Honduras Nutrition and Social Protection Project
Social Assessment and Indigenous Peoples Development Plan (IPDP)

1. Social Assessment and Indigenous Peoples Development Plan (IPDP)

The project targets two highly vulnerable groups of the Honduran population identified by the PRSP: children 0-5 years old with the highest levels of malnutrition and some of the lowest indicators of primary health care in the poorest departments (Copan, Intibucá, La Paz and Lempira); and youths at risk (15-19 years old) facing limited access to education and the work force along with the challenges of urban life in Tegucigalpa, San Pedro Sula and La Ceiba.

A social assessment was carried out in March 2005 to assess some current practices under AIN-C and consult direct beneficiaries and stakeholders on the relevance, efficiency of processes, efficacy of existing programs, perceptions on how they can be improved, and expectations of the services to be delivered by the components. The assessment had two parts: (a) a desk review assessing existing demographic composition, and the institutional and legal framework of the proposed project; and (b) a Rapid Participatory Rural Appraisal (RPRA) for the AIN-C component, and a Rapid Participatory Urban Appraisal (RPUA) for the First Employment component. The assessments were carried out by two teams of local consultants accompanied by the project teams of both Secretariats (Education and Labor), supported by the Indigenous and Afro-descendants federations, and with technical assistance from the Bank. The goals of the assessment were to: (a) explore mechanisms/strategies to improve the delivery of services to the most vulnerable groups; (b) agree on an Indigenous Peoples Development Plan that would ensure the inclusion of highly vulnerable Indigenous and Afro-descendant children and youths in the project; and (c) include recommendations to improve the project design.

Legal Framework

The Honduran Constitution and The Childhood and Adolescents' Code (Decree No. 73-9), protect the right of the child to health and provides guidelines for employment of children under 18 years of age. The Code establishes that: (a) Art. No. 1, "for legal purposes, all individuals below the age of 18 are considered children"; (b) Art. 120, "minimum working age is 14 years old", and "Under no circumstances shall a child younger than 14 years work". This is ratified by the ILO Agreement 138. In spite of the above legislation, the Census records as economically active all the children 10 years old and older who work; (c) Section No. 3 on the Apprenticeship Contract, Art 129 signals some employment options for the population served by the project. It specifies that "A child working for an employer shall be paid an agreed salary provided that employer grants the child the required technical training to learn a skill, form of art or manufacturing technique".

The ILO Convention 169 on the Rights of Indigenous Peoples (ratified by Honduras in 1994) recognizes the rights of Indigenous children and youth to health, education and social protection. Moreover, the World Bank O.D. 4.20 mandates informed consultations to be carried out with Indigenous Peoples living in the project area, and an Indigenous Peoples Development Plan (IPDP) to be agreed with said peoples to ensure services are rendered in a culturally-adequate manner.

The following Indigenous and Afro-descendant organizations are legally constituted to represent the nine ethnic groups in Honduras: The Consejo Consultivo Lenca (CCL) which includes four federations ONILH, MIL, CGL and FONDIL; COPINH (Lenca); CONIMCCH (Chortí); FITH (Tawakha); FETRIPH (Pech); FETRIXY (Tolupán); MASTA (Miskito); NABIPLA (English Speaking Black); and OFRANEH (Garífuna).

The Government commitment to fight poverty among indigenous and afro-descendants

The ethnic communities are among the poorest in the country, with much higher than average rates of malnutrition, illiteracy and unsatisfied basic needs. Due to geographic and cultural isolation, participation of these groups in Government programs is limited. A more active participation in health and nutrition programs on one hand, and youth-at-risk on the other, is key to poverty reduction among ethnic groups.

In 2001, the Government of Honduras (GOH) presented its Poverty Reduction Strategy Paper (PRSP), which seeks to reduce poverty by 24 percent during 2001-2005 through a comprehensive set of measures or pillars, including: (1) accelerating equitable and sustainable economic growth; (2) reducing poverty in rural areas; (3) reducing urban poverty; (4) investing in human capital; (5) strengthening social protection for specific groups; and (6) guaranteeing the sustainability of the strategy.

