PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

BOLIVIA

PROGRAM TO IMPROVE ACCESSIBILITY TO MATERNAL AND NEONATAL HEALTH SERVICES IN BOLIVIA

(BO-L1198)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Luis Buscarons, Project Team Leader (SPH/CBO); Xiomara Alemán, Alternate Project Team Leader (SPH/CEC); Pablo Ibarraran, María Laura Oliveri, Isabel Delfs, and Alejandra Aguilar (SCL/SPH); Verónica Tejerina (SCL/GDI); Joyce Elliot and Christian Lunstedt (CAN/CBO); Carolina Escudero and Diana De León (VPC/FMP); David Maier (VPS/ESG); Mónica Centeno (LEG/SGO); Sebastian Martinez (SPD/SDV); Jaime de los Santos (SPD/SMO); and Luz Fernández (CSD/CCS).

CONTENTS

PROJECT SUMMARY

I. DESCRIPTION AND RESULTS MONITORING 1

A. Background, problem addressed, rationale 1
B. Objectives, components, and cost 10
C. Key results indicators 12

II. FINANCING STRUCTURE AND MAIN RISKS 13

A. Financing instruments 13
B. Environmental and social risks 14
C. Fiduciary risks 14
D. Other program risks 15

III. IMPLEMENTATION AND MANAGEMENT PLAN 16

A. Summary of implementation arrangements 16
B. Summary of arrangements for monitoring results and program evaluation 18

ANNEXES	
Annex I	Summary Development Effectiveness Matrix (DEM)
Annex II	Results Matrix
Annex III	Fiduciary Agreements and Requirements

ELECTRONIC LINKS

Required

1. Multiyear Execution Plan
2. Monitoring and Evaluation Plan
3. Environmental and Social Management Report
4. Procurement Plan

Optional

1. Economic analysis
2. Bibliography
3. Table 1. Population coverage of the networks to be targeted by the program
4. Intervention map
5. Description of monitoring indicators
6. Itemized budget
7. Estimated budget for equipment and construction
8. Estimated budget for ENOC equipment in the comprehensive healthcare centers
9. Survey of field data and property law
10. Description of the health networks to be targeted by the program
11. Itemized work plan structure
12. ENOC strategy
13. Historical record of Bank projects in the health sector
14. Project monitoring report
15. Implementation arrangements and coordination levels
16. Program Operating Regulations – Program Execution Unit/Ministry of Health
17. Program Operating Regulations – Health Infrastructure and Medical Equipment Agency
18. Safeguard Policy Filter and Safeguard Screening Form for classification of projects

ABBREVIATIONS

AISEM	Agencia de Infraestructura de Salud y Equipamiento Médico [Health Infrastructure and Medical Equipment Agency]
AWP	Annual work plan
CEASS	Central Estatal de Abastecimiento de Suministros de Salud [State Health Service Supply Center]
ENOC	Essential neonatal obstetric care
ESMF	Environmental and Social Management Framework
GAD	Autonomous departmental government
GAM	Autonomous municipal government
GRUS	Grupo de Socios para el Desarrollo [Partners for Development Group]
ICAP	Institutional Capacity Assessment Platform
ICB	International competitive bidding
IEC	Information, education, and communication
NB-SABS	Basic rules of the Bolivian goods and services administration system
PEU	Program execution unit
PMR	Project monitoring report
RAMOS	Reproductive Age Maternal Mortality Survey
RMNCH	Reproductive, maternal, newborn, and child health
SEDES	Departmental Health Services
SICOES	State Procurement System
SIGEP	National Public Management System
SNIS-VE	National Health Information System – Epidemiological Surveillance
SUIS	Unified Health Information System

PROJECT SUMMARY

BOLIVIA
PROGRAM TO IMPROVE ACCESSIBILITY TO MATERNAL AND NEONATAL HEALTH SERVICES IN BOLIVIA
(BO-L1198)

Financial Terms and Conditions			
Borrower:	**Source**	**Amount (US$)**	**%**
Plurinational State of Bolivia	**IDB (Regular Ordinary Capital):**	233,750,000	85
Executing agency:	**IDB (Concessional Ordinary Capital):**	41,250,000	15
Ministry of Health, acting through the program execution unit; and the Health Infrastructure and Medical Equipment Agency.	**Total:**	275,000,000	100

	Regular Ordinary Capital (Flexible Financing Facility)[a]	**Concessional Ordinary Capital**
Amortization period:	18.5 years	40 years
Disbursement period:	5 years	
Grace period:	10.5 years[b]	40 years
Interest rate:	LIBOR-based	0.25%
Credit fee:	[c]	0.50%
Inspection and supervision fee:	[c]	N/A
Weighted average life:	15.25 years	N/A
Currency of approval:	U.S. dollars	

Program at a Glance

Program objective. The program's general objective is to reduce maternal and neonatal morbidity and mortality, by increasing the accessibility and enhancing the health outcomes of the prioritized health networks (those with the worst maternal and infant mortality and accessibility indicators). The specific objectives are: (i) to implement the essential neonatal obstetric care (ENOC) strategy and improve network performance by: (a) implementing processes for the continuous improvement of care quality, with emphasis on an ENOC service model; (b) supporting the digital transformation of the sector by improving health care management information systems in the network and monitoring of maternal and neonatal morbidity and mortality; and (c) enhancing management capacities in the network and in individual healthcare facilities; and (ii) to strengthen the infrastructure of the health services network, by investing in works and equipment that improve its health outcomes, under a comprehensive, coordinated vision of the network.

Special contractual conditions precedent to the first loan disbursement: The borrower, through the executing agencies, will submit evidence that the program Operating Regulations for each one include the Environmental and Social Management Plan and Environmental and Social Management Framework (ESMF), as applicable, as annexes, and have been approved and entered into force under the terms previously agreed upon with the Bank (paragraph 3.5).

Special contractual conditions for execution: The borrower, through the executing agencies, agrees to submit to the Bank's satisfaction evidence that the agreements between the respective executing agencies and the end beneficiaries have been signed and taken effect, establishing conditions including: (i) before the award of the contract for each of the works in Component 2 of the program, the end beneficiaries have legal possession of each of the properties in which the works in question will be undertaken (paragraph 2.8); and (ii) six months prior to the start of each of the works in Component 2, the executing agencies will submit evidence to the Bank that they have the commitment of the end beneficiaries to provide the resources necessary for the operation and maintenance of the infrastructure and equipment of these works (paragraph 2.9). See also the Environmental and Social Management Report (required link 3), Annex B.

Exceptions to Bank policies: None

Strategic Alignment

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

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

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

[b] 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 applicable policies.

[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 Rule of Law).

I. Description and Results Monitoring

A. Background, problem addressed, rationale

1.1 **Context**. In Bolivia, rates of maternal mortality (160 deaths per 100,000 live births [1]),[1] and infant mortality (50 deaths per 1,000 live births [2]), are both above the regional average [3]. As part of the Economic and Social Development Plan 2016-2020 and the Comprehensive Sector Development Plan for Living Well 2016-2020, the health authorities have proposed a National Plan for the Rapid Reduction of Severe Obstetric Morbidity and Maternal and Neonatal Mortality, under the principles of the Intercultural Community Family Health policy [4]. To address the problems of accessibility, health outcomes, and quality of the country's health services, the aforementioned sector plan also includes a hospital investment program (National Hospital Plan 2016-2020) [5], which will be implemented by the specially created Health Infrastructure and Medical Equipment Agency (AISEM).

1.2 According to the latest National Maternal Mortality Study,[2] 538 women died from complications arising during pregnancy, childbirth and postpartum in Bolivia in 2011, of whom 14% were under 19 years of age and 68% were from the indigenous population. Of maternal deaths, 42% occur in the home, 17% on the way to a healthcare facility, and 37% in the facility itself. The direct obstetric causes of death in that year were: (i) hemorrhage, 59%; (ii) hypertension, 19%; (iii) miscarriage, 13%; (iv) sepsis, 7%; and (v) prolonged labor, 2%. The highest rates of maternal mortality occur in the departments of La Paz and Potosí. Hypertensive disorders in pregnancy contribute to maternal morbidity and mortality, and in Bolivia these are aggravated by altitude [6]. In 2011, the average age of the deceased women was 28.9 years (implying a total of 19,061 potential years of life lost) [7].

1.3 Infant mortality also varies significantly between regions, with the highest rates per 1,000 live births reported in the departments of Potosí (126) and La Paz (81), and in the municipio of El Alto where the figure is 72. Over half of all infant mortality is neonatal, of which the national rate is 27 per 1,000 live births (23 in urban areas and 40 in rural zones) [8-10]. Potosí reports figures that are double the national average (52 deaths per 1,000 live births), followed by La Paz (34) and the municipio of El Alto where the figure is 29. Roughly 8,000 neonatal deaths occur in Bolivia every year; but, as only 76% of births are actually recorded, the real rate of neonatal mortality is probably higher [11]. The main direct causes are: (i) prematurity/low birth weight (33%); (ii) birth asphyxia (26%); (iii) infectious diseases (25%); (iv) congenital malformations (6%); and (v) other causes (10%). Most cases of neonatal mortality are also influenced by problems affecting the mother during pregnancy, such as her nutritional status (anemia), infections, and hypertension.

1.4 **Characterization of maternal and neonatal morbidity and mortality**. In Bolivia, only 72% of pregnant women receive four or more prenatal check-ups, and just 68%-76% of deliveries are attended by a healthcare professional [12-15]. Only 77% of births receive postnatal care within 48 hours after delivery [16-17]. According to the latest Demography and Health Survey (2016), just 32% of women of childbearing age used a modern method of contraception (34.1% in urban areas and 27.6% in

[1] Bibliography (optional link 2).

