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HONDURAS

PROJECT TO IMPROVE THE MANAGEMENT AND QUALITY OF MATERNAL-NEONATAL HEALTH SERVICES

(HO-L1195)

LOAN PROPOSAL

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3. Procurement plan

OPTIONAL

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2. Honduran maternal and neonatal health strategic simulation model
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7. Preliminary list of equipment
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ABBREVIATIONS

BCH	Banco Central de Honduras [Central Bank of Honduras]
CI+	Care Improvement Plus
CMIs	Clínicas materno-infantiles [maternal/infant health care clinics]
ENDESA	Encuesta Nacional de Demografía y Salud [National Demographic and Health Survey]
ESFAMs	Equipos de salud familiar [family health teams]
HEU	Hospital Escuela Universitario [University Teaching Hospital]
HMCR	Hospital Mario Catarino Rivas
IHSS	Instituto Hondureño de Seguridad Social [Honduran Social Security Institute]
MGD	Modelo de Gestión Descentralizada [Decentralized Management Model]
MNS	Modelo Nacional de Salud [National Health Model]
OC	Ordinary Capital
ONADICI	Oficina Nacional de Desarrollo Integral del Control Interno de las Instituciones Públicas [National Office for the Comprehensive Development of Internal Control in Public Institutions]
PAHO	Pan American Health Organization
PEU	Project execution unit
RAMNI	Reducción Acelerada de la Mortalidad Materna Infantil [Accelerated Reduction of Maternal and Child Mortality]
RAMOS	Reproductive Age Maternal Mortality Survey
RISS	Redes Integrales de Salud [Integrated Health Services Networks]
SESAL	Secretaría de Salud [Ministry of Health]
SIAFI	Sistema Integrado de Administración Financiera [Integrated Financial Administration System]
SNIPH	Sistema Nacional de Inversión Pública de Honduras [National Public Investment System of Honduras]
SRISS	Office of the Undersecretary for Integrated Health Services Networks
TSC	Tribunal Superior de Cuentas [Superior Audit Court]
UEPEX	Módulos de Unidades Ejecutoras de Proyectos con Financiamiento Externo [Modules of Execution Units for Externally Financed Projects]
UTGP	Unidad Técnica de Gestión de Proyectos [Project Technical Management Unit]
WHO	World Health Organization

PROJECT SUMMARY

HONDURAS

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(HO-L1195)

Financial Terms and Conditions					
Borrower: Republic of Honduras				**Regular OC**[a]	**Concessional OC**
			Amortization period:	25 years	40 years
Executing agency: Ministry of Health (SESAL)			**Disbursement period:**	5 years	
			Grace period:	5.5 years[b]	40 years
Source	**Amount (US$)**	**%**	**Interest rate:**	LIBOR-based	0.25%
IDB (Regular OC):	41.4 million	60%	**Credit fee:**	[c]	N/A
IDB (Concessional OC):	27.6 million	40%	**Inspection and supervision fee:**	[c]	N/A
			Weighted average life (WAL):	15.25	N/A
Total:	69.0 million	100%	**Currency of approval:**	United States dollars	

Project at a Glance

Project objective/description

The project objective is to contribute to the reduction of maternal-neonatal mortality in the poorest municipios of the country and in the prioritized hospitals by improving the quality, management, and responsiveness of health services and supporting the policy for Accelerated Reduction of Maternal and Child Mortality (RAMNI).

Special conditions precedent to the first disbursement of the loan proceeds: (i) the project Operations Manual has been approved and entered into effect on the terms agreed previously upon with the Bank; and (ii) the project's general coordinator has been appointed (see paragraph 3.10).

Special contractual conditions for execution: Prior to the signature of contracts with the managers identified in component 1, evidence will be provided to the Bank that the following have been approved: (i) the regulations governing the selection of first and second level managers; and (ii) the plan for absorbing the financing of the Decentralized Management Model (MGD). Prior to the start of the works identified in component 2, evidence will be provided to the Bank that: (i) the specialized technical staff have been contracted for the project technical management unit (UTGP) on the terms agreed previously upon with the Bank; and (ii) a health and safety plan and a waste management plan have been prepared for the works rehabilitation stage for the Bank's no objection (see paragraph 3.11).

Exceptions to Bank policy: None**.**

Strategic Alignment						
Challenges:[d]	SI	☑	PI	☐	EI	☐
Crosscutting themes:[e]	GD	☑	CC	☑	IC	☐

[a] Under the Flexible Financing Facility (FFF) (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency and interest rate conversions. The Bank will take operational and risk management considerations, prevailing market conditions, and the level of concessionality of the loan into account when reviewing such requests, in accordance with applicable Bank policies in force.

[b] Under the flexible repayment options of the Flexible Financing Facility, changes to the grace period are permitted, provided that they do not entail any extension of the original weighted average life of the loan or the last payment date as documented in the loan contract.

[c] The credit fee and the inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with the applicable policies.

[d] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[e] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. PROJECT DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1.1 **The health care system in Honduras** is segmented into three coexisting subsystems, each with its own type of financing, membership, and services. The Honduran Social Security Institute (IHSS) covers 18% of the population, particularly wage-earners; the private sector covers 7%; and the remainder is covered by the Ministry of Health (SESAL).[1]

1.2 The **Modelo Nacional de Salud [National Health Model] (MNS)**[2] establishes that public services are to be organized into Integrated Health Services Networks (RISSs), structured by level of complexity.[3] SESAL has determined that there will be 69 RISSs around the country and has prioritized the establishment of 20,[4] one for each health region.

1.3 According to the National Health Model, the public system (IHSS and SESAL) is organized into two levels.

1.4 **Level one** includes ambulatory care and consists of: (i) family health teams (ESFAMs) composed of a physician, an extension worker, and a nursing assistant for every 600 to 1,000 families, which provide prevention, promotion, and care services at the community level; (ii) health care facilities of varying complexities that provide general medical, dental, and laboratory services; and (iii) maternal/infant health care clinics, which are basic units that attend uncomplicated deliveries.

1.5 **Level two** includes hospitals: (i) type 1 or basic hospitals which provide services in four specialties (pediatrics, obstetrics and gynecology, internal medicine, and surgery), with obstetrical wards[5] and basic care for newborns,[6] but no neonatal intensive care units; (ii) type 2 or general hospitals that provide services in the four basic specialties and some subspecialties, and have basic and intermediate obstetrical and neonatal wards,[7] but no neonatal intensive care units; (iii) type 3 or specialized hospitals treat patients referred from type 1 and 2 hospitals, and have basic and intermediate obstetrical and neonatal wards, as well as neonatal intensive care units;[8] and (iv) type 4 or highly specialized hospitals, which treat highly complex cases.[9]

1.6 **Status of maternal and child health care.** In recent years, Honduras has gradually and steadily improved its health indicators. For example, life expectancy

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1 National Population and Health Survey (ENDESA) 2011-2012.

2 Approved by executive decree (PCM 051-2017).

3 PAHO 2010.

4 SESAL's health system is organized into 20 health regions.

5 Obstetrical wards include delivery and postpartum rooms.

6 Basic neonatal wards offer care for newborns with mild pathologies that require observation and monitoring.

7 Intermediate care is offered by neonatologists for premature babies born after 32 weeks and babies who weigh more than 1,500 grams, whose lives are not in danger and who do not require a ventilator.

8 Intensive care is offered by neonatologists for newborns in serious and unstable condition who require complex and continuous care, are on ventilators, and have compromised systems.

9 MNS/SESAL, September, 2017.

at birth has risen from 66.7 years in 1990 to 73.3 years in 2016.[10] The maternal mortality rate fell from 182 to 61 deaths per 100,000 live births between 1990 and 2015[11] (the Latin American and Caribbean average is 67 deaths per 100,000 live births).[12] Infant mortality has fallen 38% from 39 to 24 deaths per 1,000 live births (1990-2012).[13] However in the period 2006-2012, infant mortality fell by only 4%, from 25 to 24 per 1,000 live births,[14] which indicates that the reduction has stalled. The Bank has made a substantial contribution to improving these indicators, since the operations executed after 2009, which are mentioned below, have given priority to the mother and child population. Specifically, activities have been aimed at improving the coverage, access, and quality of prenatal, childbirth, and postpartum care, care for newborns, and treatment of obstetric and neonatal complications.

1.7 **Maternal health.** Despite the significant progress made in reducing the maternal mortality rate, the pace of reduction has slowed. Between 1990 and 1997, the rate fell from 182 to 108 for an average annual reduction of 10.6 deaths per 100,000 live births; between 1997 and 2010 the rate fell from 108 to 73, equivalent to an annual reduction of 2.7; and between 2010 and 2015, the reduction was 2.4 per year, from 73 to 61 deaths per 100,000 live births. If this pace continues, there is a risk that the target set in the Sustainable Development Objectives, which is 24 deaths per 100,000 live births by the year 2030, will not be reached.

