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HONDURAS

PROGRAM TO SUPPORT THE SOCIAL INCLUSION NETWORK WITH PRIORITY IN WESTERN HONDURAS

(HO-L1105)

LOAN PROPOSAL

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ABBREVIATIONS

AIN-C	Atención Integral a la Niñez en la Comunidad [Comprehensive Community-based Care for Children]
AWP	Annual work plan
BVM	Bono Vida Mejor
CENISS	Centro Nacional de Información del Sector Social [National Social Sector Information Center]
CESAMO	Centro de salud con médicos [health center with physicians]
CESAR	Centro de salud rural [rural health center]
CRF	Corporate Results Framework
DALY	Disability adjusted life years
CD	Direct Contracting
EAF	Equipo de atención familiar [family care team]
EAS	Equipo comunitario de salud [community health team]
ENDESA	Encuesta Nacional de Demografía y Salud [National Demographic and Health Survey]
EVM	Estrategia Vida Mejor [Strategy for a Better Life]
FACACH	Federación de Cooperativas de Ahorro y Créditos de Honduras [Federation of Savings and Loan Cooperatives of Honduras]
IMCI	Integrated Management of Childhood Illnesses
INE	Instituto Nacional de Estadística [National Statistics Institute]
MGD	Modelo de Gestión Descentralizado [Decentralized Management Model]
RUP	Registro Único de Participantes [Master Registry of Participants]
SACE	Sistema de Administración de Centros Educativos [Education Centers Administration System]
SEDIS	Secretaría de Desarrollo e Inclusión Social [Department of Development and Social Inclusion]
SEPA	Procurement Plan Execution System
SESAL	Department of Health
SIAFI	Sistema Integrado de Administración Financiera [Integrated Financial Administration System]
SSIS	Subsecretaría de Integración Social [Office of the Undersecretary for Social Integration]
SSS	Single-Source Selection
TSC	Tribunal Superior de Cuentas [Superior Audit Court]
UAFCE	Unidad Administradora de Fondos de Cooperación Externa [Administration Unit for External Cooperation Funds]
UGD	Unidad de Gestión Descentralizada [Decentralized Management Unit]

PROJECT SUMMARY

HONDURAS
PROGRAM TO SUPPORT THE SOCIAL INCLUSION NETWORK WITH PRIORITY IN WESTERN HONDURAS
(HO-L1105)

Financial Terms and Conditions					
Borrower: Republic of Honduras				**OC**	**FSO**
			Amortization period:	30 years	40 years
Executing agency: Department of Development and Social Inclusion (SEDIS) and Department of Health (SESAL)			**Disbursement period:**	4 years	4 years
			Grace period:	5.5 years	40 years
			Inspection and supervision fee:	[a]	N/A
Source	**Amount (US$)**	**%**	**Interest rate:**	SCF-Fixed [b]	0.25%
IDB (OC):	30 million	60	**Credit fee:**	[a]	N/A
IDB (FSO):	20 million	40	**Currency:**	U.S. dollars	U.S. dollars
Total	50 million	100			

Project at a Glance
Project objective/description: The program objective is to support human capital development through a comprehensive effort to alleviate poverty and improve access to health services in the poorest municipios of Honduras, giving priority to the municipios of western Honduras.
Special contractual conditions precedent to the first disbursement of the loan proceeds: (i) the Administrative and Financial Procedures Manual corresponding to Component 1 has been approved with the Bank's prior no objection; (ii) the Operations Manual corresponding to Component 2 has been approved with the Bank's prior no objection; and (iii) the interagency agreement has been signed between the Department of Development and Social Inclusion (SEDIS), the Office of the Secretary of Finance, the Office of the Secretary of Health, and the Office of the Secretary of Education, establishing the obligations of each institution and the terms for project execution (see paragraph 3.6). **Special contractual execution conditions:** (i) the contracts to be signed with the decentralized managed health care providers have the Bank's prior no objection; and (ii) prior to the signature of contract renewals for decentralized health care management, a technical review report has been delivered, to the Bank's satisfaction, verifying that the coverage targets agreed upon with the Bank have been met, and presenting a plan for any unmet targets with the proposed improvements (see paragraph 3.7).
Exceptions to Bank policies: None

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

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

[b] The borrower shall pay interest on the outstanding balances of the Ordinary Capital portion of the loan at a LIBOR based rate. Whenever the outstanding loan balance reaches 25% of the net approved loan amount, or US$3 million, whichever is greater, the interest rate will be set based on that balance.

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

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

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem to be addressed, and rationale

1.1 In early 2012, socioeconomic indicators in Honduras were stagnating or deteriorating. While GDP per capita had experienced average real growth of 2% per year between 2006 and 2012, poverty had risen from 60% to 67%, and extreme poverty from 40.4% to 46%.[1] The percentage of young people (ages 16 to 29) neither working nor studying also rose from 28% to 30% in the same span of time, and inequality was stalled with a Gini coefficient of 0.53,[2] the highest in Central America, which has one of the region's highest levels of inequality. The infant mortality rate fell only one point in that period from 25 to 24 per 1,000 live births[3] (higher than the regional rate of 18/1,000). Anemia in children from 6 to 59 months stood at 29.1%, and nearly 3 out of every 10 children under 5 years of age had some degree of malnutrition, with Honduras second only to Guatemala with the highest rate of malnutrition in Central America.[4] The maternal mortality rate was 73 per 100,000 live births.[5]

1.2 Faced with this, the Government of Honduras developed strategies with IDB support that would allow it to make substantial gains on the socioeconomic indicators of the poorest households, notably the Bono Vida Mejor (BVM) conditional cash transfer program,[6] the Decentralized Management Model (MGD) for health care services,[7] and the expansion of education coverage in the third cycle (grades 7, 8, and 9).[8]

1.3 **Bono Vida Mejor.** The Bono Vida Mejor (BVM) conditional cash transfer program is the principal poverty reduction program in Honduras and a key component of the Strategy for a Better Life (EVM), which prioritizes human development, reduction of inequality, and protection of the most vulnerable sectors, with emphasis on the poorest departments, located in the Dry Corridor, and on the indigenous population. The pillars of the EVM are a guaranteed minimum wage, access to basic education, primary health care, the promotion of healthy housing, and food security.

1.4 The BVM, created in 2010 as “Bono 10,000,” delivers an income transfer three times a year for households meeting coresponsibilities in education and health. Department of Health (SESAL) rules require BVM-participating children age 5 and under to visit a health center twice a year for checkups; all school-aged children must enroll and attend at least 80% of school days. The BVM program transfer was initially equivalent to 10,000 lempiras annually (US$442), paid when at least one child in the family met one of the program conditions. From 2015 onward, each child in the household must meet the respective condition, to receive the

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1 National Statistics Institute (INE) based on the Ongoing Household Survey.

2 CEDLAS 2016.

3 National Demographic and Health Survey (ENDESA). Honduras. 2011-2012.

4 United Nations Food and Culture Organization, 2011.

5 Department of Health (SESAL), 2010.

6 Loans 2372/BL-HO (HO-L1042), 2737/BL-HO (HO-L1071), 2937/BL-HO (HO-L1087), and 3371/BL-HO (HO-L1093).

7 Loans 2418/BL-HO (HO-L1059), 2743/BL-HO (HO-L1072), and 2943/BL-HO (HO-L1090).

8 BVM loans 3371/BL-HO (HO-L1093), and 2937/BL-HO (HO-L1087).

corresponding transfer. A household may receive transfers for up to two children in each condition, according to the following table:

Table II. BVM Transfer Amounts (US$)*

Period	Basic	Health		First and second cycle		Third cycle	
		1 child	2 children	1 child	2 children	1 child	2 children
Annually	180	60	72	60	72	108	156
Monthly	15	5	6	5	6	9	13

* For example, a household with three children in primary school and one unenrolled child of secondary school age would receive US$21 per month, or US$252 per year.

1.5 BVM coverage rose from 280,000 to 302,088 households in 2012-2015, and the government's 2017 coverage target is 400,000 extreme poor households. An experimental impact evaluation done in 2012-2013 showed that the BVM program had an effect among its beneficiaries during a 12-month period (2012-2013) of reducing poverty by 3 percentage points, increasing school attendance in the third cycle by 3 percentage points and in the second cycle by 6.2 percentage points, and increasing the rate of visits to health centers by 4.1 percentage points.[9] The evaluation also found greater impacts on the poorest households.

