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BOLIVIA

SUPPORT FOR VULNERABLE POPULATIONS AFFECTED BY CORONAVIRUS II

(BO-L1219; 5376/OC-BO)

REFORMULATION PROPOSAL

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REQUIRED:

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2. Procurement plan

OPTIONAL:

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2. Note on social protection policies in the context of COVID-19
3. Rationale for 24-month duration
4. COVID-19 strategic preparedness and response plan
5. List of WHO supplies for the COVID-19 package, including technical specifications
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7. COVID-19 vaccination coverage (percentages)
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ABBREVIATIONS

BCH	Bono Contra el Hambre [Hunger Voucher]
CNEES	Consejo Nacional Estratégico de Emergencia Sanitaria [National Strategic Health Emergency Council]
IT	Information technology
MEFP	Ministry of Economy and Public Finance
MSyD	Ministry of Health and Sport
RD	Renta Dignidad [Dignity Voucher]
SEDES	Servicios Departamentales de Salud [Departmental Health Services]
SNIS	Sistema Nacional de Información de Salud [National Health Information System]
TLM	Programa de Tele Medicina [Telemedicine Program]
WHO	World Health Organization

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(BO-L1219; 5376/OC-BO)

<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3">Borrower:</td><td colspan="2">Flexible Financing Facility[a]</td></tr>
<tr><td colspan="3">The Plurinational State of Bolivia</td><td>Amortization period:</td><td>23 years</td></tr>
<tr><td colspan="3">Executing agencies:</td><td>Disbursement period:</td><td>2 years</td></tr>
<tr><td colspan="3" rowspan="2">Ministry of Economy and Public Finance (MEFP) and Ministry of Health and Sport (MSyD)</td><td>Grace period:</td><td>10 years[b]</td></tr>
<tr><td>Interest rate:</td><td>SOFR-based[1]</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>%</td><td>Credit fee:</td><td>[c]</td></tr>
<tr><td rowspan="2">IDB (Ordinary Capital):</td><td rowspan="2">500,000,000</td><td rowspan="2">100</td><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>Weighted average life:</td><td>15.25 years</td></tr>
<tr><td>Total:</td><td>500,000,000</td><td>100</td><td>Approval currency:</td><td>U.S. dollar</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective/description: The general development objective of the reformulated program is to help ensure minimum levels of quality of life for vulnerable people amid the crisis caused by COVID-19, reduce morbidity and mortality caused by COVID-19, and mitigate the indirect effects of the pandemic on health. The project will have five specific development objectives: (i) to support minimum levels of income for those affected by coronavirus, in the immediate period and during the recovery; (ii) to strengthen coordination of the response at the country level; (iii) to improve case detection and monitoring; (iv) to support initiatives to break the chain of transmission of the disease; and (v) to improve service delivery capacity.</td></tr>
<tr><td colspan="5">Special contractual conditions precedent to the first disbursements under Component 1 and Subcomponent 3.1: The conditions in the original document are maintained: (i) the MEFP has appointed the technical coordinator and the financial personnel assigned to the project; and (ii) the MEFP and the Long-Term Public Social Security Administration have approved project Operating Regulations or signed an agreement detailing the responsibilities of the parties in the execution of the project and the payment reporting method for reimbursement and disbursement of the loan proceeds (paragraph 4.8). Special contractual conditions precedent to the first disbursements under Component 2 and Subcomponent 3.2: (i) the MSyD has created a project execution unit with technical, administrative, fiduciary, and legal autonomy; and (ii) the MSyD has approved Operating Regulations detailing the responsibilities of the parties in the execution of the project (paragraph 4.9).</td></tr>
<tr><td colspan="5">Exceptions to Bank policies: None</td></tr>
<tr><th colspan="5">Strategic Alignment</th></tr>
<tr><td>Challenges:[d]</td><td colspan="2">SI ☒</td><td>PI ☐</td><td>EI ☐</td></tr>
<tr><td>Crosscutting themes:[e]</td><td colspan="2">GE ☐ and DI ☒</td><td>CC ☐ and ES ☐</td><td>IC ☒</td></tr>
</table>

(a) Under the terms of the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency, interest rate, commodity, and disaster protection conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

(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.

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

(d) SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

(e) GE (Gender Equality) and DI (Diversity); CC (Climate Change) and ES (Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

[1] The executive summary has been included in the reformulation proposal in consideration of the change in the interest rate from LIBOR-based to SOFR-based.

I. Background and Status of the Project "Support for Vulnerable Populations Affected by Coronavirus II"

A. Government request and purpose for reformulation of the project "Support for Vulnerable Populations Affected by Coronavirus II"

1.1 **Summary of proposed modifications.** The purpose of this proposal to modify the project "Support for Vulnerable Populations Affected by Coronavirus II" (5376/OC-BO) is to redirect resources under Subcomponent 2 of the sole component of the original project, in order to use a portion of the project resources to finance public health activities to contain and control the SARS-CoV-2 (COVID-19) pandemic and its effects on the health sector.

1.2 **Background.** The general development objective of the loan proposal that was originally approved is to contribute to ensuring minimum levels of quality of life for vulnerable persons amid the crisis caused by COVID-19. The specific development objective is to support minimum levels of income for those affected by coronavirus, in the immediate period and during the recovery. To that end, the original loan proposal called for a single component, divided into two subcomponents of US$249.9 million each, to finance, respectively, the following existing cash transfer programs: Bono Contra el Hambre (BCH) and Renta Dignidad (RD). An additional US$100,000 would go to auditing for each component.

1.3 **Implementation status and government request.** The original proposal was approved by the Bank's Board of Executive Directors on 20 October 2021. By November 2021, the Government of the Plurinational State of Bolivia had authorization to sign the contract and submit it to the legislature for ratification. Around this time, the impact was being felt from the fourth and fifth waves of COVID-19 (late 2021 and early 2022), and vaccination rates were still low among Bolivia's population. These factors put pressure on the country's healthcare system, due to direct and indirect effects of the pandemic. Against that backdrop, the Bolivian government asked the Bank (optional link 10) to use the resources from Subcomponent 2 to finance the health response, particularly to: (i) strengthen the information system for managing and monitoring the pandemic; (ii) strengthen detection and monitoring capacity through improvements and interoperability of the network of laboratories for case diagnostics; (iii) support initiatives that expand vaccination coverage in order to break the chain of transmission of the disease; and (iv) improve the ability to provide services that ensure both the effective treatment of COVID-19 patients and the continuity of essential services in the system that have been interrupted by the impact of the pandemic.

1.4 **Proposed changes.** To address this request, the following specific changes are proposed. To support the health response, the total sum of US$249.9 million corresponding to Subcomponent 2 (approximately 50% of the total original amount of the loan) will be redirected to a new Component 2 divided into five subcomponents that will finance health sector needs in relation to the pandemic (see paragraphs 2.24 to 2.29) and a new Component 3 for management, monitoring, and evaluation (paragraph 2.30).

1.5 The redirection of funds requires the inclusion of an additional dimension in the general objective: the operation will help reduce morbidity and mortality caused by COVID-19 and mitigate its effects in terms of the disruption and displacement of

health services. Four new specific objectives are also required in addition to the original one of supporting minimum levels of income for those affected by coronavirus, in the immediate period and during the recovery: strengthening coordination of the response at the country level, improving case detection and monitoring, supporting initiatives to break the chain of transmission of the disease, and improving service delivery capacity.

1.6 The execution mechanism is also being modified to add the Ministry of Health and Sport (MSyD) as the executing agency for Component 2 and Subcomponent 3.2. The Ministry of Economy and Public Finance (MEFP) will remain the executing agency for Component 1 and Subcomponent 3.1.

Table 1. Proposed changes

Aspect of the project	Original proposal	Modification
General objective	To contribute to ensuring minimum levels of quality of life for vulnerable persons amid the crisis caused by COVID-19	To help ensure minimum levels of quality of life for vulnerable people amid the crisis caused by COVID-19, reduce morbidity and mortality caused by COVID-19, and mitigate the indirect effects of the pandemic on health.
Specific objective(s)	To support minimum levels of income for people affected by coronavirus, in the immediate period and during the recovery	The specific objective of supporting minimum levels of income for people affected by coronavirus, in the immediate period and during the recovery, will be maintained, and the following will be added: -To strengthen coordination of the response at the country level; -To improve case detection and monitoring; -To support initiatives to break the chain of transmission of the disease; -To improve service delivery capacity.
Structure	A single component divided into two subcomponents	The operation will have three components. Component 2 is divided into five subcomponents. A third component in the amount of US$6.3 million is added for management, monitoring, and evaluation (¶2.30).
Execution mechanism	Single executing agency: MEFP	Two co-executing agencies: MEFP and MSyD (¶4.1)

Subcomponent 1	Finances the Bono Contra el Hambre (BCH) program for US$249.9 million	Becomes Component 1 and continues to finance BCH for US$250 million (¶2.23).[2]
Subcomponent 2	Finances the Renta Dignidad (RD) program for US$249.9 million	Will finance activities under the new Components 2 and 3, consisting of public health activities for US$243.7 million (¶2.24-¶2.29) and management, monitoring, and evaluation activities for US$6.3 million (¶2.30), respectively.
Conditions precedent	Apply only to the MSyD	Adapted to apply to both executing agencies (¶4.9)
Benchmark interest rate	LIBOR-based	SOFR-based (¶1.9)

1.7 As suggested by the foregoing, the activities that will no longer be financed are those corresponding to Subcomponent 2 of the sole component of the original loan proposal, consisting in the partial payment of cash transfers to individuals participating in the Renta Dignidad program. Beneficiaries have already received the transfers, which have been paid out of the government's own funds.

1.8 **Conditions precedent to disbursement.** These will be the same as in the original loan proposal but adapted to the new execution mechanism that calls for two executing agencies (see paragraphs 4.8 and 4.9).