The objective of "Social Protection for Specific Groups" (pillar 5) is to improve the living conditions of people in extreme poverty, particularly children, adolescents, senior citizens, women, persons with disabilities and ethnic groups, in order to enable their social integration and development through equitable access to opportunities. The PRSP also calls for programs and projects that support (a) socio-economic development of ethnic communities, and (b) ethnic and ecological tourism.

Indigenous Peoples and Poverty

Honduras is one of the poorest countries in Latin America and is characterized by a high degree of income disparity. With a per capita GNI of US$920 in 2002, the country is the third poorest in Latin America. Given its high income inequality (the national Gini coefficient is 0.6), poverty is widespread. Nearly two-thirds of the population is poor and nearly half is extremely poor[1] These vulnerable groups, particularly those living in isolated regions, are in the two poorest population quintiles. Over 50 percent of rural households are considered chronically poor.

Human development indicators for ethnic groups, such as malnutrition, illiteracy and unsatisfied basic needs are higher for indigenous than for non-indigenous. Limited or inadequate access to basic services is common. The deficit of education in rural areas is above 40 percent for ethnic communities, and illiteracy is equally high (46 percent for Tolupan and Miskito) due, in part, to their geographic isolation. Shortages of potable water and electricity among ethnic peoples are noteworthy. Over 70 percent of indigenous

[1] The "extremely poor" are those living below the extreme poverty line, which is the cost of a food basket designed to meet basic nutritional needs. According to the Honduras CAS (pg. 4), "All Poor" in 2002 represented 63.3 percent of Honduras households and "extremely poor" 45.2 percent of households.

households in rural areas depend on candles for light and 40 percent depend on rivers and wells for water. Over 50 percent of the ethnic population lack basic sanitation including latrines.
The deficit in health and sanitation services is equally substantive. HIV/AIDS and other contagious diseases are significant health threats to the 54 Garifuna communities along the Atlantic Coast.

Project Targeting

The project targeting for the AIN-C component responds to the need expressed by the PRSP to improve primary health care indicators in the Western departments of Copán, Intibuca, Lempira and La Paz, particularly for neonatal and health care of children 0-5 years of age. This component will focus on 1,000 new rural villages of selected municipalities in the poorest departments.

The First Employment component targets the two largest metropolitan areas of Tegucigalpa and San Pedro Sula; and the Coastal urban center of La Ceiba.

Analysis of Demographic and Socio-Economic Factors affecting the Interventions of AIN-C and First Employment

Demographics

According to the 2001 Census, 440,323 people self-identified as indigenous or afro-descendant (7.2 percent of Honduran population), although, according to the indigenous federations the ethnic population is approximately 900,000 inhabitants or 14% of the population. Of those, the largest group is the Lenca accounting for 62 percent, followed by the Miskito 11%, the Garifuna 10%, the Chortí 8%, the English-Speaking Black[2] 3%, the Tolupan 2%, the Pech 1% and the Tawahka less than 1%. The Nahoas have not been officially recognized as a federation, but they account for 3%. Indigenous peoples belong to seven ethnic groups of diverse origin. The Lenca, and Chortí are of Mesoamerican descent; the Tolupán, Pech, Tawahka, and Miskito are believed to be of Chibcha descent; the Garifuna and English-Speaking Black of African descent.

Table 1: Urban/Rural Demographic Distribution in the Four Departments Targeted by the Project

Depts	Total Pop	Tot urban	Total rural	% R	Total IP and Afro	IP/Afro Urban	IP/Afro Rural	% IP Rural
Copán	276,083	72,168	203,915	74	15,738	322	15,416	98
Intibuca	175,107	23,400	151,707	87	73,609	8,266	66,037	89
La Paz	147,787	29,746	118,041	80	40,987	1,921	39,066	95
Lempira	243,971	12,425	231,546	95	107,000	5,490	101,510	95
	842,948	137,739	705,209	84	237,334	15,999	222,029	94

Source: Self-elaboration based on Census 2001

With regard to the ethnic composition of the population under the AIN-C component, 32 percent of the population in rural areas targeted by the project is autochthonous. In the

[2] This group prefers to be called "*Negros de Habla Inglesa* or English-Speaking Black".