1.8 The two main causes of maternal deaths during pregnancy, childbirth, and the postpartum period are hemorrhage (37%) and hypertensive disorders in pregnancy (27%).[15] The most critical period is during the delivery and postpartum stages, when 71% of deaths occur. Eighty-eight percent of deaths in the postpartum stage occur during the first 48 hours after giving birth.

1.9 The problems with the heaviest impact on maternal mortality are: (i) limited coverage and problems of access to family planning services; (ii) a large number of community childbirths, owing to the lack of access to good quality assistance by trained personnel (institutional childbirth); (iii) problems with the quality of care during childbirth and obstetrical complications at health care facilities, mainly hospitals; and (iv) poor problem-solving capacity at basic and general hospitals.

1.10 Maternal mortality in Honduras points to a large gap in access to reproductive and family planning services, particularly in the lowest income quintile, where the frequency of the use of birth control methods is 55% compared to 69% nationally. This means that deaths occur, mainly among women who have had multiple pregnancies (55%), women over 35, and girls under 19.[16] This last situation is conditioned or exacerbated by the high percentage of teenage pregnancies (24%).

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10 SESAL 2017.

11 Update of the maternal mortality rate, 2015.

12 Trends in Maternal Mortality: 1990 to 2015. WHO, UNICEF, UNFPA, World Bank, and the United Nations.

13 Encuesta de epidemiologia y Salud Familiar [Epidemiology and family health survey] (ENESF 1986) and ENDESA 2012.

14 Ibid. [1].

15 Ibid. [11].

16 Ibid. [10].

1.11 Another factor contributing to maternal mortality is community childbirth without skilled attendants and in unsafe conditions. The maternal mortality rate among women in community childbirth was 75 per 100,000 live births compared to 39 per 100,000 among women assisted at a health care facility,[17] mainly a hospital. In Honduras, 2 out of every 10 deliveries still take place in the community (home births unassisted by health professionals), with the figure rising to 4 out of 10 in rural areas,[18] which is far worse than in other countries in the region such as El Salvador, where institutional childbirth coverage is 99%.[19] The large number of noninstitutional deliveries in rural areas relates mainly to financial difficulties. Seventy percent of rural women and 50% or urban women state that the lack of money is the main barrier to access to services. Another barrier is physical access to assistance during childbirth because health centers are not fully staffed and are often closed. Lencas and Maya Chortí groups mention cultural barriers in assisted childbirth.[20]

1.12 Since a larger percentage of institutional deliveries take place in public hospitals, the majority of maternal deaths occur there as well, principally for problems associated with the quality of care. One problem with quality is failure to follow standards of care. In the baseline measurement of the Mesoamerica Health Initiative taken at hospitals in 2013, just 11% of obstetrical complications and 67% of postpartum patients were treated up to the standard of care,[21] jeopardizing the lives of mothers and newborns. Another problem with the quality of care for obstetrical complications is limited 24/7 obstetrical coverage[22] in hospitals, with just 48% offering such coverage.[23]

1.13 Maternal deaths occur mainly at the country's two maximum complexity hospitals, chiefly because the other hospitals do not have the capacity to treat obstetrical complications and must refer patients to the two hospitals at that level. Forty-two percent of maternal deaths occur at the Hospital Mario Catarino Rivas (HMCR) in San Pedro Sula, and 27% at the Hospital Escuela Universitario (HEU) [University Teaching Hospital] in Tegucigalpa. An analysis of the origin of patients in those hospitals indicates that most HMCR patients are referred from the departments of Santa Bárbara and Copan,[24] while most HEU patients are referred from the departments of Comayagua and Choluteca. Coincidentally, after HEU and HMCR, the largest numbers of maternal and neonatal deaths occur in those departments.[25]

1.14 Lastly, the country has adopted the conceptual model of the "three delays" to identify the determining factors in obstetrical complications or deaths.[26] The first delay occurs when the woman or her family fail to recognize signs of obstetrical risk and do not seek medical help. The second delay occurs between the time the

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17 Ibid. [10].

18 Idem.

19 Ministry of Health of El Salvador, 2017.

20 Estudios cualitativos de barreras a la demanda de ofertas y servicios de salud [Qualitative studies of barriers to demand for health services]. Mesoamerica Health Initiative. Honduras 2013.

21 Refers to the national standard for maternal and neonatal care. SESAL.

22 24/7 is coverage by medical specialists 24 hours a day, seven days a week.

23 Mesoamerica Health Initiative baseline, Institute for Health Metrics and Evaluation 2013.

24 Mainly from the Hospital de Occidente.

25 Ibid. [10].

26 Thaddeus and Maine, 1994.

risk is identified and the time taken to access a health care facility (financial and transportation barriers). The third delay is not receiving adequate and timely care once reaching a facility (depends on enough trained personnel, availability of medications, equipment, and infrastructure). According to the 2015 Reproductive Age Maternal Mortality Survey (RAMOS), 18.8% of maternal deaths occur in the first and second delays, while 27.4% occur during the third. This indicates that the problem with the greatest impact on maternal mortality is the quality of care and the weak response capacity of the hospital system.

1.15 **Infant health**. The biggest infant health challenge is to reduce neonatal mortality, which accounts for 62% of infant deaths. The neonatal mortality rate has not fallen in 20 years, holding steady at 18 deaths per 1,000 live births. This means that an average of 10 newborns die every 24 hours, for 3,500 deaths a year, similar to the country's homicide rate. This neonatal mortality rate is much higher than the Latin American average of 9 per 1,000 live births.[27]

1.16 To reduce neonatal mortality, it should be borne in mind that 72% of deaths occur during the first week of life. The main causes are premature birth (between 20 and 36 weeks of gestation) associated with low birth weight (28.5%), asphyxia (18.3%), congenital defects (13.4%), and respiratory infections (10%).[28] Newborns weighing less than 2,500 grams account for 60% to 80% of neonatal mortality, and 66% of infant mortality.[29] Forty-one percent of newborn deaths are due to prematurity.

1.17 The main problems linked to neonatal mortality are the quality of treatment of newborn complications and poor installed capacity in hospitals.

1.18 Like maternal deaths, most neonatal deaths (84%) occur in the hospital, and the majority are also linked to poor quality care. Just 7% of neonatal complications treated in hospitals follow the protocols[30] and standards established by SESAL,[31] owing to poor training, unfamiliarity with the standards, and lack of human resources, medications, inputs, materials, and equipment.

1.19 The common denominator in the treatment of neonatal complications is the need for technology and highly complex, more expensive interventions (Berezin 2014),[32] such as intensive care units. There are just two neonatal intensive care units in the country, one at HEU and one at HMCR, and type 1 and 2 hospitals have to transfer their cases from the different departments to Tegucigalpa and San Pedro Sula. Transferring newborns from those hospitals is complicated, since there is no specialized system for transporting neonatal emergencies between the different hospitals.

1.20 One crosscutting problem affecting both maternal and neonatal mortality is the weakness of the surveillance system,[33] which does not help to identify determining and contributing factors related to maternal deaths. The system underreports by 13%, and the information produced is not timely, hindering decision making.

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27 Latin American Center of Perinatology (CLAP) 2015.

28 Institute for Health Metrics and Evaluation (IHME) 2017.

29 Idem.

30 Ibid. [21].

31 Ibid. [23].

32 IDB, Health and Nutrition Sector Framework Document, September 2016.

33 Monitors maternal and neonatal deaths, analyzes and interprets them, generating a dashboard.

Furthermore, information on treatment is generally reported manually. Hospitals do not have automated information systems, files are kept on paper, and the treatment provided is not recorded. A variety of information systems have been implemented in piecemeal fashion by different programs, with no standardization, linkage, coordination, or interconnection.[34]

1.21 **Lessons learned and progress in the Health Sector's response.** The Bank, through its portfolio of operations in the sector[35] and the Mesoamerica Health Initiative, has supported the country in improving the coverage and quality of obstetrical and neonatal services through a series of innovative intervention strategies.

1.22 To improve access and the quality of maternal and neonatal services, SESAL has implemented a Decentralized Management Model (MGD) as a results-based financing arrangement. The model consists of contracting managers[36] to provide promotion, prevention, and health care on the primary level. SESAL finances the managers through a capitation payment for the population covered and a payment for each assisted childbirth, contingent on compliance with quality indicators. The Decentralized Management Model has also been implemented in hospitals through contracts with foundations, to which results-based budgets are transferred for hospital administration and services. From 2011 to date, the model has been extended to 90% of the poorest municipios (94 of the country's 298 municipios) and to five out of 29 SESAL hospitals, covering 1,500,000 people.[37] The model has brought about advances in access to and the quality of services, and improvements in the availability human resources, medications, and inputs.[38] Based on the lessons learned from the model, the proposed operation will implement activities through decentralized managers, to be incorporated in component 1.

1.23 Through the Decentralized Management Model, vouchers have been given to women in labor to pay for their transportation from the community to a health care facility and to midwives to accompany their patients to an obstetrical clinic. This has increased institutional deliveries in poor communities. The lessons learned from the delivery of the vouchers will be taken into account and included in component 3.