[2] Ministry of Health, 2016.

rural zones); and the adolescent pregnancy rate is 14.8%. Scientific evidence[3] shows that maternal and neonatal mortality are significantly reduced by early referral of pregnant women, prenatal check-ups, institutional delivery (in healthcare facilities that can respond to obstetric-neonatal complications), and postnatal monitoring of the mother and newborn, including preconception family planning and the spacing of pregnancies[18].

1.5 In addition, co-morbidity conditions such as anemia, preeclampsia, diabetes, intrauterine growth restriction, low birth weight, and premature birth increase the risk of maternal-neonatal mortality [20-24]. These conditions are influenced by the mother's health and nutrition status before, during, and after delivery (more than 30% of women of childbearing age suffer from anemia) [25]. Furthermore, over half of all women of reproductive age are overweight or obese [26], which increases the frequency of cesarean sections and the risk of mortality [27]. The World Health Organization (WHO) has identified cost-effective nutrition strategies that, when combined with obstetric care, help to prevent maternal and neonatal mortality [28]. Although in Bolivia most of these recommendations are included in the clinical protocols [29], the low rate of consumption of prenatal supplements by women in the lowest income quintile (70%) [30] indicates that access to and use of these services needs to be strengthened.

1.6 **Supply-side causes**. The accessibility and health outcomes of the services available are limited for several reasons: (i) qualitative and quantitative deficits in health facility infrastructure and equipment [31-32]; (ii) deficiencies in the availability, training, and distribution of health sector personnel [33]; (iii) shortage of medicines and safe blood; (iv) fragmented operational management [34] in the healthcare networks; (v) inadequate information systems for management and monitoring [35]; and (vi) lack of intercultural adaptation and community involvement in the organization of healthcare. Bolivia is one of the countries in the region with the lowest per capita number of hospital beds, which, moreover, are concentrated in the most socioeconomically advantaged areas [[36]. Although Bolivia reports an index of 1.6 beds per 1,000 inhabitants (compared to a regional average of 3.4), this figure includes the short-stay and observation beds existing in primary health centers. When these are excluded, the figure drops to 0.64. Moreover, this supply of services has little capacity to resolve obstetric-neonatal problems. According to the most recent study of gaps in essential neonatal obstetric care (ENOC) facilities, only 11% included basic emergency obstetric services, and 53% were unable to perform the six basic functions of emergency obstetric care [37]. The country has 8.9 doctors and 5.1 nurses per 10,000 inhabitants, mainly concentrated in the social security and private subsectors. The public sector has 2.7 doctors per 10,000 inhabitants, owing to the sector's low capacity to attract and retain them (mainly because of low pay levels). The supply of services is hampered by the fact that medication stocks frequently run out, both in healthcare establishments themselves and at the State Health Service Supply Center (CEASS) [38]. The supply of safe blood is scarce, with only 17 blood banks in existence in 2018.

[3] The econometric study by Marie Lebrou (2016) [19] finds that the following variables have a significant impact on maternal mortality in Bolivia: (i) percentage of women attending four prenatal check-ups; (ii) number of healthcare personnel employed; and (iii) the number of women who attend their first postpartum checkup.

1.7 Managerial issues also affect the system's health outcomes. The structure of the Bolivian health system has three levels of authority: (i) the Ministry of Health which plays a regulatory role, but is also responsible for a number of centralized programs at the lower operational levels, and has a large number of personnel at the primary care level (the Mi Salud [39], Tele-salud [40], and Bono Juana Azurduy programs [41], etc.); (ii) Departmental Health Services (SEDES), which report to the autonomous departmental governments (GADs), which are responsible for tertiary hospitals and healthcare personnel assigned in the primary, secondary, and tertiary care levels; and (iii) autonomous municipal governments (GAMs), which are responsible for the operation of primary and secodary care facilities (in some cases, they also use their own resources to hire contract health personnel to supplement the staff of those establishments). There is a lack of coordination at the operational level between staff employed at the central level (Ministry of Health) and the healthcare personnel of the individual establishments (hospitals and health centers) attached to the SEDES and/or municipios. This impairs the effectiveness and efficiency of the supply of services. There is no comprehensive information system for the management of the sector to ensure continuous care [42]; rather the country has multiple subsystems that are not interoperable [43]. There is also no permanent information system on maternal-neonatal morbidity and mortality enabling the monitoring thereof.

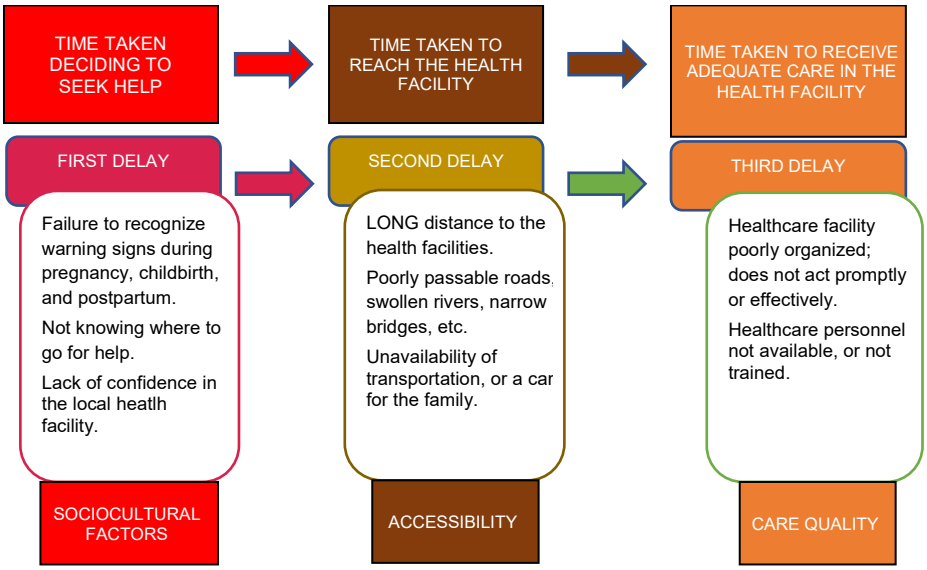
1.8 **Demand-side causes**. Statistics show that the most disadvantaged population groups make little or no use of institutional obstetric and neonatal care services. Access to free care programs for reproductive, maternal, newborn, and child health (RMNCH), and to conditional transfers varies across cultural dimensions, social groups, and geographic conditions. This can be seen even in cases of professionally supervised childbirth followed by the mother's death: in municipios with low poverty rates, 70.6% of the deceased had given birth in a healthcare facility, compared to just 19.5% in high-poverty municipios [44]. Various studies [45] have shown that, in Bolivia, the decision to seek healthcare services is restricted by: (i) geographic distance; (ii) limited hours and lack of timely care; (iii) ignorance of the language by healthcare personnel and lack of intercultural adaptation when providing care to indigenous peoples; (iv) poor-quality care, lack of equipment, or unavailability of free medicines; and (v) different perceptions of health-illness in the community. Given the socioeconomic and cultural reality prevailing in Bolivia, community health workers can play a key role in ENOC services, by providing micronutrients and other preventive services during pregnancy, along with social mobilization and transportation to healthcare facilities for at-risk pregnant women [46]. Nonetheless, Bolivia has just one community worker for every 10,000 inhabitants [47] (the average for lower-middle-income countries is 4.2). The poor RMNCH indicators are also influenced by morbidity conditions and risk factors such as unprotected sex, which leads to unwanted pregnancies and sexually transmitted diseases. This is compounded by violence against women and girls, together with cultural attitudes that restrict the woman's autonomy to make decisions on her own health. Among women aged 15 or older who had given birth under institutional supervision in the last five years, 64% reported suffering some form of psychological aggression in terms of obstetric violence.

1.9 **Program logic**. To meet the challenge of reducing maternal and neonatal morbidity and mortality in Bolivia, the government has asked the Bank to implement this

program to: (i) improve the institutional management capacity of ENOC services; (ii) increase the accessibility and quality of the supply of maternal and child healthcare services; and (iii) improve the health outcomes of its infrastructure and make it more resilient [48] to natural and climatic phenomena, and environmentally sustainable. No single action, on its own, can substantially reduce maternal and neonatal mortality. Accordingly, international recommendations advocate packages or sets of services, and propose to prioritize intrapartum care, without neglecting preventive services during pregnancy [49] and postpartum [50]. Considering the main elements of context, supply, and demand, and in the framework of the government's response, the problems surrounding the accessibility and quality of obstetric and neonatal care and family planning services will be addressed by implementing the ENOC strategy (optional link 12), in prioritized health networks. This will include support for implementation of the quality care model [51], and strengthening of supply and management processes that enable its efficient management: (i) management and training of human talent; (ii) implementation of suitable information systems for monitoring, analysis, and evaluation [52]; and (iii) improved health outcomes of prenatal, obstetric, postpartum and neonatal services and care, by investing in infrastructure and equipment, with an integrated health network vision, coordinated through a clear hierarchy of health-outcome-focused capabilities across the ambulatory, basic, and full-service levels, and by a system of referral and response that starts in the community [53].

1.10 The ENOC strategy responds to: (i) the four pillars of safe motherhood (family planning, prenatal care, clean and safe delivery, and care for high-risk pregnancy and newborns and their complications); (ii) the care continuum; and (iii) the three delays (Figure 1). The strategy is made operational by: (i) implementing rules that increase the coverage of preconception, obstetric, postpartum, and family planning services; (ii) strengthening the infrastructure and processes for continuous improvement of care; (iii) improving systems of information and surveillance of maternal-neonatal morbidity and mortality; and (iv) increasing the clinical and intercultural competencies of healthcare personnel and interaction between health system actors and the community.

Figure 1. The three delays model



Source: Thaddeus and Maine, 1994.