1.9 **Financial conditions.** The financial conditions of the original loan have been maintained, with the sole change that the LIBOR-based interest rate, in effect at the time of approval of the original operation, has been adjusted to the SOFR-based interest rate, now used by the Bank in its loan contracts.

1.10 **Environmental and social risks of the reformulation.** Given that execution never began for the original project (classified as a category "C" operation), there are no socioenvironmental liabilities stemming from its reformulation.

II. PROPOSED MODIFICATIONS AND RATIONALE

A. Background, problem addressed, and rationale

2.1 **Background.** On 11 March 2020, the World Health Organization (WHO) declared the COVID-19 outbreak to be a pandemic. COVID-19 is a respiratory disease caused by the 2019 novel coronavirus, or nCoV-2019. The pandemic triggered a profound health and social crisis that continues to unfold and has led to a sharp deterioration in the population's living conditions, basic well-being, and health status. To date (20 September 2022), more than 612 million cases have been confirmed worldwide,

[2] The increase in the amount is due to the addition of US$100,000 for auditing that had been included as part of the original operation but under the sole component.

resulting in more than 6.5 million deaths.[3] The first cases in Latin America and the Caribbean were reported in late February 2020. With more than 128.6 million cases and over 2.5 million deaths since,[4] the region has been one of the worst affected, with a mortality rate of 2.3%.[5] Compared with the other regions of the world, the number of deaths caused by the pandemic in Latin America and the Caribbean confirms the region's particular vulnerability to COVID-19: although it accounts for 8.4% of the world's population, the number of deaths from COVID-19 in the March 2020-March 2022 period accounted for 27% of the world total. The region's structural problems of poverty, inequality, gender gaps, informality, limited fiscal space, and low productivity are related to the heightened vulnerability of the population to the pandemic and the resulting crisis [1] [2]. In Bolivia, the first case was recorded on 10 March 2020 and the first death from COVID-19 was on the 29th of that month. As of 22 September 2022, 1,106,000 cases had been recorded with 22,216 deaths, for a total reported mortality rate of 2% [3].

2.2 On 17 March 2020, a National Health Emergency was declared (Supreme Decree 4,196) pursuant to the Health Code (Law 15,629 of 18 July 1978), which states that where part or all of the country is threatened or afflicted by a pandemic, the health authorities will declare an emergency zone subject to health controls and will adopt health measures. A Health Emergency Law (Law 1,357) was enacted on 17 February 2021 that created the National Strategic Health Emergency Council (CNEES). The Council, which comprises 11 ministers and is presided by the Ministry of Health, is responsible for leading the country's response to the pandemic and for cross-sector coordination. The CNEES's ability to adopt timely and effective measures has been hampered by the limitations of the National Health Information System (SNIS), including an inability to obtain real-time information on hospital occupancy rates or numbers of hospitalized COVID-19 patients, as well as a lack of interoperability in laboratory systems.

2.3 **In 2021, the Hunger Voucher (BCH) was established as a social protection instrument.**[6] In Bolivia's labor market, 82% of people under the age of 60 were employed in the informal sector in 2021 and were therefore more affected by the health crisis. According to the 2020 Household Survey, around 70% of people without fixed income who benefited from the BCH earned less than one minimum wage (Bs 2,164; US$315). A transfer of Bs 1,000 (US$146) constituted a support to maintain a minimum level of quality of life. The BCH reached four million people[7] throughout the country without stable income. The voucher could be paid at the counter at branches of any financial institution or as a deposit into the account of the

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3 https://coronavirus.jhu.edu/map.html.

4 https://ais.paho.org/phip/viz/COVID19Table.asp.

5 The mortality rate in Europe is 0.8 (SPH calculation using data from the Johns Hopkins Coronavirus Resource Center).

6 Law 1330 creating the Hunger Voucher (BCH) was enacted on 16 September 2020, and implementing regulations were established by Supreme Decree 4392 on 16 November 2020. The voucher is available to individuals over the age of 18 (as of 16 September 2020) who do not receive wages from the public or private sectors or pension or long-term social security benefits, as well as mothers receiving the Juana Azurduy Voucher and people with disabilities. The Hunger Voucher is a one-time cash transfer of Bs 1,000 (US$146).

7 The fact that the proportion of poor people in rural areas rose by 3.9 percentage points to 54.7% of the total suggests the importance of the BCH for this population.

beneficiary, which facilitated widespread dissemination throughout the country. The purpose of the voucher was to spur domestic demand and mitigate the effects of COVID-19 on vulnerable populations (people with disabilities, women who were pregnant or had children under 2, the unemployed, inactive, and people without formal jobs in the private or public sector). The extension of the deadline for payment meant that the voucher reached 98% of those who were eligible to collect it (approximately 67% in rural areas),[8] which translated into transfers that cost the Bolivian government around Bs 4.015 billion (US$585.3 million). The support for financing the BCH will be maintained, as approved in the original project.

2.4 **Prolonged health crisis.** The number of COVID-19 deaths per 1,000 population was higher in the second year of the pandemic (March 2021 to March 2022) than in the first (March 2020 to March 2021), rising from 1.15 to 1.34 deaths [4]. This was despite the fact that the vaccination process began in the region at the beginning of 2021. From late 2021 to early 2022, a new wave of infections hit Bolivia, which prompted the government to propose an adjustment to the original project in order to be able to use a portion of the project funds for the health response.[9] In the case of Bolivia, the SNIS reported a confirmed COVID-19 mortality rate of 1.85 per 1,000 population in September 2022. The Latin American and Caribbean countries have made great efforts to accelerate vaccination of their populations, and 71.5% of the region's population was fully vaccinated (with two doses) as of 6 September 2022 [5]. Nonetheless, coverage varies significantly between subregions, countries, and even geographical areas of the same country. In terms of progress in the countries to date, it is estimated that at least one third will fail to achieve 70% vaccination coverage of their populations in 2022 (the global target proposed by the World Health Organization for 30 June 2022 [6]); this is due not only to limitations in their capacity to implement vaccination plans, but also sociocultural features of their populations. Although vaccines are the main tool for controlling the health crisis, their diminishing effectiveness over time means that a third (booster) dose of the COVID-19 vaccination needs to be administered five months after the initial course in order to maintain immunity, particularly given new, more contagious variants. As of 6 September 2022, only 48.1% of the Latin American and Caribbean population had received a booster dose against COVID-19, with even greater inequalities between and within countries. In the case of Bolivia, although the country purchased a sufficient number of doses to vaccinate the entire population, vaccination rates lag far behind those for the region as a whole, particularly in the case of rural areas and indigenous populations. As of 15 August 2022, 49.9% of the population was fully immunized, but there were departments with very low coverage, such as Pando (36.8%), Beni (37.23%), and Potosí (41.20%), while only 16.98% of the population had received a booster dose (optional link 7). In the municipio of El Alto, which has a population of 1.1 million (overwhelmingly of Aymara ethnicity), only 30% of the population had received the first dose as of that date and 11% had received two doses. Unless this situation is

[8] Total support for BCH payments is approximately US$250 million, an amount that represents around 44% of the total cost. As approved in the original project, partial financing will be provided for payments made between January and May 2021.

[9] Authorization to sign the loan contract was approved in late 2021, but a decision was made to refrain from signing until the reformulation was ready, given the time it would take for the legislature to ratify the loan contract, which would then require a second legislative process as well, for the reformulation.

remedied, the Bolivian health system will be highly vulnerable to the emergence of successive outbreaks and the natural decline in individual immunity.

2.5 **Macroeconomic and social context.** The pandemic triggered a profound health and social crisis that continues to unfold and has led to a deterioration in the population's living conditions, levels of well-being, and health status. In terms of the resulting economic crisis, although there were signs of a certain recovery in 2021, a slowdown is projected in 2022, with high levels of uncertainty and lower rates of growth than before the pandemic [7]. In Bolivia, GDP fell 8.7% in 2020. At the same time, the fiscal deficit reached 12% of GDP and is expected to be around 8.5% of GDP in 2022.[10] With respect to labor markets, the unemployment rate rose from 4.3% in the third quarter of 2019 to 10.8% in the same period of 2020, while in the same period of 2021 it stood at 6.3% [8]. This effect was not, however, limited to the increase in the unemployment rate; it was also reflected in a decline in the number of hours worked by those still classified as employed, whose earnings fell due to their inability to work with the same intensity as before the health emergency.[11] According to data from the National Statistics Institute, 37.2% of the population lived below the moderate poverty line in 2019, with 12.9% below the extreme poverty line.[12] In 2020, moderate poverty stood at 39% and extreme poverty at 13.7%. Between 2019 and 2020, the numbers of people living below the moderate and extreme poverty lines rose by 299,000 and 119,000, respectively. This represents a significant change in the poverty trend in Bolivia, as the same indicators declined by 2.7 percentage points and 2.5 percentage points, respectively, between 2018 and 2019. Poverty indicators in 2021 were slightly below those in 2019, with moderate poverty of 36.3% and extreme poverty of 11.1%. However, the rapid decline in 2020 shows that people in situations of poverty or vulnerability in Bolivia lack adequate mechanisms to offset a drop in income when faced with events of this magnitude. Accordingly, a large share of the population requires income support in order to weather economic crises.

2.6 **Interaction between COVID-19 and inequality.** Although in the initial months of the pandemic it seemed that everyone faced similar risks from the COVID-19 virus, it quickly became clear that the probability of infection, of becoming seriously ill from COVID-19, or of dying from the disease varied between individuals. The impact has therefore been distributed unevenly across society, with unequal effects reflecting the inequitable distribution of the social determinants of health [10]. The impact of COVID-19 has been and still is greater in the case of people in situations of higher vulnerability, i.e., those living in poverty and extreme poverty, migrants, persons with disabilities, older adults, Afro-descendant people, and indigenous peoples, among others [11]. Taking life expectancy as a proxy for the determinants of health, excess mortality rates due to COVID-19[13] in the period to March 2022 were below 100 per 100,000 population in Chile and Costa Rica (the countries with the highest life

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10 *https://databank.worldbank.org/reports.aspx?source=2&series=NY.GDP.MKTP.CD&country=* (30 June 2021). The 2020 fiscal deficit figure is taken from the Central Bank of Bolivia (BCB), while the projection for 2021 is from the Fiscal and Financial Program prepared by the MEFP and the BCB.