1.24 The establishment of family health teams has brought about a substantial improvement in obstetric and neonatal care in the community, led to more pregnant women receiving prenatal care before the twelfth week of gestation, and increased prenatal checkups and institutional childbirths.[39] Component 1 will strengthen the family health teams in the prioritized municipios in order to improve maternal and neonatal services.

1.25 One of the innovations introduced by the Mesoamerica Health Initiative is the use of ultrasound by physicians in obstetrical clinics in rural areas, with cell phone

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34 Integrated Health Information System (SIIS). SESAL-Global Fund, 2017.

35 Supported by operations 2418/BL-HO, 2743/BL-HO, 2943/BL-HO, 3723/BL-HO, and 4030/BL-HO.

36 NGOs, municipal governments, leagues of municipios, community associations, and foundations in the case of hospitals.

37 Corresponds to 95 of the 104 poorest municipios.

38 World Bank 2007; USAID 2009; ANED Consultants 2009; Mesoamerica Health Initiative 2013 y 2017.

39 Ibid. [28].

connections to specialists to support the diagnosis and management of pregnant women and women in labor. This has allowed for timely identification of obstetric and neonatal complications and problems with neonatal growth and prematurity. The proposed operation will incorporate the use of tele-ultrasound in rural areas through components 1 and 2.

1.26 Also through the Mesoamerica Health Initiative, an exercise was conducted in dynamic systems for the analysis of the variables with most influence on reducing maternal and neonatal mortality. According to the dynamic systems analysis, the best solution is to apply a reinforced strategy to improve quality, known as Care Improvement Plus (CI+).[40] CI+ includes capacity-building for service providers to consolidate management through a systematic approach. Implementation of CI+ will be supported through component 1 of the proposed operation.

1.27 **Policy for Accelerated Reduction of Maternal and Child Mortality (RAMNI).** Based on the dynamic systems analysis, during 2017 and 2018, the Bank has worked with SESAL to prepare the RAMNI policy. The policy, which will be officially launched in November 2018, contains strategies and interventions to be supported under the proposed operation, such as: (i) reproductive health counselling services, with a gender and intercultural approach; (ii) incentives for demand; (iii) prioritization and facilitation of community health activities; (iv) family planning; (v) preconception services; (vi) services prior to hospitalization, including suitable and timely transportation; and (vii) quality care for obstetrical and neonatal complications.

1.28 As a consequence of the lessons learned and the progress in health sector response mentioned earlier, the obstetrical and neonatal services delivered in the municipios covered by the Decentralized Management Model from 2013 to 2017 have brought about the following improvements: (i) the capture of pregnant women prior to the twelfth week of gestation rose from 51% to 90%; (ii) prenatal checkups rose from 23.7% to 94.1%; (iii) institutional deliveries from 68.6% to 84.7%; (iv) three-day postpartum care from 67% to 91% and seven-day care from 47% to 60%; and (v) treatment of neonatal complications in accordance with the protocols from 7% to 43% and obstetrical complications from 11% to 63%.[41]

1.29 **Challenges.** Based on the problem areas and background described above, the country faces the following challenges in reducing maternal and neonatal mortality much more quickly.

1.30 **Strengthen reproductive health services with a gender[42] and intercultural[43] focus to improve the availability and informed use of modern family planning methods.**[44] Eleven percent of married women have unmet family planning needs, with the figure rising to 18% in rural areas.[45] Studies[46] have pointed to the role

[40] Fortalecimiento de las capacidades del sistema para crear y mantener la capacidad de MC (MC+) [Strengthening the system's capacity to create and maintain care improvement capacity (CI+)].

[41] Ibid [28].

[42] Implies that both women and men have the right and responsibility to plan pregnancies and look after their health.

[43] Respecting the beliefs, customs, and languages of ethnic groups.

[44] Modern methods include surgical sterilization and implanted devices.

[45] Decentralized Management Unit, 2018.

[46] Herrera, M. C., (2012). "Having it all": Women's Perception of Impact of Female Promotion on Threat of Domestic Violence. The Spanish Journal of Psychology, 15, 670-679.

played by the inequality of women in determining whether or not to use a given family planning method, or none at all. The road to reducing that inequality is education for couples (particularly for men) with an intercultural approach, through advisory services that include adolescents, as well as an increase in the real supply of modern family planning methods.

1.31 **Increase coverage of institutional childbirth and decrease community childbirth.** A large percentage of deliveries are still in a community childbirth setting, as mentioned in paragraph 1.9. To increase the coverage of institutional deliveries, SESAL faces the challenge of defining a strategy that enables women and their families to decide to deliver in a health care facility. This will require a reduction in cultural, economic, physical, and geographic barriers that stand in the way of increasing institutional deliveries.

1.32 **Improve the quality of care for obstetric and neonatal complications.** Although standardized treatment for obstetric and neonatal complications has improved in the decentralized hospitals and in the hospitals supported by the Mesoamerica Health Initiative,[47] as mentioned in paragraph 1.12 wide gaps still exist in applying the standards, particularly in hospitals without interventions. Shortfalls also exist in infrastructure, equipment, and personnel, and optimization of hospital care processes and flows.

1.33 **Evidence and actions to address the challenges.** The proposed operation will support the activities described below.

1.34 Improvement in reproductive services and family planning methods by strengthening: (i) family planning advisory services for couples that are pertinent from the standpoints of culture, gender, and male sexuality; (ii) postpartum birth control strategy; (iii) offer of modern methods (implanted devices); and (iv) assured supply of family planning inputs and methods. Family planning contributes to women's survival and can reduce maternal deaths by up to 32%,[48] since it reduces the number of pregnancies and potential complications.

1.35 To address the determining factors in the first and second delays, community strategies will be developed through the family health teams, including women's empowerment in deciding to seek care when signs of danger appear, preparation of a birthing plan[49] for each pregnant women, and community organization for emergency transportation. To address the third delay,[50] the Decentralized Management Model will be strengthened to guarantee the availability of the human resources, medications, and inputs necessary to attend deliveries and treat obstetric and neonatal complications.

1.36 To increase births at institutions, strategies will be implemented to lower the barriers that prevent women from accessing obstetrical clinics and hospitals, such as the certification and upgrading of maternity waiting homes and increasing the

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[47] The Mesoamerica Health Initiative assists 19 municipios (262,000 people) and six hospitals. The Decentralized Management Model exists in 94 municipios (1,500,000 people) including those supported by the Mesoamerica Health Initiative and five hospitals, one of which is assisted by the Mesoamerica Health Initiative.

[48] Winikoff and Sullivan, 1987*;* FHI, 1995; Singh et al., 2009; WHO, 2010*.*

[49] Determination of the establishment where the baby will be born, type of transportation, funds.

[50] Taken, with modifications, from: Oona M R Campbell, Wendy J Graham, on behalf of The Lancet Maternal Survival Series steering group, The Lancet 2006; 368: 1284–99*.*

vouchers for patient and midwife travel. Births in institutions have proven to be an effective measure for reducing maternal and neonatal mortality.[51]

1.37 Attempts to capture women before the twelfth week of pregnancy will be stepped up and the coverage and quality of prenatal care will be strengthened. Early checkups (before the twelfth week of gestation) allow for timely identification of at-risk pregnancies, increasing the possibility of providing adequate obstetrical care for the mother to be and her baby.[52] Quality prenatal care helps to detect and treat anemia, thus reducing the probability of complications and maternal deaths due to postpartum hemorrhage.[53]

1.38 To improve the quality of care in cases of obstetric and neonatal complications, safe delivery programs, postnatal hygiene practices, and minimum and essential care for newborns will be implemented, and personnel will be trained to manage complications. Evidence from actions to reduce neonatal mortality indicates that the day of birth and the first 28 days of life are the most vulnerable times for the survival and health of babies.[54] Seventy percent of newborn deaths from asphyxia and trauma can be prevented through safe deliveries and attention to the quality of obstetrical emergency care, and 22% can be prevented through good resuscitation techniques at birth.[55] Mortality from neonatal sepsis can be reduced by 41% with good postnatal hygiene and clean delivery practices, and 24% with adequate management of severe infections.[56]

1.39 Care processes and flows will strengthened as well as installed capacity in hospitals. The systems for referral and response to obstetrical and neonatal complications will be fortified, including improvements in specialized transportation for newborns.

1.40 Kangaroo mother care[57] (skin-to-skin) strategy: Conventional care for newborns who have low birth weights or are premature is expensive in developing countries due to the necessary use of equipment and technology. Although the kangaroo mother care strategy is not widespread in Honduras it is a very useful alternative for caring for newborns with these problems.[58]

1.41 Mobile tele-ultrasound: Another piece of evidence indicates that 32% of deaths among premature babies can be avoided if the degree of growth and health of the embryo can be adequately diagnosed in the mother's womb. Innovative techniques such as mobile ultrasound can help to detect complications caused by prematurity through timely diagnosis of the baby's development in the uterus.[59]

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51 Global Strategy for Women's, Children's, and Adolescent's Health (2016-2030), WHO 2015.