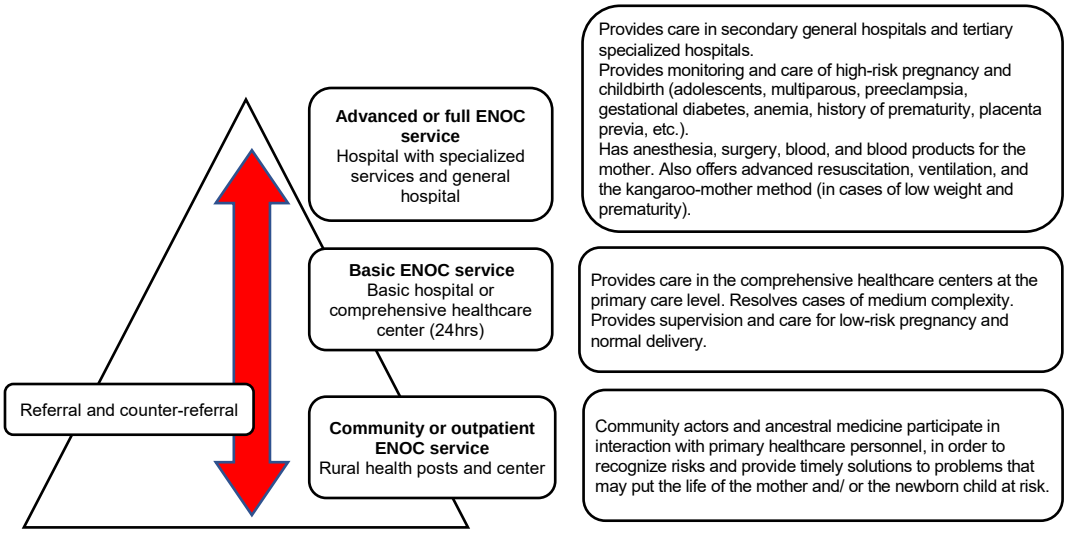
1.11 Implementation of the ENOC strategy, together with a continuous process to improve the quality of its application, will focus on services for which there is evidence of their effects in reducing maternal and neonatal deaths: (i) encouraging the early referral of the pregnant woman (before week 20); (ii) improving her nutrition and consumption of prenatal supplements; (iii) extending the coverage of prenatal checkups (at least four) and postnatal controls (within 48 hours of delivery); (iv) increasing institutional delivery (in hospitals and comprehensive healthcare centers); (v) strengthening the obstetric emergency referral system; (vi) increasing the number of healthcare personnel and enhancing their capabilities;[4] and (vii) optimizing access to family planning services for women and men. For this purpose, it will be necessary to: (i) update the National Clinical Care Standard and the portfolio of services covered by Law 475 on Comprehensive Health Service Benefits (of 30 December 2013); (ii) implement information, education and communication (IEC) programs in the community, to change attitudes towards RMNCH and family planning, creating community platforms to support ENOC services; (iii) improve obstetric emergency response systems (early diagnosis within the community, timely treatment, and transfer to a secondary or tertiary care center); (iv) increase the therapeutic and intercultural clinical capacity of healthcare personnel; and (v) ensure the existence of medicines and safe blood in healthcare facilities, as appropriate for their level of complexity. In a crosscutting way, improvement, and optimization of ENOC management processes will be supported by implementing a model of network administration and hospital network management that makes more efficient use of resources, particularly healthcare personnel, coordinating the capacities of vertical programs under the Ministry of Health with the operational levels of the SEDES and GAMs. Municipal management systems will also be strengthened for the planning and execution of healthcare resources within their annual work plans; and information systems will be

[4] Training of doctors and nurses, and inclusion of obstetric nurses in the system.

implemented to facilitate the care continuum and clinical management in the network, as well as the ongoing monitoring of maternal and neonatal morbidity and mortality.

1.12 Obstetric and neonatal care services distinguish three groups of benefits, which are summarized in Figure 2. Basic and full ENOC services should be available in secondary or tertiary hospitals. Thus, adequate hospital infrastructure and equipment is critical for resolving obstetric complications and reducing maternal and neonatal mortality [54]. Various experiences and studies have found evidence of the relationship between the adequacy of healthcare facility infrastructure and equipment, their increased use for childbirth, and the reduction of maternal and neonatal mortality, both in the region (Guatemala) [55] and globally [56-57]. Accordingly, the program will promote: (i) an improvement in health outcomes and quality in prioritized networks, by investing in improvements to hospital infrastructure and equipment (benchmark facilities for the health networks); and (ii) the new construction and/or replacement of hospitals, including the construction of adjoining maternity facilities to promote institutionally supervised delivery in populations that live far from the network nodes (50.5% of women of childbearing age cite the remoteness of healthcare services as a reason for not making use of them [58]).

Figure 2. Portfolio of ENOC service by type of healthcare establishment



Type of ENOC service	Care level in Bolivia	Healthcare facility covering
Community or outpatient	Primary	Health post (Rural with nursing assistant or health technician)
		Outpatient healthcare centers
		Healthcare center with beds
Basic	Primary	Comprehensive healthcare center (with hospitalization)
		Comprehensive healthcare center (CIS)
		Comprehensive family medicine center (CIMFA)
		Polyclinic providing comprehensive specialist care (PAISE)
Full type 1	Secondary	Secondary care level hospitals
Full type 2	Tertiary	Tertiary care level hospitals

Note: Health posts and centers:	3,001	- In the targeted networks	556
Comprehensive health centers:	122	- In the targeted networks:	26
Secondary hospitals:	76	- To be targeted by the program:	11
Tertiary hospitals:	32	- To be targeted by the program:	4

1.13 **Gender and diversity**. The healthcare gaps for the indigenous population are due to: (i) lack of access to quality services; (ii) dispersion of the population in rural areas; (iii) deficiency of the road network; (iv) inadequate cultural relevance in the delivery of services and infrastructure [59]. To ensure cultural relevance in service delivery, an intercultural service protocol will be developed for the health network, and staff will receive training. An ethnographic study will also be performed to culturally adapt the infrastructure; and healthcare personnel will receive training on issues of obstetric violence.

1.14 **Support for the digital transformation of the sector**. The upgrading of management processes in the health services network will be supported by implementation of the digital clinical record, facilitating the care continuum, and the installation of computer systems for hospital management and referrals and counter-referrals, improving the efficacy and efficiency of the system. Surveillance and monitoring systems for maternal and neonatal morbidity and mortality will also be strengthened. Investments will be made in infrastructure by adopting "Building Information Modeling," from the design stage through construction and maintenance of the facilities, thereby helping to reduce costs and shorten works deadlines, improving the transparency and traceability of processes, and enhancing the operational quality of the new assets.

1.15 **Actions to mitigate and adapt to climate change**. Hospital infrastructure has a dual relationship with climate change. First, it is highly vulnerable to the effect os climate change;[5] and, second, it is a source of greenhouse gas emissions derived from the infrastructure building and operational phases, due to these facilities' energy consumption. Under the program, two lines of action will be proposed: (i) for new infrastructures, studies will be conducted to select less vulnerable sites; and (ii) for improved and new infrastructure, energy and water saving measures will be implemented, which will make it possible to reduce greenhouse gas emissions. Definition of the measures to be implemented will draw on resources from technical assistance program ATN/OC-16801-BO,[6] which involves supporting the program on issues including energy efficiency and climate change resilience. Moreover, the Excellence in Design for Greater Efficiencies (EDGE) tool will be applied during the design and construction stages; and the new buildings will be certified.

1.16 **Geographic scope and beneficiaries of the program**. The program will act in 15 health networks of the 107 that comprise the system, covering 61 municipios. Ten of these networks are located in the two departments with relatively higher maternal and neonatal mortality rates: La Paz[7] (the Los Andes, Corea, and Senkata networks in the El Alto municipio, and rural networks 1 and 7) and Potosí (Potosí urban network and the Uncía-Sacaca, Ocurí, Tupiza, and Villazón rural networks) [60]. According to maternal mortality data for 2011, these two departments alone accounted for 51.6% of maternal deaths and have the lowest coverage rate of institutional childbirth (La Paz with 59% and Potosí with 62%) [61]. It will also act in

---

5 For example, floods or natural disasters may make it impossible to respond to the emergency and alter the routine service delivery.

6 Support for AISEM Organizational Development and the Design of an Investment Model for Network Health Services.

7 The Mother-Child hospitals of El Alto (Senkata network) and Palos de Blancos (rural network 1) make up the autonomous municipal government sample.

the departments of Santa Cruz (Germán Bush, Andrés Ibáñez, and Cordillera networks), Chuquisaca (Monteagudo network) and El Beni (San Borja network). These last three departments accounted for 40% of adolescent maternal deaths reported between January 2015 and June 2017 [62]. Optional link 3 presents the main coverage data.

1.17 Of the 2,172,950 inhabitants covered by the program's actions, 567,374 are women of childbearing age, 237,248 are children under the age of five, and 387,041 are children between five and 12 years old. The poverty rate is 59.8% and the indigenous population represents 43.9% of all beneficiaries. Healthcare personnel are also direct beneficiaries of the program, since they will receive training through a variety of activities.

1.18 **The Bank's support for the Bolivian health sector**. During the past decade, Bolivia has channeled Bank financing to improve access to hospital services and strengthen its health service networks, through comprehensive actions that have enabled improvements including the following: the start-up of the El Alto Norte tertiary hospital and the Potosí Medical Emergencies Regulatory Center; and acquisition of the first linear accelerator in the public health system (Hospital El Alto Sur, pending startup of operation). The construction of four hospitals is nearing completion (2019). These actions have also included the development and implementation of a new hospital management model, whose general replication in the system will make it possible to enhance care quality and improve the efficiency of resource use; the model prioritizes quality of care (setting standards that reduce clinical variability) and the patient's access to hospital care resources (scheduling of consultations and complementary tests, management of waiting lists and the "bed" resource, etc.). Through various technical cooperation programs, the Ministry of Health is receiving support in: (i) the design of the Unified Health Information System (SUIS) and the e-Government Strategic Plan; (ii) the implementation of a model of intercultural care and protocols for dealing with situations of gender and obstetric violence; and (iii) the quantification of investment gaps for upgrading current tertiary hospitals to the National Characterization Standard and, thus, be able to accredit them. This program will also finance equipment shortages identified in operations currently in execution (the Los Andes and Corea networks in the El Alto municipio, the Potosí urban network, and the Uncía and Ocurí networks also in Potosí) (optional link 13).