Department of Copán, 6 percent of the population is autochthonous (mostly Chortí) and 98 percent of them live in rural areas, which is the area of influence of the project. In the other three departments Intibucá, La Paz and Lempira, 40 percent of the population is autochthonous (mostly Lenca) and 93.2 percent of them live in rural areas. Consequently, AIN-C may potentially affect autochthonous peoples directly.

According to that Census, poor urban population accounts for 61.3 percent at the national level.

Table 2: Indigenous and Afro-descendant population 15-19 years of age in Honduras

	Total Populat	Mestizo	Garif	Negra	Tolup	Pech	Misk	Lenca	Tawah	Chort	Total IP
Total	**706,845**	**656,771**	**5,526**	**1,470**	**1,021**	**438**	**5,759**	**31, 624**	**256**	**3,980**	**50,074**
Urban	338,995	329,509	3,219	956	72	85	1,231	3,547	76	300	9,486
Male	157,660	153,274	1,545	452	35	38	577	1,568	31	140	5,100
Fem	181,335	176,235	1,674	504	37	47	654	1,979	45	160	4,386
Rural	367,850	327,262	2,307	514	949	353	4,528	28,077	180	3,680	40,588
Male	194,753	173,716	1,117	267	525	156	2,178	14,749	91	1,954	21,037
Fem	173,097	153,546	1,190	247	424	197	2,350	13,328	89	1,726	19,551

Source: Self-elaboration from Census 2001.

Table 3: Indigenous and Afro-descendant population 15-19 years of age in Metropolitan Areas of MDC, San Pedro Sula and La Ceiba

	Total Populat	Mestizo	Garif	Negra	Tolup	Pech	Misk	Lenca	Tawah	Chort	Total IP
Total	**165,223**	**161,649**	**1,973**	**418**	**21**	**47**	**235**	**672**	**60**	**148**	**3,574**
Male	76,368	74,751	945	190	8	20	98	272	24	60	1,617
Fem	88,855	86,898	1,028	228	13	27	137	400	36	88	1,957
SPS	**57,279**	**55,776**	**581**	**84**	**13**	**38**	**71**	**581**	**57**	**78**	**1,503**
Male	26,193	25,547	272	35	6	16	41	235	24	28	646
Female	31,086	30,229	309	49	7	22	30	346	33	50	857
MDC	**93,059**	**92,482**	**266**	**55**	**7**	**9**	**107**	**76**	**3**	**54**	**577**
Male	43,047	42,780	131	27	2	4	49	29	0	25	267
Female	50,012	49,482	135	28	5	5	58	47	3	29	530
La Ceiba	**14,885**	**13,391**	**1,126**	**279**	**1**	**0**	**57**	**15**	**0**	**16**	**1,494**
Male	7,128	6,424	542	128	0	0	19	8	0	7	704
Female	7,757	6,967	584	151	1	0	38	7	0	9	790

Source: Self-elaboration from Census 2001.

Tables 2 and 3 indicate that there are approximately 50,000 Indigenous and Afro-descendant youths 15-19 years old in the country, of whom approximately 9,500 were in urban areas in 2001, and approximately 3,500 in the metropolitan areas of the Metropolitan District (MDC), San Pedro Sula and La Ceiba. There are more indigenous females than males in these areas. It is not clear how many of them are studying and/or employed.

The Socio-economic and Health Situation of Indigenous Peoples in the Project Area

Health Care Supply. Studies carried out by the ETZTANI Research Institute (2001) stress the deficit of health care supply and limited access to services in those departments in general, particularly among indigenous groups in isolated rural areas. For the general population, the study estimates that there is one CESAR (with one nurse) for every 6,825 people and one CESAMO (with one doctor) for every 30,000 people.

