

TECHNICAL COOPERATION DOCUMENT¹

I. BASIC INFORMATION

Country/Region:	Belize
TC name:	Mesoamerican Health 2015 Belize - Second Individual Operation
TC number:	BL-G1002
Team leader/members:	Ian Mac Arthur (SPH/CGU), Team Leader; Jennifer Nelson; Diego Rios Zertuche; Mauricio Pérez Calvo; Lissie Manrique (all SCL/SPH) Elizabeth Ayala (CID/CBL); Mónica Centeno (LEG/SGO); Paula Louis-Grant and John Primo (both FMP/CBL)
Taxonomy:	Client Support
Date of TC Abstract authorization:	n/a
Beneficiary:	Belize
Executing Agency:	Ministry of Health (MOH)
Donors providing funding:	Mesoamerican Health Facility (MHF)
IDB Funding Requested:	US\$450,000
Local counterpart funding:	US\$300,000
Total Funding Requested:	
Investment tranche (IT) - MHF	US\$300,000 (40%)
Counterpart (CP)	<u>US\$300,000</u> (40%)
Subtotal investment (IT+CP)	US\$600,000 (80%)
Performance tranche (PT) – MHF	<u>US\$150,000</u> (20%)
Total (IT+CP+PT)	US\$750,000 (100%)
Disbursement period:	24 months (from project eligibility)
Required start date:	December 2014
Types of consultants:	Individual consultants and consulting firms
Prepared by Unit:	Social Protection and Health Division (SCL/SPH)
Unit of disbursement responsibility:	Country Office Belize
TC included in Country Strategy:	Yes
TC included in CPD:	Yes
GCI-9 Sector priority:	Social policy for equity and productivity

II. OBJECTIVES AND JUSTIFICATION

- 2.1 The Salud Mesoamerica 2015 Initiative (SM2015) is a public-private association among the Bill & Melinda Gates Foundation, the Carlos Slim Health Institute, the Government of Spain, the Inter-American Development Bank (IADB) and the eight countries of the Mesoamerica region.

¹ Pursuant to Title VIII, point 8.1 of Document OP-219-3 (May 20th, 2013), “all Investment Grant Operations of up to US\$3 million shall follow the standard documentation, processing and approval procedures for non-reimbursable technical cooperation.”

SM2015 supports the countries to improve reproductive, maternal, neonatal and child health and reach the Millennium Development goals for reducing maternal and infant mortality. It emphasizes improving the supply of services, increasing demand for them, implementing results-based financing schemes, and adopting evidence-based and cost-effective interventions in order to improve the health status of the poorest 20% of the population and reduce health inequities. In Belize SM2015 finances two consecutive operations, and this document describes the second individual operation.

- 2.2 **Theory of change.** Since Belize has high levels of usage and coverage of health services,² the program's theory of change centers primarily on the quality improvement of services based on the "stages of change" model.³ The program intervenes at the system and management level of the supply side to increase the quality of the services rendered. It intervenes on the demand side by increasing client satisfaction through provision of better quality services in addition to decreasing access barriers by strengthening community platforms, nutrition and sexual and reproductive health (SRH) services. Both of these aims depend on people changing various behaviors. On the supply side, this involves performance-improving behaviors which can range from enhanced teamwork to better documentation to changing processes and procedures used in clinical practices. On the demand side, this involves changing care-seeking behaviors and adoption of interventions, for example using oral rehydration salts (ORS) and zinc for the treatment of diarrhea and the decision to use modern contraceptives.⁴ The first operation (BL-G1001) focused on enabling strategies for improvement on the supply side, while this second operation uses reinforcing strategies, such as audit, feedback, incentives and competition, to maintain achievements. Similarly, the first operation took action to increase the incorporation⁵ of desired behaviors on the demand side, and this second operation will further strengthen preparation, action and maintenance activities (see [Presentation of Second SM2015 Belize Operation to Donors](#)).
- 2.3 **Interventions and achievements of the first operation.** The first operation adopted the quality improvement collaborative approach⁶ that involves the application of evidence-based standards and interventions linking specific care content or processes to a desired outcome as well as

² For example, according to the SM2015 [Community Baseline Survey](#), over 99% of women of reproductive age (15-49 years) had their most recent birth in the last two years in an institutional setting with a skilled attendant and almost 83% had at least 4 prenatal visits with attention by skilled personnel.

³ Rowe et al. (2005) argue that multifaceted interventions are important for maintaining quality. The "stages of change" theory of health worker practices indicates that individuals pass through stages (pre-contemplation, contemplation, preparation, and action and maintenance), and different interventions are appropriate at each stage. See the [Integrated Policy Dialogue, Learning and Communication Plan](#) for more detail on the theory of change.

⁴ The Community Baseline Survey revealed that only 5.3% of mothers treated their child's diarrhea with both ORS and zinc and that 47.4% of women of reproductive age were not using or unable to obtain contraception.

⁵ This involves the stages of pre-contemplation, contemplation and preparation in the stages of change model.

