

**HONDURAS**

**IMPROVEMENT OF HEALTH CONDITIONS IN HONDURAS  
PERFORMANCE-DRIVEN LOAN**

**(HO-L1002)**

**LOAN PROPOSAL**

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## CONTENTS

### PROJECT SUMMARY

I.	FRAMEWORK OF REFERENCE.....	1
A.	Socioeconomic framework.....	1
B.	The health situation in Honduras.....	2
1.	Health targets in the Poverty Reduction Strategy.....	2
2.	Monitoring of outcomes .....	5
C.	The country's strategy in the health sector .....	8
D.	Bank strategy in the sector.....	9
1.	Bank country strategy with Honduras.....	9
2.	Previous experience and lessons learned .....	9
E.	Coordination with other donors.....	10
II.	THE PROGRAM .....	12
A.	Objectives and description.....	12
B.	Structure.....	12
1.	Selected indicators .....	12
2.	Establishing the baselines .....	15
3.	Defining the targets .....	15
C.	Impact indicators .....	15
D.	Eligible financing.....	15
E.	Cost and financing .....	17
III.	PROGRAM EXECUTION.....	19
A.	Borrower and executing agency .....	19
B.	Program execution and administration .....	19
C.	Procurement of goods and services.....	20
D.	Execution period and disbursement schedule.....	21
E.	Monitoring and evaluation.....	22
1.	Monitoring and evaluation of the SS .....	23
2.	Performance audit .....	24
3.	Monitoring and evaluation by the Bank.....	24
F.	External audit .....	25
IV.	FEASIBILITY AND RISKS .....	27
A.	Institutional feasibility .....	27
B.	Socioeconomic feasibility.....	27
C.	Financial feasibility.....	27
D.	Social and environmental impact .....	28
E.	Benefits and beneficiaries.....	29
F.	Risks .....	29

Proposed resolution

**Electronic Links and References**

Basic Socioeconomic Data	<a href="http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata">http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata</a>
Status of loans in execution and loans approved	<a href="http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487607">http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487607</a>
Tentative lending program	<a href="http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487608">http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487608</a>
Information available in the RE2/SO2 technical files	<a href="http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487609">http://opsws3.reg.iadb.org/idbdocswebservices/getDocument.aspx?DOCNUM=487609</a>

## ABBREVIATIONS

CESAMO	Health center with a physician and dentist
CESAR	Rural health center
DECFS	Departamento de Extensión de Coberturas y Financiamiento de Servicios [Coverage Expansion and Service Financing Department]
ENESF	Encuesta Nacional de Epidemiología y Salud Familiar [National Survey on Epidemiology and Family Health]
EPI	Expanded Program on Immunization
FSO	Fund for Special Operations
GDP	Gross domestic product
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries
ICAS	Institutional Capacity Assessment System
INE	Instituto Nacional de Estadísticas [National Statistics Institute]
MDG	Millennium Development Goal
NGO	Nongovernmental organization
PCU	Program Coordinating Unit
PDL	Performance-driven loan
Plan 2021	Strategic Plan for the Health Sector through 2021
PPMR	Project Performance Monitoring Report
PRIESS	Program for Institutional Reorganization and Extension of Basic Services in the Health Sector
PRS	Poverty Reduction Strategy
SAH	Sectoral Approach to Health
SIERP	Sistema de Información de la ERP [PRS Information System]
SS	Ministry of Health
UPEG	Unidad de Planeamiento y Evaluación de la Gestión [Management Planning and Evaluation Unit]

## PROJECT SUMMARY

### HONDURAS IMPROVEMENT OF HEALTH CONDITIONS IN HONDURAS PERFORMANCE-DRIVEN LOAN (HO-L1002)

Financial Terms and Conditions <sup>1</sup>				
Borrower:	Republic of Honduras		Amortization period:	40 years
Executing agency:	Ministry of Health (SS)		Grace period:	10years
			Disbursement period:	Minimum 36 months, maximum 48 months
<b>Source</b>	<b>Amount (millions)</b>	<b>%</b>	Interest rate:	1% during grace period and 2% thereafter
IDB (FSO)	US\$16.6	90	Inspection and supervision fee:	1%
Local	US\$1.8	10	Credit fee:	0.5%
Total	US\$18.4	100	Currency:	United States dollars
Project at a glance				
<b>Project objective:</b>				
As a performance-driven loan, this program seeks to bring about significant improvements in a series of indicators associated with efforts to expand health coverage and enhance the quality of maternal and child services, such as prenatal check-ups and institutional deliveries that, by directly tracking performance, will make a substantial medium- and long-term contribution to improving maternal and child mortality and morbidity indicators, with a view to making significant progress on the main health-related Millennium Development Goals.				
<b>Special contractual conditions:</b>				
As contractual conditions precedent to the first disbursement of the loan proceeds: (i) the independent auditing firm that will conduct the independent performance audits must be selected and hired (paragraph 3.22); and (ii) an action plan for continuously enhancing the institutional capacity of the SS in the areas of procurement, financial management, and internal control must be presented and include proposed monitoring indicators and the corresponding baselines for evaluating performance (paragraph 3.14).				
As a condition precedent to the release of the first tranche of the performance-driven loan, an evaluation of the progress made on the aforementioned action plan and performance indicators must be presented to the Bank's satisfaction (paragraph 3.14).				
<b>Exceptions to Bank policies:</b>				
See paragraph 3.11.				
The borrower has requested an exception to Bank policy (set forth in document GN-2278-2) to have, in this specific case, the initial disbursement be subtracted proportionately from all tranches of the performance-driven loan.				
<b>Project consistent with country strategy:</b> Yes [ X ] No [ ]				
<b>Project qualifies as:</b> SEQ [ X ] PTI [ X ] Sector [ X ] Geographic [ ] Headcount [ ]				
<b>Procurement:</b>				
See paragraphs 3.7 and 3.8.				
International competitive bidding will be used for goods or related services valued at US\$350,000 or more, and for works valued at us\$1 million or more. consulting contracts equivalent to US\$200,000 or more will also be subject to international competitive bidding.				
<b>Verified by CESI on:</b>				
Project concept paper: 6 August 2004				
Project report: 14 January 2005				

## I. FRAMEWORK OF REFERENCE

### A. Socioeconomic framework

- 1.1 Honduras is the third poorest country in Latin America and the Caribbean after Haiti and Nicaragua. In 2002, approximately 63.9% of the households were below the poverty line and almost 45% below the extreme poverty line. Poverty affects a greater proportion of the rural population than the urban population, and 61% of rural households are considered extremely poor.<sup>1</sup> During the 1990s, Honduras maintained sustained economic growth, which only reduced by 9% the percentage of households below the poverty line. During that decade, each percentage point of per capita growth of the gross domestic product (GDP) reduced poverty by 0.65 points, in comparison with the Latin American average of 0.94 points. This suggests that in Honduras growth only accounts for 40% of the change in poverty over time,<sup>2</sup> and that factors associated with public policies have a marked impact on outcomes.
- 1.2 An important policy consideration is the management of social spending. According to official government figures, in the aforementioned period, economic growth was accompanied by a moderate increase in social spending, amounting to 45% of total public expenditure in 2001. However, social spending has been constrained by the size and rate of GDP growth, the reduction in the volume of fiscal revenues, and especially the limitations imposed by the weight of the external debt-servicing burden. The last data reported for the Poverty Reduction Strategy (PRS) show that between 2002 and 2003, social spending rose from 7.5% to 8.1% of GDP.
- 1.3 The Government of Honduras formulated the PRS within the framework of the Heavily Indebted Poor Countries (HIPC) Debt Initiative. The policy measures, programs, and projects that underpin the PRS pursue the following strategic lines: (i) acceleration of equitable and sustainable economic growth; (ii) reduction of poverty in rural areas; (iii) reduction of urban poverty; (iv) investment in human capital; (v) strengthening of social protection for specific groups; and (vi) ensuring the strategy's sustainability.
- 1.4 The health sector contributes to several of the strategic lines of the PRS and, for that reason, some of the strategy's targets are linked to the efforts of the Ministry of Health (SS) to improve service delivery targeting in rural areas and to reduce the serious problems of access and inequity in the health sector.