11 According to the 2019 and 2020 Household Surveys, the number of hours worked per week declined by an average of 54.7%, from 42 to 19 hours.

12 See optional link 16 and [9].

13 [12]. See also optional link 16.

expectancy at birth in the region, at 80 years in 2020). In Bolivia, meanwhile—which along with Haiti and Suriname is one of the countries with the lowest life expectancy at birth (71 years in 2020)—the excess mortality rate was the highest in the region, at over 700 deaths per 100,000 population.[14]

2.7 The pandemic in Latin America and the Caribbean has pointed up structural weaknesses in health systems. As with most other systems in the region, Bolivia's health system is fragmented and segmented. While higher-income groups and formal-sector employees enjoy access to higher quality services with better resolution rates (through private providers and the social security system, respectively), the range of health services available to lower socioeconomic groups is more precarious in terms of both quantity and quality, a situation that is frequently aggravated by accessibility problems due to geographic, economic, and/or cultural barriers. Until 2019, free care under the Bolivian public health system was limited to children under 5, older adults, and sexual and reproductive health services. In February 2019, based on Law 1,152, the country began a transition to free, universal health coverage for the entire population, particularly for those without health insurance (i.e. those not protected by the social security system, which covers only 37.6% of the population). This process, which represents a significant fiscal effort, has been affected by the pandemic. The MSyD budget rose from US$2.692 billion in 2018 to US$3.237 billion in 2021 (a 20% increase), while the confirmed budget for 2022 is US$3.438 billion. Taking financing levels as a proxy for the level of development of health systems, the evidence shows that the impact of the pandemic (measured as the number of excess deaths) has been greater in countries with lower levels of public health spending [13]. In the region, countries with higher public health spending and moderate or low out-of-pocket expenses (e.g., Uruguay and Costa Rica) have exhibited the lowest rates of excess mortality [14], while the highest rates have been observed in Peru, which has low public health spending, and also Ecuador and Bolivia, where spending has recently been rising toward medium levels but has historically been low.

2.8 The deficit in human resources for health has been one of the main barriers to accessing care, with direct consequences for the health of the population. In Bolivia, Ecuador, and Peru, between 3% and 4.5% of the population listed a lack of medical staff as a reason for not accessing health services during the pandemic. These three countries have the highest recorded rates of excess mortality in the region [14]. Countries that have experienced problems of access to the relevant health services have also exhibited the highest rates of excess mortality. Bolivia is a prime example of this, with the highest excess mortality rate in the region and one quarter of the population stating that they have not received the needed medical care or treatment.

2.9 In addition to serious structural weaknesses in health systems, which have constrained the availability of care due to the reorganization and (in some cases) collapse of healthcare services as a result of excessive demand, the most vulnerable population groups have also suffered financial barriers to access as a result of the deep economic crisis created by the pandemic. The data has fluctuated over the period, yet many households in the region report that they did not access health services at some point in 2020-2021 due to lack of money [15]. In Bolivia, the

[14] https://ghdx.healthdata.org/record/ihme-data/covid_19_excess_mortality.

percentage of households reporting having no access to health due to lack of money was 6.4% (compared with a world average of 3% over the aforementioned period).

2.10 **Problem to be addressed. Impact of the pandemic on vulnerable populations and on the Bolivian health system.** The repercussions of the crisis will hurt the income of most people, especially the poorest and most vulnerable groups, who depend on their largely informal work activities to support their consumption. Even in transitional shocks to income, most people lack the capacity to sustain consumption when faced with drastic reductions to their daily income. In this regard, according to Bolivian household surveys, it is estimated that the monthly personal income of the economically active population declined on average by 12% between 2019 and 2020 and about 163,000 individuals more than in 2019 reported income below a minimum wage of Bs 2,122 (US$304.80). Groups vulnerable to the pandemic in Bolivia notably include persons without a fixed income who benefited from the BCH voucher because they have no public or private sector salary and do not receive the old-age pension or the Renta Dignidad voucher. According to the 2020 Household Survey, about 70% of them have incomes below the minimum wage (Bs 2,164; US$315). Therefore, the transfer of Bs 1,000 (US$146) constituted support for maintaining a minimum quality of life.

2.11 From 2019 to 2020, formal employment (which is covered by social security) declined 4% in Bolivia [16], and the number of informal jobs lost may be as high as 4.2 million [17]. The population that lost formal employment was no longer covered by social security, adding to the demands for medical care from the public health system. Given that each social security member represents on average coverage for four beneficiaries, it is estimated that approximately 4 million people are no longer served by the health facilities of the different social security programs as a result of the economic crisis. These individuals now require health services from the public sector, representing a 52.9% increase in the numbers covered by the public system relative to the pre-crisis level.

2.12 At the same time, the limited capacity of Bolivia's health system and the accumulation and worsening of inequalities in the social determinants of health have created the heightened vulnerability that has been observed in relation to excess COVID-19 deaths. Bolivia has 1.4 hospital beds per 1,000 population and 11.3 doctors per 10,000 population [18] (versus regional averages of 2.3 and 23, respectively), and there is a deficit of 1,000 in the number of intensive care beds relative to the WHO standard of 1 per 10,000 population. This deficit in supply explains the collapse in the system in 2020 and 2021, when the authorities were unable to meet excess demand for care despite increasing bed numbers for some intensive care services in the first year of the pandemic and opening new hospitals for the exclusive treatment of COVID-19 patients.[15] The SNIS does not collect data on the number of times people were turned away from the health system or the reasons for those decisions. However, a recent study of the increase in maternal mortality during the pandemic shows that there was a failure in Bolivia to provide intensive care to 1 in every 3 COVID-positive pregnant women requiring such

[15] This included the Madre Obrera de Llallagua hospital (Potosí) and El Alto Sur hospital in the municipio of El Alto (La Paz), both of which were financed by the IDB.

services. Moreover, maternal deaths resulting from postpartum complications were associated with an absence of access to intensive care [19].

2.13 In addition, the sudden imbalance between supply and demand has led to the displacement and/or postponement of care, both during the pandemic and in the current phase of extended crisis, representing a significant barrier to accessing essential services. This was reflected in a reduction in the volume of obstetric and pediatric care provided in 2020-2021 relative to 2018-2019 levels, with drops of 13.2% in the number of births in health facilities and 35.4% in well-child visits for children. The number of healthcare visits for noncommunicable chronic diseases also declined by 17.6% in 2021-2022 (relative to 2018-2019) (optional link 8).

2.14 Accordingly, there is what may be referred to as a "stock" of displaced or postponed demand (in sexual and reproductive health care [20] [21] [22] and noncommunicable chronic diseases), in the form of citizens that needed health care but did not receive it. The consequence is an accumulation of unresolved health problems that will overburden current healthcare capacity to an even greater extent in the short term, with an excess of morbidity and mortality [23]. At the same time, the system must continue to face the demands of the pandemic (with new potential outbreaks due to low immunity) and its persistent effects (various chronic COVID syndromes [24] [25]), as well as the need to continue expanding the vaccination program to large subsets of the population that have not yet been immunized.

2.15 Vaccination is essential for breaking the chain of transmission [26]. The Bolivian government approved its COVID-19 vaccination plan at the end of 2020 (optional link 11) and to date has procured 22.5 million vaccine doses (Sputnik V, AstraZeneca, Sinopharm, Pfizer, and Janssen), 650,000 of which were obtained through the COVID-19 Vaccines Global Access (COVAX) mechanism. While the aim is to immunize all citizens over the age of 5, coverage levels remain low. The plan provides for a third, booster dose for the general population, and the MSyD is currently considering whether to offer a fourth dose for specific high-risk groups.

2.16 **Rationale and strategy.** As suggested by various different authors [27] [28], the current health situation in Bolivia represents a "syndemic," a situation in which epidemics clustered together in time and space interact to exacerbate the respective negative impacts. In this case, the epidemics are COVID-19, the social determinants of health (including a constrained public health system), and unattended, postponed chronic diseases, the interaction of which has created the observed inequalities in terms of COVID-19-related infections and deaths. Adding to this has been the increased demand from additional numbers of people without social security. To provide a comprehensive response to the social, economic, and health consequences of this syndemic, an intervention is proposed that combines social protection policies (cash transfers) with investments in the health system that will allow the Bolivian government to strengthen the monitoring of COVID-19 infections and institutional leadership of the response, improve the laboratory network for diagnosing the disease, increase the proportion of the population that has been vaccinated in order to break the chain of transmission of disease, and expand healthcare delivery capacity to ensure effective, timely care for COVID-19 patients while maintaining essential healthcare services.

2.17 Interventions under the health component correspond to four of the nine pillars proposed in the COVID-19 Strategic Preparedness and Response Plan (optional link 4): (i) Pillar 1, coordination, planning, and monitoring—the SNIS will be strengthened both centrally and in the departments to improve real-time coordination, communication, and information capabilities, with the creation of a business intelligence platform that facilitates timely decision-making by enabling database analysis and the design of indicators; (ii) Pillar 6, infection prevention and control—support will be provided for vaccine purchases and information and awareness-building campaigns that aim to increase the proportion of the population that is fully vaccinated (at least two doses) in those departments and geographical areas with lower vaccination coverage; (iii) Pillar 5, national laboratories—the laboratories network will be strengthened, including interoperability of its information systems, so as to increase diagnostic capabilities for the disease; and (iv) Pillar 9, maintaining essential health services—service delivery capacity will be improved through investments to (a) increase the capacity and deployment of the telemedicine program (TLM) with a view to improving access to specialized consultant services for rural populations; (b) strengthen the availability of medical equipment in health facilities, thus improving their resolution capacity to triage and manage COVID-19 cases and deliver essential services that have been interrupted or displaced (based on care level); and (c) support operating expenses in hospitals (including health workforce, health inputs, medicines, and general services) for the management of COVID-19 patients and maintenance of continuity in essential services. Evidence of the effectiveness of the proposed interventions is available (optional link 17).