52 Measurement of protein in the urine as a predictor of preeclampsia.

53 Blencowe, H., S. Cousens, B. Modell, J. Lawn. Folic acid to reduce neonatal mortality from neural tube disorders. Database Abstracts Reviews of Effects (DARE). University of York 2013.

54 Reaching every newborn national 2020 milestones: Country progress, plans and moving forward. May 2017. UNICEF.

55 The Lancet. May 2014.

56 Idem.

57 Care for premature and/or low birth weight babies, based on skin-to-skin contact between the child and parents or caregivers.

58 Conde-Agudelo A., et al., Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. Cochrane Database of Systematic Reviews 2011.

59 Primary health care project (PROAPS). SESAL. March 2018.

1.42 Interculturally pertinent care: Studies to design mother and infant health actions in Mexico, Panama, and Nicaragua, and studies by the Mesoamerica Health Initiative confirm that the sociocultural and gender contexts are relevant for understanding the decisions of indigenous and rural populations on whether to make use of services. Case studies have documented success stories with intercultural health care policies in countries such as Chile, Colombia, Ecuador, Guatemala, Peru, and Surinam (Cordero Muñoz 2010).[60]

1.43 Since the Decentralized Management Model has proven to be effective in increasing access to and the coverage and quality of obstetric and neonatal services, the actions to be taken will be based on integrating networks through decentralized managers on the first and second levels.

1.44 The proposed operation's value added includes: (i) a regional approach to obstetric and neonatal complications that involves the development of obstetrical and neonatal intensive care services in type 2 regional referral hospitals; (ii) development of regional networks for mother and child care, by integrating the family health teams, first level establishments, and type 1 and 2 hospitals; (iii) the incorporation of technological innovations and automated information systems to improve care and the management of services; (iv) implementation of CI+ as a strategy for reducing mother and newborn deaths in hospitals; and (v) the introduction of specialized transportation for newborns.

1.45 **Prioritization of municipios and hospitals to be targeted.** The prioritization criteria used to identify the municipios to be targeted are: (i) poverty level; (ii) maternal deaths per municipio;[61] (iii) provenance of women who die at the national referral hospitals (HEU and HMCR); (iv) infant deaths; and (v) coverage of prenatal, childbirth, and postpartum care per municipio. The criteria for prioritizing hospitals were rates of maternal mortality caused by sepsis, hypertensive disorders in pregnancy, and hemorrhage, and neonatal mortality caused by premature birth and sepsis (optional link 6). The prioritized municipios are among the 104 poorest, where conditional cash transfer programs exist supported by social safety net projects.[62]

1.46 **Strategic alignment.** The proposed program is consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008) and strategically aligned with the development challenge of social inclusion and equality, since it prioritizes the poorest municipios in an effort to reduce the maternal and neonatal mortality rates. The program is also aligned with the crosscutting themes of: (i) gender equality and diversity, since it improves access to services by women in the pregnancy, childbirth, and postpartum stages, including a reduction in cultural barriers to receiving services among indigenous groups, which will be measured through the outcome indicators for prenatal care for women before the twelfth week of gestation, coverage of good-quality prenatal care, assistance during delivery, care for newborns in the first three days after birth, number of family health teams established and operating, and prioritized networks established; and (ii) climate change and environmental sustainability, since it includes energy savings measures at the beneficiary hospitals and health care facilities and provides for the treatment and management of hospital waste, which are covered by the outcome

[60] Mignone et al., 2007; Gabrysch et al., 2009.

[61] RAMOS 2010 2015 study. Maternal mortality surveillance subsystem, (SESAL).

[62] HO-L1093 and HO-L1105.

indicators for the construction of high-complexity obstetrical units, neonatal intensive care units, and a neonatology ward at the HEU, rehabilitation works at prioritized hospitals, and equipment for neonatal intensive care units and obstetrics wards. About 8.01% of the operation's resources will be invested in climate change mitigation activities, as calculated using the joint methodology of the multilateral development banks for estimating climate finance. These funds will contribute to the IDB's goal of increasing the financing of climate change-related projects to 30% of total approvals by the end of 2020. In addition, the program contributes to the Corporate Results Framework 2016-2019 (document GN-2727-6) through the indicator for the reduction in the maternal mortality rate. The operation is aligned with the Alliance for Prosperity in the Northern Triangle Plan in the municipios of Choluteca, Juticalpa, and Santa Rosa de Copan, intended to develop human capital by improving health, nutrition, and early childhood development through better coverage of maternal and child health and nutrition services, and upgrading the health care infrastructure.

1.47 The operation is also included in the 2018 Operational Program Report (document GN-2915) and is consistent with the Bank's country strategy with Honduras 2015-2018 (document GN-2796-1), which has the following strategic objectives: (i) promote human capital accumulation of minors in households in extreme poverty; and (ii) improve the health indicators of children under 5, specifically the results indicator for a reduction in infant mortality. It is also consistent with the Health and Nutrition Sector Framework Document (document GN-2735-7) under Dimension of Success 2, "All have timely and continuous access to high quality health services and nutrition." It is also aligned with the Gender and Diversity Sector Framework Document (document GN-2800-8), since it promote gender equality and women's and girls' empowerment by increasing the access to sexual and reproductive health services by indigenous and nonindigenous populations.

1.48 **Coordination with other Bank operations.** The operation will coordinate with the Ciudad Mujer project to improve access to, and the coverage of, reproductive health programs, and prenatal, childbirth, and postpartum care in geographic areas where it coincides with those interventions.

1.49 It will also be coordinated with the conditional cash transfer program in the beneficiary municipios of the Bank's social welfare and health projects.[63] The proposed operation will be complemented by the Program to Support the Social Inclusion Network with Priority in Western Honduras (loan HO-L1105), which finances decentralized managers, and the third operation under the Mesoamerica Health Initiative (grant HO-G1249), which supports managers and hospitals.

B. Objectives, components, and cost

1.50 The project objective is to contribute to the reduction of maternal-neonatal mortality in the poorest municipios of the country and at the prioritized hospitals by improving the quality, management, and responsiveness of health services and supporting the policy for Accelerated Reduction of Maternal and Child Mortality (RAMNI). The operation has four components.

1.51 **Component 1: Strengthening of the management and quality of obstetric and neonatal services (US$30,870,000).** This component will continue to finance the

[63] Ibid. [35].

package of services provided by the first level Decentralized Management Model in 36 municipios[64] (optional link 6) and expand coverage of the model to 10 poor municipios in Santa Bárbara department (optional link 6) that are sources and/or repeaters of maternal mortality, including funds to strengthen, organize, and perform the activities of the family health teams. This will be done through the signature of multiyear contracts between SESAL and the managers that provide first level services. In municipios without the Decentralized Management Model, support will be provided for the establishment and training of family health teams by hiring physicians, nurses, nursing assistants, and health extension workers.

1.52 Obstetrical and neonatal services will also be financed at hospitals prioritized under the Decentralized Management Model (optional link 6) through the signature of multiyear contracts with foundations.

1.53 Technical support and training will be financed: (i) definition and implementation of CI+ in hospital services; (ii) training for staff of the family health teams, health care facilities, and hospitals in family planning advisory services that are pertinent from the standpoints of culture, gender, and masculinity; (iii) training in the postpartum birth control strategy; (iv) implementation of a comprehensive strategy for reducing teenage pregnancy; (v) strengthening of preconception care and prenatal care (folic acid supplements, iron, timely management of pathologies and risk factors); (vi) implementation of a program for safe childbirth, immediate postpartum care, and postnatal hygiene practices, and strengthening of minimum and essential care for newborns in obstetrical clinics and hospitals; (vii) implementation of a model for the care of premature babies and the kangaroo mother strategy; (viii) strengthening of hospital management, including reorganization and optimization of clinical management processes, resource management, maintenance management, and patient management; and (ix) training and monitoring the use of fixed and mobile ultrasound and tele-ultrasound.

1.54 To enhance obstetric and neonatal services, the following training activities will be financed: (i) training for staff (physicians, nurses, and nursing assistants) in neonatology and managing obstetric and neonatal complications, and courses for surgical instrument technicians through contracts with firms, NGOs, or universities; and (ii) training for paramedics and persons specializing in the transportation of newborns, pregnant women, women in labor, and women in the postpartum stage.

1.55 **Component 2: Upgrading of health services equipment and infrastructure (US$28,890,000).** The following will be financed to increase treatment capabilities in health care facilities and hospitals: (i) construction and equipping of three neonatal intensive care units at general or type 2 hospitals;[65] (ii) expansion and outfitting of neonatal wards at the HEU; (iii) construction and equipping of obstetric and neonatal wards at two basic hospitals (La Paz and Santa Bárbara)[66] and one general hospital (Hospital de Occidente) (optional link 5 and optional link 7) (iv) procurement of fixed and mobile ultrasound equipment for the family health teams and health care facilities in the prioritized municipios; (v) remodeling and modernization of the maternity waiting homes operated by beneficiary hospitals;

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[64] The IDB is currently financing 36 out of 95 municipios with Decentralized Management Models, which are among the country's 104 poorest municipios.