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<sup>1</sup> Progress report and updated Poverty Reduction Strategy for Honduras, Draft final discussion paper, Government of Honduras, 2003 (in Spanish).

<sup>2</sup> HIPC decision point document, Honduras, World Bank, International Monetary Fund, 2000.

## **B. The health situation in Honduras**

### **1. Health targets in the Poverty Reduction Strategy**

- 1.5 One of the PRS's objectives and strategic lines of investment is to develop human capital. The health sector plays an important role in monitoring progress made in this strategic line, the target of which is to reduce maternal and child mortality by half by the year 2015. These PRS targets are directly related to the targets of the Millennium Development Goals (MDG), which have been endorsed by Honduras. The MDGs aim to reduce by two thirds the mortality rate among children under 5 (from 48 per 1,000 live births in 1990 to 16 in 2015), and to reduce the maternal mortality rate by three quarters (from 220 per 100,000 live births in 1990 to 55 in 2015).<sup>3</sup>
- 1.6 Honduras has made significant strides in recent years with these health indicators. The most recent data show that in 2001 maternal mortality was 108 per 100,000 live births, and infant mortality (children under 1) was 34 per 1,000 live births.<sup>4</sup> National averages, however, mask important disparities between socioeconomic strata, departments, and especially rural and urban areas. Inter-department comparisons reveal disparities in human development indexes, child mortality, malnutrition, and literacy. The figures for seven of the country's departments fall below the national average, and for that reason those departments are being prioritized for investments.
- 1.7 Of the seven departments, the Government of Honduras has targeted Lempira, Copán, La Paz, and Intibucá for shorter-term investments and actions. In 2004, the overall population of this area was 950,000 people, approximately two thirds of whom are women of childbearing age and children. Table I-1 compares several indicators in these departments with the national averages.

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<sup>3</sup> Data taken from the official report of the United Nations Development Programme (UNDP).

<sup>4</sup> National Survey on Epidemiology and Family Health (ENESF), 2001.

**Table I-1**  
**Comparison of the four targeted departments with national averages**

Department	Child mortality (2001) <sup>5</sup>	Malnutrition in < 5 <sup>6</sup> (2001)	Literacy <sup>7</sup> (2001)	HDI <sup>8</sup> (2002)
Copán	50	52.5	60.3	0.519
Intibucá	42	62.6	59.3	0.491
La Paz	42	56.8	67.8	0.548
Lempira	44	61.7	50.7	0.447
National total	34	34.2	71.4	0.638

Source: Ministry of Health, 2004

### **a. Maternal mortality**

- 1.8 Maternal mortality is highest among low-income rural women who have little schooling and who also have the highest birth rates. About 50% of maternal deaths occur during childbirth and in the immediate postnatal period (0 to 1 day), generally due to preventable and avoidable causes (hemorrhaging, sepsis, hypertension).
- 1.9 Basic obstetric care can prevent most of the deaths caused by hemorrhaging and sepsis. This high mortality from preventable causes is due, in part, to low institutional coverage of childbirth (61% in 2001).<sup>9</sup> This, in turn, is related to the dispersal of the population in rural areas, the difficulty of access to health services, and the poor quality of services. Between the 1987 and 2001 surveys, institutional deliveries of the last live birth increased from 40.5% to 61.7%, representing a systematic increase of 1.5 percentage points per year.
- 1.10 With regard to preventive and first- and second-level care, maternal mortality can be related to the performance of other indicators, such as prenatal and postnatal care. In Honduras, prenatal check-up coverage of the last live birth stands at approximately 85% and has not varied significantly in the last 14 years. This measurement considers at least one prenatal check-up; when the group of complete visits is measured, coverage figures decline. Postnatal care has shown a slow but systematic increase over the last 14 years, and between 1996 and 2001 it rose by almost four percentage points. The government has also placed considerable

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<sup>5</sup> National Census on Population and Housing, National Statistics Institute, 2001.

<sup>6</sup> National Height Census, Family Assistance Program (PRAF), 2001.

<sup>7</sup> Human Development Report, Honduras, Human development index, by municipio, 2002.

<sup>8</sup> *Ibid.*

<sup>9</sup> National Survey on Epidemiology and Family Health (ENESF), 2001.

emphasis on family planning campaigns as a mechanism to space pregnancies and thus reduce the associated risks of mortality and morbidity.

- 1.11 The indicators for institutional childbirth and prenatal and postnatal care in the four targeted departments have improved steadily, although some peaks and valleys have been noted. These may be attributed to problems in collecting information and transmitting it to the sites where it is consolidated. These difficulties have been overcome through recent staff-training and protocol-streamlining efforts; therefore there are reliable data for 2003.

#### **b. Child mortality**

- 1.12 As in the case of maternal mortality, child mortality is highest among the children of poor rural women who have little schooling (child mortality in rural areas is 38 per 1,000 live births while in urban areas it is 29 per 1,000 live births); a sharp fall in the rate was observed last decade.
- 1.13 The leading cause of death among children continues to be pneumonia, followed by diarrhea, sepsis, premature birth, neonatal asphyxiation, and congenital malformation. Some 52% of the deaths occur in first month of life. Of these, 36% occur within the first seven days, and 16% between the eighth and 28<sup>th</sup> days. The preponderance of the first month of life in the figures is directly related to the circumstances of childbirth and to the prenatal care received by the mother during pregnancy. Therefore, changes in mortality rates are linked to the progress made or the setbacks that occurred in the coverage of prenatal care during pregnancy and institutional care during childbirth. The remaining 48% of the deaths occur between the 29<sup>th</sup> day and the first year of life, mainly due to diarrhea and pneumonia.
- 1.14 Although diarrhea declined as a cause of death between 1996 and 2001, it is still the second leading cause of death among children under 5, and for this reason it is being tackled as a priority by the health system. After a decline in the prevalence of diarrhea between 1987 and 1996 (from 30.3% to 19.2%), the National Survey on Epidemiology and Family Health (ENESF-01) noted an upward trend (22.5%). The Government of Honduras will be conducting a household survey at the start-up of and midway through program execution in the four targeted departments, to obtain additional information on the link between service delivery outcome indicators and epidemiological data on morbidity provided by the Ministry of Health on the appropriateness, at that time, of the mix of inputs under the maternal and child care strategies.
- 1.15 As vaccination is also important for preventing mortality, vaccination coverage figures are of special relevance. Recent data show that 89.2% of children between the ages of 12 and 59 months have been fully vaccinated with the four biologicals, an increase of almost 10 percentage points over 1996. The Government of

Honduras uses data on the third dose of the Sabin polio vaccine to track progress in coverage.

## **2. Monitoring of outcomes**

### **a. The targets**

- 1.16 In 2003 the Government of Honduras evaluated the progress of the first year of implementation of the PRS.<sup>10</sup> The target for maternal mortality in 2002 was 138 deaths per 100,000 live births.<sup>11</sup> ENESF data show that in 2001 the rate was 108 per 100,000 live births, indicating considerable progress. According to the SS, the national average continues to mask the regional disparities referred to in paragraph 1.7 and illustrated in Table I-1. In the case of child mortality, a slight improvement was noted vis-à-vis the target for 2001 (34 deaths per 1,000 live births as compared to 32). This was probably due to the difficulty of making significant marginal improvements after the major gains of the early 1990s, showing that the process is not linear and underscoring the need to use intermediate annual indicators to detect smaller changes.
- 1.17 The information in the United Nations progress report on the MDGs is consistent with the above data and shows that, although progress has been made in terms of maternal mortality, the figure of 108 deaths per 100,000 live births is one of the highest in the region. This situation demands greater efforts and better targeting to achieve sustained impact.

