronic diseases tend to appear later in the life cycle, preventable conditions associated with infectious diseases and lack of access or usage of health services disproportionately affect women of reproductive age and children, limiting their human development potential. Therefore, the inequities in these conditions related to socioeconomic status are particularly pernicious, since they contribute to the perpetuation of the cycle of poverty. This is the case in Belize, for example, where the prevalence of chronic malnutrition (stunting) among children under five in 2006 was 17.6% at the national level, compared to 32.6% in the poorest 20% of the population. Similarly, the rate of diarrhea among children under five years was one-third higher among the poorest quintile of the population (16.4%) compared to the national average (12.3%). In terms of treatment, there were large differences in children under five who did not receive attention for acute respiratory infections in the population as a whole (9.6%) and the bottom fifth of the wealth distribution (21.2%). Finally, the use of modern birth control methods among the national population (31.0%) was almost twice as high as among the poorest 20% (16.7%).³
- 1.3 Despite these disparities in indicators relating to maternal and child health, on average there has been progress in recent years. Regarding maternal mortality, over a 13-year timeframe, the rate per 100,000 live births fell from 91.3 (1996-1998) to 50.7 (2008-2010).⁴ Child mortality (under 5 years) has followed a similar trend, declining from 60 deaths per 1,000 live births in 1991 to 27 in 2006. The majority of these deaths correspond to infant mortality (22 per 1,000 live births in 2006),⁵ most of which (60%)⁶ in turn occur in the neonatal period. The prevalence of chronic malnutrition appears to have held or declined slightly. The Living Standards Measurement Survey (LSMS) 2001 indicated stunting rates in children under five years of age, 17.9% countrywide, virtually the same as the rate shown five years later by the Multiple Indicator Cluster Survey (MICS) 2006 (17.6%). In similar fashion, the height census among school aged children showed a growth retardation prevalence rate of 13.7% in 2006 and 12.2% in 2009.

² Statistical Institute of Belize.

³ Calculations from MICS data (Statistical Institute of Belize, 2006).

⁴ Three year rolling averages were calculated from MOH data due to the low number of annual maternal deaths.

⁵ References from the 2006 MICS.

⁶ MOH administrative data.

- 1.4 **The health system and its limitations.** The main provider of health services to Belize's total population of approximately 312,000 individuals⁷ are the four regional health authorities, which have limited autonomy for management and depend on the MOH. The country has one national referral hospital located in Belize City, three regional hospitals and three community hospitals (one hospital in each of the country's six districts, except Cayo, which has two).⁸ Primary health care, in addition to be handled by the hospitals, is addressed through a network of 3 polyclinics, 35 health centers, and 53 health posts,⁹ as well as through mobile units and community health workers. The primary level services include pre- and post-natal care, immunization, growth monitoring of children under age 5, treatment of diarrhea and minor ailments and general health education. Pharmaceuticals are also distributed at the facilities.
- 1.5 Starting in 2002, Belize began to implement a health sector reform involving the establishment of the National Health Insurance (NHI) scheme to promote the separation of financing from provision and foster the public contracting of private providers; the strengthening of the technical, normative and regulatory capacity of the MOH; and the decentralization of the sector through the creation of the four health regions and their endowment with a degree of administrative and decision-making autonomy.¹⁰ The NHI began operations as a pilot project in Southside Belize City (the poorest area of the city), where it currently covers around 46,000 persons, and was expanded to the Southern Health Region (Stann Creek and Toledo districts) in 2006, with coverage presently at 44,500.¹¹ The NHI pays public and private primary care providers (PCP) of services a monthly per capita, and the service package covers basic medical consultations, pre- and post-natal care, immunizations, family planning, deliveries, growth monitoring for children under five, detection and monitoring of hypertension, diabetes, HIV/AIDS, cancers, and tuberculosis, as well as laboratory, imaging and drugs.
- 1.6 A supply-side pay-for-performance (PFP) incentive strategy is employed by the NHI to strengthen health prevention activities, boost primary care, improve service quality and efficiency, and increase worker productivity. Each month, the NHI pays the PCPs or clinics 70% of the member capitation payment upfront, and the remaining 30% of the payment depends on how the PCP performs on groups of indicators that lead to scores for efficiency (70% of the amount withheld), quality (20% of this amount), and administrative processes (10% remaining).¹² If an indicator is not fully achieved, then the proportional weight is deducted from the clinic's total potential payment for that month. Additionally, PCPs can receive an annual bonus based on their scores on performance indicators relating to promotion of prevention programs, quality of care, use of clinical

⁷ Statistical Institute of Belize, preliminary results from the 2010 Population and Housing Census.

⁸ The public hospitals include inpatient and outpatient services for the four basic specialties (pediatrics, obstetrics, gynecology, internal medicine and surgery) and emergency care. The regional hospitals provide routine primary health care and a wide range of secondary care, while the community hospitals offer only a minimum amount of secondary care. Laboratory tests are carried out in the regional hospitals and at the Central Medical Laboratory.

⁹ The health posts do not have permanent staff but rather are locked facilities used periodically by the mobile clinics according to their schedule of community visits.

¹⁰ The reform was designed and implemented with the collaboration and financing of the Inter-American Development Bank (IDB) (\$9,8 million), the Caribbean Development Bank (\$4,7 million) and the European Union (\$1.6 million).

¹¹ Based on these enrollment figures for Southside Belize City and the Southern Health Region, total NHI coverage is around 29% of the population of Belize.

¹² See Vanzie, et.al., 2010.

protocols, patient satisfaction, and appropriate delivery of key services.¹³ Once a clinic meets the minimum score needed, the NHI determines the total bonus payment by applying each indicator's weight against 10% of annual revenues generated.¹⁴

- 1.7 In the health regions where the NHI does not operate (Northern, Western and Central Regions, except Southside Belize City),¹⁵ the MOH maintains a standard system of input supply-side financing. It does utilize Service Level Agreements (SLA) with the health regions, and the indicators employed in the SLAs deal principally with prevention, early detection and quality of care.¹⁶ However, the SLAs are not linked to an incentive mechanism that could lead to improvements in efficiency and in health outcomes, as occurs with the NHI PFP scheme. Evaluations of the NHI pilot suggest that its PCP model could provide greater efficiency in providing primary health care than public provision by the MOH, reflected in reduced outpatient visit costs. Moreover, there is evidence that the NHI reduces out-of-pocket payments by beneficiary households and improves performance on access and the quality of care.¹⁷ Despite these results, after implementing the NHI model in poorer areas of the country, there is now reluctance to expand it due primarily to concerns regarding increased spending associated with growth in demand for services.¹⁸ However, there is interest in consolidating some of its features in the rest of the system (for example, strengthening the SLAs along the lines of the PFP scheme). For this reason as well as poverty targeting criteria, the project focuses on the rural, poor population in the Northern and Western health regions.¹⁹
- 1.8 **Selected health sector challenges.** Coverage of many basic health services in Belize is quite high by regional standards. For example, according to the 2006 MICS, the institutional birth rate was 88%; the portion of pregnant women receiving at least one blood and urine test, 95% and 88%, respectively; and vaccination compliance, above 85% (BCG, DPT, MMR). Given this situation, the MOH has oriented its health policy approach toward improving the quality of services and started its efforts in 2009 in the area of maternal and

¹³ These indicators include (i) percentage of women age 19-64 who had a pap smear test in the last two years; (ii) percentage of pregnant women with one prenatal care visit during the first trimester; (iii) percentage of high-risk pregnancy cases with at least seven prenatal care visits; (iv) percentage of men over 50 years of age who had a Prostate Specific Antigen (PSA) test during the past two years.

¹⁴ One worldwide literature review of supply and demand side results-based financing (RBF) schemes found that when used with simple and distinct, well defined behavioral goals, financial incentives targeting recipients of healthcare and individual healthcare professionals appear to be effective in the short run (Oxman and Fretheim, 2008). Another review concluded that RBF programs have demonstrated improvements in indicators including utilization, coverage and emergency referral, and quality of health provider performance (Canavan, et.al., 2008).

¹⁵ The Northern Region covers Corozal and Orange Walk districts; the Western Region, Cayo district; and the Central Region, Belize district. The Southern Region contains Stann Creek and Toledo districts.

¹⁶ For example, the principal maternal and child health indicators and targets are: % coverage for each vaccine (95%), % of rash and fever cases investigated < 48 hours (100%), maternal and perinatal mortality reduction (compliance with recommendations from maternal and perinatal death analysis, 100%), % of institutional maternal deaths where protocols not fully applied (0%), increase in pap smear coverage (first time) in women 25-55 years old (10%), % of still births ≥ 500 grams in intra partum period (100%).

¹⁷ Cercone et.al., 2002.

¹⁸ See [Health Spending and National Health Accounts](#). Public sector debt was equivalent to 82.7% of Gross Domestic Product (GDP) at the end of 2010 and on current policies the level of debt will remain elevated for a considerable time.