[65] Occidente, Comayagua, and Juticalpa hospitals.

[66] These are referral hospitals in a network of municipios that are sources or repeaters of maternal mortality.

and (vi) contracting of a firm to design the works, and a firm to supervise them. The foundations that administer hospital services are responsible for hospital and equipment maintenance, as stated in the management contracts. SESAL has legal ownership of hospital land where the infrastructure works will be built. Preliminary technical designs are available for the works, as are the technical specifications for the equipment. The infrastructure and upgrading works will adopt an intercultural approach, to eliminate cultural barriers to access to obstetric and neonatal health services. The hospital works will include measures to mitigate the impact of climate change and to save energy, such as: (i) high ceilings to allow for air circulation; (ii) use of special exterior paint on roofs and interior insulation to protect against heat and reduce use of air conditioning; (iii) use of high energy efficiency equipment for air conditioning and lighting; (iv) use of LED equipment for lighting; and (v) a study on the use of photovoltaic self-generation systems. This component will also finance a preinvestment and medical architecture study for the works at Hospital de Occidente.

1.56 The following will be financed to strengthen the transportation system for obstetric and neonatal emergencies: (i) procurement of specially-equipped ambulances; (ii) implementation of a radio communications system; and (iii) certification of human resources for neonatal emergency transportation.

1.57 **Component 3: Institution-strengthening, technological innovations, and information system (US$7,370,000).** To strengthen the Decentralized Management Model, technical support will be financed to: (i) improve the management contracts and payment mechanisms for hospitals using the model; (ii) systemize and regulate the costing mechanism for the first and second levels; (iii) strengthen the transportation vouchers for pregnant women and midwives; (iv) establish and operate the prioritized networks according to WHO requirements, as well as the corresponding referral and response systems; (v) improve the intercultural approach to services; (vi) strengthen managers in the administration of human resources, inventories, procurement, and service delivery; (vii) support SESAL and the managers in procurement processes and the logistics cycle for assuring the supply of inputs, medications, and family planning methods; and (viii) strengthen the maternal and neonatal mortality surveillance system, including an auditing system to identify compliance with treatment protocols.[67]

1.58 To support management of health care facilities in the prioritized municipios, the following will be financed: (i) a diagnostic assessment of the condition of the information system and design of a strategic plan; and (ii) engagement of a firm to design, develop, and implement SESAL's automated health services information system, which will include digitization of service production data, electronic files, standards, coordination, governance of the system, and a data dictionary, as well as software procurement and maintenance, an information platform, connectivity, and hardware, user training, and system administration. Information on managers will be digitized in the system, and a platform will be developed to exchange information for distance diagnosis between health care facilities and hospitals in the prioritized municipal networks, in addition to the use of tools to improve care in the services. To improve the quality and timeliness of data in the Decentralized Management Model for making payments under the management contracts, the system should include the design and implementation of a component for the

[67] Ibid. [21].

supervision and audit of the payment indicators by the Decentralized Management Unit. It will also finance mobile health technologies (mHealth) on the community level for behavioral change.

1.59 **Component 4: Program administration and evaluation (US$1,870,000).** Financing will be provided for operation of the project execution unit (PEU) and audits. Technical support will be contracted for a study to update the maternal mortality rate. This component will finance reflexive evaluations, including annual evaluations, a final project evaluation, and a baseline measurement at the start of the project. Technical support will also be financed for an analysis of fiscal commitments and alternative strategies of financing the Decentralized Management Model.

C. Key results indicators

1.60 The impact indicators are: the national maternal mortality rate; the neonatal lethality rate from sepsis and asphyxia at the beneficiary hospitals; and the maternal mortality rate at the beneficiary hospitals. The outcome indicators in the beneficiary municipios are: the percentage of pregnant women receiving prenatal care before the twelfth week of gestation over the last 12 months; high quality prenatal care; coverage of assisted childbirths by qualified personnel; coverage of care for newborns in the first three days of life; number of family health teams established and operating in the prioritized municipios that are not decentralized; the percentage of obstetrical complications caused by hypertensive disorders in pregnancy and hemorrhage that are managed according to the protocol; the percentage of neonatal complications caused by sepsis and asphyxia that are managed according to the protocol; and the percentage of prioritized networks created.

1.61 The most representative activities in terms of amounts were selected for the economic analysis. The calculation of benefits is based on disability-adjusted life years (DALYs) and a 5% discount rate. In component 1, “Persons covered by decentralized managers on the first level of care” and “Management contracts signed with the second level of care” were analyzed. The first generates a net present value (NPV) of over US$147 million, and the second a NPV of over US$193 million. The third activity, “Construction of five high complexity obstetrical and neonatal intensive care units” belongs to component 2. The calculation is based on a case study adapted for Honduras. The NPV is in excess of US$16.5 million. Lastly, the activity, “Rehabilitation and adequate operation of obstetrical and neonatal wards” was analyzed, yielding an NPV of US$18.2 million. Considering that the loan is for US$69 million, under the assumptions made, the operation’s benefits exceed its cost. The sensitivity analyses take the discount rate and effectiveness of the actions into account and suggest that even in pessimistic scenarios, the NPVs will be positive.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 **Cost and financing.** The project will have a total cost of US$69 million. Of that amount, US$41.4 million will be financed from Regular Ordinary Capital resources, and US$27.6 million from Concessional Ordinary Capital resources (see Table II.1).

Table II.1. Summary of program costs

Components	Amount (US$)	%
1. Strengthening of the management and quality of obstetric and neonatal services	30,870,000	**44.74**
2. Upgrading of health services equipment and infrastructure	28,890,000	**41.87**
3. Institution-strengthening, technological innovations and information system	7,370,000	**10.68**
4. Program administration and evaluation	1,870,000	**2.71**
TOTAL	**$69,000,000**	**100.00**

2.2 The program will be financed through a specific investment loan with a disbursement period of five years,

Table II.2. Projected disbursements (US$)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	11,500,000	35,000,000	14,000,000	6,500,000	2,000,000	69,000,000
%	17	51	20	9	3	100

B. Environmental and social safeguard risks

2.3 This operation has been classified as category “C” under the IDB’s Environmental and Safeguards Compliance Policy (Operational Policy OP-703), since the associated socioenvironmental and cultural impacts caused by the infrastructure works and hospital equipment in component 2 will be minimal. The other components have no negative socioenvironmental or cultural impacts. Furthermore, under the Disaster Risk Management Policy (Operational Policy OP-704), the program has been evaluated as type 1, low. As for the Operational Policy on Gender Equality in Development (Operational Policy OP-761), the operation is designed to benefit women and children. With regard to the Indigenous Peoples Policy (Operational Policy OP-765), the operation will benefit indigenous groups by reinforcing the intercultural approach in care for beneficiaries in the social services networks in areas where indigenous groups currently served by the hospitals to be rehabilitated are concentrated, through the expansion of services for those patients. However, owing to the difficulty in obtaining environmental permits, there is a moderate risk of delays in the start of the works, SESAL will begin the process of obtaining the licenses once the operation is approved by the Bank’s Board of Executive Directors.

C. Fiduciary risks

2.4 The fiduciary team determined that there is a moderate risk associated with financial and procurement fiduciary management of the project. The main risks are related to delays in budget amendments and contributions. For procurement, there is a risk stemming from weak capacity in the areas of infrastructure and equipment. These risks are mitigated by SESAL’s prior experience in the satisfactory execution of operations and the use of SIAFI/UEPEX (Integrated Financial Administration System/Financial Management Module for the Execution Units for Externally Financed Projects) for financial execution of the funds, in addition to the internal controls related to their use. The figure established for new advances of

funds will be justification of 70% of the advance already received. Furthermore, the PEU will have fiduciary autonomy and staff with job descriptions and terms of reference agreed upon with the Bank. The financial supervision plan will include audits to support monitoring of fiduciary management. Specifications, designs, and costing may not be prepared properly, leading to noncompliant offers, failed processes, or delays in execution, so technical assistance will be engaged to support SESAL using funds earmarked for supervision.

D. Other risks

2.5 This operation's risks were classified as moderate and are described below. As a fiscal sustainability risk, it was identified that SESAL does not have the capacity to absorb the Decentralized Management Model with national funds, so the Honduran government will present a plan to absorb the financing for the model.

2.6 The following were identified as public management risks: (i) changes in SESAL's priorities may influence project outputs and objectives; to mitigate this risk, the Bank will hold meetings to raise awareness of the scope of the project and it's alignment with the country's health priorities; (ii) SESAL may have difficulty in selecting or may not find suitable managers for the hospitals to be decentralized, which would lead to delays in execution and/or failure to decentralize the hospitals; the Decentralized Management Model will therefore be explained and publicized to authorized civil society organizations, to encourage their participation in the model; (iii) hospital unions may oppose decentralization, so SESAL will implement a change management strategy; and (iv) owing to the increase in coverage of the Decentralized Management Model, the health regions and the Decentralized Management Unit are likely to encounter limitations on their ability to provide technical support for the municipios involved; the loan proceeds will therefore be used to strengthen SESAL's technical capacity.