### **b. The instruments**

- 1.18 The Government of Honduras has designed and launched the PRS information system (SIERP), which collects and organizes the sectoral information generated by the ministries and other State institutions. Primary health information is collected in all the municipios through the country's Health Units,<sup>12</sup> which report to the departmental divisions (formerly regional authorities).<sup>13</sup> These, in turn, process information, calculate statistics, and report to the central level of the SS. This process is automated in some departments and manual in others, which sometimes delays the immediate generation of data. A review of the process in the four targeted departments revealed some difficulties that have already begun to be remedied and the system now has the procedures and tools to reliably define

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<sup>10</sup> Progress report on the implementation of the PRS, Government of Honduras, 2003. (in Spanish).

<sup>11</sup> As a projection from data collected in 1995.

<sup>12</sup> There are two kinds of health units: health centers with a physician and dentist (CESAMO) and rural health centers (CESAR).

<sup>13</sup> The country worked with nine health regions, which have been converted to departments, and which have complete authority in health matters.

baselines and calculate annual targets. According to Bank observations, to achieve a constant flow of timely, automated information of the highest quality, it will be necessary to conduct training actions, slightly adjust the forms used to consolidate information at the local and regional levels, and strengthen the information exchange system, all of which can be financed with this performance-driven loan (PDL). The Ministry is in the advanced stages of mounting the Integral Management Monitoring and Evaluation System (SIMEG), with financial and technical support from the donor community, to strengthen technical and human capacity in the regions and provide additional reliable input for monitoring indicators.

- 1.19 For the most part, the demographic information used to calculate the indicators is drawn from censuses and surveys designed and applied nationwide by the Instituto Nacional de Estadística [National Statistics Institute] (INE); this information is supplemented by primary sectoral information and consolidated by the SIERP. However, in the opinion of the SS, the information provided by the Expanded Program on Immunization (EPI) on the estimated population of children in the four departments is more reliable than the INE's projections from the 2001 census. Therefore, EPI estimates were used to plan coverage targets. The SS is notified of maternal deaths on an ongoing basis and investigates them immediately. Subsequently, the surveys provide the definitive data on maternal and child mortality every four and five years. The information on intermediate indicators collected by the SS can be available on a monthly basis. The SS is currently planning the next ENESF with a view to supporting harmonization efforts of the donors and providing data on maternal mortality and other epidemiological variables.

### **c. The institutional framework**

- 1.20 Public spending on health represents 4.5% of GDP and the private sector accounts for an additional 2.5%, essentially as out-of-pocket payment by citizens. Health services are provided primarily by the SS, which is responsible for public services through six levels of care. The country is divided into nine health regions, which are further subdivided into 41 health areas. Eighty-two percent of the population has access to health services: 60% through the SS, 12% through the Instituto Hondureño de Seguridad Social [Honduran Social Security Institute], and 10% through the private sector. This means that 18% of the population (nearly 1.2 million people) have no or very limited access to health services.
- 1.21 The SS's services are offered through a network of 1,167 facilities: 28 hospitals, 13 peripheral clinics attached to the teaching hospital and located in the capital, 824 rural health centers (CESARs), 289 health centers with a physician and dentist (CESAMOs), and 23 maternal and child clinics. For the administrative purposes of the SS, the country was formerly divided into nine regions: the metropolitan area plus eight regions encompassing from one to three departments. In 2004, however,

the SS changed the divisions according to territorial and geographical considerations and the criteria of concentration of populations. The purpose was to harmonize operations with the administrative units of the departments which, as deconcentrated units, serve in a leadership capacity and administer the services provided. The SS currently works with 20 departmental regions.

- 1.22 The SS has engaged in a variety of institutional reorganization processes, ranging from changes in its organizational structure to preliminary attempts to deliver greater competencies and larger amounts of resources to the regions and departments. Recently, the SS decided that the departments would play the lead role in decentralization and would gradually receive the necessary competencies. One result has been the redesign of financial management mechanisms, which included the first attempts to formulate budgets on a program-by-program basis. For 2005, the SS prepared an initial trial budget broken down by program that links expenditures to planned outcomes. Starting in 2006, this will make it possible to monitor expenditures more accurately and, consequently, allocate resources more efficiently.

#### **d. Capacity for execution**

- 1.23 Since 1999, Honduras has been implementing the program for institutional reorganization and extension of basic services in the health sector (PRIESS, loan 1005/SF-HO), which has helped reorganize critical financial management and planning processes within the SS, reform the hospital sector to upgrade management and productivity, and expand access to services by enabling the private sector to offer services.
- 1.24 As the responsible agency, the SS has a program coordinating unit (PCU) that administers and coordinates the program. Although the PCU operates outside the formal structure of the SS, it is attached and subordinate to the Office of the Minister of Health. As part of its initiative to harmonize the involvement of cooperating parties under its technical and administrative leadership, and in order to institutionalize the PRIESS-fostered reforms, the SS recently began to transfer technical responsibilities to sections in the formal structure. Within the SS, the Management Planning and Evaluation Unit (UPEG), with its Statistics Department, has been responsible for providing the information, monitoring PRS targets, and fostering acceptance of the culture of performance audits promoted, among other things, by the policy-based loan for the poverty reduction support program (loan 1532/SF-HO). The project performance monitoring report (PPMR) for loan 1005/SF-HO states that the program is being implemented satisfactorily and is likely to achieve the development objectives.
- 1.25 The PCU is responsible for monitoring and evaluating all aspects of program execution. This includes all bidding processes, preparation of disbursement requests, justification of expenditures, administration of program accounts, and

preparation of the corresponding reports, all in keeping with Bank policies and procedures. To this end, the PCU has received support from the United Nations Development Programme in the form of technical assistance, and support for the procurement process and the management of funds.

- 1.26 The independent auditors, Ernst & Young–Morales Group, audited the statements on cash received and disbursements made by the PRIESS for the years ending 31 December 2002 and 2003, as well as the corresponding investment statements to those dates. In their opinion, except for some adjustments, the financial statements present reasonably, in all material aspects, the flow of cash received and disbursed, and the investments made by the program for the years ending 31 December 2002 and 2003, in accordance with the cash method.

### **C. The country's strategy in the health sector**

- 1.27 The central element of the country's strategy in the health sector is the new "Strategic Plan for the Health Sector through 2021 (Plan 2021)" (in execution), which was formulated and presented by the SS in 2003. It includes a number of strategic initiatives to address problems and challenges in the health sector, including: (i) expanding coverage by strengthening primary care; (ii) working to attain universal insurance coverage; (iii) promoting further decentralization; and (iv) strengthening health sector institutions by fostering the principles of equity, solidarity, quality, efficiency, and social participation.
- 1.28 The Government of Honduras is promoting the Sectoral Approach to Health (SAH), with a view to organizing and harmonizing the international cooperation that provides technical and financial support for executing Plan 2021. The SS currently administers the implementation of over 20 different projects financed by various agencies, involving different objectives, expected results, procurement procedures, and monitoring and evaluation methodologies. Under the SAH, external financing will be channeled toward a common national program, the strategic underpinning of which is Plan 2021. A five-year plan detailing and prioritizing interventions, the financial resources needed, and the specific outcomes expected for the 2005-2009 period will frame the operational aspects of the plan and will be closely linked to the millennium goals and the targets of the PRS.
- 1.29 The five-year plan is being formulated under the leadership of the SS and is expected to be completed by late 2005. The members of the donor community that agree with the content of this plan will sign a memorandum of understanding pledging their strategic and financial commitment to the country within the framework of the SAH.
- 1.30 One of the strategic initiatives of Plan 2021 is to improve health coverage. This opened up the possibility of designing and discussing a new maternal and child policy, with a view to defining actions and formulating specific targets as part of

efforts to draw up the five-year health plan. The aim is to gradually expand coverage of the basic health services package and improve quality through better patient referrals from basic care levels to hospitals. Critical elements of the maternal and child policy defined by the SS include the expansion and strengthening of maternal and child clinics, a new role for midwives, local work with health committees and mayors' offices, promotion of community maternity homes, and the upgrading of emergency obstetric care services. Educational campaigns to prevent early pregnancies, targeting both women and men, are also included.