⁶ A health improvement collaborative incorporates a large number of teams from different facilities or sites to work in a structured way over a short time (12 to 24 months) to improve a specific area of care and provides them with assistance in process analysis, systematic indicator measurement, job aid tools, training and coaching. Catsambas et al. (2008) revealed that collaboratives in several countries produced important gains in compliance with standards (80% or above within 8-18 months) in key technical areas and proved effective in scaling up best practices.

measurement of gaps between observed and desired practices.⁷ It provided technical assistance for the assessment and expansion of a maternal and neonatal collaborative and the development of two new collaboratives for sexual and reproductive health services (including adolescents) and child health and nutrition (for community health workers-CHW and facilities). The MOH organized 64 participants such as medical officers, public health nurses, rural health nurses, health educators and CHW into multi-disciplinary facility-based quality improvement teams. They also introduced the Plan-Do-Study-Act (PDSA) approach, and the teams learned to use data collection tools, standards and indicators to establish the baseline and follow-up measurements for the two new collaboratives. The implementation of the maternal and neonatal collaborative has contributed to improved performance relating to the monitoring of labor using partograph (obstructed labor) to reduce perinatal asphyxia, active management of third stage of labor (AMTSL) involving application of oxytocin to prevent post-partum hemorrhage (PPH) and management of obstetric complications (severe preeclampsia and eclampsia) (see [IADB Technical Note: Quality Improvement of Health Care in Belize](#)).

- 2.4 Alongside the collaborative model, a key element of the quality improvement (QI) effort is the Quality Innovation Fund (QIF), through which the first operation implemented supply-side results-based financing (RBF) at the level of the service provider (QI team).⁸ Twenty facilities (two regional hospitals, two community hospitals, twelve rural health centers and four urban health centers) in the Northern and Western Regions⁹ participated in the QIF (see [QIF Operating Manual](#)), which allows them to present proposals and receive in-kind awards valued at up to US\$2,500 after 6 months if they reach goals on a series of indicators aligned with the SM2015 performance framework; the majority of indicators improved by more than 50 percentage points within 6 months. For example, in rural health centers the indicator relating to “health facility patients of reproductive age given family planning counseling according to the norms” rose from 63% to 90% (for more details and results, see [IADB Technical Note: Quality Improvement of Health Care in Belize](#)). This incentive mechanism rewards local goal achievement and motivates facility teams while permitting them to improve their working conditions and the quality of their services.¹⁰ The development of a proposal by each facility seeks to generate buy-in from participants and empower them to obtain specific items they normally are unable to procure but consider relevant for facility improvement. The QIF may

⁷ Quality improvement teams noted that gaps existed around adherence to protocols and procedures (for example not all staff members knew how to correctly interpret a partograph). Additionally, lab tests, key supplies and adequate human resources were not always available for quality provision of services. Information gaps also existed, as community level providers did not have data on child nutrition and adolescent health, and not all health centers were connected to the health information system.

⁸ The literature identifies several outcomes incentivized by the RBF schemes, including cost containment, the supply of cost-effective interventions, improvement in the quality of health care, increases in health worker productivity, greater utilization of care, and expanded coverage, among others. Recent studies with a strong design and use of statistical methods (Basinga et al., 2010; Basinga et al., 2011; Soeters et al., 2011; Huntington et al., 2010) strengthen the literature suggesting that RBF can have positive effects on quality of care and other variables.

⁹ The project targets the public health service networks in the Northern and Western Regions (Cayo, Corozal and Orange Walk districts) due to poverty criteria and the Government’s interest in introducing performance-based financing to regions not covered by National Health Insurance (NHI), which incorporates a pay-for-performance scheme. For further information, see the [Project Targeting Technical Note](#).

¹⁰ This modality of providing incentives for innovation has been employed in previous projects financed by the IADB and found to show positive results (for example, CUANTO, 2006).

generate social comparisons among facilities, a process relevant for leveraging commitment. To roll out the QIF, the project team organized regional meetings with stakeholders to explain the innovation fund and the indicators and receive input from the health facility staff.

- 2.5 An essential aspect of the QIF is the establishment of Quality Assurance Teams composed of technical and administrative professionals from the MOH and regions, who conduct monthly facility visits to monitor indicator performance and provide timely feedback and guidance to health facility staff. This includes reframing the role of the QI officer position. QI officers apply standard QI forms to collect data from each health facility on desired indicators and then use this information to discuss successes and areas for improvement with facility teams. As part of this process, facility teams will propose safe-to-fail experiments to test new ideas in the following month to improve quality, which will then be evaluated by the QI Officer. The QI officer will also act as a knowledge broker by sharing best-practices from other facilities with facility teams during monthly visits, in addition to sharing them with other colleagues during their own quarterly meetings.
- 2.6 Given the relevance of data gathering, processing and analysis for quality improvement, the project assisted in the expansion and increased usage of the Belize Health Information System (BHIS). The first operation provided for a 25% increase in connectivity of facilities through the installation of hardware and internet service. During the first operation, it was noted that although the BHIS can create various management reports, many front-line workers did not have permissions or training in how to generate their reports. Therefore, the operation also trained health providers in standard reporting mechanisms and information access for decision making. With counterpart funds the MOH completed the BHIS Data Dictionary, which will permit more accurate routine reporting. Certain QIF indicators related to coverage are verified using BHIS data as a primary source. However, some quality data is calculated using individualized patient charts and is therefore not captured in the BHIS. This information will be collected using the QI tablet tool during the second operation.
- 2.7 In order to complement the quality improvement component, the first operation proposed to strengthen priority areas of service delivery, principally through the provision of key inputs. The operation supplied over 20 health facilities with maternal and neonatal health care equipment and instruments to comply with SM2015 Essential Obstetric and Neonatal Care (EONC) performance indicators.¹¹ Considering the relatively low rates of use of family planning methods and the high level of unmet need for contraception, especially among adolescents, the project developed and reproduced job aid tools for providers at the community and institutional level¹² as well as informational and promotional material for clients, in addition to procuring additional methods with counterpart funds. In order to expand the coverage of permanent methods, the operation financed training in tubal ligation without general anesthesia to generate capacity in two community hospitals for this procedure. Finally, the operation incorporated a performance