2.18 **The Bank's experience and lessons learned.** As part of the response to the health crisis, the Bank has provided support to the country under the two lines of activity proposed in the operation. The program Support for Vulnerable Populations Affected by Coronavirus (5039/OC-BO) benefited 870,968 people through ordinary Renta Dignidad (RD) payments and 581,825 through extra payments.[16] A further 2,057,589 households received electricity subsidies. As part of other interventions to support the country in addressing the health crisis, US$5,617,174 was redirected under the Program to Improve Accessibility to Maternal and Neonatal Health Services in Bolivia (4612/BL-BO) for the purchase of equipment, medicines, inputs, reagents, and personal protective equipment, supporting the MSyD with its immediate healthcare response for COVID-19 patients. The reformulated project draws on the lessons learned from program 5039/OC-BO regarding the need to establish mechanisms for expanding transfer coverage during the crisis, as well as the existence of comprehensive social registries and the availability of electronic payment mechanisms. It also incorporates the lessons learned from the Immediate Public Health Response Project in the Context of the COVID-19 Pandemic to Contain, Control, and Mitigate its Impact on Health Service Delivery in Argentina (5032/OC-AR), in terms of leveraging telehealth programs to ensure the continuity of essential services, particularly in the case of patients with chronic diseases, where the importance of determining the service delivery model for this form of care was observed. It also includes lessons learned from the portfolio of operations executed and under implementation in Bolivia's health sector: Strengthening of Integrated Health Networks in the Department of Potosí (2614/BL-BO); Improved Access to

[16] RD reduced the probability of experiencing hunger by 40% during the pandemic. [29]

Hospital Services in Bolivia (2822/BL-BO); and Improved Access to Health Services in El Alto, Bolivia (3151/BL-BO). See optional link 14. The Global Credit Program for Safeguarding the Productive Fabric and Employment (5078/OC-BO) was approved in July 2020 with the objective of safeguarding the productive fabric and employment through support for financing for micro, small, and medium-sized enterprises. After several meetings with the counterparts aimed at reformulating the operation, and before the contract was signed, the Government of Bolivia decided to forgo the entire loan in October 2022.

2.19 **Coordination with other multilateral organizations and/or development agencies and partners.** The government of Japan, through the Japan International Cooperation Agency (JICA), is processing a US$136 million policy-based budget support loan in parallel to this project, thus achieving complementarity in the intervention to support funding for extraordinary transfers. Operation 5039/OC-BO was also accompanied by parallel loans from the World Bank and the Andean Development Corporation for cash transfers in 2020. Actions to support the health response have also been coordinated within the health subgroup of the Development Partners Group for Bolivia.[14] See optional link 15.

2.20 **Strategic alignment.** The reformulated project is consistent with the Second Update to the Institutional Strategy (document AB-3190-2) and is aligned with the challenges of social inclusion and equality through its focus on ensuring minimum income levels for vulnerable persons and supporting equitable access to health services and immunization based on a safe and effective COVID-19 vaccine. It is also aligned with the crosscutting areas of gender equality and diversity, in that it supports equitable access to, among other things, immunization and essential health services for the indigenous population and vulnerable groups (who currently have a low level of coverage), and institutional capacity and the rule of law, as it will enhance the MSyD's capacity to lead the COVID-19 response at the national level. The project contributes to the Corporate Results Framework 2020-2023 (document GN-2727-12) by strengthening the management capabilities and digital technology of the CNEES, and by increasing the numbers of beneficiaries of health services and programs to combat poverty. It is also aligned with the third priority area of the IDB Group's country strategy with Bolivia 2022-2025 (document GN-3088), relating to inclusive and sustainable social development. The project is consistent with the Health Sector Framework Document (document GN-2735-12), as it supports: (i) the strengthening of behavioral change communication and information actions relating to the vaccination programs; and (ii) the strengthening of service delivery, including providing the medical equipment and inputs that are needed to manage COVID-19 cases, maintain essential health services, and improve the cold chain for the logistical management of vaccines. Accordingly, it is consistent with the IDB Group's Governance Response to the COVID-19 Pandemic Outbreak (document GN-2996) as regards the immediate public health response, as the proposed actions seek to: (i) contain the disease by strengthening institutional capacity for expanding vaccination coverage and managing case response, diagnosis, and monitoring, thereby slowing and/or halting transmission; and (ii) mitigating the impact of the disease by improving service delivery capacity for providing case care and ensuring continuity in essential services.

B. Objectives, components, and cost

2.21 **Objectives.** The general development objective of the reformulated program is to help ensure minimum levels of quality of life for vulnerable people amid the crisis caused by COVID-19, reduce morbidity and mortality caused by COVID-19, and mitigate the indirect effects of the pandemic on health. The reformulated project will have five specific development objectives: (i) to support minimum levels of income for those affected by coronavirus, in the immediate period and during the recovery; (ii) to strengthen coordination of the response at the country level; (iii) to improve case detection and monitoring; (iv) to support initiatives to break the chain of transmission of the disease; and (v) to improve service delivery capacity.

2.22 The reformulated operation will be divided into three components:

2.23 **Component 1. Protection of the vulnerable population through the use of the Hunger Voucher (BCH) (US$250 million).** This component, as approved in the original loan proposal, will finance the payment of part of the costs of the BCH. To support the efficient distribution of the transfers, it may also reimburse the cost of the fee to perform the transfers to date of up to Bs 2 per transfer. As approved in the original loan proposal, this financing may be retroactive, provided that: (i) requirements substantially analogous to those established in the loan contract have been met; (ii) contracting procedures are in accordance with the Basic Procurement Principles; and (iii) expenditures were made on or after 1 January 2021. As described in the originally approved loan proposal, the extraordinary circumstances of the global health emergency justified the authorization, on an exceptional basis, of the recognition of these expenditures.[17]

2.24 **Component 2. Reduction of morbidity and mortality caused by COVID-19 and mitigation of the indirect effects of the pandemic on health (US$243.7 million).** These actions seek to address new infections and the sequelae of the disease and the initial deployment of essential services that have translated into a stock of built-up demand marked by greater complexity due to delays in testing and/or treatment. This component is divided into five subcomponents:

2.25 **Subcomponent 2.1. Strengthening of coordination of the response at the country level (US$15.1 million).** This will strengthen the MSyD in its leadership role for the national response, improving monitoring in terms of infections and use/occupancy rates for healthcare resources, including dashboards for monitoring and managing coverage of the vaccination program. Financing may be provided for activities including: (i) investments in information technology (IT) equipment (hardware and software); (ii) the procurement of virtual servers; (iii) procurement of software licenses, certificates, and production; (iv) technical assistance to the SNIS, including the development of protocols and training events; (v) expenditures necessary to facilitate communication and operational support, and logistics expenses for mobilizing personnel; and (vi) development of a regulatory framework to provide legal support for the use of technology in service delivery. These activities are expected to produce: (i) a new architecture for the Consolidated Health Information System (SUIS); (ii) a smart business platform for managing databases and creating indicators; and (iii) a proposed regulatory framework for information and communication

[17] See PR-4924, paragraphs 3.4 and 3.5.

technologies in health, with the development of a digital ecosystem that strengthens the coordination, management, and monitoring of the COVID-19 pandemic and improves leadership of the response by the MSyD and the different departmental health services (SEDES).

2.26 **Subcomponent 2.2. Detection and monitoring of cases (US$5.0 million).** This will support actions to accelerate the timely detection and monitoring of cases by strengthening the laboratory network and incorporating digital tools and real-time communication for case notification and monitoring. This subcomponent may finance, among other activities: purchases of equipment, laboratory reagents and inputs, information and communication technologies, and equipment and technology for connectivity and access points (e.g., tablets, laptops, routers, software licenses, etc.); connectivity services; consulting services for the development and adaptation of new IT solutions (software); and the implementation of IT solutions in the field.

2.27 **Subcomponent 2.3. Support for initiatives to break the chain of transmission of the disease (US$21.5 million).** This will support an expansion in vaccination coverage of the population, based on safe, effective COVID-19 vaccines.[18] Among other activities, financing may be provided for bilateral purchases from the laboratories that manufacture COVID-19 vaccines. Transportation, freight, and insurance expenses for transporting vaccines may also be financed, as well as fungible inputs for vaccinations and the equipment needed to strengthen the cold chain associated with the vaccine management and supply chain. Likewise, the component may finance the development and implementation of intercultural communication strategies (such as cultural adaptations and translations for indigenous peoples) and visibility campaigns for vaccinations in locations with low immunization coverage, such as in the municipio of El Alto and in the departments of Pando, Beni, and Potosí, where a large percentage of the population is indigenous, as well as logistics expenses and procurement of the equipment and services needed to implement these campaigns.

2.28 **Subcomponent 2.4. Improved service delivery capacity—care for COVID-19 patients (US$54.2 million).** This will support the delivery of healthcare services for COVID-19 patients at the different levels of care. Funding may be provided for medical and other healthcare equipment, furnishings, health workforce expenses,[19] and inputs and medicines, including personal protective equipment (optional links 5 and 6). Similarly, technical assistance and training in the implementation of health and biosecurity protocols may be financed, together with hospital accommodation and other service expenses for COVID-19 patients.