1.6 The BVM program introduced operational improvements with Bank support, such as the use of bank accounts combined with financial education for the payment of transfers and the development of an information system to measure education coresponsibilities online, making the program more efficient. The National Social Sector Information Center (CENISS) was also created as independent administrator of an information system that identifies the poorest households to bring them into social programs through a proxy means test. Flexible mechanisms were added to expand educational offerings in the third cycle (grades 7, 8, and 9) in rural areas. Lastly, a family health training initiative was designed for women heads of household and their partners with a gender perspective, as part of SESAL's health promotion activities, in coordination with BVM staff.[10] The program's target population was shifted to extreme poor households. The program has also benefited from close coordination, especially with the IDB and the World Bank, which supported loans 4774-HN, 5294-HN, and 5603-HN for a total amount of US$70.3 million.

1.7 **Decentralized Management Model.** The Decentralized Management Model (MGD)[11] involves contracting managed health care providers[12] on a capitation

[9] University of Chicago, 2014.

[10] These include: sexual and reproductive health care for themselves and their children, equitable relationships in decision-making and use of household resources, shared responsibilities for reproductive health and childcare, domestic violence prevention, and better gender relations.

[11] The Honduran health system is comprised of a first level of low-complexity ambulatory care services, and a second level of hospital services.

[12] Managed care providers may be municipal governments, leagues of municipal governments, community-based associations, or nongovernmental organizations. Contracts are generally signed with them on an annual basis.

basis (payment per person) to provide a set of primary care services.[13] A portion of the payment to the managed care providers is tied to the achievement of access, coverage, and quality indicators. In this model, the priority is on actions to improve maternal and child health in a given geographic area, normally a municipio or group of municipios comprising a service network. In addition to the BVM demand incentives for the use of mother and child health services, the model includes others such as payment of a transportation allowance for expectant mothers and midwife allowances as an incentive for institutional childbirth, to lower the financial barriers that keep women from seeking care. The managed care providers are responsible for hiring health workers, purchasing supplies and medications, and organizing, administering, and delivering services using hiring and procurement methods that are much faster and more nimble, supervised by SESAL. The managed care providers are also responsible for organizing the family care teams (EAFs), made up of a physician, a practical nurse, and an outreach worker to serve and provide healthcare for 300 families located in a specific geographic area. The EAFs' activities include home visits and prevention and promotion actions in the community.

1.8 The capitation cost of the MGD is set by SESAL based on independent costing studies (see Guide for estimating costs at the first level of care). To be commissioned, the managed care providers must submit organization and function, accounting, internal control, procurement, and other manuals to SESAL. SESAL furnishes the managed care providers with rules, guidelines, and protocols governing the delivery of health care services. Staff hired by the managed care providers must receive prior approval from SESAL. The quality of services provided is audited by the Decentralized Management Unit (UGD) and the departmental health regions on a quarterly basis. If shortcomings are found in the quality of services, SESAL provides technical support to the managed care provider. The contract/agreement may be rescinded if the quality of service delivery fails to improve.[14] Service quality is deemed to fall short if the managed care provider scores less than 60% during monitoring on the indicators established in the agreement.

1.9 The MGD for first-level health care services expanded to 82 municipios between 2011 and 2015, and currently encompasses a population of 1,337,884 inhabitants, representing 18% of the total population. As a result, several indicators have improved in the municipios where it was implemented. For example,[15] between 2011 and 2013, the use of family planning methods increased from 69.6% to 73.2%; and in 2015 the coverage of checkups in the first seven days after birth increased from 32.3% to 61%; institutional childbirth improved from 47.1% to

[13] These include: community growth and development checkups through Comprehensive Community-based Care for Children (AIN-C); the strategy for Integrated Management of Childhood Illnesses (IMCI); family planning counseling and delivery of contraceptive methods; prenatal, postnatal, and neonatal care; community-based approach to maternal/neonatal complications based on the three delay model; preparation of a birth plan and following it; and micronutrients provided to children from 6 to 24 months.

[14] At least three contracts have been rescinded on these grounds.

[15] Mesoamerica Health Initiative, 2013.

63.5%; and the percent coverage of five-in-one vaccination among one-year-olds increased from 90.3% to 96.1%.[16]

1.10 Based on its success, the government has been implementing MGD with Bank support[17] at the second level, i.e., in hospital care, since 2013. This involves entering into agreements with foundations to administer and provide hospital services. These foundations administer the SESAL staff working at the hospital and hire additional personnel to ensure 24/7 coverage for obstetric/neonatal complications, purchase the supplies and medicines necessary to provide the services, and organize and administer hospital services based on SESAL guidelines. The process of selecting these foundations involves the identification of organizations with long-standing experience supporting the hospital to be decentralized.[18] If there is no organization or foundation, SESAL organizes a foundation with different civil society actors[19] to administer the hospital, which has made the process very transparent. These foundations must have a strong organizational and financial structure, as well as community acceptance. The amount transferred to the foundations is equal to the budget historically allocated to the hospitals. Since the budget runs at a deficit, an additional amount is transferred to bridge the financial gap, so that 24/7 coverage for obstetric/neonatal complications can be ensured according to the requirements. To enter into the agreement with SESAL, each foundation must also guarantee core operational staff including experts in hospital finance, administration, and operation. At those hospitals not decentralized, the government, with support from the Mesoamerica Health Initiative, signed agreements with support committees responsible for managing resources not included in the hospital budget for coverage of obstetric/neonatal complications.

1.11 The first hospital to be decentralized was San Lorenzo Hospital in the southern part of the country, which made substantial gains in 2013-2015 such as: decreasing intrahospital maternal and neonatal mortality to 0; decreasing hospital stays from 3.5 to 2.5 days; increasing hospital discharges by 55% (from 6,700 to 10,400); increasing attended childbirths by 15%; and increasing medication supplies from 22% to 97%.[20] The management of four more hospitals was decentralized in 2015.

1.12 **Challenges persisting in the poorest parts of the country.** Despite substantial gains at the national level, there are disparities that reveal shortcomings in the multiple dimensions of poverty in the poorest parts of the country, reflecting the need to support a comprehensive approach in the neediest areas (see paragraphs 1.17 and 1.18). Western Honduras has higher poverty levels, lower educational achievement, and less access to quality healthcare services in comparison with the rest of the country. The extreme poverty rate in western Honduras is 58%, higher than the national level of 38%. The percentage of young

16 Data from UGD monitoring reports for 2015, in comparison with 2011.

17 Loan 2743/BL-HO (HO-L1072).

18 In Honduras there are foundations styled as “Foundation to Support Hospital X” that support improvements in infrastructure, facilities and equipment, and fundraising for the hospital.

19 These associations include: indigenous organizations, trade unions, chambers of commerce, Rotary groups, other foundations of business groups, and community associations.

20 Source of statistics: San Lorenzo Hospital and SESAL monitoring reports.

people ages 6 to 18 who fail to complete the third cycle of education (grades 7, 8, and 9) is 67% in the West, compared with 51% in the rest of the country. An 18- to 22-year-old there has two years less schooling on average than in the rest of the country.[21]

1.13 When the baseline was measured for the Mesoamerica Health Initiative in several western municipios, some degree of malnutrition was found in half of children under 5, and 1 out of 4 children between 6 and 59 months suffered from anemia; only 67% of pregnant women had at least four prenatal checkups,[22] and only 67.5% had assisted childbirths attended by a health care professional.[23] In addition, 11.6% of women in western rural areas have unmet need for family planning, i.e., they fail to use modern family planning methods even though they wish to space or limit births. This is generally due to the woman's limited involvement in decision-making about her sexual and reproductive health.[24] Furthermore, less than half of postnatal women and newborns get at least one checkup in the first seven days after birth.[25]

1.14 Hospitals in the West are fuller to overcapacity than in the rest of the country with occupancy percentages of up to 200%, principally in maternal/child services.[26] They are also less well supplied and equipped for emergency obstetric and neonatal care with 24/7 coverage for OB/GYNs and pediatricians at 67%, and just 10% for anesthesiology.[27] This impacts the quality of care provided: only 58% of postpartum care, 11% of care for obstetric complications, and 6.9% of care for neonatal complications was up to the standard, and the neonatal lethality rate in hospitals was 12%.[28]

1.15 **Factors contributing to the identified gaps.** The factors identified on the demand side include distance, lack of information, bargaining power, and women's lack of own resources[29] [30] (financial barriers) to bear the costs associated with obtaining services. This makes the high poverty levels in western Honduras a significant barrier to access to health services. The economic dependency of women is aggravated by their limited involvement in independent decision-making on their reproductive health and the expenses associated with it. For example, 18% of women with a primary school education and 17.8% of the first quintile said they had to get permission (from their husband) to go to a health center.[31] Another barrier is that the services, especially rural health centers with a practical nurse (CESARs) and health centers with physicians (CESAMOs), are unstaffed and

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21 IDB, 2014.