¹⁹ See [Targeting Note](#). The project will also encompass Toledo district through counterpart activities.

neonatal health. The quality improvement model involves establishing standards and protocols, building capacity among service providers to implement them, and monitoring and supervising their application. Hospitals in the Southern Region that adopted the model have shown increased protocol compliance in the accurate completion of perinatal records, management of severe pre-eclampsia and eclampsia, active management of the third stage of labor, monitoring of women during immediate postpartum, immediate newborn care, and management of obstetric hemorrhage.²⁰ However, there is still a need to sensitize health workers on cultural differences and proper interpersonal treatment of patients ([Supply and Demand Side Barriers to Health Services](#)).²¹ Furthermore, although the MOH established a regulatory unit that has developed licensing and accreditation standards for inpatient facilities, it requires assistance in its role of institutionalizing mechanisms for setting and measuring standards for quality care improvement.

- 1.9 Despite the high level of coverage of many services, the MOH has identified several areas that require attention. In order to further reduce the infant mortality rate (¶1.3), there is a need to increase the capacity of certain facilities to handle neonatal complications, such as asphyxia and sepsis as well as low birth weight (LBW) in infants.²² In terms of nutrition, the exclusive breastfeeding rate during the infant's first six months is low (10.2%), as is vitamin A supplementation for under-fives (23.8%). Sexual and reproductive health is another critical area where supply and usage of services lags. Unmet need for contraception in the general population ranges from 28-34% in the districts, and the largest need is found among adolescents, ages 15-19 (45.4%), and young adults, ages 20-24 (41.5%).²³ The average annual proportion of live births to mothers aged 15-19 is just under 20%.²⁴ Moreover, the early initiation of sexual activity and the prevalence of sexually transmitted infections are public health concerns in this age group; from 2001-2005, there were 145 (41 males and 104 females) new HIV infections in adolescents 10-19 years (6.9% of total new HIV infections), of which 16 occurred in the 10-14 age group. While fear, embarrassment, cost and lack of knowledge represent barriers to the use of family planning services for adolescents, the MOH currently does not offer differentiated services for them, and special efforts are needed to provide better access to information, methods and quality services to this population.²⁵
- 1.10 As a strategy to expand primary health care, Belize established a Community Health Worker (CHW) program in the 1980s, but it has declined over the years and is currently underutilized.²⁶ In the context of the country's chronic human resource shortage in the health

²⁰ For a case study of using quality assessment to improve maternal care in Nicaragua, see Lin et.al. 2003.

²¹ Important cultural and language barriers exist in Belize. The five main ethnic groups (Mestizo-50%, Creole-21%, Maya-10%, Garifuna-4.6% and Mennonite-3.6%) use different languages. Mestizos and Mayans are under-represented in the health workforce (36% total) (Cameron Health Strategies, 2009).

²² LBW cases have averaged 9-10% of births in recent years (MOH data), similar to the MICS rate (8.1%).

²³ All preceding data is from MICS 2006.

²⁴ MOH administrative data.

²⁵ See Blanc et.al., 2009. The Mesoamerican Health Initiative's Reproductive, Maternal and Neonatal Health Master Plan advocates for exclusive services for adolescents, noting their higher cost but also their cost-effectiveness. The International Planned Parenthood Foundation recommends involving youth in the design and implementation of social marketing strategies (La Rosa et.al., 2007).

²⁶ The CHW program is assigned to the MOH's Health Education and Community Participation Bureau (HECOPAB). However, there has been no technical advisor in charge of HECOPAB since 2003. There are also

sector,²⁷ the MOH would like to recover the CHW service delivery platform. This approach follows evidence indicating that “task-shifting,” which involves sharing or transferring responsibility for delivering certain high impact interventions to lower cadres of skilled and unskilled workers, can be an effective strategy to optimize the accessibility and efficiency of health services under human resources constraints.²⁸ Throughout the world, CHWs have been found to be effective in promoting immunization and breastfeeding uptake, reducing mortality and morbidity from common childhood illnesses, improving tuberculosis treatment outcomes and providing contraceptive methods, including injectibles.²⁹ Many studies show the motivation, retention and productivity of CHWs can be improved through the use and variation of multiple non-monetary incentives, such as job aids, supplies, peer support, refresher training, communication systems, monitoring, supervision and recognition.³⁰ PFP schemes have also shown positive results with CHWs. In one program in Bangladesh, field-workers’ pay was tied to fast-cycle feedback on indicators related to teaching mothers to make oral-rehydration solution (ORS), and this approach improved CHW effectiveness and the mothers’ ability to prepare ORS.³¹ Similarly, in India CHWs are paid for their performance in community-based neo-natal care and distribution of antibiotics.³²

- 1.11 An important tool for policy making, human resources management and quality improvement of services is Belize’s Health Information System (BHIS). It is constructed around the patient encounter and focuses on the capture of clinical data through electronic health records with unique identifiers for each patient.³³ Currently, the system is operative at most of the hospitals and urban health centers, accounting for around 45 facilities where approximately 80% of encounters in public establishments occur.³⁴ Since the system is web-based and each facility node server contains a copy of the database that it synchronizes periodically with the central master data store at the MOH, functionality is maintained even during periods when connectivity is inoperative. Despite these strengths of the system, an assessment using the Health Metrics Network framework³⁵ revealed poor scores in data management, dissemination and use of information, and system resources.³⁶ The study also determined that Belize lacks a policy and legal

several vacant positions in the districts for Health Educator, whose role is to provide guidance, materials and supervision to the CHWs. The CHW role is not well defined, and lack training, supplies, equipment, educational tools, and resources for communication and transportation.

²⁷ In 2005 Belize reached the World Health Organization’s minimum target of 25 health care providers (doctors, nurses and midwives) per 10,000 persons, but this indicator fell to 18.8 by 2009. Belize has no medical school, and the University of Belize graduates an annual average of only 53 students, including 14 nurses and midwives, from all of its health training programs. Aggravating this situation is the emigration of human resources, especially nurses, due to “push” factors (inadequate career paths, remuneration and contracts) and “pull” factors (active recruiting by wealthier countries).

²⁸ See, for example, Nabudere et.al., 2010.

²⁹ Lewin et.al., 2006; Lehmann and Sanders, 2007; Prasad and Muraleedharan, 2007.

³⁰ Bhattacharyya et.al., 2001, and Shakir, 2011.

³¹ Chowdhury, 2001.

³² Bang et.al., 2005.

³³ The system has the following modules: electronic health record and admission-discharge-transfer, clinician order entry, financial, maternal and child health, HIV/AIDS, laboratory and testing, supply chain management, public health, and human resources.

³⁴ The system is also installed at two private hospitals in Belize City.

³⁵ Health Metrics Network (2007).

³⁶ Vanguard Consulting (2008).

framework to permit enforcement of regulations relating to vital registration, disease notification, private sector reporting and privacy of health information. Other sources indicate potentially significant underreporting of health problems.³⁷ To make the system more useful for monitoring the SLAs and for decision making through the development of dashboards for managers, it is necessary to invest in technology and in services to construct interfaces allowing for easier data processing from transactional databases.³⁸

- 1.12 **Government response.** In order to address some of the most fundamental issues in the health sector, the government of Belize, with technical cooperation from the IDB, designed a health sector reform program in the late 1990s. Financing for over US\$18 million was negotiated with the IDB, the Caribbean Development Bank and the European Union, and the project was implemented essentially during the last decade. Its principal components involved strengthening the institutional capabilities of the MOH in regulation and policy design while deconcentrating management authority to newly created health regions and autonomous hospital bodies, upgrading physical infrastructure and medical equipment while concentrating sophisticated services in regional centers to increase the utilization of capacity and to improve quality, and establishing the NHI system. Although the expansion of NHI has been halted, for 2011 the service contracts with PCPs in the Southern Health Region have incorporated a new nutrition component³⁹ and a corresponding increase in the per capita payment. Furthermore, the government recently prepared a project for community-based maternal and child health and nutrition in the Toledo district to be financed with a US\$3 million donation from the World Bank.
- 1.13 **Program rationale and theory of change.** The MHF2015 program in Belize will intervene at the system and management level of the supply side to increase the quality of the services for women and children. This in turn will affect demand by raising client satisfaction with services. In addition, the program will decrease barriers to health services, especially by strengthening the community-based delivery platform and extending sexual and reproductive health services. The quality improvement activities on the supply side are based on the Institute for Healthcare Improvement's "plan-do-study-act" cycle which involves setting aims, establishing measures, and then selecting, testing, implementing and spreading changes. The MHF2015 program in Belize hypothesizes that improved inputs for "planning" and "doing" and processes in clinical service provision, as well as monitoring and evaluation for "studying" and "acting" will have a positive effect on behavior change in providers that lead to improved health outputs and outcomes.
- 1.14 **Policy dialogue.** The program provides an opportunity to accompany the MOH in advancing the agenda of priority health policies to improve the state of maternal and child health and nutritional status of disadvantaged populations in the country. Specific proposed issues for policy discussion include: (i) technical aspects of norms for (adolescent) reproductive health and the child nutrition intervention (supplements and platform design) to support evidence based policy development; (ii) refinement of service level agreements, key indicators and the institutionalization of quality promotion, assurance and control mechanisms; (iii) sustainability of primary health services financing; (iv) renovation of the

³⁷ [Costing of MH2015 Health Services](#), and Meerhoff, 2007.