2.29 **Subcomponent 2.5. Improved service delivery capacity—continuity of essential care (US$147.9 million).** To mitigate the impact of the lasting aftereffects of COVID-19, as well as complications due to a lack of regular care for chronically ill patients and/or the delayed diagnosis of illnesses, this subcomponent will help to ensure continuity in the delivery of essential services to susceptible and vulnerable populations, such as chronically ill patients, children, and pregnant women. It will also use digital solutions to improve the accessibility of specialized health services

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[18] The vaccines must meet the technical eligibility criteria set out in OP-2091 (optional link 16).

[19] In addition to healthcare staff, this will include professional staff in patient management units, staff responsible for user information, and intercultural mediators attending to COVID-19 patients in health facilities.

for rural populations. Among other activities, financing may be provided for investments in medical and other healthcare equipment and for the installation of said equipment in primary health care establishments, hospitals, and specialized centers (both inpatient and outpatient) for the treatment of chronic pathologies and/or noncommunicable diseases. The procurement of equipment and software for the TLM program will also be financed. Other expenditures eligible for financing will include health-related human resources, inputs, and medicines, as well as technical assistance for the TLM program to help determine the service delivery model (services portfolio, flowcharts for each problem, and a description of the profiles and functions of assigned staff).

2.30 **Component 3. Administration, monitoring and evaluation (US$6.3 million).** This component will finance actions relating to project execution and the monitoring of indicators and targets to generate feedback and facilitate decision-making. It will be divided into two subcomponents: Subcomponent 3.1 (US$300,000) will finance the MEFP's administration and audit expenses, while Subcomponent 3.2 (US$6 million) will finance the project execution team in the MSyD (including technical assistance to support the team), the recurring expenses of the project execution unit, audits (annual and final), program monitoring studies, and program evaluation with a view to generating lessons learned that can be applied in other programs.

2.31 **Beneficiaries.** It is expected that: (i) around 1.7 million eligible beneficiaries will receive extraordinary transfers for protection during the crisis (BCH), as proposed in the original project; and (ii) the population in general will also benefit through actions to prevent and halt the chain of transmission of the disease and maintain essential health services. Due to their low levels of immunization, the intervention under Component 2 will focus on the municipio of El Alto and the departments of Pando, Beni, and Potosí. These have a total population of 2.6 million, of which 1.5 million are indigenous peoples. However, support for treating COVID-19 patients and maintaining essential services will extend to all nine of the country's departments, so that all departments can provide a response to the complex care needs of this disease.

2.32 **Key results indicators.** The reformulated program seeks to: (i) help maintain the standard of living for people vulnerable to COVID-19, whose income level continued to be impacted during the months of the health emergency and the first months of the recovery; and (ii) reduce morbidity and mortality caused by COVID-19 and mitigate its indirect effects on health. To this end, the following general outcomes are expected: (a) help maintain the level of income for vulnerable families (the three poorest quintiles) with respect to the income level for families that are not vulnerable (two richest quintiles) 24 months after the start of the crisis; (b) strengthen the core institutional arrangements for coordinating the COVID-19 response with real-time tools for analysis and decision-making; (c) improve detection and monitoring capacity for the disease through laboratories with interoperability; (d) expand vaccination coverage among the indigenous population; (e) increase specialized care capabilities in rural areas by means of digital solutions; and (f) improve care for COVID-19 patients requiring high-complexity assistance. The outcomes for Component 1 remain the same as in the original document.

2.33 **Economic feasibility.** The strategies pursued in this operation are based on both protecting the vulnerable population through the use of cash transfers and reducing morbidity and mortality caused by COVID-19 and the indirect effects of the pandemic on the health system. Based on specific evidence for Bolivia, the economic analysis quantifies the incremental benefits arising from program investments, including: (i) returns from the direct protective effects of BCH transfers on consumption and human capital during the crisis; (ii) the reduction in morbidity and mortality and the resulting savings, given the potential impact of interventions that improve the health of the population and the capacity of the health system to confront the COVID-19 pandemic; (iii) savings in terms of avoidable days of hospitalization and the number of lives saved; and (iv) returns from the project in terms of population health from implementation of the healthcare lines of activity. The base scenario in the analysis of the overall program (Components 1 and 2) is based on conservative assumptions in terms of the effectiveness of the interventions; it shows a benefit-cost ratio of 1.8 over a time horizon that varies between 2 and 8 years, depending on the intervention. Although other discount rate scenarios were included to evaluate the cost-benefit ratio in the analysis performed, a rate of 3% was preferred in accordance with WHO recommendations, which indicate that a 3% discount rate is most appropriate for evaluating social projects (particularly health-focused projects).[20] In the scenario considered most feasible, the net present value of the program is US$503 million based on a 3% discount rate, while the modified internal rate of return for the same scenario is 15%. In the case of Component 2, which focuses on the health interventions, an analysis also shows a positive net present value of over US$430 million based on the same discount rate.

III. Finance Structure and Main Risks

A. Financing instruments

3.1 This operation continues to be a specific investment loan for a total amount of US$500 million and will be financed with resources from the Bank's Ordinary Capital. The disbursement period remains 24 months (see optional link 3). The loan was approved by the Board of Executive Directors without disbursement restrictions pursuant to Resolution DE-82/21 and in accordance with Resolution AG-9/20.

[20] López (2008) has also estimated that discount rates in Latin American countries depend on economic growth expectations, which stand at 3%-4%. Other studies that evaluate health- and education-focused projects use discount rates of between 3% and 8% (Castillo and Lema, 1998; Martínez and Fernández, 2008; Heckman et al., 2010; Lomborg, 2010).

Table 2. Estimated project costs* (US$ million)

Components	Total IDB	%
Component 1. Protection of the vulnerable population through the use of the Hunger Voucher (BCH)	250.0	50.00
Component 2. Reduction of morbidity and mortality caused by COVID-19 and mitigation of the indirect effects of the pandemic on health	243.7	48.74
Subcomponent 2.1. Strengthening of coordination of the response at the country level	15.1	
Subcomponent 2.2. Detection and monitoring of cases	5.0	
Subcomponent 2.3. Support for initiatives to break the chain of transmission of the disease	21.5	
Subcomponent 2.4. Improved service delivery capacity – care for COVID-19 patients	54.2	
Subcomponent 2.5. Improved service delivery capacity – continuity of essential care	147.9	
Component 3. Administration, monitoring, and evaluation	6.3	1.26
Subcomponent 3.1. MEFP	0.3	
Subcomponent 3.2. MSyD	6.0	
Total	**500.0**	**100.00**

* Subcomponent costs are indicative.

Table 3. Disbursement schedule (US$ million)

IDB	2023	2024	Total
Component 1	250.0	0.0	250.0
Component 2	104.4	139.3	243.7
Component 3	2.9	3.4	6.3
Total	357.3	142.7	500.0
%	**71.0**	**29.0**	**100.0**

B. Environmental and social risks

3.2 In accordance with the Bank's Environment and Safeguards Compliance Policy (OP-703), the reformulated project has been classified as a category "C" operation as it will not finance any type of infrastructure and any environmental or social impacts will be minimal or nil.

C. Fiduciary risks

3.3 In the case of Component 2, four risks were identified, of the following levels: (i) high, if the project execution unit team lacks experience in executing Bank-financed investment loans, this could lead to management delays, with a negative impact on the timeline for procuring goods and, consequently, the timely achievement of program targets; (ii) medium-high, if the project execution unit team lacks staff who are sufficiently trained in following Bank procurement policies, ineligible expenditures may occur; (iii) medium-high, in the event of high turnover among the project execution unit staff, there could be delays in procurement processes,

preventing the timely attainment of program targets; and (iv) medium-high, if the project execution unit lacks professional staff with the necessary capacities, this could lead to delays in procurement processes or weaknesses in the quality of program procurement, preventing the timely attainment of program targets. To mitigate these risks, the project execution unit will hire staff to manage the project who will work full-time on the project and will have the background and experience stipulated in terms of reference. These terms of reference will require previous experience with the Bank's fiduciary policies, and the selected staff will also receive training in the policies. The multiyear contract modality will be used for specialists, with annual renewals subject to performance evaluations. The project execution unit staff may be hired from operation 3151/BL-BO (closing in December 2022) in light of their experience and the fact that they were previously selected through a competitive process. This will ensure their rapid incorporation into the program and knowledge of IDB policies.

D. Other key issues and risks

3.4 **Development risks.** Another identified risk is: medium-high, if communication plans are not developed based on differentiated aspects of interculturality for the different areas and population segments, the expected target of expanding the vaccinated population may not be achieved, particularly in regions with the lowest rates of coverage. To mitigate this risk, the project execution unit will be strengthened with a specialist in intercultural issues who has knowledge of the different ethnicities and groups that exist in Bolivia.

3.5 **Sustainability.** The project is considered sustainable given that the financial support for the BCH and health expenditures is targeted and supports preexisting entities with management budgets. Support for additional staffing is limited and is not expected to be maintained once the health crisis and the additional pressure on the health system have passed. An asset management system will be implemented to ensure that the biomedical equipment purchased is maintained, supported by an operational support technical cooperation agreement. This operation supports Bolivia's efforts to respond to the pandemic and mitigate its economic impacts on the most vulnerable groups. The loan represents a fraction of the financial and social effort being made by the country, which is determined to assume economic costs to address the crisis, as well as advance an inclusive recovery once the emergency has been contained.

IV. Implementation and Management Plan

A. Summary of implementation arrangements

4.1 **Borrower and executing agencies.** The borrower continues to be the Plurinational State of Bolivia. The Ministry of Economy and Public Finance (MEFP), with the support of the Long-Term Public Social Security Administration (hereinafter Administration), remains the executing agency for the resources under Component 1 and Subcomponent 3.1, consistent with the arrangements for the original project. The Ministry of Health and Sport (MSyD), acting through a program execution unit, will be the executing agency for resources under Component 2 and Subcomponent 3.2.