1.19 **Lessons learned**. The program design draws on lessons learned from previous Bank-financed operations in the Bolivian health sector, and also on the Bank's experience in investment projects and the strengthening of health systems in the region:

a. Improving the accessibility and quality of health services requires a comprehensive network intervention, covering the three care levels, referral and counter-referral systems and management considerations (including information systems).

b. In complex health infrastructure investment projects, specialized technical assistance provided through external consulting firms on design, supervision, and fiduciary issues, is a key factor for achieving objectives in a high-quality and timely manner.

c. In decentralized health systems such as Bolivia's, coordination of those responsible for program execution with the subnational levels is fundamental for understanding and correcting implementation difficulties, thereby saving cost and time.

d. Periodic top-level monitoring and coordination meetings with national counterparts facilitates rapid and timely decision-making to resolve bottlenecks that can delay the achievement of results.

e. Dialogue and coordination with other cooperation partners makes it possible to achieve synergies in the actions and integrate them into a common alignment framework, thereby making them more effective and efficient.

1.20 The program design reflects the following lessons learned: (i) it includes comprehensive action at the three levels of care and management (Components 1 and 2); (ii) it will finance specialized technical assistance for the executing agency (Component 3); (iii) it will ensure coordination at the different levels of the system (national, departmental, and municipal) (paragraph 3.4); and (iv) it will coordinate with the other agencies operating in the sector.

1.21 **Coordination with other donors**. The various donors that contribute to the Bolivian health sector[8] are members of the Partners for Development Group (GRUS), which is currently chaired by Canada. The following priority areas of support for international cooperation have been identified: (i) the National Hospital Plan; (ii) the Maternal and Child Morbidity and Mortality Reduction Plan; (iii) development of the SUIS; and (iv) training for healthcare personnel. The program focuses on these four priorities, and will be coordinated with donors who are also involved in health infrastructure investments (World Bank, Republic of Korea, France, and Italy), healthcare personnel training (Spain, Belgium) and general training on obstetric and neonatal issues (WHO, United Nations Population Fund). The operation recently approved by the World Bank will take action in 10 other healthcare networks across the country and will support measures to expand capacity to train specialist doctors. Along with this program, it is part of the National Hospital Plan 2016-2020 and will be developed in parallel using the same executing agencies.

1.22 **Strategic alignment**. The program is consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008) and is strategically aligned with the development challenge of Social Inclusion and Equality, since it aims to reduce maternal and neonatal mortality in vulnerable population groups. It is also aligned with the following crosscutting themes: (i) Gender Equality and Diversity, by promoting the empowerment of women in relation to RMNCH, the intercultural adaptation of ENOC services, and the incorporation of protocols for dealing with situations of gender and obstetric violence; (ii) Climate Change and Environmental Sustainability, by promoting efficient, sustainable and resilient infrastructures; and (iii) Institutional Capacity and the Rule of Law, by expanding the portfolio of benefits covered by Law 475 and strengthening municipal health management capacities and hospital and health network management. The program will also contribute to the Corporate Results Framework (CRF) 2016-2019 (document GN-2727-6) by

[8] Bilateral cooperation including with Belgium, Canada, France, Germany, Italy, Japan, Republic of Korea, and Spain, as well as with United Nations agencies and the World Bank, is coordinated within the GRUS health group.

reducing the maternal mortality ratio (Country Development Results Indicator 2); increasing the number of beneficiaries receiving health services (Indicator 9), and enabling healthcare personnel to benefit from on-the-job training (Indicator 13). It is also consistent with the Health and Nutrition Sector Framework Document (document GN-2735-7) because: (i) it encourages the reduction of gender, ethnic, and cultural barriers to using health services; (ii) it promotes the sufficiency and relevance of infrastructure, technology, inputs, and human resources required for the creation of service networks; and (iii) it increases revenue collection in the municipios through Law 475, and strengthens the economic planning of health spending, as well as centralized purchasing processes at the CEASS. It is also aligned with the Bank's country strategy with Bolivia (2016-2020) (document GN-2843), by helping to expand access to social services and improve their quality, as it will facilitate access to ENOC services in an equitable and timely manner for the most vulnerable population. It will also improve the effectiveness of public management, strengthening the health sector's managerial capacity by implementing more efficient management models, and by supporting its digital transformation. The program is included in the 2018 Operational Program Report (document GN-2915).

1.23 Some 39.16% of the operation's resources are invested in climate-change mitigation activities, according to the multilateral development banks' joint methodology for estimating climate finance. These funds contribute to the IDB Group's target of increasing lending for climate change projects to 30% of all loan approvals by end-2020.

B. Objectives, components, and cost

1.24 **Objective**. The program's general objective is to reduce maternal and neonatal morbidity and mortality, by increasing the accessibility and enhancing the health outcomes of the prioritized health networks (those with the worst maternal and infant mortality and accessibility indicators). The specific objectives are: (i) to implement the ENOC strategy and improve network performance by: (a) implementing processes for the continuous improvement of care quality, with emphasis on an ENOC service model; (b) supporting the digital transformation of the sector by improving health care management information systems in the network and monitoring of maternal and neonatal morbidity and mortality; and (c) enhancing management capacities in the network and in individual healthcare facilities; and (ii) to strengthen the infrastructure of the health services network, by investing in works and equipment that improve its health outcomes, under a comprehensive, coordinated vision of the network.

1.25 **Component 1. ENOC strategy, management, and healthcare human resource training (US$16.6 million)**.

a. **Subcomponent 1.1. ENOC care model (US$9.7 million)**. This subcomponent aims to implement the ENOC strategy in the prioritized networks under a continuous quality improvement approach. Financing will be provided to: (i) support the redefinition of the ENOC services portfolio within the framework of Law 475 and the preparation and dissemination of standards, guidelines, and/or regulations that facilitate its implementation; (ii) implement a program for the continuous quality improvement and optimization of ENOC processes, including actions that improve the nutrition of pregnant women and newborn

children; (iii) train health outreach workers to implement community platforms for ENOC services; (iv) implement actions to reduce gender and obstetric violence, and violence against children, as well as IEC for behavioral change in relation to RMNCH, targeting young people, women of childbearing age, and the general population; (v) strengthen the centralized system for purchasing supplies and medicines for ENOC and family planning services, through the CEASS; (vi) strengthen the safe blood system in hospitals and comprehensive health centers; and (vii) improve referral and counter-referral systems. For these activities, financing will also be provided for the procurement of medical instruments, inputs, medicines, and software, and for bringing obstetric nurses into the system.

b. **Subcomponent 1.2. Information systems and management (US$5.3 million)**. The objective of this subcomponent is to optimize and improve managerial processes in the healthcare networks. Finacning will be provided to: (i) implement a hospital management model; (ii) strengthen management systems at the municipal and departmental levels to improve enforcement of Law 475, and the planning and monitoring of the municipal health budget; (iii) strengthen maternal mortality surveillance using the Reproductive Age Mortality Survey (RAMOS) methodology. The subcomponent will also finance the procurement of hospital and health network management software for these activities.

c. **Subcomponent 1.3. Training of healthcare personnel (US$1.6 million)**. The objective is to improve the clinical, intercultural, and managerial capacities of healthcare personnel. Financing will be provided for: (i) continuous on-the-job training on ENOC, intercultural care, and health service management; and (ii) scholarships for the training of medical specialists to work in the program's hospitals.

1.26 **Component 2. Infrastructure and equipment (US$249.7 million).**[9] This component's objective is to strengthen the secondary and tertiary hospital system in the prioritized networks, to enable them to satisfactorily meet the advanced ENOC and pediatric demand in its coverage area. Optional link 4 shows the geographical distribution of the investments:

a. **Subcomponent 2.1. Coverage of equipment gaps (US$49.5 million)**. The objective of this subcomponent is to improve the health outcomes and operational capacity of the hospitals financed by the Bank in other operations, by upgrading and increasing their current level of equipment. The subcomponent will finance the procurement of medical-assistance, communication, and information equipment, including software, and furniture for the El Alto Norte, El Alto Sur, Ocurí, and Llallagua hospitals and the tertiary hospital in Potosí.

b. **Subcomponent 2.2. Strengthening of secondary care in prioritized networks (US$128.5 million)**. The objective is to improve the supply of healthcare, by enhancing health outcomes and quality of care in nine

[9] Optional link 7 lists the equipment for secondary and tertiary hospitals and estimates infrastructure costs. The technical specifications of hospital equipment are available from loans currently in execution.

secondary hospitals.[10] The following activities will be financed: (i) preparation of preinvestment studies for the construction and/or expansion and equipping of healthcare facilities; (ii) construction and/or expansion of healthcare infrastructure, including maternity facilities (when applicable); (iii) medical-assistance, communication, and information equipment, including software, and furniture; and (iv) supervision of previous activities.

c. **Subcomponent 2.3. Strengthening of tertiary care in the municipio of El Alto (US$69 million)**. The objective of this subcomponent is to increase the hospital coverage of tertiary maternal and child care services in El Alto, by building and equipping a new hospital with roughly 180 pediatric beds and 30 neonatal beds, subject to the findings of the preinvestment study. Financing will be provided for: (i) preparation of preinvestment studies; (ii) construction and equipping; and (iii) supervision of the foregoing activities.

d. **Subcomponent 2.4. Commissioning of new hospitals (US$2.7 million)**. This subcomponent aims to support the start-up of new hospitals under an organizational structure and an efficient and patient-centered management model. Financing will be provided for: (i) preparation of opening and/or migration plans; and (ii) technical assistance for commissioning of the new hospitals and support as they start to operate. Consulting firms and/or individual consultants may be hired for this purpose.