³⁸ Connect-to-Health and MOH, 2009.

³⁹ Resources for the nutrition component will be eligible as counterpart funding for the MH2015 project.

primary care platform (community health workers) and inclusion of incentives to enhance the impact of frontline health services workers; and (v) introduction of performance incentives for supply (facility based) and (eventually) demand in MOH services to promote innovation and allow for greater decentralization of decision making.

- 1.15 **Bank strategy with the country.** One of the principal objectives of the IDB Country Strategy with Belize 2008-2012 is to improve the coverage and quality of primary health care for the poor. In addition to its support of this objective through the health care reform project, the IDB included conditions in its Social Policy Support Program (2198/OC-BL) relating to the expansion of coverage and the incorporation of preventive services for chronic diseases and nutrition in the basic health care package provided by the PCPs in the Southern Region. Furthermore, in developing the Mesoamerica Health 2015 (MHF2015) Initiative, the IDB delimited priority areas in primary health care with the intention of reducing the dramatic health inequities in the region. MHF2015 involves a results-based financing mechanism that implies results measurement and strengthening mechanisms for data gathering and processing. The program is aligned with the IDB-9 institutional strategy and results framework goals to reduce maternal and infant mortality.

B. Objective, Components and Cost

- 1.16 **Objective.** The general objective of the Belize program, which will consist of three individual operations⁴⁰, is to contribute to the reduction of maternal, infant and child mortality in the poorest districts of the country through interventions that strengthen primary health care services within the framework of the MHF2015 Initiative. The specific objective is to improve maternal and infant, child and reproductive health in terms of access, usage and quality. The objective of the first individual operation is to contribute to the reduction of maternal, infant and child mortality through interventions that strengthen primary health care services within the framework of the MHF2015 Initiative in the poorest districts of the country. In order to achieve these objectives, the program has the following three components: (i) quality improvement of maternal, neonatal, child and reproductive health services; (ii) strengthening health service delivery platforms to increase coverage; and (iii) administration and auditing.
- 1.17 **Component 1. Quality improvement of maternal, neonatal, child and reproductive health services** (US\$229,355; CP US\$152,940). Under this component, the first individual operation will develop and instal a quality assurance platform for priority MOH services, focused on improving the functionality of key management mechanisms to measure and motive better performance. This involves establishing norms for quality of services, informing and assisting health professionals in their application, developing the means for measuring compliance and performance, incorporating indicators in management agreements, and providing for systematic data collection and processing. This platform is an “a priori” requirement for extending coverage of quality services.
- 1.18 **Subcomponent 1.1. Establishing and applying standards for service quality** (US\$112,105; CP US\$12,940). The program will support the design of policies, norms/standards, protocols and job aid tools comprising the framework for quality

⁴⁰ The first operation is presented for consideration in this document. The second and third operations will be presented for approval once the minimum score is met on the goals adopted in the performance framework of each financed operation and the respective operation is approved by the donor's committee.

improvement of the provision of health services. Currently, the MOH has an approved policy for quality improvement in obstetric and neonatal care and has piloted a successful program in the southern region of the country. Additionally, it has protocols for these service areas and more than 25 quality assurance instruments regarding their proper application by service providers. In order to establish basic parameters for increasing the quality of services more broadly, it is necessary to develop similar instruments in additional critical service areas. In this regard, the first individual operation will finance specialized technical assistance to prepare the structure and mechanisms needed for quality improvement of reproductive health and child nutrition services.⁴¹

- 1.19 Although in late 2009 the MOH approved a policy for “Quality Improvement Activity for Maternal and Neonatal Care,” until now it has been implemented thoroughly only in the Southern Region (¶ 1.8), and the MOH would like to expand its application to other regions in the country. Therefore, the technical assistance will include an assessment of the maternal and neonatal health care collaborative quality improvement model that will propose improvements to its operability.⁴² Once the model is refined, it will be expanded to health facilities within the regions participating in the project. The technical assistance will provide orientation and training to health professionals in the facilities regarding protocol compliance and maintenance of proper medical records. It will also work to facilitate the adoption of a monitoring system of quality standards and indicators by the regional management teams and health facility administrators.
- 1.20 The initial success of the collaborative quality improvement model for maternal and neonatal care has generated interest on the part of the MOH to adapt it to other service areas. Once the standards and protocols for reproductive health and child nutrition are completed, it will be possible to apply the model in these areas on a pilot basis in some of the facilities of the project regions and expand the model in subsequent phases of the project (second and third operations). This will require technical assistance for the development of an operations manual specific to these health service areas containing data gathering instruments that allow for measurement of compliance with established protocols from facility medical records, reporting formats and requirements, indicators, auditing procedures,⁴³ roles and responsibilities of actors (MOH staff, regional health managers, and health facility staff), among other key criteria for adequate performance. It will also be necessary to assist in the roll-out of the model through the organization of orientation and coaching sessions for health sector staff. With the purpose of institutionalizing the quality measurement, control and promotion practices, the MOH Regulatory Unit will receive technical assistance in structuring and implementing regulatory and accreditation mechanisms.⁴⁴
- 1.21 **Subcomponent 1.2. Incorporation of quality components into management agreements** (US\$71,830; CP US\$0). Key quality performance indicators will be added to the SLAs

⁴¹ The resources of World Food Program and United Nations Population Fund technical assistance for the production of nutrition and reproductive health policies will be considered as counterpart funding.

⁴² The recommendations for strengthening the model will be described in a diagnostic report, and a proposal for the systemization of its operating procedures will be presented as an Operating Manual.

⁴³ This considers the systematization of procedures for conducting clinical audits.

⁴⁴ See Zeribi and Marquez (2005), for a review of experiences in Latin America and the Caribbean in strengthening the regulation of health services quality. Also, Salmon et.al. (2003) present the positive results of a health facilities accreditation program in South Africa.

between the MOH and the Northern and Western Health Regions. The SLA legal instruments will be reformulated and adapted for application between the MOH and the health regions, as well as the regions and their individual health facilities.⁴⁵ This process will be facilitated with appropriate technical assistance, which will also elaborate an operations manual for the SLAs based on international best practice experiences. Facilities (regional and community hospitals, health centers and mobile teams) that meet standards will be invited to apply to a Quality Innovation Fund (QIF) supported by this component to reward local goal achievement and motivate facility teams.⁴⁶ To roll out this activity, a regional meeting with stakeholders to explain the indicators and the innovation fund will be funded. Additionally, the operation will support the establishment of Quality Assurance Teams composed of technical and administrative staff from the MOH and regions, which will receive monthly reports from facilities and conduct periodic visits to evaluate key performance indicators established in the SLAs to determine eligibility for the QIF. In the first operation, options for introducing performance incentives will be explored through the technical assistance, including the adoption of new payment schemes to replace existing supply-based financing, such as per capita with pay-for-performance characteristics and fee-for-service for variable costs with price schedules encouraging certain procedures.⁴⁷ The intention is that a new payment scheme be implemented during the following two operations.

1.22 **Subcomponent 1.3. Consolidation of the health information system** (US\$45,420; CP US\$140,000). Given that data on patient encounters and health service provision is essential to effective management and health sector performance, it is essential to address the current weaknesses of the BHIS (¶1.11). For this reason, the project will commission a diagnosis of the BHIS in terms of design and user functionality. The scope of work will encompass consultations with the MOH managers to determine key indicators for monitoring health sector outcomes and processes to be generated from the BHIS. Some of these indicators will be included in the SLAs between the key actors in the health system. Separate services will be contracted to design report formats for the interface with the BHIS transactional database.⁴⁸ This will permit managers to develop and track the selected key indicators after having been trained in the use of the system. This information will be used to evaluate facility and team eligibility for the QIF. The BHIS platform will be made more robust through the purchase of servers for the Northern and Western Health Regions and tablet devices for use in health facilities and by the mobile clinics.

1.23 **Component 2. Strengthening health service delivery platforms to increase coverage** (US\$200,262; CP US\$228,603). The objective of this component is to expand higher

⁴⁵ This implies the reformulation of the existing legal instrument but not the implementation of new legislation.

⁴⁶ The Quality Innovation Fund allows facilities that meet their goals to apply for small performance grants for improving their working conditions and increasing the quality of their services. Specific details regarding the use and funding and determining eligibility will be included in the project Operating Manual. This modality of providing incentives for innovation has been employed in previous projects financed by the IDB and found to show positive results (for example, CUANTO, 2006).

⁴⁷ These payment schemes could be used between the MOH and the health regions, and in turn, between the regions and their facilities. The IDB is exploring the possibility of disbursing SM2015 funds from the second and third operations to the MOH according to the costs of services delivered per quality standards.

⁴⁸ Global Fund grant resources (US\$750,000) for the creation of a data warehouse for the BHIS database will allow for easier manipulation of the data and report processing. Part of these grant monies will be considered as counterpart funding for the MHF2015 resources that finance all other activities in this subcomponent.

resolution health services in priority areas for the target population. It will do this by overcoming some critical weaknesses identified by the MOH with existing channels of service delivery.