Dwelling overcrowding and 'chagas' epidemic. According to the census, 93 percent of ethnic peoples suffer from overcrowding. The Social Investment Fund (FHIS), through the *Nuestras Raíces* Program with support of SOH, has rehabilitated 500 dwellings and plans to rebuild 4,000 more infested houses to fight the epidemic**.**

Water and sanitation facilities. This is one of the biggest problems affecting the entire country with dramatic consequences for health and nutrition. Whereas 73 percent of households at the national level have access to a household or public connection, access is limited to 30 percent of the population in rural areas. Well water is less common and limited to 6 percent of the households nationwide, although it is more popular among the Garifuna (17 percent) and the Chortí (11 percent) in rural areas. 12 percent of Hondurans still depend on river or lake water for drinking and cooking, but the number is higher for the indigenous. 24 percent of rural Lencas, and 16 percent of Chortí consume only river water.

With regard to sanitation, 42 percent of Lenca, 50 percent of Chortí and 18 percent of Garifuna households have no installed sanitation facilities, compared to 22 percent at the national level. Also, 23 percent of Lenca, 20 percent of Chortí and 10 percent of Garifuna use simple latrines as opposed to 25 percent at the national level. In terms of connections to a seward system, only 7 percent of Lenca and Chortí and 22 percent of Garifuna are connected, as compared to 28 percent at the national level.

Electricity. Out of 601,273 rural households existing in Honduras, only 29 percent have public or private electricity, a private plant or solar energy. The other 71 percent use wax or gas candles, torches or candle lamps.

Education. For the population in general, the census indicates that illiteracy is 6.4 percent for the Department of Francisco Morazán (Tegucigalpa), and an average of 9.3 years of schooling;13 percent of illiteracy and an average of 7.7 years of schooling for Cortés (San Pedro Sula); and 7 percent illiteracy and an average of 8.3 years of schooling for Atlántida (La Ceiba).

The low education levels contribute to deficient health indicators. For people 15 years of age and older, literacy is calculated at 80 percent at the national level, and 90 percent in urban areas. However, in the Metropolitan areas, close to 40 percent of youths with access to primary education did not finish it; 95 percent of youths who started secondary education did not complete it. About 10 percent attend a vocational school. About 30 percent are economically active. The average schooling of working youths is of 8^{th} grade.

Urban literacy for the Garifuna is higher than the national urban level, at 94 percent (14,212 Garifunas); as compared to 87 percent for the Lenca and 88 percent for the urban Chortí. The latter are important factors to bear in mind for the First Employment component. The rural scenario is worse, as 31 percent of rural populations at the national level, and 38 percent for the Chortí and Lenca are illiterate, of relevance for the AIN-C component.

The economically-active population. In Honduran terms, the economically active population is 10 years old and older. The main occupation of Hondurans is agriculture, forestry and fishing (40 percent), followed by trade (15 percent) manufacturing (13 percent) and community-based activities (11 percent). For the urban Garifuna, the most common occupation is tourism services (26 percent) followed by community-based services (22 percent), while for the rural Garifuna, agriculture and fishing are the most common (48 percent). For the urban Lencas, the most common activities are community-based (23 percent), while agriculture, fishing, hunting occupies 83 percent of Lenca and 82 percent of Chorti in rural areas. The majority of working Lencas and Chortí 10+ years old and up are self-employed (60 percent on average), around 20 percent are private employees, and 4 percent work in the public sector.

An important source of income for the target population of both components is the remittances from relatives overseas.

The Need for Intercultural Strategies for Health and Social Protection. Understanding the cultural context of the components is key to the attainment of the objectives. Although language is an important indicator of cultural differences, the latter may be historically preserved despite the absence of the native language itself.

Although the Lenca language is dead, the culture and traditions are alive

The Lenca group is the largest in Honduras, accounting for 62 percent of ethnic population or 279,507 people (2001 census) inhabiting mostly west Honduras. The AIN-C program will focus on the departments of Intibucá, Lempira and La Paz, where the ethnic population accounts for 220,290 of which 98.5 percent are Lenca. Although the Lenca language (of the family of Mayan languages) disappeared in Honduras at the beginning of the 20th century, the behaviors and preferences of peasants of Lenca ancestry and Lenca peoples indicate their culture and traditions are vivid. This is significant for the framing of "intercultural health".