2.7 The lack of timely and reliable information on health services was identified as a monitoring and accountability risk that measurements for monitoring project activities and targets will not be available in a timely manner. This risk will be mitigated through technical assistance for SESAL to improve the services monitoring system.

2.8 **Sustainability of the Decentralized Management Model.** The Honduran government has expressed its intention to sustain the Decentralized Management Model. Initially, all financing for the model came from the IDB but expenditures have been gradually absorbed by SESAL (the IDB is currently financing 37%, and the government 63%, of the budget invested in the model). This operation will continue with IDB financing of 37% for 2019 and 2020, using the funds to finance 9 of the 38 managers, covering a current population of 419,530. Thereafter, the Government of Honduras will finance 100% of the managers.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 The program will be executed through a project execution unit (PEU) of the Ministry of Health (SESAL), consisting of a general coordinator, a financial specialist, a procurement specialist, a monitoring and evaluation specialist, and other specialists as required. The PEU will be responsible for administering, reporting, and accounting for the project resources and for preparing and

monitoring the project's annual work plan, the procurement plan, and physical and financial monitoring.

3.2 The Office of the Undersecretary for Integrated Health Services Networks (SRISS) will be responsible for policy and technical management inside SESAL. SRISS will establish coordination and guidelines for the different health departments and regions. The Decentralized Management Unit, which reports to SRISS, will be in charge of the process of selecting and signing contracts and monitoring and evaluating the managers, as established in the project Operations Manual. It will also coordinate with SESAL's first and second level departments for technical support for the hospitals and health services in charge of implementing project activities.

3.3 The first and second level departments will be responsible for preparing the terms of reference and technical specification and for submitting them to the PEU. The Decentralized Management Unit will prepare the management contracts to be signed by SESAL and the managers, which will be delivered to the IDB through the PEU for the purpose of registering the contracts at the Bank.

3.4 The management contracts will define the roles and responsibilities of SESAL and the managers, and the indicators to be met, which will be linked to the financing. SESAL, through the Decentralized Management Unit and in coordination with the health regions, will be in charge of supervising and verifying attainment of the targets agreed upon with the managers, through quarterly monitoring and annual performance evaluations, on which the per capital payments will be contingent.

3.5 SESAL has a project technical management unit (UTGP) responsible for technical guidance of the infrastructure and equipment projects. The UTGP will support SRISS, the first and second level departments, hospitals, and the PEU in preparing the technical conditions and in the processes of contracting, reviewing plans, supervising the infrastructure works, and preparing the technical specifications, and procurement, installation, and maintenance of the equipment. SESAL, acting through the PEU and the UTGP, will coordinate the process of obtaining the respective environmental licenses and construction permits with the hospitals, managers, municipal governments, and, as applicable, the Environmental Management Unit (a central government agency).

3.6 **Procurement**. The Policies for the Procurement of Goods and Works Financed by the IDB (document GN-2349-9) and the Policies for the Selection and Contracting of Consultants Financed by the IDB (document GN-2350-9) will be applied.

3.7 For procurement planning, the PEU will update the procurement plan annually, or as necessary, using the procurement plan execution and monitoring system determined by the Bank, both for planning and reporting progress. Any changes to the procurement plan will be submitted to the Bank for approval. The PEU will take steps to reduce the likelihood of corruption, in accordance with the provisions of documents GN-2349-9 and GN-2350-9 on prohibited practices (lists of ineligible firms and individuals of multilateral agencies).

3.8 The PEU has ample experience in executing different loans financed by the Bank, so competitive contracting processes for individual consulting services may be subject to ex post review. However, consulting services by firms, works, goods, and nonconsulting services will be subject to ex ante supervision by the Bank, regardless of contract size. The Bank may change the procurement supervision

arrangement, based on experience in execution and improvements in institutional capacity, or the fiduciary visits carried out.

3.9 The PEU will be responsible for maintaining the files and original supporting documentation for procurement processes conducted with the resources of the operation, and will keep records following established procedures.

3.10 **Special conditions precedent to the first disbursement of the loan proceeds: (i) the project Operations Manual has been approved and entered into effect on the terms agreed previously upon with the Bank**, governing the operations and responsibilities of the PEU and SESAL's technical bodies involved in technical management of the project; it will also address technical aspects of project execution, especially activities related to the prioritization of hospitals and municipios, monitoring of the project Results Matrix, the methodology for monitoring and evaluating decentralized management, procurement and contracting processes and payment mechanisms for health services, supervision of design, construction of infrastructure, and equipment, etc., and (ii) **the project's general coordinator has been appointed**, which will ensure the appointment and operation of the PEU.

3.11 **Special contractual conditions for execution.** Prior to the signature of contracts with the managers identified in component 1, evidence will be provided to the Bank that the following have been approved: (i) the regulations governing the selection of first and second level managers, since currently there is no instrument that clearly and transparently defines and integrates procedures for selecting managers and ensures their capacity and suitability; and (ii) the plan for absorbing the financing of the Decentralized Management Model, to ensure that the model will be sustainable after the operation ends. Prior to the start of the works identified in component 2, evidence will be provided to the Bank that: (i) the specialized technical staff (at least one engineer, one architect, and one biomedical specialist) have been contracted for the project technical management unit (UTGP) on the terms agreed previously upon with the Bank, to strengthen the unit in the technical direction of activities for the design, supervision, and construction of infrastructure and equipment; and (ii) a health and safety plan and a waste management plan have been prepared for the works rehabilitation stage for the Bank's no objection, to ensure sound management of occupational risks and of solid and liquid hospital waste, since there is no environmental and social management report.

3.12 **Project financial and budget execution.** Financial and accounting transactions for the project will be performed through the Integrated Financial Administration System (SIAFI). Cash basis accounting will be used. For disbursements and cash flow, the PEU will open a special account in the project's name at the Central Bank of Honduras (BCH). The maximum amount of each advance of funds will be established by the Bank depending on the projected cash flow analysis for a period of at least six months. To govern this operation, the Bank will use the versions of the Financial Management Policy for IDB-financed Projects (document OP-273) and the Financial Management Operational Guidelines for IDB-financed projects (document OP-274) in effect at the time of project approval.

3.13 **Audits.** The project's financial statements, audited by the supreme audit authority or an independent audit firm acceptable to the Bank, will be requested annually within 120 days after the close of each financial year or after the final disbursement.

B. Summary of arrangements for monitoring results

3.14 That Bank's standard tools will be used, including the project execution plan and the procurement plan through the Procurement Plan Execution System (SEPA), and the indicators will be tracked by the project monitoring report (PMR) system through six-monthly reports to be prepared by SESAL.

3.15 A reflexive evaluation (before and after) will be conducted, for which purpose a baseline will be surveyed in the first year of the operation, and annual measurements taken. The purpose is to obtain timely results, so that adjustments can be made in project processes. The evaluation will measure the outcome indicators in the Results Matrix, based on a sample of first and second level health care facilities in the areas served by the program. An evaluation based on all the information compiled during the operation will be conducted at the end of the program. The details of the performance evaluation can be consulted in required link 3.

Development Effectiveness Matrix		
Summary		
I. Corporate and Country Priorities		
1. IDB Development Objectives	Yes	
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change and Environmental Sustainability	
Country Development Results Indicators	-Maternal mortality ratio (number of maternal deaths per 100,000 live births) -Beneficiaries receiving health services (#)*	
2. Country Development Objectives	Yes	
Country Strategy Results Matrix	GN-2796-1	i) To promote human capital accumulation of minors in households in extreme poverty. Ii) To improve the health indicators of children under 5.
Country Program Results Matrix	GN-2915	The intervention is included in the 2018 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution	9.5	
3.1 Program Diagnosis	3.0	
3.2 Proposed Interventions or Solutions	4.0	
3.3 Results Matrix Quality	2.5	
4. Ex ante Economic Analysis	10.0	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	2.2	
4.2 Identified and Quantified Benefits and Costs	3.3	
4.3 Reasonable Assumptions	1.0	
4.4 Sensitivity Analysis	2.2	
4.5 Consistency with results matrix	1.4	
5. Monitoring and Evaluation	7.0	
5.1 Monitoring Mechanisms	2.5	
5.2 Evaluation Plan	4.5	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	Medium	
Identified risks have been rated for magnitude and likelihood	Yes	
Mitigation measures have been identified for major risks	Yes	
Mitigation measures have indicators for tracking their implementation		
Environmental & social risk classification	C	
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, Accounting and Reporting, External Control, Internal Audit. Procurement: Information System, Price Comparison, Contracting Individual Consultant, National Public Bidding.
Non-Fiduciary	Yes	Strategic Planning National System, Monitoring and Evaluation National System.
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
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		

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The objective of this program consists in contributing to the reduction of maternal and neonatal mortality, focusing on medical centers with priority and poor municipalities. To achieve this objective, the program considers four components which aim to (i) strengthen management practices, (ii) improve on equipment and infrastructure, (iii) increase the institutional strength and (iv) dedicate resources to administration and evaluation of the program.
The vertical logic is consistent with the policy conditions and indicators presented in the results matrix. The results matrix includes indicators for the main outputs, outcomes and impacts. Indicators in the results matrix meet SMART criteria and include baseline values and targets for most indicators —but not for all of them— , as well as the sources and means of verification that will be used to measure them. The project proposes an external evaluation, but it lacks a design allowing for causal estimation of impacts. Results will be measured using a before-after comparison methodology, with no control group.