1.27 **Component 3. Audits, administration, monitoring, and evaluation (US$8.7 million)**. This component aims to ensure effective and efficient program execution. It will finance the following activities: (i) the program's executing teams and technical and fiduciary support for them (including strengthening capacities for oversight of preinvestments, works, and equipment in the case of Component 2);[11] (ii) program audits; and (iii) the midterm and final evaluations.

C. Key results indicators

1.28 **Expected impacts and outcomes**. The program's general intended impact is a reduction in maternal and neonatal mortality in Bolivia. The maternal mortality ratio will be measured using the RAMOS methodology; and the neonatal mortality rate will be estimated on the basis of the National Demographic and Health Surveys, both implemented by the National Institute of Statistics. The program's expected outcomes are: (i) better quality and accessibility of ENOC and family planning services; (ii) improved health outcomes of the health networks in the provision of ENOC services; and (iii) improved management capacity and efficiency of networks and healthcare facilities. Components 1 and 2 of the program will contribute to the first and second outcomes; and Component 1 will contribute to the third (Annex II and required link 2).

[10] Tentatively: Palos Blancos (rural network 7), Ixiamas (rural network 1), Puerto Suarez (Germán Bush network), El Torno (Andrés Ibáñez network), Camiri (Cordillera network), San Borja (San Borja network), Monteagudo (Monteagudo network), Villazón (Villazón network) and Tupiza (Tupiza network). The final portfolio will be defined based on the pre-financing studies of technical conditions by ATN/OC-16801-BO.

[11] Technical Assistance program ATN/OC-16801-BO will also finance the development of an investment model in network health infrastructure, and issues related to the planning, formulation, and evaluation of public investment projects in the country's hospital network.

1.29 **Ex ante cost-benefit evaluation**. Based on relevant scientific evidence for Bolivia, an economic analysis (optional link 1) was performed to quantify the expected benefits, using Disability Adjusted Life Years (DALY), which result from the implementation of care lines that have proven effective in integrated health services networks. These benefits stem from the population's increased consumption of healthcare services, and the costs generated by the investment and by the operating expenses of the new hospitals. The program shows a return and positive social benefits under various scenarios. The benefit-cost ratio is 2.84, considering a five-year time horizon (2018-2023) and a conservative scenario.[12] Under a longer horizon, with annual operating costs of US$34.9 million, the benefit is even greater. The analysis takes account of ENOC, early childhood, chronic, emergency, and general primary care services.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 This operation is an investment loan under the multiple works program modality, involving physically similar but independent projects.[13] The total cost is US$275 million, which will be financed by the Bank as follows: US$233,750,000 from regular Ordinary Capital resources and US$41.25 million with concessional Ordinary Capital funds. The consolidated budget by component is indicated below (optional link 6).

Table 2.1. Program costs (US$)

Component	Amount			%
	Ministry of Health/PEU	AISEM	Total	
Component 1. ENOC strategy, management, and healthcare human resource training	16,600,000	-	16,600,000	6.0
Component 2. Infrastructure and equipment	-	249,700,000	249,700,000	90.8
Component 3. Audits, administration, monitoring, and evaluation	3,600,000	5,100,000	8,700,000	3.2
Total	**20,200,000**	**254,800,000**	**275,000,000**	**100.0**

2.2 The program's expected disbursement period is five years from the loan contract's effective date. Program works will physically start within two years from that date. Loan disbursements relating to the foregoing works will be completed within five years following the loan's effective date.

[12] The discount rate used in the baseline scenario is 3%, ranging from 2% (which, according to the WHO, is the relevant discount rate for the economic analysis of health investment projects) up to 9%. The benefit-cost ratio is above 1 in all cases (optional link 1).

[13] Operations Processing Policy PR-202 Multiple Works Programs.

Table 2.2. Disbursement schedule (US$)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	Total
IDB	24,747,898	62,800,374	86,923,314	72,476,816	28,051,598	**275,000,000**
%	9.0	22.8	31.6	26.4	10.2	**100.0**

2.3 The projects to be financed under the program's subcomponents 2.2 and 2.3 will have the Bank's no objection and meet the following eligibility criteria: (i) be included in the National Hospital Plan 2016-2020; (ii) be implemented in secondary or tertiary hospitals; (iii) be located in health network nodes; (iv) be located in rural municipios or urban areas receiving rural migration; and (v) not be classified as catetory "A" operations or involve involuntary resettlement, pursuant to the Bank's safeguards policies.

2.4 A representative sample,[14] covering more than 30% of the program cost, was evaluated during program preparation. The sample covers the two types of planned hospital investments (secondary and tertiary) and the intervention's different types of ecological terrain (highlands and tropical).

B. Environmental and social risks

2.5 According to Operational Policy OP-703, the operation has been classified as a category "B" operation, since the potential environmental and social risks and the negative impacts arising from the program's construction works are expected to be manageable, low-intensity and localized, with adequate environmental, social, and health and safety (ESHS) safeguards in place. The impacts typically associated with infrastructure building, such as noise and dust, traffic disruption, pollution, waste and debris, and challenges in terms of worker health and safety, are expected to occur mainly during the construction period and will be duly mitigated. No indigenous community or territory in particular will be affected; but indigenous peoples are present in the different intervention areas of this project, and they are expected to be among the program's main beneficiary groups. The lessons learned from previous health-sector operations in Bolivia show that special attention needs to be devoted to issues related to property rights, access to basic services (drinking water, electricity) for the hospitals before receiving the equipment, and the storage and disposal of hazardous and infectious waste during the operation. The disaster risk-level for this operation was rated medium; and the eligibility criteria of the Environmental and Social Management Framework (ESMF) prevent future construction in disaster-prone areas. No resettlement is envisaged and the ESMF eligibility criteria will not allow financing for projects that involve physical or economic displacement under the program. Public consultations have been held for the projects in the sample; and their Environmental and Social Management Plans and the program's ESMF have been released in a timely manner.

C. Fiduciary risks

2.6 The program's executing agencies are AISEM and the Ministry of Health acting through a program execution unit (PEU). These do not have technical staff who are familiar with the Bank's fiduciary procedures. In the case of AISEM, this is because it was created only recently and lacks experience; and in the case of the Ministry of

[14] Mother and Child Hospitals of El Alto and Palos Blancos.

Health, it is because of the ministry's high rate of staff turnover, which could result in inadequate implementation of the procurement policies and a failure to meet the minimum quality standards desired for the products to be procured. The limited experience of local firms in hospital design, construction, and supervision could impose a constraint on finding quality suppliers, with the result that the program's outputs are not obtained in a timely and adequate manner. Both are identified as medium fiduciary risks.

2.7 These risks will be mitigated by: (i) strengthening the executing agencies' technical, administrative, financial, planning, and procurement teams, by incorporating specialists who already have experience with Bank programs (closed operations), and by providing training for the fiduciary team of both executing agencies; (ii) using multiyear contracts for the executing agencies' specialists, subject to performance evaluations; (iii) creating lots/packages of preinvestments, works, and/or equipment to make bidding more attractive; and (iv) at the same time extensively advertising public calls for proposals.

D. Other program risks

2.8 The fact that some GAMs have not yet completed the process of obtaining legal possession[15] of the properties where the Component 2 works will take place was identified as a high development risk. To mitigate this risk, a special execution condition will require that the borrower, through the executing agencies, agree to submit to the Bank's satisfaction evidence that the agreements between the respective executing agencies and the end beneficiaries have been signed and taken effect, establishing conditions including that: the end beneficiaries hold legal possession of each of the properties in which the Component 2 works will take place before the award of the corresponding contract. This condition is critical because it must be confirmed that the properties on which the hospitals will be built actually belong to the end beneficiaries.

2.9 The sustainable financing of hospital operating costs (supplies, medicines, logistics, infrastructure, and equipment maintenance), which must be assumed by subnational governments, was identified as high-risk in terms of fiscal sustainability. To mitigate this risk, a special execution condition will require that the borrower, through the executing agencies, agree to submit to the Bank's satisfaction evidence that the agreements between the respective executing agencies and the end beneficiaries have been signed and taken effect, establishing conditions including that: six months before the start of operation of each of the works under Component 2, the executing agencies will submit evidence to the Bank that they have the commitment of the end beneficiaries that they have the resources needed to operate and maintain the infrastructure and equipment of the works in question.

2.10 Two public management and governance risks were also considered high: (i) the timely availability of the human resources needed to operate the new hospitals, which will be contracted by the Ministry of Health with funds from the National Treasury; (ii) planning of the training of specialist doctors to be assigned to these hospitals. To mitigate the first risk, six months before the start of the operation of each of the works in Component 2, the executing agencies will submit evidence to

[15] Legal possession is deemed to exist when the folio record of the property in question is registered at the Real Estate Office, in the name of the end beneficiaries.

the Bank that they have received the allocation by the Ministry of Health for new healthcare personnel. The second risk will be mitigated by the approval in 2019 of a specialist training plan financed by Subcomponent 1.3. Prior to works execution, the Ministry of Public Health and the Ministry of Economy and Public Finance will make an express commitment to make the corresponding healthcare staff allocation to the respective hospitals, through a written communication to the Bank.

2.11 To ensure the sustainability of the investment in healthcare personnel, doctors trained abroad will only receive certification as a specialist doctor in Bolivia, under agreements entered into with foreign training institutions. On the other hand, doctors that have received scholarships, whether in Bolivia or abroad, will be assigned to a specific hospital from the start of their training.

2.12 Public management and governance risk was rated medium: the need for effective coordination between the executing agencies and the general services and planning departments of the Ministry of Health, on the one hand, and with the subnational levels (GAM and GAD) on the other, for the approval and application of new clinical-care and management regulations, within the program framework. To mitigate this risk, coordination levels and periodicity will be specified in the program Operating Regulations (paragraph 3.5).