The Rapid Participatory Rural and Urban Appraisals (RPRA and RPUA)

Two Rapid Appraisals were carried out: a rural appraisal (RPRA) for the AIN-C component, and an urban appraisal (RPUA) for the "My First Employment" component. The RPRA was carried out by a local multi-disciplinary team with the purpose of consulting with 12 communities presently participating in the AIN-C program, as well as with four non-beneficiary communities in the four departments of the project. Informed consultations were geared to assess: (a) the level of satisfaction and expectations of direct beneficiaries; (b) the level of commitment of local governments and SOH units; and (c) the level of participation of the local health network (Health Committee, midwives, traditional healers, SOH health and sanitation workers (TSA), NGOs) as well as their perceptions and expectations.

For the First Employment component, the urban assessment was implemented by a local team, accompanied by the SLSS. Informed consultations were carried out with students, training centers, employers and indigenous federations. The goal of the consultations was to assess the mechanisms to be used on the pilot project. A series of workshops with employers/firms remains to be carried out as part of the social assessment.

It was difficult to analyze results of AIN-C on ethnic groups, as existing studies and evaluations do not disaggregate data with the variables "ethnicity and gender". The incorporation of variables on ethnicity, gender and age is an important recommendation for both components.

Main highlights of the Rapid Participatory Rural Appraisal

AIN-C

1. The existing AIN-C strategy in the 16 communities visited covers children 0-2 years old. The central activity of the strategy is to monitor children's weight, and refer children to the Health Unit. AIN-C only monitors weight, but other NGOs, i.e., Plan International (Plan Honduras) monitors children's height and weight.
2. Since the CESAMOs (larger health centers) have only one medical doctor, a nurse and auxiliary nurse to serve an average of 30,000 people, basing the AIN-C strategy on the CESAMO would appear to be a burden for the center. The CESAR (village level) is closer to the community physically and culturally, and more likely to embrace the program, even though it is only staffed with a nurse and auxiliary nurse.

Intercultural Health

3. As agreed with SOH, an Intercultural Approach is needed for the AIN-C Component in the autochthonous communities. In those communities, approaches to health care are governed by particular traditional behaviors.
4. A module on "Intercultural health; safe and unsafe practices" may be added to the training program taught to health workers. There is a need for systematic training in 'intercultural health' to health care workers of the SOH as well as the communities as suggested by the Department of Indigenous Health at the SOH during consultations. This training should include safe traditional practices (i.e. the staple sacate tea) as well as unsafe traditional practices (i.e. tobacco leaves chewed by a first-time pregnant woman, wrapped in a rag, and given to the colicky baby as a pacifier to suck on; or using leftover antibiotics from previous illnesses; rubbing (*sobadas*), use of hen oil or other potions, etc. for bronchial illnesses).
5. Training to community-based networks should include, among other things, prevention against the 'chagas' disease, which may be affecting hundreds of children in the project area, and which will manifest itself later as heart problems.

The Community-based health networks

6. The community-based health networks (health committees, midwives, health monitors/guardians, traditional healers) are the only permanent health care providers in the community. The RPRA indicates that in rural settings, most people seek a member of the community-based network (monitor, midwife, healer) for advice and treatment of all diseases. People go to a health unit only when the self-medication, pharmacy or local healers have not been able to solve the problem, or in emergencies.
7. The consultations found that self-medication is the first step to solve a health problem. This is done mostly with fitotherapy (plants), sometimes combined with medication bought in the food store (*pulpería*) or pharmacy, including antibiotics. People are reluctant to approach health units that have no medication (which was the case of 50% of CESAMOs and CESARs) visited.