- 1.24 **Subcomponent 2.1. Reinforcement of neonatal care capacity** (US\$105,802; CP US\$0). In addition to the quality improvement efforts in the area of neonatal care, it is important to address specific systemic problems that prevent further reductions in neonatal morbidity and mortality. In order to increase the capacity of the Northern and Western Regional Hospitals to handle neonatal complications, basic neonatal emergency care equipment supported by the Regional Master Plans in Health will be acquired. The project will also finance the production of educational modules and the provision of emergency neonatal care training (travel and per diem) for nursing and medical staff in the regional hospitals. Furthermore, nurses will participate in rotations, financed by the project (travel and per diem), in tertiary-level hospitals in Belize (Karl Heusner Memorial Hospital) and in neighboring countries⁴⁹ so as to raise their knowledge and capacity, which they will subsequently convey to their colleagues upon return to Belize. Both project and national counterpart resources will be dedicated to making the San Ignacio Community Hospital and Western Regional Hospital “baby friendly” and will provide for relevant materials, training, and internal/external assessments.⁵⁰
- 1.25 **Subcomponent 2.2. Expansion of the coverage and complexity of reproductive health services** (US\$32,820; CP US\$50,000). Considering the relatively low rates of use of family planning methods and the high level of unmet need for contraception, especially among adolescents (¶ 1.9), the project will provide specific inputs to expand sexual and reproductive health services, thereby reinforcing the quality improvement measures. Family planning methods will be made available, which will require orientation, training regarding protocols, and counseling, as well as the purchase of minor equipment. Specialized services for adolescents with a differential focus by gender will be developed and provided in the hospitals and clinics in the participating districts. These will incorporate educational materials designed with input from adolescents and distributed for individual use and group sessions in the health facilities, which will be scheduled during convenient hours for the beneficiaries to provide differentiated attention. Modern contraceptive methods will be procured with project resources to satisfy unmet demand.⁵¹
- 1.26 **Subcomponent 2.3. Renovation of community-level services** (US\$61,640; CP US\$178,603). The CHW platform needs to be revitalized to fulfill its role in extending primary health care services to the poor rural population in Belize, which is a priority

⁴⁹ Training would occur preferably in Guatemala, Mexico and Trinidad and Tobago. Internships or rotations in perinatal technologies have proved effective in Peru on a number of outcomes related to deliveries and postpartum results (Diaz and Jaramillo, 2009). In order to evaluate the effectiveness of rotations in foreign countries, the project will promote the evaluation and comparison of the results of these rotations with those within Belize.

⁵⁰ The Baby-Friendly Hospital Initiative (BFHI) was launched in 1991 and is an effort by UNICEF and the World Health Organization to ensure that all maternities implement practices that protect, promote and support breastfeeding. See Quality Assurance Project and UNICEF/Nicaragua (2006) for a description of a country’s experience in instituting and sustaining a baby-friendly health units initiative.

⁵¹ In addition, resources for the procurement of modern contraceptive methods will be increased to approximately BZD100, 000 in the 2012 budget from the current (2011) value of BZD50, 000. These additional resources will be considered as counterpart funding (approximately US\$25,000).

goal for the MOH. The District Health Teams (DHT) once provided important support for primary health care, community involvement and the CHW program, but now the only district in which a DHT still functions, reconstituted as a District Health Council, is Toledo. Restructuring community-based primary health care will first require technical assistance to apply an assessment tool⁵² to provide a diagnostic report on the current state of the CHW program, evaluate options for strengthening it, and propose a clearly defined packet of services for the Integrated Management of Child Illnesses (IMCI) for delivery by the CHWs.⁵³ Once the platform is functioning, additional interventions in basic maternal and child health, nutrition and sexual and reproductive health will be added to the service packet during the second and third operations, provided they are approved.

- 1.27 The project will support training for the CHWs and district health educators⁵⁴ in areas identified by the assessment, benefiting an estimated 60 CHWs from the districts of Corozal, Orange Walk and Cayo. The project will finance the acquisition of basic supplies (medical kit, educational material, backpack, boots and field clothes) to allow the CHWs to perform their expanded functions and also to increase their morale. Radios and allowances for transportation will be provided to diminish effective barriers to service delivery. During the first operation, the MOH will organize three bi-annual coordination, refresher training and recognition events with project funding. In subsequent operations, CHWs' performance will be evaluated using a set of core indicators on the knowledge, attitudes and practices of community members, correct diagnosis and referral. The incorporation of performance incentives, such as bonuses to the BZD100 monthly salary for CHWs who meet established goals, will be explored.
- 1.28 **Component 3. Administration and auditing** (US\$70,383; CP US\$118,457). The administrative aspects of project implementation will be handled by the MOH Project Management Unit (PMU). The consulting contracts of the financial specialist, procurement specialist and executive assistant under this component will be financed with counterpart resources. Resources of the IT will finance the consulting services of a Quality Improvement (QI) Manager who will coordinate inputs from the MOH technical advisors and staff. This professional will also oversee the Regional Quality Assurance Teams, and have special responsibilities for supervision of project execution, monitoring of indicators and reporting. This component will contain an allocation of funds for financial auditing.
- 1.29 **First Individual Operation's Cost.** This first operation has a total cost of US\$1,250,000, consisting of investment tranche (IT) resources in the amount of US\$1,000,000 (Table I-1), financed in equal portions by the MHF and Belize, through counterpart (CP) funds, and a performance tranche (PT) for US\$250,000 (see [Detailed Budget](#)). The PT will be

⁵² USAID has developed a methodology and tools for assessing CHW programs and protocols based on best practices (see Crigler et.al. 2011).

⁵³ This includes antibiotic treatment of severe and non-severe pneumonia, oral rehydration therapy and antibiotic treatment for bloody diarrhea, treatment of fever and ear infections, infant feeding, and treatment of helminthiasis. Resources from a World Bank Japan Social Development Fund grant that finance similar interventions for MCH and nutrition through CHWs in Toledo District will figure as counterpart funding.

⁵⁴ The assessment of the CHW program will also encompass the district health educator position, which needs to be strengthened in terms of its supervisory role. A clear job description, requirements and terms of reference will be developed.

disbursed if the minimum score regarding the goals of the Performance Framework is met, in accordance with the RBF scheme established by the MHF2015 Initiative.

Table I-1. First Individual Operation Investment Costs (US\$)

Components	IADB	CP	Total	%
Quality improvement of maternal, neonatal, child and reproductive health services	229,355	152,940	382,295	38.2
Strengthening health service delivery platforms to increase coverage	200,262	228,603	428,865	42.9
Administration and auditing	70,383	118,457	188,840	18.9
Total	500,000	500,000	1,000,000	100

C. Key Results Indicators

1.30 Table I-2 presents the main indicators included for payment of the performance tranche (described in detail in the [Monitoring and Evaluation Plan](#)). The complete list of indicators is contained in the Performance Framework (Annex IV).

Table I-2. Results Indicators from the Results Framework

<ul style="list-style-type: none"> • Deliveries for which oxytocin was administered immediately after birth as part of active management of the third stage of labor. • Pregnancies with one ante-natal care visit during the first trimester according to the norms. • Infants with complications (prematurity, asphyxia and sepsis) handled according to norms. • Obstetric complications (sepsis, hemorrhage and eclampsia) handled according to norms. • Unmet need for contraception. • Infants 0-5 months of age fed exclusively with breast milk during the previous day. • Mothers (15-49) with children 0-24 months that can properly identify danger signs in neonates. • Mothers with children aged 0-59 months that during their last episode of diarrhea gave their children ORS and zinc. • Percentage of children aged 6-23 months that consumed 60 sachets of micronutrients in the last 6 months
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II. FINANCING STRUCTURE AND MAIN RISKS

A. Financing Instruments

2.1 The financing for this first individual operation is non reimbursable and contemplates an investment tranche and a performance tranche. The Belize program consists of three individual operations (Table II-1), each one with an 18-month disbursement period as established by the MHF2015 Initiative. The first individual operation (see footnote 40) will disburse according to the [Multi-Annual Execution Plan](#).

Table II-1. Total Program Financing

Category of financing	Operations			
	First	Second	Third	Total
Investment tranche	500,000	250,000	250,000	1,000,000
Counterpart	500,000	250,000	250,000	1,000,000
Subtotal investment	1,000,000	500,000	500,000	2,000,000
Performance tranche	250,000	125,000	125,000	500,000
Total	1,250,000	725,000	725,000	2,500,000

B. Environmental and Social Safeguard Risks

2.2 The first individual operation classifies as category “C” according to the safeguard screening process. No current or potential safeguard policy items were identified. There are no negative social or environmental effects expected from the program according to the Environment and Safeguards Compliance Policy (OP-703). On the contrary, the first individual operation is expected to produce positive social benefits for the poor, rural population, which is composed disproportionately of ethnic minorities. This will be achieved by increasing the access to higher quality health services for these beneficiaries.