22 The national standard requires at least five checkups during pregnancy.

23 ENDESA 2011-2012 at the national level reports 83%.

24 ENDESA 2012.

25 The most recent ENDESA survey was taken in 2012, so there are no more recent data on mortality.

26 SESAL Statistical Yearbooks 2013, 2014, and 2015.

27 Mesoamerica Health Initiative, 2013.

28 Idem.

29 Alvarado, V. 2011.

30 In rural areas, 49.3% of women have no income of their own, versus 17.2% of men. Special tabulations of the Honduras household survey.

31 ENDESA 2012.

often closed in municipios that have not yet adopted decentralized management. The supply-side barriers reported by staff of first-level services such as practical nurses and physicians are lack of supplies and basic equipment to do the work, followed by the poor condition of the facilities.

1.16 **Operational challenges.** The government programs also face operational challenges. For example: (i) coverage of extreme poor households in the western part of the country is low (25%). In 2015 the BVM program purged its rolls of non-extreme poor households (moderate poor), households no longer eligible given their family structure, and households on which there was incomplete documentation, so the registry needs to be updated to include new eligible households; (ii) the BVM program still has weaknesses in measuring whether health conditions are met. Compliance is verified for 18% of eligible children, but for the rest noncompliance cannot be differentiated due to lack of information. One of the causes is that the program has not yet been internalized at SESAL as a factor supporting the elimination of financial barriers to access to health services;[32] (iii) compliance with education conditions declines from 86% in the first and second cycles to 31% in the third cycle; (iv) the territorial development approach that binds the two interventions and enables human development needs strengthening, especially in the country's poorest municipios; (v) the absence of an up-to-date poverty measure at the municipal level kept the municipios with the highest levels of poverty from being identified, to coordinate joint actions;[33] (vi) although the BVM program encourages the use of health services, the network's response is still poor, principally at the nondecentralized facilities where human resources and supplies are lacking,[34] and many healthcare facilities are closed, affecting quality and continuity of service delivery;[35] (vii) in addition, the responsiveness of hospital services is poor, chiefly in obstetric and neonatal services;[36] (viii) a certification system for managed care providers needs to be implemented, to improve their health service management capabilities, and weaknesses persist in the contracting process for managed care providers and in the process for monitoring and evaluation of management agreements at both the SESAL central level and the departmental regions.

1.17 **Territorial approach.** The Bank's country strategy with Honduras 2015-2018 (document GN-2796-1) identifies the western part of the country as a priority area for targeting with human development strategies and recognizes that social programs have greater impact when there are complementary interventions in the same geographic areas. To realize the integrated territorial development approach and make health care services more responsive with the goal of reducing the

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[32] Under the previous program Operating Regulations, there were also no incentives to measure the health condition for households with children attending school. These households automatically received the full transfer, regardless of whether or not they complied with the health condition. Additionally, the health center forms had to be modified in 2015 to add the fields necessary to measure health conditions for children over age 2.

[33] The most recent poverty map was based on the 2001 population census.

[34] There are just 5.7 physicians and 13.2 nurses and midwives per 10,000 population versus an average for low- to middle-income countries of 10.1 physicians and 16.8 nurses and midwives per 10,000 population.

[35] University of Colorado. 2012-2013.

[36] There is no neonatal intensive care unit in the western part of the country.

inequities among regions of the country, the project will combine the BVM and the MGD in the poorest municipios,[37] based on the most recent poverty map, where the government is not financing the MGD with local resources.[38] Employing the approach described and using preliminary information from the poverty map based on the 2013 census, 33 municipios were selected to be assigned priority under the project for an increase in BVM coverage and strengthening of the health care services offered via the MGD.[39] Those municipios contain some 73,123 households, and the extreme poverty rate is 76%, versus 38% nationwide. Only 17,200 of these 73,123 households received BVM transfer payments in the second payment of 2015.

1.18 **Theory of change.** Integrated supply and demand actions will be implemented in the priority municipios, to build the human capital of the population. On the demand side, extreme poor households will be brought into the BVM program. These households will receive BVM income transfers that, combined with the conditions under the new program Operating Regulations, will lower the financial barriers to access to health care services affecting mainly women and children, and create incentives to use them. The new program Operating Regulations will also create greater demand incentives for the third cycle of education (grades 7, 8, and 9). The approach taken by Component 2 of this operation includes identification and design of the actions necessary to achieve the expected outcomes and relies on the expansion and strengthening of the MGD. This will build capacity to provide timely information to women and their partners on reproductive health care and informed decision-making about modern family planning methods. Comprehensive Community-based Care for Children (AIN-C) will also be implemented through the decentralized managed care providers (including face-to-face counseling to improve nutritional care and habits in childhood), to improve the malnutrition levels among children under age 5. In conjunction, micronutrients will also be provided to children from 6 to 24 months through the decentralized managed care providers, to improve anemia among beneficiary children.

1.19 On the supply side, to improve coverage and geographic access to services, the delivery of health care services through the MGD will be guaranteed for at least two years, after which the government will have to absorb the continuity of expenditure. The increase in effective access to health care services will in turn increase early care of pregnant women and newborns and improve hospital referrals of complications and institutional childbirth. To handle the additional demand generated at the second level and increase coverage of the first level of healthcare, treatment capacity will be strengthened at the hospital level for individuals referred by the first level.[40]

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[37] Three municipios outside the western part of the country will be included since they are part of the Mesoamerica Health Initiative, which also targets its investments to high-poverty municipios.

[38] Preliminary data are now available from the poverty map based on the 2013 population census. The IDB is supporting development of the poverty map through technical cooperation operation HO-T1216 (ATN/OC-15156-HO). The list will be updated with the final version.

[39] Since the model is based on health care networks, individual municipios cannot be selected, but rather groups of municipios where new service networks can be established.

[40] Increased coverage and treatment capacity at the first level of health care should reduce hospital demand in the long term, but models of this type will increase demand for hospital services in the short term as more cases are detected and referred to the second level.

1.20 **Other measures to overcome the identified challenges.** To support coordination and integration between the BVM and the MGD, the payment mechanisms included in the agreements to be signed with the decentralized managed care providers will give greater weight to BVM-related activities.[41] Additionally, as a special execution condition for this operation, prior to the signature of contract renewals with decentralized managed care providers, the annual targets must be met based on indicators for supplies and medications, staffing, and organization of family care teams (EAFs) consistent with those of the individual agreements with the leagues of municipal governments and foundations, as well as targets tied to the strengthening of SESAL. These targets will be tracked via a concurrent technical review to be commissioned with project funds in the last quarter of the first year. Where such targets are not met, the country will prepare an improvement plan incorporating the changes to be reflected in the agreements being renewed with the managed care providers.

1.21 The three delay strategy[42] adopted by Honduras will be used to address the problem of maternal and infant mortality. The first delay will be addressed by strengthening and expanding the MGD for first-level health care services and organizing the EAFs in communities, so that they can: (i) verify the health care condition for pregnant and postnatal women and newborns in the community; (ii) improve the education provided to pregnant women, their partners, and their social circle on the danger signs of obstetric emergencies, to promote informed decision-making by the woman and the use of reproductive health services; (iii) increase early intake of pregnant women before 12 weeks, and increase coverage of prenatal care; and (iv) strengthen birth plan implementation and monitoring of care provided to BVM beneficiaries, as well as capacity-building for family care teams in community education and promotion of family health with a gender perspective. These efforts will be supplemented with the BVM payment as an incentive for pregnant women to seek care. The second delay will be addressed through payment of the transportation allowance to the expectant mother, which is being introduced through the decentralized managed care providers. In western Honduras, this transportation allowance will go to BVM beneficiary women on a priority basis. The third delay will be addressed through the decentralization of hospital management and agreements entered into with support committees implementing continuous improvement processes for obstetric and neonatal care services at the hospitals.

1.22 **Lessons learned.** The Bank has implemented studies in Honduras that led to improvements in its programs. The impact evaluation of the BVM program financed with operation 2737/BL-HO resulted in rule changes that each child must meet his or her respective condition, and the program should concentrate on extreme poverty. Payments were scaled up through bank branches under a pilot

[41] Seven indicators for coverage, risk identification, and monthly monitoring of BVM participating families were added to the agreements in 2015.