- 1.31 This PDL fits into the strategy with its focus on attaining the targets of the PRS that served as the conceptual base for defining the maternal and child policy; moreover, its eligible expenditures include the actions needed to develop the policy and five-year plan. By being aligned with this plan, the PDL will be involved from the outset in developing the SAH, providing financial support for initial priority investments, establishing a framework for monitoring outcomes and a structure for execution that can contribute to its success. The Government of Honduras wants the PDL's strategic and financial execution plan, which focuses on a specific area and is closely linked to PRS targets, to be the first step in efforts to develop the five-year plan.

#### **D. Bank strategy in the sector**

##### **1. Bank country strategy with Honduras**

- 1.32 The objective of the Bank's strategy is to support the Government of Honduras in stabilizing the economy, accelerating growth by improving competitiveness, enhancing the development of human capital, increasing environmental sustainability, and improving governance by strengthening national institutions. The objectives set out by the Bank in its country paper are consistent with the targets of the PRS and the MDG. By concentrating on monitoring and achieving targets associated with the PRS and the MDG, especially by focusing the eligibility of expenditures on expanding coverage to the most vulnerable populations in the poorest municipios, the operation described in this document promotes human capital accumulation among groups where inequitable access to health services is most pronounced. In addition, in Honduras the Bank is promoting the move from project-based financial support to support for sectoral programs that harmonize external aid and facilitate the achievement of outcomes.

##### **2. Previous experience and lessons learned**

- 1.33 The Bank has financed the program for institutional reorganization and extension of basic services in the health sector (PRIESS, loan 1005/SF-HO), which supported, among other things, expansion of coverage. With the hiring of nongovernmental organizations (NGOs), it made it possible to provide itinerant health services to

almost 200,000 people who, until then, had no access to basic health care. Program execution provided several important lessons for the country and for the Bank: (i) the country developed and refined a model for selecting proposals for hiring NGOs, which is upgraded on an ongoing basis and includes criteria for measuring quality; (ii) the hiring of NGOs should be done with a long-term view and contract renewals should be based on contractors' performance; delivery of their services should be combined with the investments in order to strengthen public services; (iii) the establishment of baselines by the NGOs is of key importance for the performance audit and for strengthening ties between providers and beneficiaries; it is also a way to emphasize outcomes over resources spent; and (iv) to ensure the initiative's sustainability, it is of vital importance that participating NGOs be subject to performance audits. These lessons were of crucial importance for the formulation of this PDL because they made it possible to reach agreement with the government on baselines for a series of indicators and the need to focus efforts on achieving the health targets, which means demanding results from both public and private service providers.

- 1.34 The Bank has also provided support to Honduras through the policy-based loan for the poverty reduction support program (loan 1532/SF-HO), the first tranche of which was recently released. This PDL uses some of the indicators selected for the policy-based loan, supplementing them with others developed for the maternal and child policy. The selected targets of the two programs are consistent. While the targets set out for loan 1532/SF-HO are of national scope, this PDL concentrates on four priority departments, offering a strategic and financial vehicle for achieving the national targets and ultimately fulfilling the MDGs.
- 1.35 Also in Honduras, the Bank is financing the comprehensive social safety net program which uses financial incentives, including timely visits to health facilities, to promote behavioral changes in families. This approach drives demand and is supplemented by the actions to improve services financed by this PDL and that have the common targets of improving maternal and child health. The proposed PDL and the comprehensive social safety net program overlap in the departments of Intibucá, La Paz, and Lempira, and the SS will coordinate the actions so that they support common goals, especially with regard to increasing institutional childbirth.

#### **E. Coordination with other donors**

- 1.36 The Bank team has worked with representatives of bilateral cooperation (Japan, Sweden, the Netherlands, England, the United States) and multilateral cooperation agencies (World Bank, Pan American Health Organization, United Nations) in the SAH coordinating groups led by the Government of Honduras. They advocate following a road map that defines the strategic and operational stages needed to fully implement an SAH, and which will include the signing of a memorandum of understanding by the agencies that provide technical and financial support for implementing the five-year plan. The work to draw up the program's matrix of

outcomes has given rise to valuable discussions with the donor community and is the first tangible element of the SAH. Within the framework of this interagency cooperation, the team is preparing a technical-cooperation operation to be financed by the Swedish International Development Authority/Bank Partnership Agreement Fund, which will offer information on the progress made in service and morbidity indicators, so that the mix of inputs can be adjusted to help achieve the MDGs.

## **II. THE PROGRAM**

### **A. Objectives and description**

- 2.1 As a performance-driven loan, this program seeks to bring about significant improvements in a series of indicators associated with efforts to expand health coverage and enhance the quality of maternal and child services, such as prenatal check-ups and institutional deliveries that, by directly tracking performance, will make a substantial medium- and long-term contribution to improving maternal and child mortality and morbidity indicators, with a view to making significant progress on the main health-related Millennium Development Goals.
- 2.2 The program will focus on the population in four priority departments (Lempira, Intibucá, La Paz, and Copán). Approximately 70% of this population (part of the universe of 1.2 million Hondurans with limited access to health services and the highest morbidity and mortality rates) has no or limited access to health services. The four above-mentioned departments have been targeted because they lag behind national averages in most of the maternal and child morbidity and mortality indicators.
- 2.3 With regard to eligibility of expenditures and the monitoring of program targets, outcomes will be measured in a population of 950,000 people in the four prioritized departments who meet the criterion of living in one of the four departments and whose respective municipios have morbidity and mortality rates that are higher than the national averages. Moreover, a large proportion of the communities in these departments face serious obstacles in accessing health services because of the time it takes to travel from their homes to health care centers. Between 30% and 40% of the total population in the four targeted departments are from the Lenca population group. Whether additional departments are included in the SAH or other indicators are monitored will depend on the severity of morbidity and mortality rates, conditions of access to services, and funding possibilities that arise from the SAH agreements and the signing of the aforementioned memorandum of understanding.

### **B. Structure**

#### **1. Selected indicators**

- 2.4 Table II-1 shows the five indicators that will be used to measure program outcomes along with their medium- and long-term objectives.

**Table II – 1**  
**Summary of outcome indicators**

Outcome indicators	Medium- and long-term objective
<ul style="list-style-type: none"> <li>▪ Number of childbirths recorded in maternal and child clinics and hospitals in the SS network.</li> </ul>	<ul style="list-style-type: none"> <li>▪ To help reduce maternal and child mortality among the most vulnerable population of the country, and to reduce disparities between these indicators and national averages by increasing prenatal check-up coverage and institutional deliveries among this population, in accordance with the Ministry’s technical quality standards.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Total number of prenatal check-ups.</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Number of women served in the first 42 days after childbirth.</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Number of women of childbearing age that use some form of family planning.</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Number of children under 1 vaccinated with the Sabin series (third complete dose before the first year of life).</li> </ul>	

- 2.5 These indicators will make it possible to track the progress attained and measure the outcome of efforts to reduce the main burden of maternal and child morbidity and mortality from the avoidable causes described at the beginning of this document. The indicators will track coverage of preventive and promotional activities such as prenatal care, together with corrective measures, that make it possible to assess the system’s referral capabilities, such as the coverage of institutional childbirths in accordance with the Ministry’s technical quality standards. These indicators were selected with the technical criterion of addressing the entire pregnancy-childbirth-postnatal cycle, where the main causes of maternal and child mortality are avoidable and subject to greater control through the health system.
- 2.6 For example, increased family planning coverage helps reduce the number of unwanted pregnancies and increase the spacing between births, thereby reducing the risks to mothers and infants. Increased coverage of prenatal check-ups, in turn, ensures timely intervention by health services to detect obstetric risk early and prevent complications during pregnancy and childbirth, while allowing for timely referrals to the appropriate level of care, to prevent injury or death in mothers and newborns. Expanded coverage of institutional childbirth would ensure that deliveries take place in health facilities under the care of trained staff, with the guarantees that provides. The foregoing are important factors in significantly reducing maternal and child mortality and morbidity in Honduras, particularly among the most vulnerable segments of the population, where a high percentage of mothers do not have any prenatal check-ups and give birth outside of health facilities, without the minimum conditions of safety and hygiene.
- 2.7 The following criteria were used to select the indicators: (i) technical consistence with efforts to reduce maternal and child morbidity and mortality; (ii) can be calculated with the information collected by the health units, consolidated by the statistics department of the SS’s Management Planning and Evaluation Unit

(UPEG), and which are also considered consistent and replicable; and (iii) should be calculated at least once a year.