¹¹ The items included incubators, delivery beds, infusion pumps, laryngoscopes, pulse oxymeters, examination lights, aspirators, vital sign monitors, digital thermometers, pediatric nebulizers, surgery instruments, child/newborn resuscitators, sphygmomanometers, IUD training models, steam sterilizers, delivery sets, reflex hammers, etc.

¹² The tools consisted of items such as checklists for screening and improving counseling.

indicator relating to the revision of reproductive health protocols for women of reproductive age and adolescents.

- 2.8 Given the limited supply of human resources within the health sector, the first operation concentrated on revitalizing the CHW platform. The MOH established norms regarding CHW roles and responsibilities and trained 107 CHW in a curriculum addressing: (i) the formal health system; (ii) community leadership; (iii) community health for children, women, and adolescents; and (iv) practical field experience. With the goal of reaching more isolated populations and conducting improved health promotion, the operation introduced different types of non-financial incentives for CHWs. District health educators and CHWs benefited from training and technical assistance as well as basic supplies (medical kit, educational material, backpack, boots and field clothes) to allow them to perform expanded functions and also to increase their morale. To assist the CHWs in their daily tasks and monitoring visits, the QIF created new forms, including a Home Visit Record, Patient Register, Referral Form, Supervision Checklist and Supportive Supervision Notes. Four of the 12 QIF indicators related to enhancing CHWs' capabilities or service provision and collaboration with health facilities. The Health Education and Community Participation Bureau (HECOPAB) Technical Advisor and district health education officers now conduct more regular supervision of the CHWs and offer orientation and feedback. The CHW platform is essential not only to extend coverage of health education and prevention to more remote communities but also to generate more demand for institutional services through orientation and referrals.
- 2.9 **First operation performance results.** Belize met targets on 4 of 12 performance indicators, thereby achieving a score of 0.333 in the Performance Framework of the First Individual Operation. However, there was impressive progress on all indicators, and Belize reached goals on several key performance indicators, such as the adoption of norms for improving the quality of reproductive and child health and nutrition services and for the establishment of a community platform of services. Belize also achieved the target on permanent availability of modern family planning methods, reaching a value of 89.5 [+/-22.6], 4.5 percentage points above the target. Two other indicators for which targets were accomplished were related to new interventions: 95% of all eligible health facilities submitted a Quality Improvement Fund proposal to the national quality audit team, and 100% of District HECOPAB Officers were monitoring community health workers. Within the operation's 24 months, Belize also implemented quality of care job aid tools for reproductive health in 55.3% of health facilities in the target area; installed the infrastructure for the Belize Health Information System (BHIS) in all of the 10 eligible facilities; developed sexual and reproductive health educational materials targeted at adolescents reaching 63.9% of health facilities; trained 58.0% of all community health workers in the community platform; and increased the continuous availability of supplies and equipment for prenatal and postnatal care from 2.9 to 17.2%.
- 2.10 Although significant progress was made, Belize advances to the second operation without receiving the Performance Tranche. Belize faced very ambitious targets on a large number of indicators during the first operation. Indicators related to diverse activities, such as the permanent availability of inputs and supplies for maternal and child care, the implementation of new interventions and the adoption and update of national norms, each one with its own peculiar complexities. In this context, even though Belize did not attain the targets on several indicators, it did make valuable progress on all of them with respect to the baseline. This was

even more apparent when analyzing each input and piece of equipment separately. Special attention will be needed to ensure that health facilities are adequately equipped to manage obstetric and neonatal complications according to the norm and for the provision of child care according to the norm. Nevertheless, if the improvement trend continues, Belize will probably be under way to meet targets for the second operation performance indicators.