[42] The first delay occurs in the identification of signs of illness and/or danger during pregnancy or childbirth, when no decision is made to access services due to the influence of the family environment or ignorance of danger signs. The second delay occurs between the decision and actually reaching health care services due to financial and community organization limitations for transportation. The third delay occurs in the time to receive timely treatment and in service quality related to availability and the installed capacity of the services according to standards at the hospital level.

financed with funding from operation 2737/BL-HO. The project completion report for 2737/BL-HO highlights as principal lesson learned the need for closer collaboration between the BVM program and SESAL to meet health objectives. These criteria have been strengthened in the present operation. Operation 2418/BL-HO demonstrated the effectiveness of the childbirth allowance paid to the woman, the transportation allowance, and payment to the midwife to increase the number of institutional deliveries at mother and child clinics, and operation 2743/BL-HO demonstrated the applicability of MGS in hospitals. The project builds on operational improvements and complements the sector portfolio with loan 3371/BL-HO strengthening third cycle educational offerings in 20 of the 33 priority municipios through alternative modalities and supplementing loan 2743/BL-HO in hospital decentralization, as well as loan 2943/BL-HO in first level care.

1.23 **Pilot for graduation from extreme poverty.** Households whose children age out of the program no longer receive income support, but have no short-term strategy to improve their standard of living. A pilot project will be conducted to graduate BVM participants out of extreme poverty,[43] based on a mechanism that has been successful in five developing countries[44] producing returns on investment of up to 433% in India and increases in consumption of 37% in Bangladesh seven years after completion of the intervention. The pilot consists of a combination of seven components: transfer of a productive asset, technical training, support for consumption, promotion of savings, home visits by facilitator, and basic health education. The pilot will be implemented in 1,000 households, experience documented, and training handbooks prepared for the government to replicate and expand coverage of the model, if successful (Preliminary Design of the Poverty Graduation Pilot in Honduras).

1.24 **Strategic alignment.** The project is consistent with the Bank's country strategy with Honduras, approved in 2015-2018 (document GN-2796-1), which has as strategic objectives: (i) to protect minimum levels of consumption among the population in poverty; (ii) to promote human capital accumulation of minors in households in extreme poverty; and (iii) to improve the health indicators of children under 5. The project is included in the 2016 Operational Program Report (document GN-2849), consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008), and aligned with the development challenge of social inclusion and equality in promoting human capital accumulation of extreme poor households, and with the crosscutting area of gender equality and diversity in expanding access to reproductive health services. The program will also contribute to the Corporate Results Framework 2016-2019 (document GN-2727-4) by increasing the number of beneficiaries of health services and beneficiaries of targeted antipoverty programs. It is aligned with the objectives of the Strategy on Social Policy for Equity and Productivity (document GN-2588-4) in addressing structural poverty, and with the lines of action of the Health and Nutrition Sector

[43] The extreme poverty graduation pilot will not necessarily be implemented in the 33 priority municipios. Final identification of the municipios will take place once the firm has been contracted, based on criteria related to the pilot components (banking presence, number of families soon to leave the BVM program).

[44] https://www.povertyactionlab.org/about-j-pal/news/graduation-model-release. The model was tested in Ghana, India, Peru, Ethiopia, Honduras, and Pakistan with returns of 133% to 433%, except in Honduras where the executing agency chose as the productive asset to import hens not adapted to the local climate, which sickened and died.

Framework Document (document GN-2735-3) and the Social Protection and Poverty Sector Framework Document (document GN-2784-3) in promoting timely, ongoing access to efficient redistributive programs and high-quality health and nutrition services. Additionally, the program will contribute to the human capital lines of activity of the Plan of the Alliance for Prosperity in the Northern Triangle, since it includes one of the priority municipios under the plan.

B. Objectives, components, and cost

1.25 The program objective is to support human capital development through a comprehensive effort to alleviate poverty and improve access to health services in the poorest municipios of Honduras, giving priority to the municipios of western Honduras. The operation has two components.

1.26 **Component 1. Poverty alleviation and investment in human capital (US$20 million).** Financing will be provided for conditional cash transfers[45] to BVM beneficiaries in the poorest municipios of Honduras, giving priority to the municipios of western Honduras.[46] Also financed will be a pilot for graduation from extreme poverty and institutional strengthening of the Office of the Undersecretary for Social Integration (SSIS) and the Department of Development and Social Inclusion (SEDIS) through the purchase of computer hardware (laptops, servers, tablets, etc.) and furniture. Training initiatives will also continue in family health and gender,[47] financial inclusion, and data digitization; payments will continue to be processed through efficient mechanisms such as basic savings accounts that make the program more transparent and leave users better off; and health coresponsibilities will be measured better through the use of technology.[48]

1.27 **Component 2. Strengthening of health care service offerings (US$30 million).** This component will finance the expansion of coverage of first-level health care services through the Decentralized Management Model (MGD) in the poorest municipios of Honduras,[49] giving priority to the municipios of western Honduras. This will improve the sourcing of supplies and medications, as well as staffing, to make health care services more responsive. Expanding the MGD will increase the number of family care teams (EAFs) in the communities to implement programs that provide counseling and build knowledge for decision-making and the use of family planning methods, as well as the use of birth plans and catching danger signs during pregnancy, delivery, and the postpartum period and in AIN-C and IMCI newborns, among other actions. Financing will also be provided for labor and delivery care at mother and child clinics and for the purchase of micronutrients for children from 6 to 24 months, to reduce the prevalence of anemia. This component will continue to finance the contracting of managed care providers for the

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45 See paragraphs 1.4, 1.6, and 1.22 for the innovations implemented in the transfer mechanism as part of IDB project support.

46 Preliminary list of priority municipios.

47 The training inputs have already been prepared, and the human resources to implement the plan will be recruited with the managed care providers, so the support under this operation will be strategic, ensuring that the operational logistics are appropriate but not necessarily from the financial standpoint.

48 The social managers will use tablets to digitize health center information and keep a photographic record of their forms.

49 Preliminary list of priority municipios.

decentralization and operation of the five currently decentralized hospitals[50] and three more to be decentralized under this project, and for hospital management agreements and commitments at three additional hospitals.[51] Decentralized management agreements will be signed with the foundations and associations to finance the recruitment of human resources and purchase of supplies and medications necessary to ensure 24/7 coverage for obstetric/neonatal complications (see link, Financial sustainability, for the relevant analysis). Technical assistance will be financed for the strengthening and certification of decentralized managed care providers at the first and second levels, as well as for strengthening of the roles of health care services planning and contracting and monitoring and evaluation of agreements, and for capacity-building in health analysis and development of health care strategies and actions at SESAL, its UGD,[52] and the departmental regions. Conditions will be set to reflect improvement in the quality and responsiveness of decentralized health care facilities and institutional strengthening,[53] funding a concurrent technical evaluation under this component.

1.28 The two components will also finance the administration and audits of their respective components.

Table II-1 Program Cost

Component	Amount (US$000)	%
Component 1. Poverty alleviation and investment in human capital	**20,000.00**	**40**
Conditional cash transfers	17,000.00	34
Institutional strengthening of SSIS/SEDIS	731.00	1.46
Pilot for graduation from extreme poverty	500.00	1
Preparation of socioeconomic profile	1,000.00	2
Program administration and audits	769.00	1.54
Component 2: Strengthening of health care service offerings	**30,000.00**	**60**
First-level decentralized managed care providers and management agreements and/or commitments	19,690.00	40
Second-level decentralized managed care providers	7,500.00	15
Purchase of micronutrients	110.00	0.22
Strengthening of hospitals	500.00	1
Institutional strengthening of SESAL	1,150.00	2
Program management and audits	1,050.00	2
TOTAL	**US$50,000.00**	**100**

[50] Hospital Mario Catarino Rivas, Hospital Leonardo Martinez, San Pedro Sula; Hospital Enrique Aguilar Cerrato, Intibucá, Hospital San Lorenzo, Valle; and Hospital Juan Manuel Gálvez, Lempira.

[51] Of the following hospitals, three will be decentralized and three will have management agreements and commitments: Hospital de Choluteca, Hospital de Juticalpa, Hospital de Comayagua, Hospital de La Paz, Hospital de Occidente, and Hospital de Ocotepeque.

[52] The UGD is the SESAL unit responsible for administering decentralized management agreements for health care services, monitoring, evaluations, approval of payments and penalties, etc.

[53] Indicator Technical Compliance Manual for the financing of the second year of Component 2.

C. Key results indicators

1.29 At the impact level, the project seeks to build human capital through reductions in the poverty of beneficiaries and reductions in anemia and neonatal mortality at hospitals. At the outcome level, the project seeks to improve coverage of the BVM program, especially in the selected municipios, improve the net enrollment rate in the third cycle of basic education, guarantee transfer payments to participants in the priority municipios, and increase the percentage of beneficiaries who receive transfers because they fulfill coresponsibilities, the percent coverage of new prenatal care in the first 12 weeks of pregnancy, the percent coverage of postpartum care in the first seven days after childbirth, and the percentage of neonatal care in the first three days after birth.