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 **Borrower and executing agency.** The Plurinational State of Bolivia is the borrower; with the Ministry of Health (acting through the PEU) and the AISEM serving as co-executing agencies.

3.2 **Program execution, administration, and coordination mechanisms (optional link 15)**. The Ministry of Health will execute Component 1 through the PEU. The latter will have technical-operational, administrative-fiduciary, and legal autonomy. It will also have a full-time staff, consisting of a Technical Coordinator with planning, management, administration, and general coordination responsibilities; together with staff with other technical profiles related to the program, including at least one specialist in public health and/or health services management, a human resource planning specialist, a lawyer, a monitoring and planning specialist, an administrative professional; and administrative support staff. The PEU will also have a financial specialist and a procurement specialist to handle fiduciary issues. The terms of reference and the professional profiles of these specialists will be agreed upon in advance with the Bank. Additionally, at the local level, the PEU will have at least six professionals distributed in the different departments, according to the geographic distribution and the number of networks in each case. All equipment and supplies will be provided to enable them to assume responsibilities for program execution.

3.3 Component 2 will be implemented by AISEM as co-executing agency. To execute the activities under its responsibility, it will draw on its own organizational structure, supplemented by a multidisciplinary team assigned full-time to the program, consisting of at least: a works supervisor, a lawyer, an environmental and social management specialist, a monitoring and evaluation specialist, a financial specialist, and a procurement specialist. In addition, all equipment and supplies will be provided

to them so that they can take responsibility for program execution. Subcomponent 2.1 will be executed with support from the execution units of loans 2614/BL-BO, 2822/BL-BO, and 3151/BL-BO.

3.4 The program's activities will be undertaken in coordination with the technical departments of the Ministry of Health, the SEDES, and the corresponding autonomous territorial entities, within the framework of the competencies defined in the program Operating Regulations (optional link 16/optional link 17). A general program management team will be created at the level of the Office of the Deputy Minister, which will coordinate the co-executing agencies and the SEDES (optional link 15). The program Operating Regulations will define the responsibilities and functions of the different actors, along with execution processes and procedures, including details of coordination between the various entities. These will be based on intergovernmental agreements between the Ministry of Health and the GAMs/GADs.

3.5 **A special contractual condition precedent to the first loan disbursement will require the borrower, through the executing agencies, to present evidence that the program Operating Regulations of each one include the Environmental and Social Management Plan and ESMF as annexes, as applicable, and have been approved and have entered into force under the terms previously agreed upon with the Bank**. This condition is critical for the program to have operating regulations in place and to establish the guidelines and procedures to be followed by the executing agencies. The program Operating Regulations will provide details of procedures for implementing the program's components, the composition and characteristics of the executing agencies, the responsibilities, functions, and coordination mechanisms of the entities involved in the operation, and the financial management, procurement, and contracting arrangements. Any modification of the Operating Regulations will require the Bank's no objection. The Operating Regulations should specify the following conditions: (i) that the PEU has been created in the Ministry of Health, and will have administrative and legal operational-technical independence; (ii) that the minimum teams needed have been formed to work under each executing agency to implement the program; (iii) six months before the completion of the works under Component 2, the end beneficiaries, through the Ministry of Health, will present evidence to the Bank that they have the budget for the healthcare personnel necessary to operate the Component 2 works; and (iv) other conditions established in the Environmental and Social Management Report, Annex B (required link 3).

3.6 **Procurement and contracting**. All procurement and contracting under the program will adhere to the Policies for the Procurement of Works and Goods Financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9), respectively. Members of the executing agency teams may be contracted for up to 12 months with funds from ATN/OC-16805-BO. Subsequently, the performance of the members of the executing team will be evaluated, and those with satisfactory performance will continue to provide their services, and will be financed out of program funds, through single-source selection.[16] Similarly, the personnel currently in charge of the

[16] Pursuant to the policy set forth in document GN-2350-9, paragraph 5.4 (a).

execution of loans 2614/BL-BO and 3151/BL-BO, scheduled for completion in 2019, may also be considered for single-source selection[17] to fill the necessary positions in the executing agencies. Some or all of the executing agency staff may be simultaneously assigned to the execution of other Bank-financed projects that are approaching completion, in coordination and prior agreement with the Bank.

3.7 **Retroactive financing**. The Bank may draw on the loan proceeds to retroactively finance eligible expenses incurred by the borrower before the loan approval date, to finance activities foreseen in Component 2, up to the amount of US$27.5 million (10% of the proposed loan amount), provided that requirements substantially similar to those specified in the loan contract have been met. The expenses in question will have been incurred on or after the project profile approval date of 4 June 2018, but in no case more than 18 months before the loan approval date.

3.8 **Financial management and audits**. Financial management will follow the Bank's Financial Management Guidelines (OP-273-6) (see Annex III). Financial management will be undertaken through the National Public Management System (SIGEP), which allows for online financial management and issueance of financial reports directly from the national system and in the program currency. For the processing of disbursements, the executing agencies will use the Bank's e-disbursement system. Each executing agency will be responsible for contracting its respective annual and final audits.

B. Summary of arrangements for monitoring results and program evaluation

3.9 The Monitoring and Evaluation Plan (required link 2) describes the arrangements for program monitoring and evaluations. The main monitoring instruments will be: (i) the semiannual reports, detailing the level of progress in physical and financial execution achieved during the six-month period, the planning of the respective targets for the following six-month period, and the updated matrices of the Program Monitoring Report (PMR) (optional link 14), multiyear execution plan (required link 1), procurement plan (required link 4), Program Risk Management, and financial planning; (ii) annual financial audits; and (iii) Bank missions or inspection visits and portfolio review meetings.

3.10 A midterm and final evaluation of the program will also be performed and submitted by the PEU to the Bank in the third and final years of execution, respectively. These descriptive evaluations will assess progress towards the output and outcome targets specified in the original Results Matrix and the PMRs of the second half of each year of execution. They will be conducted by external consulting firms.

3.11 The impacts attributable to the operation will be measured by the PEU, through an impact assessment using the difference in differences method. Various versions of this model and different criteria for data use will be applied to test the robustness of the results; and the evaluation will be complemented by a triple difference analysis. The findings of this evaluation will serve as inputs for decisions concerning the expansion of ENOC services to other networks based on the evidence and recommendations generated.

[17] Idem.

Development Effectiveness Matrix		
Summary		
I. Corporate and Country Priorities		
1. IDB Development Objectives	**Yes**	
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change and Environmental Sustainability -Institutional Capacity and the Rule of Law**	
Country Development Results Indicators	**-Maternal mortality ratio (number of maternal deaths per 100,000 live births)**	
2. Country Development Objectives	**Yes**	
Country Strategy Results Matrix	**GN-2843**	**1. Improve access and quality of social services. 2. Improve the effectiveness of public governance.**
Country Program Results Matrix	**GN-2915**	**The intervention is included in the 2018 Operational Program.**
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		**Evaluable**
3. Evidence-based Assessment & Solution	**8.4**	
3.1 Program Diagnosis	**2.4**	
3.2 Proposed Interventions or Solutions	**3.6**	
3.3 Results Matrix Quality	**2.4**	
4. Ex ante Economic Analysis	**10.0**	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	**3.0**	
4.2 Identified and Quantified Benefits and Costs	**3.0**	
4.3 Reasonable Assumptions	**1.0**	
4.4 Sensitivity Analysis	**2.0**	
4.5 Consistency with results matrix	**1.0**	
5. Monitoring and Evaluation	**9.3**	
5.1 Monitoring Mechanisms	**2.5**	
5.2 Evaluation Plan	**6.8**	
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	**B**	
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.**
Non-Fiduciary		
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	**BO-T1311 y BO-T1313**

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

The loan proposal identifies high maternal and infant mortality rates as the problem to be solved by the project. The document describes causal factors like demand conditions that reduce the use of institutional services by the disadvantaged population, and supply constraints such as infrastructure deficits, management fragmentation, inadequate information systems and cultural inadequacy. The project proposes financing the Neonatal Essential Obstetric Care strategy, as well as second and third level infrastructure and equipment of the prioritized health networks. The document presents empirical evidence of the effectiveness of the proposed interventions with internal validity.

The project's results matrix presents SMART impact and outcome indicators. However, output indicators are not specific and do not have a clear source of information. The project has a solid economic analysis based on a cost-benefit exercise that yields positive results under various sensitivity scenarios. The evaluation plan proposes differences in differences and time series analyses to estimate the impact of the project on the utilization, quality and final results of health services.

RESULTS MATRIX

Project objective:	To reduce maternal and neonatal morbidity and mortality, by increasing the accessibility and enhancing the quality of health outcomes of the prioritized health networks (those with the worst maternal and infant mortality and accessibility indicators).

EXPECTED IMPACT

Indicators	Unit of measure	Baseline	Baseline year	Final target	Final target year	Means of verification	Comments
IMPACT 1: Reduced maternal and neonatal morbidity and mortality							
1. Bolivia's maternal mortality ratio	Ratio	160	2011	140	2023	Mortality study/Ministry of Health.	The sisterhood and post-2012 census verbal autopsy methods were used to calculate the baseline. **Corporate Results Framework (CRF) Indicator 2.**
2. Bolivia neonatal mortality rate	Rate	27	2008	22			Baseline: Latest value estimated through the 2008 National Demography and Health Survey (ENDSA).