- 2.11 **Improvement plan.** During this second operation, the MOH will work to address shortcomings detected in the performance indicator measurement. Considering that several goals were missed by a very small margin, this effort has a high probability of success. For instance, regarding the indicator on inputs for emergency obstetric and neonatal care, of 12 equipment items, three hospitals lacked one item (pinard stethoscope/portable doppler); one each lacked one different item; and two each lacked two different items. Therefore, by acquiring merely nine items and distributing them to four facilities the MOH could ensure goal compliance on this indicator. A similar pattern holds for the input indicators relating to pre- and post-natal care and child health care although the deficiencies were greater at the ambulatory facilities, which include health posts utilized by mobile clinics. In order to ensure availability of inputs at these facilities, the project promoted the use of transportable kits by the mobile teams. However, the follow-up survey revealed that the medical teams did not always carry kits with all required equipment items and did not restock them sufficiently with consumable items (supplies and medicines). In the second operation, the Quality Assurance (QA) teams will provide continued and strengthened orientation regarding the proper management of the mobile clinic kits.
- 2.12 Two additional input indicators related to new interventions in reproductive health that intended to increase the availability in health facilities of quality-of-care job aid tools and sexual/reproductive health education materials for adolescents. While all four hospitals possessed the required materials, between 50-60% of the ambulatory facilities complied, which was insufficient to meet the indicator goals. As with the equipment and supplies for quality care, the job aid tools and educational materials were normally present in the health centers but not always in the health posts operative during the mobile clinic visits. Therefore, during the second operation, the QA teams will take additional measures to ensure that the mobile clinics always utilize the reproductive health improvement inputs on their rounds in the health posts.
- 2.13 The MOH also made impressive progress on the three remaining indicators related to the information system, patient complaint mechanism and community health worker training but did not reach the respective targets, which proved to be very ambitious. With regard to the BHIS indicator, the project permitted the installation of the necessary infrastructure (computers, cabling, printers, internet, etc.), access to the system and staff training, but at the time of the follow-up survey, only 30% of the ten eligible facilities were actually able to produce the required reports. To address this problem the BHIS unit at MOH will plan more training and orientation activities to key health facility staff regarding data entry and report generation. In its effort to improve quality through patient feedback, the MOH set up suggestion boxes for patient satisfaction surveys in all of the twenty facilities that participated in the QIF; however, the corresponding indicator required that all facilities, including health posts used by the mobile clinics, have some mechanism to receive anonymous input from users. The survey revealed that only 55% of services complied. Therefore, the second operation will work to promote that each mobile clinic carries a suggestion box (plastic) when it attends patients in the health posts. Finally, the operation strengthened the community health worker platform (see ¶ 2.8);

however, the original target of training 85% of 157 CHWs was not met. Although the MOH successfully recruited 187 CHWs, only 107 graduated from the comprehensive training program due to an unexpectedly high rate of attrition related to the increased workload required by the new platform and illiteracy among some CHWs. The MOH will continue its recruitment efforts of qualified candidates and improve the regularity of CHW stipend payment to address the issue of their exit from the program.

- 2.14 **Lessons learned.** An analysis of the positive and negative aspects of the first operation, bottlenecks in implementation, and potential new activities allowed for the identification of the principal “lessons learned” to improve the preparation of the second operation. The stakeholders in Belize felt that several interventions should be continued and strengthened in the second operation: (i) the QIF and continuous facilities monitoring, with indicators adjusted according to the performance framework for the second operation and varied incentives, and (ii) CHW program strengthening with incentives. In the stakeholders’ opinion the technical assistance in quality improvement collaborative was a positive aspect of the operation, but it should not be contracted with an international firm due to concerns relating to adequate dedication.¹³ They also felt more time was required for the introduction new practices and tools with CHWs. A key bottleneck related to limited transportation necessary to conduct health facility supervision visits in the context of the QIF. Finally, a key unmet need had to do with the development of more efficient means of data collection and processing for QIF implementation. All of these lessons learned have been incorporated in the design of the second operation.
- 2.15 **Justification.** Based on the positive results during the first operation, SM2015 plans to continue using the QIF model, while realigning its indicators and goals with the revised performance framework.¹⁴ Until the MOH is able to scale up its NHI model (see footnote 8), the QIF offers a pay-for-performance alternative for the Northern and Western Regions, which has shown that it can be quickly implemented and yield results with a relatively small investment and low administrative burden. This second operation will also invest in inputs to overcome obstacles encountered in the first one, such vehicles to address the lack of transportation for supervision and community visits and a mobile data collection and analysis tool to reduce time constraints on QI teams.¹⁵ Additionally, the project will incorporate incentives for CHWs to combat attrition associated with increased workload.
- 2.16 **Policy Dialogue and Learning:** During the first operation, SM2015 concentrated on two policy dialogue topics in Belize: (i) norms for improving the quality of reproductive and child health and nutrition services and for the establishing a community platform, and (ii) the introduction of facility-based performance incentives to promote innovation and allow

¹³ Due to the firm’s additional commitments in other countries at times there were delays to arrange visits for technical assistance activities and to present products.

¹⁴ The QIF indicators for the first operation emphasized not only inputs but also process related to quality service provision, and the indicators for the second operation will reinforce service quality measurement where the [Baseline Health Facility Survey](#) revealed deficiencies (for example, less than 10% of obstetric and neonatal complications managed according to the norm), as well as communication to families to improve poor practices regarding prevention and care seeking (less than 20% recognition of danger signs and use of ORS and zinc during diarrhea).