RESULTS MATRIX[1]

Project objective:	The project objective is to contribute to the reduction of maternal-neonatal mortality in the poorest municipios of the country and at the prioritized hospitals by improving the quality, management, and responsiveness of health services.

EXPECTED IMPACT

Indicator	Unit of measure	Baseline[2]	Base year	End target[3]	Means of verification
Impact					
National maternal mortality rate	Rate per 100,000 live births	61	2015	49	RAMOS study
Neonatal lethality rate from sepsis and asphyxia at the beneficiary hospitals	Rate per 1,000 discharges	16.42	2019	15% reduction	Project final evaluation
Maternal mortality rate in the beneficiary hospitals	Hospital maternal mortality rate	14.7	2015	10% reduction	RAMOS study

[1] See the detailed results matrix in Annex 1, REL No. 3.

[2] The baseline is preliminary and will be revised through technical assistance that will perform an operations investigation in the health care establishments in the project beneficiary municipios, to be financed with funds from this operation in 2019.

[3] To be performed at the end of the project.

EXPECTED OUTCOMES

Nº	Result	Unit of measure	Baseline	Base year	End target[4]	Means of verification
1	**Increase in the coverage of maternal and neonatal care, with the focus on primary care**					
1.1	% of pregnant women receiving prenatal care before the twelfth week of gestation over the last 12 months in the beneficiary networks	%	51	2019	10 percentage points	Project final evaluation[5]
1.2	High quality prenatal care coverage over the last 12 months in the beneficiary networks	%	24	2019	20 percentage points	
1.3	Coverage of assisted childbirths by qualified personnel over the last 12 months in the beneficiary networks	%	69	2010	10 percentage points	
1.4	Coverage of care for newborns by family health teams and health care establishments in the first three days of life over the last 12 months	%	68	2019	15 percentage points	
1.5	Number of family health teams established and operating in priority municipios that are not decentralized	Number	0	2019	20 percentage points	
1.6	% of networks prioritized on the basis of six health attributes	%	0	2019	100%	Project final evaluation
2	**Improvement in the quality of hospital care for obstetric and neonatal complications**					
2.1	% of obstetrical complications caused by hypertensive disorders in pregnancy and hemorrhage that are managed according to the protocol	%	11	2019	30 percentage points	Project final evaluation
2.2	% of neonatal complications caused by sepsis and asphyxia that are managed according to the protocol	%	7	2019	20 percentage points	

[4] The estimated increase in percentage points for indicators 1.1,1.2,1.3,1.4, 2.1, and 2.2 was calculated on the basis of national experience as measured by the Mesoamerica Health Initiative.

[5] The project baseline and final evaluation will be based on the files kept by health care facilities and the tools used to report and monitor treatment.

OUTPUTS

No.	Output	Unit of measure	Base year	Year 1	Year 2	Year 3	Year 4	End target	Means of verification
1	**Component 1. Strengthening of the management and quality of obstetric and neonatal services**								
1.1	Number of people covered by decentralized managers on the first level of care, prioritizing the poorest municipios	Beneficiaries	2018	419,530	425,045	0	0	425,045	Population, National Statistics Bureau
1.2	Strengthening the family health teams for their expansion to prioritized municipios (establishment of 20 teams for municipios that are not decentralized)	Teams		20	0	0	0	20	Decentralized management unit report
1.3	Management contracts[6] signed with level 2 managers	Number		3	3	3	0	9	Contracts signed
1.4	Hospital support committees			3	3	0	0	6	
1.5	Technical assistance to strengthen the decentralized management model			4	4	0	0	8	PEU report
1.6	Technical assistance to contract a firm for hospital strengthening	Firm		0	0	1	0	1	Approval certificate
2	**Component 2. Upgrading of health services equipment and infrastructure**								
2.1	Construction of high complexity units and neonatal intensive care units	Number	2018	0	2	1	0	3	Works acceptance certificate
2.2	Construction of a neonatology ward at HEU			0	1	0	0	1	Works acceptance certificate
2.3	Rehabilitation of priority hospitals			0	1	1	0	2	Acceptance certification of works
2.4	Equipment for neonatal intensive care units and obstetrics wards; equipment for prioritized areas			0	2	2	2	6	Equipment acceptance certificate
2.5	Procurement of medical and computer equipment to strengthen the family health teams		2018	1	0	0	0	1	Equipment acceptance certificate
2.6	Procurement of monitoring and communication equipment for the referral system			0	1	0	0	1	Equipment acceptance certificate
2.7	Preinvestment and medical architecture study for the works at Hospital de Occidente	Firm		0	1	0	0	1	Approval certificate
2.8	Technical assistance for the design and preparation of construction plans			0	1	0	0	1	Approval certificate
2.9	Technical assistance for works supervision			0	0	0	1	1	Approval certificate

[6] Involves management contracts between SESAL and second-level managers.

No.	Output	Unit of measure	Base year	Year 1	Year 2	Year 3	Year 4	End target	Means of verification
3	**Component 3. Institution-strengthening, technological innovations, and information system**								
3.1	Technical assistance to strengthen the family health teams	Consulting services	2018	0	3	3	0	6	Final report
3.2	Technical assistance for the master investment plan	Firm		0	0	1	0	1	
3.3	Technical assistance to implement the master patient file and information system			0	0	1	0	1	
3.4	Technical assistance to strengthen the Hospital Department	Consulting services		0	0	5	0	5	
3.5	Technical assistance to strengthen SESAL			0	0	0	10	10	
4	**Component 4. Program administration and evaluation**								
4.1	RAMOS 2021 study	Study	2018	0	0	0	1	1	Final report
4.2	Baseline and operations evaluation	Evaluation	2018	1	0	0	1	2	
4.3	Program final evaluation			0	0	0	1	1	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Honduras
Program:	Project to Improve the Management and Quality of Maternal-Neonatal Health Services
Executing agency:	Ministry of Health (SESAL)
Fiduciary team:	Nalda Morales (financial management); María Cecilia del Puerto (procurement), FMP/CHO.

I. EXECUTIVE SUMMARY

1.1 The Bank is continuing to support the strengthening of the public sector's institutional capacity to mitigate risk factors in project execution. The most recent diagnostic assessments in Honduras point to significant progress toward good practices and international standards, mainly in modernization of the institutional framework and integration of the budgeting, treasury, and accounting and reporting subsystems. The financial and accounting management of operations in Honduras is performed using country systems, the Integrated Financial Administration System (SIAFI), the budgeting, accounting, and treasury subsystems, and the National Public Investment System (SNIPH), which are mandatory for projects with external financing. Financial statements, bank reconciliations, disbursement requests, auditors' reports, etc., are generated through the SIAFI/UEPEX module for project execution units. In 2014, an agreement was signed with the Tribunal Superior de Cuentas [Superior Audit Court] (TSC), enabling it to perform financial audits of projects with external financing as an alternative to private auditors. With regard to the government procurement system, the country has strengths identified in the MAPS/OECD analysis of 2017, particularly a legal framework adjusted to most of the best international practices.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 SESAL has implemented SIAFI, including its budgeting, accounting, and treasury subsystems, and the UEPEX module for reporting. This system is currently being used by projects 3723/BL-HO-2 (Program to Support the Social Inclusion Network with Priority in Western Honduras) and GRT/HE14662HO (Second Individual Operation under the Mesoamerican Health Facility 2015). As for procurement, judging by the executing agency's experience in previous projects, its execution capacity is weak, particularly in the technical aspects of infrastructure works. Since the proposed operation includes different works and equipment, it will be necessary to set aside funds and clearly establish in the project documents the need to strengthen SESAL's project technical management unit (UTGP) by contracting specialized technical personnel. Contracting processes will follow the Bank's policies, be published at the national level, and may use

HONDUCOMPRAS, the government's official site for publicizing its procurement and contracting opportunities. Standard documents for national competitive bidding and price comparison will be used to procure goods and works agreed upon by the IDB and the Oficina Normativa de Contratación y Adquisiciones del Estado [Government Procurement Standards Office] (ONCAE).

III. Fiduciary Risk Evaluation and Mitigation Measures

3.1 Based on the information available, the fiduciary team determined that the risk associated with project financial and procurement management is MODERATE.