4.2 **Execution and administration.** The MSyD project execution unit will have technical, operational, administrative, fiduciary, and legal independence, and its team will work full time on the project. The team will comprise a general coordinator with planning, management, administration, and general coordination responsibilities; technical specialists in areas relating to the program, including (at a minimum) a specialist in public health and/or health services management, a specialist in health-related human resource planning, a specialist in intercultural communication in the health field, an attorney, a monitoring and planning specialist, and an administrative professional; and administrative support staff. In the area of fiduciary management, it will have a financial specialist and a procurement specialist. The terms of reference and professional qualifications required for the specialist will be previously agreed upon with the Bank. At the local level, the project execution unit may also have professional staff distributed across the different departments. These staff will be provided with all of the equipment and inputs needed for them to assume program execution responsibilities. The project execution unit for the program may be formed by the human resources in the current unit for operation 3151/BL-BO, which concludes in December 2022, as this team has experience in executing Bank-financed projects.

4.3 **Institutional coordination.** For efficient implementation of Component 1, the project will use the same coordination bodies used during execution of loan 5039/OC-BO. Through them, it will seek to establish technical guidelines for project execution, monitor the physical and financial progress of the implementation of the transfers, and establish itself as an operational coordination body. In the case of Component 2, program activities will be executed in coordination with the relevant technical departments of the MSyD, the SEDES, and the autonomous territorial entities (ETA), according to the responsibilities set out in the project Operating Regulations (optional link 9), with a team to be created at the vice-ministerial level that will be responsible for general leadership of the program, ensuring coordination with the SEDES and the territorial entities. The project Operating Regulations will establish the responsibilities and functions of the actors, as well as the execution processes and procedures, including the details of coordination between the entities. To this end, intergovernmental agreements will be established between the MSyD and the autonomous municipal and departmental governments.

4.4 **Retroactive financing.** There will be no changes to the retroactive financing approved in the original loan proposal for Subcomponent 1, which will become Component 1. In accordance with the provisions of that proposal, the Bank may retroactively finance eligible expenditures incurred by the borrower prior to the loan approval date in order to pay direct BCH transfers up to the amount of US$250 million (50% of the loan amount), provided that requirements substantially similar to those set forth in the loan contract have been met, among other requirements (see paragraph 2.23).

4.5 **Disbursements.** Disbursements will be made primarily through advances of funds and/or reimbursements or other modality provided for in the Financial Management Guidelines for IDB-Financed Projects (document OP-273-12) or the guidelines in effect at the time of program execution, as described in Annex III. Advances of funds will be based on a financial/cash flow plan covering contracted commitments and will cover actual liquidity needs for up to 180 days or other period. With the exception of the first advance of funds, subsequent advances may be processed once

documentation has been provided for at least 80% of the accumulated balance pending documentation. The Treasury Single Account (TSA subaccount ledger for exclusive use) will be used to manage the funds. The procurement plan (required link 2) includes a list of project procurement items.

4.6 **Procurement.** Procurements financed in whole or part with Bank funds will be conducted in accordance with the Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank (document GN-2349-15) and the Policies for the Selection and Contracting of Consultants Financed by the Inter-American Development Bank (document GN-2350-15), or the policies in effect during the execution period, and with the Financial Management Guidelines for IDB-financed projects (document OP-273-12). The Bolivian government may eventually decide to finance vaccination purchases, in which case the Bank will analyze the viability of this direct contract.

4.7 **Financial management and audit.** The principles and criteria to be observed will be those set out in the Financial Management Guidelines for IDB-Financed Projects (OP-273-12 or other document in effect) and the Guide for Financial Reports and Management of External Audits. Audit: For Component 1, the Long-Term Public Social Security Administration will be responsible for contracting external audit services for the project. Given the specific nature of this type of project, the type of report required will be an audit of the special purpose financial statements, together with a special purpose audit report and/or a reasonable assurance. For Component 2 and Subcomponent 3.2, the MSyD will be responsible for contracting external audit services for the project in the form of an audit of the special purpose financial statements. External audit costs will be financed with project resources. Throughout the original loan disbursement period and any extension thereof, the program's audited financial statements will be submitted to the Bank within 120 days following the end of the executing agencies' fiscal year and within 120 days following the last loan disbursement. The statements will be duly audited by an independent audit firm acceptable to the Bank, in accordance with the terms of reference that the Bank agrees to with the executing agencies.

4.8 **Special contractual conditions precedent to the first disbursements under Component 1 and Subcomponent 3.1. The conditions in the original document are maintained: (i) the MEFP has appointed the technical coordinator and the financial personnel assigned to the project; and (ii) the MEFP and the Long-Term Public Social Security Administration have approved project Operating Regulations or signed an agreement detailing the responsibilities of the parties in the execution of the project and the payment reporting method for reimbursement and disbursement of the loan proceeds.** The first condition is necessary so that staff will be available to coordinate the flow of payment-related information and to perform activities related to reporting and monitoring. The second is needed to determine the project execution responsibilities of each of the entities.

4.9 **Special contractual conditions precedent to the first disbursements under Component 2 and Subcomponent 3.2. (i) the MSyD has created a project execution unit with technical, administrative, fiduciary, and legal autonomy; and (ii) the MSyD has approved Operating Regulations detailing the responsibilities of the parties in the execution of the project.** The first condition

is necessary so that staff will be available to coordinate the flow of payment-related information and to perform activities related to reporting and monitoring. The second is needed to determine the project execution responsibilities of the MSyD departments.

B. Summary of arrangements for monitoring results

4.10 **Monitoring.** Each executing agency will be in charge of implementing the monitoring and evaluation plan for the actions for which they are responsible. The main monitoring tools for this project will be the Results Matrix and the procurement plan. The main sources of information for monitoring impact, outcome, and output indicators will be the household surveys and the administrative records from the transfer program. In the case of Component 2, the main sources for monitoring impact, outcome, and output indicators will be the service delivery records and epidemiological data reported by the SNIS. The executing agencies will prepare multiyear execution plans and annual work plans, and the main reporting tool will be the progress monitoring report (PMR), which will use the project's semiannual reports as its source of information.

4.11 **Evaluation.** Given the nature of Component 1, a before-and-after analysis will be performed for this component using available time series data on the results indicators, particularly for the coverage of transfers. In the case of Component 2, a final program evaluation will be performed. This evaluation will be descriptive in nature and will focus on explaining progress in relation to the output and outcome indicators set out in the Results Matrix; it will be performed by an external consulting firm.

V. RECOMMENDATION

5.1 Based on the information and analysis presented in this document, it is recommended that the Board of Executive Directors of the IDB approve, by short procedure, pursuant to paragraph 6 of document CS-3953-4 (List of matters to be considered by the Board via short procedure) and the provisions set out in paragraph 3.29(c) of the Regulations of the Board of Executive Directors of the IDB (document DR-398-19), this reformulation proposal, in accordance with the terms and conditions described herein.

Development Effectiveness Matrix		
Summary	BO-L1219	
I. Corporate and Country Priorities		
1. IDB Group Strategic Priorities and CRF Indicators		
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity -Institutional Capacity and the Rule of Law	
CRF Level 2 Indicators: IDB Group Contributions to Development Results	-Beneficiaries receiving health services (#) -Beneficiaries of targeted anti-poverty programs (#) -Agencies with strengthened digital technology and managerial capacity (#)	
2. Country Development Objectives		
Country Strategy Results Matrix	GN-3088	Inclusive and Sustainable Social Development.
Country Program Results Matrix		The intervention is not included in the 2020 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	9.6	
3.1 Program Diagnosis	3.0	
3.2 Proposed Interventions or Solutions	3.6	
3.3 Results Matrix Quality	3.0	
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	7.0	
5.1 Monitoring Mechanisms	2.5	
5.2 Evaluation Plan	4.5	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	Medium	
Identified risks have been rated for magnitude and likelihood	Yes	
Mitigation measures have been identified for major risks	Yes	
Mitigation measures have indicators for tracking their implementation	Yes	
Environmental & social risk classification	C	
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury. Procurement: Information System.
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	Technical cooperations were approved to support both the Ministry of Economy and Public Finances (ATN/OC-18147-BO) and the Ministry of Health and Sports (BO-T1398)

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

Evaluability Assessment Note:
The Government of Bolivia (GoB) requested the Bank to redirect a total amount of US$249 million from the project Support for Vulnerable Populations Affected by Coronavirus II (BO-L1219). As the GoB has financed with its own resources the extraordinary transfers associated with the pandemic of the Renta Dignidad (RD) bonus, subcomponent 1.2 of the original project, and given the continuation of the health emergency, the GoB has asked the Bank to use the resources of this subcomponent to finance the health response to reduce morbidity and mortality caused by COVID-19 and mitigate the indirect effects of the pandemic on health. The proposed changes imply changes to the general objective, which becomes to contribute to ensuring minimum levels of quality of life for vulnerable populations in the face of the crisis caused by COVID-19 and to reduce the morbidity and mortality caused by COVID-19 and to mitigate the indirect effects of the pandemic on health. Additionally, it implies adjusting the specific objectives, adding four new ones to the original. These become: (i) support minimum income levels for people affected by the coronavirus, in the immediate period and during the recovery (original objective); (ii) strengthen the management of the response at the country level; (iii) improve case detection and follow-up; (iv) support initiatives to interrupt the chain of transmission of the disease; and (v) improve the capacity to provide services. The reformulation proposal presents a clear diagnosis of the problems faced by the health sector as a result of the pandemic. The proposed solutions are appropriate to respond to the identified problems and their contributing factors. The results matrix is consistent with the vertical logic of the project, presenting adequate indicators at the level of impacts and results. The proposal clearly explains the changes in the reformulated operation and presents adjusted results matrices that are appropriate.

The economic evaluation shows that the operation has a net present value of US$503 million (using a discount rate of 3%, following WHO recommendations for interventions of this type) and a modified internal rate of return of 15%. Additionally, the analysis shows that the component 2 health intervention has an associated net present value of US$403 million. Sensitivity analyzes are appropriate.