¹⁵ Technical assistance funds additional to the donation will finance tablets for both on- and offline data collection, analysis and visualization to complement monthly QIF visits and eliminate time spent digitizing paper files.

for more decentralized decision-making. The norm changes were included as an indicator in the performance framework during the first operation. The interventions supported by the operation strengthened the basic package of services and began to bring services closer to the populations in need. During the second operation, the SM2015 Belize agenda includes influencing decisions regarding the sustainability of (i) incentives for health care providers through the QIF and CHWs, while the MOH continues to discuss the scale up of the NHI, and (ii) institutionalization of learning and collaborative practices. SM2015 will continue the policy dialogue regarding the implementation of the updated norms and strengthening the health information system in terms of funding and human resources (involving key actors, including the Information Technology and Epidemiology Departments). Additionally, aligned with policy dialogue, learning activities will focus on the creation and institutionalization of an Effective System for Rapid Improvement, in addition to participation in SM2015 regional learning activities and creation of the Belize Success/Failure Report as detailed in the [Integrated Policy Dialogue, Learning and Communication Plan](#).

- 2.17 The operation is the second in a series that addresses key priorities of the MOH health sector strategy in Belize. Furthermore, it is fully aligned with the IADB's Health and Nutrition Sector Framework Document (GN-2735-3) and the GCI-9 Social Policy for Equity and Productivity (GN-288-4).¹⁶ The IDB Country Strategy with Belize 2013-2017 (GN-2746) identifies the Mesoamerican Health Initiative as a platform for dialogue with the government regarding the health sector.
- 2.18 The project's objective in Belize is to contribute to the reduction of maternal and child morbidity and mortality through the improvement of access, use and quality of maternal-infant and neonatal health services in Corazol, Orange Walk and Cayo.

III. DESCRIPTION OF ACTIVITIES, COMPONENTS AND BUDGET

- 3.1 **Component 1: Strengthening the supply and demand for health services for women of reproductive age and children under 5 (US\$360,000).** This component includes two subcomponents: (i) Quality improvement of maternal, neonatal, child, and reproductive health services; and (ii) Strengthening health service delivery capacity to increase coverage, demand and behavior change. The first subcomponent will finance the development, implementation and supervision of 40 QIF proposals (2 rounds for 20 facilities). The QIF will incorporate indicators to reflect the performance framework indicators for this second operation at the community, primary and secondary levels. Since consistent supervision is a fundamental component of the QIF model, the operation will allow for quality improvement officers to continue providing monthly monitoring and feedback in each health facility and will strengthen this process through the provision of improved transport to the most remote sites. In order to offer greater and varied incentives, members of QI teams whose facilities have complied with their goals will be eligible to receive individual awards through a lottery system.¹⁷ Given the importance of applying proper procedures to improve quality, this operation will finance

¹⁶ It supports the general goal for "poverty reduction and improved equity" and the regional goals for "reduction of maternal and infant mortality."

¹⁷ See WHO, 2013; HeSPA Network, 2013; Gneezy, 2011.

training for approximately 120 health care workers in facilities (health posts, centers and hospitals) regarding technical competencies related to clinical protocols in obstetric, neonatal and family planning.

- 3.2 The second subcomponent focuses on inducing behavior change in the target population for increased use of certain services and practices, as reflected in the performance and QIF indicators. The operation will provide additional training for nearly 160 CHW and HECOBAP officers regarding maternal and child health and establish financial performance incentives for CHWs linked to the delivery of effective behavior change counseling related to care-seeking for early prenatal and post-natal controls, treatment of diarrhea with ORS and zinc, exclusive breastfeeding, complementary feeding and family planning. Both facility and community-level staff will benefit from training in the Communication for Behavioral Impact (COMBI) methodology. So as to complement the greater installed capacity for individual counseling, this subcomponent will finance the development of specific content and messages for behavior change communication to raise awareness, knowledge and demand for services.¹⁸ CHWs will also work with health centers to implement community level activities such as health fairs to transmit information.
- 3.3 **Component 2: Improving management and health information systems for maternal and child health (US\$240,000).** Includes three subcomponents: (i) Improving sector management skills; (ii) Expanding the BHIS; and (iii) Supporting the Project Management Unit (PMU). Since the MOH considers technical management skills relating to supervision, data use in decision-making and proper recording of clinical information as critical to quality improvement but also recognizes the need for strengthening soft skills such as leadership, negotiation, working under pressure and team-building,¹⁹ the operation will invest in a strategy to develop capacities and skills in these areas for approximately 120 employees participating in SM2015. Considering the essential nature of accurate data gathering and recording for project interventions in quality improvement, the BHIS will also be installed in two additional facilities, and an improved filing system will be introduced in facilities that are not yet eligible for the BHIS due to lack of proper infrastructure, internet coverage, and human resources for trouble-shooting and training. The generation of new user-friendly report templates through the QI tablet application will be consolidated during this operation. The PMU will continue to receive funds for key human resources and auditing.
- 3.4 The [Results Matrix](#) and [Performance Framework](#) contain the project indicators that will be monitored and measured for potential payment of the performance tranche. Table 1 presents some of the key indicators from the Results Matrix. Based on the results of the baseline survey, three goals in the performance framework were modified, and one indicator was removed.²⁰

¹⁸ See Wakefield, 2010; Fjeldsoe, 2009.

¹⁹ See Leonard, 2004; Borrill; McGuire, 2006; West, 1999.

²⁰ The 36-month targets for 3 indicators were reduced: indicator 4410, from 75% to 37.5% (given the low baseline value of 1.4%); indicator 5135, from 100% to 80% (initial estimate was too high); indicator 4060, from 60 percentage points (PP) to 30 PP (no baseline). Indicator 4120 was removed given the potential for the creation of a perverse incentive. The [Monitoring and Evaluation Arrangements](#) provide detailed justification for these changes.