1.30 **Economic evaluation.** A cost-benefit analysis was done, drawing on the findings of the 2012-2013 impact evaluation of the BVM program and microsimulations of the changes to the program instituted in 2015 (see Economic analysis). The main benefits are an increase in household consumption and an increase in future income associated with greater labor productivity resulting from more years of education and better nutrition, which depends partly on the efficient distribution of micronutrients at the first level of healthcare. In terms of health, the complementarity between the demand stimulus from the BVM program and quality health service offerings under the MGD will lead to gains in disability adjusted life years (DALY). The costs include investment in transfers and operating, administrative, and management costs of the BVM program, as well as capitation payments of under the MGD. Based on conservative scenarios, the cost-benefit ratio is in the range of 2 to 2.5. This value reflects a discount rate of 4%, which is consistent with the social project economic evaluation literature. The findings are robust to the sensitivity analysis.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This is a specific investment loan program in the amount of US$50 million, to be disbursed in four years, with 60% of the loan amount drawn from the Ordinary Capital, and 40% from the Fund for Special Operations (FSO).

B. Environmental and social safeguard risks

2.2 This operation has been classified as category “C” under Directive B.3,”Screening and classification,” of the Environment and Safeguards Compliance Policy (Operational Policy OP-703), since the program is unlikely to cause negative social and environmental impacts and risks.

C. Fiduciary risks

2.3 The program risk associated with financial management and procurement is medium, considering that the executing agencies have prior experience and proven capacity from the execution of Bank-financed operations in the sector. Additionally, both executing agencies employ the SIAFI/UEPEX system, which has been validated by the Bank, as well as all country controls deriving from its use. Both executing agencies also have staff specialized in conducting procurements under Bank procedures. Nevertheless, refresher courses will be given on Bank

procedures during the operation (including nonfiduciary staff), and the monitoring and supervision system implemented will extend to the planning of required procurements for the program using the Procurement Plan Execution System (SEPA).

D. Other project risks

2.4 The project carries a high risk that the coverage of both the BVM program and the MGD will shrink due to a lack of local resources. According to the study of Financial sustainability, currently 60% of the MGD and 24% of the BVM program is paid with local resources. Having met and exceeded the fiscal targets agreed upon with the IMF[54] and with extrabudgetary resources available from the Vida Mejor Trust Fund financed from the sales tax for annual funding on the order of US$220 million (1.1% of GDP), the Government of Honduras will have the ability, in the short term, to fully finance both programs with local resources. Nontheless, the government needs to make these programs a priority to be financed with budgetary or trust fund resources ahead of other commitments. To mitigate the risk, there must be monitoring to confirm that the country gradually assumes the costs of the two programs, and the financial sustainability study will be used to support the government in the financial planning of the necessary resources. The same study includes an analysis suggesting that investments in decentralized management result in a net increase in service coverage, so the outcome is a net increase in SESAL's total expenditure even though the MGD is more efficient.

2.5 To mitigate the risk related to the managerial know-how of the decentralized managed care providers, a certification system will be established with minimum criteria for management skills. To mitigate the risk related to the low budget ceiling, the portfolio review meetings will be used to monitor the timely approval of budgetary amendments. To mitigate the risks related to coordination problems between SESAL and SSIS, an execution agreement will be in place and reflected in the interagency agreement that forms part of the eligibility conditions. The agreement involves bimonthly coordination meetings between the execution units for each component with progress reports to the Technical Committee of the BVM program. Additionally, the BVM support unit currently operating at SESAL with personnel hired by the BVM program but not coordinating with the rest of SESAL will be transferred to its First Level Department. Workshops on the preparation of bidding documents will be organized for technical staff, to prevent vacated competitive bidding processes. To improve planning, execution plans will be better disseminated to technical staff so that they can stay on top of budget allocations and deadlines for the execution of procurement processes.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 Project Component 1 will be executed by the Office of the Undersecretary for Social Integration (SSIS) of the Department of Development and Social Inclusion (SEDIS), acting through its project coordination unit (PCU), and Component 2 will

[54] Second review under the standby arrangement, available at http://www.imf.org/external/pubs/cat/longres.aspx?sk=43545.0.

be executed by the Department of Health (SESAL), acting through the Decentralized Management Unit (UGD) and the Administration Unit for External Cooperation Funds (UAFCE).

3.2 The PCU at SSIS/SEDIS has five areas: (i) coordination, (ii) monitoring and supervision; (iii) administrative/financial; (iv) procurement; and (v) technical. SSIS will coordinate with the National Social Sector Information Center (CENISS), which is responsible for the Master Registry of Participants, for the addition of new households to the Bono Vida Mejor (BVM) program; and with the National Early Childhood Registry (RENPI); and with the Education Centers Administration System (SACE) for the monitoring of health and education coresponsibilities.

3.3 SESAL will operate through the UGD managing project HO-L1090 and the UAFCE currently providing resource administration, logistical support, procurement, and monitoring activities for IDB projects, both reporting to the Office of the Minister of SESAL.

3.4 The PCU and UAFCE will perform the following functions for their respective components: (i) general and financial administration for the project, ensuring efficient management of resources; (ii) project execution planning, including preparation and implementation of annual work plans (AWP); (iii) monitoring of project progress and preestablished targets met; (iv) planning, execution, and monitoring of procurement processes for goods, services, and works, ensuring compliance with the Bank's procurement and contracting policies; (v) preparation and processing of the relevant payments; (vi) maintaining an effective accounting/financial system for recording financial transactions made using project resources, preparation of financial statements, and processing of requests for advances; and (vii) preparation and delivery of six-monthly project status reports to the Bank; and others as described in the Administrative and Financial Procedures Manual and operations manuals to be approved as a eligibility condition for the operation. The UGD, moreover, will be responsible for technical coordination, technical monitoring, and preparation of terms of reference.

3.5 The BVM program has a coordination body, known as the Technical Committee, comprised of the SSIS, Office of the Secretary of Finance, Office of the Secretary of Education, SESAL, and CENISS, responsible for setting the rules governing the program, ensuring that each of the participating entities meets its responsibilities, strategic decision-making, approving changes to the program Operating Regulations, and following up on recommendations arising from evaluations. In addition, operational review meetings will be held with SSIS, UAFCE, and the Office of the Undersecretary for Integrated Health Services Networks, as well as bimonthly strategy review meetings, for coordination and execution of the program components and a comprehensive review of gains made. A further eligibility condition will be an interagency agreement setting out the roles and responsibilities of the institutions involved, such as support for the verification of education and health coresponsibilities under the BVM program.

3.6 **Special contractual conditions precedent to the first disbursement of the loan proceeds: (i) the Administrative and Financial Procedures Manual corresponding to Component 1 has been approved with the Bank's prior no objection; (ii) the Operations Manual corresponding to Component 2 has been approved with the Bank's prior no objection; and (iii) the interagency**

agreement has been signed between the Department of Development and Social Inclusion (SEDIS), the Office of the Secretary of Finance, the Office of the Secretary of Health, and the Office of the Secretary of Education, establishing the obligations of each institution and the terms for project execution.

3.7 **Special contractual execution conditions:** (i) the contracts to be signed with the decentralized managed health care providers have the Bank's prior no objection; and (ii) prior to the signature of contract renewals for decentralized health care management, a technical review report has been delivered to the Bank's satisfaction, verifying that the coverage targets[55] agreed upon with the Bank have been met, and presenting a plan for any unmet targets with the proposed improvements.

3.8 Managed care providers at the first and second levels will be contracted via single-source selection on grounds of continuity of existing contracts awarded in accordance with the Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank and because the services are obtainable from only one source in their respective regions of influence (document GN-2349-9, paragraphs 3.6(a) and (c)). A performance evaluation of the managed health care providers to be contracted based on a set of indicators established by SESAL returned an index of not less than 85% per provider.[56] In addition, micronutrient powders will be purchased from DSM Nutritional Products, and services will be engaged for the payment of BVM program transfers, since these are obtainable only from one source in the region and in the country, respectively (document GN-2349-9, paragraph 3.6(c)). Fundación Capital will also be commissioned to implement a pilot for graduation from extreme poverty, given its experience of exceptional worth for the delivery of such services in the region (document GN-2350-9, paragraph 3.10(d)). An interagency agreement will be entered into with the National Statistics Institute (INE), as the relevant government agency, for the preparation of socioeconomic profiles. For details, see Annex III, paragraphs 5.3 and 5.4.