The monitoring and evaluation plan proposes to carry out a reflexive analysis of the results indicators included in the results matrix, as well as an analysis of the theory of change to establish the attribution of the observed results to the program interventions. These analyzes will not allow empirical attribution of the results.

RESULTS MATRIX

Project objective:	The specific objectives of this operation are: (i) to support minimum levels of income for those affected by coronavirus, in the immediate period and during the recovery; (ii) to strengthen coordination of the response at the country level; (iii) to improve case detection and monitoring; (iv) to support initiatives to break the chain of transmission of the disease; and (v) to improve service delivery capacity. Achievement of these objectives will contribute to the general objective of helping ensure minimum levels of quality of life for vulnerable people amid the crisis caused by COVID-19, reduce morbidity and mortality caused by COVID-19, and mitigate the indirect effects of the pandemic on health.

EXPECTED IMPACT

Indicators	Unit of measure	Baseline	Baseline year	Final target	Means of verification	Comments
General development objective: To help ensure minimum levels of quality of life for vulnerable people amid the crisis caused by COVID-19, reduce morbidity and mortality caused by COVID-19, and mitigate the indirect effects of the pandemic on health.						
Income level of vulnerable families (three poorest quintiles) with respect to the income level of families that are not vulnerable (two richest quintiles) 24 months after the start of the crisis.	Percentage	0.2595	2020	0.2595	Household survey, total per capita income of household.	The vulnerable population comprises the three poorest income quintiles; the two richest quintiles are not vulnerable.
Annual number of new COVID-19 cases in the areas of intervention (municipio of El Alto and the departments of Pando, Beni, and Potosí).	Number	228,852	2021	160,000	National Health Information System (SNIS)	The SNIS collects data on this indicator as “suspected.”

EXPECTED OUTCOMES

Indicators	Unit of measure	Baseline	Year Baseline	Year 1	Year 2	Final Target	Means of verification	Comments (see monitoring and evaluation plan)
Specific development objective 1: To support minimum income levels for those affected by the coronavirus in the immediate period and during the recovery.								
Eligible beneficiaries receiving extraordinary transfers for protection during the crisis.	Percentage	0	2019	98	0	98	Long-Term Public Social Security Administration records of transfers to the eligible population.	
Specific development objective 2: To strengthen coordination of the response at the country level.								
National Strategic Health Emergency Council (CNEES) responsible for coordinating the COVID-19 response with a health intelligence platform implemented and in use	Number	0	2022	0	1	1	Program records	To deem the platform as “in use,” evidence should be provided of the preparation of reports with indicators of cases and use of care resources in real time.

Indicators	Unit of measure	Baseline	Year Baseline	Year 1	Year 2	Final Target	Means of verification	Comments (see monitoring and evaluation plan)
Specific development objective 3: To improve case detection and monitoring.								
Laboratories with COVID-19 diagnostic capability that use information and communication technologies	Number	0	2021	5	5	10	Program records	Evidence will be provided of the use of **logs** or records of the reports that the system of laboratories generates for real-time reporting on results and new cases by geographic location that will feed the National Emergency Council that coordinates the response. These are the central labs located in the department capitals and in the municipio of El Alto.
Specific development objective 4: To support initiatives to break the chain of transmission of the disease.								
Individuals in the priority groups—the populations of El Alto, Beni, Pando, and Potosí—vaccinated against COVID-19 (at least two doses)	Percentage	23.4	2021			28.4	National Health Information System (SNIS)	The areas of intervention are three departments (Pando, Beni, and Potosí) and one municipio (El Alto), population > 5a.[1]
Specific development objective 5: To improve service delivery capacity.								
Outpatient maternal and child health appointments at the secondary and tertiary care levels	Number	867,612	2021			911,000	SNIS	(Pre-pandemic value: 1,192,338)
Outpatient internal and/or general medicine appointments at the secondary and tertiary care levels	Number	1,093,403	2021			1,150,000	SNIS	(Pre-pandemic value: 1,170,535)
Total primary outpatient healthcare appointments	Number	24,084,874	2021			25,290,000	SNIS	(Pre-pandemic value: 26,125,042)
Primary healthcare facilities providing telehealth care services	Percentage	8.33%	2021			30%	Program records	With equipment in service, personnel trained, and evidence that care is being provided.

[1] These are departments that have a high percentage of indigenous population—particularly in the municipio of El Alto (62.2%) and the department of Potosí (69.2%)—and have an immunization coverage rate that is well below the national average.

OUTPUTS

Outputs	Unit of measure	Baseline	Year baseline	Year 1	Year 2	Final target	Means of verification	Comments
Component 1: Protection of the vulnerable population through the use of the Hunger Voucher (BCH)								
Individuals receiving the Hunger Voucher (BCH)	Individuals	0	2022	1,700,000	0	1,700,000	Administrative records	This refers to individual beneficiaries of the BCH in 2021, in accordance with its eligibility requirements.
Component 2. Reduction of morbidity and mortality caused by COVID-19 and mitigation of the indirect effects of the pandemic on health								
Subcomponent 2.1. Strengthening coordination of the response at the country level.								
New architecture for the Consolidated Health Information System (SUIS) developed and implemented	Number	0	2022	0	1	1	Program records	
Business intelligence platform developed and implemented	Number	0	2022	0	1	1	Program records	
Subcomponent 2.2. Detection and monitoring of cases.								
Laboratories with COVID-19 diagnosis capability and interoperability	Number	0	2022	10	10	20	Program records	In addition to labs in the department capitals and the municipio of El Alto, an additional 10 labs with interoperability.
Subcomponent 2.3. Support for initiatives to break the chain of transmission of the disease								
Municipal health networks with intercultural social mobilization campaigns aimed at increasing COVID-19 vaccination among indigenous peoples	Number	0	2022	10	0	10	Program records	In the municipio of El Alto and at least three municipios in each of the departments of Pando, Beni, and Potosí.
Subcomponent 2.4. Improved service delivery capacity – care for COVID-19 patients								
Tertiary hospitals strengthened with intensive care units for treating COVID-19 patients	Number	0	2022	0	10	10	Program records	
Primary and secondary healthcare facilities strengthened for the treatment of COVID-19 patients	Number	0	2022	50	50	100	Program records	
Subcomponent 2.5. Improved service delivery capacity – continuity of essential care								
Primary healthcare facilities strengthened with telemedicine to ensure the continuity of essential health care	Number	0	2022	50	70	120	Program records	With equipment in service, personnel trained, and evidence that care is being provided.

Country: Bolivia **Division:** SCL/LMK-SPH **Operation No.:** BO-L1219 **Year:** 2022

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Executing agencies: The Ministry of Economy and Public Finance (MEFP) will be the executing agency for Component 1 and Subcomponent 3.1, through the Long-Term Public Social Security Administration (the Administration). The Ministry of Health and Sport (MSyD) will be the executing agency for Component 2 and Subcomponent 3.2, through a project execution unit (PEU).

Operation name: Support for Vulnerable Populations Affected by Coronavirus II-Reformulation

I. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

1. Use of country systems in the operation

☒ Budget	☐ Reporting	☒ Information system	☐ National Competitive Bidding (NCB)
☒ Treasury	☐ Internal audit	☐ Shopping	☐ Other
☒ Accounting	☐ External control	☐ Individual consultants	

2. Fiduciary execution mechanism

☒	Special features of fiduciary execution	The borrower remains the Plurinational State of Bolivia. The MEFP, acting through the Department of Administrative Issues (DGAA), for financial management of the project, and with technical support from the Administration, is the executing agency for the resources under Component 1 and Component 3.1. The MSyD, acting through a project execution unit established in the framework of the Project Management Unit (UGESPRO), is the executing agency for resources under Component 2 and Subcomponent 3.2. The executing agencies will perform the technical, administrative, legal, fiduciary, environmental, and social activities for the program. The resources of the IDB will be granted in accordance with the program Operating Regulations prepared for this operation. Given its previous experience with voucher payments under loan 5039/OC-BO, the Administration, under the supervision of the MEFP, will be the supporting entity and will manage and pay the Hunger Voucher (BCH) and prepare the reports.

3. Fiduciary capacity

Fiduciary capacity of the executing agency	The analysis performed indicates that institutional and fiduciary capacities need to be strengthened. In the case of Component 1, this will be through the appointment of the technical coordinator and financial staff for the project. In the case of the MSyD, it will be through the creation of a project execution team with budgetary, administrative, fiduciary, and legal autonomy for assuming responsibility for management of program resources, including financial administration/accounting and procurement. A number of interventions were also identified to strengthen the project execution unit's technical and administrative operating capacity, as well as the preparation of flowcharts for processes and procedures associated with program execution.

4. Fiduciary risks and risk response

Risk classification	Risk	Risk level	Risk response
MSyD Internal processes and organizational structure (MSyD)	If the project execution unit team lacks experience in executing Bank-financed investment loans, this could lead to management delays, with a negative impact on the timeline for procuring goods and, consequently, the timely achievement of program targets.	High	Create project execution units in UGESPRO with technical, administrative, fiduciary, and legal autonomy and specialists with experience in IDB financial and procurement policies, and prepare project Operating Regulations with details of coordination between entities. Interagency agreements will be established with the different autonomous municipal and/or departmental governments benefiting from the investments. The following will be included in the project Operating Regulations, among other things (details to be provided in the Operating Regulations): (i) organizational charts for the participating units; (ii) details of the units involved, the positions responsible, time frames, and documents/deliverables; (iii) flowcharts; (iv) procedures; and (v) a list of bottlenecks.
Human resources	If the PEU team lacks staff who are sufficiently trained in following Bank procurement policies, ineligible expenditures may occur.	Medium-high	The specialists in the project execution unit must have the appropriate qualifications and experience, as well as knowledge of the Bank's fiduciary policies; the selected staff will also receive

Risk classification	Risk	Risk level	Risk response
	In the event of high turnover among the project execution unit staff, there could be delays in procurement processes, preventing the timely attainment of program targets.	Medium-high	training in the Bank's fiduciary policies. The multiyear contract modality will be used for specialists, with annual renewals subject to performance evaluations.
	If the project execution unit lacks professional staff with the necessary capacities, this could lead to delays in procurement processes or weaknesses in the quality of program procurement, preventing the timely attainment of program targets.	Medium-high	

5. Policies and guidelines applicable to the operation: Procurement will be listed in the procurement plan approved by the Bank and will be conducted in accordance with the Policies for the Procurement of Goods and Works Financed by the IDB (document GN-2349-15) and Policies for the Selection and Contracting of Consultants Financed by the IDB (document GN-2350-15), or those policies in effect.