- 2.8 Table II-2 is the matrix of program outcomes, which shows the baselines and targets agreed to that will trigger program disbursements. Targets were selected taking into account criteria considered to be realistic by the SS, a certain initial phased approach leading up to full operation of the SAH, and the amount of time required for initial investments to produce the outcomes. The technical files for this operation contain the manual of indicators, which defines each selected indicator and its sources of information and describes how the information is recorded, consolidated, and aggregated at the different management levels.

**Table II-2**  
**Matrix of program outcomes**

Indicator	Unit of measure	Baseline	Targets by tranche		
			I	II	III
Coverage of institutional childbirth	Number of deliveries recorded in maternal and child clinics and hospitals of the SS network, attended according to the Ministry's technical quality standards.	10,500	11,300	12,100	13,100
Prenatal check-ups	Number of prenatal check-ups received by pregnant women, according to the Ministry's technical quality standards.	142,900	148,200	151,800	156,500
Postpartum check-ups	Number of women served in the first 42 days following childbirth, according to the Ministry's technical quality standards.	19,000	19,900	20,800	21,900
Family planning	Number of women of childbearing age who use some form of family planning, according to the Ministry's technical quality standards.	16,600	21,400	26,300	32,600
Third dose of Sabin vaccine in children under 1	Number of children under 1 completing the Sabin vaccination series, according to the Ministry's technical quality standards.	27,600	28,000	28,400	28,800

## **2. Establishing the baselines**

- 2.9 Baselines were defined using the SS's information records on the four targeted departments for the 2000-2003 period. The following information from that period was examined: the trend of the aggregate of the number of institutional childbirths, the number of pregnant women receiving check-ups, the number of women served within the 42 days following childbirth, the number of women of childbearing age who use some family planning method, and the number of children who received the third dose of the Sabin vaccination series. Because the information for 2003 was obtained from the municipios, it showed the best level of disaggregation, which suggests more reliability and consistency. For these reasons, the values for 2003 were chosen as the baseline for all indicators. The consolidated value of the baseline for each indicator was obtained from the sum of estimated values in the four targeted departments.

## **3. Defining the targets**

- 2.10 Targets were keyed to the expected impact of program interventions and the gradual expansion of coverage in rural areas with limited access to services. An analysis was made of the expected growth of each indicator, taking into account the trend of the 2000-2003 period, inertial growth, and the program's marginal impact. Targets are expressed in terms of the number of persons served in the target population during periods of 12 consecutive months. In addition to the number of people served, the manual of indicators in the program's technical files shows an estimate of the target population for each type of indicator and the source of the estimate. Target achievement will be confirmed by an independent performance audit, as described in the section on the execution of this PDL.

### **C. Impact indicators**

- 2.11 Maternal and infant mortality have been selected as the impact indicators to be assessed in the ex post evaluation.

### **D. Eligible financing**

- 2.12 To achieve the targets associated with the aforementioned indicators, the following expenditures will be considered eligible under the program:
- 2.13 **Purchase of institutional and noninstitutional services.** One group of eligible expenditures will cover efforts to expand coverage to vulnerable populations in the four selected departments. This will include the cost of hiring individuals or private entities (NGOs or others) to deliver the basic health services package, or services provided in support of Honduras' maternal and child strategy.
- 2.14 **Training, consulting services, and technical assistance to strengthen capabilities at the central level and in the health units.** Another group of eligible

- expenditures will finance technical assistance, equipment, and training to upgrade the technical and administrative capabilities of the health units that supplement the expanded coverage provided by private entities and facilitate achievement of the targets in the matrix of outcomes. This line of expenditures will also cover technical assistance actions and consulting services to develop and apply health care protocols and suitable referral and counter-referral mechanisms between the first and second levels of care, as well as the training needed at the central and decentralized levels for achieving the expected outcomes.
- 2.15 Eligible expenditures will also include the technical assistance, equipment, consulting services, and training required at the central and decentralized levels for mounting and operating the information systems and the computer equipment needed to ensure a permanent flow of information; consolidating and analyzing the information to determine the progress made in achieving the outcomes, both intermediate and final; and conducting the final impact assessment.
- 2.16 **Infrastructure, equipment, clinical and administrative inputs, and maintenance.** Investments in infrastructure, equipment, and maintenance for the health units (including maternal and child clinics, hospitals, and community maternity homes) will be eligible when they support basic services related to the strategy and policies to reduce maternal and child mortality in Honduras. Equipment needed to strengthen obstetric care and to create a technical environment that facilitates institutional childbirth in accordance with Ministry technical quality standards will be eligible; training and support activities for midwives in their new role in the aforementioned strategy<sup>14</sup> will also be covered. In addition, technical assistance, equipment, dissemination, communication, education, or start-up funding to enable community organizations to transport critical care patients from local providers to regional facilities; local assistance for running the health committees; and the partnerships with the mayors' offices will also be considered eligible expenditures. For purposes of eligibility, expenditures on infrastructure for all investments in public works and purchases of equipment will require verification of compliance with current regulations on environmental licenses for hospital waste management.
- 2.17 Expenditures associated with program administration will also be eligible, including the fees of technical and support personnel, the cost of assistance and consulting services for program monitoring and evaluation activities, computer equipment, supplies, technical assistance to strengthen internal and financial controls, and procurement activities, provided they do not exceed 10% of total financing. The program also includes as eligible expenditures the purchase of the modes of transportation (vehicles, ambulances, motor boats) needed to conduct

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<sup>14</sup> The individual, family, and community strategy.

monitoring and evaluation activities and to transport patients, provided the cost does not exceed 2% of the total loan.

- 2.18 Lastly, the cost of the independent performance audit and the external financial and operations audits conducted during execution, as well as the financial costs of the loan (interest, inspection and supervision), are considered eligible expenditures.

**E. Cost and financing**

- 2.19 Within the framework of the SAH, the Bank will contribute a total of US\$16.6 million in financing to the combined budget resources that the Government of Honduras will earmark for achieving the intermediate and final outcomes agreed to for the target population. The Government of Honduras will provide the remaining 10% in local counterpart funds, bringing the total program budget to US\$18.4 million. This amount has been keyed to the estimate of eligible expenditures needed to achieve the outcomes, as a proportion of the total funding the SS will earmark for these purposes from its own resources and from contributions provided by the donor community.

- 2.20 Data submitted by the SS in 2004 show that the government’s preliminary estimates for attaining the MDGs by 2015 will require sustained increases in the health budget until it represents 7.5% of GDP in 2015. The cumulative incremental expenses during this ten-year period will come from the government’s fiscal revenues and the larger part of external funds channeled to support the five-year plan under the SAH. The proceeds of this loan will be the first concrete contribution to the SAH, focused on achieving outcomes in the four targeted departments. The five-year plan will expand the range of indicators and target population.