Stakeholder participation and social auditing

8. The inclusion of traditional authorities is key to project sustainability. For example, the Auxiliary Mayor is the highest traditional authority in the rural *aldeas* and *caseríos* and should be included in the strategy. In urban areas, the Auxiliary Mayor is the representative of the Mayor in the neighborhood; therefore, his inclusion can be a key factor of success. In addition, the health committees, *Patronatos*, community leaders, water committees, etc. are important representatives of civil society. They should be informed about AIN-C, particularly as sources of support (logistic). They are presently not included.
9. The assessment found that the level of interest and involvement of the Municipalities visited in AIN-C goes from minimal (ex.: a one time-contribution of Lps 100 for transportation of monitors) to non-existent.
10. The MDs at the CESAMO are on a one-year practical training program, and do not get involved in programs such as AIN-C. In contrast, the nurse is the permanent staff responsible for implementing the program in the community, leading the PHC efforts, and chairing the monthly AIN-C meetings with the monitors.
11. The SOH facilities (CESAMO and CESAR) only respond to health care demands of patients who visit the units. They also provide vaccination, and primary or family health care through brigades in the villages.
12. The Monitors (community volunteers) are the pillars of AIN-C due to their daily commitment. They are the heart of the community-based network. Monitors also provide preventive and curative care on demand.
13. Although the SOH Manual indicates Monitors should be selected by the community, most Monitors are chosen, at the moment, by the Head Nurse of the CESAMO.

Gender

14. The AIN-C strategy is targeted to women. Men interviewed requested that men be educated to share the responsibility of parenthood and the health care of their children.

Training

15. Most Monitors received the first training module (5 days) during the first year and the second module (3 days) during the third or fourth year of volunteerism. Most of the time, there was no training in the interim.
16. Training provided in the health facility is attended only by few monitors, leaving out the majority of community volunteers who practice traditional medicine.
17. Communities request that someone in the community be trained in giving injections, particularly for elders, the handicapped and very small children who do not usually reach the CESAMO because of distances.

The Chagas Epidemic

18. Many school children, particularly in the area of Copán were found to be carriers of the chagas epidemic. According to PAHO, there are presently approximately 10,000 households infested with chagas particularly in the Northwestern regions (AIN-C area).

Main highlights of the Rapid Participatory Urban Appraisal for First Employment

1. The results of the social assessment show that the opportunities of youths to study are as limited as the job opportunities. Students interviewed from the EDUCATODOS list (average age 16.5 years old) have only finished sixth or seventh grade, and are over-age to sit in regular school classrooms. These students need alternative formal education opportunities.

2. Low schooling and low quality of job opportunities correspond to low income in the formal and informal sectors.

3. There was great enthusiasm among the 338 youths interviewed to get trained and access their first job opportunity. The majority expressed preference for training close to home to save time and avoid traveling, because many of them study, and 63 percent work.

4. The most popular jobs among youths are: auto mechanics, trade, restaurant cooking/waiting, welding, masonry, and working in hotels. The most popular among young women are: house/office/hotel cleaning, sewing, washing/ironing, chambermaids, and childcare.

5. The indigenous federations have shown great interest in coordinating with the program. They have offered to use their social networks to inform/guide eligible youth at risk to register in EDUCATODOS or other participating programs, in order to be eligible for the First Employment program.

6. Twenty-six firms were interviewed in San Pedro and La Ceiba as part of the assessment. Firms confirmed their interest in participating in the program. Some 54.8 percent of those interviewed indicated their interest in financing in-house training for eligible youths. Sixty-six of interviewed firms do not employ youths at the moment.

Recommendations for project design of Component 2: AIN-C

1. Include an "Intercultural health module" which includes the practices of western medicine and local traditions. The module should cover both safe and unsafe practices, and be targeted to: (a) staff involved in health care service delivery at the Central, departmental municipal, and local levels; and (b) facilitators, NGOs and monitors for AIN-C.

2. Change the name '*monitoras*' to "*Monitores*" to include men.

3. Strengthen the existing "community-based health networks" (Monitors, midwives, healers, guardians) which operate traditionally and permanently in the communities to provide traditional preventive and curative care. Since they enjoy respect and credibility in the community, AIN-C would benefit from including them in the strategy, and their involvement would convey greater credibility and sustainability to the program.