Table 1. Indicative Results Matrix

Indicators	Unit of measure	Goal	Means of verification
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	%	49.1%	Health facility survey
Neonatal complications (prematurity, low birth weight, asphyxia and sepsis) managed according to norms in the last two years	%	37.5%	Health facility survey
Newborns enrolled for child health services within seven days of birth in the last two years	%	35.3%	Health facility survey

- 3.5 This second operation has a total cost of US\$750,000, consisting of investment tranche (IT) resources in the amount of US\$600,000 (Table 2), financed in equal portions by the MHF and Belize, through counterpart (CP) funds, and a performance tranche (PT) for US\$150,000. The PT will be disbursed if the minimum score is met regarding the goals of the Performance Framework for the Second Individual Operation, in accordance with the SM2015 RBF scheme, within thirty months from the date of eligibility of the operation.

Table 2. Indicative Budget (US\$)

Activity/Component	IDB	Counterpart	Total
Component 1: Strengthening the supply and demand for health services for women of reproductive age and children under 5	195,600	164,400	360,000
Component 2: Improving management and health information systems for maternal and child health	104,400	135,600	240,000
Total	300,000	300,000	600,000

- 3.6 As indicated in the [Monitoring and Evaluation Arrangements](#), progress on output, outcome and impact indicators will be monitored using administrative data, population surveys and national statistics, and the relevant information will be maintained in an operation “dashboard.” For the measurement of the performance tranche indicators, independent household and health facility surveys will provide baseline data. Follow-up verification of indicators will be done through facility-based surveys and a household survey. Belize was not among the SM2015 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.

IV. EXECUTING AGENCY AND EXECUTION STRUCTURE

- 4.1 As with the first individual operation, the Ministry of Health will execute this operation through its Project Management Unit, which will be responsible for tasks relating to project administration, procurement and financial 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. The ratification of the Quality Improvement Manager will be a condition prior to first disbursement.
- 4.2 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 in the implementation of the [Procurement Plan](#). If the performance tranche is disbursed, the resources will be used in the health sector but will not be subject to the Bank's procurement policies. These and other provisions are reflected in the [Fiduciary Agreements and Requirements](#) and the [Project Operations Manual](#) (POM). The POM will be reviewed and updated as a condition prior to first disbursement.
- 4.3 As a special condition for implementation of the operation, 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, in compliance with paragraph 1.27 b. and c. of Annex 1 to the MHF2015 Operating Regulations.

V. MAJOR ISSUES

- 5.1 The [Project Risk Analysis](#) categorized risks in execution according to probability and impact, and in the cases where the risks were classified as "medium" or "high," the risk management plan proposes appropriate mitigation measures.

VI. EXCEPTIONS TO BANK POLICY

- 6.1 The operation does not contain exceptions to Bank policy.

VII. ENVIRONMENTAL AND SOCIAL CLASSIFICATION

- 7.1 This operation classifies as category "C" according to the Environment and Safeguards Compliance Policy (OP-703) (see [Safeguard Screening Filters](#)). No current or potential safeguard policy items were identified. There are no negative social or environmental effects expected from the program. On the contrary, the second 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.

REQUIRED ANNEXES:

- Annex I: [Request from the client](#)
Annex II: [Procurement Plan](#)

**INICIATIVA SALUD MESOAMÉRICA 2015 BELICE - SEGUNDA OPERACIÓN
INDIVIDUAL**

BL-G1002

CERTIFICACIÓN

Por la presente certifico que esta operación de inversión no reembolsable fue aprobada para financiamiento por el Fondo Mesoamericano de Salud (MHF por sus siglas en inglés) en la reunión del Comité de Donantes del día 15 de septiembre de 2014.

Igualmente, certifico que existen recursos disponibles en el mencionado fondo, hasta la suma de US\$450.000 (cuatrocientos cincuenta mil dólares estadounidenses) para financiar las actividades descritas y presupuestadas en este documento. Este monto se divide en (i) US\$300.000 (trescientos mil dólares estadounidenses) para cubrir el Tramo de Inversión (IT) y (ii) US\$150.000 (ciento cincuenta mil dólares estadounidenses) para cubrir el Tramo de Desempeño (PT) sujeto a que se cumplan las metas preestablecidas para su desembolso.

El compromiso y desembolso de los recursos correspondientes a esta certificación sólo debe ser efectuado por el Banco en dólares estadounidenses. Esta misma moneda será utilizada para estipular la remuneración y pagos a consultores, a excepción de los pagos a consultores locales que trabajen en su propio país, quienes recibirán su remuneración y pagos contratados en la moneda de ese país. No se podrá destinar ningún recurso del Fondo para cubrir sumas superiores al monto certificado para la implementación de esta operación. Montos superiores al certificado pueden originarse de compromisos estipulados en contratos que sean denominados en una moneda diferente a la moneda del Fondo, lo cual puede resultar en diferencias cambiarias de conversión de monedas sobre las cuales el Fondo no asume riesgo alguno.