**Table II-3  
Categories of eligible expenditures and means of verification**

<b>Category of eligible expenditures</b>	<b>Means of verification<sup>15</sup></b>
1. Purchases of institutional and noninstitutional services	Management agreements or contracts with service providers
2. Infrastructure, equipment, and inputs	Agreements or contracts, progress reports, clearance certificates of works, and evidence of receipt from the health unit that received the goods
3. Maintenance and/or support of medical and industrial infrastructure and equipment	Agreements or contracts, invoices, evidence of acceptance of works.

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<sup>15</sup> In addition to the contracts, it is necessary to keep evidence of approval of the works or service and proof of payment (invoices and receipts).

Category of eligible expenditures		Means of verification <sup>15</sup>	
4.	Training, consulting services, and technical assistance, primarily for the institutional strengthening of the SS	Agreements or contracts, invoices, consulting services and technical assistance reports, assessment reports, proceedings of events, and lists of participants	
5.	Program administration	Contracts and invoices	
6.	Modes of transportation and patient transfer	Invoices and proofs of purchase	
7.	Audits and evaluations	Contracts, invoices, and final reports	
8.	Financial costs (interest, inspection and supervision)	Bank reports	
Source of financing		Amount (in US\$ millions)	%
IDB		16.6	90
Local		1.8	10
Total		18.4	100

2.21 The financing arrangement for this program is a performance-driven investment loan justified by the three strategies that underpin the program: (i) support for the government-led SAH, under which the donor agencies are expected endorse an intervention strategy and some common outcomes in order to bolster the impact of external financing; (ii) financial impetus for attaining the health targets of the PRS and the MDGs, therefore focusing program resources on the monitoring of intermediate outcomes that lead to the achievement of the final targets; and (iii) support the interest of the Government of Honduras in focusing planning and budgeting on outcomes rather than inputs. On the basis of these considerations, the PDL is the most appropriate instrument for supporting implementation of these strategies.

### **III. PROGRAM EXECUTION**

#### **A. Borrower and executing agency**

- 3.1 The borrower will be the Republic of Honduras, and the program will be executed by the Ministry of Health (SS).

#### **B. Program execution and administration**

- 3.2 Within the SS, the highest strategic responsibility for the program will lie with the Minister of Health; the Coverage Expansion and Service Financing Department (DECFS) will have technical and operational responsibility. Under the SAH, the program fosters early institutionalization of responsibilities within the formal structure of the SS; it will therefore not be supported by ad hoc units that are not part of the formal structure of responsibilities.
- 3.3 The DECFS will fulfill two roles. First, it will provide technical coordination for efforts to program the physical and financial aspects of all the actions and investments needed to achieve the outcomes, specifically with regard to expanding basic health services coverage, creating the health services network, undertaking institution-strengthening actions to ensure suitable monitoring, supervision, and evaluation of the overall process, and reaching the targets agreed to for improving maternal and child health. Second, it will be responsible for program procurements and for financial and internal control to ensure the timely and full submission of documentation for the ex post evaluation of disbursements. Within the SAH, the DECFS will be responsible for harmonizing the financial resources provided by external sources.
- 3.4 To ensure optimal program execution, the DECFS will have the following functions: (i) guide, coordinate, and supervise all program activities with the SS's substantive central, regional, and support entities; (ii) design annual work plans for all the actions needed to achieve the outcomes, in coordination with the relevant sections of the SS; (iii) prepare regular technical monitoring reports; (iv) formulate terms of reference for specialized consulting services, technical assistance, and training eligible as program expenditures, in coordination with the relevant sections of the SS; (v) oversee fulfillment of the annual work plans required for achieving planned targets; (vi) coordinate and foster the strengthening of the SS's information systems for monitoring and evaluating outcomes as well as financial and operational performance; (vii) prepare all documentation related to fulfillment of contractual conditions; (viii) hire and oversee firms and individuals that supply goods and services eligible as program expenditures, in coordination with the relevant SS line units; (ix) ensure that the financial and internal control environment is consistent with Bank policies and procedures so as to safeguard documentation for ex post evaluations of eligible expenditures and disbursements; and (x) report

- periodically on progress made to achieve the agreed outcome targets. A process to officially approve the administrative and financial procedure manuals, the staffing plan, and organizational and operational manuals that fully incorporate the PRIESS manuals with their best practices, has formed part of the efforts to create the DECFS. The new manuals will be officially authorized by late February 2005.
- 3.5 The role of the SS's Administrative and Financial Division will be to serve as a liaison between the DECFS and the Ministry of Finance for purposes of information exchange and to secure support for administering the financial control systems. This will enable the DECFS to properly maintain accounting records, handle disbursements in a timely fashion, prepare financial reports, and conduct related activities according to Bank procedures so that the use of program resources can be ascertained at all times.
- 3.6 The experience gained and the administrative and financial lessons learned by the PRIESS Coordinating Unit during its four years of execution will be tapped by the DECFS, especially with regard to the application of Bank procedures for program procurements.

**C. Procurement of goods and services**

- 3.7 For this PDL, and at the request of the Government of Honduras, the procurement of goods, works, and related services will be subject to the Bank's bidding procedures. For goods and related services valued at the equivalent of US\$350,000 or more, and for works valued at the equivalent of US\$1 million or more, international competitive bidding will be used, as provided for under Bank bidding procedures. Procurements of goods, works, and related services below those thresholds may be governed by national legislation, provided those laws are compatible with Bank principles. Except for the procurement of goods, works, and related services that require international competitive bidding, and which will be supervised ex ante by the Bank (before contracts are signed), the Bank will supervise public tendering or other forms of procurement, if any, on an ex post basis (after the procurement contracts have been signed).
- 3.8 Similarly, the contracting of consulting firms, specialized institutions, or individual experts will be subject to Bank policies and procedures for the procurement of consulting services, as set out in document GN-2220-10 of February 2004. Consulting contracts equivalent to US\$200,000 or more will be subject to international competitive bidding, as provided for under the aforementioned Bank procedures. Consulting services for amounts below that threshold will also be governed by Bank procedures, except that in such cases an open prequalification process is not required to establish a short list of providers of such services. Except for consulting contracts requiring international competitive bidding, which the Bank will supervise ex ante (before contracts are signed), the Bank will supervise contracts on an ex post basis (after the consulting contracts are signed).

**D. Execution period and disbursement schedule**

3.9 The program’s execution period is estimated at three years, and its disbursement period will be a maximum of four years. According to the tentative net disbursement plan below, there will be one initial disbursement and three subsequent tranches dependent, except the first, on the attainment of outcomes.

**Table III-I  
Tentative net disbursement plan**

Source	Initial disbursement	Performance-driven disbursement I	Performance-driven disbursement II	Performance-driven disbursement III	Total (millions)
IDB (FSO)	3.3	3.3	6.6	3.4	<b>16.6</b>
Percentage	20%	20%	40%	20%	<b>100%</b>

3.10 The first tranche of 20% for the initial disbursement will become effective when the loan contract enters into force and the conditions precedent to the first disbursement have been met. This disbursement will provide an initial financial impetus for signature of the contracts with NGOs for expanding coverage, other actions to strengthen public services, and the strengthening of the performance audit mechanism, as well as interventions in the regions, departments, and health care facilities. It will also cover start-up costs to strengthen obstetric care in the health care facilities involved in coverage expansion. The other tranches will reimburse eligible expenditures and will become effective when the annual outcome targets have been met, which will be verified during the first quarter of the subsequent calendar year.