3.2 The following main fiduciary risks have been identified. (i) delays in budget amendments and contributions, and for procurement, there is a risk stemming from weak capacity in the areas of infrastructure and equipment. These risks are mitigated by SESAL's prior experience in the satisfactory execution of operations and the use of SIAFI/UEPEX for financial execution of the funds, in addition to the internal controls related to their use. The figure established for new advances of funds will be justification of 70% of the advance already received. Furthermore, the execution unit will have fiduciary autonomy and staff with job descriptions and terms of reference agreed upon with the Bank. The financial supervision plan will include audits to support monitoring of fiduciary management; (ii) specifications, designs, and costing may not be prepared properly, leading to noncompliant offers, failed processes, or delays in execution. To mitigate this risk, technical assistance will be engaged to support SESAL using funds earmarked for supervision.

IV. Considerations for the Special Provisions of the Contracts

4.1 Regarding financial fiduciary management, no special considerations are added to those established in the General Conditions of the Loan Contract.

4.2 **Exchange rate agreed upon with the executing agency/borrower for accounting purposes.** For the purposes of Article 4.10(b) of the General Conditions of the Loan Contract, the exchange rate to be used will be the rate stipulated in Article 4.10(b)(ii). In such case, the exchange rate will be the rate in effect on the date the borrower, the executing agency, or any other person or corporation with delegated authority to incur expenditures makes the respective payments.

4.3 **Financial statements.** The executing agency will deliver the project financial statements, audited by the TSC or independent auditors acceptable to the Bank, within 120 days after the close of each of fiscal year of the executing agency (1 January to 31 December) during the disbursement period. The last such report will be delivered within the 120 days after the date stipulated for the last disbursement of the loan proceeds or on a date agreed upon with the Bank.

V. Procurement Execution Agreements and Requirements

A. Procurement execution

5.1 The executing agency, acting through the PEU, will be responsible for the selection, bidding, contracting, and supervision of project procurements, in accordance with Bank procurement policy documents GN-2349-9 and GN-2350-9 and the procurement plan, which will set out: (i) the scheduled contracts for works, goods, and consulting services; (ii) the methods for the procurement of goods and selection of consultants; and (iii) the procedures applied by the Bank for examining each of the procurement processes. For procurement planning, the executing agency, acting through the PEU, will be responsible for preparing the procurement plan.[1][2] The Bank's procurement specialist will provide assistance to ensure that the procedures conform to Bank policies. The procurement plan will be updated annually, or as necessary for the project. All changes to the plan will be submitted to the Bank for approval.

5.2 Procurements of works, goods, and nonconsulting services[3] subject to international competitive bidding (ICB) will use the Bank's standard bidding documents. Processes subject to national competitive bidding (NCB) will use national bidding documents acceptable to the Bank and published on the ONCAE website.

5.3 Contracts for consulting services arising under the project will be executed using the standard request for proposals issued by or agreed upon with the Bank.

5.4 For the selection of individual consultants, the executing agency may place local or international notices to prepare a short list, when the names of suitable candidates for the consulting service are not known. The consultants contracted to assist the executing agency during execution may be contracted for the entire operation by obtaining a no objection to the initial competitive selection process, without the requirement for one per annual budget execution period, regardless of whether more than one contract is signed in each period. This does not preclude the possibility of rescinding the consulting contract should the performance evaluation so indicate.

5.5 **Domestic preference.** No domestic preference is envisaged.

B. Thresholds (US$000s)

5.6 The thresholds for ICB and the preparation of short lists of international consultants will be made available to the executing agency at www.iadb.org/procurement. Below these thresholds, the selection methods will be determined on the basis of the complexity and nature of the procurement or contract, which will be reflected in the procurement plan approved by the Bank.

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[1] Policies GN-2349-9, paragraph 1.16, and GN-2350-9, paragraph 1.23.

[2] See Guidelines for preparation and application PA18
http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39307352

[3] Policies for the procurement of goods and works financed by the Inter-American Development Bank (document GN-2349-9), paragraph 1.1: Nonconsulting services are treated as goods.

C. Main procurements

5.7 The procurement plan is attached as an electronic link and is summarized below:

Table V.1. Special procurements

Activity	Type of process	Estimated date	Estimated amount (US$)
Works			
Construction of three obstetrical and neonatal intensive care units	ICB	Q1 2019	13,426,000.00
Construction of a neonatology ward at HEU	NCB	Q1 2019	1,310,000.00
Rehabilitation and/or construction of obstetrical and/or neonatal wards and maternity waiting homes	NCB	Q1 2019	1,400,000.00
Consulting firms[4]			
Technical assistance for the design and preparation of construction plans	QCBS	Q1 2019	1,290,000.00
Works supervision firm	QCBS	Q1 2019	1,600,000.00
Technical assistance for implementation of the master patient file and the information system	QCBS	Q1 2020	4,000,000.00
Technical assistance to strengthen hospitals	QCBS	Q1 2019	2,450,000.00
Goods			
Equipment for five neonatal intensive care units	ICB	Q1 2019	6,404,000.00
Equipment for HEU (neonatal intensive care unit and neonatal ward)	ICB	Q1 2019	1,500,000.00
New ambulances	ICB	Q1 2019	1,080,000.00
Mobile and fixed ultrasound equipment for the family health teams	ICB	Q1 2019	290,000.00
Monitoring and communication system for the referral system	ICB	Q1 2019	300,000.00
Computer equipment	ICB	Q1 2020	300,000.00

D. Procurement supervision

5.8 According to the assessment of procurement fiduciary risk, supervision will be ex post, as established in the procurement plan. However, the Bank may, at its discretion, change the type of supervision, based on the institutional capacity demonstrated.

5.9 Consulting services by firms will be subject to ex ante supervision by the Bank, regardless of the amount of the contract.

E. Special provisions

5.10 **Measures to reduce the likelihood of corruption.** The provisions of policy documents GN-2349-9 and GN-2350-9 relating to prohibited practices will be applied (lists of firms and individuals declared ineligible by multilateral agencies).

[4] For consulting services, refers to shorts lists composed of firms of different nationalities. See policy document GN-2350-9, paragraph 2.6.

F. Records and files

5.11 The execution unit will be responsible for maintaining the files and original supporting documentation for procurement processes conducted with project resources, as well as keeping records. The project Operations Manual will document the internal work flows and separation of functions.

VI. Financial Management Agreements and Requirements

A. Programming and budget

6.1 **Programming and budget.** Financial management will be conducted through SIAFI and the Treasury Single Account (TSA).

6.2 **Accounting and information systems**. The SIAFI/UEPEX module will be used for financial reports. The project's financial and accounting transactions will follow the practices in this country system. Cash basis accounting will be used.

6.3 **Disbursements and cash flow.** The executing agency will open a special account in the project's name at the Central Bank of Honduras (BCH). The maximum amount for advances of funds will be established by the Bank depending on the cash flow analysis or financial plan agreed upon with the executing agency. Since budget contributions and amendments are subject to delays, it is recommended that justification of 70% of an advance already received be required for new advances of finds.

6.4 **Internal control and audits.** SESAL's internal audit units support implementation of the recommendations and findings of audits. In the extent to which they continue to be strengthened by the National Office for the Comprehensive Development of Internal Control in Public Institutions (ONADICI), they will continue to be used in the proposed operation.

6.5 **External control and reports.** The external audits may be performed by the country's supreme audit authority or an external audit firm acceptable to the Bank.

6.6 Based on the above, the following has been determined:

a. The external financial audits will be annual, and the interim reports will be six-monthly.

b. To govern this operation, the Bank will use the versions of the Financial Management Policy for IDB-financed Projects (document OP-273) and the Financial Management Operational Guidelines for IDB-financed projects (document OP-274) in effect at the time of project approval.

c. The total cost of the auditing services will be financed from the loan proceeds. The selection and contracting of audit services will follow the guidelines established in the Instructions for Financial Reports and Audits.

6.7 **Financial supervision plan.** The Bank will supervise and monitor the project's financial management through the financial management specialist, in coordination with the Project Team Leader. Visits and meetings may also be conducted to monitor the fiduciary risks. Disbursements will be subject to ex post review as part of the work of the external auditors.

6.8 **Execution mechanism.** The project will be executed through the project execution unit (PEU), consisting of at least a general coordinator, a financial specialist, a procurement specialist, a monitoring specialist, and other specialists as required, selected on the basis of job descriptions and terms of reference acceptable to the Bank.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/18

Honduras. Loan ____/BL-HO to the Republic of Honduras
Project to Improve the Management and Quality of
Maternal-Neonatal Health Services

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Honduras, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a project to improve the management and quality of maternal-neonatal health services. Such financing will be chargeable to the Bank´s Ordinary Capital (OC) resources in the following manner: (i) up to the amount of US$27,600,000, subject to concessional financial terms and conditions ("Concessional OC"); and (ii) up to the amount of US$41,400,000, subject to financial terms and conditions applicable to loan operations financed from the Bank's regular program of OC resources ("Regular OC"), as indicated in the Project Summary of the Loan Proposal, and subject to the Special Contractual Conditions of said Project Summary.

(Adopted on __ _____ 2018)

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