C. Fiduciary Risk

- 2.3 The PMU responsible for the implementation of the first individual operation has experience with IADB procurement and financial policies and procedures. The PMU team will be reinforced by the Quality Improvement Manager who will handle general coordination and management oversight of the operation. Currently the national financial management system does not comply with IADB requirements, but it is hoped that by 2013 advances in the system will permit its use with Bank projects. Until then, the PMU will acquire software that allows it to maintain parallel accounting that meets Bank standards. Moreover, the PMU staff will receive refresher training from Bank fiduciary specialists regarding procurement, disbursements, auditing, control and reporting of the use of resources.

D. Other Key Issues and Risks

- 2.4 The Project Risk Management approach was used to assess the risks in operation execution. Each risk was evaluated, and in the cases where the risks were classified as “medium” or “high,” appropriate mitigation measures were developed.
- 2.5 **Project sustainability.** The MHF2015 Initiative established that in the case of Belize, the minimum counterpart funding must match the amount of donated investment resources. The first operation has been designed to provide technical assistance to help the MOH build its institutional capacity in key areas such as quality improvement of services in the MHF2015 package, information usage for better management, and strengthening of service delivery platforms. This will allow for the MOH to continue pursuing program objectives even after the MHF2015 financing has been utilized. In the second and third operations, project resources will finance the cost of provision of priority MHF2015 services according to a payment mechanism prioritizing these services (§ 1.19) and drawing in additional counterpart funds (See [Costing of MH2015 Health Services](#)). Furthermore, the [Ex ante Cost-Effectiveness Analysis](#) performed on the project interventions indicates favorable returns (between US\$4 and US\$ 269/DALY, which are well below GDP per capita of US\$4,153) for the resources invested, which is a positive factor in terms of their sustainability.

III. IMPLEMENTATION AND MANAGEMENT PLAN

A. Summary of Implementation Arrangements

- 3.1 **Executing agency.** The first operation will be implemented by the MOH, through the PMU, which will have responsibility for the administrative and financial aspects of resource management. The technical inputs required for the execution of the operation will be coordinated by the Quality Improvement (QI) Manager under the supervision and technical oversight of the Policy and Planning Unit and with the support of the MOH technical advisors. **A condition prior to first disbursement of the IT will be the selection of the QI (project) manager.**
- 3.2 The MOH will apply the general norms for the public sector in terms of financial management and will also comply with respective Bank policy. It will follow Bank procurement policy and procedures. The performance tranche will be disbursed if the minimum score regarding the established goals is met and will be used in the health sector; however, these resources will not be subject to the Bank’s procurement policies. These and other provisions are reflected in the Fiduciary Agreements and Requirements (Annex III) and will be detailed in the **Project Operations Manual, whose approval**

will be a condition prior to first disbursement of the IT. For the purposes of complying with paragraph 1.27 b. and c. of Annex 1 to the MHF2015 Operating Regulations, the MOH shall remit annually, up to two (2) years after the disbursement of the PT a report on the amount of resources expended on public primary health care services that allows for an analysis of the additionality of MHF resources.

B. Summary of Arrangements for Monitoring Results

- 3.3 **Monitoring and evaluation.** As indicated in the [Monitoring and Evaluation Arrangements](#), progress during the implementation of the operation on indicators of output, outcome and impact will be monitored using administrative data, population surveys and national statistics.⁵⁵ The relevant information will be maintained in two main instruments: a “dashboard” specially constructed for the Belize program and the Bank’s performance monitoring report (PMR). For the measurement of the performance tranche indicators, baseline household data will be provided by a MICS and a biomarkers survey currently underway, and from an independent survey of health services, which includes the review of administrative and medical records. Follow-up verification of process and quality of care indicators will be done through facility-based surveys at 18, 36 and 54 months, provided the second and third operations are approved, and population indicators will also be measured at 54 months using a Lot Quality Assurance Sample (LQAS) design or a similar method on the beneficiary population and a representative sampling of health services, within the geographic areas of the regions in which this Individual Operation will be implemented. In each of the health services selected for the survey, a random sampling of administrative and medical records will be selected for review.⁵⁶ Belize was not among the MHF2015 Initiative countries chosen for impact evaluation with experimental design, and the project evaluation will be reflexive, comparing indicators before and after intervention but not allowing for attribution. However, using the facility surveys, the pre-post evaluations in the northern and southern regions will allow for a comparison of the variations of performance funding and their effect on quality services in a clinical setting.
- 3.4 **Progress reports.** Project reports will be presented as follows: (i) when at least fifty per cent (50%) of the IT has been disbursed an unaudited financial report regarding the activities financed by the IT and the CP during the corresponding period; (ii) the final audited financial statements of the resources corresponding to the IT and CP; and (iii) an audited financial report on the use and destination of the resources of the PT as per request of the Bank.
- 3.5 **Learning.** The [Project Description and Implementation and Management Scheme](#) contains a section describing the provisions for systematizing the knowledge and lessons generated during the project design and execution. Documenting project learning will facilitate the preparation of the subsequent operations and will contribute to the sustainability of the program activities.

⁵⁵ In the event that differences are encountered between administrative and survey data, the survey data will be used.

⁵⁶ The LQAS method allows for measuring if a target is met using a smaller sample than that required for traditional household surveys. This will permit cost reduction given the financial constraints for monitoring and evaluation of this operation. The surveys discussed in this section will be financed by the MH2015 Initiative with resources separate from those used for the project activities described in this document. The surveys at 36 and 54 months will be conducted provided that the second and third operations are approved by the Bank.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	The intervention contributes to the lending program for small and vulnerable countries and for poverty reduction and equity enhancement.		
Regional Development Goals	The intervention contributes to the reductions in maternal and infant mortality ratios.		
Bank Output Contribution (as defined in Results Framework of IDB-9)	The intervention contributes to Bank output: individuals receiving a basic package of health services.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2520-2	The operation contributes to the objective of improving coverage and quality of health and education especially for the poorest districts.	
Country Program Results Matrix	GN-2617	The operation is included in the 2011 Country Program Document.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	9.3		10
3. Evidence-based Assessment & Solution	9.6	25%	10
4. Ex ante Economic Analysis	10.0	25%	10
5. Monitoring and Evaluation	7.8	25%	10
6. Risks & Mitigation Monitoring Matrix	10.0	25%	10
Overall risks rate = magnitude of risks*likelihood	Medium		
Environmental & social risk classification	C		
III. IDB's Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	Yes	Budget and treasury for financial management.	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	Consultancy on adolescent reproductive health policy.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan.			

This is a project with non-reimbursable financing for Belize which is part of the 2015 Mesoamerica Health Initiative. It contributes to the support to small and vulnerable countries, as well as to the reduction of poverty and equity enhancement. The project is aligned with the Bank's strategy in Belize and it is included in the 2011 country program document.

The document describes maternal and infant health indicators in Belize, as well as an analysis of the national health system, its structure, coverage, mechanisms and some quality indicators. The program identifies the need to improve quality, to expand the incentive mechanisms and thus contribute to improve health outcomes. The objective of the program is well defined and the proposed interventions respond directly to the identified causes. The results matrix adequately defines output, outcome and impact indicators. The economic analysis is adequate, and the monitoring and evaluation plan is also adequate to monitor results and manage the results based financing scheme of the initiative. The risk matrix is well defined and it includes monitoring indicators for the mitigation measures.

RESULTS MATRIX

Objective: to contribute to the reduction of maternal, infant and child mortality and morbidity in the poorest districts of the country through interventions that strengthen primary health care services within the framework of the Initiative. The specific objective is to improve maternal and infant, child and reproductive health in terms of access, usage and quality and increase the use of information in decision making.

IMPACT INDICATORS

Indicators	Unit of Measurement	Baseline	PP ¹ Change	MH2015 Verification Source	Baseline Observations
		2011 ²	54 months		
<u>Expected Impact:</u> Health and Nutrition status improvements in women of reproductive age and children less than 5 that live in the poorest areas of the country. ³					
Maternal mortality rate	Rate (x 100.000 live births)	56.4	-0.5	Vital Statistics	IHME ⁴ Estimates
Neonatal mortality	Rate (x 1.000 live births)	6.2	-0.15	Vital Statistics	IHME Estimates
Infant mortality	Rate (x 1,000 live births)	9.5	-0.2	Vital Statistics	IHME Estimates
Under 5 mortality rate	Rate (x 1,000 live births)	11.3	-0.15	Vital Statistics	IHME Estimates
Stunting in children 0-59 months	%	11.8	-2.5 ⁵	Not included in MH2015 verification in Belize ⁶	Belize MICS 2006
Total fertility rate	Rate (child/woman)	2.7	-0.5	Vital Statistics	National level rate, Belize basic indicators 2008

¹ PP = percentage point.

² Baseline estimates shown here represent the simple average of the rates for the three targeted districts for 2010 taken from Ministry of Health data. The Facility Survey will be available in May 2012; before signing the contract, the baseline values will be updated. Additionally, in early 2012, results from the Multiple Indicator Cluster Survey (MICS) 2010 and National Biomarkers Survey will become available to update population-based data.

n.d. = no baseline data available

³ Impact Indicators will only be evaluated at the beginning and end of the program.

⁴ Institute for Health Metrics and Evaluation.