ORIGINAL FIRMADO

11/19/14

Sonia M. Rivera
Jefe

Fecha

Unidad de Gestión de Donaciones y Cofinanciamiento
ORP/GCM

Procurement Plan																
Project: Mesoamerican Health 2015 - Belize Program (Second Individual Operation)																
Period Comprised in this Procurement Plan: From January 2015 to January 2017																
Ref. No (WBS)	Ref. No.		Estimated Cost in (US\$)	Actual Cost (US\$)	Actual Cost in (US\$)	Procurement Method	Review (Ex ante/Ex-Post)	Source of		Prequalification (Yes/No)	Publication of Specific Procurement Notice	Estimated Dates			Status (pending, in process awarded, cancelled)	Comments
								IDB	GOB			Bids/RFP Submission Date	Contract Signing	Completion of contract		
GOODS																
2.1.1.5.3	BZ/SM2/G/002	Vehicles for Monitoring (2)	\$ 60,000.00		\$ -	NCB	Ex-ante	100%	0%	No	Apr-15	May-15	May-15	Jul-15	Pending	
2.2.1.4	BZ/SM2/G/003	Basic supplies for CHWs (incentive program)	\$ 20,000.00		\$ -	PC	Ex-ante	100%	0%	No	Sep-15	Oct-15	Oct-15	Jan-16	Pending	
3.2.1.1	BZ/SM2/G/004	Hardware for BHIS	\$ 30,000.00		\$ -	NCB	Ex-ante	100%	0%	No	Apr-15	Jun-15	Jun-15	Sep-15	Pending	
3.2.1.3	BZ/SM2/G/005	Internet	\$ 3,600.00		\$ -	GOB's Limited Tendering Procedure	N/A	0%	100%	No	Feb-16	Feb-16	Feb-16	Feb-16	Pending	
3.3.1.4	BZ/SM2/G/006	Cabinets and Other Office Supplies	\$ 15,000.00		\$ -	GOB's Selective Tendering Procedure	N/A	0%	100%	No	Sep-15	Oct-15	Oct-15	Nov-15	Pending	
SUB-TOTAL - GOODS			\$ 128,600.00	\$ -	\$ -											
NON-CONSULTING SERVICES																
2.1.1.4.3 2.1.1.4.4 and 2.1.1.4.5	BZ/SM2/G/001	Quality Improvement Fund	\$ 60,000.00	\$ -	\$ -	PC	Ex-ante	100%	0	No	Jul-15	Jul-15	Jul-15	Jul-16	Pending	
3.3.1.3	BZ/SM2/NCS/001	Printing of Monitoring Forms	\$ 25,000.00		\$ -	GOB's Selective Tendering Procedure	N/A	0%	100%	No	Sep-15	Oct-15	Oct-15	Nov-15	Pending	
2.2.3	BZ/SM2/CS/005	Implementation of behavior change campaign (airing of spots)	\$ 52,500.00		\$ -	PC	Ex-ante	38%	62%	No	Aug-15	Sep-15	Sep-15	Dec-16	Pending	
SUB-TOTAL NON-CONSULTING SERVICES			\$ 137,500.00		\$ -											
CONSULTING SERVICES																
2.1.1.5.2	BZ/SM2/CS/001	Quality Improvement Officer (1)	\$ 30,600.00		\$ -	SSS	Ex-ante	100%	0%	No	Jan-15	Feb-15	Feb-15	Jan-17	Pending	GN-2350-9, 3.10 (a) a natural continuation of previous work.
2.1.1.5.2	BZ/SM2/CS/002	Drivers (2)	\$ 28,224.00	\$ -	\$ -	SSS	Ex-ante	48%	52%	No	Jan-15	Feb-15	Feb-15	Jan-17	Pending	GN-2350-9, 3.10 (a) a natural continuation of previous work.
2.1.2.2.1	BZ/SM2/CS/003	Technical Assistance for training of CHWs and PHCWs on improved technical capacity	\$ 85,000.00			GOB's Selective Tendering Procedure	N/A	0%	100%	No	Mar-15	Apr-15	Apr-15	Mar-16	Pending	
2.2.2.1	BZ/SM2/CS/004	Technical Assistance to Develop Mass Media Behavior Change Campaign	\$ 15,000.00		\$ -	NICQ	Ex-ante	100%	0%	No	May-15	Jun-15	Jun-15	Oct-15	Pending	
3.1.2	BZ/SM2/CS/006	Technical Assistance for Management Development Training	\$ 39,800.00		\$ -	NICQ	Ex-ante	63%	37%	No	May-15	Jun-15	Jul-15	Apr-16	Pending	