3.11 In accordance with document GN-2278-2, which approved a pilot program for performance-driven loans, this initial disbursement should be subtracted from the next disbursement. In this connection, the borrower has requested an exception to the policy to have, in this specific case, where Bank procurement procedures will apply, the initial disbursement be subtracted proportionately from all the performance-driven tranches. The rationale is that a major investment effort is required at the outset to be able to achieve the final outcomes and the country has a low margin of incremental budget resources for stabilizing the initial flow of financing. If the initial disbursement has to be subtracted from the subsequent tranche, this will seriously compromise the SS’s capacity to invest further in achieving outcomes. This is because there will be low net disbursement of resources in the first performance-driven tranche because reimbursement for eligible expenditures covered by resources from the initial disbursement will, for the most part, be justified. On the other hand, the option of subtracting the initial

- disbursement proportionately from the subsequent performance-driven tranches, (US\$1.1 million per tranche) will make it possible to stabilize the flow of funds at up to a net US\$5 million of disbursements for the first tranche, US\$4.2 million for the second, and US\$4.1 million for the third.
- 3.12 The disbursements for eligible expenditures will become effective when the agreed outcome targets have been met and a favorable performance audit report has been received. On the whole, the financing tranches are expected to be released at the beginning of the given calendar years, when the statistics on the fulfillment of the agreed targets of the intermediate and final indicators are available.
- 3.13 For all the performance-driven tranches, supporting information for the respective disbursements will be reviewed on an ex post basis. As indicated in this proposal's background information and as a result of implementation of the Institutional Capacity Assessment System (ICAS), through their experience with executing loan 1005/SF-HO, the SS and especially the PCU of the PRIESS have sound financial management, accounting, and internal control systems that make this a suitable approach for the review of supporting documentation.
- 3.14 In the framework of efforts to strengthen public management being supported by the international community, the country has pledged to continue to enhance the institutional capacity of the SS in the areas of procurement, financial management, and internal control. To that end, as a condition precedent to the first disbursement, the SS will present an action plan for continuously enhancing these three specific areas of management during project execution; that plan will include proposed monitoring indicators and baselines for evaluating performance. As a condition precedent to the release of the first tranche of the performance-driven loan, the borrower must present, to the Bank's satisfaction, an evaluation, using the new ICAS, of the progress made on the aforementioned action plan and performance indicators.

#### **E. Monitoring and evaluation**

- 3.15 A robust system of monitoring and evaluation will be set up to measure program outcomes and to continuously assess progress and delays in order to be able to design and implement corrective measures or reorient actions. It will combine the SS's internal capabilities and the participation of independent auditors in the review of outcomes. Throughout program execution, the correlation between morbidity indicators and the service delivery outcome indicators mentioned in the matrix of outcomes will be established through the surveys mentioned in paragraph 1.14. Data will be obtained on maternal morbidity (hemorrhages, infections) and child morbidity (respiratory and digestive infections, dehydration). In the ex post evaluation, the morbidity outcomes will be linked to indicators of the impact of mortality. As was mentioned earlier, the basic objective of the surveys is to compile data on the actual availability of services in the neediest populations, thereby

enabling the SS to adjust the mix of inputs, so as to increase the likelihood of improving the intermediate indicators for these populations. The survey findings do not need to be linked to the targets in the program matrix of outcomes, since they do not provide annual information in line with the disbursement mechanics for this PDL.

### **1. Monitoring and evaluation of the SS**

- 3.16 The SS has provided for a series of mechanisms to monitor the program, both with regard to the implementation of planned actions and efforts to strengthen the administrative and financial processes, and to the compilation and analysis of information on the progress in achieving the outcomes. The technical files for this proposal detail several of these mechanisms and instruments, including: (i) the manual of indicators, and (ii) the terms of reference for the performance audit. With regard to the information systems, the program will use the existing institutional systems of the UPEG statistics department for sectoral output, and the Sistema Integrado de Administración Financiera [Integrated Financial Management System] (SIAFI) for budgetary, financial, and accounting records. To supplement this, specific information will be generated by the private providers involved in expanding basic health services coverage, which will be included in the institutional systems.
- 3.17 Monitoring and evaluation will take place at the central level, the department level, and the local level. The central level of the DECFS, working with the statistics department, will coordinate system administration and information flow from the service providers and the departments, producing the program's periodic monitoring reports on physical and financial execution and on the achievement of performance targets and indicators. It will also serve as counterpart to the technical teams conducting the performance audit. Two working teams will be created within the DECFS to coordinate the monitoring and evaluation system. One will focus on information systems and the other on monitoring and evaluation. The first will coordinate and work closely with the statistics department to analyze and interpret progress in the indicators, suggest changes in the mixture of inputs, and adjust the thrust of interventions. The second will supervise and oversee quality control, prepare quarterly execution reports, and coordinate actions with the SS's technical units and technical assistance for the executing units.
- 3.18 Each departmental division will coordinate program-related programming and operations in its realm and will coordinate the collection and consolidation of information both manually and by automated means, verifying and validating information records to ensure the quality of data. Within the departmental divisions, the statistics units will be responsible for administering the system's data and for reporting on program outcomes; they will also serve as liaison and departmental coordinator for everything having to do with program supervision and monitoring.

- 3.19 Information on the output of services will be generated and consolidated at the municipal level by the health units (CESAMOs, CESARs, and hospitals). Data generated at this level are compiled and forwarded to the departmental division for consolidation. The health units' statistics units will play the most important role in data processing and consolidation. The directors of the CESAMOs, CESARs, and hospitals will be responsible for quality review and analysis of the information reported.
- 3.20 As administrator of the program monitoring and evaluation system, the DECFS will organize, in coordination with the departmental divisions, inspection visits to verify the information reported and to review the information consolidation and flow processes. This review process will also serve to: (i) provide information and feedback to the local executing units on the program's progress and outcomes; (ii) generate a culture of performance measurement within the program and the health units; (iii) establish a structured and systematic process for program monitoring; and (iv) improve information quality control mechanisms.

## **2. Performance audit**

- 3.21 To ensure independent verification of the fulfillment of the outcomes associated with each disbursement (except the initial disbursement), achievement of targets will be reviewed by means of a performance audit that examines and assesses the quality of data generated by the outcomes monitoring systems, and the accuracy, reliability, relevance, validity, and credibility of the data. As part of the performance audit, the Bank, the SS, and the technical audit team will hold quarterly meetings to review program progress vis-à-vis the targets, identify any problems of data consistency and validity, and propose corrective measures to support program execution and achievement of the targets.
- 3.22 This independent performance audit will be conducted by an international entity (private consulting firm, university, or independent international organization), selected and hired by the Government of Honduras, to the Bank's satisfaction, and paid for with proceeds from the loan. The audit reports will be delivered directly to the Bank. The terms of reference for the performance audit can be found in the technical files for this operation and will form an integral part of the loan contract, which will establish that payments to that entity will be independent of the program disbursement structure. As a condition precedent to the first disbursement, the executing agency must select and hire the auditing firm that will conduct the independent performance audit, in accordance with the terms of reference previously approved by the Bank.

## **3. Monitoring and evaluation by the Bank**

- 3.23 The Bank will monitor the program with the active participation of Headquarters and the Country Office in Honduras, using inspection and supervision procedures

for satisfactory execution suited to the pilot nature of a PDL. The borrower will be expected to cooperate with the Bank by providing the necessary assistance and information. To this end, support by administrative missions will be considered as often as deemed necessary.

- 3.24 The executing agency will submit semiannual execution reports to the Bank, describing the progress made to achieve program outcomes, which will be assessed against the intermediate and final indicators in the matrix of program outcomes (Table II-2). These reports will also specify progress made in attaining the monitoring objectives and indicators for the institutional strengthening of the SS as agreed to before the loan contract entered into effect, through the instruments described in the paragraph above. Information will also be included on expenditures made under each eligible category for attaining these outcomes. In each case, the report will note measures taken by the executing agency to correct any delays in the original schedule for the outcomes, institution-strengthening indicators, and eligible expenditures.
- 3.25 On the basis of all this information, the Bank will periodically update the project performance monitoring report, which will be amended to emphasize monitoring of program outcomes so as to report in a timely fashion on the measures taken by the executing agency to address any significant shortfalls in progress to achieve the agreed targets for each tranche release. Moreover, emphasis will be placed on the periodic reports of the external auditors on financial and operational aspects of program execution.
- 3.26 In addition, the Bank will conduct annual reviews, a midterm evaluation, and a final evaluation, which will use as their principal inputs the outcomes achieved in the indicators agreed in the matrix of outcomes (Table II-2) for each stage, as reported semiannually by the executing agency and in the respective PPMR. The midterm evaluation will examine indicator trends as they relate to the baseline and the findings of the household survey and its morbidity indicators, with a view to linking them to advances in the program's outcome indicators. The final evaluation will examine the matrix of outcomes vis-à-vis the baseline. All the foregoing information will provide input for the project completion report. These mechanisms will also report continually on progress made in the SS's institutional strengthening process in the areas of procurement, financial management, and internal control.