⁵ Estimates based on expected reduction in Guatemala.

⁶ If the next MICS occurs in 2016, this indicator can be verified using the household survey data.

Indicators	Unit of Measurement	Baseline	PP ¹ Change	MH2015 Verification Source	Baseline Observations
		2011 ²	54 months		
Adolescent fertility rate	Rate (number of births to women between 15-19 years per year/1,000 women)	76.8	-13.5	Vital Statistics	National level rate, Belize basic indicators 2008

RESULTS INDICATORS

Indicators	Unit of Measurement	Baseline	PP Change	PP Change	MH2015 Verification Source	Baseline Observations
		2011 ⁷	36	54		
Expected Results: Increase in coverage, quality and use of health services in reproductive, maternal, neonatal and child health in targeted areas.						
Women of reproductive age (15-49) whose most recent birth was attended by a skilled attendant in an institutional setting	%	84.1	3.3	5.5	Attainment of target verified at 54 months using Lot Quality Assessment Sampling (LQAS) household survey/BHIS ⁸	Simple average of 2010 rates for three targeted districts (MOH data)
Children 0-59 months identified as having received full vaccinations for age	%	65.6	5	10	Attainment of target verified at 54 months using LQAS household survey/BHIS	Rate in poorest 60% of population, Belize MICS 2006
Children (12-59 months) who received two doses* of de-worming treatment in the last year according to facility records	%	*	5	10	Health facility survey	
Women of reproductive age ⁹ (15-49 years) who currently use (or whose partner is using) a modern method ¹⁰ of family planning	%	25	0.66	0.1	Attainment of target verified at 54 months using LQAS household survey/BHIS	MICS
Women of reproductive age (15-49) who attended at least 4 antenatal care visits by skilled attendant for their most recent pregnancy during the last two years	%	*	*	* ¹¹	Attainment of target verified at 54 months using LQAS household survey/BHIS	MICS 2006

⁷ Baseline estimates shown here represent the simple average of the rates for the three targeted districts predicted by the IHME model unless otherwise stated. Targets are calculated based on the Observed Average Annual change presented in the IHME target setting guidelines. The Facility Survey will be available in May 2012; before signing the contract, the baseline values will be updated. Additionally, in early 2012, results from the MICS 2010 and National Biomarkers Survey will become available to update population-based data.

⁸ If this indicator is not measured with LQAS, it will be monitored by the Belize Health Information System (BHIS).

⁹ Excluding those who report any of the following: does not have sexual relations, virgin, menopausal, hysterectomy, pregnant, or wants to become pregnant.

¹⁰ Includes the following methods: sterilization, inter-uterine device (IUD), injections/implants, oral contraception, barrier methods, emergency contraception, or "other modern method."

¹¹ With results from the MICS 2010 a goal can be based on the trends between 2006-2010.

Indicators	Unit of Measurement	Baseline	PP Change	PP Change	MH2015 Verification Source	Baseline Observations
		2011 ⁷	36	54		
Children born in the last 24 months who were put to the breast within one hour of birth	%	50.6	13.33	20 ¹²	Attainment of target verified at 54 months using LQAS household survey/BHIS	MICS 2006
Institutional deliveries for which oxytocin was administered immediately following birth as part of Active Management of the Third Stage of Labor (AMTSL)¹³	%	80	15	15	Health Facility Survey	Current estimates from MOH staff
Pregnancies for which the woman attended at least one antenatal care visit during the first trimester that was carried out according to the norms	%	26	7	14	Health Facility Survey	Simple average of Corozal, Orange and Cayo, MOH 2010
Institutional deliveries for which immediate neonatal care was provided to the infant according to the norms	%	50	20	40	Health Facility Survey	Current estimates from MOH staff
Neonates with complications (low birth weight, asphyxia and sepsis) managed according to the norms	%	15	30	75	Health Facility Survey	Current estimates from MOH staff
Obstetric complications (sepsis, hemorrhage, severe pre-eclampsia and eclampsia) handled according to the norms	%	20	35	70	Health Facility Survey	Current estimates from MOH staff
C-sections that were carried out unnecessarily¹⁴	%	30	20	10	Health Facility Survey	Current estimates from MOH staff

¹² Estimate based on postnatal care according to the norms.

* Baseline data to be provided by Belize MICS 2011.

¹³ Indicators in **BOLD** are considered for performance tranche disbursement.

¹⁴ A more precise definition of this indicator will be acquired during the next mission.

Indicators	Unit of Measurement	Baseline	PP Change	PP Change	MH2015 Verification Source	Baseline Observations
		2011 ⁷	36	54		
Children 0-23 months with low weight-for-age managed according to norms	%	*	75 ¹⁵	n/a	Health Facility Survey	Program has just started, no data available
Female health facility patients of reproductive age that are given family planning counseling according to the norms	%	25	50	n/a	Health Facility Survey (of patients)	Current estimates from MOH staff
Diarrhea cases in infants that were treated with ORS and ZINC	%	0	90	n/a	Health Facility Survey	Current estimates from MOH staff
Deliveries for which a partograph was carried out and correctly interpreted according to the norms	%	30	60	n/a	Health Facility Survey	Current estimates from MOH staff
Newborns enrolled for child health services within seven days of birth	%	75	10	n/a	Health Facility Survey	Coverage of timely BCG vaccines according to 2010 census to be used a proxy
Live births for which the women received post-partum care within the first 7 days of birth	%	28	32	n/a	Health Facility Survey	Current estimates from MOH staff
Female health facility patients of reproductive age that are given family planning counseling according to the norms	%	25	n/a	50	Health Facility Survey	Program does not yet exist

¹⁵ Percentage point change target is not available because the baseline is unknown.

Indicators	Unit of Measurement	Baseline	PP Change	PP Change	MH2015 Verification Source	Baseline Observations
		2011 ⁷	36	54		
Percentage of women of reproductive age ¹⁶ (15-49 years) who were not using/unable to obtain contraception during last year	%	31	n/a	-5	Household-based survey (using LQAS)	Simple average of Corozal, Orange Walk and Cayo, MICS 2006
Infants 0–5 months of age who are fed exclusively with breast milk the previous day	%	23	n/a	10	Household-based survey (using LQAS)	Simple average of Corozal, Orange Walk and Cayo, MICS 2006
Mothers with a child 2 years or younger that can recognize 3 out of 5 signs of danger ¹⁷	%	20	n/a	40	Household-based survey (using LQAS)	Simple average of Corozal, Orange Walk and Cayo, MICS 2006
Children aged 6-23 months that consumed 60 sachets of micronutrients in the last 6 months	%	0	n/a	30	Household-based survey (using LQAS)	Program does not currently exist
Mothers who gave their children (0-59 months) ORS and zinc supplements during the last episode of diarrhea in the last month.	%	0	n/a	40	Household-based survey (using LQAS)	Program does not currently exist ¹⁸

¹⁶ Excluding those who report any of the following: does not have sexual relations, virgin, menopausal, hysterectomy, pregnant, or wants to become pregnant.

¹⁷ Danger sings include feeding problems, or if the newborn has reduced activity, difficult breathing, a fever, fits or convulsions, or feels cold.

¹⁸ Zinc will be procured beginning in 2012; current coverage of ORS is 44% (MICS 2006).

PRODUCT INDICATORS (18 month indicators)

Indicators	Unit of Measurement	Baseline	PP Change	SM2015 Verification Source	Baseline Observations
		2011 ¹⁹	18 months		
Health facilities that have the necessary inputs for providing emergency obstetric and neonatal care according to the norms	%	*	85%	Health Facility Survey	Will be updated with baseline information
Health facilities that have the necessary inputs for providing pre- and post natal care according to the norms	%	*	85%	Health Facility Survey	Will be updated with baseline information
Health facilities that have submitted a QIF proposal to the national quality audit team	%	0	85%	Health Facility Survey	Program does not currently exist
Health facilities that have the necessary inputs to provide child health care according to the norms	%	*	85%	Health Facility Survey	Will be updated with baseline information
Health facilities that have Quality of Care job aid tools for reproductive health	%	0	85%	Health Facility Survey	Program does not currently exist
Health facilities that have the necessary inputs to submit and receive data from the BHIS data system	%	0	85%	Health Facility Survey	Will be updated with baseline information
Health facilities that have an adequate supply of all 5 types of modern family planning methods (injectable, barrier, oral, IUD, permanent)	%	*	85%	Health Facility Survey	Will be updated with baseline information
Health facilities that have SRH educational materials specifically targeted at adolescents	%	0	85%	Health Facility Survey	Program does not currently exist
Norms for improving the quality of reproductive and child health and nutrition services and for the establishment of a community platform of services developed, adopted and implemented in health facilities	Yes/No	No	Yes	Health Facility Survey	Program does not currently exist

¹⁹ The facility survey will be available in May 2012; before signing the contract, the baseline values will be updated. Additionally, in early 2012, results from the MICS 2010 and National Biomarkers Survey will become available to update population-based data.