Procurement Plan																
Project: Mesoamerican Health 2015 - Belize Program (Second Individual Operation)																
Period Comprised in this Procurement Plan: From January 2015 to January 2017																
Ref. No (WBS)	Ref. No.		Estimated Cost in (US\$)	Actual Cost (US\$)	Actual Cost in (US\$)	Procurement Method	Review (Ex ante/Ex-Post)	Source of		Prequalification (Yes/No)	Estimated Dates				Status (pending, in process awarded, cancelled)	Comments
								IDB	GOB		Publication of Specific Procurement Notice	Bids/RFP Submission Date	Contract Signing	Completion of contract		
4.1.3.5	BZ/SM2/CS/007	Technical Assistance for Capacity Development Training - PMU	\$ 15,882.00		\$ -	SSS	Ex-ante	37%	63%	No	Jan-15	Feb-15	Feb-15	Aug-15	Pending	
5.2	BZ/SM2/CS/008	Financial Audit	\$ 20,000.00	\$ -	\$ -	LCS	Ex-ante	100%	0%	No	Mar-16	Mar-16	Mar-16	Apr-16	Pending	
SUB-TOTAL - CONSULTING SERVICES			\$ 234,506.00	\$ -	\$ -											
OPERATING COST																
2.1.1.5.4	BZ/SM2/OC/001	Maintenance Cost - Vehicles	\$ 5,400.00		\$ -	N/A	N/A	0%	100%	No	N/A	N/A	N/A	Jun-16	Pending	Does not require hiring process because the new vehicles would be under warranty supplier / manufacturer.
2.1.1.4.1	BZ/SM2/OC/002	QIF Supervision Visists	\$ 10,200.00		\$ -	N/A	N/A	0%	100%	No	N/A	N/A	N/A	Jan-16	Pending	
4.1.2	BZ/SM2/OC/003	Operational Cost - PMU	\$ 98,500.00		\$ -	N/A	N/A	0%	100%	No	N/A	N/A	N/A	Jul-16	Pending	
SUB-TOTAL - OPERATING COST			\$ 114,100.00		\$ -											
GRAND TOTAL			\$ 614,706.00	\$ -	\$ -											

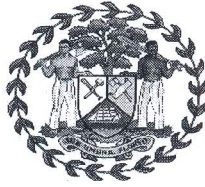
Goods and works: CB: Competitive bidding; PC: Price comparison; DC: Direct contracting.

Consulting firms: CQS: Selection Based on the Consultants' Qualifications; QCBS: Quality and cost-based selection; LCS: Least Cost Selection; FBS: Selection under a Fixed Budget; SSS: Single Source Selection; QBS: Quality Based selection

Individual consultants: IICQ: International Individual Consultant Selection Based on Qualifications; SSS: Single Source Selection.

Ex ante/ex post review: In general, depending on the institutional capacity and level of risk associated with the procurement, ex post review is the standard modality. Ex ante review can be specified for critical or complex process.

Technical review: The PTL will use this column to define those procurement he/she considers "critical" or "complex" that require ex ante review of the terms of reference, technical specifications, reports, outputs, or other items.



GOVERNMENT OF BELIZE
Ministry of Finance & Economic Development

*P.O. Box 42
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Belmopan City
Belize, Central America*

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Tel: (501) 822-2526
(501) 822-2527
Email: econdev@btl.net*

Our Ref.: IA/IDB/24/13(5)

23 September, 2013

Mr. Ian MacArthur
Team Leader
Mesoamerican Health 2015 – Belize Program
Inter American Development Bank
Marina Towers
1024 Newton Barracks
Belize City
BELIZE, C.A.

Dear Mr. MacArthur,

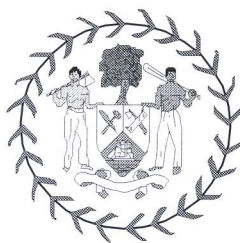
RE: GRT/HE-13134-BL and GRT/HE-13135/BL (BL-G1001)
MESOAMERICA HEALTH 2015 – BELIZE PROGRAM
Request for Initiation of the Second Individual Operation

The first operation for the Mesoamerican Health 2015 – Belize Project will conclude in January 2014. For continuity to the second operation, the Ministry of Finance and Economic Development hereby requests the initiation of the preparation of the second individual operation as per Section 3.6 and 3.7, Consideration and Financing of the 2nd Individual Operation, of the signed Framework Agreement for Non-Reimbursable Financing.

Sincerely,

A handwritten signature in purple ink, appearing to read 'YH' with a flourish.

YVONNE HYDE
CHIEF EXECUTIVE OFFICER
ECONOMIC DEVELOPMENT



**Ministry of Health
Project Management Unit
Ground Floor Garden City Hotel
Mountain View Blvd.
Belmopan City
BELIZE, C.A.
E-mail: pmu@health.gov.bz**

PROJECT MANAGEMENT UNIT

Phone: (501) 822-0992 Fax: (501) 822-0994

REF: 6425/PMU/102/13(261)

August 29, 2013

Mr. Ian MacArthur
Team Leader
Mesoamerica Health 2015 - Belize Program
Inter American Development Bank
Marina Towers
1024 Newton Barracks
Belize City
BELIZE, C.A.

**RE: GRT/HE-13134-BL and GRT/HE-13135/BL (BL-G1001)
MESOAMERICAN HEALTH 2015 – BELIZE PROGRAM
REQUEST FOR INITIATION OF THE SECOND INDIVIDUAL OPERATION**

The first operation for the Mesoamerica Health - Belize project will conclude in January 2014 and for continuity to the second operation, the Ministry hereby request for the initiation of the preparation of the second individual operation as per Section 3.6 and 3.7, Consideration and Financing of the 2nd Individual Operation, of the signed Framework Agreement for Non – Reimbursable Financing.

Sincerely,

**DR. PETER ALLEN
CHIEF EXECUTIVE OFFICER**