#### **F. External audit**

- 3.27 The external audit of entities participating in program execution will be conducted by a firm of independent auditors acceptable to the Bank, in accordance with Bank policies and procedures (AF-200). This will be a financial and operational audit, designed to ensure that program funds have been used to cover eligible expenditures necessary for achieving the planned outcomes, and that Bank procedures have been followed. To this end, an ex post review will be made of all

supporting documentation for disbursements made under each tranche. The financing of the external audit will fall under the category of eligible program expenditures for technical assistance and consulting services.

- 3.28 For these purposes, the executing agency will submit annual financial statements on the program to the Bank, based on the terms of reference previously approved by the Bank (AF-400), and audited by the firm of external auditors. Within 60 days following each disbursement request, the executing agency will submit a comprehensive ex post review of the disbursement processes subject to this modality, as well as all the supporting documentation for the request, pursuant to the terms of reference previously approved by the Bank (AF-500).

## **IV. FEASIBILITY AND RISKS**

### **A. Institutional feasibility**

- 4.1 An important element for determining institutional capacity for monitoring outcomes was the preparation and execution of loan 1532/SF-HO, which included a conditionality for disbursement tied to the achievement of targets under the Poverty Reduction Strategy. Indicators and targets were selected after a careful review of the data collection and processing systems, after which some indicators were discarded and others maintained because of greater reliability. The project team considers that the necessary monitoring capacity exists for establishing reasonable baselines and defining attainable targets for the selected indicators in the selected departments. Institutional capacity will be further strengthened through the execution of the program.
- 4.2 With respect to institutional capacity for procurement and for performing internal and financial controls, the project team, with the support of independent consultants, applied the Institutional Capacity Assessment System (ICAS), which showed that the SS had the capacity to execute the program. The ICAS identified some risks that should be addressed by preparing an action plan whose preparation and fulfillment elements are linked to program disbursements. The government has decided that the new DECFS should use all the manuals and know-how accumulated to date by the PRIESS and that received a favorable assessment from the independent auditors.

### **B. Socioeconomic feasibility**

- 4.3 As detailed in the matrix of program outcomes (Table II-2), intermediate indicators associated with reducing the profile of maternal and child morbidity and mortality, including prenatal check-ups and institutional childbirth, are expected to improve in the short and medium terms. Over the medium and long terms, this progress will bring down the maternal and child morbidity and mortality rates provided they are accompanied by improvements in country's general demographic, economic, and social conditions, thereby producing substantial savings for the health system and a better basis for human capital formation through efforts of prevention, improved care, and results-based management. The country will then be in a better position to achieve the MDG targets in health, its population will be healthier and therefore more productive, and it will be able to generate significant savings through managing for results and a preventive and promotional approach to health care.

### **C. Financial feasibility**

- 4.4 Honduras is close to reaching the completion point under the HIPC Initiative. When it does, funds freed up from debt repayment obligations will support financing of

the five-year health plan. As part of that plan, this loan will support actions to improve five indicators in four priority departments with a total population of 950,000 people. The loan proceeds alone will suffice for achieving the expected results, regardless of whether multi- or bilateral agencies allocate additional funds for improving these or other indicators in these or broader population groups. In short, financial feasibility is ensured by: (i) the link between the financing and program targets; and (ii) the additional funding expected under the five-year plan, from sources outside the country and from the funds freed up when the country reaches the HIPC completion point.

- 4.5 Furthermore, the tie between disbursements and the achievement of outcomes can have a significant impact on the sustainability of these efforts beyond the program's time horizon, because if the planned outcomes result in a concrete improvement in maternal and child health, this will facilitate a continued flow of external and internal funding to the health sector.

#### **D. Social and environmental impact**

- 4.6 This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704). Furthermore, this operation automatically qualifies as a poverty-targeted investment (PTI) because it basically supports the expansion of primary health care coverage for the country's poor.
- 4.7 In terms of cultural adaptation, the principal method used by the SS to expand coverage has been to hire NGOs to deliver basic health service packages to populations with limited or no access to health care. For geographic reasons, a sizeable portion of the population with poor access to health care is indigenous. Accordingly, in order to overcome cultural barriers, the terms of reference for the contracts and the operational and supervisory manuals specify that it is necessary to secure the support of official and unofficial indigenous authorities for designing service delivery schedules, arranging transportation logistics, and making arrangements to take into account language and customs. As part of service delivery strategies, the NGOs will hire people from the targeted ethnic groups—a technique that has proven to bring people closer together. Service delivery will take into account the authority of traditional leaders and will accept traditional medicine and specific ceremonies and rituals as part of the comprehensive approach to health care. Despite initial resistance, the services delivered and the evidence of mutual respect have done much to build trust.
- 4.8 With regard to the gender perspective, the operation prioritizes the expansion of health service coverage to mothers and children from poor families, thereby promoting greater equality of access to such services for this target population.

- 4.9 From the environmental standpoint, the program will include current regulations on environmental licenses for handling hospital waste into all loan-financed public works and purchases of equipment. In addition, all service contracts submitted for eligibility will contain clauses requiring contractors to comply with environmental regulations in force.

**E. Benefits and beneficiaries**

- 4.10 The SAH aims to offer effective access to 1.2 million Hondurans who currently have little or no access to health services, a situation largely responsible for the high rates of maternal and child morbidity and mortality. The program will provide financial support for expanding coverage to a population of up to 950,000 people living in conditions of extreme vulnerability. It specifically targets women and children living in four departments that rank lowest in the indicators chosen for monitoring maternal and child morbidity and mortality, and that have extremely high rates of poverty. Reduction of mortality rates in this population group will contribute substantially to human capital accumulation, especially through the elimination of preventable causes of morbidity and mortality. Additional efforts by the donor community in support of this common strategy will further strengthen the positive impact on the Honduran population. Between 30% and 40% of the total population in the four selected departments belong to the Lenca population group.
- 4.11 The program aims to help reduce maternal and child mortality rates by improving a number of indicators in the matrix of outcomes and contributing to closing the gap between the national averages of these indicators and the targets of the PRS and the MDGs. By not focusing disbursements on these final outcomes, the program seeks to focus the attention of decision makers on a few intermediate outcome indicators, to focus government action where it can most effectively achieve the objectives of improving the population's health. The project team believes that a positive impact will be had on planning and budgeting practices as a result of the permanent focus on the achievement of outcomes in specific populations.

**F. Risks**

- 4.12 Several risks are involved in the execution of this program. For one, difficulties may arise in monitoring and achieving the outcomes. This has prompted the Government of Honduras to flag interventions for strengthening the information system as eligible expenses. The risks are ostensibly mitigated by the fact that those interventions are based on a system the team considers reliable and that follows the progress of the Integral Management Monitoring and Evaluation System (SIMEG).
- 4.13 In addition, the government may not fulfill some of the outcomes agreed upon, although this is addressed specifically by the underlying principle of the PDL. This risk is mitigated by strong Bank technical assistance in the preparation of the matrix of outcomes closely related to the PRS, and by the focus on realistic outcomes,

given the resources available and the country's current institutional capacities. Moreover, the intermediate indicators make it possible to identify possible nonfulfillment in early stages, which will help mitigate the aforementioned risk.