Indicators	Unit of Measurement	Baseline	PP Change	SM2015 Verification Source	Baseline Observations
		2011 ¹⁹	18 months		
Community Health Workers trained in the community platform	%	0	85%	Health Facility Survey	Program does not currently exist

Fiduciary Agreements and Requirements

Country: Belize
Project: BL-G1001
Name: Mesoamerica Health 2015
Executing Agency: Ministry of Health
Prepared by: Ian Mac Arthur (SPH/CGU); Luis Acosta (PDP/CDR); Willy Bendix (PDP/CCR)

I. Introduction

The project BL-G1001 will be executed by the Ministry of Health (MOH) of Belize. The MOH has been the executing agency of a recently closed loan operation financed by the Bank (BL0014 Health Sector Reform Program). In this regard, the proposed executing agency of the current operation has previous experience in the administration of Bank financing. The Project Management Unit (PMU) of the MOH, whose finance and procurement staff is familiar with Bank policies and procedures, will be responsible for project implementation.

II. Fiduciary Context of the Executing Agency

According to the 2009 Public Expenditure and Financial Accountability (PEFA) Assessment, in general the budget process (planning, execution, and reporting) in Belize has several deficiencies that undermine fiscal discipline. The PEFA document indicates that the lack of information on the cost of programs and use of resources undermines the ability to allocate resources to government priorities. Also, the lack of regular monitoring of budget execution does not facilitate identification of problems which may lead to significant changes in the executed budget and, thus, affect the strategic allocation of resources. In addition, inadequate information and records reduces the capacity to undertake effective audit and oversight of the use of funds and could provide the opportunity for leakages, corrupt procurement practices or use of resources in an unintended manner.

A diagnostic and test of the Smartstream accounting system was conducted and recommendations were formulated regarding accounting and reporting aspects for IDB-financed projects. Although there has been progress in improving national financial management systems, especially the accounting module, currently the MOH will need to maintain a parallel system of accounting for project resources from the start of execution. It is hoped that by 2013 the national financial management system will meet Bank standards and can be used with Bank projects.

In terms of procurement, an assessment based on MAPS¹/OECD4 was conducted. Results show a low score (average score < 1.5), and opportunities to improve on risk reduction and transaction costs. Belize does not possess a strong structure of norms nor an adequate electronic public procurement system. This obligates the multilateral and bilateral organisms to ensure the use of their own procurement procedures instead of a national system.

¹ MAPS (Methodology for Assessment of Procurement Systems).

III. Evaluation of Fiduciary Risk and Mitigation Actions

It was not possible to conduct a formal evaluation of fiduciary risk during project preparation in order to determine the level of risk in financial management and procurement, but with available information certain relevant risks and their corresponding mitigation measures were identified. The principal risks and corrective actions are identified in Table No. 1.

Table No. 1: Risks and Mitigation Actions

Risk/Weakness	Preventive/Corrective Action
The PMU finance specialist is familiar with Bank policies and procedures but lacks sufficient knowledge and experience to ensure their complete application.	During the first trimester of project implementation, the Bank Financial Specialist will conduct special training regarding Bank requirements for planning, disbursements, auditing and control and reporting of project funds.
Currently the national financial management system does not comply with Bank requirements, especially regarding the accounting module, but it is hoped that by 2013 advances in the system will permit its use with Bank projects.	Until the national system meets Bank requirements, the PMU will acquire and use a software solution that allows it to maintain parallel accounting that complies with Bank standards.
The PMU does not have a general project coordinator that could articulate inputs from MOH technical advisers, for example, regarding the terms of reference for the consultancies to be financed with project funds.	Project resources will finance the contract of a Quality Improvement Manager for the PMU that will reinforce the team and bear overall responsibility for project coordination and management.
There may be delays in procurement exercises due to limited capacity within the PMU to manage the respective processes.	The Bank Procurement Specialist will visit the PMU during the first trimester of project implementation in order to conduct refresher training on Bank policy and procedures in the area of procurement.

IV. Elements to be Considered in the Grant Agreement

In order to facilitate the negotiation of the special conditions on the part of the project team and the Legal Department, the following elements are identified and recommended for inclusion in the special conditions of the grant agreement:

- a) The executing agency should present the project Operating Manual for Bank approval.
- b) The Project Quality Improvement Manager who will work in the PMU should be approved by the Bank and contracted.

In addition, the agreement will reflect the following standard conditions:

- a) The PMU should adjust and maintain the Project Execution Plan updated at all times.
- b) All contracting processes conducted after the approval of the operation that are detailed in the Procurement Plan and that have followed the Policies GN-2349-9 and GN-2350-9, will be eligible for retroactive financing once the project resources are available. In these cases, the selection and contracting procedures should comply with these policies so that the contracts are eligible for financing, and the Bank will examine the process used by the beneficiary. The beneficiary undertakes contracting in-advance at its own risk, and the grant agreement with the Bank regarding the procedures, the procurement documents and the award proposal do not commit the Bank to financing the contract.

V. Agreements and Requirements for Procurement Activities

1. Execution of Procurement Activities

The contracting of required consulting services and the procurement of goods and related services financed with the project's resources carried out by the MOH will follow the Bank's procurement policies and procedures, including "Policies for the Selection and Contracting of Consultants financed by the Bank" (GN-2350-9), and "Policies for the Procurement of Goods and Works (GN-2349-9) of March 2011, as well as the conditions established in the grant agreement and the procurement plan.

- a) **Works procurement:** The procurement of works is not foreseen under the project.
- b) **Procurement of Goods and Services Different from Consulting:** The contracts for Goods and Services Different from Consulting² generated under the project and subject to International Competitive Bidding (ICB) will be procured using Standard Bidding Documents issued by the Bank. The bidding processes subject to National Competitive Bidding (NCB) will be conducted using National Bidding Documents agreed to with the Bank (or acceptable to the Bank if they have not been agreed to as of the present date). The procurement of Goods and Services Different from Consulting will be carried out using the Bank's Policies for the Procurement of Goods and Works financed by the Inter-American Development Bank (GN-2349-9). The contracting of goods and services different from consulting whose estimated cost is equal to or greater than US\$100,000 will be conducted through International Competitive Bidding (ICB); equal or superior to US\$25,000 and less than US\$100,000, National Competitive Bidding (NCB); and less than US\$25,000, price comparison (shopping).
- c) **Procurement of Consulting Services:** The contracting of Consulting Services with project resources will be done using the document Standard Request for Proposals (SRP)

² According to the Procurement Policy of the IDB, services different from consulting are treated in a manner similar to goods.

distributed by the Bank or agreed to with the Bank (acceptable to the Bank if documents have not been agreed upon), independent of the contract amount. The selection and contracting of consultants will be done using the Policies for the Selection and Contracting of Consultants financed by the Inter-American Development Bank (GN-2350-9) and in accordance with the following procedures:

- **Selection of Consulting Firms:** For the selection of a consulting firm, the Quality- and Cost-Based Selection (QCBS) method will be used; however, when the circumstances allow, other selection methods contemplated in the Policies for the Selection and Contracting of Consultants financed by the Inter-American Development Bank (GN-2350-9) (QBS, FBS, LCS and CQS) may be used.
- **Short List for Consulting Firms³:** For the preparation of the short lists, the dispositions of number 2.6 of the Policies for the Selection and Contracting of Consultants financed by the Inter-American Development Bank (GN-2350-9) will be considered. The short lists can be made up entirely (100%) of national firms when the value of the contracts is less than US\$200,000.
- **Selection of Individual Consultants:** The qualifications of the consultants for performing the required work will be considered, on the basis of at least three candidates. When necessary, announcements can be published in the local or international press in order to obtain expressions of interest from qualified candidates.

2. Procurement Plan

The procurement plan for the Mesoamerica Health 2015 project in Belize covers the period of project implementation from January 2012 through June 2013. It indicates the procedures to be used for the procurement of goods, the contracting of works or services, and the method of selecting consultants, for each contract or group of contracts. It also indicates the estimated cost of the contracts and the form of review by the Bank (ex ante or ex post). Procurement for the project will be carried out in accordance with the provisions established in the grant agreement and this procurement plan.

The goods and services other than consulting that will be procured under this project include, among other items, computer equipment, medical equipment and instruments, radio communications devices, and training events (locale and catering).

Some of the most important consulting contracts to be implemented under the program include the following: design of health policies, norms, protocols and job aid tools; expansion of a health services quality improvement model; design of a quality innovation fund; development of options for new payment schemes; diagnosis of the health information system; and assessment of

³ According to section V of the Policies for the Selection and Contracting of Consulting Services, the selection of individual consultants does not require the use of a Short List nor the SRP.

the community health worker program. For details regarding the individual procurement items, see the [Procurement Plan](#).

3. Procurement Supervision

Unless the Bank agrees otherwise in writing, the contracts for the acquisition of goods and services shall be subject to ex ante review.

4. Records and Files

The PMU will be responsible for maintaining records and files of all procurement processes. It will store the documentation in a single, secure location. Each procurement process will have its own individual file that contains all relevant documentation of each step in the selection or bidding and contracting exercise.

VI. Agreements and Requirements for Financial Management

1. Accounting and Financial Reports

The MOH will maintain project accounting records in software purchased specifically for this purpose that allows it to maintain parallel accounting (to the national system) that complies with Bank standards.