EXPECTED OUTCOMES

Indicators	Unit of measure	Baseline	Baseline year	Final target	Final target year	Source/Means of verification	Comments
OUTCOME 1: Increased quality and accessibility of obstetric and neonatal care and family planning							
I1. Births attended in healthcare facilities	%	71.44	2017	85	2023	National Health Information System – Epidemiological Surveillance (SNIS-VE)	In the 9 health networks prioritized for 2017 (SNIS-VE closed data).
I2. Births attended in a hospital/comprehensive health center	%	53.07	2017	63			
I3. Pregnant women who receive prenatal care before week 20	%	89.06	2017	94			
I4. Women who attend at least four obstetric checkups	%	73.18	2017	85			
I5. Newborns who receive postnatal care within 48 hours of delivery	%	65.28	2017	75			
I6. Women of childbearing age who use modern family planning methods	%	42.21	2017	55			
I7. Pregnant women who are undernourished	%	7.37	2017	5.5			
I8. Low birth weight prevalence	Rate	27.41	2017	18			

Indicators	Unit of measure	Baseline	Baseline year	Final target	Final target year	Source/Means of verification	Comments
I9. Hospital attendance (hospitalization) (disaggregated between men and women)	Rate	99.22 women per 1,000 Inhab. 41.98 men per 1,.000 Inhab.	2017	125 women per 1,000 Inhab. 65 men per 1,000 Inhab.			
I10. Hospital attendance (consultations) (disaggregated between men and women)	Rate	781.63 women per 1,000 Inhab. 562.79 men per 1,000 Inhab.	2017	900 women per 1,000 Inhab. 650 men per 1,000 Inhab.	2023	SNIS-VE	In the nine secondary hospitals prioritized.
I11. Hospital discharges (beneficiaries receiving health services)	Persons	14,453 women 6,115 men	2017	18,789 women 7,950 men			In the nine secondary hospitals prioritized. **CRF indicator 9.**
OUTCOME 2: Improve health outcomes of the health service network							
I1. Rate of early neonatal mortality in hospital in the municipio of El Alto	Rate	1.91 per 1,000 live births	2017	1.30 per 1,000 live births	2023	SNIS-VE	In the municipio of El Alto.
I2. Rating of hospital referrals (Adequate - Justified - Ontime)	%	Adequate: 26 Justified: 35 On time: 29	2018	Adequate: 51 Justified: 51 On time: 51		SIRECO complaints and consultation system	In prioritized health networks. Baseline determined from the Los Andes and Potosí networks (SIRECO system).
OUTCOME 3: Increased management capacity and efficiency of health service networks and facilities							
I1. Average stay in the secondary hospitals targeted by the program	Days	3.5	2017	3.1	2023	SNIS-VE	In the nine secondary hospitals prioritized.
I2. Patients discharged per bed	Number	72.1	2017	85			
I3. Bed occupation	%	52.61	2017	75			
I4. Weighted healthcare unit (UPA) produced by healthcare personnel in secondary hospitals targeted by the program	Number	865.75	2017	975.0			
I5. Cost of UPA in the secondary hospitals targeted by the program	Bolivianos per UPA	481.28	2017	460.0			

OUTPUTS

Outputs	Unit of measure	Base–line	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Final target	Means of verification	Comments
Component 1. Obstetric and Neonatal Care (ENOC) strategy, staff management, and training											
Subcomponent 1.1: ENOC service model											
1.1.1 ENOC strategy implemented	Networks	0	2018		5	5	5		15	Program management report	
1.1.2 Program of continuous ENOC quality improvement prepared and implemented	Networks	0	2018		5	5	5		15		
1.1.3 Community platforms for recruitment and supervision of pregnant women, developed and functioning	Networks	0	2018		5	5	5		15		
1.1.4 Information, education, and communication (IEC) programs to foster behavioral change in relation to sexual and reproductive health and family planning, implemented	Networks	0	2018		5	5	5		15		
1.1.5 Actions to improve the nutritional status of pregnant women and newborns, implemented	Persons	0	2018		100	100			200		
1.1.6 Obstetric nursing graduates incorporated into community networks	Persons	0	2018			20	20	21	61		
1.1.7 Improvement and update of the system of centralized purchases of supplies and medicines of the sector, completed	System	0	2018		1				1		
1.1.8 Strengthening of the safe blood bank/deposit system completed	System	0	2018			1			1		
1.1.9 Strengthening of referral and counter-referral systems completed	System	0	2018		5	5	5		15		
Subcomponent 1.2: Management and information systems											
1.2.1 Hospital management model providing increased efficiency and better-quality care implemented	Model	0	2018					1	1	Program management report	

Outputs	Unit of measure	Base–line	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Final target	Means of verification	Comments
1.2.2 Strengthening of municipal management systems and network coordination implemented	Scorecard	0	2018		5	5	5		15		
1.2.3 Information systems for clinical management, implemented	System	0	2018				5	5	10		
1.2.4 Reproductive Age Maternal Mortality Survey (RAMOS), or similar methodology for monitoring maternal mortality, implemented	Method-ology	0	2018		1				1		
Subcomponent 1.3: Healthcare personnel training											
1.3.1 Strengthening clinical-diagnostic and therapeutic capacities of health personnel through training programs completed	Networks	0	2018		5	5	5		15	Program management report	
1.3.2 Training in hospital management for managers of hospitals, health networks and departmental health services (SEDES)	Persons	0	2018		50	50	50	50	200		**CRF Indicator 13**
Component 2: Infrastructure and equipment											
Subcomponent 2.1: Coverage of equipment gaps											
2.1.1 El Alto Norte Hospital equipment completed	Global	0	2018	1					1	Program management report	
2.1.2 El Alto Sur Hospital equipment completed	Global	0	2018	1					1		
2.1.3 Ocurí Hospital equipment completed	Global	0	2018	1					1		
2.1.4 Llallagua Hospital equipment completed	Global	0	2018	1					1		
2.1.5 Potosí tertiary hospital equipment completed	Global	0	2018		1				1		
Subcomponent 2.2: Strengthening of secondary care in prioritized networks											
2.2.1 Secondary hospitals, built, equipped, and operating	Hospital	0	2018				5	3	8	Program management report	
2.2.2 Puerto Suarez Secondary Hospital, equipped and operating	Hospital	0	2018				1		1		

Outputs	Unit of measure	Base–line	Baseline year	Year 1 2019	Year 2 2020	Year 3 2021	Year 4 2022	Year 5 2023	Final target	Means of verification	Comments
2.2.3 Equipment of comprehensive health centers, delivered and installed	Global	0	2018				1		1		
Subcomponent 2.3: Strengthening of tertiary care in the municipio of El Alto											
2.3.1 Tertiary pediatric hospital, designed	Design	0	2018	1					1	Program management report	
2.3.2 Tertiary pediatric hospital built	Hospital	0	2018				1		1		
2.3.3 Tertiary pediatric hospital equipped	Global	0	2018				1		1		
2.3.4 Design, construction, and startup supervised	Global	0	2018					1	1		
Subcomponent 2.4: Startup of the new hospitals											
2.4.1 Plans for opening and/or migration of the new hospitals prepared	Plan	0	2018			1			1	Program management report	
2.4.2 Technical assistance for the start-up and monitoring of secondary and tertiary hospitals completed	Global	0	2018					1	1		

* The secondary hospital of El Torno and the tertiary pediatric hospital of El Alto are part of the two-project sample.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Plurinational State of Bolivia
Name:	Program to Improve Accessibility to Maternal and Neonatal Health Services in Bolivia (BO-L1198)
Executing agency:	Ministry of Health, through the program execution unit; and the Health Infrastructure and Medical Equipment Agency
Prepared by:	Carolina Escudero and Diana M. De León (FMP/CBO)

I. EXECUTIVE SUMMARY

1.1 The program will be executed by the Ministry of Health, through the program execution unit (PEU), and by the Health Infrastructure and Medical Equipment Agency (AISEM), which will be jointly responsible for the program's fiduciary management.

1.2 The institutional capacity of the executing agencies was analyzed using the Institutional Capacity Assessment Platform (ICAP). This concluded that, although the Ministry of Health displays a satisfactory level of institutional development, AISEM does not have project execution or management experience with any funding source. The program's fiduciary risk has therefore been rated as medium.

1.3 Financial management will be conducted through the National Public Management System (SIGEP). By the time the program starts, the Ministry of Economy and Public Finance (MEFP) will have implemented the Accounting Management of Agreements Module within SIGEP, which will enable online financial management and direct financial reporting from the national system in the program currency. The Single Treasury Account System (CUT) will also be used, which has national scope and handles local or foreign currency without distinction. The executing agencies will process disbursements using the Bank's e-disbursement system.

1.4 Procurement processes will adhere to the Policies for the Procurement of Works and Goods Financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-9). The Bank's current standard bidding documents (SBDs) will be used for any international competitive bidding (ICB) or consultant selection for more than US$200,000; in other cases, the current bidding documents available in the State Procurement System (SICOES)[1] may be used.

1.5 Procurement subject to ICB (invitations to tender, clarifications, and amendments to the bidding documents, and results of tenders) and the selection of consultants for more than US$200,000 (requests for expressions of interest and results of the

[1] SICOES. Bidding documents approved by the Bank, to be applied for procurement in amounts below ICB thresholds.

tenders) will be advertised on the United Nations Development Business portal. Other procurement may be advertised on the SICOES website and in national newspapers.

1.6 In application of the agreement for the partial use of the basic rules of the Bolivian goods and services administration system (NB-SABS), signed between the Plurinational State of Bolivia and the Bank, the contracting modality for national support for production and employment agreed upon with the Bank (ANPE-BID) will be used, as indicated in the approved Procurement Plan. The loan contract will include provisions on the use of this subsystem.

1.7 The fiduciary agreements and requirements set forth in this document will be reflected in the program Operating Regulations.

II. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

2.1 Law 1178 on Government Administration and Oversight, of 20 July 1990 (the SAFCO Law) regulates systems for the administration and oversight of government resources and their relationship with national planning and public investment systems. This law is compulsory for all public entities.

2.2 Except as provided in paragraph 1.6, and considering Article 17 of Supreme Decree 00181, NB-SABS will not be applicable to procurement financed in whole or in part with Bank resources.

III. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

3.1 The ICAP assessment rates the program's fiduciary risk as medium, (see paragraph 1.2), since the executing agencies do not have technical staff familiar with the Bank's fiduciary procedures. In the case of AISEM, this is because it was created only recently and lacks experience; and in the case of the Ministry of Health, it is because of the ministry's high staff turnover rate, which could result in inadequate implementation of the procurement policies and a failure to meet the minimum quality standards desired for the products to be acquired. Limited experience among local Bolivian firms in hospital design, construction, and supervision could impose a constraint on finding quality suppliers, with the result that the program's outputs are not obtained in a timely and adequate manner. Both are rated medium fiduciary risks.

3.2 These risks will be mitigated by: (i) strengthening the executing agencies' technical, administrative, financial, planning, and procurement teams, by incorporating specialists who already have experience with Bank programs (closed operations), and by providing training for the fiduciary team of both executing agencies; (ii) using multiyear contracts for the executing agencies' specialists, subject to performance evaluations; (iii) creating lots/packages of preinvestments, works, and/or equipment to make bidding more attractive; and (iv) at the same time extensively advertising public calls for proposals.

3.3 The Agreement Accounting Management Module in SIGEP will be used, which guarantees the integrity and timeliness of the information. If it is not possible to

execute the operation from this module, the PEU will have access to the Bank's Project Management System (SIAP-IDB).

IV. Considerations for the Special Provisions of the Contract

4.1 **Exchange rate for accounting purposes**. The exchange rate prevailing in Bolivia on the date on which foreign currency funds are converted into local currency in the accounts of each executing agency will be used.

4.2 **Financial statements and other audited reports**. An annual external audit will be performed on the program's financial statements, which will be received within 120 days following the end of the fiscal cycle; and a final audit to be received within 120 days after the date of the last disbursement, to be conducted by an independent audit firm acceptable to the Bank. Each executing agency will sign multiyear contracts with the audit firm covering at least the first three years. Each executing agency will also contract the audit firm for the final audit.

4.3 **Retroactive financing**. The Bank may draw on the loan proceeds to retroactively finance eligible expenses incurred by the borrower before the loan approval date, to finance activities foreseen in Component 2, up to the amount of US$27.5 million (10% of the proposed loan amount), provided that requirements substantially similar to those specified in the loan contract have been met. The expenses in question will have been incurred on or after the project profile approval date of 4 June 2018, but in no case more than 18 months before the loan approval date.

4.4 **Disbursement modality**. Disbursements will be made mainly through advances of funds based on cash programming, without ruling out any other mechanism in force for the Bank. Future disbursements will require the executing agencies to have presented expense justifications for at least 80% of funds previously advanced. Direct payments will be made in exceptional cases, subject to agreement with the Bank.

4.5 **Terms of reference, technical specifications, and qualification criteria**. Any revision of criteria for the selection of shortlists, terms of reference, technical specifications, and bidder or consultant qualifications, for the evaluation of bids or proposals, will require ex ante no objection from the Project Team Leader, regardless of the procurement review modality (ex ante or ex post).

V. Agreements and Requirements for Procurement Execution

5.1 **Procurement execution**. All procurement will be specified in the procurement plan approved by the Bank and will be implemented according to the policies set out in documents GN-2349-9 and GN-2350-9, for which no exception is foreseen. The ANPE-BID contract modality referred to in paragraph 1.6 will also apply.

5.2 **Threshold amounts, procurement methods, and applicable documents**. The threshold amounts are as shown in Table 1. The following rules will apply with respect to methods and documents:

A. Procurement of goods, works, and nonconsulting services

5.3 All procurement within the ICB threshold will use the Bank's standard bidding documents (SBDs).

5.4 All procurement within the threshold for National Public Bidding (NCB) will use the Bank's SBDs which are available in SICOES.

5.5 Procurements involving simple works or off-the-shelf goods and services within the NCB threshold may apply the shopping method, provided that the approved procurement plan so allows.

5.6 All procurement for amounts within the threshold for shopping will apply the provisions of paragraph 1.6, provided that the approved procurement plan so allows.

B. Selection and contracting of consulting firms and individual consultants.

The standard public documents will be used without any modification, subject to the following:

5.7 Any contracting of a consulting firm for US$200,000 or more will use the Bank's standard request for proposals (SRP).

5.8 The contracting of consulting firms for amounts less than US$200,000 will use the standard request for proposals which is available in SICOES.

5.9 Selection based on the consultants' qualifications (CQS) will be used to contract firms to perform the program's annual and final audits.

5.10 Single-source selection will be used as indicated in the approved procurement plan.

5.11 Individual consultants will be contracted pursuant to the provisions of paragraph 1.6, provided that the approved procurement plan so allows.

5.12 Personnel in charge of currently executing operations 2614/BL-BO and 3151/BL-BO, scheduled to complete in 2019, may be considered for single-source selection[2] to fill the necessary positions in the executing agencies.

C. Operating or recurrent expenses

5.13 The executing agency's administrative procedures as referenced in the program Operating Regulations will be applied. The Bank may decline to finance such expenses if the procedures applied are found to have violated the principles of competition, efficiency, and economy.

Table 1. Threshold amounts (US$)

ICB		NCB		Shopping		International shortlist	National shortlist
Works	Goods	Works	Goods	Works	Goods	Consultants	Consultants
> 3,000,000	> 200,000	> 250,000 up to 3,000,000	> 50,000 up to 200,000	up to 250,000	up to 50,000	> 200,000	up to 200,000

[2] Pursuant to paragraph 5.4(a) of policy GN-2350-9.

5.14 **Procurement plan**. The procurement plan will be prepared on the basis of the multiyear execution plan (PEP) and the annual work plan (AWP) approved by the Bank, in the Procurement Plan Execution System (SEPA). The initial plan will cover at least 18 months and will be updated at least annually. No procurement process can be started unless previously included in the procurement plan approved by the Bank. The procurements envisaged in this program have been so included.

5.15 **National preference**. National preference is not expected to apply in any procurement procedure.

5.16 **Procurement supervision**. The ex ante review modality will be used for all international procurement processes and to exceptions such as direct contracting and single-source selection.

5.17 **Ex post review**. An external audit firm will conduct an ex post review of procurements at least once a year, as determined by the Bank.

5.18 **Reviews**. The Bank may make periodic visits to update the level of procurement management capacity and fiduciary risk associated with program execution.

5.19 **Records and files**. Each executing agency will put controls in place as needed for the safekeeping and integrity of the documentation generated by the ex ante or ex post execution of the program. The Bank may, at any time, check the standards of organization, control, and security of the corresponding files.

VI. FINANCIAL MANAGEMENT

6.1 The project's financial management will be done through SIGEP, which contains integrated budget, treasury, accounting, and reporting subsystems.[3]These conditions are applicable both to the PEU and to AISEM.

6.2 **Programming and budget**. The national budget system has an extensive regulatory framework that is clearly explained in user manuals. Its programmatic structure makes it easy to associate expenditure with the objectives and outcomes envisaged in the AWP; and it allows for integrated and up-to-date management of transactions. The executing agencies will undertake programming and formulation tasks according to the agreed-upon AWPs.

6.3 **Accounting and information systems**. The accounting and reporting subsystem applies generally accepted accounting principles, as described in the Basic Standards of the Integrated Accounting System (NBSCI). These are "compatible" with the International Public Sector Accounting Standards (IPSAS), which have not been adopted by the Bolivian Government. This subsystem integrates the different accounting processes in a single record: budget, assets, and cash management.

6.4 **Disbursements and cash flow**. The treasury subsystem has a simple and complete regulatory framework. The CUT has national coverage and advanced control, monitoring, and reporting procedures. The fact that it operates with multiple currencies makes it a reliable, effective, and efficient system for managing cash and project funds. Its computerized procedures are efficient and cover all

[3] Once the new agreement accounting management module has been implemented in SIGEP.

treasury management processes that can be automated, along with their integration into the budget and accounting systems.

6.5 **Administration of the loan proceeds**. The resources disbursed to the program will be deposited in a passbook account within the CUT at the Central Bank of Bolivia and later converted into local currency and transferred into another account, in the corresponding amount and at the appropriate time, following the procedures established by the MEFP for management of the loan proceeds. Both accounts will be used exclusively for the program.

6.6 **Internal control and internal audit**. The financial management of the Ministry of Health and its various departments is subject to audits by the Internal Audit Unit (UAI) of the State Comptroller General's Office (CGE) and the entity itself. The program is expected to be included in these audits.

6.7 **External control and reports**. The lender's standard terms of reference will be used, which may include midterm reviews of the operation. The hiring, scope and presentation procedures of the aforementioned audits will be governed by the current Financial Management Policy according to paragraph 4.2 of this document. The Bank will publish the annual audited financial statements in accordance with its current access to information policy.

6.8 **Financial supervision plan**. Supervision activities may be adjusted to take account of any reassessment of program risks.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/18

Bolivia. Loan ____/BL-BO to the Plurinational State of Bolivia
Program to Improve Accessibility to Maternal and Neonatal
Health Services in Bolivia

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Plurinational State of Bolivia, as borrower, for the purpose of granting it a financing to cooperate in the execution of the Program to Improve Accessibility to Maternal and N eonatal Health Services in Bolivia. Such financing will be chargeable to the Bank´s Ordinary Capital (OC) resources in the following manner: (i) up to the amount of US$41,250,000, subject to concessional financial terms and conditions ("Concessional OC"); and (ii) up to the amount of US$233,750,000, subject to financial terms and conditions applicable to loan operations financed from the Bank's regular program of OC resources ("Regular OC"), as indicated in the Project Summary of the Loan Proposal, and subject to the Special Contractual Conditions of said Project Summary.

(Adopted on ___ _____ 2018)

LEG/SGO/CAN/EZSHARE-1720032226-13013
BO-L1198