4. Organize the training of *Monitores* in the communities themselves (CESAR), to allow for higher participation of the entire health network, instead of having monitors travel to the CESAMO. The CESAR is more accessible to rural communities. Training can also be provided in schools.

5. To improve the nutrition part of AIN-C, coordinate with other agencies to provide the community the opportunity to access agricultural programs, seed distribution, etc. Also, liaise with institutions/NGOs working on medicinal plants cultivation programs.

Recommendations for project design of Component 3: First Employment

1. Include the variables of "ethnicity, gender and age" in the baseline and M&E systems.

2. Seek to avoid exclusion of youths based on ethnicity, gender, or social strata.

3. The targeting study for the program could consider the broader "Metropolitan" areas, that is, MDC (Tegucigalpa and Comayaguela); San Pedro Sula and La Ceiba and satellite municipalities whose inhabitants commute to the city for work and study.

4. Socialize/promote the program inside the SLSS in MDC as well as San Pedro Sula and La Ceiba. Socialize/promote the program outside the SLSS through informed consultations with stakeholders (employers, unions, training providers, indigenous federations, youth groups and civil society).

5. Strengthen the Central and Regional Directorates of the SLSS to collaborate with the project.

2. Participatory Indigenous, Afro-descendant Peoples and Gender Plan (IPDP)

The presence of indigenous peoples in the project areas triggers compliance with the Bank's O.D. 4.20, which requires that the needs of these populations be taken into account in the design of the project, to enable them to benefit in a culturally appropriate way. Given that the Departments of AIN-C are in a multi-cultural area (over 30 percent Lenca and Chorti, and almost 50 percent peasants of Lenca tradition), the IPDP is intended to include all of the above under a culturally-appropriate strategy that benefits the entire region. In the case of the First Employment component, the IPDP recommends coordination with the indigenous and Afro-descendant organizations and their social networks to identify youth at risk in the project area and invite them to participate.

Both the Health and Labor Secretariats have agreed to include the variables "ethnicity, gender and age" in their baseline data, and in all databases to be used for monitoring and measuring the impact of the two components.

Both components of the project will coordinate important actions with the Indigenous and Afro-descendant Federations to activate the social networks in rural and urban communities as needed. Both Secretariats will inform the organizations about project opportunities, to allow their groups to participate in the programs as beneficiaries, or as service providers, having met eligibility and selection criteria. Training and supervision of the 'intercultural health' module are the responsibility of the Indigenous Health Unit at the SOH.

Component 2: Consolidation and Expansion of the AIN-C Program

(a) Elaboration of the module on "Intercultural Approach to health care delivery for children 0 to 5 years old" by the Indigenous Health Unit at the SOH. This module will be taught along

with the AIN-C training modules. Training will be provided to health staff at the Central and Departmental levels, and to facilitators. US$17,000

(b) Contract with a local firm for training of module on "Intercultural Health" US$47,000

(c) Supervision of NGOs in the field to ensure quality of intercultural approach to health US$ 10,000

(d) Workshop with the Indigenous Federations to agree on their participation in (i) identifying remote indigenous communities lacking health services, where AIN-C may be introduced; and (ii) promotion of the program among local NGOs eligible for delivery of AIN-C package US$ 5,000

(e) Equipping of Monitors in remote communities with workbags containing first aid materials, scales, umbrella, rain poncho, basic medicines. Budgeted under project.

Component 3: First Employment Program for Youth at Risk

(a) Socialization and promotion of the project with personnel from the Regional Offices of Tegucigalpa, San Pedro Sula and La Ceiba, and other important stakeholders such as employers, youth organizations training providers, ethnic organizations and beneficiaries, and other civil society groups, 3 @ 3,500 US$10,500

(b) A one-day workshop to inform the Indigenous and Afro-descendant organizations and 14 federations about the objectives of the project and its content. US$8,000

(c) Program promotion on radio stations most popular among youths. Posters and brochures to attract indigenous and Afro-descendant urban youth US$10,000