2. Disbursements and Cash Flow

The MOH will open and operate a special account for the project in the Central Bank, as well as an operational account in a commercial bank from which it will make payments to providers and contractors.

In accordance with the new Bank policy on financial management (OP-273-2), disbursements will be made on the basis of the liquidity needs for project implementation, for which the MOH will prepare a financial plan. Disbursements will be made under the modality of advance of funds, whose value will be determined by the financial plan. When further resources are needed for project implementation, the MOH will present a disbursement request in which it justifies the incurred expenditures.

3. External Control and Reports

The Bank will require an external financial audit after the 18-month project implementation period. The performance tranche resources will not be subject to audit.

4. Supervision

The MOH will maintain proper proof of expenditure. This information will be subject to ex-post review by the Bank and audit review.

Performance Framework

Objective: to contribute to the reduction of maternal, infant and child mortality and morbidity in the poorest districts of the country through interventions that strengthen primary health care services within the framework of the Initiative. The specific objective is to improve maternal and infant, child and reproductive health in terms of access, usage and quality and increase the use of information in decision making.

Indicators for disbursement of the Performance Tranche at 18 months

Indicator ¹	Unit of measurement	Weight	Baseline ²	Target	Source of verification ³
Health facilities that have the necessary inputs for providing emergency obstetric and neonatal care according to the norms	%	0.083	60%	75%	Health Facility Survey
Health facilities that have the necessary inputs for providing pre- and post natal care according to the norms	%	0.083	75%	85%	Health Facility Survey
Health facilities that have submitted a Quality Improvement Fund (QIF) proposal to the national quality audit team	%	0.083	0	75%	Health Facility Survey
Health facilities that have the necessary inputs to provide child health care according to the norms	%	0.083	*	85%	Health Facility Survey
Health facilities that have implemented Quality of Care job aid tools for reproductive health	%	0.083	*	85%	Health Facility Survey

¹ The numerator and demonitor for each indicator will be included in the Operations Manual, including definition of inputs and norms

² The baseline data has been estimated in consultation with program staff and/or using the estimates produced by the model created by Institute of Health Metrics and Evaluation (IHME).

* To be updated as soon as the baseline data become available according to Section 3.5(b) of the Framework Agreement..

³ All verifications are independent surveys. Health facility surveys include revision of medical records and verification of inputs, in agreement with the definitions in the Operations Manual

Indicador ¹	Unit of measurement	Weight	Baseline ²	Target	Source of verification ³
Health facilities that can submit and receive data from the Belize Health Information System (BHIS)	%	0.083	*	85%	Health Facility Survey
Health facilities that have permanent availability of all 5 types of modern family planning methods (injectable, barrier, oral, IUD, permanent) according to the norms	%	0.083	*	85%	Health Facility Survey
Health facilities that have sexual and reproductive health (SRH) educational materials specifically targeted at adolescents	%	0.083	0	85%	Health Facility Survey
Norms for improving the quality of reproductive and child health and nutrition services and for the establishment of a community platform of services adopted	Yes/No	0.083	0	Yes	Norm Approved
Community health workers (CHW) trained in the community platform	%	0.083	*	85%	Health Facility Survey
District HECOPAB ⁴ Officers that are currently monitoring the CHWs	%	0.083	*	85%	Health Facility Survey
Health facilities with a mechanism in place for carrying out patient satisfaction surveys	%	0.083	*	85%	Health Facility Survey

⁴ Health Education and Community Participation Bureau.

Indicators for disbursement of the Performance Tranche at 36 months

Indicator⁵	Unit of measurement	Weight	Baseline⁶	PP change	Source of verification⁷
Institutional deliveries for which oxytocin was administered immediately following birth as part of Active Management of the Third Stage of Labor (AMTSL) in the last two years for the most recent delivery	%	0.083	80%	15	Health Facility Survey
Pregnancies for which the woman attended at least one antenatal care visit during the first trimester for the most recent pregnancy in the last two years	%	0.083	26%	7	Health Facility Survey
Institutional deliveries for which immediate (within 24 hours) neonatal care was provided to the infant according to the norms in the last two years	%	0.083	50%	20	Health Facility Survey
Neonatal complications (prematurity, low birth weight, asphyxia and sepsis) managed according to norms in the last two years	%	0.083	15%	30	Health Facility Survey
Obstetric complications (sepsis, hemorrhage, severe pre-eclampsia and eclampsia) managed according to the norms in the past two years	%	0.083	20%	35	Health Facility Survey

⁵ The numerator and demonitor for each indicator will be included in the Operations Manual

⁶ The baseline data has been estimated in consultation with program staff and/or using the estimates produced by the model created by Institute of Health Metrics and Evaluation (IHME).

* To be updated as soon as the baseline data become available according to Section 3.5(b) of the Framework Agreement..

⁷ All verifications are independent surveys. Health facility surveys include revision of medical records and verification of inputs, in agreement with the definitions in the Operations Manual, including definition of inputs and norms.

Indicator⁵	Unit of measurement	Weight	Baseline⁶	PP change	Source of verification⁷
C-sections as proportion of childbirths in the last two years ⁸	%	0.083	30%	-10	Health Facility Survey
Children 0-23 months with low weight-for-age managed according to norms in the last two years	%	0.083	*	75% ⁹	Health Facility Survey
Female health facility patients of reproductive age that are given family planning counseling according to the norms in the last two years	%	0.083	25%	50	Health Facility Survey (of patients)
Diarrhea cases in children 0-59 months presenting in health facilities that were treated with Oral Rehydration Solution (ORS) and zinc during their last visit	%	0.083	0	90	Health Facility Survey
Deliveries for which a partograph was carried out and correctly interpreted according to the norms in the last two years for the most recent delivery	%	0.083	30%	60	Health Facility Survey
Newborns enrolled for child health services within seven days of birth in the last two years	%	0.083	75%	10	Health Facility Survey
Live births for which the women received post-partum care before the first 7 days of birth in the last two years for the most recent pregnancy	%	0.083	28%	32	Health Facility Survey

⁸ The Optimal Range for C-sections as a proportion of childbirths is between 10-15%.

⁹ Percentage point change target is not available because the baseline is unknown.

Indicators for disbursement of the Performance Tranche at 54 months

Indicator¹⁰	Unit of measurement	Weight	Baseline¹¹	Target	Source of verification¹²
Institutional deliveries for which oxytocin was administered immediately following birth as part of Active Management of the Third Stage of Labor (AMTSL) in the last two years for the most recent delivery	%	0.083	80%	15	Health Facility Survey
Pregnancies for which the woman attended at least one antenatal care visit during the first trimester that was carried out according to the norms for the most recent pregnancy in the last two years	%	0.083	26%	14	Health Facility Survey
Institutional deliveries for which immediate neonatal care (within 24 hours) was provided to the infant according to the norms in the last two years for the most recent pregnancy	%	0.083	50%	40	Health Facility Survey
Neonatal complications (prematurity, low birth weight, asphyxia and sepsis) handled according to norms in the last two years	%	0.083	15%	75	Health Facility Survey
Obstetric complications (sepsis, hemorrhage, severe pre-eclampsia and eclampsia) handled according to the norms in the last two years	%	0.083	20%	70	Health Facility Survey

¹⁰ The numerator and demonitor for each indicator will be included in the Operations Manual, including definition of inputs and norms.

¹¹ The baseline data has been estimated in consultation with program staff and using the estimates produced by the IHME model.

* To be updated as soon as the baseline data become available according to Section 3.5(b) of the Framework Agreement..

¹² All verifications are independent surveys. Health facility surveys include revision of medical records and verification of inputs, in agreement with the definitions in the Operations Manual, including definition of inputs and norms.

Indicator ¹⁰	Unit of measurement	Weight	Baseline ¹¹	Target	Source of verification ¹²
C-sections as a proportion of childbirths in the last two years ¹³	%	0.083	30%	-20	Health Facility Survey
Female health facility patients of reproductive age that are given family planning counseling according to the norms in the last two years	%	0.083	25%	50	Health Facility Survey
Women of reproductive age ¹⁴ (15-49 years) who were not using/unable to obtain contraception during last year	%	0.083	31%	-5	Household-based survey
Infants 0–5 months of age who were fed exclusively with breast milk the previous day	%	0.083	23%	10	Household-based survey
Mothers with a child 0-23 months that that can recognize 3 out of 5 signs of danger ¹⁵	%	0.083	20%	40	Household-based survey
Percentage of children aged 6-23 months that consumed 60 sachets of micronutrients in the last 6 months	%	0.083	0	30	Household-based survey
Mothers who gave their children (0-5 9 months) ORS and zinc supplements during the last episode of diarrhea in the two weeks	%	0.083	0	40	Household-based survey

¹³ The Optimal Range for C-sections as a proportion of childbirths is between 10-15%.

¹⁴ Excluding those who report any of the following: does not have sexual relations, virgin, menopausal, hysterectomy, pregnant, or wants to become pregnant.

¹⁵ Danger sings include feeding problems, or if the newborn has reduced activity, difficult breathing, a fever, fits or convulsions, or feels cold.