6. Exceptions to policies and guidelines: None.

II. CONSIDERATIONS FOR THE SPECIAL PROVISIONS OF THE LOAN CONTRACT

Exchange rate: For the purposes of the activities stipulated in Article 4.10 of the General Conditions, the Parties agree that the applicable exchange rate will be the one indicated in subparagraph (b)(i) of said Article. For the purposes of determining the equivalent value of expenses incurred in local currency as part of local counterpart funding, or for the reimbursement of expenses from loan resources, the agreed exchange rate will be that in effect on the date that the relevant payments are made to contractors, suppliers, or beneficiaries by the borrower, executing agency, or any other natural or legal person to whom the authority to incur expenses has been delegated.

Type of audit: Audited program financial statements. Throughout the original loan disbursement period and any extension thereof, the executing agencies will submit the program's annual financial statements to the Bank within 120 days following the end of their fiscal year and within 120 days following the last loan disbursement. The statements will be duly audited by an independent audit firm acceptable to the Bank, in accordance with the terms of reference that the Bank agrees upon with the executing agencies.

In the case of the funds executed by the MEFP, this will involve a special purpose financial audit and/or a reasonable assurance. For the funds executed by the MSyD's UGESPRO, program financial statements will be subject to a standard audit.

III. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

☒	Bidding documents	The procurement of works, goods, and nonconsulting services subject to international competitive bidding (ICB) under the Bank's procurement policies (document GN-2349-15) will be carried out using either the standard bidding documents issued by the Bank or those documents agreed upon between the executing agency and the Bank for the specific contract. The selection and contracting of consulting services will be carried out in accordance with the Policies for the Selection and Contracting of Consultants (document GN-2350-15) and will use either the Bank's standard request for proposals or the request for proposals agreed between the executing agency and the Bank for the specific contract. In the case of national competitive bidding, shopping, and individual consultants, a procurement document will be developed and agreed between the relevant national authority and the Bank. The review of technical specifications and terms of reference for contracts during preparation of the selection processes is the responsibility of the project sector specialist. This technical review may be carried out ex ante and is independent of the method of procurement review.
☒	Retroactive financing	The Bank may retroactively finance eligible expenditures of up to US$250 million (50% of the loan amount) for direct transfer payments made by the borrower prior to the loan approval date, provided that requirements substantially similar to those established in loan contract 5376/OC-BO (currently being reformulated) have been met.
☒	Recurrent costs	Recurrent costs financed under the loan and required to initiate the project, as approved by the Project Team Leader, will be carried out in accordance with the executing agency's administrative procedures. The latter will be reviewed and accepted by the Bank as long as they are consistent with principles of competition, efficiency, and economy.
☒	Procurement supervision	Supervision will be conducted on an ex post basis, with the exception of those cases in which ex ante supervision is justified. Where procurement processes are executed through the country system, supervision will be performed through the country supervision system. The supervision method—(i) ex ante, (ii) ex post, or (iii) country system—will be determined for each selection process. Ex post reviews will be conducted every 12 months in accordance with the project supervision plan, which is subject to change during execution. Ex post review reports will include at least one physical inspection visit, selected from among the procurement processes subject to ex post review (no less than 10%). (The inspection will verify the existence of the procurement items, leaving verification of quality and specifications compliance to the sector specialist). Ex post review thresholds will be specified in the program procurement plan.
☒	Records and files	For Component 2 and Subcomponent 3.2, the project execution unit in UGESPRO will be responsible for establishing the controls needed to safeguard and protect the integrity of program documentation generated through ex post or ex ante program execution. The Bank may, at any time, verify the standards of organization, control, and security of the files.

☒	Vaccine procurement	Financing may be provided for bilateral purchases from the laboratories manufacturing the vaccines (e.g., COVID-19, among others), as well as transportation, freight, and insurance expenses for transporting vaccines; fungible inputs for vaccinations; and the equipment needed to strengthen the cold chain associated with the vaccine management and supply chain. The development and implementation of communication strategies may also be financed to promote demand for vaccination.

Main procurements

Description	Selection method	Estimated date	Estimated amount (US$)
Goods			
Procurement of IT equipment (software and hardware) for the Consolidated Health Information System (SUIS)	ICB	Q2 2023	4,000,000
Procurement of virtual servers for the SUIS			2,500,000
Procurement of laboratory equipment and inputs			2,700,000
Procurement of technology equipment to connect laboratories			2,300,000
Procurement of medical equipment for outpatient centers			45,852,500
Procurement of telemedicine equipment for outpatient centers			51,112,500
Procurement of equipment for secondary-level hospitals			24,250,000
Procurement of equipment for telemedicine			10,150,000
Procurement of equipment for tertiary-level hospitals			21,000,000
Procurement of fungible inputs and equipment for the cold chain			4,000,000
Procurement of vaccines	Direct contracting		16,000,000

Description	Selection method	Estimated date	Estimated amount (US$)
Nonconsulting services			
Implementation of communication campaigns	ICB	Q3 2023	1,000,000
Firms			
Development of software for the SUIS	QCBS	Q2 2023	2,350,000
Technical assistance for the SNIS (protocols and training)		Q2 2023	1,750,000
Development of a business intelligence platform		Q2 2024	3,000,000
Development of communication plans in intercultural issues		Q1 2023	500,000

See link for procurement plan.

IV. Agreements and Requirements for Financial Management

☒	Programming and budget	Since the borrower is the Plurinational State of Bolivia, the reformulated operation's funds will be included in the national budget and subsequently transferred to the designated accounts of each executing agency in the Central Bank of Bolivia (Treasury Single Account ledger subaccount). The executing agencies must also include them in their budget. No delays are expected that could affect budget execution.
☒	Treasury and disbursement management	**Special fiduciary conditions for the first disbursement are as follows: (i) for Component 1 and Subcomponent 3.1**, appointment of the technical coordinator and financial staff. **For Component 2 and Subcomponent 3.1**, which are to be executed by the MSyD, creation of a project execution unit in UGESPRO with technical, administrative, fiduciary, and legal autonomy and specialists with experience in IDB financial and procurement policies. **The fiduciary condition relating to execution for Component 2 and Subcomponent 3.2** will be to include the following elements in the project Operating Regulations: (i) flowcharts of the main processes in the integrated project management cycle, including (a) organizational charts for the participating units; (b) details of the units involved, the positions responsible, time frames, and documents / deliverables; (c) flowcharts; (d) procedures; and (e) a list of bottlenecks. **The exchange rate** for accounting purposes will be the rate in effect on the date that the borrower, executing agencies, or other natural person or legal entity to whom spending authority has been delegated makes the respective payments or transfers. (Article 4.01(b)(i) of the General Conditions).

		The disbursement method will consist of advances of funds and/or reimbursements. **The disbursement mechanism** will consist of the submission of online disbursement requests using the Online Disbursements platform. **Bank account:** The borrower/executing agencies will keep the advanced funds in a U.S. dollar bank account in the Central Bank of Bolivia to be used exclusively for the program and the receipt of disbursements. This will be controlled/reconciled through the Treasury Single Account ledger subaccount (the designated account). **Financial plan:** Advances will be for periods of up to six months (180 days), depending on liquidity requirements for adequate project execution based on actual acquired commitments. **The percentage for the rendering of accounts** will be 80% of the advances pending substantiation. **Cash flow:** The funds will be disbursed to each executing agency's account in the Central Bank of Bolivia, from where they will be transferred as payments for goods and services to contractors/suppliers.
☒	Accounting, information systems, and reporting	The specific accounting standards for execution of the **reformulated** project will be those included in the regulatory framework of the Plurinational State of Bolivia. The accounting reports will be the Statement of Cash Receipts and Disbursements and the Statement of Cumulative Investments, with their respective notes, prepared on the basis of the accounts generated by the public financial information system (SIGEP). **Accounting method and currency:** Accounts will be kept on an accruals basis, but the financial reports to be submitted to the Bank will be prepared on a cash basis in U.S. dollars.
☒	Financial supervision of the operation	Given the medium-high financial management risk associated with the **reformulated** operation, financial supervision will be conducted through: (i) at least one comprehensive visit to the executing agencies and other institutions involved in executing the operation, in the first six months of project execution; (ii) work meetings; and (iii) a desk review of the audited financial statements, inter alia, carried out by the Bank's financial management team, support consultants, and the audit firm contracted to carry out the annual audit of program financial statements. Supervision may be adjusted based on experience in executing the program.[1]

[1] Opinions on the annual audited financial statements and internal control comments/findings, where applicable.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/22

Bolivia. Modification to the project “Support for Vulnerable Populations Affected by Coronavirus II” (Modification to Loan 5376/OC-BO)

The Board of Executive Directors

RESOLVES:

1. To approve the modification to the project “Support for Vulnerable Populations Affected by Coronavirus II”, in accordance with the terms and conditions established in document PR-4924-1.

2. 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, to implement the modification to which reference is made in paragraph 1.

(Adopted on ___ _____ 2022)

LEG/SGO/CAN/EZSHARE-1720032226-17286
BO-L1219 - Modification