3.9 **Audit.** The services of independent auditors acceptable to the Bank will be employed to conduct annual financial audits, in accordance with terms of reference to be previously agreed upon with the Bank (see Annex III, Section IV(c)).

B. Summary of arrangements for monitoring results

3.10 The objective of the six-monthly status reports will be to inform the IDB of the outcomes and outputs completed under the AWP and procurement plan in relation to the execution processes. These reports will be delivered within 60 days after the end of the relevant six-month period and will be the main source of information used as input for the status report in the Progress Monitoring Report. The PCU at SSIS/SEDIS and the technical unit and UAFCE at SESAL must prepare a single, integrated report for delivery to the Bank, summarizing progress under both components.

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55 Proposed indicators for performance framework.

56 Performance evaluation report on decentralized managed health care providers. UGD/SESAL, January 2016.

3.11 At the request of SEDIS, the Bank will support the implementation of an experimental impact evaluation, to measure the impact of the BVM program with the new transfer structure and strategy of targeting the extreme poor population. Impacts will be measured in the areas of consumption, poverty, food, nutrition, health, and school attendance. Coverage will be increased in 2016 in 176 rural villages selected from among 877 with low coverage of the BVM program and high levels of extreme poverty. Coverage will be increased in more of these from 2018 onward, which will constitute the comparison group. In health, efforts under the Mesoamerica Health Initiative will be built upon, to evaluate the impact of anemia measures and supplement the information in the monitoring reports of the decentralized managed care providers prepared for the coverage indicators, such as postpartum care in the first seven days after childbirth and neonatal care in the first three days after birth. The impact evaluation for the Mesoamerica Health Initiative encompasses 28 of the 33 municipios selected for this operation as part of the treatment group or the control group. A process evaluation and outcome evaluation will be conducted for the graduation pilot, to measure the change in household consumption before and after. For more detail, see Monitoring and evaluation plan.

C. Design activities post-approval

3.12 Finalize design of the graduation pilot and finalize the Administrative and Financial Procedures Manual for both components.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity		
Regional Context Indicators	-Poverty headcount ratio (US $4 per day PPP) (%) -Gini coefficient -Social Progress Index		
Country Development Results Indicators	-Countries in the region with improved learning outcomes according to PISA (%) -Beneficiaries receiving health services (#) -Beneficiaries of targeted anti-poverty programs (#)		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2796-1	i) To protect minimum levels of consumption among the population in poverty, ii) To promote human capital accumulation of minors in households in extreme poverty, and iii) To improve the health indicators of children under 5.	
Country Program Results Matrix	GN-2849	The intervention is included in the 2016 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	10.0		10
3. Evidence-based Assessment & Solution	10.0	33.33%	10
3.1 Program Diagnosis	3.0		
3.2 Proposed Interventions or Solutions	4.0		
3.3 Results Matrix Quality	3.0		
4. Ex ante Economic Analysis	10.0	33.33%	10
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	4.0		
4.2 Identified and Quantified Benefits	1.5		
4.3 Identified and Quantified Costs	1.5		
4.4 Reasonable Assumptions	1.5		
4.5 Sensitivity Analysis	1.5		
5. Monitoring and Evaluation	10.0	33.33%	10
5.1 Monitoring Mechanisms	2.5		
5.2 Evaluation Plan	7.5		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	Medium		
Identified risks have been rated for magnitude and likelihood	Yes		
Mitigation measures have been identified for major risks	Yes		
Mitigation measures have indicators for tracking their implementation	Yes		
Environmental & social risk classification	C		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, Accounting and Reporting. Procurement: National Public Bidding.	
Non-Fiduciary	Yes	Statistics National System.	
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	There is evidence that the program promotes female empowerment on decisionmaking in the household. Additionally the program is currently introducing training on family health with a focus on gender for its beneficiaries.	
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project			
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	Yes	The evaluation assesses the impact of the reformulated conditional transfer model in Honduras.	

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

The objective of the program is to support the development of human capital through a comprehensive intervention for poverty alleviation and improving access to health services, giving priority to the 33 poorest municipalities of western Honduras. The project document provides an informed diagnosis of the challenges facing the social protection and health sectors, which justify the implementation of the program.

The proposal presents evidence on the effectiveness of the proposed solutions with evaluations of similar interventions conducted both within the context of Honduras as well as references to the international literature. The results matrix includes SMART indicators suitable for measuring impacts, outcomes and outputs.

The project has a cost-benefit analysis supporting the economic viability of the proposed activities. Monitoring activities have been identified with their particular costs. The project proposes an experimental impact evaluation of the new conditional cash transfer program model. The Monitoring and Evaluation annex covers the questions, methodology, and budget necessary to carry out the evaluation.

RESULTS MATRIX

Program objective: The program objective is to support human capital development through a comprehensive effort to alleviate poverty and improve access to health services in the poorest municipios of Honduras, giving priority to the municipios of western Honduras.

IMPACT INDICATORS

Impact	Unit of measure	Current value	Year	End-of-project	Means of verification	Notes/observations
Poverty alleviation and investment in human capital						
Poverty						
1. Extreme poverty rate for Bono Vida Mejor (BVM) program beneficiaries in rural areas.[2]	%	61.2[1]	2016	58.2	Continuous Household Survey	Contributes to impact measured at the level of the BVM program
Health						
Maternal and child health						
2. Percentage of neonatal mortality at hospitals financed by the project	%	12[2]	2016	10	Hospital records	Baseline according to the Information Management Unit for Western Hospitals. In 2016, Intibucá, Lempira, Valle, and San Pedro Sula. Copan, La Paz, and Comayagua are expected to be added in 2018.
Nutrition						
3. Prevalence of anemia in children from 6 to 59 months among the BVM program participant population	Prevalence rate	23.1	2016	20	Household survey of the BVM impact evaluation	Tracking data (2013 Household Survey); anemia according to WHO classification.

[1] To be updated based on the most recent survey. The size of the effect will remain at 3 percentage points.

[2] To be updated based on an external measurement exercise commissioned by SESAL, completed in March 2017.

OUTCOME INDICATORS

(All outcome indicators except 7, 8, 9, and 15 are measured over the 33 priority municipios. Detailed calculations for each indicator are given in Annex V of required electronic link 3.)

Outcomes	Unit of measure	Baseline	Year	End-of-project	Means of verification	Notes/observations
Education						
1. Net enrollment rate for the third cycle of education					SACE administrative information in the areas where the Honduran Radio Education Institute (IHER) is active[3]	Third cycle includes grades 7, 8, and 9.
All[4]	%	24	2016	30		
Men	%	23	2016	29		
Women	%	25	2016	31		
2. School promotion rate of students enrolled in alternate modalities[5]						
All	%	27.9	2016	32		
Men	%	29.2	2016	33		
Women	%	26.7	2016	31		

[3] IHER face-to-face third-cycle teaching in remote parts of Western Honduras.

[4] The gender indicators will be reported and tracked, but only the total amount with the service providers will be included.

[5] The number of municipios where the coverage strategy is being implemented at the time of measurement will be used.

Health						
3. Percentage of pregnant women treated prior to 12 weeks of gestation in the past 12 months.	%	44.3[6]	2016	49	UGD monitoring reports	
4. Percent coverage of institutional childbirth in the past 12 months	%	64	2016	69	UGD monitoring reports	
5. Percent coverage of postpartum care in the first 7 days after childbirth* for hospitals, family care teams (EAFs), and SESAL health units in the past 12 months	%	48	2016	52		
6. Percentage of neonatal care in the first 3 days after birth** for hospitals, EAFs, and SESAL health units in the past 12 months	%	48	2016	52		
7. OB/GYNs available at hospitals 24/7 at the 8 decentralized hospitals in the past 12 months	%	70	2016	80		
8. First and second level health care facilities with family planning methods in the 33 priority municipios and the 8 decentralized hospitals in the past 12 months	%	86.4	2016	89	Warehouse cardex cards	
9. Percentage of human resources trained in use of the family planning counseling methodology	%	0	2016	50	Training reports	

[6] Baseline study of the 2013 Mesoamerica Health Program in Western Honduras for indicators 3, 4, and 5.

Efficiency and effectiveness of the Bono 10,000 program						
10. Coverage of households eligible for the program	%	32	2016	70	Management information system (MIS) (numerator) Poverty map (denominator)	The MIS is used to track coresponsibilities of the BVM program beneficiaries. Refers to the change with respect to the condition before the project began.
11. Percentage of rural beneficiary households that have received three transfers in the course of the year.	%	0	2015[7]	80	MIS	
12. Percentage of participating children who meet the health condition under the program Operating Regulations on the most recent payment	%	17%[8]	2015	27%		
13. Percentage of participating children who meet the education condition under the program Operating Regulations on the most recent payment	%	74%	2015	83%		
14. Increase in monthly per capita consumption at households participating in the graduation pilot[9]	%	0	2016	8	Evaluation of Fundación Capital[10]	

7 The baseline will be updated according to the 2016 outcome.

8 The figure will be updated after the 2016 survey, to maintain the expected gain in the indicator.

9 The municipios in the pilot are not among the 33 priority municipios.

10 Based on the findings of studies in six countries. http://news.mit.edu/2015/anti-poverty-program-boosts-income-0514.

OUTPUTS

Output	Unit of measure	Baseline	2017	2018	2019	2020	Total	Comments
COMPONENT 1. Poverty alleviation and investment in human capital (US$20 million)								
1.1 Number of individuals in households receiving cash transfers[11]	Number	99,790	0	151,000	151,000	0	[12]151,000	Based on the corresponding end-of-year template. Average household size: 5.87 according to 2013 Ongoing Household Survey (EPH).
1.2 MIS hardware and equipment	Number	0	1	0	0	0	1	The hardware and equipment condition is met when the unit has laptops, servers, diskstation, GPS, monitors, furniture, and security system.
1.3 Number of households added to the graduation pilot	Number	0	0	1,000		0	1,000	Pilot outcome evaluation report.
1.4 Number of households added to the Master Registry of Participants (RUP)	Number	0	0	100,000	0	0	100,000	RUP report.
1.5 Number of health coresponsibility verifications at the national level.	Number	0	1	2	2	0	5	SSIS management information system.

[11] Contributes to the target for beneficiaries of targeted antipoverty programs under the Bank's Corporate Results Framework (CRF).

[12] Outputs 1.1, 2.1, 2.2, and 2.3 are not added together.

Output	Unit of measure	Baseline	2017	2018	2019	2020	Total	Comments
COMPONENT 2. Strengthening of health care service offerings (US$30 million)								
2.1 Persons covered by decentralized managed care providers, giving priority to the 33 selected municipios (see link for list of municipios)[13]	Persons	292,631	412,000	414,000	0	0	414,000	The baseline is calculated on a population registered by the National Statistics Institute (INE) with a per capita average of US$23.00 for two years. Additional municipios may be added according to the poverty map, as long as coverage of the 33 priority municipios is guaranteed.
2.2 Management agreements signed with support committees	Number	3	3	3	0	0	3	Copies of agreements signed with support committees. Three agreements signed with support committees (San Marcos de Ocotepeque, Choluteca, and Juticalpa).
2.3 Number of management agreements signed with second-level managed care providers	Number	5	5	8	0	0	8	The agreements are to be signed by SESAL. The baseline hospitals are: 1 in Intibucá, Lempira, Valle, and 2 in San Pedro Sula. Three more hospitals are expected to be decentralized by 2018.
2.4 Health care facilities supplied[14] with micronutrient powders.	Number	0	75	75	75	75	75	UGD monitoring reports
2.5. Consulting services for hospital strengthening	Consulting engagements	0	0	5	0	0	5	
2.6 Consulting services for institutional strengthening of SESAL	Number	0	6	6	6	0	6	Final consulting reports

[13] Contributes to the CRF target for the number of beneficiaries of health services.

[14] The inventory record will be checked to verify that there is no zero supply on any day in the past three months.

Output	Unit of measure	Baseline	2017	2018	2019	2020	Total	Comments
2.7 Concurrent technical evaluation	Number	0	0	1	0	0	1	
2.8 Certification manual approved for first- and second-level decentralized managed-care providers	Number	0	0	1	0	0	1	Considered approved by SESAL by ministerial resolution.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Honduras
Project number:	HO-L1105
Name:	Program to Support the Social Inclusion Network with Priority in Western Honduras
Executing agency:	Department of Development and Social Inclusion (SEDIS) and Department of Health (SESAL)
Fiduciary team:	Kelvin Suero (FMP/CHO) and María Cecilia Del Puerto Corra (FMP/CHO)

I. EXECUTIVE SUMMARY

1.1 Despite risk factors related to the country's institutional capacity to execute projects with external financing, the Bank continues to pursue ongoing technical support and public sector strengthening activities in a number of areas, particularly in terms of improving the country systems for managing public finances. With respect to fiduciary management systems, the latest diagnostic assessments of **public financial management systems** in Honduras show significant progress toward good practices and international standards, primarily through modernization of the institutional framework and the integration of budget, treasury, and government accounting systems. The Bank supported the development and implementation of the SIAFI/UEPEX module for managing projects with external financing, and is now supporting its strengthening. Major efforts are now being made with the country authorities to strengthen the country control system for public resources. With respect to the **public procurement system**, Honduras has strengths identified in the MAPS/OECD analysis from 2010, in particular a legal framework aligned with the majority of international best practices. Nevertheless, there are challenges for achieving standards that would allow the Bank to use the country system for IDB-financed operations.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

2.1 The operation will have an execution arrangement involving two executing agencies: (i) SEDIS, acting through the project coordination unit (PCU) of the Office of the Undersecretary for Social Integration (SSIS); and (ii) SESAL, acting through the Administration Unit for External Cooperation Funds (UAFCE) and the Decentralized Management Unit (UGD). The PCU has been executing IDB-financed operations efficiently (HO-L1032, HO-L1042, HO-L1071, HO-L1087, and HO-1093). The UAFCE is currently executing several Bank-financed operations (HO-L1090 and HO-L1072), with fiduciary staff trained to apply Bank procurement policies and IDB financial procedures. Both agencies

use the Integrated Financial Administration System (SIAFI) with its UEPEX Module for issuing reports on operations with external financing. For procurement, although in the case of Honduras the country system is not to be used for Bank-financed operations, it is common practice to use HONDUCOMPRAS to publicize government procurement and contracting opportunities. There are standard national competitive bidding (NCB) and shopping documents for the procurement of goods and works that have been harmonized with the country's apex agency for public procurement and are used on Bank-financed operations.

III. Fiduciary Risk Assessment and Mitigation Measures

3.1 The total risk to the program associated with financial management and procurement was determined to be MEDIUM. In this particular case the fiduciary risk is low, considering that in terms of financial and accounting management the executing agencies have prior experience and proven capacity in executing Bank-financed operations in the sector, for which they use the SIAFI/UEPEX system and all the country controls derived from such use. The procurement risks are mitigated with the designation of SEDIS and SESAL as executing agencies, since both have staff specialized in procurement under IDB procedures. Refresher courses will be taught on Bank procedures during the operation, if necessary, and a monitoring and evaluation system will be implemented for the planning of required program procurements, using the Procurement Plan Execution System (SEPA).

IV. Considerations for the Special Provisions of the Contract

4.1 The agreements and requirements to be included in the Special Provisions of the loan contract are as follows:

a. **Conditions precedent to the first disbursement:** (i) the Administrative and Financial Procedures Manual corresponding to Component 1 has been approved with the Bank's prior no objection; (ii) the Operations Manual corresponding to Component 2 has been approved with the Bank's prior no objection; and (iii) the interagency agreement has been signed between the Department of Development and Social Inclusion (SEDIS), the Office of the Secretary of Finance, the Office of the Secretary of Health, and the Office of the Secretary of Education, establishing the obligations of each institution and the terms for project execution.

b. **Special contractual execution conditions:** (i) the contracts to be signed with the decentralized managed health care providers have the Bank's prior no objection; and (ii) prior to the signature of contract renewals for decentralized health care management, a technical review report has been delivered to the Bank's satisfaction, verifying that the coverage targets[1] agreed upon with the Bank have been met, and presenting a plan for any unmet targets with the proposed improvements.

[1] According to the indicators stated in paragraph 1.17 of the loan proposal.

c. For purposes of Article 4.10 (b) of the General Conditions of the loan contract, the parties agree that the applicable exchange rate will be as indicated in section (b)(ii) of the same article. In such case, the applicable exchange rate will be the rate in effect on the date the beneficiary, executing agencies, or any other person or corporation authorized to effect expenditures makes the relevant payments to the contractor or supplier.

d. **Audited financial statements.** The borrower agrees to deliver the audited financial statements for the program with an opinion issued by an independent auditor acceptable to the Bank, either directly or through the executing agencies, annually within 120 days after the close of each fiscal year of the executing agency, during the disbursement period of the loan. The last such report will be delivered within 120 days after the date stipulated for the last disbursement of the loan proceeds. One set of audited financial statements may be submitted by each executing agency.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

5.1 The applicable provisions for the execution of all procurements envisaged under the project will be as follows:

A. Procurement execution

5.2 The PCU, UGD, and UAFCE will be responsible, each within its respective area, for the selection, competitive bidding, contracting, supervision, and acceptance processes for program procurements, which will be conducted in accordance with the Bank's procurement policies set forth in documents GN-2349-9 and GN-2350-9, and the provisions of the procurement plan for the operation, to be prepared by each execution unit. The procurement plans will describe: (i) the contracts for works, goods, and consulting services required to carry out the program; (ii) the methods proposed for the procurement of goods and selection of consultants; and (iii) the procedures followed by the Bank for review of each of the procurement processes.

a. **Procurement of works, goods, and nonconsulting services.**[2] generated under the project and subject to international competitive bidding (ICB) will be conducted using the standard bidding documents (SBDs) issued by the Bank. Bidding processes subject to national competitive bidding (NCB) will be executed using national bidding documents agreed upon with the Bank and published on the website of the Regulatory Office of State Contracting and Procurement (ONCAE),www.honducompras.hn.

5.3 This operation will finance the continuation of activities financed by the Bank and conducted by the Government of Honduras, employing new and better approaches. Given its nature, therefore, execution of this operation will in practice require a continuation of the innovative mechanisms for payment of the transfer, community engagement in decentralized health care management, and preservation of the management capacity gained by the executing agency through execution of the previous operations. In accordance with paragraph

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

3.6(a) of document GN-2349-9, nonconsulting services for payment of the transfer will be extended via direct contracting by single source selection: (i) Banco Nacional de Desarrollo Agrícola [National Agricultural Development Bank] (BANADESA) for up to US$500,000; (iii) Federación de Cooperativas de Ahorro y Créditos de Honduras [Federation of Savings and Loan Cooperatives of Honduras] (FACACH) for US$200,000; (iii) Instituto Nacional de Estadísticas [National Statistics Institute] (INE) for continuation of a US$1 million interagency agreement to prepare master socioeconomic profiles for the addition of new households to the Bono Vida Mejor (BVM) program. In addition, Fundación Capital will be contracted for US$1 million to design and implement a graduation pilot for BVM program participants, as the only institution with exceptional experience in the implementation of such pilots in the region.

5.4 The borrower may engage health care managers at the first and second levels of care using single-source contracting for an amount of up to US$27.69 million, on the grounds of continuity of previously contracted health care managers, which may be mayor's offices and/or confederations of mayor's offices, or community-based social organizations, provided that they have delivered the services efficiently. Where none of these exist or a contract has been terminated for demonstrated nonperformance, a nongovernmental organization legally organized and operating in the community and meeting the previously established conditions may be selected, pursuant to paragraphs 3.6(a) and 3.17 of document GN-2349-9. The agreement with health managers will be governed by a model agreement previously agreed upon with the Bank. Additionally, in accordance with paragraph 3.6(c) of document GN-2349-9, direct procurement is envisaged for the purchase of micronutrients from DSM Nutritional Products for US$110,000, on the grounds that only one supplier of such inputs is eligible for the Bank and meets SESAL's requirements in terms of formula and dosage, out of all the suppliers identified after international competitive processes and market studies for such items.

a. Consulting service contracts arising under the program will be executed using the standard request for proposals (SRFP) issued by or agreed upon with the Bank. The project sector specialist will be responsible for reviewing the terms of reference for the contracting of consulting services.

b. At the discretion of each executing agency, individual consultants may be contracted by publishing notices locally or internationally in order to form a short list of qualified individuals.

c. Recurrent expenditures are operating and maintenance expenses required for the program during its useful life, which will be financed by the project in accordance with procedures agreed upon with the Bank. Operating costs do not include the salaries of public employees or other ordinary operating expenses of SEDIS and SESAL, which will be given priority for implementation of the program within the agency's institutional budget.

B. Table of threshold amounts

5.5 The thresholds for international competitive bidding and for the establishment of short lists of international consultants will be made available to the executing agencies on the website www.iadb.org/procurement.

C. Main procurements

5.6 Each executing agency will be responsible for preparing the procurement plan[3],[4] for its area of operation. The main procurements for this operation are detailed below:

Activity	Type of bidding	Estimated date	Estimated amount (US$000)
Services			
Delivery of transfer at BANADESA branch offices	DC		500
Delivery of transfer at FACACH offices and affiliated cooperatives	DC		200
Design and implementation of a graduation pilot for BVM program participants, Fundación Capital	DC		1,000
Preparation of household socioeconomic profiles for recertification process, National Statistics Institute (INE)	SSS		500
Basic package of health care services including micronutrients	DC		110
Agreements with health managers	SSS		27,690
Firms[5]			

* To access the 18-month procurement plan (PA18), click here.

D. Procurement supervision

5.7 Based on the fiduciary risk analysis for procurement, the supervision methods will be established in the respective procurement plan for each executing agency.

5.8 Special provisions: (i) **Measures to reduce the likelihood of corruption.** The provisions of documents GN-2349-9 and GN-2350-9 will be observed with respect to prohibited practices (multilateral agency lists of ineligible companies and individuals); and (ii) **Other special procedures.** The Bank may, at its discretion, change the procurement supervision method, based on experience in execution and institutional capacity updates, or fiduciary visits.

5.9 **Records and files.** SEDIS and SESAL will be responsible for maintaining files and original supporting documentation for the procurement processes conducted by each institution.

VI. Agreements and Requirements for Financial Management

6.1 With implementation of the Integrated Financial Administration System (SIAFI) and the General Treasury Account (CUT), cash resources are now managed in a prudential and disciplined manner and the cash management function has been

[3] "Policies for the procurement of goods and works financed by the Inter-American Development Bank" (document GN-2349-9), paragraph 1.16.; "Policies for the selection and contracting of consulting services financed by the Inter-American Development Bank" (document GN-2350-9) paragraph 1.23.: The borrower shall prepare and provide to the Bank for its approval in advance of loan negotiations, a procurement plan acceptable to the Bank for an initial period of at least 18 months.

[4] See Guidelines for procurement plan preparation and implementation

[5] In the case of consulting services, this means the short list comprises firms of various different nationalities. See document GN-2350-9), paragraph 2.6.

decentralized. The Bank's financial parameters for the country allow a project or program to be financed in full.

6.2 The SIAFI/UEPEX module and relevant national rules are used for financial reporting and accountability in relation to Bank-financed projects. Accounting is on a cash basis.

6.3 For the advance of funds modality, the executing agencies will open a special account for disbursing funds, in the program's name. The maximum amount of each advance of funds will be set by the Bank, based on the cash flow analysis presented by the executing agency. More than one advance may be made, depending on the cash flow. The advances of funds may be made separately for each component, according to the program operating structure, so each executing agency may account for the advances and deliver audited financial statements separately. In the event of reimbursements, the borrower/executing agency will specify the official account into which the resources are to be transferred.

6.4 The executing agencies will employ the proper staff and effective systems to perform their fiduciary functions. The Bank is considering continued work to strengthen internal control in the country.

6.5 The Tribunal Superior de Cuentas [Superior Audit Court] (TSC) is responsible under its charter for external control. The external audit function for the operation will be performed by a firm of independent auditors acceptable to the Bank, to be financed with the loan proceeds. Nevertheless, pending due diligence, the project team may agree with the Bank to engage the services of the TSC.

6.6 On the basis of the foregoing, the following financial agreements and arrangements have been identified for consideration:

a. External financial audits of the program are to be conducted, including six-monthly preliminary reports.

b. The policies to be used in this operation are the "Financial management policy for IDB-financed projects" (document OP-273-6), "Financial management operational guidelines for IDB-financed projects" (document OP-274-2), and "Guidelines on financial reports and external audits for IDB-financed operations."

c. The total estimated cost of audit services is US$750,000, to be financed with the loan proceeds.

d. The selection and contracting of audit services will be based on document AF-200; or external audit services may be engaged by single-source selection, if contracted on a competitive basis under document AF-200 for IDB-financed operations currently administered by the executing agencies.

6.7 **Financial supervision plan.** The Bank will supervise the financial management of the program, monitoring the actions to be taken by the executing agencies or borrower to address any observations and findings identified by the external audits.

6.8 **Execution mechanism.** The program will have an execution mechanism comprised of two executing agencies: (i) SEDIS, with administrative/financial support from the project coordination unit (PCU) of the Office of the Undersecretary for Social Integration (SSIS); and (ii) SESAL, acting through the Administration Unit for External Cooperation Funds (UAFCE) and the UGD.